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Pepperdine University
Graduate School of Education and Psychology

RELIGIOUS/SPIRITUAL BELIEFS AND PRACTICES OF ASIAN/ASIAN
AMERICAN MENTAL HEALTH PROFESSIONALS & STUDENTS AND THE
IMPACT ON TREATMENT

A clinical dissertation submitted in partial satisfaction
of the requirements for the degree of
Doctor of Psychology

by

Georgia Yu

April, 2013

Edward P. Shafranske, Ph.D., ABPP – Dissertation Chairperson

This clinical dissertation, written by

Georgia Yu

under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

Doctoral Committee:

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DEDICATION

To my family

ACKNOWLEDGEMENTS

First and foremost, I would like to thank my dissertation chairperson, Dr. Edward Shafranske, for his continued guidance, commitment, and knowledge in shaping me to become a better researcher and critical thinker.

I would also like to thank my committee members, Drs. Yuying Tsong and Gene Ano, for their contributions, dedication, and energy.

To my parents: thank you for supporting me through my professional career. To my cohort, classmates, and alumni: I could not have survived graduate school without you all. A special thanks goes to Chris and Gina Howells: for sharing in the many heartaches and tears that were crucial to this process. To my internship “wives,” Saira, LaKeyetta, and Kim: I’m glad I survived the year with you ladies. Finally, to my significant other, Rod: thank you for being my rock, for cheering me on every step of the way, and sharing in each small accomplishment.

VITA

Georgia Yu, M.A.

EDUCATION

Doctoral Student in Clinical Psychology
Pepperdine University, an APA-accredited Psy.D. program – Los Angeles, CA
Dissertation: *Religious and Spiritual Beliefs and Practices of Asian/Asian American Mental Health Professionals and the Impact on Treatment*

Master of Arts in Clinical Psychology May 2006
Teachers College, Columbia University– New York, NY

Bachelor of Arts in Psychology August
2004Rutgers College, Rutgers University – New Brunswick, NJ

CLINICAL TRAINING EXPERIENCE

Post-doctoral Fellow September 2012-current

Desert Psychological Services

- Conduct psychological, psycho-educational, and vocational rehabilitation evaluations for diagnostic clarification and treatment planning
- Provide individual and family therapy to clients who have been in the foster care system
- Run a differential diagnosis group twice to three times per month for social work interns and practicum students to develop assessment and case conceptualization skills
- Attend trainings facilitated by Desert Psychological, the Department of Family Services, Legal Aid, and other contracting agencies
- Receive weekly supervision individually and in a group format
- Supervise psychology practicum students in assessment and clinical training opportunities
- Trained in providing compensation and pension examinations through the VA system
- Assist in linking clients to basic skills training and psychosocial rehabilitation services to enhance treatment outcome
- Engage in program development activities such as the development of an internship program at an affiliated residential treatment facility and social skills training group for Vocational Rehabilitation clients

Pre-doctoral Intern September 2011-August 2012

Berea Children's Home and Family Services, an APA-accredited internship

- Early Childhood Mental Health (major rotation)
 - Carried a caseload of 8-12 clients and provide in-home services
 - Attended weekly individual supervision meetings focused on the conceptualization of clients from a developmental trauma model and additional clinical issues

- Conducted Early Childhood Mental Health Assessments and utilize the Marschak Interaction Method and Achenbach Child Behavior Checklist (ages 1½-5) to assess the family's presenting concerns
- Developed the client's Individual Service Plan to identify problems and needs and interventions for treatment
- Provided early interventions and family therapy (e.g., Theraplay, TF-CBT, Solution-Focused Brief Therapy, Nurturing Parenting)
- Provided linkages to and consulted with referral sources and other service providers
- Psychological Evaluation (major rotation)
 - Utilized a wide array of measures to assess for cognitive functioning, academic functioning, executive functioning, adaptive functioning, reality testing, and socio-emotional functioning concerns
 - Reports were completed to clarify diagnosis, provide treatment recommendations, assess trauma on client's functioning, and determine additional treatment needs upon discharge
 - Provided verbal feedback and written reports to children, families, and other professionals
 - Provided weekly supervision to a doctoral-level practicum student in the area of test administration, scoring, and report-writing
 - Attended weekly supervision of supervision and individual supervision meetings
- Group Therapy
 - Co-facilitated an anger management group for 8-10 adolescent males in a residential setting
 - Attended weekly group supervision to discuss group process and review relevant literature
- Diversity Didactics
 - Attended twice monthly meetings to utilize the guidelines for multicultural education and training within individual and group work
 - Examined individual attitudes and beliefs about race, ethnicity, and clinical issues in the context of a multicultural organization and community
- Open Didactics
 - Attended ongoing lecture series covering a wide range of clinical issues related to the practice of professional psychology (e.g., family-based and parenting interventions, child-led play therapy, consultation, developmental trauma, executive functioning, art therapy, couples therapy, and program evaluation)
- Professional Conduct and Ethics Didactics
 - Attend 6 two-hour meetings to cover professional conduct and legal/ethical issues related to professional psychology (e.g., licensure, professional responsibility and documentation, managed care models, and administrative competency)
- Scholarly Inquiry and Application
 - Developed and delivered a professional training on vicarious trauma which was presented at the Cleveland Psychological Association (May, 2012)
- Formal Case and Dissertation Presentations
 - Completed a formal case presentation involving a case conceptualization and discussion of socio-cultural and clinical issues; and a dissertation presentation involving the topic and process

Doctoral Practicum ExternHELP Group-UCLA/Neuropsychiatric Institute

August 2010-July 2011

- Administered, scored, and interpreted a wide range of test measures including but limited to cognitive functioning, adaptive functioning, academic achievement, executive functioning, language, learning and memory, visuomotor integration, and socio-emotional functioning
- Wrote comprehensive neuropsychological reports by integrating information gathered from the clinical interview, behavioral observations, and test results
- Participated in parent intake to identify the reasons for referral and feedback sessions to discuss treatment recommendations
- Attended weekly didactics in pediatric neuropsychology, functional neuroanatomy, and Neuropsychology Brown Bag Lunch series (NIBBL)
- Attended individual and group supervision once per week to discuss and conceptualize clinical cases
- Completed professional readings in adult and pediatric neuropsychology topics

Doctoral Practicum ExternPepperdine Counseling Clinic

September 2007- August 2011

- Conducted intake interviews with adults presenting with various symptoms and concerns
- Administered and interpreted clinical measures assessing current level of functioning as well as follow-up measures to assess symptom reduction
- Provided ongoing individual therapy to help clients develop better coping skills and gain insight into their current concerns
- Provided educational therapy for children with academic and related emotional concerns
- Participated in two years of weekly case conference with other therapists, peer supervisors and clinic supervisors, to develop treatment plans and discuss legal and ethical issues
- Maintained and completed all relevant chart materials and records for clients in order to track progress and prepare for any transfer of documents to another facility
- Administered, scored, interpreted and conducted a comprehensive psychoeducational battery

Doctoral Practicum ExternBehavioral Assessment & Treatment Clinic, Child & Adolescent Psychiatry

Harbor-UCLA Medical Center

September 2009-August 2010

- Conducted clinical interview with primary treatment providers and auxiliary mental health professionals regarding client's behavioral concerns and reviewed records
- Consulted with family to identify client's strengths, family routines, schedules of reinforcement, and obtained detailed history
- Conducted classroom assessments utilizing an interval-based data collection system
- Performed home assessments utilizing the Positive Environment Checklist (PEC)
- Reviewed professional readings in evidence-based treatments for children with disruptive behaviors
- Prepared the assessment report, with special attention to: functional behavioral assessment and service delivery recommendations
- Conducted feedback sessions with caregivers
- Consulted weekly with primary treatment providers on behavioral intervention plan
- Provided case management for referrals (Department of Mental Health paperwork)

Behavioral TherapistAutism Spectrum Therapies

October 2008- August 2009

- Provided Applied Behavioral Analysis/Pivotal Role Techniques with children ages 2-9 with autism three times per week
- Collected data detailing frequency of functional behaviors
- Completed weekly session notes and monthly summaries to track progress of children's behaviors

Fieldwork TraineeMount Sinai Medical Center

September 2005-May 2006

Psychiatric Day Treatment Program

- Provided individual counseling for out-patient adult patients with schizophrenia and comorbid disorders
- Participated and led weekly group meetings in social skills training and weight management strategies

Fieldwork TraineeHarlem Family Institute

February 2005-May 2006

- Provided individual play therapy sessions for children and adolescents referred through a foster care agency and local elementary school in East Harlem once per week
- Attended supervision meetings twice per week to discuss clinical cases
- Attended courses and reviewed professional readings in child/adolescent development, assessment and diagnosis, psychoanalytic theories, and play therapy techniques

Fieldwork TraineeRutgers University, Douglass Developmental Disabilities Center

January-May 2004

- Worked one-on-one with students ages 17-21 with autism three times per week
- Implemented individualized Applied Behavioral Analysis programs to increase students' academic and occupational skills

Undergraduate Community & Applied Psychology InternBartle Elementary School-Rutgers University

September 2003-May 2004

- Provided on-site training and implementation of a social decision-making skills lab in an elementary school
- Worked with 3-5 students individually on a weekly basis to increase prosocial behaviors
- Senior Project: Created a social skills training group for children with anger management concerns

Undergraduate Community & Applied Psychology InternHead Start Program-Rutgers University

January-May 2003

- Assisted head teacher in working with pre-school children
- Taught and enriched children in various disciplines including art, music, and literature

PROFESSIONAL EXPERIENCE

Peer Supervisor

Pepperdine Counseling Clinic

2010- August 2011

- Met with two Psy.D. (first and second year) students on a weekly basis to help increase their clinical and case management skills through videotaped therapy sessions and review chart notes
- Attended case conference to provide support in clinical conceptualization and address diagnostic and treatment recommendation questions
- Carried clinic emergency pager and provide ongoing crisis intervention training and services

Comprehensive Assessment Examination Peer Supervisor

Pepperdine Counseling Clinic

September 2010- August 2011

- Provided support to third year students completing required comprehensive assessment report
- Attended weekly supervision meetings to discuss clinical cases
- Provided training and review of test administration, scoring, and interpretation
- Reviewed students' reports prior to submission to the assessment committee

Research Assistant

Pepperdine University

September 2010-August 2011

- Assisted with appendices and tables for edition of Rapid Psychological Assessment, a professional reference and graduate-level textbook
- Collected relevant journal articles and library resources

Teaching Assistant

Pepperdine University

June 2010

Instructor: Keegan Tangeman, Psy.D., PSY 603 Assessment for Marriage and Family Therapists

- Assisted in lecture preparation and classroom demonstrations of the FAM-III and MSI-R measures
- Fielded students' questions regarding test administration and report-writing
- Assisted in scoring and grading students' assignments and tests

Teaching Assistant

Pepperdine University

September 2009-August 2010

Instructor: Linda Nelson, Ph.D., PSY 601 Cognitive Assessment

- Reviewed and scored masters' students WAIS-IV/WISC-IV reports
- Created scripts and participated in classroom demonstrations of test administration and scoring
- Maintained and organized weekly lecture notes
- Fielded students' questions regarding test administration and report-writing
- Scored midterm and final exams and reviewed students' testing reports

Graduate AssistantPepperdine University, APA Dissertation Support

August 2008-December 2009

Director: Regina Meister

- Edited education and psychology students' dissertation for appropriate APA formatting
- Drafted and submitted review and clearance letters to students
- Maintained records on database

Graduate AssistantTeachers College, CEPS

September 2004-May 2006

- Assisted clerical staff with responsibilities of daily operations at the Center for Educational and Psychological Services (CEPS)
- Provided outreach by contacting various mental health agencies as potential referrals
- Screened requests for psychological/educational services
- Provided referrals to clients for psychological and/or psychoeducational services
- Provided administrative assistance such as filing, typing, answering phones, and organizing materials in the main office and batteries in the testing library

RESEARCH EXPERIENCE**Research Assistant**New York University, Department of Applied Psychology

October 2006-August 2007

- Coded baseline and post-intervention child/caregiver interactions utilizing the Interact software
- Scheduled and led classroom observations using an interval-based data collection system
- Provided administrative and technical support to the program manager and principal investigator
- Participated in weekly team meetings

Research AssistantTeachers College, Columbia University (Adjustment Lab)

June 2005-May 2006

- Compiled and aggregated data on college adjustment
- Attended weekly lab meetings
- Brainstormed ideas and performed literature searches for possible paper topics

Research AssistantTeachers College, Columbia University (Child Psychopathology Lab)

January-May 2005

- Used Access program for data entry/collection
- Attended weekly lab meetings
- Analyzed data set using SPSS software

Research AssistantRutgers University (Community Psychology Lab)

May 2003-May 2004

- Interviewed middle school students for Laws of Life essay contest
- Implemented social-emotional learning program in middle schools in Plainfield, New Jersey
- Imported data using SPSS software program

Research Assistant

Center for Alcohol Studies, Rutgers University

February-August 2002

- Traced lateral ventricles of children with pervasive developmental and bipolar disorders
- Studied the brain structures comparing children with autism and those without autism

PROFESSIONAL DEVELOPMENT

- Teachers College, Winter Round Table on Cultural Psychology and Education, 2005
- Group presentation on diagnostic considerations and behavioral characteristics of schizophrenia to staff members at The Union Rescue Mission (LA), a faith-based treatment program, 2007
- Asian American Psychological Association- Division of Women, Regional conference, 2008
- Presentation on diagnostic considerations and treatment recommendations of Reactive Attachment Disorder of Infancy or Early Childhood, Harbor-UCLA Medical Center, Behavioral Assessment and Treatment clinic seminar, 2010

PROFESSIONAL ASSOCIATIONS

American Psychological Association, APAGS Member (2007-current)

Multicultural Research and Training Lab, Pepperdine University, 2007-2008

CAPS West- Christian Association for Psychological Studies, 2007-2008

Asian American Psychological Association member, 2008-current

AWARDS

Psy.D. Diversity Scholarship, 2007-2010

GSEP Colleagues' Grant, 2007-2010

London Royal School of Music, Teaching Certificate (piano & theory), May 2000

PUBLICATION

Contributor, Encyclopedia of Cross-Cultural School Psychology, January 2011

Entries: Childhood; Cultural Enmeshment; Ego Identity Statuses, GAF; Gender Bias; Personality Disorders; Personality Tests; Schizophrenia; Social Skills

Editor-in-Chief: Caroline Clauss-Ehlers, Ph.D., Rutgers University Graduate School of Education

ABSTRACT

Religion and spirituality is often an overlooked feature of culture and diversity. Robust research suggests that that religion and spiritual beliefs and practices of clinicians and clients can influence the treatment process and provide benefits to overall mental health and psychological well-being. This dissertation study provides an overview of the religious and spiritual beliefs, practices, and affiliations of psychologists compared to the general population. A specific focus is placed on that of mental health professionals and students of Asian and Asian-American descent, particularly given the religious and spiritual diversity among this ethnic group. Despite nearly 3 decades of research among Asians and Asian Americans, there is still very little known about this group of mental health professionals and how religious and spiritual belief systems and practices influence education, training, and service provision. This study found that individuals generally endorsed a higher degree of spiritual rather than religious salience, which was consistent with national surveys of psychologists but slightly less than the general population. Furthermore, specific education and clinical training experiences did not appear to have an effect on individuals' religious and spiritual beliefs, nor did they feel religious/spiritual issues were addressed frequently or adequately. These findings may increase insight into how specific populations of clinicians and students address religious/spiritual beliefs and practices in their personal and professional lives and how to best increase sensitivity of diversity issues in this area.

Introduction

It is widely acknowledged that culture plays a critical role in mental health, including having impact on the delivery and effectiveness of psychological services. Religion and spirituality as features of culture have been identified to uniquely contribute to the therapeutic process. Therefore, effects are needed to be taken to advance our understanding of the influence of culture, including religion and spirituality, on clinical practice. We begin with a brief discussion of culture.

Culture is defined as a broad set of beliefs, norms, and values and refers to the shared characteristics of a particular group (Lawrence, 2002; Thompson, 2008). Culture is an important area of consideration because it impacts what all individuals bring into the clinical setting, and accounts for the variations in treatment outcomes and therapy processes (Thompson, 2008). Culture is “the mediating element between the structural and personal; it is a structure, in a sense, since it has a power that is hard to resist, but yet cultural values and behaviors involve some choice” (Jindra, 2007, p. 73). Falicov (1995) further asserts the idea of a *multidimensional position* in which one addresses additional contextual variables. Falicov provides an alternative definition of culture as:

those sets of shared world views, meanings and adaptive behaviors derived from simultaneous membership and participation in a multiplicity of contexts, such as rural, urban or suburban setting; language, age, gender, cohort, family configuration, race, ethnicity, religion, nationality, socioeconomic status, employment, education, occupation, sexual orientation, political ideology; migration and stage of acculturation. (p. 375)

Having cultural values and beliefs refers to a complex interplay of various contexts in which an individual is involved and adheres.

A 2002 American Psychological Association (APA) document, *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists*, addressed the diversity issues specific to the professional practice of psychology. These guidelines outline principles psychologists should keep in mind when working with culturally diverse individuals, such as: (a) Guideline 2: “Psychologists are encouraged to recognize the importance of multicultural sensitivity/responsiveness, knowledge, and understanding about ethnically and racially different individuals” (APA, 2002, p. 25) and; (b) Guideline 3: “As educators, psychologists are encouraged to employ the constructs of multiculturalism and diversity in psychological education” (APA, 2002, p. 30). According to these professional guidelines, *culture* is defined as:

the belief systems and value orientations that influence customs, norms, practices, and value orientations that influence customs, norms, practices, and social institutions, including psychological processes (language, care taking practices, media, educational systems) and organizations (media, educational systems)...Inherent in this definition is the acknowledgment that all individuals are cultural beings and have a cultural, ethnic, and racial heritage. *Culture has been described as the embodiment of a worldview through learned and transmitted beliefs, values, and practices, including religious and spiritual traditions* [emphasis added]. (APA, 2002, p. 8)

Furthermore, the APA policy statement on Evidence-Based Practice in Psychology requires that “patients’ characteristics, values, and context...[including] sociocultural and

familial factors” (APA, 2005, p. 2) be considered when providing psychological services. However, there continues to be a surprisingly “limited exposure to diversity” (Green, Callands, Radcliffe, Luebbe, & Klonoff, 2009, p. 1058) within most graduate programs, despite the continuing interest and importance of multicultural competence in working with more diverse populations. The Green et al. (2009) study, which surveyed over 400 clinical psychology doctoral students, indicated that students primarily identified narrow facets of diversity such as ethnicity, race, and gender with “very few...explicitly [identifying] disability, nationality, education, or language in their definitions of diversity” (p. 1066). This study suggests that there is a need for a stronger push for multicultural competence, with more research and clinical experiences available for students to be exposed to various populations. Sue and Sue (2003) and other critiques (e.g., Betancourt & López, 1993) argue for increased consideration of the role of culture in clinical application as well as in research.

Religion as a Dimension of Culture

Religion and spirituality are often disregarded as salient or minimized as important aspects of the cultural context even when understanding the cultural identity of an individual is undertaken (Tarakeshwar, Stanton, & Pargament, 2003). For example, Green et al. (2009) study reported that unfortunately, there “continues to be a bias associated with the conceptualization of diversity. Specifically, areas such as religion, physical disabilities, and language continue to receive less attention in research, clinical training, and curricula” (Green et al., pp. 1068-1069; Hage, 2006). Furthermore, a person’s religious and spiritual beliefs and practices should not be viewed as isolated features of his or her identity rather they should be considered in light of their interaction

with other multicultural identities (Smith & Richards, 2002). This is particularly important when one examines the similarities between religion and culture. The complexity with which religion and spirituality interface with other dimensions of one's cultural being cannot be discredited or separated from other individual factors.

Fukuyama and Sevig (1999) contend that, "In many cultures, spiritual or religious concerns are not separated from physical, mental health concerns [and] [s]piritual forces are believed to be related to illness or psychosocial distress" (p. 13). Spiritual belief systems are embedded within most ethnic traditions. Fukuyama and Sevig posit, "the multicultural-spiritual interplay continues in a spiral fashion as one becomes multiculturally competent - in short, spiritual values can help one become multiculturally competent" (p. 75). Fukuyama, Sevig, and Soet (2008) also suggest that researchers and practitioners in multicultural psychology have become more aware of the relevance of religiosity and spirituality within and across cultures and their impact on client mental health; however, efforts to increase awareness throughout the field of psychology is required.

