Clinical Behaviors for Addressing Religious/Spiritual Issues: Do We Practice What We Preach?

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Abstract:

To determine if counselors integrate clinical behaviors for addressing religious/spiritual issues in counseling consistent with their ratings of the importance of such behaviors, the authors conducted a national survey of American Counseling Association (ACA) members. Seventy-eight ACA members rated the importance of and frequency with which they engaged in a set of 30 clinical behaviors that were identified in the existing literature as addressing religious/spiritual issues within counseling. Results indicated possible disparities between importance and frequency ratings. Potential barriers to counselors' utilization of religious and spiritually directed clinical behaviors were identified.

Keywords: Clinical behaviors | Counselors | Religion | Clinical practice | Spirituality

Article:

Within the counseling field, the integration of religion and spirituality into counseling has garnered more attention over the last 15–20 years. In the 1990s, the Association for Spiritual, Ethical and Religious Values in Counseling (ASERVIC, n.d.; see also Miller, 1999) developed competencies to guide practice in this area, and recently these competencies have been revised to reflect factor analytic investigation of their validity (Cashwell & Watts, 2010). These competencies address four areas of counselor competence: (a) knowledge pertaining to spiritual phenomena, (b) self-awareness related to spiritual views, (c) understanding of clients' spiritual outlook, and (d) interventions related to spirituality (Young, Cashwell, Wiggins-Frame, & Belaire, 2002). Spirituality competencies have been endorsed by the American Counseling

Association (ACA) and empirically supported in principle by professional counselors (Young, Wiggins-Frame, & Cashwell, 2007). It is unclear, however, how readily practicing counselors endorse clinical behaviors that address spiritual/religious issues or how frequently they use these in-session behaviors.

The importance of religion and spirituality in the lives of counseling consumers is well documented. A large portion of the U.S. population (75%) has reported that religion and spirituality are important in their lives (University of Pennsylvania, 2003). Similarly, 96% of people in the United States report a belief in a higher power; over 90% pray; 69% are members of a religious community; and 43% have attended church, synagogue, or temple within the past 7 days (Princeton Religion Research Center, 2000). Furthermore, only approximately 7.5% of the U.S. population self-identifies as nonreligious (Largest Religious Groups in the United States of America, n.d.). Among those who identify as nonreligious, some engage in forms of spiritual practice that do not involve participation in an organized religion or that may not include a higher power. As Maslow (1968) suggested, each person possesses a central core that he or she, when able to access the needed determinants, will tend to actualize. This self-actualizing potential is a cornerstone of the developmental view of the counseling profession (Myers & Sweeney, 2005). For some clients, self-actualization involves a religious perspective. For many, it is potentially a spiritual question.

If and how counselors respond to the religious/spiritual issues with which many clients struggle is important for several reasons. First, the *ACA Code of Ethics* (ACA, 2005) guides counselors to practice only within the boundaries of their competence and to refrain from imposing values that do not coincide with clients' goals. In an effort to comply with these guidelines, some counselors might choose to avoid topics of religion and spirituality within their clinical work. Nevertheless, Myers, Sweeney, and Witmer (2000) theorized spirituality as a central component to individual wellness and psychological coping, raising the question of what counselors do when faced with religious/spiritual issues in session.

Given the clinical relevance of religious and spiritual issues, surprisingly little is known about the perspectives of practicing counselors in terms of how they respond in session to clients' religious and spiritual issues. In a recent study, Frazier and Hansen (2009) surveyed 96 psychologists regarding their utilization of a set of 29 recommended religious/spiritual psychotherapy in-session behaviors. Results of this study indicated that the majority of the clinical behaviors were used far less than their importance ratings would suggest. This finding raised the question regarding why behaviors rated as important would be infrequently used.

