Health Beliefs, Religious Values, and the Counseling Process: A Comparison of Counselors and Other Mental Health Professionals

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Article:

A. E. Bergin (1985) studied the religious values and beliefs of mental health professionals and the relationship of those values to the counseling process. This study replicated Bergin's research with a sample of professional counselors. Differences were found in each of 10 beliefs areas and 10 values areas between the total sample in both studies. Within-group differences revealed greater similarities between professional counselors and social workers and marriage and family therapists and greater differences between counselors and either psychologists or psychiatrists. Implications for counseling and counselor training are discussed.

Bergin (1980) cited a poll conducted by the American Institute of Public Opinion, which estimated that 90% of the American population hold strong religious beliefs. Kroll and Sheehan (1989) reached the same conclusion following an extensive review of the literature, noting that over 90% of the American population affirm a belief in God. One third of the respondents in a Gallup poll indicated that religion was an important aspect of their lives, whereas another one third noted that while not the most important, religion was a very important part of their lives (Gallup, 1985). Gallup and Castelli (1989) found that 8 of 10 individuals valued their religion.
It is clear that religious values are important to a large segment of the population. It is not surprising, then, that many people consider such values to be an important part of needed therapy when problems arise (Bergin, 1985; Bergin & Jensen, 1990). The role of religion in psychological adjustment, while not well understood, appears to be significant (Masters, Bergin, Reynolds, & Sullivan, 1991; Miller, 1992). Clemens, Conradi, and Wasman (1978) found that 42% of individuals first seek pastoral counseling when experiencing emotional distress. Quakenbos, Privette, and Klentz (1985) found that 35% of persons prefer religious counseling, and 79% believe that religious values are an important area to be addressed in therapy.

Given the large percentage of persons who value their religious beliefs, it is interesting that such beliefs are not universally accepted by mental health professionals as an appropriate and necessary aspect of their clients' lives to address in therapy. Freud (1912/1959), for example, saw psychotherapy as a very objective process that did not involve the therapist's values, religious or otherwise. Ellis (1991) negated the importance of religion in stating that, because there is a high probability that there is no supreme deity, people should assume that none exists and live their lives accordingly. Ellis also theorized that much human distress is caused by absolutistic thinking; therefore, extremely religious individuals may be viewed as emotionally disturbed.

Walls (1980) noted that "the burden of developing an open set of rational values for psychotherapy rests with psychologists themselves and should not be determined by the beliefs of the majority of the public" (p. 641). Walls agreed with Ellis (1991) that religious beliefs are not rational, further noting that such beliefs have no place in psychotherapy. He stated that "the fact that the values of psychotherapists differ from the public's is not alarming, it is encouraging" (Walls, 1980, p. 641). The conclusion that seems apparent on the basis of the literature cited here is that mental health professionals do not share a view of the importance of religious beliefs that is congruent with that of their clients. Clients place a high priority on religious values, whereas many therapists do not, or they do not consider such values an important part of the therapy process.

Jensen and Bergin (1988) and Bergin (1985) further explored this apparent dichotomy among mental health providers. These authors developed and administered an extensive values survey to a national sample of psychologists, psychiatrists, social workers, and marriage and family therapists. Their findings suggest that the religious beliefs of therapists affect not only how they live their own lives but also (a) their definition of mental health and (b) their perception of the role of values in the therapeutic process. Whereas 77% of therapists in their study reported trying to live their lives according to their personal religious beliefs, only 29% felt that religious issues were important in treating the presenting problems of all or many of their clients. It appears that many mental health professionals either "pathologize" religious beliefs and practices when they arise within the course of therapy (e.g., Ellis, 1991; Gartner, Harmatz, Hohmann, Larson, & Gartner, 1990; Walls, 1980) or possibly ignore them altogether (Jensen & Bergin, 1988). Of equal importance is Jensen and Bergin's (1988) conclusion that therapists do have an influence "upon client values during the process of psychotherapy, in the form of clients acquiring therapists' values often very divergent from their own" (p. 46).

Professional counselors have not been included in the samples of mental health professionals on which the conclusions stated here have been based (Bergin, 1985; Haugen, Tyler, & Clark, 1991; Jensen & Bergin, 1988). Prior studies have included psychologists, psychiatrists, social workers, and psychotherapists (Bergin, 1985). Counselors in many ways are unique among the mental health professions (Ivey, 1989; Ivey & DiRigazio-Gilio, 1991; Myers, 1992; Remley, 1992), hence the existing literature may be misleading in regard to the responses of counselors to the expressed religious values of their clients.