Such a recommendation is in keeping with requirements set forth by APA. Their Code of Ethics (2002a) clearly states that psychologists should include religion in their consideration of diversity factors. Specifically the Code states:

Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status and consider these factors when working with members of such groups. (APA, 2002a, p. 1063)

This guideline as well as those guidelines set forth in the *Multicultural Guidelines* (APA, 2002b), including its definition of culture, underscore and acknowledge the inclusion of religious and spiritual beliefs and practices with other diversity factors. In addition, the American Psychological Association passed in 2007 the *Resolution on Religious, Religion-Based and/or Religion Derived Prejudice*, which emphasizes the collaboration between, rather than divergence from, the fields of psychology and religion and commented on psychologists' role as clinicians and social advocates in understanding and facilitating discourse regarding persons discriminated based on their religious preferences and/or affiliation. This resolution stated, "...evidence exists that religious and spiritual factors are under-examined in psychological research both in terms of their prevalence within various research populations and in terms of their possible relevance as influential variables" (APA, 2007, para. 11). Other professional bodies, for example, the Joint Commission on the Accreditation of Health Organizations (Meyerstein, 2004) and the Association for Spiritual, Ethical, and Religious Values in Counseling ([AERVIC], Fukuyama et al., 2008), emphasize the integration of spirituality into clinical practice. Such recommendations and policy statements reflect the growing appreciation of the important role religion and spirituality serves in mental health and in treatment. Pargament and Saunders (2007), following their reviewing of the psychology and religion literature, conclude that "there is a spiritual dimension to human problems and solutions," (p. 904; see also Pargament, Magyar-Russell, & Murray-Swank, 2005), and that this cultural element can be the source of or solution to the client's presenting concerns (Pargament, 2002). Finally, studying the associations between religion and mental health provide a justification for viewing religious and spiritual values of clients

as important cultural variables to consider and a possible resource in therapy (Bergen, Payne, & Richards, 1996; Carone & Barone, 2001). The following sections address specific ways in which psychology, religion, and spirituality intersect, including the concept of sanctification, the interaction of religion/spirituality and mental health, and client and clinician characteristics.

Religion and Mental Health

Within the last few decades, many studies have been conducted to examine the associations between religiosity and spirituality with mental and physical health outcomes. Based on a review of several major meta-analyses, a robust finding within the research has yielded positive associations between religious and spiritual beliefs and practices with psychological and physical well-being (Aukst-Margetić & Margetić, 2005; Belzen, 2004; Dezutter, Soenens, & Hutsebaut, 2006; Jones, 2004; Koenig, 2009; Lee & Newberg, 2005; Moreira-Almeida, Neto, & Koenig, 2006; Oman & Thoresen, 2005; Pargament & Saunders, 2007; Powell, Shahabi, & Thoresen, 2003; Smith, Bartz, & Richards, 2007; Williams & Sternthal, 2007). While a substantial amount of literature point to significant improvements in psychological adjustment and physical health, researchers have also identified spiritual risk factors that may contribute to poor mental and physical health such as “feelings of anger toward God, conflicts with congregation and clergy, and spiritual doubts and confusion” (Pargament & Saunders, 2007, p. 904). However, it should be noted that in general, studies conducted of individuals of various ethnic backgrounds, in clinical and non-clinical settings, and different geographical locations support the claim that religious involvement has a positive effect on decreased negative affective states and increased coping strategies (Koenig, 2009). Table 1 presents

the physical and mental health outcomes related to various aspects of religious and spiritual resources and involvement.

Progress has been made to disengage religious thought as a component of psychopathology in recent revisions of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)* published by the American Psychiatric Association, which “exhibits a great sensitivity to religious belief and omits any potentially offensive references to religious belief” (Thielman, 1999, p. 17). Thus, “religious or spiritual problem” is recognized as a “pervasive influence on people’s lives and [is] now included as a separate category” (Haque, 2001, p. 248), which further points to a prerequisite for clinicians to be adequately trained and competent in religious and spiritual issues (Delaney, Miller, & Bisonó, 2007; Johansen, 2010).

Sanctification and its Implications

In addition to associations with physical and mental health, religion and spirituality also play an important role how people generally make sense of their lives and find value. According to Pargament (1997), religion is defined as “a search for significance in ways related to the sacred” (p. 34). A fundamental aspect of religiosity and spirituality is how individuals find meaning and are able to preserve and transform what they consider to be sacred in their lives (Pargament, 1999). This process, in which “aspects of life are perceived as having divine character and significance,” (Pargament & Mahoney, 2005, p. 183) is characterized as sanctification. Sanctification can be perceived as either theistic or non-theistic. Objects or experiences can be perceived as symbols, images or beliefs about God, be imbued with divine qualities, or both (Pargament & Mahoney, 2005). How each individual constructs the nature of the sacred

is not an arbitrary, rational choice. Rather, it includes understanding or experience that transcends reality and cannot be explained logically. For many persons their determination of what is sacred in life may be connected to religious affiliation, traditions, and/or cultural values (Pargament & Mahoney, 2005).

Several implications have been identified as a result of the sanctification of certain life experiences and events. Certain spiritual emotions may be elicited, such as feelings of adoration, gratitude, awe, or humility (Pargament & Mahoney, 2005). Loss of sacred objects or experiences may also cause individuals to experience negative personal or emotional consequences, such as guilt, shame, or feelings of vulnerability (Pargament & Mahoney, 2005). Results from one study of a community sample of 150 adults indicated that among the various short-term and long-term goals participants pursued in their daily lives: (a) there were varying degrees of sacred qualities across individuals; (b) goals that were not explicitly religious or spiritual had some dimension of sanctification (e.g., significance or spiritual character); (c) goals that were perceived to be more sanctified involved more investment, motivation, and satisfaction; (d) sanctification was also linked to more positive social supports; and (e) stronger religious beliefs was evidenced by greater personal accountability and responsibility in achieving those goals (Pargament & Mahoney, 2005).

In underscoring that religious and spiritual value and significance is important to individuals day to day, it is crucial to consider how various religious and ethnic groups consider sanctification in their personal and professional lives (Pargament & Mahoney, 2005). These relationships should also be considered within and between cultures in order to gain a better understanding of “tolerance and intolerance of the sacred matters of

other groups” (p. 194). This is also the case in therapeutic relationships in which clinicians and clients may have similar or different approaches to personal meaning and sanctification.

Clinician and Client Characteristics

The concept of culture should not be restricted to simply understanding clients, but also to the clinicians who work with them (Thompson, 2008). Groups of mental health practitioners also develop their own set of shared beliefs, values, and norms, thus embodying a professional *culture*. Clients come in with their own unique cultural characteristics which impact the service provision and mental health outcomes. The systemic culture of the mental health services interacts with the clinician by influencing how a client is diagnosed, treated, and able to have access to and finance services (Thompson, 2008).

While scholarship has continued to focus on the incorporation of spiritual and religious interventions in therapy and understanding the religious and spiritual dimensions within a client’s background, little has been studied to understand the relationship between the clinician’s cultural identity and how it impacts the consideration of religious and spiritual aspects in the therapeutic relationship and service provision (Carone & Barone, 2001; Pargament & Saunders, 2007; Shafranske, 2005). A recent meta-analysis conducted by Smith et al. (2007) reviewed 31 outcome studies to assess the impact of spiritual treatments on psychological variables. Overall, results indicated that spiritual interventions were effective and that there was a greater impact on measures of psychological well-being compared to other measures assessing mental health symptoms. The study’s authors highlighted several major limitations including the large percentage

of Christian clients (73%), citing that it could not determine the extent to which individuals of other religious faiths would benefit from spiritual interventions. In addition, the analysis could not demonstrate differences across ethnicities due to the predominantly Caucasian sample. In reviewing studies of culturally competent interventions, Sue, Zane, Nagayama-Hall, & Berger (2009) also stated that most studies have been conducted on African-American and Hispanic samples, with very few including American Indians and Alaskan Natives.

Finally, only recently has greater emphasis been placed on variable-focused studies that examine how specific psychological elements associated with ethnic or cultural group differences affect treatment or moderate treatment effectiveness. This shift to study cultural variables such as cultural value orientation, cultural identity, shame and stigma, and so forth, has allowed us to better explain and understand the specific effects of cultural influences (Jeung, 2010; Zane, Morton, Chu, & Lin, 2008). Much of the research have looked at the importance and impact of religiosity and spirituality among the African-American, Hispanic, and Native American communities (de las Fuentes, 2003; Dudley-Grant, 2003; Zane et al., 2008), with the bulk of the research being conducted with White Christians utilizing convenience samples such as college students (Paloutzian & Park, 2005).

More culturally responsive and ethnically-sensitive care is needed among the psychological community to meet the increasing demands of a changing demographic. This continues to be a challenge as mental health professionals continue to obtain a core knowledge base and sensitivity towards diverse issues while at the same time developing specific skills. Moreover, there continues to be a need for research to assess the

relationship between competency among psychologists and actual treatment processes and outcomes (Abreu, Chung, & Atkinson, 2008; Delaney et al., 2007; Ponterotto & Mallinckrodt, 2007). The field of psychology has become more open to the idea of religion and spirituality due to openness and interest to explore other paradigms such as positive psychology and the inclusion of Eastern religions. However, clinicians continue to report that they are still ill-equipped to include religious and spiritual issues in psychological assessment and treatment (Delaney et al., 2007; Kahle & Robbins, 2004; Pargmanent & Saunders, 2007; Shafranske, 1996, 2005). Even as more graduate training programs are integrating predominantly Christian teachings and psychology than other world religions, there is still a lack of formal training in diversity issues, whether it is a cursory course in multicultural and sociocultural issues or a broad overview of multicultural competence (Green et al., 2009; Hage, 2006; Haque, 2001). However, journals and clinical programs are becoming more integrative, reflecting a growing need and support for competency in the area of spirituality and religion (Haque, 2001).

Much of the research has focused on the utilization of spiritual and/or religious interventions in psychotherapy (Pargament & Saunders, 2007). However, unlike a dyadic relationship, this research appears to be one-sided. In other words, it is also important to understand the therapist's cultural identities and how they impact the therapeutic relationship, treatment planning and recommendations, and ultimately treatment outcomes. These observations further draw attention to the need for more research regarding the salience of religious and spiritual beliefs of ethnically and racially diverse mental health professionals. Furthermore, while many studies conducted have explored how religion and spirituality are important in clients' lives in terms of coping and

reducing psychological stress and focused on clients' beliefs, only a handful of studies within the last 20 years have investigated the religious and spiritual attitudes of psychologists and other mental health professionals (Kahle & Robbins, 2004; Sorenson & Hales, 2002; Wagenfeld-Heintz, 2008). Moreover, what we can learn from research by studying client samples of various ethnic groups is the importance and impact religious and spiritual beliefs and practices may have on the therapeutic process and in coping with psychological stressors (Kahle & Robbins, 2004). Additionally, to simply consider the client characteristics on treatment outcome would be a disservice to the idea of the therapy process, which requires the examination of the interaction between client and therapist cultural values.

Psychologists' R/S Beliefs and Practices

Studies have shown that psychologists are much less religious than the general population (Bergin & Jensen, 1990; Delaney et al., 2007; Kahle & Robbins, 2004; Shafranske, 1996, 2000; Shafranske & Malony, 1990a, 1990b; Smith & Orlinsky, 2004). Psychologists are also much less spiritual than the general population (Bergin & Jensen, 1990; Delaney et al., 2007; Plante, 2008; Shafranske, 1996, 2000; Shafranske & Malony, 1990a, 1990b; Smith & Orlinsky, 2004). However, the research also suggests that a majority of psychologists did profess religious and spiritual beliefs and felt that these personal religious beliefs were important (Bilgrave & Deluty, 2002; Delaney et al., 2007). While overall, a majority of those surveyed felt that religion was beneficial (82%) rather than harmful (7%) to overall mental health (Delaney et al., 2007), these results are interesting given the lack of training in religious and spiritual issues within the framework of multicultural competence (Delaney et al.; Richards & Bergin, 2000;

Shafranske & Malony, 199a, 1990b). While the research points to psychologists finding ways to become more cognizant of their own views of religion and spirituality and how they potentially impact their work, the inclusion of religion and spirituality into training appear to be a “secondhand observation- than an undeserved population happens to be religious- rather than a formal discussion of the beliefs and behaviors of religious affiliated individuals” (Yarhouse & Fisher, 2002, p. 172).

Even though psychologists are considered less religious than the general public, which is consistent with other studies, they do believe that a religious belief system is personally important. While the investigation of religious and spiritual attitudes of psychotherapists is an important area of research, many of these major studies have not considered the inter-relationship between religious orientation and ethnicity (Bergin & Jensen, 1990; Delaney et al., 2007; Shafranske, 1996, 2000; Shafranske & Malony, 1990a, 1990b; Smith & Orlinsky, 2004). Many of the participants surveyed were predominantly White and research variables did not take into account the role of ethnicity- or identified the ethnicity of the participants- and its interaction with religious attitudes and beliefs. Thus, if multicultural competence is indeed important in understanding the therapeutic process and relevant in clinical practice, then one needs to understand if there is a difference among White and non-White psychologists’ attitudes and beliefs about religiosity and spirituality. A literature review in the areas of religious and spiritual beliefs among psychologists and graduate students can be found in Appendices A and B.

Cultural and Religious Diversity of AAs and the U.S. Population

It is becoming increasingly important to have an appreciation and awareness of multicultural issues, particularly when the growing population is becoming more diverse. According to trends projected by the Pew Research Center (2008) within the next 50 years, nearly 20% of the United States population will be foreign-born, compared to just 12% in 2005. The Hispanic population, which is currently the nation's largest minority group, will constitute almost 30% of the population in 2050, with "births in the United States play[ing] a growing role in Hispanic and Asian population growth" (Pew Research, 2008). Compared to other racial and ethnic groups, the non-Hispanic white population will increase much slowly and will become a minority, at approximately 47%, by 2050 (Pew Research, 2008). The U.S. Census (Kimko, 2010; Liu, Murakami, Eap, & Nagayama-Hall, 2009; UCLA Asian American Studies Center [UCLA AACS], 2010; U.S. Census Bureau, 2010a, 2010b) further reports that Asian Americans and Pacific Islanders are among the fastest growing ethnic group, comprising of approximately 5% of the United States population. Six major ethnic groups constitute this diverse racial/ethnic group, with Chinese-American as the largest, followed by Filipinos, Asian Indians, Vietnamese, Korean, and Japanese subgroups (Chen & Kelly, 2010; UCLA AACS, 2010). Those that consist of 2% or less of the Asian American population include Cambodians, Laotians, Pakistanis, Thai, Hmong, Taiwanese, Indonesian, and Bangladeshi. Included in this group are also Sri Lankans, Nepalese, Malaysian, Burmese, Okinawan, and Tibetan (Chen & Kelly, 2010), many of which have continued to contribute to the increase in the Asian American population recently.

An increasingly diverse national make-up has resulted in more first-generation and beyond who are “not of European ancestry and do not speak either a German language (including English) or a Slavic language as their first language” (United States demographics, 2010, para 1). Following the second most commonly spoken language, Chinese, are Tagalog, Vietnamese, and Korean (UCLA AACS, 2010). To add to the complexity of the various ethnic and linguistic considerations is the multitude of religious separate and combined entities that is part of the Asian American way of life (Goto & Abe, 2010; Min & Kim, 1999; Yoo, 1999). Even though Asian Americans make up 5% of the total population, this may vary by region and community enclaves. For example, areas such as New York consist of 12% of Asian Americans; Sugarland, Texas consists of 25%; the city of San Francisco is 33% Asian; and other areas in California consist of as high as 50% Asians or Asia Americans. In addition, Asian Americans are a highly diverse group, comprising of more than 16 major ethnic subgroups with various cultural, linguistic, and immigrant backgrounds and histories (Chen & Kelly, 2010). However, “collection of racial and ethnic data is complicated by many factors, including language barriers, cultural barriers, educational levels, immigration status, and trust issues with government agencies. These factors can affect the response rate in many communities,” (Chen & Kelly, 2010, p. 13) suggesting that the true numbers may not be reflected in the Census given the limited English proficiency among certain Asian ethnic groups and the other issues mentioned previously.

As mentioned previously, one of the oldest and the largest Asian subgroup include Chinese- Americans (Kwong & Chen, 2010). The Chinese “are considered ‘new immigrants,’ despite more than 150 years of presence in the country” (Kwong & Chen,

2010, p. 16) and hail from mainland China, Taiwan, Hong Kong, Southeast Asia, Latin America, among other countries.

Filipino Americans are the second largest group at approximately 3 million (Aquino, 2010). Like the Chinese, there are populations of Filipinos in various cities, such as those outside of California (i.e., Chicago and Jersey City) that “have Filipino American populations that grew from the settlement of medical workers and their families during the 1970s.” Furthermore, “...here are specific American urban sectors, such as Stockton’s ‘Little Manila’ and Los Angeles’ ‘Historic Filipinotown’ that are officially recognized for their historical significant” (p. 28).

South Asian Americans, also one of the fastest growing ethnic groups, have roots from five countries: India, Pakistan, Bangladesh, Sri Lanka, and Nepal, with Nepalese, Bhutanese and Maldivians numbering less than 10,000 (Purkayastha & Ray, 2010). Indians are multilingual and follow multiple cultures and religions. Most are Hindus, while others are Muslims, Sikhs, Christians, Jains, and other religious groups (Purkayastha & Ray, 2010). Approximately 30% of the Muslim population the United States constitutes Asian countries (e.g., Indonesia, Pakistan, India, Sri Lanka, and Nepal), with Islam playing a significant role in these individuals’ lives (Misra, Kwon, & Yoo, 2010). Many have had to “contend with finding a religious space in multicultural, but Christian-dominant America” (p. 57).

Southeast Asians collectively refer to those who come from Vietnam, Laos, and Cambodia, often with refugee, immigrant, and reunification histories (Um, 2010). For this ethnic group, religion has remained an issue of contention. On the one hand, “conversion has seen to the growth of the Southeast Asian Christian community and to

the Southeast Asians' ascension in the church" (p. 74). On the other hand however, for the "highland Laotian community," for example, "Christianization has entailed a difficult renunciation of key aspects of traditional culture" (p. 74).

Korean Americans are the fifth largest ethnic group with a population of more than 1.5 million and among one of the fastest growing with a 27% increase from 2000 to 2007 (Chang & Kim, 2010). Like other Asian ethnic groups, Korean Americans are heterogeneous and "bimodal in areas of language, nativity, generation, identity and class backgrounds. Language usually divides Korean Americans into three identities: Koreans in America, 1.5 generation, and second-generation" (p. 42). According to Chang & Kim (2010), the church is integral aspect of Korean American culture with 70% of Korean immigrants in the United States who engage in regular church attendance, with Protestants and Catholics making up 25% of the South Korean population. In addition, "many Korean churches maintain cultural traditions by celebrating holidays, serving Korean food after services and at functions, and teaching the Korean language to second-generation children" (p. 43). Korean churches also serve other community functions such as providing information and assistance in education, unemployment, house, health care, translation and interpretation and legal issues (Chang & Kim, 2010). For many Korean Americans, "religion is a public, communal experience that connects and intersects race, ethnicity, and faith" (p. 44).

Japanese-Americans consist of the fourth largest ethnic group with a history that dates back to the Second World War (Niiya, 2010). Finally, Thai Americans represent approximately 1.4% of all Asian Americans and about 200,744 in 2007 (Patraporn, 2010). They are a relatively newer immigrant group and have a shorter history in the

United States, unlike the Chinese or Japanese (Patraporn, 2010). Like the Korean and Chinese churches, “religion in the Thai community is often linked to culture and language, as many temples in the United States offer instruction the Thai language and practice instilling Thai culture in youth” (Patraporn, 2010, p. 84). However, these efforts do not appear to have the same effect as many other Asian American groups that have been in the United States longer, in that temples “remain small in number, sometimes geographically isolated, and not necessarily located where the population resides” (Patraporn, 2010, p. 85). From the 2007 United States Census Bureau, “of the 15 million Asian Americans, approximately 1.8 million are multiracial...when taking multiracial Native Hawaiian and other Pacific Islanders (e.g., Samoans, Guamanians) into consideration, there are 333,482 multiracial individuals and they comprise 0.12 percent of the total U.S. population” (Huynh-Hohnbaum & Kelly, 2010, p. 438)

Several surveys have been conducted to provide a sense of the religious makeup of the American people, providing some mixed yet interesting data. The Pew Forum on Religion and Public Life also published the U.S. Religious Landscape Survey which focused on participants’ religious beliefs and social and political views. It suggests that while the religious composition of the national population as of 2008 is predominantly Christian ([78.4%]; Pew Forum, 2008a), the survey “confirms that the United States is on the verge of becoming a minority Protestant country...[with] members of Protestant denominations now stand[ing] at barely 51%” (para. 4). The survey indicates that U.S. adults believe overwhelmingly in God (92%) and 58% say they pray at least once per day (Pew, 2008b). However, the study’s authors suggest that there is a “stunning” lack of alignment between people’s beliefs or practices and their professed faiths, with changes

in religious affiliations. Furthermore, the survey also suggests that immigration continues to play a role in the changes and shifts in religious diversity. Thus, our roles as psychologists in accordance to multicultural competency, professional and ethical guidelines should reflect those complexities.