Although much has been written regarding spirituality as an important counseling consideration (Cashwell & Young, 2011; Frame, 2003;Kelly, 1995), there is a paucity of research examining the perspective of counselors on the importance and frequency of use of specific clinical behaviors to address religion/spirituality with clients. Counselors practice in a range of clinical settings under an array of systemic influences (e.g., school board rules, hospital or agency

procedures) and work with diverse client populations. Ultimately, the questions are timely regarding what counselors do in session and what barriers exist, if any, to integrating interventions that address spiritual/religious issues. To address the lack of extant literature, the current study examined importance and frequency ratings for a set of specific behaviors for addressing religious/spiritual concerns among a sample of ACA members. Thus, the purpose of the study was to answer the following research questions:

1. How important do practicing counselors rate a set of specific clinical behaviors for addressing religious/spiritual issues?

2. How frequently do practicing counselors report utilizing specific clinical behaviors to address religious/spiritual issues?

3. What barriers, if any, impede counselors from utilizing religious/spiritually oriented clinical behaviors?

Method

Participants

A stratified random sample of 200 ACA members was obtained from the Member Services Department of ACA by means of a computer program designed to extract randomized samples. The sample intentionally included only professional members of ACA because these individuals were thought to be most likely to be practicing counselors. Of the original 200 ACA member sample, 78 individuals completed the survey, yielding a response rate of 39%. Three cases were omitted due to missing data. See Table 1 for demographic descriptions of participants.

Table 1. Demographic Information for Participants

Characteristic	***M***	***SD***	***f***	**%**
Age (in years)	52	10.88		
Years of post-master's counseling experience	12.31	10.61		
Sex				
Women			51	65.4
Men			27	34.6
Ethnicity				
African American/Black			4	5.1

Caucasian/White			70	89.7
Hispanic/Latino(a)			2	2.6
Biracial/multiracial			1	1.3
Other			1	1.3
Education level				
Student			1	1.3
Master's degree			57	73.1
Doctoral-level degree			20	25.6
Primary work setting (can choose more than one)				
Private practice			31	39.7
Community agency			15	19.2
School (K-12)			5	6.4
Religious setting			9	11.5
Medical setting			4	5.1
University			14	17.9
Other			16	20.5

1. *Note. N*= 78.

Similar to the demographic profile of ACA's overall membership, the sample was predominately master's-level (73.1%) practitioners who were Caucasian (89.7%) and female (65.4%). Furthermore, respondents were experienced counselors, with an average age of 52 years and 12.6 years of post-master's counseling experience.

Procedure

A three-part electronic questionnaire was constructed that included items selected from Frazier and Hansen (2009), the ASERVIC competencies (Cashwell & Watts, 2010), and a review of the existing professional literature. A team of nine researchers met over a period of 6 weeks to engage in a careful process of item development, critique, rewriting, field testing, and composing pilot questions so that the resulting items were ones that, according to Dillman (2007), “every potential respondent will interpret in the same way, be able to respond to accurately, and be

willing to answer" (p. 32). The final set of 30 items was designed to assess discrete counselor behaviors, cognitions, and intervention strategies that might be utilized in addressing religious/spiritual topics in counseling (see Table 2).

Table 2. Importance and Frequency Means, t Tests, and Cohen's d for 30 Religious/Spiritual Counseling Behaviors