Recent attention to diversity issues in counseling has underscored the need for training counselors to respond to the unique spiritual and religious needs of their clients (Bishop, 1992; Burke & Miranti, 1995). Pate and Bondi (1992) outlined succinct and practical recommendations for ensuring that the religious beliefs of clients are appropriately addressed in counselor education training programs. Their recommendations include addressing religious values in course content, experiential training relating to religious values, and collaboration with religious counselors in the training and supervision process. To fully implement Pate and Bondi's recommendations, one must have information concerning current perceptions and beliefs of counselors. It is both timely and important to determine if the values and actions of counselors in regard to mental health and religious values are similar to or different from those of other mental health professionals.

We undertook the present study to replicate research by Jensen and Bergin (1988) and Bergin (1985) using a sample of professional counselors. Two primary research questions were addressed:

1. Are professional counselors' perceptions of the relation of religion to mental health the same as those of other mental health professionals?

2. Are professional counselors' perceptions of the role of values in counseling the same as those of other mental health professionals?

METHOD

To address the research questions for this study, we administered the 69item Mentally Healthy Lifestyle Scale (MHLSS) developed by Jensen and Bergin (1988) to a sample of professional counselors. The original item pool was developed from descriptions of optimal adjustment provided by "major therapy theorists" (Haugen et al., 1991, p. 33). Each item is a statement to which respondents note their extent of agreement regarding (a) the importance of the statement for a positive, mentally healthy lifestyle and (b) the importance of the statement in guiding and evaluating psychotherapy with their clients. The first set of responses uses a 7-point Likert-type scale ranging from high, medium, and low agreement through undecided or neutral to low, medium, or high disagreement. The second set of responses requires the identification of importance with all, many, few, or no clients.

The MHLSS items were repeated verbatim in the present study, as were the demographic items used by Bergin (1985) and Jensen and Bergin (1988). In addition, we added several demographic items for the purpose of

describing the sample of professional counselors. These included graduate program accreditation, credentials, American Counseling Association (ACA) division memberships, and frequency of participation in both organized and individual religious activities. In addition, whereas Jensen and Bergin asked how much training and education respondents had received in addressing the values issues of clients, in the present survey, this question was subdivided such that respondents indicated the amount of training received as part of their degree and post-degree programs.

Both content and factorial validity for the MHLSS are reported. They identify 10 themes into which the items cluster: competent perception and expression of feelings; freedom/autonomy/responsibility; integration, coping, and work; self-awareness/growth; human relatedness/interpersonal and family commitment; self-maintenance/ physical fitness; mature values; forgiveness; regulated sexual fulfillment; and spirituality/religiosity. Demographic data and norms are provided for each of the mental health professional groups included in their national sample: clinical psychologists, psychiatrists, social workers, and marriage and family therapists.

Jensen and Bergin (1988) did not report data on reliability for the MHLSS. Therefore, after obtaining permission from Jensen to use the instrument, we conducted a pilot study to determine test-retest reliability of the items and scales. The MHLSS was administered twice over a 2-week period to 27 master's and doctoral students in a counselor education training program. The test-retest correlation for the total scale was .91. The instrument was determined to have adequate consistency of responses over time for use in the present study.

The MHLSS was administered by mail to a random sample of 600 professional counselors, including 300 members of the Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC) and 300 additional members of the ACA. Mailing lists for these counselors were purchased from the ACA, which provided the computer-generated, stratified random list of members. This procedure paralleled the earlier study by Jensen and Bergin (1988), as those authors selected respondents randomly from the memberships lists of the American Psychological Association (Division 12, Clinical Psychology), the American Psychiatric Association, the National Association of Social Workers, and the American Association of Marriage and Family Therapy.

After the 6-week time period allotted for return of the surveys, 138, or 23%, had been received. Available funding did not permit a follow-up mailing. The data were analyzed using standard statistical packages to compute frequencies, means, and standard deviations for all items. Jensen (1985) did not provide standard deviations for his data. We computed an estimate of standard deviations, allowing for an analysis of variance and a series of t tests to determine possible differences between Jensen's total sample as well as each of his subgroups and the present sample of professional counselors.