Another recent report in which approximately 54,000 individuals were surveyed regarding whether they considered themselves adherents to a religious community (Kosmin & Keysar, 2009; American Religious Identification Survey [ARIS]) indicated that the American population which was predominantly Christian was becoming increasingly less so. For example, in 1990, it was reported that 86% of adults were Christian but the percentage decreased to 76% in 2008 (Kosmin & Keysar, 2009). When asked about their beliefs, 70% indicated that they believed in a personal God, approximately 12% self-identified as atheist or agnostic, and 12% as deistic. The data also showed that in 2008, 20% of American adults did not identify with any religion compared with 10% in 1990. The survey also reflects steady growth in non-Christian religious groups and faiths since 1990, however, that percentage is small ([4%]; Kosmin & Keysar, 2009). Additionally, compared to other ethnic groups, 11% of Asian Americans self-identified as having no religious identity compared to 6% of the total population (Jeung, 2010; Kosmin & Keysar, 2009). One explanation for Asian Americans to self-report non-religiosity may be due to the nature of Asian religions differing from that of West Christianity. Asian religious traditions emphasize more inclusive beliefs and spiritual practices, which may be engaged within the home or workplace, as compared to ritualized Western worship (Jeung, 2010). Furthermore, due to the immigration of Asian Americans into more *secularized* professions in the U.S.

such as science or management, this may explain why scientists self-identify as having no religious affiliation (52%) compared to the general American population ([14%]; Jeung, 2010).

Asian Religions and the Impact on Culture

The diversity of Asian Americans extends to their “religions, religious affiliations and practice of spirituality and faith. The religions Asian and Asian Americans are affiliated with play a role in coping mechanisms for adapting and adjusting to new cultures by some Asian subgroups” (Misra et al., 2010, p. 266). To understand the changing makeup of Asian American religions, one must also delve into the intersection of individual, societal, familial, and historical contexts and how Asian Americans negotiate these relationships (Carnes & Yang, 2004). The overwhelming complexity of Asian American religions cannot be viewed “through the lens of Euro-American Protestantism” (Yoo, 1999, p. 3). Additionally, what anthropologist Ulf Hannerz (1969, as cited in Carnes & Yang, 2004) said of African Americans might very well be said about Asian Americans, “Their social life cannot be understood apart from their understanding of soul, its struggles and its hopes” (p. 1). Research within the last five or so years have examined the trends in the Asian American religious landscape. In the early to mid-2000s, almost two-thirds of Asian Americans reported that religion played an important role in their lives, with Filipino and Korean Americans as the most religious (Carnes & Yang, 2004). Furthermore, over 60% of Asian Americans self-identified as Christians with a large concentration seen among Asian American college student organizations (Carnes & Yang, 2004). “Asian Americans use religious conversations in religious spaces to face questions about their relation to their country of origin, personal

and collective identities, and the organization of American society and culture” (Carnes & Yang, p. 3; Jeung, 2005). Another unique aspect of Asian American religions is the inclusion of a “formalized, traditional, hierarchical, group-oriented culture” with an “emphasis on religion as a doing- rather than a believing- of ritual, worship attendance, charity, and age hierarchy- and an especially strong patriarchy (Carnes & Yang, 2004, p. 5; Jeung, 2005). Racial diversity reveals not only the significance of religion but also the impact it has on Asian Americans and their beliefs, thus shedding light on the relationship between religion and race (Jeung, 2005). However, one of the continuing challenges remains to be the constant back-and-forth of studying “Asian Americans” as a group but also giving individual attention to the over 24 ethnic subgroups that are currently residing in the United States (Hune & Park, 2010; Min, 2006). Thus, one needs to constantly be mindful of what Trimble, Helms, and Root (2008) refer to as “ethnic gloss” (p. 167) in which overgeneralization across groups are made, despite the fact that Asian Americans have no common language or religion, and are physically and culturally distinct from one another (Min, 2006; Zane et al., 2008). Moreover, some Asian religious organizations are created in a way that reflect Asian cultural values and may be utilized as an attempt to hold onto their own values and rituals. For example, “Filipinos, Asian Indians, and Southeast Asians have established religious institutions in the US increasing numbers, but they are less likely to be Pan-Asian or Protestant Christian because of the religious and ethnic diversity within these groups” (Jeung, 2005, p. 3).

Carnes and Yang (2004) continue to explain that the essential elements to every Asian American religious and social boundary include their “revealing and concealing capacities” (p. 10). These functions include offering

the most mystery and understanding of the depths of existence; simultaneously concealing and revealing the divine, salvation or damnation, morality, persons, groups, time, and space...Concealing is accomplished by establishing boundaries (sacred-secular, mystery-reason); revealing is done by making boundaries permeable in some ways through evangelism, conversion, prophecy, preaching, methods of insight. (Carnes & Yang, p. 10)

Asian American religions also provide resources from the spiritual, therapeutic, cultural and symbolic to socioeconomic. Finally, relationships with invisible beings, which may provide strength, comfort, empowerment, and healing, are often contained in the private sphere, except “for specified times like prayer and services” (Carnes & Yang, 2004, p. 11). What may be considered the most recognized therapeutic resource, the purpose of Asian American religions may range from occupational advice and marital counseling (Carnes & Yang, 2004, p. 12). Other roles of Asian American religions may include providing individuals with “new or renewed individual and social identities in strong religious worldviews” (p. 12) and for “affirming and making visible self-reflection and new identities for Asian American immigrants” (p. 13).

Furthermore, other societal forces such as family patterns and generational differences in values have also impacted the Asian American religious geography (Min & Kim, 2002; Zane et al., 2008). Immigration, particularly in Hispanic and Asian ethnic groups, has transformed the religious landscape since the 1990s (Leonard, Stepick, Vasquez, & Holdaway, 2005). The younger generations, in an attempt to embrace American cultural values of independence, individualism, and equality, has a tendency to view their parents’ religion as *inauthentic* and conservative, but “defin[ing] religion as

authentic self-expression and religious community as a democratic fraternity” (Carnes & Yang, 2004, p. 5). The religious makeup of Asian Americans has changed over time primarily as a result of immigration. What is known from the immigration research is that individuals often utilize religion as a way to provide “cultural continuity” (Leonard et al., 2005, p. 15) in the midst of turmoil, confusion, and loneliness, brought on by being transplanted from another country (Lawrence, 2002; Min, 2003). In addition, “religious switching...has significantly changed the religious profile of some states and regions” (Kosmin & Keysar, 2009, p. 1; United States demographics, 2010), with individuals at times rejecting the religions and belief systems they knew in their homeland to seek a different religion in order to belong. Moreover, the rapid growth of the Hispanic population, and to a lesser extent the Asian population, has replaced the African-American population as the nation’s largest minority (Kosmin & Keysar, 2009). “The entry of Chinese, Koreans, and Indian immigrants has diminished the Catholic proportion since 1990” (Kosmin & Keysar, 2009, p. 15; Tewari, Inman, & Sandhu, 2003) and increased the popularity of Eastern religions within the last decade. Additionally as previously mentioned, an increasing presence of those born in the U.S. or have come to the U.S. as young children “raises issues of generational identity, assimilation, and conflict” (Carnes & Yang, 2004, p. 24) within the family and more broadly in immigrant churches. To further complicate the cultural diversity subject is a group that is often assumed to be an extension of the first generation as it ages and hold onto traditional/conservative religious values, the elderly Asian American group (Carnes & Yang, 2004, p. 29). Thus, fundamental elements of Asian religions

emphasize the centrality of family, the place of individuals in a larger cosmos, the spiritual connection with deceased ancestors as a link to the spiritual world, and a holistic view of body, mind, and spirit. Beyond this, the therapist must tactfully probe for spiritual and culture-specific explanations of the manifest of the symptoms and attendant culture-prescribed remedies. (Zane et al., 2008, p. 251)

Religious patterns is an important factor to study as the American population becomes more ethnically and racially diverse, particularly because these variables cannot be separated. Religious identification and social variables create a multifaceted interface. In 2001, the Pilot National Asian American Political Survey (PNAAPS) collected data from over 1,200 individuals of Chinese, Korean, Vietnamese, Japanese, Filipino, and Asian Indian/South Asian descent, across five major metropolitan areas to gauge political attitudes at the national level (Carnes & Yang, 2004). One of the findings indicated that 72% of Asian Americans have a religious identity. Five major religious identifications were identified: Christian (likely Protestant), Catholic, Buddhist, Hindu, and Muslim. Of these, the largest Asian American religious group comprised of Christians (46%), though their proportion was still much less than the general public (82%). Furthermore, across the five major Asian subgroups, Filipino Americans self-identified as Catholic and were considered the most religious Asian American group (94%), with almost three-quarters attending religious services at least once per month (71%), followed closely by Korean Americans (87%). The least religious were Japanese and Chinese Americans, with the West Coast general population having the lowest religious identification rates in the U.S (Carnes & Yang, 2004). This may be a result of historical and social conditions, particularly with the high concentration of Japanese-Americans living on the West Coast

(Carnes & Yang, 2004). However, due to the high visibility of new immigrants and some stark contrasts in their public religious presence, many researchers have overestimated how much the U.S. has changed in its religious demography. In 2001, Diana Eck reported that the nation was moving from being predominantly Christian to a “new multi-religious America” (Carnes & Yang, 2004, p. 31). However, the percentages of Asian Americans that make up Muslims, Buddhists, and Hindus (4%) are even smaller still (Carnes & Yang, 2004).

In 1990, the National Survey of Religious Identification (NSRI) was one of the major studies to be conducted on religious identification, which examined religious preferences and other characteristics among 113,000 Americans (Kosmin, 1991). Since then, the American Religious Identity Survey (ARIS), has followed up in 2001 and 2008 to “track changes in the religious loyalties of the U.S. adult population” (Kosmin & Keysar, 2009, p. 2). Table 2 measures the changes in religious identification over time among Asians and Asian Americans in the United States based on the NSRI and ARIS studies. A list of the religious groups broken down into more specific categories or denominations is included in Appendix B. The data provided in Table 2 is particularly striking as one recognizes two patterns: (a) there is the slight decrease in religious affiliation identification between 1990 and 2008; the (b) there is a slight increase from 4% to 5% in the Don’t Know/Refused row indicating some reluctance to reveal their religious identification (Kosmin & Keysar, 2009) or that those who do not disclose is engaged in some form of religious and/or spiritual involvement at home.

Three social variables were considered during the ARIS (Kosmin & Keysar, 2009) survey; however, the indicator that is of most significance given the present study is racial composition. Across 13 religious groupings (comprised of even more specific subgroups) surveyed from 1990 to 2008, the following decreases in percentages were noted: Catholics from 27% to 13%; Baptists from 9% to 3%; Mainline Christians: 11% to 6%; Christian generic from 13% to 10%; Pentacostal/Charismatic from 2% to 0%; Protestant Denominations: 2% to 2%. However, increases were also noted in other religious groupings such as Eastern Religions (8% to 21%), Muslim (3% to 8%), and atheism (16% to 27%).

Given the historical and social impact immigration has had on Asian American religions, there has also been an amalgamation of faiths, such as religious and spiritual values embedded in culturally-based ideas (Inman & Yeh, 2006; Yeh & Kwong, 2009; Zane et al., 2008). Additionally, old and new Asian immigrants have integrated the religious beliefs and practices from their homelands with Judeo-Christian values or convert to Christianity after arriving, resulting in many variations of what we know to be American Protestantism/Christianity (Zane et al., 2008). The rich and complex history of faith among the Asian/Asian American community implicates the need to know more about how faith influences Asian American psychologists respective to addressing issues of religiosity and spirituality (Alba, Lam, & Alvarez, 2010; Ano, Mathew, & Fukuyama, 2009; Carnes & Yang, 2004; Jeung, 2005, 2010; Yoo, 1999).

R/S Beliefs and Practices of Asian American MHPs

What we know about the interface between ethnicity and religiosity or spirituality among Asian American mental health professionals (MHPs) is that research in this area is

limited, yielding only two articles within the last decade. One study (Nagai, 2008) investigated the self-assessment of 30 Asian American clinicians' cultural and spiritual competency in working with Asian American clients. The ethnic and racial makeup included Japanese, Cambodian, Korean, Filipino, Mien, Laotian, Caucasian, Chinese-Native Hawaiian, Chinese-Korean, and Caucasian-Filipino-Native American. The religious background was equally diverse with Buddhism, Christian, Catholic, ancestor worship, spiritual, New Age, no religion, or a combination (e.g., Buddhism, Christian, Hinduism, Confucius, Taoism, Shintoism, Animism, and/or self-directed religion). Results indicated that overall, clinicians scored higher on self-rated dimensions of awareness and counseling process/relationship than understanding, knowledge, and skill in both cultural and spiritual competency. Furthermore, these mental health professionals perceived themselves to be more culturally competent than spiritually competent, and identified a need for additional training in spirituality, and Western and Eastern spiritual beliefs, with an emphasis on an integration of both the cultural and spiritual identities (Nagai, 2008).

Another study examined the therapeutic views of 16 Asian American therapists in an Asian American mental health clinic (Ito & Maramba, 2002). The demographic characteristics included Chinese (56%), Korean, Vietnamese, and Japanese Americans, with all clinicians proficient in another Asian language besides English. Aside from the therapists' educational and ethnic backgrounds, affiliations with any religious or spiritual orientations were not identified. Results from this study indicated that therapists readily adapted and modified therapeutic interventions to the needs of their Asian American or immigrant clients (e.g., language, family values and beliefs) while at times incorporating

more Westernized ideas of therapy (e.g., educating the client and family regarding their role in therapy, offering insight-oriented services while disregarding alternative treatments). Finally, a third study by a group of South Asian psychologists (Maker, Mittal, & Rastogi, 2005) on the development of a more empirically-based assessment model for South Asian clients was introduced. The three female mental health professionals address what they perceived to be the various socio-cultural issues and attitudes toward therapy that contribute to different ways of conceptualizing and working with this particular ethnic group. However, Maker et al. do not include a religious/spiritual dimension to their analysis nor highlight the lack of inclusion of this cultural construct. None of the three studies addressed spiritual and religious beliefs and practices beyond basic demographic information (e.g., religious affiliation). In order to understand why the intersection of culture and religion is important, one must understand more broadly the historical and current trends that impact the findings of this type of cross-cultural study.

Purpose of Study

While the importance of R/S in mental health and psychological treatment appears in the professional literature and a body of empirical research exists regarding the R/S beliefs, affiliations and practices of psychologists generally, little is known specifically about Asian/Asian American psychologists. This research attempted to address this gap in knowledge. The proposed research achieved several objectives: (a) to describe the religious and spiritual beliefs, affiliations, and practices of Asian/Asian American mental health professionals; and (b) their attitudes towards and practices addressing religious and spiritual issues in treatment.

Method

Research Approach

This research study employed the survey approach and data was collected from participants by utilizing a self-administered questionnaire to obtain self-reports from mental health professionals and students (Creswell, 2009; Mertens, 2005). Several advantages are indicated. Surveys provide valuable information about the general traits, patterns, or opinions of a large population during one or over the course of several administration periods (Creswell, 2009; Mertens, 2005). Surveys are also relatively cost-effective and can be administered quickly compared to other research methods, particularly when electronically administered by means of the Internet. This investigator utilized a self-report questionnaire online to obtain the attitudes, beliefs, practices, religious affiliations, as well as clinical and educational training experiences of Asian/Asian American mental health professionals and students.

The survey method also imposed several challenges. A primary requirement is that an adequate number of the research sample responds and completes the survey. After receiving approval from the current president of the Asian American Psychological Association (AAPA) listserv, this investigator recruited Asian/Asian American mental health professionals and students from the mailing list as well as from state and regional psychological associations. Snowball sampling was also utilized in an effort to obtain an adequate number of participants. Furthermore, whereas forced-choice items allow for comparison of responses across subjects in a reliable manner, such items restrict the quality of the information being provided. In order to address this limitation, qualitative items were added to allow participants to further elaborate on their responses if the force-

choices answers were not adequate. However, the relatively few qualitative responses that were obtained suggested that participants did not feel the need to further elaborate on their responses to forced-choice items. In sum, the disadvantages were minimal compared to the advantages in providing a useful approach upon which to conduct this research. This study aimed to obtain descriptive information about this unique group of psychologists, mental health professionals, and psychology students and no hypotheses were proposed or variables were associated.

Participants

Of the 125 surveys that were started, 13 participants did not answer approximately one-third of the survey, therefore those surveys were excluded. Sixty-six completed surveys by respondents who identified as non-Asian or multiracial/multiethnic (e.g., inclusion of a non-Asian ethnic background) were also excluded. A total of 46 surveys were included for final data analysis; these participants identified as Asian, Pacific Islander, or “Other” (i.e., South or Southeast Asian).

Personal characteristics. When asked to provide qualitative data regarding their specific ethnicity, the two largest ethnic groups were those who identified themselves as Chinese/Taiwanese ($n= 18$) or Indian/Pakistani/South/Southeast Asian ($n= 12$). The next largest groups were Korean ($n= 6$), Filipino ($n= 4$), and Japanese ($n= 3$). One participant identified as Vietnamese, one identified as Korean/Chinese, and another identified as Chinese/Okinawan. Demographic characteristics are provided in Table 3.

Professional characteristics. The majority of participants received a master of arts/master of science ($n= 20$, 43.5%) or doctor of philosophy ($n= 16$, 34.8%), followed by a doctor of psychology ($n= 5$, 10.9%), bachelor of arts/bachelor of science ($n= 3$,

6.5%), and “other” ($n= 2, 4.3\%$). The two individuals who endorsed “other” indicated their highest degrees received thus far were a high school diploma or educational specialist degree (Ed. S.). Regarding the nature of the highest degree completed, most endorsed clinical psychology ($n= 19, 41.3\%$) or counseling psychology ($n= 12, 26.1\%$), followed by “other” ($n= 9, 19.6\%$). The nine individuals who endorsed “other” noted several fields that were not listed, including education (i.e., special education, school counseling), psychology or a combination of specializations (e.g., psychology/anthropology, human development and psychological services), or some other field (e.g., MBA). Most participants indicated they were no longer students or the categories did not apply to them ($n= 18, 43.9\%$) followed by those who were either currently enrolled in a clinical psychology ($n= 12, 29.3\%$) or counseling psychology program ($n= 8; 19.5\%$). Participants endorsed cognitive/behavioral ($n= 11, 23.9\%$) or integrative ($n= 11, 23.9\%$) as their primary theoretical orientation followed by psychodynamic/psychoanalytic ($n= 6, 13.0\%$). The majority of participants identified themselves as unlicensed clinicians ($n= 26; 57.8\%$) followed by the second largest group, licensed psychologists ($n= 14, 31.1\%$). Four participants indicated their year of licensure. Finally, those who indicated they were members of the American Psychological Association ($n= 32, 69.6\%$) were also members of the Asian American Psychological Association. Professional characteristics are summarized in Tables 4.1, 4.2, and 4.3.

Representativeness of sample. Of the 650 or more individuals subscribed to the mailing list since this researcher’s last communication with the mailing list’s membership officer (see Appendix C), only 140 are members according to Asian American Psychological Association’s most recent newsletter (Asian American Psychologist,

2012). Membership statuses of these 140 members are as follows: 57 professional and 5 professional members hold “a master’s or doctorate degree in psychology, mental health, health or related fields and/or professionals whose work and interests are consistent with the purposes of the AAPA”; 10 early career members are “within 2 years of receiving their terminal degree and hold positions as post-doctoral interns, post-doctoral fellows, assistant professionals, or comparable level positions”; and 48 student members who are “undergraduate or graduate students in psychology, counseling, mental health, or related fields.” Eighteen individuals are “lifetime” members and two are “emeritus” members. Specific racial/ethnic demographics of the members on this mailing list were not available. Furthermore, according to the APA Center for Workforce Studies, of the approximately 96,000 members within APA, 2.5% ($n = 2,428$) are of Asian descent (Demographic characteristics, 2010). However, there is unavailable data as to whether members on the AAPA mailing list are also members of APA, therefore, an item was included in the survey instrument to obtain this information.

The response rate could not be established for this population since this researcher recruited not only from the AAPA mailing list but also from state and regional mailing lists, of which this researcher did not know the exact number of members. This researcher also utilized snowball sampling in an effort to obtain more participants; however, it was also unknown whether executive directors of the state and regional psychological associations forwarded the recruitment letter. Therefore, there may have been a smaller rate of return than what is expected for Internet-based surveys, which is an average rate of 39.6% (Cook, Heath, & Thompson, 2000). In light of the features (and

limitations) of the sampling methods, an assertion cannot be made regarding the representativeness of the sample due to the low response rate.

Instrumentation

Online administration of a 42-item questionnaire provided a description of religious and spiritual beliefs, practices, affiliations, religious involvement, and the impact on professional psychology of Asian and Asian American mental health professionals, which include masters-level and doctoral-level clinicians (please see Appendix D).

Instrument development. The survey is based on an item pool developed by Shafranske and Pargament (2010) as well as selected items from national surveys. The instrument drew upon survey items used in a number of studies focusing on the religious and spiritual beliefs, affiliations, and practices of psychologists within professional psychology (Bergin & Jensen, 1990; Bilgave & Deluty, 2002; Delaney et al., 2007; Plante, 2008; Shafranske, 1996, 2000; Shafranske & Maloney, 1990; Smith & Orlinsky, 2004). Modifications to the survey included: (a) a list of religious affiliations and ethnic identities providing greater discrimination, specific to Asian and Asian Americans; (b) items related to changes in religious affiliations; and (c) questions related to the impact of personal and professional identity on the treatment of religious and spiritual issues.