		Importance		Frequency			
Item		***M***	***SD***	***M***	***SD***	***t***	***d***
1.	Use religious or spiritual metaphors/analogies that are consistent with client beliefs	3.73	1.06	2.97	1.26	7.88*	0.65
2.	Coconstruct therapeutic goals with clients that are consistent with their spiritual/religious beliefs and values	4.30	0.78	3.49	1.13	7.68*	0.83
3.	When appropriate, refer a client to a practitioner who can more effectively work with his/her spiritual/religious perspective	4.25	1.00	3.15	1.50	7.43*	0.87
4.	Draw upon spiritual or religious texts that are consistent with client beliefs	3.45	1.08	2.66	1.34	7.25*	0.65
5.	Identify spiritual/religious themes in client communications	4.13	0.76	3.49	1.08	6.93*	1.18
6.	Determine the extent to which client's spiritual/religious beliefs support or impede psychosocial functioning	4.19	0.87	3.40	1.13	6.79*	0.78
7.	Include client's religious/spiritual perspective as a component of case conceptualization	4.25	0.77	3.53	1.14	6.19*	0.74
8.	Describe similarities and differences between the concepts *spirituality* and *religion*	3.08	1.18	2.51	1.13	6.05*	0.50
9.	Explore with clients their interest in addressing spiritual/religious issues in counseling	3.87	0.98	3.21	1.13	5.55*	0.62
10.	Consider client development with regard to models of spiritual and/or religious development across the life span	3.29	1.22	2.71	1.29	5.46*	0.49
11.	Actively communicate respect for client's spiritual/religious beliefs	4.80	0.52	4.20	1.01	5.00*	0.74
12.	Draw upon client spiritual/religious perspectives as an intervention strategy	3.44	1.02	2.89	1.24	4.92*	0.48
13.	Determine when my spiritual/religious biases could be affecting the counseling process	4.76	0.57	4.17	1.14	4.82*	0.65
14.	When appropriate, initiate discussion of client's spiritual/religious perspectives	3.97	0.91	3.45	1.14	4.48*	0.50
15.	Explore client's spiritual/religious questions in counseling	3.57	1.14	3.04	1.25	4.46*	0.44
16.	Address client's maladaptive spiritual/religious beliefs	2.86	1.18	2.36	1.02	4.35*	0.46
17.	Talk with clients about their beliefs of good	3.07	1.07	2.58	1.05	4.15*	0.46

	and evil						
18.	Use formal and informal spiritually oriented assessments	2.04	1.11	1.61	0.97	4.12*	0.41
19.	Pray for clients outside of session	3.01	1.47	2.62	1.39	4.02*	0.28
20.	Work on forgiveness	3.92	1.00	3.52	1.17	3.98*	0.37
21.	Pray with clients in session	1.78	0.96	1.44	0.84	3.85*	0.38
22.	Self-disclose my own spiritual/religious beliefs when requested by a client	2.97	1.24	2.61	1.24	3.17	0.29
23.	Teach clients spiritual/religious practices in session	1.73	1.02	1.53	0.86	2.92	0.21
24.	Respond to client's spiritual/religious communications with acceptance and sensitivity	4.73	0.62	4.57	0.90	1.84	0.21
25.	Talk with clients about God	2.57	1.02	2.43	1.15	1.52	0.13
26.	Encourage clients to deepen their spiritual/religious commitments	2.47	1.29	2.32	1.19	1.50	0.12
27.	Integrate principles of 12-step spirituality	2.40	1.22	2.25	1.27	1.50	0.12
28.	Avoid imposing my religious/spiritual perspectives on a client	4.71	0.80	4.53	1.12	1.47	0.18
29.	Articulate my spiritual/religious beliefs to a client	2.16	0.99	2.05	0.90	1.24	0.11
30.	Encourage clients to pray meditate, or participate in other spiritual/religious practices	2.78	1.13	2.69	1.24	0.84	0.80

Note. Item order based on descending *t*-test results. *$p < .002$.

In the first section of the questionnaire, respondents were asked to rate the importance of each of the 30 behaviors using a Likert-type scale ranging from 1 (*very unimportant*) to 5 (*very important*). Respondents were prompted to answer the question, “How important is … to effectively address client religious/spiritual concerns?” for each of the 30 clinical behaviors.

The second part of the questionnaire asked respondents to rate the frequency with which they engaged in each of the same 30 clinical behaviors from Section 1 of the questionnaires using a Likert-type scale with the ratings of 1 (*never*) to 5 (*always*). Respondents were prompted to answer the question, “How frequently do you …?” for each of the 30 clinical behaviors. The frequency ratings were intentionally separated from the importance ratings to reduce the likelihood of socially desirable responses (i.e., having just rated an item as important, a respondent might be inclined to inflate its frequency rating). The final section of the questionnaire elicited demographic information about the respondents, including educational level, current work setting, personal spiritual/religious commitments, resources/training for spirituality and religion in counseling, and barriers faced in addressing these issues in their practice setting.