RESULTS

Description of Sample

Of the respondents, 46% were members of ASERVIC. Forty-one percent graduated from training programs accredited by the Council for Accreditation of Counseling and Related Educational Programs and 2% from programs accredited by the Council on Rehabilitation Education. Thirty-one percent of the respondents were Nationally Certified Counselors and 37% were licensed as professional counselors in their state. In terms of work setting, 23% were in private practice and 13% worked in schools (K-12), 10% in colleges and universities, 2% in pastoral counseling settings, and 9% in community mental health settings.

A comparison of the sample of counselors with demographic characteristics of the ACA membership was conducted. As a result of deliberate oversampling of ASERVIC members, division memberships of respondents did not parallel the proportion of division members in ACA. However, for all other demographic characteristics reported in Table 1, the proportion of respondents was within 15 percentage points of the corresponding ACA membership characteristic.

The demographic characteristics of the respondents with comparisons to Jensen and Bergin's (1988) sample are shown in Table 1. As can be seen from the table, the sample of counselors was slightly younger and included

significantly more women than the comparative sample of other mental health professionals. The counselors who responded to this survey were predominantly Caucasian women with a master's degree. One quarter was single, and almost two thirds were in their first marriage. Half of them had a liberal political outlook. More professional counselors reported the master's degree as the highest degree received (60%) compared with doctorate (43%) and medical (18%) degrees that were more frequently reported by Jensen and Bergin's respondents (referred to in the following text as J&B).

TABLE 1

Demographic Characteristics of Respondents With Comparisons to Jensen and Bergin's (1988) Participants

	Professional Counselors		Other Mental Health Professionals	
Demographics	N	%	N	%
Total sample	138	100	338	100
Age (years)				
Under 30	11	8	1	0.3
30-39	23	17	85	22
40-49	45	33	113	29
50 and over	57	42	189	49
Gender				
Male	39	29	233	60
Female	97	71	155	40
Highest degree				
Master's	83	60	151	45
Doctorate	27	20	167	49
M.D.	0	0	70	21
Other	28	20	1	0.2
Ethnic background				
Caucasian	130	97	318	94
Native American	1	0.8	0	0
African American	1	0.8	10	3
Asian American	2	1.5	10	3
Marital status				
Single	26	20	32	8
1st marriage	63	47	237	57
2nd marriage	25	19	83	20
Separated/widowed/divorced	19	14	65	15
Years postdegree experience				
0-5	63	46	18	4
6-10	20	15	80	19
11-15	19	14	98	23
1 6-25	26	19	124	30
26 or more	9	7	98	23
Preferred theoretical orientation				
Behavioral	1	0.7	125	37
Cognitive	6	4	7	2
Humanistic/Rogerian	8	6	7	2

Psychodynamic	4	3	57	17
Eclectic	3	2	230	68
Systemic	100	72	17	5
Other	15	10	7	2
Political outlook				
Strong conservative	4	3	3	0.7
Conservative	34	25	49	12
Moderate	50	36	157	38
Liberal	40	29	165	40
Strong liberal	10	7	38	9
Education/training in values issues for clients In degree program				
Much	37	27	91	27
Some	59	43	155	46
Little	31	22	71	21
None	11	8	20	6
Postdegree				
Much	33	25	--	--
Some	58	44	--	--
Little	26	20	--	--
None	16	12	--	--
Religious orientation				
Protestant	64	46	159	38
Jewish	8	6	76	18
Catholic	33	24	63	15
Agnostic	10	7	42	10
Atheist	1	0.7	24	6
Other	22	16	50	12

Note. Numbers and percentages may not add to 100 because of incomplete or missing data for individual items, Dashes indicate that the data were not included in Jensen and Bergin's (1988) study.

The average years of experience for the J&B sample exceeded that for counselors, with almost half of all counselors reporting less than 5 years of professional experience compared with only 4% of the J&B sample reporting in this category. Fifty-three percent of the J&B sample reported 16 or more years of experience, compared with only 26% of counselors. Both groups of respondents expressed a strong preference for systemic therapeutic orientations; the J&B sample also expressed preferences for behavioral and psychodynamic approaches.

Politically, there were more conservatives among the counselors and more liberals among the J&B sample. The amount of training received in degree programs relating to the values issues of clients was similar for both samples.