Demographic information. General demographic information was obtained, as discussed in the previous section regarding participant characteristics. The racial classifications for item 4 were taken from the 2010 Demographic Characteristics of APA Members (Demographic characteristics, 2010). For item 6, clarification regarding the classification of “1.5 generation” status was based on longstanding and recent research on

immigration and acculturation (Baker, 2004; National Center for Educational Statistics, 1998; Second generation immigrants, 2008; Zambrano, 2010). Theoretical orientation selections for item 10 were taken from the 2008 Current Primary Theoretical Orientation by Degree for Psychology Health Service Providers (Current primary theoretical orientation, 2008).

Religious and spiritual salience. This section includes items regarding the participants' developmental trajectory of religious/spiritual experiences and involvement. Item 14 was taken from the Gallup Poll (Gallup Poll, n.d.). Item 20 addressed the extent to which religiosity/spirituality is involved in participants' understanding/dealing with stressful situations. This item is taken from Fetzer's (1999) Multidimensional Measure of Religion/Spirituality. For Item 23, participants were asked to select from a list of religious and spiritual beliefs and/or practices they considered important. Items were selected from a list developed by Plante (2008) and from the U.S. Religious Landscape Survey (Pew Forum, 2008b). Items 24 and 25 addressed the participants' ideological positions regarding God and spiritual/religious matters. Item 24 was taken from the most recent American Religious Identification Survey (Kosmin & Keyar, 2009). Item 25 was taken from The Spiritual Life of College Students (The spiritual life, 2003) study conducted by the Higher Education Research Institute. Items 26 through 30 surveyed how mainly professional experiences have changed participants' religious/spiritual beliefs, and were taken from the College Students' Beliefs and Values Pilot Questionnaire by the Higher Education Research Institute (College students' beliefs and values, 2003).

Education and training. This section inquired participants' education and training in religious and spiritual issues. Specifically, respondents were asked to select among nine professional activities that had contributed to their ability to address religion or spirituality in treatment. Respondents were also asked to rate the adequacy of graduate and clinical training respective to dealing with religious/spiritual issues in psychotherapy; the level of receptivity of psychology graduate faculty members in regards to discussing issues of religion or spirituality; their level of comfort in discussing issues of religion and spirituality within the graduate program or work setting; and their level of preparedness in integrating religious or spiritual resources in psychotherapy. Participants also included qualitatively data regarding the frequency with which religious or spiritual issues are involved treatment, in addition to selecting a number of religious or spiritual issues clients have presented in treatment.

Sanctification. This selection examined at the extent to which participants considered professional activities to be sanctified. Sanctification refers to the process by which individuals perceive certain life events or circumstances to have spiritual significance or meaning (Pargament & Mahoney, 2005). The first item inquired about the degree to which participants' work is an expression of religiosity/spirituality. The second item inquired about the extent to which participants' roles as psychologists are consistent with their spiritual/religious identity. The third item inquired about the extent to which participants believe their work as psychologists is sacred. These items were taken from a survey (Prest, Russel, & D'Souza, 1993) in which marriage and family therapists were asked about the role of spirituality in the development of their professional identity.

Consultation in the Instrument Development

Three practicing clinical or counseling psychologists and five graduate students in doctoral-level clinical psychology programs who were not subscribed to or affiliated with AAPA were selected to complete the survey and to provide evaluative comments to assess for clarity and identify areas of improvement. Of those, 50% ($n = 4$) were Asian/Asian American and the other 50% ($n = 4$) identified as Hispanic, non-White. Six participants completed and returned the survey with feedback via email, while two completed the survey in the presence of this investigator. Survey administration was approximately 20 to 30 minutes. Items were found to be clear with the exception of four items, which were revised for clarity or omitted. Further consultation with current faculty members knowledgeable in Asian American mental health issues and cultural factors also provided more clarity in survey items.

Procedures

Recruitment. Subsequent to receiving approval from Pepperdine University's Graduate and Professional Schools Institutional Review Board (IRB), this investigator recruited from the AAPA mailing list in addition to regional and state psychological associations through the snowballing method and Internet surveying. Participants recruited met the following criteria: (a) they were of Asian/Asian American descent; and (b) were currently in or had completed a graduate (master's or doctoral) level program emphasizing some concentration in clinical psychology, counseling psychology, educational psychology or other related mental health field. Participants were required to be at least 18 years old to give consent in order to participate in the study. In light of the

target population, i.e., master's and doctoral level clinicians, it was assumed that no one under the age of 18 was the member of the recruitment group.

According to Saw and Okazaki (2009), “researchers [may] tap into intact ethnic organizations, such as kinship associations, professional associations, religious centers, and social clubs” (p. 58) to recruit Asian/Asian American subjects due to difficulties to accessing in this population. However, these researchers also indicate that “while these organizations provide good sources of participants, they too represent a narrow subset of Asian Americans” (p. 58). Therefore, participants in this study were Asian/Asian American mental health professionals and students enrolled in clinical psychology, counseling psychology, or any other related mental health field recruited primarily from AAPA as well as individuals who were not members or affiliated with AAPA. The following sections indicate the various recruitment strategies that were used.

AAPA mailing list. This investigator contacted the current AAPA president to determine whether this researcher could recruit participants for this study through the mailing list. According to a policy by the American Psychological Association regarding the practice of soliciting research participants from email lists (Policy on the solicitation, 2011, p. 1), “Outside research requests or requests for research participants will not be posted to e-mail lists maintained by APA.” However, because AAPA is a free-standing, unaffiliated organization separate from APA, this investigator was able to seek individuals from this mailing list despite the restrictions. Permission was granted by the current AAPA president to post a recruitment letter on the listserv (please see Appendix E). A recruitment email indicated the explorative and descriptive nature of the study. The email delineated specifically to AAPA those who was asked to participate in the

study i.e., mental health professionals who identify as Asian or Asian American (please see Appendix F). The letter also addressed the benefits and risks in participating in this study and provided contact information should the participants request an abstract of findings.

Additional recruitment strategies. To expand the participant pool, this researcher approached mailing list administrators of regional and state psychological associations (please see Appendix G) in an attempt to forward the recruitment letter. However, this researcher was prohibited from recruitment due to mailing list policies. Finally, snowball sampling was employed in which this researcher submitted an email requesting potential participants to forward the survey to those who they believed were appropriate for this study. A follow-up email was sent two weeks later to the AAPA mailing list as a reminder to those who had not completed the survey (see Appendix H).

Human subjects protection. An application was submitted to the Pepperdine University Graduate and Professional Schools IRB prior to participant recruitment to make certain that individuals would be protected in accordance with the principles of respect for persons, beneficence, and justice delineated in the Belmont Report (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979).

Consent for participation. A request for a modification of documentation of informed consent was also submitted to the Pepperdine Graduate and Professional Schools IRB. A modification was sought since the research presented no greater than minimal risk, as defined by the Protection of Human Subjects (please see Appendix I). Potential participants were informed of the purpose of the study, rights to confidentiality,

steps taken to maintain confidentiality, recruitment procedures, possible risks and benefits of participation, and their rights to decline to participate or leave the study at any time. Implicit consent occurred when the participant completed the survey. As such, participation implied that each participant who volunteered to complete the survey also comprehended the nature of the research as well as the risks and benefits of participation (IRB, 2010; Leigh & Rouse, 2009).

Benefits and potential risks. There were no direct benefits from participating in the study; however, potential benefits may have included participants reflecting on their religious and spiritual beliefs and practices and the possible impacts of these factors in conjunction with their clinical training on their provision of services to their clients. This may also have increased their ability to be more aware and seek out additional resources necessary for culturally-competent treatment. Furthermore, benefits for clinical training and professional psychology in general might have included increased knowledge about understanding the influence of culture and religious and spiritual issues among professional psychologists and students of other ethnic groups. Finally, this knowledge may contribute to a greater understanding of how to better serve the Asian/Asian American psychological community as a whole and provide appropriate resources for clinicians and clients. Participants were also offered the opportunity to enter a drawing for one of four \$25 cash rewards awarded after completing the survey.

Participation in this research study presented no greater than minimal risk to subjects, such as the experience of fatigue, boredom, or discomfort in reflecting upon or answering questions regarding religion and spirituality. A review of the extant survey literature in this area finds that there have been no reports of adverse effects anticipated

from clinicians thinking about and answering questions regarding their own religious and spiritual beliefs, practices, and affiliations as indicated in studies reported in the literature (Miller & Thoresen, 2003; Oman & Thoresen, 2005). Further, psychologists are trained to take into account cultural factors and to be mindful of the influence of personal values and other factors, including those related to religion and spirituality. In fact, there is a greater need for this type of research to be conducted among other ethnicities and religious groups (Plante, 2008; Tarakeshwar et al., 2003). Finally, research conducted on the Internet also does not carry any more risk than traditional methods (Kraut et al., 2004). The major risk is a breach of confidentiality, but this investigator limited this risk by not requesting or obtaining identifying information (Kraut et al., 2004) and data was securely stored.

Data collection. The online survey was utilized for this study for several reasons. Online research afforded the ability for data to be collected with ease and efficiency. Additional advantages included increased access to certain samples, reduced social desirability, and reduced cost. Given the research objectives and the specific participant characteristics, the survey method was considered the appropriate research method. Finally, evidence suggests that online research is just as reliable as traditional paper-and-pencil surveys (Gosling, Vazire, Srivastava, & John, 2004; Kraut et al., 2004; Skitka & Sargi, 2006). Survey responses were collected from May 17, 2012 to June 17, 2012. All data was collected by an online service that provided Internet-based survey administration (i.e., SurveyMonkey). Participants accessed the survey through a link that was embedded in the recruitment email. SurveyMonkey then reported the results as

descriptive statistics, which was sent to a database for additional analysis (Creswell, 2009). An Excel spreadsheet was generated which provided an aggregation of responses.

Storage and destruction of data. Subsequent to the spreadsheet being downloaded, the data was deleted from the site. No Internet Protocol (IP) addresses were collected by SurveyMonkey nor were any identifying information such as participants' email addresses collected and linked to individual responses. Participants' email addresses, which were voluntarily provided to the investigator by the participant, were only used for the purpose of the raffle drawing. The data reported was anonymous. The data was stored on a universal serial bus (USB) drive and kept in a secure locked file cabinet, which will be subsequently destroyed after 5 years (August, 2017).

Data analysis. This researcher utilized SPSS-19.0 to code and analyze the data. Prior to running analyzes, data was screened for accuracy and missing data (Mertler & Vannatta, 2010). Descriptive statistics was primarily use to obtain participant demographic information; religious/spiritual beliefs, attitudes, practices; graduate education training and clinical experiences; and the impact on service provision. Due to the small sample size, secondary analyses were not performed.

Results

This section presents findings from the survey in several areas, including participants' religious and spiritual salience; involvement in religion and spirituality; and religion and spirituality in professional practice. The sample included 46 participants completed the survey for this exploratory study examining the religious/spiritual beliefs, affiliations and practices of Asian/Asian American mental health professionals and students. Appendix K includes a descriptive summary of non-Asian participants who completed the survey instrument but were not included in the final data analysis.

Salience of Religion and Salience of Spirituality

Traditionally, a quick snapshot of religiousness in a population has been gained by asking a simple question about the personal importance (or salience) of religion. Nationally representative studies have consistently found that a large majority of Americans say religion is very or fairly important to them (Shafranske & Cummings, in press). However, a majority of participants in this study indicated that religion was not very important in their lives. In contrast, over 75% of the participants identified spirituality as being fairly to very important in their lives. Table 5 provides a summary of religious and spiritual salience among participants. This finding may indicate that for this group of psychologists the transcendent dimension to which religion/spirituality refers is of importance; however, preference is placed on individual spirituality rather than on institutional affiliation. These findings appear to be in keeping with a trend observed in the general population. According to Gallup (Religion, n.d.), which surveyed the general population from 1992 to 2011, there was a slight decrease of those who indicated religion to be very important in their lives, similar to this present exploratory study of Asian

American mental health professionals and students. Furthermore, the 2012 Pew study (Religious affiliation of Asian Americans) also reported that 39% of U.S. Asians compared to 58% of the general public reported religion to be very important in their lives.

Involvement in Religion and Spirituality

General orientation. With regards to their religious or spiritual identity, participants mainly endorsed that they were either distinctly spiritual or both religious and spiritual. Consistent with this finding, one study that examined religiosity and spirituality among marriage and family therapists (Prest, Russel, & Souza, 1999) indicated that most students valued religious and spiritual dimensions in their own lives. Overall, psychologists have consistently reported higher salience of spirituality as compared to salience of religion. Delaney et al.'s 2007 study of APA members indicated that over 80% held some sort of "belief...in some transcendent realm" (p. 539) This is compared to a 2003 Gallup study in which 9% identified themselves as both religious and spiritual, 49% as "religious," and 39% as "spiritual but not religious" (Gallup poll, n.d., p.1). Table 6 provides a summary of the participants' endorsement of their spiritual/religious orientation.

Ideology and beliefs. When asked to identify factors that influenced their current religious involvement, participants endorsed most frequently: provides a meaning or purpose in life ($n= 31, 77.5\%$); a source of comfort and support during stressful situations ($n= 29, 72.5\%$); and a part of their personal beliefs ($n= 26; 65.0\%$). Table 7.1 provides a summary of the participants' endorsements. Two participants provided additional verbatim responses regarding additional factors influencing their current

religious/spiritual involvement: “Experienced God personally and feel that there is no other way to live fully in life” and “It sounds that definition of ‘spiritual’ in this survey is different from my definition of spirituality.” The Pew study also reported that 22% of U.S. Asians compared to 20% of the general public believed that “living a very religious life” was “one of the most important things” in their lives (Religious affiliation of Asian Americans, 2012). In addition to explicitly religious beliefs or ideologies, the participants reported a number of beliefs, values or practices that might be considered associated with spiritual traditions to be of personal importance. These included acceptance of self and others; ethical values and behaviors; meaning, purpose, and calling in life; forgiveness, gratitude, and kindness; and social justice. Table 7.2 provides a summary of the participants’ endorsements.

Two participants provided additional verbatim responses regarding additional beliefs and practices participants considered important: “Helping others through channeling Johrei (universal energy) to improve physical, emotional, and spiritual well-being” and “Prayer but directly with God/Jesus- not shrines or religious symbols.” The 2012 Pew Study (Religious affiliation of Asian Americans) also reported that 67% of U.S. Asians who identified themselves as Buddhist and 34% of U.S. Asians who identified themselves as Hindu believed in ancestral spirits. In addition, 64% of U.S. Asian Buddhists and 59% of U.S. Hindus believed in reincarnation. Fifty-eight percent of U.S. Asian Buddhists and 73% of U.S. Hindus also reported believing in yoga as a spiritual practice. The Pew study also reported that 32% of U.S. Asians attended worship services at least once a week compared to 36% of the U.S. public. Only 11 participants (23.9%) indicated attendance at religious services to be important. In Delaney et al.’s

2007 study regarding religious and spiritual behaviors, 55% psychologists surveyed indicated that they rarely or never attended religious services and less likely (22%) to attend more frequently. The Pew study reported that 40% of U.S. Asians prayed daily or more compared to 56% of the U.S. population; 54% of psychologists surveyed in Delaney's study reported praying frequently. In this current study, 39.1% ($n= 18$) indicated that prayer (at a shrine/symbols at home) was important to them. Pew also reported that 34% of U.S. Asians meditated weekly or more compared to 21.7% of this study's participants ($n= 10$) who considered this practice to be important to them. Compared to 30.4% ($n= 14$) of participants in study who endorsed reading Scripture or sacred text, 36% of psychologists (Delaney et al., 2007) reported engaging in this practice.

Regarding the existence of God, half of those surveyed endorsed that there is definitely a personal God. In addition, participants generally endorsed a secure view about religious/spiritual matters. Table 7.3 provides a summary of the participants' endorsements. These results were similar to a study by Shafranske (1996) in which 40% of counseling or clinical psychologists held a belief in a personal God. In another study of graduate students in social work (Hodge & McGrew, 2006), a third defined spirituality in personal or individual terms without any reference to the transcendent, while the second largest category included those who defined spirituality in terms of a higher power or being. Finally, the 2012 Pew study (Religious affiliation of Asian Americans) also reported that 79% of U.S. Asians compared to 92% of the general public believed in God or a Universal Spirit.

Religious affiliation. One means of assessing an individual's religiousness or spirituality is to inquire about affiliation with an organized religious body or institution. Of importance in this study was to assess religious affiliation in the family of origin and current affiliation. The majority of the participants reported a religious affiliation within their families of origin (see Table 8.1), with the majority ($n= 14$; 30.4%) indicating affiliation in one of the Eastern religions; 8 (17.7%) reported no affiliation. In contrast, more participants endorsed their current religious affiliation as either no affiliation/secular ($n= 13$; 28.3%), or did not respond to the item ($n= 10$; 21.7%). Table 8.1 provides a summary of the qualitative information as provided by the participants. One participant skipped the qualitative item when asked to report the religious affiliation of his/her family of origin and 10 participants skipped the qualitative item when asked to report his/her current religious affiliation.

Regarding the change in affiliations or lack thereof, 34.5% ($n= 16$) of participants endorsed the same religious affiliation during childhood and currently while 21.7% who indicated the religious affiliation of their family of origin to be none/secular did not provide a qualitative response regarding their current religious affiliation. Even smaller percentages of participants endorsed a change from previously affiliated to no affiliation, no affiliation/secular to a religious affiliation, or remaining unaffiliated. Table 8.2 includes a summary of changes in religious affiliation as reported by the participants. These results appear to be consistent with the 2008 ARIS study from which the religious categorizations were derived. Asians in the general population who were surveyed from 1990 to 2008, there appeared to be an increase in those who endorsed Eastern religions or no affiliation and a slight decrease in affiliations with Catholicism and Christianity.

Aggregates of Gallup Polls from 1948 to 2011 (Religion, n.d.) also indicated a decrease for those in the general population who identified as Protestant and a slight increase for individuals who endorsed none, similar to findings in this study and the ARIS study.

While the religious affiliations of Asian Americans are quite varied, a recent Pew study on Asian Americans (Religious affiliation of Asian Americans, 2012) reported that 42% identified their current religious affiliation as Christian compared to 75% of the U.S. population. Furthermore, 19% of the general population compared to 26% of Asian Americans in the U.S. identified themselves as being unaffiliated with any religion; 14% and 10% of Asian Americans also endorsed Buddhism and Hinduism, respectively, as their religious affiliation (among other religions), compared to 5% of the general population. These results are similar to what this investigator found in that Asian Americans are more religiously diverse. The Pew study also reported that compared with the religious affiliation of their family of origin, 32% of U.S. Asians were affiliated with a different religion compared to 66% who still remained with the same religion; in this current study, this investigator found that only 34.5% ($n= 16$) of participants remained in the same religion while the majority changed to a different religion, became unaffiliated, or chose not to respond to the item. Regarding the religious affiliations of psychologists, Shafranske and Cummings (in press) found that Protestant and Catholic psychologists were consistently underrepresented, with a mixed proportion of non-affiliated psychologists. They suggest that training and education in psychology may negatively influence psychologists' religious beliefs and practices or offer a varied perspective for those who have switched affiliations or choose to become unaffiliated. Although a definitive understanding for changes in affiliation has not been established,

the finding that over 60% of the participants have switched their affiliation may have implications for their understanding of religious struggles and/or the changes in affiliations of their clients.

Religious participation. Most participants in this current study also endorsed “regular participation with some involvement” or “identification with religion with very limited to no involvement” both with their family of origin and their current level involvement. This suggests that even though there are changes in how individuals view religion and spirituality over the course of their lives, they have continued to find some value in the participation of some type of religious and/or spiritual activity. Table 9 provides a summary of the previously mentioned results. Similarly, Shafranske and Cumming (in press) also report that about 40% to 60% of psychologists engage regularly or actively in some type of organized religion, however, Delaney et al. (2007) reported that only 20% participated in some organized religion.

Religious coping. The majority of participants also endorsed that they considered religion and spirituality to be somewhat to very involved in their coping of stressful situations. This is consistent with a study of graduate students in which 60% expressed spirituality through personal religious beliefs and had greater spiritual health and ability to cope with stressors (Graham, Furr, Flowers, & Burke, 2001). Furthermore, Curlin, Lantos, Roach, Sellergren, and Chin (2005) compared U.S. physicians to the general population in terms of religious coping; 48% of physicians compared to 64% of the U.S. population endorsed looking to God for strength and guidance quite a bit or a great deal. However, a larger percentage of physicians (61%) compared to 29% of the U.S.

population endorsed attempting to make sense a situation with relying on God quite a bit or a great deal. Table 10 provides a descriptive summary of this information.