Using procedures outlined by Dillman (2007) for online survey data collection, we contacted potential respondents multiple times to solicit their participation. First, all members of the

sample were e-mailed a request to participate in an online survey available through a secure online survey website. The initial request to participate was followed after 1 week by a second e-mail reminder and invitation to individuals who had not yet participated. A third reminder was sent 1 week later to nonrespondents. Finally, after three rounds of e-mail requests, the remaining potential participants were contacted via telephone and asked to complete the online survey.

Results

Overall, the 30 items in Section 1 of the questionnaire measuring the respondents' perceptions of the importance of behaviors for addressing spiritual/religious issues received an above-average rating (average item mean = 3.41, *SD*= 1.0) and had acceptable evidence of internal consistency (coefficient alpha = .92). The items receiving the highest importance ratings were (a) actively communicate respect for client's spiritual/religious beliefs, (b) determine when my spiritual/religious biases could be affecting the counseling process, (c) respond to client's spiritual/religious communications with acceptance and sensitivity, (d) avoid imposing my religious/spiritual perspectives on a client, and (e) coconstruct therapeutic goals with clients that are consistent with their spiritual/religious beliefs and values (Items 11, 13, 24, 28, and 2, respectively, from Table 2).

In Section 2 of the questionnaire, participants rated the frequency with which they engaged in the same 30 behaviors that they had rated in Section 1. The reported frequency was somewhat lower and with a slightly higher variance (*M*= 2.93, *SD*= 1.14); again, acceptable evidence of internal consistency (coefficient alpha = .94) was obtained. The five behaviors with the highest frequency ratings were (a) respond to client's spiritual/religious communications with acceptance and sensitivity, (b) avoid imposing my religious/spiritual perspectives on a client, (c) actively communicate respect for client's spiritual/religious beliefs, (d) determine when my spiritual/religious biases could be affecting the counseling process, and (e) include client's religious/spiritual perspective as a component of case conceptualization (Items 24, 28, 11, 13, and 7, respectively; see Table 2).

Relationships and differences between the importance and frequency ratings also were of interest. Overall, there was a moderately strong correlation between the two sets of ratings (r= .81, $p < .01$). At the discrete item level, paired t tests comparing importance items with frequency items were conducted for all items in the questionnaire (see Table 2). A conservative alpha (.002) was established by using a Bonferroni correction to control for Type I error (.05/30 = .0016 = .002). Of the 30 items, 70% (21 of 30) yielded a significant difference in importance and frequency ratings. In every case, the frequency rating was lower than the importance ratings. Effect sizes also were computed using Cohen's d, using established criteria (Cohen, 1988). Four of 30 tests (13.33%) yielded a large effect size (i.e., > .80), nine tests (30%) yielded a medium effect size (i.e., > .50), and 12 tests (40%) yielded a small effect size (i.e., > .20). Five tests (16.67%) yielded an effect size of less than .20.

In the third portion of the questionnaire (i.e., demographic section), participants were asked to rate themselves on items pertaining to their personal religious/spiritual orientation on a 7-point Likert scale (see Table 3). Fifty participants (67%) responded with a 6 or 7 (1 =*strongly disagree* to 7 =*strongly agree*) on the statement "I am confident in my ability to address spiritual/religious issues in counseling." Of the participants who did not rate themselves as "confident," nearly 82% cited a need for more continuing education. Consistent with previous samples of mental health professionals, this sample indicated a higher agreement with the statement "I am a spiritual person" (M= 6.41,SD= 1.16) than with the statement "I am a religious person" (M= 4.35, SD= 2.27), $t(73) = 10.68$, $p < .001$. There was a similar trend, albeit less skewed, to the prompt "I am committed to a spiritual practice," in that 36 of the 74 respondents who answered this item strongly agreed. This also can be seen in the frequency distribution in Table 3, because 36 participants answered at the midpoint or lower level to the statement "I am a religious person," whereas only six participants answered at the midpoint or lower level to the statement "I am a spiritual person." Thus, participants in this study indicated a fairly strong spiritual identity, but were more evenly mixed with regard to religiosity.

