THE ROLES OF CLIENT RELIGION, COUNSELOR RELIGIOSITY, AND SPIRITUAL COMPETENCE IN COUNSELORS' CLINICAL JUDGMENT

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ABSTRACT

The present study explored the roles that clients' religious beliefs, therapists' spiritual/religious beliefs, and therapists' attitudes toward spirituality and religion may play in how therapists conceptualize a prospective client case. The study also explored the role that the construct "spiritual competence" played in moderating the relationship between therapists' attitudes toward spirituality and religion and factors related to their clinical judgment of the client's concerns. One hundred seventy-six therapists and doctoral students were randomly assigned to read one of four vignettes differing only on the client's spiritual/religious beliefs and practices (Christian, Muslim, Buddhist, or an unstated religious preference). In order to account for various forms of clinical decision-making, a MANCOVA was used with dependent constructs of psychopathology, attribution for the problem, and prognosis. A separate MANCOVA was conducted in order to determine whether the interaction of client religious orientation (religious vs. unidentified religion) and counselor spiritual competence (high vs. low) would be related to different clinical judgments.

APPROVAL PAGE

The faculty listed below, appointed by the Dean of the School of Education, have examined a dissertation titled, "The Roles of Client Religion, Counselor Religiosity, and Spiritual Competence in Counselors' Clinical Judgment," presented by Dominick Anthony Scalise, candidate for the Doctor of Philosophy degree, and certify that in their opinion it is worthy of acceptance.

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CHAPTER 1

INTRODUCTION

The field of Counseling Psychology has increased its attention to issues related to multicultural diversity over the last three decades. During that time, theorists like Cross (1971), Helms (1990), Ponterotto (1997), and Sue and Sue (2003) have become champions for the causes of underrepresented groups within the field. Due to these advances in understanding the intricacies of applied psychological research with special populations, Counseling Psychology has taken on the agenda of promoting multicultural competence in a world bustling with starkly diverse groups of people (Sue, Arrendondo, & McDavies, 1992; Sue & Sue, 2003). Still, even prominent multicultural theorists have accused the field of neglecting spirituality and religiosity as prominent cultural factors in shaping many diverse clients' worldviews (Sue, 2001). As such, spirituality and religion have recently been included as pertinent factors when examining psychotherapy clients' worldviews (Fukayama & Sevig, 1999). While the relationship between psychology and religion has been tumultuous at times (Aten & Leach, 2009), many in the field have promoted an integration of the two areas (Bergin, 1980; Burke, Hackney, Hudson, Miranti, Watts, & Epp, 1999; Richards & Bergin, 2005). Bergin's (1980) work implored psychotherapists to be wary of associating spiritual or religious beliefs with pathology, citing many psychological benefits of intact spiritual or religious beliefs.

Still, there are some who doubt the appropriateness of viewing spiritual or religious beliefs through an adaptive lens during the counseling relationship. For example Claridge (2001) pointed out that religiosity has been framed as "healthy psychosis" (p.91). Further research has found that while some therapists are comfortable integrating the spiritual into therapy, others do

not feel adequately prepared to do so, thereby avoiding a potential strength for clients (Aten & Leach, 2009; Schulte, Skinner, & Claiborn, 2002). One reason for this may be illuminated by findings that psychologists have tended to endorse fewer spiritual or religious beliefs and a lower commitment to spiritual or religious values than the general population (Hathaway, Scott, & Garver, 2004; Shafranske & Newton, 1990). These two studies showed that, although psychologists tend to believe that spiritual or religious functioning is a clinically relevant domain, it is rarely integrated into the therapeutic process. This is particularly troubling given recent work showing that clients who adhere to religious or spiritual beliefs expect their therapists to be able to both respect their beliefs and integrate them into therapy when appropriate (Belaire & Young, 2000; Cashwell & Belaire, 2001; Richards & Bergin, 2005). However, little is known regarding how therapists might attend to clients' spiritual or religious information given their diverse training and individual experiences. Therefore, the purpose of the present study is to examine how religious or spiritual factors for clients and therapists may influence therapists' clinical judgment of that client.