Impact of Graduate Education and Training

R/S in current clinical practice. Given the high frequency of change in religious affiliation (from family of origin to current involvement), it was important to assess whether participation in psychology education and training played any role in this change. The current study showed that for the most part, participants did not report that personal psychotherapy, new ideas encountered in their graduate psychology program, or attitudes/opinions of psychology and non-psychology faculty resulted in any changes in their religious/spiritual beliefs. These findings were consistent with an exploratory study (Francis, 2011) of psychology interns in which 71% reported no change in their religious/spiritual beliefs when exposed to attitudes and opinions of psychology professors, compared to 77.8% in this current study. In fact, 50.0% of participants ($n=23$) reported that working as a mental health professional or a psychologist strengthened their religious/spiritual beliefs; 39.1% of the participants ($n=18$) reported no change. Table 11.1 provides a summary of the participants' endorsements. Most participants indicated that religious/spiritual issues were presented or discussed sometimes or rarely in their training experiences as student therapists, psychologists, and mental health professionals. Similarly, most psychologists found religion and spirituality to be occasionally relevant in treatment (Delaney et al., 2007; Shafranske, 2000). Table 11.2 provides a summary of the participants' endorsements. When participants were asked to provide a qualitative response regarding the frequency with which religious and spiritual issues were involved in treatment, "sometimes" or "rarely" were endorsed most

frequently, similarly to the Delaney et al. and Shafranske studies, as previously mentioned. Table 11.3 provides a summary of the participants' qualitative responses. Participants also endorsed the client's loss or questioning of faith, followed by changes in the client's relationship to a higher power not associated with the religious organization, and terminal or life-threatening illness as the three most frequent religious or spiritual issues that were presented in treatment. Table 11.4 provides a summary of the participants' endorsements. More recent studies on the religiousness and spiritual practices and behaviors of social workers (Hodge & McGrew, 2006) and doctoral-level psychology students (Walker, Gorsuch, Tan, & Otis, 2008) have also expressed some degree of personal religiosity and spirituality but limiting the use of spiritual and religious interventions in clinical practice.

Education and training in R/S. On a 7-point Likert scale in which "1" was "not at all adequate" and "7" was "very adequate," 13 out of 46 participants (28.3%) endorsed "4" or higher, suggesting that most did not feel that their graduate education and clinical training respective to dealing with religious or spiritual issues in psychotherapy was adequate. Furthermore, -on a 7-point Likert scale in which "1" was "not at all receptive" and "7" was "very receptive," 26 out of 44 participants (59.1%) endorsed "4" or higher suggesting that most felt that their psychology graduate school faculty members were receptive in regards to discussing issues of religion or spirituality. With regards to participants' comfort level in discussing religious or spiritual issues in graduate school or professional setting in which "1" was "not at all comfortable" and "7" was "very comfortable," 27 out of 45 participants (60.0%) endorsed "4" or higher. Finally, when asked to rate participants' own ability to integrate religious or spiritual resources in

psychotherapy in which “1” was “not at all prepared” and “7” was “very prepared,”- 29 out of 46 participants (63.0%) endorsed “4” or higher; this is similar to 68% of psychologists surveyed in Young, Wiggins-Frame, and Cashwell’s 2007 study regarding their level of preparedness in addressing religious/spiritual issues in treatment. Table 12 provides a summary of the participants’ ratings. These results are consistent with a study of marriage and family therapists in that while most students valued religious and spiritual dimensions in their own and in their clients’ lives and most considered spiritual issues in practice, these therapists felt constrained from discussing spirituality within the professional community (Prest et al., 1999). In Shafranske’s 2000 study, 78% of psychologists felt inadequate in providing religious/spiritual services, compared to 71.7% of participants in the current study who rated less than a “4.”

Contributing factors. Education and clinical training are the primary means by which psychologists and other mental health professionals develop clinical competence, including the ability to address clinically relevant features of religion and spirituality. A number of items were included to assess the degree and quality of preparation to address R/S factors. Participants endorsed the completion of coursework in multicultural competence or diversity issues (82.5%) to be the leading factor that contributed to this sample’s ability to address religious/spiritual issues in treatment as compared to 47% of psychologists surveyed by Young et al. (2007). Second and third most frequently endorsed experiences included clinical training and supervision and workshops or presentations on religious/spiritual issues, respectively. Table 13 provides a summary of the participants’ endorsements.

Sanctification. One area of interest is whether the choice of profession was influenced by or related to their personal religiousness or spirituality. Participants were asked to rate on a 7-point Likert scale whether they strongly disagreed (“1”) or strongly agreed (“7”) with the following statements. Regarding their choice in pursuing psychology or other mental health field to be an expression of their spirituality or religiosity, 17 out of 46 participants (40.0%) endorsed a rating of “4” or higher. Regarding whether they agreed that their role as a psychologist or therapist was consistent with their spiritual or religious identity, 35 out of 45 participants (77.8%) endorsed “4” or higher. Finally, regarding whether they agreed that their choice to work as a psychologist or psychotherapist was considered sacred to them, 32 out of 46 participants (70.0%) endorsed “4” or higher. Table 14 provides a summary of the participants’ endorsement.

Discussion

This exploratory study examined the religious and spiritual beliefs, affiliations, and practices of Asian/Asian American mental health professionals and students. This study also explored the professional attitudes and behaviors regarding religion and spirituality in mental health and the impact on providing treatment. Qualitative data of participants' religious and spiritual beliefs, practices, and religious affiliations were also examined to gain possible insight into how personal and professional activities as related to one's religiosity and/or spirituality intersect. Differences were also examined between this sample and other psychologists and mental health professionals as well as the general population related to identifying religious and spiritual factors in psychological treatment.

Limitations

One of the primary limitations of this study was the small sample size, which may partly be due to the challenge of contacting participants, despite the use of multiple mailing lists and snowball sampling. Even though the primary recruitment procedure was through the AAPA listserv, of the approximately 650 individuals who were on the mailing list, only 33 responded. Another factor may have been the large number of requests for participants that are sent to the mailing list, which may have contributed to reluctance by potential participants to respond to the survey.

Another limitation relates to non-response, which might have been a cause of error. Response bias refers to the extent to which answers of those who did answer differ significantly from those who did not (Fowler, 1993). Individuals who did not engage in any spiritual or religious practices or may have experienced a negative view towards religion may have opted not to participate in the study. Conversely, individuals may be

more willing to complete the study because of stronger personal religious and/or spiritual beliefs (Shafranske & Cummings, in press).

Additional limitations are associated with the research design and methodology. As this study was primarily descriptive in nature, no hypotheses were postulated, nor could the characteristics of this sample be generalized. This study utilized self-report methods, therefore inaccurate self-reports involving social desirability bias (Mitchell & Jolley, 2007) was an issue to consider. With online surveying, the investigator had no control over the physical environment in which participants responded to the survey nor the ability to confirm that participants were accurately reporting their demographic information (Kraut et al., 2004). A final limitation was related to the challenges of the survey instrument itself. This researcher utilized the item pool that was developed by Shafranske and Pargament (2010). However, because many of the items were skewed more toward Judeo-Christian values and may not have been relevant with this particular population given this investigator's understanding of the research, existing items were modified and new items were developed for the purposes of this study.

Finally, given that this study focused primarily on Asian/Asian American mental health professionals, some survey items may not have been relevant to the individual participant. What is known about Asian and Asian Americans in general is that this ethnic group cannot be characterized by one religion or religious affiliation, as participants have endorsed different levels of personal involvement, changes in religious affiliation, and a wide range of belief systems and practices.

Implications

Previous studies have indicated that while psychologists are less religiously affiliated and report lower degrees of salience in respect to religion than the general population spirituality appears to be important for many psychologists. In this study, participants generally indicated that they were either more spiritual or religious and spiritual than religious. Similarly, spirituality rather than religion was reported to be fairly or very important in their lives. In addition, the majority of the participants indicated that religiosity and/or spirituality was either somewhat to very involved in their coping of stressful situations. These findings suggest in this study that the spiritual dimension is salient.

Results from this current study indicated that although there was some variability across religious affiliations, however, participants generally endorsed a higher degree of spiritual than religious salience, similar to previously conducted studies on religious/spiritual salience of psychologists. Furthermore, participants from this survey were similar to psychologists in reference to the changes across religious affiliations, specifically towards a trend of a different affiliation (non-Christian) or becoming unaffiliated, as compared to the general population which has remained predominantly Christian. Because of the differences among religious and spiritual salience among Asian/Asian American clinicians, treatment with clients may be challenging, particularly if a client comes in with a particular belief system that is dissimilar to the clinician. Furthermore, these clinicians also claim to endorse a high level of preparedness in being able to integrate religious and spiritual issues in psychological treatment despite the report lack of training in those areas. What might we make of the apparent dissonance

between degree of training and self-assessment of competence to address R/S in psychological treatment? This dissonance may be partly the result of the lack of coverage in the area. If religious and spiritual issues were rarely if ever discussed or presented in the context of psychological treatment, psychologists may errantly underestimate the knowledge, skills or attitudes required to competently address religious or spiritual issues. Further, without adequate training, clinicians may actually miss client reports or fail to inquire about client experiences pertaining to religion and spirituality. These speculations are consistent with previous studies which indicated that graduate students and psychologists felt constrained from discussing spiritual/religious issues within the professional community (Francis, 2011; Prest et al., 1999; Shafranske & Cumming, in press). Without adequate exposure to the applied psychology of religion and spirituality and training, mental health professionals may not be prepared to perceive the emergence of clinically relevant R/S features in treatment. It is of interest in light of the preceding discussion that 50.0% of those surveyed stated that working as a mental health professional or therapist did strengthen their beliefs and many participants also reported that they considered their role as a psychologist or psychotherapist to be sacred to them. In sum, this exploratory study, similar to other investigations, found that mental health professionals receive relatively little explicit preparation and training to address R/S issues in practice. This raises significant ethical issues given the importance religion holds for the majority of the population and the role religion plays in mental health.

This exploratory study addresses the repeated call in the literature to highlight diversity as a relevant variable. In this study, this investigator also aimed to highlight the unique experiences of Asian/Asian American mental health professionals and students

given the paucity in this area. While this group may prefer not to ascribe to a particular organized religion, most Asian/Asian American individuals do acknowledge a higher power or sense of spirituality rather than formal membership in any place of worship. Participants also tend to engage in religious switching in which over the course of their lives, the religious affiliation of their family of origin was different from what they currently ascribed. Additionally, what Carnes and Yang (2004) indicate as “revealing and concealing capacities” (p. 45) of how Asian/Asian American individuals perceive or utilize their religious/spiritual beliefs is reflected in responses by participants in this study who indicated that their religious and/or spiritual involvement provides meaning or purpose in their lives, are a source of comfort and support during stressful situations, are parts of their personal beliefs, or contribute their beliefs of forgiveness, ethical behaviors, gratitude, and social justice. A handful of participants also provided responses that were not indicated in the forced choice items, reflecting, again, a diversity and wide range of beliefs that cannot be captured in a single survey instrument. While many chose to endorse beliefs and practices that were important to them, a small number, for example, did not indicate a response for their current religious affiliation. This may suggest a sense of privacy in not wanting to disclose this information, uncertainty about the participant’s religious identity, or some other reason that cannot be determined.

Recommendations for Future Research

Given the limited knowledge in the religious/spiritual beliefs and practices of Asian/Asian American mental health professionals and students, there are many areas to investigate in future research. For example, do differences in religious practices and beliefs among specific ethnic groups (i.e., Filipinos who practice Catholicism, Koreans

who are Presbyterian) impact how religious/spiritual-based interventions are provided?

As for the percentage of those who are not affiliated, a greater understanding of this subgroup's religious and spiritual beliefs and practices may be particularly interesting to explore, such what are the factors that attribute to the change(s) in affiliation and how this change may impact treatment?

Finally, other methodological strategies can be considered. For instance, alternative sampling methods may be utilized for this particular population. One way may be to survey participants through random sampling via personal mail or by telephone. Networking and having contacts through clinics, community centers, and organizations (e.g., universities) may increase the number of participants. More in-depth qualitative information may be more useful in obtaining a greater depth and breadth of extent to which personal religious and/or spiritual beliefs and practices influenced how they provide treatment to clients. Survey items that address the specific types of religious/spiritual interventions that are utilized in treatment may have also been useful in exploring how clinicians and student therapists can move toward more sensitive and responsive care.

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Table 1

Religion/Spirituality and the Physical/Mental Health Connection

Positive physical and mental health outcomes:

Increased longevity	Lower cancer morbidity rates
Lower cardiovascular disease and chronic pain	Better psychological well-being
Promote access to health-care services	Increased social networks
Prevention of high-risk sexual behaviors	
Increased health behaviors and lifestyles	
Better outcomes after major illnesses and medical procedures	
Less likely to engage in addictive behaviors and substance use	

Clinical symptoms with mixed outcomes:

Depression	Schizophrenia	Psychosis
Anxiety	Suicidality	

Table 2

Religious Traditions Among Asians, 1990, 2001, 2008

Religious Traditions	1990 ^a	2001	2008
Catholic	27	20	17
Mainline Christian	11	6	6
Baptist	9	4	3
Christian Generic	13	11	10
Pentecostal/Charismatic	2	1	0
Protestant Denominations	2	1	2
Mormon/LDS	2	0*	0
Jewish	1	0	0
Eastern Religions	8	22	21
Muslim	3	8	8
NRM & Other Religions	2	1	2
None	16	22	27
DK/Refused	4	5	5
Total	100	100	100

Note. Adapted from the “American Religious Identification Survey Summary Report,” 2008. Retrieved from http://www.americanreligionsurvey-aris.org/reports/ARIS_Report_2008.pdf.

^aAsian and Other Race combined in National Survey of Religious Identification (NSRI 1990)

*Refers to < 0.5 percent of the group.

Table 3

Demographics (N= 46)

Race/Ethnicity	<i>n</i>	<i>%</i>
Asian	42	84.0
Pacific Islander	1	2.0
Other	3	6.0
Gender	<i>n</i>	<i>%</i>
Female	37	80.4
Male	9	19.6
Transgender	0	0.0
Prefer Not to Answer	0	0.0
Age (<i>n</i> = 43)	<i>n</i>	<i>%</i>
	34.6	8.6
Generational Status	<i>n</i>	<i>%</i>
First Generation	12	26.2
1.5 Generation	7	15.2
Second Generation	23	50.0
Third Generation	2	4.3
Four or more Generations	2	4.3

Table 4.1

Professional Characteristics- Degrees (N=46)

Highest Degree Awarded	<i>n</i>	<i>%</i>
A.A.	0	0.0
B.A./B.S.	3	6.5
M.A./M.S.	20	43.5
Ed.D.	0	0.0
Ph.D.	16	34.8
Psy.D.	5	10.9
Other	2	4.3
Highest Degree Awarded	<i>n</i>	<i>%</i>
Clinical Psychology	19	41.3
Counseling Psychology	12	26.1
Educational Psychology	2	4.2
Combined	1	2.2
Marriage and Family Therapy	1	2.2
Social Work	1	2.2
Other	9	19.6
Did Not Respond	1	2.2
Academic Program Currently Enrolled	<i>n</i>	<i>%</i>
Clinical Psychology	12	29.3
Counseling Psychology	8	19.5
Educational Psychology	0	0.0
Combined	1	2.4
Marriage and Family Therapy	1	2.4
Social Work	0	0.0
Not Applicable/Not Currently Student	18	43.9
Other/Did Not Respond	6	7.7

Table 4.2

Theoretical Orientation (N=46)

Theoretical Orientation	<i>n</i>	%
Behavioral	1	2.2
Biological	0	0.0
Cognitive	0	0.0
Cognitive/Behavioral	11	23.9
Developmental	4	8.7
Family	0	0.0
Humanistic/Existential	5	10.9
Integrative	11	23.9
Interpersonal	4	8.7
Psychodynamic/Psychoanalytic	6	13.0
Systems	3	6.5
Not Applicable	1	2.2
Other	0	0.0

Table 4.3

Licensure/Organizational Membership (N=46)

Licensure/Year	<i>n</i>	%
Licensed Psychologist	14	31.1
Licensed Educational Psychologist	0	0.0
Master's in Social Work/LCSW	2	4.4
Licensed Professional Counselor	2	4.4
Unlicensed	26	57.8
Other	5	11.1
Did Not Respond	1	2.2
Year of License	<i>n</i>	
1990	1	
2009	3	
2012	1	
Organizational Membership	<i>n</i>	%
American Psychological Association		
Yes	32	69.6
No	14	30.4
Asian American Psychological Association		
Yes	32	69.6
No	14	30.4

Table 5

Religion/Spiritual Salience (N=46)

Importance of Religion in Your Life	<i>n</i>	%
Very Important	12	26.1
Fairly Important	14	30.4
Not Very Important	19	41.3
No Opinion	1	2.2
Importance of Spirituality in Your Life	<i>n</i>	%
Very Important	22	47.8
Fairly Important	13	28.3
Not Very Important	10	21.7
No Opinion	1	2.2

Table 6

General Orientation to R/S (N=46)

General Orientation/Identity	<i>n</i>	%
Religious	4	8.9
Spiritual	20	44.4
Religious and Spiritual	14	31.1
Neither Religious nor Spiritual	7	15.6
Did Not Respond	1	2.2

Table 7.1

Ideology and Beliefs (N=46)

Factors Influencing Current Involvement*	<i>n</i>	%
Strong Ties to Family Values	16	40.0
Maintain Identity	19	47.5
Source of Comfort and Support	29	72.5
Major Aspect of Personal Identity	21	52.5
Provides Meaning/Purpose in Life	31	77.5
Part of Personal Beliefs	26	65.0
Not Religious	3	7.5
Other	2	5.0
Did Not Respond	6	13.0

Note. Participants endorsed more than one response.

Table 7.2

Additional Ideology and Beliefs (N=46)

Beliefs/Practices Considered Important*	<i>n</i>	%
Meaning, Purpose, Calling in Life	38	82.6
Ethical Values and Behaviors	39	84.8
Forgiveness, Gratitude, Kindness	37	80.4
Social Justice	35	76.1
Acceptance of Self and Others	42	91.3
Being Part of Something Larger	26	56.5
Appreciating the Sacredness of Life	23	50.0
Belief in God or Universal Spirit	24	52.2
Belief in an Afterlife	16	34.8
Belief in Miracles/Supernatural	14	30.4
Prayer (at Shrine/Symbols in Home)	18	39.1
Meditation	10	21.7
Attendance at Religious Services	11	23.9
Formal Membership	5	10.9
Reading of Scriptures/Sacred Texts	14	30.4
Learning from Spiritual Models	11	23.9
Attending Community Services	10	21.7
Volunteerism and Charity	26	56.5
Religious Upbringing of Children	12	26.1
Sharing Faith with Others	20	43.5
Other	2	4.3

Note. Participants endorsed more than one response.

Table 7.3

Ideology and Current View (N=46)

Ideology/Secularization- Existence of God	<i>n</i>	%
There is no Such Thing	2	4.3
There is no way to Know	5	10.9
I'm not Sure	8	17.4
There is a Higher Power but no Personal God	9	15.2
There is Definitely a Personal God	23	45.7
There is More than one God	1	2.2
Prefer not to Answer	2	4.3
Current Views about R/S Matters	<i>n</i>	%
Conflicted	3	6.5
Secure	29	63.0
Doubting	3	6.5
Seeking	6	13.1
Not Interested	5	10.9

Table 8.1

Religious Affiliation (N=46)

Family of Origin (F.O.O)	<i>n</i>	%
Catholic	5	10.9
Mainline Christian	4	8.7
Baptist	0	0.0
Christian Generic	6	13.0
Pentecostal/Charismatic	0	0.0
Protestant Denominations	0	0.0
Mormon/LDS	0	0.0
Jewish	0	0.0
Eastern Religions	14	30.4
Muslim	3	6.5
NRM & Other Religions	0	0.0
None	8	17.4
DK/Refused/Skipped	1	2.2
Multiple ^b	5	10.9
Current	<i>n</i>	%
Catholic	4	8.7
Mainline Christian	2	4.3
Baptist	0	0.0
Christian Generic	8	17.4
Pentecostal/Charismatic	1	2.2
Protestant Denominations	0	0.0
Mormon/LDS	0	0.0
Jewish	0	0.0
Eastern Religions	4	8.7
Muslim	3	6.5
NRM & Other Religions	1	2.2
None	13	28.3
DK/Refused/Did Not Respond	10	21.7
Multiple ^b	0	0.0

^a Categories are based on the 2008 ARIS Taxonomy (Appendix B)

^b The category *Multiple* was created following an inspection of narrative responses.

Table 8.2

Changes in Religious Affiliation (N=46)

	<i>n</i>	<i>%</i>
Same Affiliation	16	34.5
None/No Affiliation » No Response*	10	21.7
Affiliation » No Affiliation**	8	17.4
Different Affiliation	5	10.9
None/No Affiliation » Affiliation***	5	10.9
No Affiliation	2	4.3

^a Participants endorsed “None” for F.O.O. and left the item blank for current R.A.

^b Participants endorsed an affiliation for F.O.O. and indicated no affiliation/none for current R.A.

^c Participants endorsed no affiliation for F.O.O. and endorsed a current R.A.