Table 3. Participants' Religious and Spiritual Views

Item	**1**	**2**	**3**	**4**	**5**	**6**	**7**
I am a religious person	14	7	5	10	9	9	20
I am a spiritual person	1	0	2	3	4	13	52
I am committed to a spiritual practice	4	3	8	6	4	13	36
I view counseling as an inherently spiritual process	4	7	8	10	15	14	15
My spiritual/religious perspective influences my case conceptualizations	12	17	9	13	7	10	7
I am confident in my ability to address spiritual/religious issues in counseling	1	1	6	3	13	32	18

Note. N= 78. 1 =*strongly disagree*, 2 =*disagree*, 3 =*disagree somewhat*, 4 =*neither agree nor disagree*, 5 =*agree somewhat*, 6 =*agree*, 7 =*strongly agree*.

Discussion

The current study examined how practicing counselors who were ACA members viewed both the importance of and their own frequency of engagement in clinical behaviors for addressing spiritual/religious issues in counseling. Overall, participants rated a set of 30 clinical behaviors as important to effectively addressing spiritual/religious issues in counseling (average item mean = 3.41, SD= 1.0). They rated the same 30 behaviors as ones they personally used with moderate frequency (M= 2.93, SD= 1.14).

Participants rated the importance of most behaviors (21 of 30) significantly higher than they rated the frequency with which they engaged in these behaviors. This finding must be viewed cautiously because the two ratings (importance and frequency) used different anchors for the

Likert-type scales. Nevertheless, it is interesting that frequency ratings suggest that respondents were, in fact, integrating clinical behaviors into their clinical work to address the spiritual aspects of clients lives, thus providing some corroboration for the idea that counselors support the importance of integrating spirituality into counseling (Cashwell & Young, 2011). Data from this study do not provide a context for this finding, because we made no attempt to determine if the frequency with which participants integrated spiritual/religious interventions is clinically appropriate or if it represents an overusage or underusage of these interventions. In other words, we did not assess the quality or effectiveness of the interventions in this study.

Although there are a number of possible explanations for the lower frequency ratings, it appears that respondents erred on the side of caution when addressing client religious/spiritual concerns. Evidence of this can be found in the five items that received the highest importance rating: (a) actively communicate respect for client's spiritual/religious beliefs, (b) determine when my spiritual/religious biases could be affecting the counseling process, (c) respond to client's spiritual/religious communications with acceptance and sensitivity, (d) avoid imposing my religious/spiritual perspectives on a client, and (e) coconstruct therapeutic goals with clients that are consistent with their spiritual/religious beliefs and values. Each of these behaviors addresses the importance of valuing the diversity of client beliefs. This is consistent with the ethical imperative to “do no harm” and is central to competent counseling practice. It appears, therefore, that participants were conscious of ethical considerations and potential personal spiritual and religious biases when working with clients and had a desire to respect a client's particular belief system. At the same time, this finding suggests that counselors might have been so concerned with respecting diversity and avoiding the imposition of counselor values that they did not assess for the relevance of clients' spirituality/religiosity to presenting concerns, thus preventing them from intervening appropriately.

One clear theme that emerged from the data was that the counselors tended to not explicitly address spiritual or religious issues. For example, Item 7 (i.e., include client's religious/spiritual perspective as a component of case conceptualization) received relatively high importance (4.25) and frequency (3.53) ratings, suggesting that participants saw the integration of client religiosity and spirituality into case conceptualization as important and did so with some regularity. By contrast, Item 18 (i.e., use formal and informal spiritually oriented assessments) received a low importance rating (2.04) and was the third lowest rated frequency item (1.61). This finding could be a result of counselors conceptualizing a client based on information that the individual freely provided, but may demonstrate a reticence to assess spirituality and religion more fully for fear of imposing values or alienating the client. An alternative explanation also seems plausible. From our perspective, clinical interviewing, as an informal assessment process, falls within the purview of Item 18. It is unknown, however, if participants considered clinical interviewing as part of the informal assessment process. Instead, they may have been indicating limited use and importance of informal techniques such as spiritual genograms or spiritual eco-maps (Gill,

Harper, & Dailey, 2011). Future research should more closely examine how counselors assess the clinical relevance of client spirituality and religiosity.