In addition, the counselors were asked about training in values issues received through continuing education. Almost one third reported little (20%) or none (12%), whereas two thirds reported some (44%) or much (25%). The J&B sample included more Jewish individuals and more atheists, whereas the counselors reported greater preferences for both Catholic and Protestant religious orientations. Over half of the counselors (57%) reported participating in organized religious practices weekly, whereas 24% indicated doing so only during religious holidays, 9% daily, and 19% never. Concerning individual religious practices, 63% reported engaging in such

practices daily, 12% weekly, 8% only on holidays, and 8% reported never engaging in individual spiritual practices.

Research Question 1

The first research question was addressed by testing the following hypothesis: Professional counselors' perceptions of the relationship of religion to mental health are the same as those of other mental health professionals. To answer this question, the J&B survey asked respondents to indicate for each item whether that item was important for a mentally healthy lifestyle. The responses to this part of the survey for professional counselors are found in Table 2 (p. 113-115), along with comparisons to J&B's sample.

TABLE 2

Univariate and Multivariate Analyses of Variance for Professional Counselors' and Other Mental Health Professionals' Perceptions of the Relationship of Religion to Mental Health

Pt1

Value Theme	Professional Counselors M	SD	N
1. Freedom/autonomy/ responsibility	1.52	0.41	138
2. Competent perception & expression of feelings	1.64	0.47	138
3. Integration/coping ability	1.67	0.41	138
4. Self-maintenance/physical fitness	1.51	0.41	138
5. Self-awareness/growth	1.72	0.48	138
6. Human relatedness/ interpersonal commitment	1.76	0.52	138
7. Mature frame of orientation	1.98	0.56	138
8. Forgiveness	1.87	0.65	138
9. Regulated sexual behavior	2.85	1.08	138
10. Spirituality/religiosity	2.42	1.34	138

Pt2

Value Theme	Other Mental Health Professionals Group	M	SD	N
1. Freedom/autonomy/ responsibility	APA Div 12	1.75		86
	AAMFT	1.65		71
	NASW	1.48		64
	APA	1.68		47
	Total	1.64	0.11	268
2. Competent perception & expression of feelings	APA Div 12	1.83		86
	AAMFT	1.66		71
	NASW	1.41		64
	APA	1.72		47
	Total	1.66	0.18	268
3. Integration/coping ability	APA Div 12	1.99		86
	AAMFT	1.79		71

	NASW	1.60		64
	APA	1.80		47
	Total	1.80	0.16	268
4. Self-maintenance/physical fitness	APA Div 12	2.20		86
	AAMFT	1.81		71
	NASW	1.73		64
	APA	1.86		47
	Total	1.91	0.21	268
5. Self-awareness/growth	APA Div 12	2.34		86
	AAMFT	2.01		71
	NASW	1.79		64
	APA	2.02		47
	Total	2.05	0.23	268
6. Human relatedness/ interpersonal commitment	APA Div 12	2.28		86
	AAMFT	1.93		71
	NASW	1.84		64
	APA	2.09		47
	Total	2.03	0.19	268
7. Mature frame of orientation	APA Div 12	2.56		86
	AAMFT	2.24		71
	NASW	2.05		64
	APA	2.37		47
	Total	2.31	0.21	268
8. Forgiveness	APA Div 12	2.53		65
	AAMFT	2.13		71
	NASW	2.22		64
	APA	2.45		47
	Total	2.32	0.19	268
9. Regulated sexual behavior	APA Div 12	3.58		86
	AAMFT	3.12		71
	NASW	3.23		64
	APA	3.11		47
	Total	3.28	0.22	268
10. Spirituality/religiosity	APA Div 12	4.57		86
	AAMFT	3.28		71
	NASW	3.86		64
	APA	3.92		47
	Total	3.90	0.53	268

Pt3

Value Theme	df	t or F
1. Freedom/autonomy/ responsibility	222	-4.85[**]
	207	-2.70[**]
	200	0.86
	183	-3.67[**]
	404	4.28[**]
2. Competent perception & expression of feelings	222	-2.24[*]
	207	-0.18
	200	2.75[**]
	183	-1.02
	404	8.92[**]
3. Integration/coping ability	222	-4.86[**]
	207	-1.85
	200	1.08