Table 9

Religious Participation (N=46)

<i>Religious Participation (N=46)</i>		
Family of Origin Religious Involvement	<i>n</i>	%
Active Participation	7	15.2
Regular Participation	20	43.5
Identification with Religion	13	28.3
No Identification	4	8.7
Somewhat Negative Reaction	1	2.2
Disdain or Very Negative Reaction	1	2.2
Current Religious Involvement	<i>n</i>	%
Active Participation	6	13.0
Regular Participation	13	28.3
Identification with Religion	16	34.8
No Identification	6	13.0
Somewhat Negative Reaction	5	10.9
Disdain or Very Negative Reaction	0	0.0

Table 10

Religious Coping (N=46)

Extent of R/S in Coping	<i>n</i>	%
Very Involved	17	37.0
Somewhat Involved	15	32.6
Not Very Involved	6	13.0
Not Involved at All	8	17.4

Table 11.1

R/S in Clinical Practice (N=46)

<u>Training Experiences</u>	<u>Weakened</u>	<u><i>n</i> (%)</u> <u>No Change</u>	<u>Strengthened</u>	<u>Not Applicable</u>
Own Personal Psychotherapy	0 (0.0)	24 (52.2)	12 (26.1)	10 (21.7)
New Ideas Encountered	4 (8.7)	25 (54.3)	13 (28.3)	4 (8.7)
Attitudes/Opinions of Psychology Professors ^a	4 (8.9)	35 (77.8)	2 (4.4)	4 (8.9)
Attitudes/Opinions of Non-Psychology Professors ^b	3 (6.8)	28 (63.6)	4 (9.1)	9 (20.5)
Working as a MHP/Psychologist	2 (4.3)	18 (39.1)	23 (50.0)	3 (6.5)

^a One participant did not respond to this item.^b Two participants did not respond to this item.

Table 11.2

Frequency of Issues Presented (N=46)

R/S Issues Presented or Discussed	<i>n</i>	%
A Great Deal of Time	1	2.2
Often	1	2.2
Sometimes	20	43.5
Rarely	18	39.1
Never	6	13.0

Table 11.3

Additional R/S Issues (N=46)

Frequency R/S Issues Involved in Treatment	<i>n</i>	%
A Great Deal of Time	0	0.0
Often	5	10.9
Sometimes ^a	20	43.5
Rarely ^b	17	37.0
Never	2	4.3
Did Not Respond	2	4.3

^a The category “Sometimes” also includes “It depends,” “moderately,” “periodically,” and “occasionally.”

^b The category “Rarely” also includes “Infrequently.”

Table 11.4

Types of R/S Issues (N= 46)

Client Presentation of R/S Issues*	<i>n</i>	%
Loss/Questioning of Faith	27	67.5
Conversion to New Faith	10	25.0
Terminal/Life-Threatening Illness	18	45.0
Near-Death Experience	10	25.0
Changes in Relationship to Higher Power	18	45.0
Evil Spirits	5	12.5
Disruption of Harmony	6	15.0
Bad Luck/Misfortune	7	17.5
Other	9	22.5
Did Not Respond	6	12.0

Note. Participants endorsed more than one response

Table 12

Education and Training in R/S (N=46)

	<i>M</i>	<i>SD</i>
Adequacy of Graduate Education/Clinical Training	2.9	1.6
Receptivity of Psychology Graduate Faculty ^a	4.0	1.8
Comfort with Discussing Issues of Religion/Spirituality ^b	4.3	1.8
Preparedness to Integrate Religious/Spiritual Resources	4.0	1.8

^a Two participants did not respond to this item.

^b One participant did not respond to this item.

Table 13

Contributing Factors in R/S (N=46)

Ability to Address R/S Issues*	<i>n</i>	%
Majored/Minored as Undergraduate	4	10.0
Coursework in Diversity Issues	33	82.5
Graduate Level Course	7	17.5
Academic Course in R/S	7	17.5
Integrated Graduate Program	1	2.5
Workshops/Presentations	17	42.5
Formal Study	6	15.0
Clinical Training and Supervision	20	50.0
Independent Study	15	37.5
Other	6	15.0
Did Not Respond	6	13.0

Note. Participants endorsed more than one response.

Table 14

Sanctification (N=46)

	<i>M</i>	<i>SD</i>
Choice to Pursue Career in Psychology as an Expression of R/S	3.3	2.3
Role as Psychologist is Consistent with Religious/Spiritual Identity ^a	4.9	1.8
Choice to Work is Sacred	4.3	1.8

^a One participant did not respond to this item.

APPENDIX A

Literature Review Tables

Affiliations, Beliefs, and Practices of Psychologists

Based on the research objectives and the nature of this investigator's exploratory study, this appendix (see Table 3) presents a review of the literature on the religious and spiritual beliefs, practices and involvement, religious affiliations, and influence on professional practice among clinical and counseling psychologists. Religious and spiritual beliefs and practices of clinicians have been areas of interest, particularly when examining how cultural considerations impact clinical work. Studies have shown that the use of religious and spiritual interventions in therapy is associated with the personal religiosity of the clinician. Religious and spiritual practices such as church attendance and prayer as well as the therapist's religious attitudes also influence the degree to which clinicians utilize religious and spiritual interventions in professional practice (Bilgrave & Deluty, 2002; Shafranske & Mahony, 1990b). Several seminal papers identifying the religious and spiritual orientations and behaviors have suggested that compared to other mental health professionals, clinical psychologists are the least likely to be affiliated with an organized religion (Bergin & Jensen, 1990; Shafranske, 1996) and continue to be less religious than the general population (Delaney, Miller, & Bisonó, 2007).

Bergin and Jensen (1990) conducted a national survey of 118 marital and family therapists, 106 clinical social workers, 71 psychiatrists, and 119 clinical psychologists ($N= 414$ clinicians). Eighty percent claimed some type of religious preference, specifically, Protestantism (38%) with the second largest combined group consisting of agnostics, atheists, humanists, and none (10%, 6%, 1%, and 3% respectively). Additionally, in regards to religious service attendance, 41% reported occasional or non-attendance. When asked whether clinicians tried hard to live their lives according to their

religious beliefs, 77% affirmed to that statement, suggesting that overall, most clinicians identified spirituality and/or religious belief as important dimensions in their lives.

Shafranske and Malony (1990a, 1990b) conducted two separate studies which examined psychologists' religious involvement and the extent to which they believe religious and spiritual issues were relevant to their clinical work. In one study of 47 California psychologists (Shafranske & Malony, 1990a), over half of those surveyed (66%) reported that spirituality was personally relevant and that for those (96%) who were raised in a particular organized religion regardless of the level of involvement, the many psychologists were no longer involved in organized religion. In Shafranske and Malony's second study (1990b) where they surveyed over 400 members of the American Psychological Association, 97% was raised in a particular religion, 40% endorsed a personal, transcendent God orientation, 65% reported that spirituality was relevant in their personal lives, 18% perceived their organized religion as a source of support, and the average religious service attendance was approximately twice a month. However, most clinicians agreed that religious and spiritual issues were relevant to their clinical work and they appreciated the religious and spiritual dimensions of their clients.

Delany, Miller, and Bisonó (2007) conducted a more recent survey of 259 members from the American Psychological Association. Eighty-four percent endorsed a religious preference with about a third reporting that they were less likely to attend religious service within the last week. Less than half surveyed (48%) indicated that religion was not important in their lives, even though over 80% agreed that there was a positive association between religion and mental health. Finally, Bilgrave and Deluty (2002) surveyed 233 clinical and counseling psychologists, the majority of whom held

some religious and/or spiritual beliefs (71%). Only 20% participated in some organized religion, over 80% held some sort of “belief and participation in some transcendent realm,” and less than a third agreed strongly that personal religious beliefs influenced clinical practice. Interestingly, clinicians who held Eastern or mystical beliefs and practices or atheism/agnosticism predicted humanistic orientation while those who held more conservative Christian predicted a cognitive-behavioral orientation, and those who committed to the psychodynamic orientation agreed less to Eastern/mystical beliefs.

Overall, these studies suggest the trend continues to remain the same: that while psychologists in general are less religious than the general population, they do ascribed to more private forms of beliefs and practices that are relevant to their personal and professional lives. Additionally, while clinicians believe that it is important to be aware of their clients’ religious and spiritual issues as they relate to their diagnoses and treatment, they appear to be less likely to perform more overtly religious practices in the clinical setting, e.g., therapist disclosure of personal religious affiliation or belief orientation. However, given these discrepancies, it is still important to consider the role therapist’ religious and spiritual belief systems play in understanding and treating clients from various cultural backgrounds.

Researchers	Study	Sample	Findings
Bergin & Jensen (1990)	Religiosity of psychotherapists: A national survey	118 MFTs, 106 clinical, social workers, 71 psychiatrists, 119 clinical psychologists across the following religious preferences: Protestant, Jewish, Catholic, Agnostic, Atheist, None, LDS, Unitarian, Eastern (Asian), Other, Humanist, Greek Orthodox	<p>*80% claimed some type of religious preference; majority: Protestants (38%); second largest combined: agnostic, atheist, humanist, none (20%)</p> <p>*Religious service attendance: 41%; Occasional or non-attendance: 59% 100 self-classified as intrinsically religious; 28 as extrinsically religious; 1-2 as pro-religious (high in both intrinsic/extrinsic); 89 non-religious (low in both intrinsic/extrinsic); 106 no response; 77%; “I try hard to live my life according to my religious beliefs” vs. 46%: “My whole approach to life is based on my religion.”</p> <p>*68% - “Seek a spiritual understanding of the universe and one’s place in it” vs. 44%: a “religious affiliation in which one actively participates”</p> <p>*Across professions, MFTs reflect highest religiosity</p>
Bilgrave & Deluty (1998)	Religious beliefs and therapeutic orientations of clinical and counseling psychologists	237 doctoral-level clinical and counseling psychologists; 66% male 90% European American, 66% believed strongly or very strongly in “God or Universal Spirit,” 74% considered religion to	<p>*Eastern and mystical beliefs positively assoc. with humanistic and existential perspectives</p> <p>*Psychologists who agree with orthodox Christian beliefs tend to choose the cognitive-behavioral</p>

		<p>be “moderately important” to “extremely important” in their lives; self- designated as Protestant (26%), Jew and Catholic (both 6%), “other” (15%), Agnostic (12%), Eastern (8%), Atheist (6%), Fundamentalist Christian (1%); 72%: claimed their religious beliefs influenced practice at mod or higher level; 66% claimed their practice influenced their religious beliefs</p>	<p>perspective; 72%: agreed that their religious beliefs influenced their practice of therapy; tended to rate religion as personally important and to experience high levels of spiritual support; those who self-identified as Jewish were not as likely to assert that their religious beliefs influence their practice. *Strong agreement with Orthodox Christian beliefs predicted higher levels of agreement with statement that one's religious beliefs influenced one's practice of therapy; self- designation as Christian predicted lower levels of agreement. *66%: believed at moderate or greater level that practice influenced religious beliefs; significantly more likely than the others to consider religion personally important, feel supported by their religious beliefs, to self-identify as Eastern, and endorse Eastern or mystical beliefs; those less likely to believe practice had influenced their religious beliefs tended to self-id. *As Jewish and nonbelievers and to affirm atheist/agnostic beliefs</p>
Bilgrave & Deluty (2002)	Religious beliefs and political ideologies as predictors of	233 clinical and counseling psychologists; 71% held	*57% of psychologists agreed at a strong/very strong level to belief

	<p>psychotherapeutic orientations of clinical and counseling psychologists</p>	<p>religious/spiritual beliefs; largest group was Judaism (25%), mainstream Protestantism (23%), Catholicism (14%); 14% had born-again experience; 21%: “participating with an organized religion” vs. 50%- “belief and participation in some transcendental realm” 86%- “qualities and characteristics of exemplary humanity” 34%- totally or mostly true regarding the extent to which religious beliefs lay behind whole approach to life, 11%-moderate; 30% believed quite a bit that religious beliefs influenced practice of psychotherapy, 33%- moderately; 13%- no</p>	<p>in “God or a Universal Spirit”; 44% believed either in “God or a Supreme Being” or in an “eternal, universal essence or One” (27%) *Large portion considered religious beliefs to be personally important *Distinguished between organized religion and a more private spirituality, and as a group endorsed spirituality more strongly *Eastern/mystical religious beliefs and atheism-agnosticism predicted humanistic orientation *Conservative Christian beliefs predicted cognitive-behavioral orientation; those committed to psychodynamic orientation agreed less with Eastern/mystical religious beliefs</p>
<p>Carlson, Kirkpatrick, Hecker, & Killmer (2002)</p>	<p>Religion, spirituality, and marriage and family therapy: A study of family therapists’ beliefs about the appropriateness of addressing religious and spiritual issues in therapy</p>	<p>1200 randomly selected members from AAMFT 153 surveys returned; 56% Protestant, 41% secular institution; 7% religious degree; 76%: MFT as primary profession; 71% private practice; 5% church-related agency</p>	<p>*96% believe there is relationship between spiritual health and MH; 95% considered selves to be spiritual; 82% regularly spent time getting in touch with own spirituality *71% pray regularly; strong connection between spirituality and MFT as discipline; 62%: spiritual dimension should be considered in clinical practice; 47%: necessary to address clients’ spirituality in order to help them;</p>

			<p>88%: appropriate to ask clients about their spirituality; 66% about clients' religion; 47%: appropriate to talk with clients about God; 52%: appropriate to use spiritual language with clients; 36%: appropriate to use spiritual language in therapy</p> <p>*Of the 20 participants who provided comments, majority believed therapists should discuss R/S issues if clients brings up first</p>
Case & McMinn (2001)	Spiritual coping and well-functioning among psychologists	400 members from APA; 51% male 95% White, 1% African American, 0.8% Asian 0.8% Hispanic, 0.3% Native American, 2.1% biracial	*Religious psychologists tend to use spiritually-oriented coping methods- "prayer or meditation" and "attended religious services"
Delaney, Miller, & Bisonó (2007)	Religiosity and spirituality among psychologists: A survey of clinician members of the American Psychological Association	259 members from APA; 93% non-Hispanic White, 6 Hispanic, 4 African American, 2 Native American, 1 each: Asian, Caribbean, American, Middle Eastern, Pacific Islander	<p>*Religious preference endorsed by 84%; believed in God at some point in their lives (91%), no longer do (25%); less likely to attend church, synagogue, mosque within last week (33%); daily/almost daily prayer: 61% of Catholics, 50% Protestants, 36% Jews</p> <p>*48% described religion as unimportant in their lives</p> <p>*82% agreed to positive relationship between religion and MH; 7% perceived religion to be harmful overall, remain far less religious than general population;</p>

			more than 2x to claim no religion, 3x to describe religion as unimportant, 5x to deny belief in God; less likely to pray, be member of religious congregation, attend worship; most ascribed to spirituality in their lives
Frazier & Hansen (2009)	Religious/spiritual psychotherapy behaviors: Do we do what we believe to be important?	104 doctoral level clinicians; 93% European American, 3% Hispanic, 2% Asian, 1% African American, 66% clinical, 25% counseling; 38% cognitive-behavioral, 28% integrative, 27% psychodynamic; 30% clients discuss R/S issues	*78% tried hard to live by religious beliefs; 14% approach to life based on religion; somewhat competent in addressing R/S issues; R/S domain somewhat to very important in their lives *Two clinician variables predicted higher use of R/S psychotherapy behaviors: hours of R/S continuing education and level of R/S self-identification *Discrepancy between actual engagement of psychotherapy behaviors and importance ratings *57% hesitant to refer to more R/S qualified provider
Gregory, Pomerantz, Pettibone, & Segrist (2008)	The effect of psychologists' disclose of personal religious background on prospective clients	165 undergraduates 78.1%, European American, 11.5% African American, 4.2% Hispanic, 2.4% Asian American, 84.8% Christian, 9.7% Agnostic, 1.8% Atheist, 0.6% Buddhist, 3%, other, no response; 48.5%: high religiosity	*Likelihood of seeing atheist therapist significantly lower than seeing both Christian and Jewish therapist *Among high-religiosity subjects, seeing atheist therapist significantly lower than seeing Christian, Jewish, or Islamic therapist *Low-religiosity participants, no

			<p>significant differences</p> <p>*Participants may be primarily concerned with fundamental question of whether psychologist subscribes to any traditional or familiar religion at all (as opposed to atheism), rather than specific religious affiliation</p>
Hathaway, Scott, & Garver (2004)	Assessing religious/spiritual functioning: A neglected domain in clinical practice?	<p><i>First study:</i> 34 clinicians from 4 specialty clinics <i>Second study:</i> 333 clinicians from APA; 94.4% Caucasian, 1.5% African American, 1.5% Hispanic, 0.6% Asian American, 1.5% "other"</p>	<p>*Majority of those in both studies reported believe that client's R/S functioning is important domain</p> <p>*Majority believed they can distinguish between healthy/unhealthy religious and being familiar with their clients' beliefs</p> <p>*Some percentage asked about client R/S during assessment, set R/S treatment goals, sought consultation or collaborated with religious professionals</p> <p>*Majority did not routinely evaluate whether clients' disorders resulted in impaired R/S functioning</p> <p>*About 20% in "best practice" settings and about 10% of national survey did not consider R/S functioning to be more than a slightly important domain of adaptive functioning for their clients</p>
Jensen & Bergin (1988)	Mental health values of	425 participants: 67% clinical	*Value themes of self-assessment/

	<p>professional therapists: A national interdisciplinary survey</p>	<p>psychologists, 63% MFTs, 64% social workers, 40% psychiatrists; 94% Caucasian, 3% Asian/ Pacific Islander, 3% American Indians/Alaskan Natives, Blacks/Afro-Americans, and Hispanics; 38% Protestants, 18% Jews, 15% Catholics, 20% not religious in any traditional sense</p>	<p>growth, forgiveness, and S/R were partially associated with theoretical with self-awareness/growth, behavioral and systems therapists expressed lower agreement than did dynamic/eclectic therapists *Agnostics/atheists agreed to significantly lower degree than those of traditional religions in themes of freedom/autonomy or responsibility, human relatedness/interpersonal commitment *Pro-religious group had highest rate of agreement on very value theme of self-awareness/growth</p>
<p>Shafranske (1996)</p>	<p>Religious beliefs, affiliations, and practices of clinical psychologists</p>	<p>N/A- Review Article</p>	<p>*Psychologists rank among least likely to affiliate with religion; although receptive to R/S beliefs, are less likely to affiliate with and become involved in organized religion *In general, view R/S issues to be relevant in their work; majority report spirituality is relevant in their professional life; also appreciate R/S dimensions of their clients' experiences; tend to not participate or actively seek to influence clients' lives by sharing belief orientation or opinions regarding client's religious experience</p>

			*Personal experience of religion significantly correlated with attitude/behaviors regarding interventions of a religious nature
Shafranske (2000)	Religious involvement and professional practices of psychiatrists and other mental health professionals	111 members from American Psychiatric Association; 31% male	*73% affirmed belief in God; 42%: religion not very important; 49% reported that R/S issues were involved in psychiatric treatment most/great deal of the time; 43% somewhat, 8% rarely; 44%: "loss of purpose or meaning in life" was focus of treatment most/great deal of time *Almost 50% knew patients' religious background and exploring religious beliefs *More than 50% approved of/recommended these practices; 74% disapproved of praying with patient, 56% disapproved of personal religious on clinician's part
Shafranske & Malony (1990a)	California psychologists' religiosity and psychotherapy	47 psychologists	*66% reported spirituality as personally relevant; 96% raised in particular organized religion regardless of degree of involvement *75% no longer participate in religion of childhood; relatively uninvolved in organized religion; in general view R/S as relevant in work
Shafranske & Malony (1990b)	Clinical psychologists' religious	409 members of APA; 73% male,	*40% endorsed personal,

	and spiritual orientations and their practice of psychotherapy	1% no response	<p>God orientation, 30%: dimension in all nature; 26%: ideologies are illusions meaningful, 2%: all and their and their illusion & irrelevant to real world</p> <p>*65% reported spirituality personally relevant; 97% raised in particular religion; 71%: current affiliation with organized religion; average attendance less than twice/month; 18%: organized religion primary source of spirituality;</p> <p>*Overall, view R/S issues relevant to their work and appreciate R/S dimensions of clients' experiences</p>
Smith & Orlinsky (2004)	Religious and spiritual among psychotherapists	975 international psychotherapists from New Zealand, Canada, psychologists by profession; 94% raised in a particular religious tradition; 45% Protestant, 20% Roman Catholics, 21% Jews	<p>*56% of therapists overall; 65% in U.S. reported being affiliated with specific religious denomination</p> <p>*Orientation of most therapists: personal Spirituality; 71.4%</p> <p>*Sizeable group characterized by Religious Spirituality, for whom all aspects of religiosity were highly important (27%)</p> <p>*Secular morality for whom all aspects of religiosity except personal moral/ethical were unimportant (20.7%)</p>
Wagenfeld- Heintz (2008)	One mind or two? How psychiatrists and psychologists	2 male Fundamentalist Protestant psychiatrists, 2 female	*For majority of psychiatrists psychologists, medical-scientific

	reconcile faith and science	Moderate Protestant psychologists, 2 Fundamentalist Protestant psychologists, other categories, 1 of each: Liberal Protestant, Roman Catholic, Conservative Jewish, Reformed Jewish, non-affiliated believers	and R/S paradigms able to co-exist as equal spheres of knowledge; most defined their field of practice in scientific/behavioristic terms, yet a number still viewed R/S as legitimately incorporated into psychotherapy *A number of participants stated combining their professional their religious denomination “Just who I am” *2 Fundamentalist Protestants stated feeling short as Christians conflict between value of psychiatry and Christianity *Many participants described caution about sharing their R/S beliefs with colleagues as well as integration of these beliefs into professional practice
Walker, Gorsuch, & Tan (2004)	Therapists’ integration of religion and spirituality in counseling: A meta-analysis	26 studies; clinical and counseling psychologists (44.15%), explicitly Christian counselors (21.3%), MFTs (14%), social workers (5.85%), psychiatrists (4.32%), explicitly Mormon psychotherapists (3.54%). Psychotherapists (2.77%), LPCs (1.82%), pastoral counselors (1.71%)	*In 18 studies of 3,813 34.51% Protestant, 19.61% 13.89% Catholic; clinical and counseling psychologists were more likely to be either agnostic or when compared with MFTs but not with social workers; *They were also more likely to endorse no religion psychotherapists (3.54%), *Personal religiousness on part of both explicitly religious therapists from part of mixed

			sample associated with being able to integrate R/S into several aspects of counseling *Much larger percentage using R/S techniques in therapy for therapists in mixed samples than for explicitly religious therapists
Worthington, Hook, Davis, & McDaniel (2011)	Religion and spirituality	N/A	*Few studies have focused specifically on influence of therapists' R/S values on own or convergence and matching of clients' and therapist' religions *Non-religious therapists found to effectively deliver religiously accommodative approach to cognitive therapy for depression with highly religious clients; nine empirical studies examining Christian (n = 6) and Muslim (n= 3) psychotherapy