Cashwell and Belaire (2001) contended that some clinicians may associate certain spiritual or religious beliefs (or behaviors) with psychopathology, when perhaps they are simply indicative of one's commitment to a worldview. In other words, clinicians' lack of knowledge or awareness with diverse religious beliefs may put them at risk for confusing benign (or beneficial) religious commitment with psychopathology. Presently, there has been no systematic, empirical investigation of how diverse religious or spiritual beliefs may impact the counseling process when counselor judgment is concerned. Of the studies that do examine the role spirituality or religiosity plays in the counseling process, few take both client and counselor factors into consideration, hence the need for future research to address this gap in the literature. Researchers

examining the interface of psychotherapy and spirituality have alluded to the role that client spirituality may play in the counseling process, suggesting it is a crucial factor for some clients (Hathaway, Scott, & Garver, 2002). Still, examining the effects of client spirituality/religion on the counseling process has resulted in mixed findings. Some studies indicate that client religious or spiritual orientation is associated with less optimistic clinical impressions (Gartner, Harmatz, Hohmann, Larson, & Gartner, 1990; Houts & Graham, 1986; Lewis & Lewis, 1985) and other findings show that client spiritual/religious orientation is associated with a more positive impression (Gerson et al., 2000). Additionally, other studies have found no effect of client spiritual/religious orientation on counselor clinical judgment (Reed, 1992; Worthington & Scott, 1983).

Still, little can be concluded from this literature base as few empirical studies have investigated whether more spiritual or religious clients are treated any differently than less spiritual or religious clients by their therapists. Perhaps more importantly, it is unclear whether clinicians tend to project biased conceptualizations onto a client who endorses certain spiritual or religious beliefs. In addition, the role of therapists' spiritual and religious attitudes (versus simply their religious beliefs) has not been vigorously studied in empirical attempts to answer these questions.

In order to discuss the impact that religion and spirituality have had on the counseling process it is first necessary to operationally define each construct. Although spirituality and religion may share some similarities, their precise operational definitions have been hotly debated by researchers (Zinnbauer, Pargament, & Scott, 1999). However, many in the field refer to spirituality as "a personal or group search for the sacred," while referring to religion as the practice of spirituality within a traditional sacred context (Zinnbauer & Pargament, 2005, p. 35).

Likewise, a recent poll (Gallup, 2003) found that U.S. citizens tended to refer to spirituality as something that is personal and individual, transcending areas related to tradition, ritual, and doctrine, which are often associated with religion. Richards and Bergin (2005) noted that while religion and spirituality do share commonalties, it is entirely possible for a person to be religious without being spiritual or vice versa, implying that they are ultimately distinct constructs which may or may not be correlated for a given individual. Although many researchers continue to refer to the two constructs interchangeably, this trend is beginning to wane (Aten & Leach, 2009).

Nevertheless, it is important to point out that simply labeling religion as a rigid, fixed system of ideological commitment and spirituality as the subjective component of religious experience may be detrimental (Hill & Pargament, 2003). In other words, critics of the above conceptualization take issue with this operationalization as it may undermine the interpretation that religion includes a positive and perhaps individualistic element. Accurate conceptualizations are complicated further by the idea that all spiritual behaviors unfold in a social context and all religious thought emphasizes a personal, subjective component to some extent (Wuthnow, 1998). For these reasons, religion and spirituality will be referred to in tandem throughout the paper.

Like many other important cultural factors, those religious beliefs that are less common or less familiar to clinicians may activate existing biases against or misunderstandings of certain religious orientations (Sue & Sue, 2003). For example, the familiarity effect described by social psychologists (Fiske, 2004; Gladwell, 2005) indicates that the more time and energy one person spends with another, the more attracted and accepting they become of that person. The same principle has been noted to apply to cultural diversity (Fiske, 2004). When someone is not familiar with a faith tradition, they may be less inclined to view that piece of culture favorably.

In the past few decades, interest in integrating spirituality/religion into counseling has increased (Richards & Bergin, 2005). This increased attention may be due to data suggesting that spirituality/religion is important for a majority of the American people. For example, it was estimated that over 95% of Americans believed in a Higher Power of some kind while 87% believed that a Higher Power answers prayers, and 84% reported they try to live according to their spiritual beliefs (Gallup, 1999). In an estimate of the clinical population, Eck (2002) suggested that between 50-90% of clients presenting for psychotherapy are committed to practicing their understanding of spirituality. Together, these data suggest that a majority of Americans presenting for therapy may endorse a spiritual or religious belief system as being an important part of their lives.

However, as Pargament (2007) noted, many therapists are either untrained or unwilling to deal with spiritual or religious matters in the therapeutic context. Prest and Keller (1993) described this sentiment among many therapists noting the belief that, "priests should stay out of therapy and therapists should stay out of spirituality" (p.139). However, recent theorists have stated that the field of psychology has opened up to the idea of integrating spiritual matters in therapy over the past few years (Richards & Bergin, 2005; Pargament, 2007) and that perhaps the sentiment described by Prest and Keller (1993) has decreased among practitioners. Still, the impact that counselor and client spiritual beliefs or their interaction may have on a counselor's clinical judgment is unclear.