Inferential statistics were used to assess the statistical significance of importance–frequency discrepancies. It is interesting that the clinical behavior resulting in the single greatest discrepancy was Item 5 (i.e., identify spiritual/religious themes in client communications; Cohen's *d*= 1.18). This large effect size suggests a discrepancy in the ratings such that participants believe this is important clinical activity but engage in it less frequently than the importance ratings suggest, raising another issue related to client conceptualization. If participants believe that integrating spirituality and religiosity is important to case conceptualization but report that they less frequently listen for spiritual/religious themes in client communication and do not actively use informal and formal assessments of spirituality, how then are counselors gaining the necessary information to adequately integrate client spirituality and religiosity into the case conceptualization process? Future researchers should consider this question.

Barriers

To a limited extent, the finding of a possible importance–frequency split may be explained by barriers that participants cited regarding integrating spirituality/religion into counseling. Althoughexternal impediments may be intractable (e.g., expectations based on work setting), a closer examination of the data suggests that some barriers are more internal to the counselor. The single most frequently listed barrier (*n*= 6) was work setting, with participants indicating that barriers existed because they worked for a government agency (*n*= 1), school (*n*= 2), community agency (*n*= 1), and state university (*n*= 2). Collectively, however, all of the authors of this article have worked as counselors in many of these types of settings and have not inherently found the work setting to be an insurmountable barrier to addressing spirituality/religion in counseling. For example, although the manner in which spirituality is attended to might be more implicit and client initiated in a public school setting, it is plausible for school counselors to address a student's spirituality (Sink, 2004).

The second and third most cited barriers provide additional insight into the importance–frequency disparity. The second most frequently indicated barrier (i.e., spirituality/religion were addressed only when the topic was raised by the client) might have been related to the third barrier, that is, counselor unease with addressing spirituality/religion. It is striking that practicing counselors would report that they tended to discuss spirituality and religion only when it was initiated by the client as it is often incumbent upon counselors to raise sensitive clinical topics (e.g., a client's sexuality, addiction, abuse). Extant literature suggests that spirituality is a vital aspect of one's culture, meaning making, and coping (Frame, 2011), and failure to assess and intervene with sensitivity to this facet of the client's worldview is to potentially ignore a central feature of a client's identity.

Person of the Counselor

One notable aspect of the results is the personal belief systems of study participants. Consistent with previous findings, participants reported a stronger spiritual identity than religious identity. This suggests that, overall, the participants self-identified as highly spiritual but were quite varied in religious identity. In fact, the response with the largest number of respondents (n= 14) to the statement “I am a religious person” was *strongly disagree*. Although beyond the scope of the data, it is likely that some individuals who identify as spiritual but not religious are spiritually committed, whereas others may be hostile toward religion (Kelly, 1995; Young & Cashwell, 2011), raising questions about how these counselors work with highly religious clients. Furthermore, this result raises the question of how the construct of spirituality may conceptually and practically differ for counselors. How this might affect the results of this study is unknown, constituting a limitation of the findings of this study. For example, might a counselor whose spirituality is inextricably linked to her or his religion be less inclined to integrate spirituality within a government or public school setting than a counselor who views spirituality as quite distinct from religion? Similarly, might a counselor whose personal spirituality is wholly connected to organized religion need support (via supervision and training) to discuss personal spirituality with a nonreligious client? Finally, the strong positive skew toward a spiritual identity likely indicates a response bias because those who chose to participate in the study may self-identify as more spiritual than those who chose not to respond, suggesting a limitation regarding the generalizability of the results.