R/S Beliefs, Practices, and Affiliations of Graduate Students

The current study includes surveying clinical and counseling graduate level students. Therefore this appendix (see Table 4) provides an overview of the religious and spiritual experiences beliefs and practices of graduate students. Currently, there has been very limited literature reporting the religious and spiritual beliefs and experiences, affiliations, and influence on professional training

and clinical practice of graduates in other professions beyond marriage and family therapy and social work. Most of the studies conducted on religiosity and spirituality have used older populations or specific religious groups and have overlooked younger individuals or students. In one of the few studies surveying graduate students, 60% expressed spirituality through personal religious beliefs and had greater spiritual health and ability to cope with stressors (Graham, Furr, Flowers, & Burke, 2001). However, these students also indicated stronger discomfort towards counseling clients who held more extreme religious and/or spiritual interventions. In another study examining religiosity and spirituality of marriage and family therapists (Prest, Russel, & Souza, 1999), most students valued religious and spiritual dimensions in their own and in their clients' lives. While a majority considered spiritual issues in practice, most felt constrained from discussing spirituality within the professional community. More recent studies on the religiousness and spiritual practices and behaviors of social workers (Hodge & McGrew, 2006) and doctoral-level psychology students (Walker, Gorsuch, Tan, & Otis, 2008) have also expressed some degree of personal religiosity and spirituality but limiting the use of spiritual and religious interventions in clinical practice. Personal psychotherapy was highly correlated with greater frequency of utilizing religious and spiritual interventions. These studies highlight not only the dearth of research on graduate students' personal religious and spiritual beliefs but also the impact of how their perceived discomfort in clients' religious and spiritual issues may also be a result of two systemic forces: (a) the continued lack of diversity training at the doctoral level in religiosity and spirituality within the context of multiculturalism and diversity issues, despite the proliferation of integrated graduate programs that integrate psychology

and theology, and (b) conventional behaviors within the medical and scientific professions to dismiss or limit spiritual and religious conversations between clinicians and clients.

Researchers	Study	Sample	Findings
Calicchia & Graham (2006)	Assessing the relationship between spirituality, life stressors, and social resources: buffers of stress in graduate students	56 graduate students, 41 women; majority were Caucasian; specific religious denominations unknown, 90% indicated belief in God, majority considered selves Christian; master's level in counseling	*Social resources negatively associated with stress, but not cases; spirituality has limited to buffer stress *Existential well-being and well-being are separate since only existential well-significantly correlated with stress scales
Graham, Furr, Flowers, & Burke (2001)	Religion and spirituality in coping with stress	115 master's level counseling students in U.S.; 73.9% Caucasian, 13% African American, 3.5% Asian, 3.5% other ethnic/racial (e.g., Native American, biracial)	*60% expressed spirituality religious belief; 33.9% were but with no set of religious *2.7% considered selves as but not spiritual; 0.9% neither spiritual *Students indicated more counseling clients who were extreme ends of R/S *Students who expressed their spirituality through their religious beliefs had greater spiritual health & immunity
Hodge & McGrew (2006)	Spirituality, religion, and the interrelationship: A nationally representative study	303 National Association of Social Workers- affiliated graduate students 76% White, 10% African American, 5% Hispanic, 3% Asian, 1% Native American, 5% "other" or declined	*One-third of sample defined spirituality in personal or terms without any reference transcendent. *Second largest category those who defined spirituality

		<p>35% Protestant, 25% other type of faith,” 24% Catholic, 8% no faith, 7% Jewish, 1% declined</p>	<p>terms of higher power or being *Race associated with using 2 personally constructed and community with non-Euro Americans being significantly more likely to view religion as constructed and Euro-Am. more likely to define religion in terms of community Respondents' religious trad. significantly related to using the organized beliefs or doctrine theme to define religion; Jewish/secular adherents were most likely to use this theme (36%), then Protestants (27%), other faiths (26%), and Catholics (14%)</p>
<p>Prest, Russel, & Souza (1999)</p>	<p>Spirituality and religion in training, practice and personal development</p>	<p>52 first- or second-year master's or doctoral level marriage and family therapy students in U.S. 88.2% Caucasian Raised in Catholic church (15.2%), Protestant (67.4%), “other” Christian (7.6%), not raised to believe in certain religion (9.8%) 10.6% - Catholicism as current denomination, 53.2% Protestant, 26.4% “other” religion, 9.8% not raised to believe in certain religion</p>	<p>*Most MFT graduate students value role of R/S in own and clients' lives. *Most perceived selves as both spiritual and religious, view spirituality as significantly connected to other aspects of life (e.g., mental/physical and devote energy to religious/spiritual lives *More likely to see selves as spiritual than religious, but identified with an organized religion *Divided on whether or not</p>

			<p>religion was primary source spirituality</p> <p>*Vast majority indicated belief transcendent dimension or found in all nature; majority identified their work as spirit. path” but felt constrained from discussing spirituality in community; majority spiritual issues in practice; value and promote clients’ spirituality and, to lesser religiosity</p>
Walker, Gorsuch, Tan, & Otis (2008)	Use of religious and spiritual interventions by trainees in APA-accredited Christian clinical psychology programs	162 doctoral-level student therapists from three explicitly Christian APA-accredited clinical psychology programs; 108 European Americans, 20 Asian Americans, 10 Hispanic Americans, 8 African Americans, 16 other ethnic/racial heritages	<p>*Theology/integration well as personal psychotherapy part of therapist were associated with using explicit religious in therapy</p> <p>*Trainee personal to correlate significantly with reported frequency of using R/S interventions</p> <p>*Highest multiple correlation with therapists’ self-reported frequency using R/S interventions were obtained related to specific training, clinical with religious clients, general professional training followed by personal religiousness, personal psychotherapy, and theology and integration work</p>

Williamson & Sandage (2009)	Longitudinal analyses of religious and spiritual development among seminary students	119 seminary students; 95% Euro-American, 2% Asian American, 2% African American, 1% Latino/Hispanic; master's level graduate students in divinity, theological studies, MFT, and undeclared	<p>*Demonstrated growth in religiosity, spiritual well-being spiritual openness</p> <p>*Those who were more intrinsically religious became more active in higher in spiritual well-being, developed a realistic view; however there was also reported to be some turbulence associated relationship to divine</p>
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APPENDIX B

Taxonomy of Religious Traditions Based on 2008 ARIS Survey

Catholic: Roman, Greek, Eastern Rites

Mainline Christian: Methodist, United Methodist, African Methodist, Lutheran, Presbyterian, Episcopal/Anglican, United Church of Christ/Congregational, Reformed/Dutch Reform, Disciples of Christ, Moravian, Quaker, Orthodox (Greek, Russian, Eastern, Christian)

Baptist: Southern Baptist, American Baptist, Free-Will, Missionary, African-American denominations

Christian Generic: Christian, Protestant, Evangelical/ Born Again Christian, Born Again, Fundamentalist, Independent Christian, Missionary Alliance Church, Non-Denominational Christian

Pentecostal/Charismatic: Pentecostal, Assemblies of God, Full Gospel, Four Square Gospel, Church of God, Holiness, Nazarene, Salvation Army

Protestant Denomination: Churches of Christ, Seventh Day Adventist, Mennonite, Brethren, Apostle, Covenant, Christian Reform, Jehovah's Witness, Christian Science, Messianic Jews

Mormon/Latter Day Saints

Jewish/Judaism

Eastern Religions: Buddhist, Hindu, Taoist, Baha'i, Shintoist, Zoroastrian, Sikh

Muslim/Islam

New Religious Movements and Other Religions: Scientology, New Age, Eckankar, Spiritualist, Unitarian-Universalist, Deist, Wiccan, Pagan, Druid, Indian Religion, Santeria, Rastafarian

None: None, No religion, Humanistic, Ethical Culture, Agnostic, Atheist, Secular

Refused: Don't Know

APPENDIX C

Email Correspondence to Obtain AAPA Membership Number

from **Wei, Meifen [PSYCH]**
sender-Sent at 7:04 AM (GMT-06:00). Current time there: 12:28 AM.
time
to Georgia Yu

date Wed, Nov 24, 2010 at 7:04 AM
subject RE: AAPA members list

Dear Georgia,

I receive an email from Alvin. We have about 650 in the email listserv. Hope this information help!

Please let me know if anything else I can do for you!

Happy Thanksgiving!
Meifen

Meifen Wei, Ph.D.
Associate Professor
Department of Psychology
Iowa State University

-----Original Message-----
From: Georgia Yu [mailto:]
Sent: Thursday, November 18, 2010 1:33 PM
To: Wei, Meifen [PSYCH]
Subject: Re: AAPA members list

Hi Dr. Wei,
Ok. I think a better question might be what percentage of those who are members are actually on the listserv, but maybe Dr. Alvarez might be able to answer that.

Thanks!
Georgia

APPENDIX D

Survey Instrument

1. Consent and Introduction to the Survey

My name is <redacted>, and I am a doctoral student in clinical psychology at the Graduate School of Education and Psychology, Pepperdine University conducting a study to meet dissertation requirements. My dissertation chairperson is Dr. Edward Shafranske, Professor of Psychology. This survey examines the religious and spiritual beliefs and practices of Asian and Asian American mental health professionals and graduate students in clinical and counseling psychology and their attitudes and practices regarding approaches to address religion and spirituality in psychotherapy as compared to other ethnicities.

This study has been approved by the Pepperdine University Graduate and Professional Schools Institutional Review Board (IRB) and that participation in this study is voluntary. Further, anonymity will be ensured because the survey information will be gathered with no identifying information or IP addresses obtained. While there are no direct benefits to all participants in the study, subjects may experience satisfaction in knowing that their participation will contribute to knowledge in the field of psychology as well as increase their awareness of the role of religion and spirituality in their personal and professional life. Additionally, subjects may choose to provide their email address to the investigator in order to enter a drawing to win one of four \$25 gift certificates to [Amazon.com](https://www.amazon.com). It is not necessary to complete the survey in order to participate in the drawing. Email addresses will not be linked to individual survey responses. However, anonymity as a participant will be compromised as the researcher may learn the identity if the entry is the winning entry. Furthermore, the study poses no greater than minimal risk of harm, for example, possible boredom, fatigue, or discomfort in answering questions related to personal religious or spiritual beliefs, practices or attitudes. Subjects may discontinue participation at any time and that it is recommended that they consult with a trusted faculty member, clinical supervisor, or mental health professional should they experience negative reactions to the survey. If you have additional questions about the study please contact Edward Shafranske, Ph.D., ABPP at (XXX) XXX-XXXX, or for questions concerning your rights as a research participant, contact Jean Kang, Manager of the Graduate and Professional Schools Institutional Review Board, Graduate School of Education and Psychology, Pepperdine University, at (XXX) XXX-XXXX.

I understand that by checking the box below, I have indicated my voluntary consent to participate in this research.

Investigator: Georgia Yu, M.A.

Dissertation Chair: Dr. Edward P. Shafanske, Ph.D., ABPP
Graduate School of Education and Psychology, Pepperdine University

I wish to participate in this study.

I do not wish to participate in this study.

2. Sex: Female Male Transgender Prefer not to answer

3. Age: _____
4. Describe your ethnicity. **NOTE:** If you specified Asian, Pacific Islander, Multiracial/multiethnic, or other please **also** answer Question 5.
- ____ American Indian
 ____ Asian
 ____ Hispanic
 ____ Black
 ____ White
 ____ Pacific Islander
 ____ Multiracial/Multiethnic
 ____ Other
 ____ Not Specified
5. If you indicated Asian, Pacific Islander, Multiracial/Multiethnic, or Other, please specify your ethnicity. All other participants should not answer this item.
- _____
6. Identify your generational status:
- ____ First generation: You were foreign-born
 ____ 1.5 generation: You came to the United States before the age of 12
 ____ Second generation: You were U.S.-born with at least one parent born outside of the United States
 ____ Third generation: You were U.S.-born and your parents were also U.S.-born
 ____ Fourth or more generation
7. Please indicate the highest degree earned as of **December 31, 2011:**
- ____ A.A.
 ____ B.A./B.S.
 ____ M.A./M.S.
 ____ Ed.D.
 ____ Ph.D.
 ____ Psy.D.
 ____ Other, please describe: _____
8. Indicate the academic program of your highest degree as indicated in the previous question:
- ____ Clinical Psychology
 ____ Counseling Psychology
 ____ Educational Psychology
 ____ Combined (e.g., Clinical/Counseling/School Psychology)
 ____ Marriage & Family Therapy
 ____ Social Work
 ____ Other, please describe: _____
9. Indicate the academic program in which you are currently enrolled:

- Clinical Psychology
- Counseling Psychology
- Educational Psychology
- Combined (e.g., Clinical/School Psychology)
- Marriage & Family Therapy
- Social Work
- Not currently enrolled in an academic program
- Other, please describe: _____

10. Which of the following theoretical orientations do you **most** identify? (Please choose one only)

- Behavioral
- Biological
- Cognitive
- Cognitive/Behavioral
- Developmental
- Family
- Humanistic/Existential
- Integrative
- Interpersonal
- Psychodynamic/Psychoanalytic
- Systems
- Not applicable
- Other, please describe: _____

11. If you are a licensed mental health professional, please indicate the license(s) you hold and specify the year you were first licensed, or mark “Unlicensed”:

- Licensed Psychologist
- Licensed Educational Psychologist
- Master’s in Social Work/Licensed Clinical Social Work
- Licensed Professional Counselor
- Other, please describe: _____
- Unlicensed

Please specify year: _____

12. Are you a member of the American Psychological Association?:

- Yes No

13. Are you a member of the Asian American Psychological Association?:

- Yes No

14. How important would you say religion is in your own life?

- Very important
- Fairly important
- Not very important
- No opinion

15. How important would you say spirituality is in your own life?
 Very important
 Fairly important
 Not very important
 No opinion
16. Identify the primary religious affiliation(s), if any, of your family of origin (e.g., Southern Baptist, Catholic, Jewish, Buddhist, Pagan, Atheist, Agnostic): _____
17. Describe your family of origin's level of religious involvement, when you were a child:
 Active participation, high level of involvement
 Regular participation, some involvement
 Identification with religion, very limited or no involvement
 No identification, participation, or involvement in religion
 Somewhat negative reaction to religion
 Disdain or very negative reaction to religion
18. Identify your current religious affiliation(s): _____
19. Describe your current level of religious involvement:
 Active participation, high level of involvement
 Regular participation, some involvement
 Identification with religion, very limited or no involvement
 No identification, participation, or involvement in religion
 Somewhat negative reaction to religion
 Disdain or very negative reaction to religion
20. To what extent is religion or spirituality involved in your coping with stressful situations?
 Very involved
 Somewhat involved
 Not very involved
 Not involved at all
21. Do you consider yourself:
 Religious
 Spiritual
 Religious and spiritual
 Neither religious nor spiritual
22. If you answered "Religious," "Spiritual," or "Religious and Spiritual," in Question 21, identify each of the factors that have influenced your current religious affiliation and practices (Please check all that apply):

- Strong ties to family values (e.g., filial piety)
- Maintain my identity or affiliation with my cultural heritage/values (e.g., traditional, group-oriented)
- Source of comfort and support during stressful life events
- Major aspect of personal identity (e.g., “Part of who I am”)
- Provides a meaning or purpose in life
- It is part of my personal beliefs
- Not religious
- Other, please describe: _____

23. Which of the following beliefs and/or practices are important to you (Please check all that apply):

- Meaning, purpose, and calling in life
- Ethical values and behavior
- Forgiveness, gratitude, and kindness
- Social justice
- Acceptance of self and other (even with faults)
- Being part of something larger than yourself
- Appreciating the sacredness of life
- Belief in God or a universal spirit
- Belief in an afterlife
- Belief in miracles and the supernatural phenomena
- Prayer (at shrines or religious symbols at home)
- Meditation
- Attendance at religious services
- Formal membership in a house of worship
- Reading scriptures/sacred texts outside of religious services
- Learning from spiritual models
- Attending community services and rituals
- Volunteerism and charity
- Religious upbringing of children
- Sharing faith with others
- Other, please describe: _____

24. Regarding the existence of God, do you think?”

- There is no such thing
- There is no way to know
- I’m not sure
- There is a higher power but no personal God
- There is more than one God
- There is definitely a personal God
- Prefer not to answer

25. How would you describe your current views about spiritual/religious matters? (Please

- choose only one):
- Conflicted

- Secure
- Doubting
- Seeking
- Not interested

Indicate how the following experiences (depicted in items 26-30) changed your religious/spiritual beliefs:

26. My own personal psychotherapy
 Weakened
 No change
 Strengthened
 Not applicable
Please explain: _____
27. New ideas encountered in graduate psychology program
 Weakened
 No change
 Strengthened
 Not applicable
Please explain: _____
28. Attitudes and opinions of psychology professors
 Weakened
 No change
 Strengthened
 Not applicable
Please explain: _____
29. Attitudes and opinions of professors (outside of psychology)
 Weakened
 No change
 Strengthened
 Not applicable
Please explain: _____
30. Working as a mental health professional/psychologist
 Weakened
 No change
 Strengthened
 Not applicable
Please explain: _____
31. In your training as a student therapist, mental health professional, or psychologist, religious and spiritual issues were presented and discussed:
 A great deal of time

- ___ Often
- ___ Sometimes
- ___ Rarely
- ___ Never

32. Check each of the following that has contributed to your ability to address religion or spirituality in treatment (Please include all that apply):
- ___ Majored/minored in any of the following as an undergraduate: philosophy, theology, religious studies
 - ___ Completed coursework in multicultural competence/diversity issues
 - ___ Completed graduate level courses in the psychology of religion and spirituality
 - ___ Completed academic courses in religion and/or spirituality
 - ___ Enrolled in or completed graduate program that integrated religion/spirituality/psychology (e.g., Fuller Theological Seminary)
 - ___ Workshops/presentations on religious/spiritual issues
 - ___ Formal study in Scripture or other religious texts (e.g., coursework, Hebrew school, Sunday school)
 - ___ Clinical training and supervision
 - ___ Independent study
 - ___ Other, please describe: _____
33. How adequate was your graduate education and clinical training respective of dealing with religious or spiritual issues in psychotherapy?
- (Not at all adequate) 1 2 3 4 5 6 7 (Very adequate)
34. How receptive were/are your psychology graduate school faculty members to discussing issues of religion or spirituality?
- (Not at all receptive) 1 2 3 4 5 6 7 (Very receptive)
35. How comfortable would you feel in discussing issues of religion and spirituality at your graduate school or work setting?
- (Not at all comfortable) 1 2 3 4 5 6 7 (Very comfortable)
36. How prepared are you to integrate religious or spiritual resources in psychotherapy (e.g., religious-accommodative forms of psychotherapy)?
- (Not at all prepared) 1 2 3 4 5 6 7 (Very prepared)
37. In your experience providing psychological treatment, how often are religious or spiritual issues involved in treatment (e.g., often, rarely)? _____

38. In your experience providing psychological treatment, please indicate at least one of the following religious or spiritual issues that clients have presented. If “Other,” please go to the next question to provide a qualitative response:
- ___ Loss or questioning of faith
 - ___ Conversion to a new faith/changes in membership, practices, and beliefs
 - ___ Terminal or life-threatening illness
 - ___ Near-death experience
 - ___ Changes in individual’s relationship to higher power not associated with religious organization (e.g., isolation from/anger towards higher power)
 - ___ Belief that mental illness is caused by evil spirits
 - ___ Belief that mental illness is caused by disruption of harmony within individual
 - ___ Belief that mental illness is caused by bad luck or misfortune
 - ___ Other
39. Please describe a religious/spiritual issue that has occurred in your experience providing psychological treatment not listed previously: _____
40. My choice in pursuing a career in psychology or other mental health field is an expression of my spirituality or religiousness.
- (Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree)
41. My role as a psychologist/therapist is consistent with my spiritual or religious identity.
- (Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree)
42. My choice to work as a psychologist/therapist is sacred to me.
- (Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree)

Thank you for completing this survey. Please be reminded that you may choose to enter a drawing to win one of four \$25 gift certificates to Amazon.com. It is not necessary to complete the survey in order to participate in the drawing. If you would like to be entered in the drawing, please email georgia.yu@gmail.com and type “Amazon” in the subject line. The researcher will randomly select four email addresses and will contact these individuals by email to inform each one that he or she has won a gift certificate. The winners will also receive an email from Amazon.com with a claim code for the gift certificate. Email addresses will not be linked to individual survey responses. However, your anonymity as a participant will be compromised as the researcher may learn your identity if your email address is one of the winning entries.