	183	-2.10[*]
	404	7.00[**]
4. Self-maintenance/physical fitness	222	-8.11[**]
	207	-3.53[**]
	200	-2.60[**]
	183	-4.47[**]
	404	4.66[**]
5. Self-awareness/growth	222	-5.66[**]
	207	-2.66[**]
	200	-0.62
	183	-2.95[**]
	404	8.22[**]
6. Human relatedness/ interpersonal committment	222	-5.16[**]
	207	-1.69
	200	-0.82
	183	-3.57[**]
	404	7.52[**]
7. Mature frame of orientation	222	-4.84[**]
	207	-2.21[*]
	200	-0.61
	183	-3.48[**]
	404	6.79[**]
8. Forgiveness	222	-5.35[**]
	207	-2.09[*]
	200	-2.86[**]
	183	-5.03[**]
	404	-3.80[**]
9. Regulated sexual behavior	222	-3.05[**]
	207	-1.13
	200	-1.58
	183	-1.17
	404	4.55[**]
10. Spirituality/religiosity	222	-3.02[**]
	207	-1.20
	200	-2.02[*]
	183	-2.25[*]
	404	8.51[**]

Note. APA Div 12 = American Psychological Association Division 12; AAMFT = American Association of Marriage and Family Therapy; NASW = National Association of Social Workers; APA = American Psychiatric Association.
p < .05.
****p < .01.***

As can be seen from Table 2, professional counselors' perceptions of the relationship of religion to mental health were significantly different from the total sample of other mental health professionals ($p < .01$) for all 10 value themes. The mean rating given by the counselors was lower in each instance than the total for the other mental health professionals. Lower means in this instance mean that the counselors gave greater importance to the scale. Counselors also differed in each instance from members of Division 12 of the American Psychological Association and from members of the American Psychiatric Association. Significant differences were found between counselors and marriage and family therapists on five of the scales (freedom/autonomy, serf-maintenance, self-awareness, mature frame of orientation, and regulated sexual behavior) and between counselors and social workers on four of the scales (competent perception and expression of feelings, self-

maintenance, forgiveness, and spirituality). Counselors scored lower than marriage and family therapists on a]] five scales and lower than social workers on all scales except competent perception and expression of feelings.

Research Question 2

The second research question was addressed by testing the following hypothesis: Professional counselors' perceptions of the roles of values in counseling are the same as those of other mental health professionals. Respondents to Jensen and Bergin's (1988) survey were asked to respond to each value in terms of its importance in guiding and evaluating psychotherapy with their clients. The responses to this part of the survey for professional counselors are found in Table 3, along with comparisons to J&B's sample.

TABLE 3

Univariate and Multivariate Analyses of Variance for Professional Counselors' and Other Mental Health Professionals' Perceptions of the Role of Values In Counseling

Pt1

	Professional Counselors		
Value Theme	M	SD	N
1. Freedom/autonomy/ responsibility	1.65	0.37	138
2. Competent perception & expression of feelings	1.74	0.45	138
3. Integration/coping ability	1.75	0.43	138
4. Self-awareness/growth	1.83	0.46	138
5. Self-maintenance/physical fitness	1.65	0.65	138
6. Human relatedness/ interpersonal commitment	1.84	0.50	138
7. Mature frame of orientation	1.84	0.47	138
8. Forgiveness	1.97	0.62	138
9. Regulated sexual behavior	2.34	.68	138
10. Spirituality/religiosity	2.28	.81	138

Pt2

	Other Mental, Health Professionals			
Value Theme	Group	M	SD	N
1. Freedom/autonomy/ responsibility	APA Div 12	1.88		86
	AAMFT	1.76		71
	NASW	1.62		64
	APA	1.76		47
	Total	1.76	0.11	268
2. Competent perception & expression of feelings	APA Div 12	1.96		86
	AAMFT	1.71		71
	NASW	1.55		64
	APA	1.81		47
	Total	1.77	0.18	268
3. Integration/coping ability	APA Div 12	2.05		86

	AAMFT	1.81		71
	NASW	1.66		64
	APA	1.82		47
	Total	1.85	0.16	268
4. Self-awareness/growth	APA Div 12	2.22		86
	AAMFT	1.90		71
	NASW	1.78		64
	APA	2.00		47
	Total	1.99	0.18	268
5. Self-maintenance/physical fitness	APA Div 12	2.21		86
	AAMFT	1.90		71
	NASW	1.73		64
	APA	1.91		47
	Total	1.96	0.20	268
6. Human relatedness/ interpersonal commitment	APA Div 12	2.25		86
	AAMFT	1.93		71
	NASW	1.83		64
	APA	2.10		47
	Total	2.03	1.16	268
7. Mature frame of orientation	APA Div 12	2.31		86
	AAMFT	2.08		71
	NASW	1.86		64
	APA	2.16		47
	Total	2.11	0.19	268
8. Forgiveness	APA Div 12	2.44		86
	AAMFT	2.12		71
	NASW	2.07		64
	APA	2.24		47
	Total	2.23	0.17	268
9. Regulated sexual behavior	APA Div 12	2.70		86
	AAMFT	2.44		71
	NASW	2.28		64
	APA	1.52		47
	Total	2.45	0.59	268
10. Spirituality/religiosity	APA Div 12	3.12		86
	AAMFT	2.59		71
	NASW	2.83		64
	APA	3.40		47
	Total	2.92	0.26	268