The present study aims to fill this gap in the literature by investigating whether or not a spiritual or religious bias exists when counselors are provided with a case involving spiritual or religious values with a Muslim, Buddhist, or Christian client compared to a client with an unspecified religion. Additionally, given the support that both client and counselor factors (and

the interaction of the two) are important determinants in the counseling process (Norcross, 2002), counselor religious and spiritual beliefs, attitudes toward religion, and perceived spiritual competence were included in the analysis to determine their effect on the counseling process constructs of pathology assignment, attribution for problem, and ratings of prognosis. The study will involve an analogue, between-subjects design to determine whether counselors' clinical judgment process were different when comparing four clients coming from different religious worldviews, while controlling for the aforementioned therapist variables.

CHAPTER 2

REVIEW OF THE LITERATURE

Counseling research has documented the integral role of a therapist's clinical judgment in counseling process and outcome research (Garb, 2005; Spengler, White, Aegisdotter, Maugherman, Anderson, Cook, et al., 2009). Studies also point to shifting standards of clinical judgment due to its sensitivity to change based on counselors' biases (Arkes, 1981; Lawless & Lu, 1977; Spengler et al., 2009). To date, few studies have examined the impact of both counselor and client religious/spiritual beliefs on counselors' clinical judgment using experimental conditions. In the current study, I will examine the roles that client spiritual/religious factors and counselor spiritual/religious factors play in influencing counselors' clinical judgment. The following chapter will provide an in-depth background related to how biases in clinical judgment currently exist, the roles of spiritual/religious identity in counseling, and cultural competence as it applies to spirituality/religion. Lastly, the study's hypotheses will be presented.

Clinical Judgment

Gambrill (2005) stated that at the heart of clinical practice is the process of making decisions. In that regard, clinical judgment has been defined as not only the thoughts, feelings, and behaviors of a clinician in response to a client, but the meta-cognition involved with making decisions regarding clients' best interests (Ridley & Shaw-Ridley, 2009). For the purposes of the present study, clinical judgment will refer to counselor impressions of a client's psychopathology, prognosis in therapy, and attributions of the presenting concern (including etiological factors), each of which is consistent with previous conceptualizations of clinical

judgment in counseling process and outcome research (Bowers & Bieschke, 2005; Eubanks-Carter & Goldfried, 2006; Mohr, Weiner, Chopp, & Wong, 2009; Ridley & Shaw-Ridley, 2009).

Goldberg (1970) conducted one of the earliest studies investigating whether or not clinical judgments were sensitive to biases. In this study, the author found that human-based judgments about diagnostic criteria (in the DSM-II) were less accurate than standardized actuarial formulas developed to predict how each clinician might interpret client data. In fact, using 861 clients, the formula developed by the researcher was more accurate than 86% of the 29 clinicians included in the study when diagnosis was concerned. Since that time, numerous follow-up studies have revealed that psychologists' clinical judgment is indeed subject to certain biases that can have an impact on their treatment and prognoses for clients (Kahneman & Kline, 2009; Mohr et al., 2009). These studies will be discussed in greater detail below.

By definition, judgment subsumes a certain subjective and intrapersonal element. The difficulty when considering clinical judgment in counseling is that this subjectivity, even if well-informed by empirical and theoretical competence and training, can have implications for how a client is diagnosed and treated in the counseling relationship. As Ridley and Shaw-Ridley (2009) pointed out, it is assumed that psychologists are trained to be competent in their assessment, diagnosis, and overall treatment of clients, yet the results of an extensive meta-analysis revealed only a small effect (Cohen's $d = .12$) for the role of training and experience on accurate clinical judgments (Spengler et al., 2009).

Empirical literature has supported the association between clinician biases and subsequent differential clinical judgments (Al-Issa, 1995; Rosenthal & Berven, 1999; Strakowski et al., 1997; Whaley, 1997). Although clinicians rely upon their clinical intuition, these data reveal that often clinical intuition often results in biased evaluations of clients. Kahneman and

Kline (2009) outlined two theoretical perspectives in the role intuition plays when making important decisions. The Natural Decision Making (NDM) line of thought follows that intuition, when carefully trained under appropriate conditions, can produce robustly accurate predictions. Contrarily, the Heuristics and Bias (HB) approach advocates that even the most well-informed decisions are subject to cognitive shortcuts and rose-colored inferences, which can leave the decider with an "illusion of validity," or an unjustified feeling of confidence in clinical judgments (p. 517). Taking the two perspectives together, the authors pointed out that even well-informed clinical judgments are sensitive to bias, although specialized and genuinely informed intuition development skills can help reduce such biases.