APPENDIX E

Permission to Post Recruitment Email

----- Forwarded message -----

From: **Richard Lee**
Date: Mon, Jan 30, 2012 at 11:23 AM
Subject: Re: Research Inquiry through AAPA
To: "Georgia Yu"

hi georgia,

thank you for an interest in AAPA. AAPA does have a listserv that is used by researchers to solicit research participants (assuming there is study IRB approval for such recruitment). however, you must be an active AAPA member to subscribe to the list. i encourage you to join AAPA as a student member as you could then subscribe to the list. in addition, i truly believe you would benefit professionally from such membership.

membership info is available at <website..

-rich

On Mon, Jan 30, 2012 at 10:11 AM, Georgia Yu wrote:

Dear Dr. Lee,

I am currently a fifth year doctoral student in clinical psychology at Pepperdine University. I am working on my dissertation, chaired by Dr. Edward Shafranske, and am interested in inviting AAPA members to be a part of my study. If this is a possibility, I was wondering how I would go about doing so.

Thank you,
Georgia Yu

--

Richard M Lee, PhD, LP
President, Asian American Psychological Association
Associate Editor, Cultural Diversity and Ethnic Minority Psychology
Associate Professor, Department of Psychology, University of Minnesota

APPENDIX F

Recruitment Email to AAPA

Dear Participant:

My name is <redacted>, and I am a doctoral student in clinical psychology at the Graduate School of Education and Psychology, Pepperdine University. My dissertation chairperson is Dr. Edward Shafranske, Professor of Psychology. I am currently recruiting individuals for my study investigating the religious and/or spiritual beliefs, preferences, and attitudes of Asian and Asian American mental health professionals and the impact of these beliefs, preferences, and attitudes on service provision. I am inviting individuals who have received a graduate degree in clinical, counseling or educational psychology, or other mental health fields, or are currently enrolled in a graduate program in such a field to participate in this research study. The study has been approved by the Pepperdine University Graduate and Professional Schools Institutional Review Board.

Please understand that your participation in my study is strictly voluntary. While there are no direct benefits to all participants in the study, you may experience satisfaction in knowing that your participation will contribute to knowledge in the field of psychology as well as increase my awareness of the role of religion and spirituality in your personal and professional life. Furthermore, participation in this research study presents no greater than minimal risk to subjects, such as the experience of fatigue, boredom, or discomfort in reflecting upon or answering questions regarding religion and spirituality. Should you decide to participate and find you are not interested in completing the survey in its entirety, you have the right to discontinue at any point without being questioned about your decision. You also do not have to answer any of the questions on the survey that you prefer not to answer and leave those items blank. This survey should take approximately 20 minutes to complete. This survey is to be completed online and is completely anonymous. No identifying information will be requested and your answers will not be linked to you in any way. You can follow the link below or paste it into your browser to access the survey: [include link]

If you should decide to participate in the study, you may click on the “I wish to participate in this study” icon and proceed with the confidential Web survey. You will be asked to answer a series of questions about the extent to which familial factors contribute to your religious and/or spiritual preferences and affiliation as well as your personal and professional identities. This is one of the few studies to explore the interface of ethnicity and religion/spirituality and the impact on treatment, specifically among Asian/Asian American mental health professionals. As an appreciation for your participation in this survey, you may choose to enter into a raffle for one of four \$25 gift cards from Amazon.com. Email addresses will be collected for those who wish to enter the raffle and will not be linked to any survey responses.

Thank you for taking the time to read this information, and I hope you decide to complete the survey. If you have any questions regarding the information that I have provided above or would like to request an abstract of my findings, please do not hesitate to contact me at the email address provided below. If you have questions about the study please contact Edward Shafranske, Ph.D., ABPP at (XXX) XXX-XXXX, or for questions concerning your rights as a research participant, contact Jean Kang, Manager of the Graduate and Professional Schools Institutional Review Board, Graduate School of Education and Psychology, Pepperdine University, at (XXX) XXX-XXXX.

Investigator:
Georgia Yu, M.A.

Dissertation Chair:
Edward P. Shafranske, Ph.D., ABPP,

APPENDIX G

List of State and Provincial Psychological Associations

United States and Territories

Alabama Psychological Association

Kelley Durrance- Executive Director; Email:

Alaska Psychological Association

Loretta Keim- Executive Director; Webmaster & Listserv Administrator:

Arizona Psychological Association

Kate G. Gagne; Email:

Arkansas Psychological Association

Anne Fuller- Executive Director; Email:

California Psychological Association

Jo Linder-Crow, PhD- Executive Director; Email:

Colorado Psychological Association

Karen Wojdyla- Executive Director; Email:

Connecticut Psychological Association

Tricia Priebe- Co-Executive Director; Email:

Lisa Winkler- Co-Executive Director

Delaware Psychological Association

Bill Mentzer- Executive Director; Email:

Florida Psychological Association

Connie Galietti, JD- Executive Director; Email:

Georgia Psychological Association

Kathie Garland- Executive Director; Email:

Hawaii Psychological Association

Melissa Pavlicke, JD- Executive Director; Email:

Idaho Psychological Association

Deborah Katz- Executive Director; Email:

Illinois Psychological Association

Terrence J. Koller, PhD- Executive Director; Email:

Indiana Psychological Association

Susan McMahon- Executive Director; Email:

Iowa Psychological Association

Carmella Schultes- Executive Director; Online form:

Kansas Psychological Association

Sherry Reisman- Executive Director; Email:

Kentucky Psychological Association

Lisa Willner, PhD- Executive Director; Email:

Louisiana Psychological Association

Gail Lowe, CMP- Executive Director; Email:

Maine Psychological Association

Sheila Comerford- Executive Director; Email:

Maryland Psychological Association

Judith DeVito- Executive Director; Email:

Massachusetts Psychological Association

Elena J. Eisman, EdD- Executive Director; Email:

Michigan Psychological Association

Judith Kovach, PhD- Executive Director; Email:

Minnesota Psychological Association

Trisha Stark, Ph.D., LP- Executive Director; Email:

Mississippi Psychological Association

Tracey Curtis- Executive Director; Online form:

Missouri Psychological Association

Ellen McLean, MA, MBA- Executive Director; Email:

Montana Psychological Association

Marti Wangen- Executive Director; Email:

Nebraska Psychological Association

Julie Erickson- Executive Director; Email:

William Spaulding, Ph.D., President- Email:

Nevada Psychological Association

Wendi O'Conner- Executive Director; Email:

New Hampshire Psychological Association

Kathryn E. Saylor, PsyD- Executive Director; Email:

New Jersey Psychological Association

Josephine Minardo, PsyD- Executive Director; Email:

New Mexico Psychological Association

Amelia Myer — Executive Director; Email:

New York State Psychological Association

Tracy Russell, CAE- Executive Director; Email:

North Carolina Psychological Association

Sally R. Cameron- Executive Director; Email:

North Dakota Psychological Association

Bonnie Staiger- Executive Director; Email:

Ohio Psychological Association

Michael O. Ranney, MPA- Executive Director

John Rudisill, Ph.D.- President; Email:

Oklahoma Psychological Association

Richard Hess, CAE- Executive Director; Email:

Oregon Psychological Association

Sandra Fisher, CAE- Executive Director; Email:

Pennsylvania Psychological Association

Thomas H. DeWall, CAE- Executive Director; Email:

Rhode Island Psychological Association

Jack Hutson- Executive Director; Email:

South Carolina Psychological Association

Leigh Flaircloth — Executive Director; Online contact form:

South Dakota Psychological Association

Michael Wyland, CSL- Executive Director; Online form:

Tennessee Psychological Association

Connie S. Paul, PhD- Executive Director; Email:

Texas Psychological Association

David White, CAE- Executive Director; Email:

Utah Psychological Association

Teresa Bruce- Executive Director; Online form:

Vermont Psychological Association

Rosanna Lak — Executive Director; no email contact; phone

Virginia Psychological Association

Bruce Keeney — Executive Director; Email:

Washington State Psychological Association

Douglas M. Wear, PhD- Executive Director; Email:

West Virginia Psychological Association

Diane Slaughter, CAE- Executive Director; Email:

Wisconsin Psychological Association

Sarah Bowen- Executive Director; Email:

Wyoming Psychological Association

Chris Bass- Executive Director; Email:

* Retrieved from <http://www.apa.org/about/organizations/associations.aspx>.

Regional Psychological Associations

Eastern Psychological Association (EPA)

Contact information:

Frederick Bonato, Executive Officer; Email:

Midwestern Psychological Association (MPA)

Contact information:

Judith Elaine Blakemore, Interim Secretary Treasurer; Email:

New England Psychological Association (NEPA)

Contact information:

Emily Saltano, Secretary; Email:

Rocky Mountain Psychological Association (RMPA)

Contact information:

Robert F. Rycek, Secretary; Email:

Southeastern Psychological Association (SEPA)

Contact information:

Amy Limehouse-Eager; Email:

Southwestern Psychological Association (SWPA)

Contact information:

Shelia Kennison; Email:

Western Psychological Association (WPA)

Contact information:

Chris Cozby, Executive Officer; Email:

* Retrieved from <http://www.apa.org/about/organizations/regionals.aspx>

Additional Local and National Psychological Associations

American Board of Professional Psychology: Email:

Los Angeles County Psychological Association: Email:

Orange County Psychological Association

Email Announcements to Members: Nancy Woods, Psy.D.

APPENDIX H

Follow-Up Recruitment Email to AAPA

Dear Participant:

My name is <redacted>, and I am a doctoral student in clinical psychology at the Graduate School of Education and Psychology, Pepperdine University. My dissertation chairperson is Dr. Edward Shafranske, Professor of Psychology. I am currently recruiting individuals for my study investigating the religious and/or spiritual beliefs, preferences, and attitudes of Asian and Asian American mental health professionals and the impact of these beliefs, preferences, and attitudes on service provision. I am inviting individuals who have received a graduate degree in clinical, counseling or educational psychology, or other mental health fields, or are currently enrolled in a graduate program in such a field to participate in this research study. The study has been approved by the Pepperdine University Graduate and Professional Schools Institutional Review Board.

Please understand that your participation in my study is strictly voluntary. While there are no direct benefits to all participants in the study, you may experience satisfaction in knowing that your participation will contribute to knowledge in the field of psychology as well as increase my awareness of the role of religion and spirituality in your personal and professional life. Furthermore, participation in this research study presents no greater than minimal risk to subjects, such as the experience of fatigue, boredom, or discomfort in reflecting upon or answering questions regarding religion and spirituality. Should you decide to participate and find you are not interested in completing the survey in its entirety, you have the right to discontinue at any point without being questioned about your decision. You also do not have to answer any of the questions on the survey that you prefer not to answer and leave those items blank. This survey should take approximately 20 minutes to complete. This survey is to be completed online and is completely anonymous. No identifying information will be requested and your answers will not be linked to you in any way. You can follow the link below or paste it into your browser to access the survey: [include link]

If you should decide to participate in the study, you may click on the “I wish to participate in this study” icon and proceed with the confidential Web survey. You will be asked to answer a series of questions about the extent to which familial factors contribute to your religious and/or spiritual preferences and affiliation as well as your personal and professional identities. This is one of the few studies to explore the interface of ethnicity and religion/spirituality and the impact on treatment, specifically among Asian/Asian American mental health professionals. As an appreciation for your participation in this survey, you may choose to enter into a raffle for one of four \$25 gift cards from Amazon.com. Email addresses will be collected for those who wish to enter the raffle and will not be linked to any survey responses.

Thank you for taking the time to read this information, and I hope you decide to complete the survey. If you have any questions regarding the information that I have provided above or would like to request an abstract of my findings, please do not hesitate to contact me at the email address provided below. If you have questions about the study please contact Edward Shafranske, Ph.D., ABPP at (XXX) XXX-XXXX, or for questions concerning your rights as a research participant, contact Jean Kang, Manager of the Graduate and Professional Schools Institutional Review Board, Graduate School of Education and Psychology, Pepperdine University, at (XXX) XXX-XXXX.

Investigator:
Georgia Yu, M.A.

Dissertation Chair:
Edward P. Shafranske, Ph.D., ABPP

APPENDIX I

Pepperdine University Application for Waiver or Alteration of Informed Consent
Procedures

Date: March 7, 2012

IRB Application/Protocol #: **P0412D02**

Principal Investigator: Georgia Yu, M.A.

School/Unit: Faculty Staff Student Other
 GSBM GSEP Seaver SOL
SPP
 Administration Other:

Street Address:

City:

State:

Zip Code:

Telephone (work):

Telephone (home):

Email Address:

Faculty Supervisor: **Edward Shafranske, Ph.D., ABPP** (*if applicable*)

School/Unit: GSBM GSEP Seaver SOL
SPP
 Administration Other:

Telephone (work):

Email Address:

Is the Faculty Supervisor Review Form Attached? Yes No
N/A

Project Title: Religious and Spiritual Beliefs and Practices of Asian/Asian American Mental Health Professionals and the Impact on Treatment

Type of Project (Check all that apply):

Dissertation Thesis
 Undergraduate Research Independent Study
 Classroom Project Faculty Research
 Other:

Has the investigator completed education on research with human subjects?

Yes No N/A

If applicable, attach certification forms to this application.

Informed consent of the subject is one of the fundamental principles of ethical research for human subjects. Informed consent also is mandated by Federal regulations ([45 CFR 46](#)) and University policy for research with human subjects. An investigator should seek a waiver of written or verbal informed consent, or required elements thereof, only under compelling circumstances.

SECTION A

Check the appropriate boxes regarding your application for waiver or alteration of informed consent procedures.

- Requesting Waiver or Alteration of the Informed Consent Process
 Requesting Waiver of Documentation of Informed Consent

If you are requesting a waiver or alteration of the informed consent process, complete Section B of the application.

If you are requesting a waiver of documentation of informed consent, complete Section C of the application.

SECTION B

Request for Waiver or Alteration of the Informed Consent Process - 45 CFR 46.116(c) & 45 CFR 46.111(d)

Under certain circumstances, the IRB may approve a consent procedure which does not include, or which alters, some or all of the elements of informed consent, or the IRB may waive the requirements to obtain informed consent. The following questions are designed to guide the decision making of the investigator and the IRB. Check your answer to each question.

- YES NO B.1. Will the proposed research or demonstration project be conducted by or subject to the approval of state or local government officials. {45 CFR 46.116(c)(1)}

Comments:

If you answered no to question B.1, skip to question B.3.

- YES NO B.2. Is the proposed project designed to study, evaluate, or otherwise examine:
(i) public benefit or service programs;
(ii) procedures for obtaining benefits or services under those programs; (iii) possible changes in or alternatives to those programs or procedures; or (iv) possible changes in methods or levels of payment for benefits or services under those programs {45 CFR 46.116(c)(1)}

Comments:

If you answered yes to questions B.1 and B.2, skip to question B.6.

- YES NO B.3. Will the proposed research involve greater than minimal risk? (Minimal risk is defined as the probability and magnitude of harm or discomfort anticipated in the research which are not greater in and of themselves than those ordinarily encountered in

daily life or during the performance of routine physical or psychological examinations or tests.)

{45 CFR 46.116(d)(1)}

Comments:

YES NO B.4. Will waiving or altering the informed consent process adversely affect the rights and welfare of the subjects?**{45 CFR 46.116(d)(2)}**

Comments:

YES NO B.5. Will pertinent information regarding the research be provided to the subjects later, if appropriate?**{45 CFR 46.116(d)(4)}**

Comments:

YES NO B.6. Is it practicable to conduct the research without the waiver or alteration? (*"Practicable" is not an inconvenience or increase in time or expense to the investigator or investigation, rather it is for instances in which the additional cost would make the research prohibitively expensive or where the identification and contact of thousands of potential subjects, while not impossible, may not be feasible for the anticipated results of the study.*) **{45 CFR 46.116(d)(3)}**

Comments:

Waiver or alteration of the informed consent process is only allowable if:

- ***The answer to questions B.1 and B.2 are yes and the answer to question B.6 is no, OR***
- ***The answers to question B.1 is no, B.3 is no, B.4 is no, B.5 is yes, and B.6 is no.***

If your application meets the conditions for waiver or alteration of the informed consent process, provide the following information for IRB review.

- A brief explanation of your experimental protocol in support of your answers to questions B.1 - B.6.
- Identify which elements of consent will be altered or omitted, and provide justification for the alteration.
- The risks involved in the proposed research and why the research presents no more than minimal risk to the subject.
- Describe how the waiver or alteration of consent will not adversely affect the rights, including the privacy rights, and the welfare of the individual.
- Define the plan, where appropriate, to provide individuals with additional pertinent information after participation.
- Explain why the research could not practicably be conducted without the waiver or alteration.
- Other information, as required, in support of your answers to questions B.1 - B.6.

SECTION C

Request for Waiver of Documentation of Informed Consent - 45 CFR 46.117(c)

An IRB may waive the requirement for the investigator to obtain a signed consent form for some or all of the subjects. The following questions are designed to guide the decision making of the investigator and the IRB regarding this topic. Circle your answer to each question.

YES NO C.1. Was informed consent waived in Section B of this application? If yes, skip Section C, documentation of informed consent if not applicable.

YES NO C.2. Does the proposed research project qualify for alteration of the informed consent process under Section B of this application?
Comments:

YES NO C.3. The consent document is the only record linking the subject and the research, and the principal risk is potential harm resulting from a breach of confidentiality. ***{45 CFR 46.117(c)(1)}***
*Comments:*A request for a modification of documentation of informed consent will be submitted to the Pepperdine IRB. A modification will be sought since the research presents no greater than minimal risk, as defined by the Protection of Human Subjects (Federal Regulation, 2009). Implicit consent will be obtained when the participant completes the survey. Participation will imply that the participant volunteers to complete the survey and comprehends the nature of the research as well as the risks and benefits of participation (IRB, 2010). In addition, no Internet Protocol (IP) addresses will be collected by SurveyMonkey nor will identifying information such as participants' email addresses be collected and linked to individual responses.

YES NO C.4. The research presents no more than minimal risk of harm to subjects and involves no procedures for which written consent is normally required outside the research context. ***{45 CFR 46.117(c)(2)}*** (*Minimal risk is defined as the probability and magnitude of harm or discomfort anticipated in the research which are not greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests.*)
*Comments:*Participation in this research study presents no greater than minimal risk to subjects, such as the experience of fatigue, boredom, or discomfort in reflecting upon or answering questions regarding religion and spirituality. A review of the extant survey literature in this area finds that there have been no

reports of adverse effects anticipated from clinicians thinking about and answering questions regarding their own religious and spiritual beliefs, practices, and affiliations as indicated in studies reported in the literature (Miller & Thoresen, 2003; Oman & Thoresen, 2005).

Waiver of documentation of the informed consent is only allowable if:

- ***The answer to question C.1 is yes, OR***
- ***The answer to questions C.1 is no and the answer to either question C.3 or C.4 is yes.***

If your application meets the conditions for waiver of documentation of informed consent, provide the following additional information, supplementing the material provided in Part C of this application, for IRB review.

- How the consent document is the only record linking the subject to the research.
- How the principal risk to the subject is the potential harm from a breach of confidentiality.
- Why, if performed outside the research context, written consent is not normally required for the proposed experimental procedures.

If the IRB approves a Waiver of Documentation of Informed Consent, the investigator must:

- Ask each participant if he or she wants documentation linking the participant with the research (i.e., wishes to complete an informed consent form). The participant's wishes will govern whether informed consent is documented.
{45 CFR 46.117(c)(1)}

AND

- At the direction of the IRB, provide participants with a written statement regarding the research.
{45 CFR 46.117(c)}