Pt3

Value	df	t or F
1. Freedom/autonomy/ responsibility	222	-8.08[**]
	207	-5.32[**]
	200	-2.17[*]
	183	-5.49[**]
	404	4.60[**]
2. Competent perception & expression of feelings	222	-3.90[**]
	207	-0.88
	200	1.12
	183	-2.18[*]
	404	8.54[**]
3. Integration/coping ability	222	-5.73[**]
	207	-2.14[*]

	200	0.11
	183	-2.35[*]
	404	8.90[**]
4. Self-awareness/growth	222	-5.60[**]
	207	-2.08[*]
	200	-0.72
	183	-3.26[**]
	404	8.41[**]
5. Self-maintenance/physical fitness	222	-8.51[**]
	207	-4.76[**]
	200	-2.72[**]
	183	-5.06[**]
	404	6.79[**]
	222	-3.65[**]
6. Human relatedness/ interpersonal commitment	207	-0.62
	200	0.09
	183	-2.12[*]
	404	8.01[**]
7. Mature frame of orientation	222	-3.08[**]
	207	-0.90
	200	1.16
	183	-1.78[*]
	404	7.85[**]
8. Forgiveness	222	-5.24[**]
	207	-2.18[*]
	200	-1.86
	183	-3.52[**]
	404	5.33[**]
9. Regulated sexual behavior	222	0.24
	207	0.64
	200	0.88
	183	2.16[*]
	404	6.39[**]
10. Spirituality/religiosity	222	-2.17[*]
	207	-0.47
	200	-1.15
	183	-1.84
	404	8.56[**]

Note. See Table 2 Note.
p < .05.
****p < .01.***

As shown in Table 3, counselors' perceptions of the role of values in counseling were significantly different from Bergin's total sample for all 10 value themes. Again, lower mean scores reflect greater concern for the value categories by the professional counselors. Counselors differed from members of the American Psychological Association Division 12 on every item except regulated sexual behavior, with counselors scoring lower on every scale. Differences were found between counselors and members of the American Psychiatric Association on all but two scales-mature frame of orientation and spirituality/religiosity--again with counselors scoring lower on every scale. Differences were found between counselors and marriage and family therapists on five scales, with counselors scoring lower on each of these scales. Only two differences were found between counselors and social workers. These were for freedom/ autonomy, in which counselors scored higher, and self-maintenance/physical fitness, in which social workers scored higher.

DISCUSSION

The findings from this study have important implications for counselor preparation and the delivery of counseling services to clients. However, they must be interpreted in light of several possible limitations. The first such limitation is due to the low return rate for the sample. Lack of funding prevented either a follow-up mailing or telephone interviews with nonrespondents. As a consequence, it is not possible to determine how similar to or different the responses of nonrespondents would be to those of respondents. The fact that the sample characteristics reflect those of ACA's membership is encouraging, however, and lends strength to the interpretation of the results.

A third issue that was not reflected in the present study concerns differences in the content of curricular experiences in training programs within the mental health professions. The infusion of spirituality into counselor training is increasingly evident (Burke & Miranti, 1995). Spirituality competencies for counselors have been proposed and distributed nationally and are beginning to be assimilated into counselor training programs (personal communication, M. T. Burke, September 20, 1997). This focus within the counseling profession may contribute to a heightened awareness of religious values among counselors, and thus may affect the interpretation of the results. A comparative analysis of curricula and training experiences across professions was beyond the scope of the present study. However, it is noteworthy that serf-reports of training in values issues for clients in degree programs were virtually equal for the counselors and other mental health professionals (see Table 1).