Given that clinical judgment is not solely due to experience or education (Spengler et al., 2009), we still need to understand what factors may be responsible for clinical judgment. In other words, if not training and education, what other factors are important ingredients in counselors' clinical judgments? Based on Kahneman and Kline's (2009) review, it is important to evaluate the role that biases play in decision-making. Researchers have found that counselors may be prone to increased biases in their clinical judgments when their thinking consists of less cognitive complexity (Spengler & Strohmer, 1994). In other words, clinicians' ability to think deeply and broadly about a client in his or her social context may be a possible way of avoiding biased clinical judgments. Arkes (1981) took this a step further identifying five constructs that are theoretically and empirically related to increased bias in clinical judgment: inability to assess covariation, influence of preconceived notions, lack of awareness of one's judgment processes, overconfidence, and the hindsight bias. To minimize the impact of these constructs on clinical judgment, Arkes (1981) advocated for clinicians to become increasingly active in considering alternative hypotheses to conceptualize clients, to increase attention toward client data that is

typically ignored, and to minimize the role of memory in establishing clinical judgments. However, time constraints and comfort of routine can often blind clinicians when considering what impact their biases have on clinical judgments.

In discussing the common types of mistakes made in the clinical judgment process, Gambrill (2005) indicated that focusing on individualistic (at the expense of environmental) conditions could be a major contributor to inaccurate clinical judgments. Furthermore, the author pointed out that all too often clinicians fail to view clients' strengths and assets in their conceptualizations, instead focusing on problematic functioning through their own theoretical lens. Theoretically, these cognitive schemas immersed in the structures of various counseling theories, are then applied with little hesitancy to clients with a few matching symptoms. When discussing the impact that schemas regarding spiritual or religious traditions have for therapists, it may be important to understand therapists' existing heuristics which relate to each of these five areas (Arkes, 1981).

More recent empirical data also indicate that a therapist's a priori cognitive schemas can influence their perceptions of clients (Bradshaw, Carscaddon, Wright, & Fleming, 2007). Specifically, the authors found that when counselors were randomly assigned to one of three conditions prepping them to focus on strengths, weaknesses, or general observations of the same client, counselors instructed to look for strengths had significantly higher ratings of the client's ability to change and perceived likelihood that the client would change compared with the other two conditions. This study provides empirical support for the idea that a counselor's own frame of mind is an important factor in how they conceptualize clients.

Clinical judgment entails critical thought about a client from earliest information processing (i.e. referral information) continuing through the termination stage (what therapists

think about clients after they leave treatment; Ridley & Shaw-Ridley, 2009). As the meta-analytic work from Spengler et al. (2009) showed, counseling psychologists should take great caution in attributing their clinical decision making skills to their levels of training. Although counseling training programs focus experiences on helping therapists refrain from imposing biased clinical judgments on clients, the meta-analysis revealed only a marginal effect size for the effect of training on decreasing biased clinical judgments. This finding is important as a lack of accuracy in clinical judgment impedes clinicians' abilities to create an accurate picture of a client's presenting concerns which, in turn, can impede their ability to offer the most appropriate treatment plan (Ridley & Shaw-Ridley, 2009). Although these data do help answer the question of whether or not clinician training and education help prevent biased clinical judgments, they do not offer empirical evidence to help account for where these biases originate. Perhaps counselors are using cognitive heuristics and relying on pre-conceived notions enough to impede their ability to think deeply and broadly about their clients.

Knowing where these biases come from, how they are maintained, and under what circumstances they are most likely to occur is at the heart of the present study. Biases in clinical judgment may overlap with biases and prejudices inherent in the larger social fabric, given the evidence that cultural factors can account for prejudicial treatment (Sue, 2003). The following sections outline the role that cultural factors can play in clinical judgment for psychologists.

Clinical Judgment and Race, Sex, and Sexual Orientation

The civil rights movement in the 1960s brought to light some of the glaring social injustices of the 20th century. A number of political and social changes were made as a result, but many of the previously held attitudes, which contributed to those injustices remained. Sue and Sue (2001a) have been among the most active psychologists attempting to educate the field on

the detrimental impact that these residual attitudes can have for people of underrepresented groups today.

In counseling, bias can be operationalized as prejudgments or prejudices which result in inaccurate or errant decisions, or existing ideas which can have some differential impact on the counseling process (Lopez, 1989; Sue & Sue, 2003). Clinician bias, when judgments are made about clients or their specific symptoms, has been found to be influenced by clinicians' pre-existing cultural biases or worldviews and clients' own cultural identity (Aklin & Turner, 2007). Clients from lower-SES groups seeking therapy have been found to be judged more severely than individuals from higher SES backgrounds in counseling (Bentacourt & Lopez, 1993; Kessler et al., 1994). Differences in client race and ethnicity have also been shown to elicit differential clinical judgments both experimentally (Rahimi, Rosenthal, & Chan, 2003) and in more naturalistic designs (Neighbors et al., 2003).