When compared with Frazier and Hansen's (2009) results among a sample of psychologists, the importance ratings of spiritual and religious clinical behaviors in the current study were higher. It is unclear whether this is a function of professional identity or whether it simply reflects the strong spiritual identity of this sample. It is important to keep in mind, however, that participants in this study self-identified as significantly more spiritual than religious. This finding is consistent with previous surveys of mental health practitioners and may be important clinically because 75% to 88% of Americans make no distinctions between their religion and their spirituality, but instead identify equally with both (Koenig, George, & Titus, 2004; Zinnbauer et al., 1997). Thus, counselors and the clients they serve may differ in their conceptualization of spirituality and religion. Explicitly asking clients about their perception of both their spirituality and their religion may serve to strengthen the therapeutic relationship by providing more accurate and detailed client conceptualization. Relatedly, counselors need not consider it unethical to explore with a client her or his spiritual/religious life and assess relevance to presenting concerns. As any seasoned practitioner knows, if the client finds a topic objectionable, the wise counselor recognizes such reluctance as useful information.

While overall discrepancies existed between participants' importance and frequency ratings, that incongruity did not exist for nine of the 30 items. For each of those nine items, both the importance and frequency ratings were in agreement (see Table 2, Items 22–30). Of interest, however, was that among these items were survey items related to direct spiritual and religious

interventions. These items were rated as least important and least frequently used by respondents (from lowest frequency to higher frequency): (a) pray with clients in session, (b) teach clients spiritual/religious practices in session, (c) use formal and informal spiritually oriented assessments, (d) articulate my spiritual/religious beliefs to a client, (e) integrate principles of 12-step spirituality, (f) encourage clients to deepen their spiritual/religious commitments, and (g) address client's maladaptive spiritual/religious beliefs. Of the aforementioned seven items, only one (i.e., pray with clients in session) is controversial, with most scholars arguing that counselor-initiated in-session prayer blurs the professional boundaries and is inappropriate. The remaining six behaviors, however, when used with a careful and respectful assessment of client spirituality, may be highly relevant and therapeutic.

Considering those items rated as most important and most utilized and those rated as least important and least utilized, it appears that some counselors may struggle to balance practicing in a manner that is ethical (i.e., valuing of client autonomy) while integrating spiritual and religious interventions. Based on this finding, it may be important to focus on Competency 13 of the ASERVIC Spiritual Competencies: “The professional counselor is able to a) modify therapeutic techniques to include a client's spiritual and/or religious perspectives, and b) utilize spiritual and/or religious practices as techniques when appropriate and acceptable to a client's viewpoint” (ASERVIC, n.d.). Results of this study suggest that this is an important area for additional focus in training and scholarly writing. Additionally, future researchers could explore the process by which counselors decide on the inclusion/exclusion of clinical interventions to address the spiritual/religious domains of clients' lives.

In light of the participants' strong personal identification with spirituality, the findings do raise the question of why spiritual and religious behaviors are not integrated into counseling as frequently as their importance ratings suggest that they should be. One possible explanation is the counselor's sense of competency to engage in these in-session behaviors. Only three participants, however, listed “unease” as a barrier and three other participants identified “knowledge” as a difficulty. Furthermore, 67% of participants responded to “I am confident in my ability to address spiritual/religious issues in counseling” with a rating of 6 or 7 on a 7-point scale. Therefore, future research is needed to examine the nature of the discrepancy between perceived importance and frequency of use, because results from this study do not clearly outline why this discrepancy occurred. Researchers might undertake in-depth qualitative interviews with practicing counselors to explore the cognitive processes practitioners engage in to assess the relevance of spiritual/religious issues in the counseling process and to intervene appropriately.

Conclusion

The work of Frazier and Hansen (2009) and the current study found significant differences in participants' ratings of the importance of and frequency with which they used spiritual and religious behaviors in clinical settings. The consistency of this finding suggests the possible existence of a gap between perceived importance and utilization rates of the behaviors surveyed

in these studies. Understanding the possible gap between importance and frequency ratings found in this study and by previous researchers warrants additional attention. More research is needed to both inform and guide counselor training and to increase understanding of how to effectively engage clinical interventions aimed at positively utilizing the spiritual and religious assets of clients. Such insights would strengthen the field and potentially benefit the many clients who would value competent, ethical, and caring integration of their spiritual and religious life into the assessment and counseling process.

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