The sample of counselors differed in several ways from the other mental health professionals studied by Jensen and Bergin (1988). Taken as a whole, the counselors were younger, they had much less work experience in the field, many more of them were female, and more of them had a master's rather than a doctoral degree. The degree status reflects the fact that the master's degree is the entry-level degree for the counseling profession. Their age and recency of graduation also reflect more recent training experiences than for Jensen and Bergin's sample, who had been in the field much longer.

The fact that counselors differed from the total sample of other mental health providers in every area measured in this study is interesting, as is the direction of those differences. In virtually every instance, including both the perception of counselors of the importance of religious beliefs and values in their own life and the perceived importance of those values in guiding the process of psychotherapy with clients, counselors rated the items as being more important than did the other mental health professionals. These differences may reflect differences in training or philosophical orientation between the counselors and other mental health professionals, or perhaps even differences in life experiences, which led the respondents to choose a career in counseling rather than a related mental health profession.

A review of the within-group differences reveals a similar pattern, with counselors considering religious beliefs and values as significantly more important that did psychiatrists in every instance. Counselors differed from psychologists in every instance except for perceptions of the value of regulated sexual behavior for guiding work with clients, and in each case counselors considered the religious belief or value to be of more importance. The professional counselors in this study were most similar to marriage and family therapists (10 significant differences within the 20 scales examined) and social workers (6 significant differences in the 20 scales examined) in their perceptions of the importance of religious beliefs for a mentally healthy lifestyle and their perceptions of the importance of these values for guiding client interventions. Counselors differed from social workers on only two dimensions of the values scales. The counselors assigned more importance to competent perception and expression of feelings and spirituality/religiosity as being important in the process of counseling with clients. These differences may reflect greater similarities in training between the counselors and either marriage and family therapists or social workers than between counselors and the clinical psychiatrists and psychologists in this sample.

In general, the findings of this study lend support to the hypothesis that professional counselors are unique among the mental health professions, especially in regard to the integration of spirituality in the counseling

process. The existing literature on the relationship between religious and mental health beliefs and values may not be applicable to the counseling profession. The recent attention to issues of diversity in counseling and the emphasis on training counselors to respond to the unique spiritual and religious needs of clients may be more successful than has been documented. Given that counselors may be more open to such training, as evidenced by their perceptions of the importance of their own religious beliefs and values and the importance of those values for client interventions, it is both appropriate and timely for counselor education training programs to ensure that the religious beliefs of clients, and perhaps also of counselor trainees, are included in counselor training.

A good basis for developing such training would be the spirituality competencies (Summit on Spirituality, 1997) developed through ASERVIC. There are four major elements of the competencies that need to be addressed in counselor training. The first is "believing that a general understanding of religious, spiritual, and transpersonal phenomena (experiences, beliefs, practices) is important to the counseling process" (p. 16). As a consequence, counselor trainees should be provided opportunities to discuss their views, study relevant research, and explore the relationship between such phenomena and mental health. The second competency is "believing that awareness of one's own religious/spiritual/transtheoretical belief system is important to the counseling process" (p. 16). Counselor trainees can meet this competency through actively engaging in a process of examining their own belief systems and developing perspectives on how their belief systems relates to that of other persons. The third major competency area is "believing that an understanding of the client's religious/spiritual/ transtheoretical worldview is important to the counseling process" (p. 16). Counselors in training can learn to be open to learning about clients' worldviews and can demonstrate understanding and tolerance for differing worldviews. The final competency is "believing that appropriate intervention strategies and techniques are important to the counseling process" (p. 16). Counselor trainees can be helped to conceptualize clients' issues from varying theoretical points of view and are encouraged to seek consultation and supervision to enhance spiritual integration into counseling practice.

The importance of supervision in the development of these competencies cannot be overemphasized. Integral to each competency statement is a need for counselors to examine their personal belief systems and the manner in which these belief systems function to affect counseling interactions. Through supervision, counselors can be helped to understand the effects of their beliefs and develop greater tolerance and understanding for the differing belief systems of others.

CONCLUSION

Pate and Bondi's (1992) recommendations for training are fully supported by the results of this study. Further research is needed to determine the most effective methods for addressing religious values in the training process, as well as within the counseling process itself. Outcome studies are needed to determine differences among the mental health professions in perceptions of client satisfaction with the extent to which their spiritual needs are integrated within the counseling process. The results of this study suggest that clients with spiritual needs may have a greater chance of those needs being met if they choose a professional counselor for their mental health concerns.

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