Even though an emphasis on cultural sensitivity has increased within professional psychology, the trend for members of minority groups to be over-pathologized continues (Strawkowski, Keck, Arnold, Collins, Wilson, Fleck, et al., 2003; Strawkowski, McElroy, Keck, & West, 1996). In a study of an inpatient population, even when strict and seemingly objective DSM criteria were used, Caucasian inpatients were more likely to be diagnosed with mood disorders and African-Americans were more likely to be given psychotic disorders given similar symptom presentations (Neighbors et al., 2003).

Evidence from racism. As Neighbors et al. (2003) pointed out, the field at times has failed at investigating how or why these racial diagnostic differences are born and sustained. Part of their hypothesis was that the Diagnostic and Statistical Manual-III (DSM-III) and subsequent revisions are based upon an assumption that the diagnostic system is universally applicable to all

people groups. The DSM-IV (1994) included a statement that the diagnostic procedures should not be applied mechanically in clinical settings. Still, the DSM system has been criticized for being insensitive to ethnic and racial heterogeneity (Blue & Gaines, 1992) as well as cultural heterogeneity (Mezzich, Kleinman, Fabrega Jr., & Parron, 1996, Tseng, 1996).

One possible explanation for the differential judgments based upon race is the role of indirect or implicit racist attitudes within White counselors who make up the majority of clinicians and counseling faculty (Aklin & Turner, 2007; Sue & Sue, 2003). Perceptions of African American and Hispanic individuals as being violent, hostile, and unmotivated have been theorized to influence diagnostic processes, with counselors who tend to endorse these attitudes rating people of color from these ethnic backgrounds as having more severe diagnoses than their Caucasian counterparts (Monteith, 1996; Rosenthal & Berven, 1999; Whaley, 1998).

After assessing baseline judgments from counselors on hypothetical vignettes, Rosenthal and Berven (1999) presented additional positive information about their hypothetical Caucasian and African American clients (whose vignettes were otherwise identical). They found that their sample of Caucasian graduate students actually retained their original negative perspective of African American clients but improved their opinions of the Caucasian client after reading the positive information. Garb (1996) has referred to this phenomenon as confirmatory bias, which is thought to occur when clinicians either ignore data that contradicts their original impressions or interpret ambiguous clinical stimuli in a way that confirms their original impressions.

Neighbors et al. (2003) pointed out that clinical bias can be due to the quality of therapist training, as well as the tendency to attend selectively to presenting concerns that can confirm a hasty clinical hypothesis, a finding documented in earlier work (Nurius & Gibson, 1990; Stahler & Rappaport, 1986) and noted among the authors of the DSM-IV (Spitzer, Gibbon, Skodol,

Williams, & First, 1994). Cultural differences, if not well-understood by practitioners, could be mistaken for signs of psychopathology (e.g. pervasive mistrust felt by someone of a racial minority status may better reflect an external reality than an internal paranoia; Whaley, 2002). While the evidence for differential clinical judgment for people of color has been clear (Neighbors et al., 2003; Whaley, 2002), less work has been conducted to evaluate the differential judgments based on religious or spiritual factors.

Sue and Sue (2003) discussed that the evolution of racist attitudes today have become evident in less telling behavioral manifestations, thanks to the modern emphasis on respecting diversity. However, these attitudes still exist and even though overt acts of racism are rare, more covert acts, referred to as micro-aggressions, still abound. These attitudes of intolerance which can be either conscious or unconscious, influence the treatment of minorities and can lead to detrimental psychological consequences for those individuals identified as victims of micro-aggressions. Studies examining how counselors commit micro-aggressions against people from underrepresented groups in the counseling process are beginning to reveal that counselors with more affirming personal beliefs for certain groups may be more likely to consider cultural explanations for their presenting concerns (Constantine, 2007). Indeed, there is evidence supporting that clinicians using a flexible diagnostic interview may tend to utilize different decision-making processes depending upon the race or ethnicity of the client (Trierweiler & Stricker, 2000). If a similar logic were applied to the role of a client's religious beliefs or practices, counselors' unfamiliarity with or bias against religious traditions or spiritual expressions may be an important factor in understanding when this bias exists.

Evidence from gender bias. Similar to discussions of race, the constructs of gender role beliefs and sexist attitudes have been theorized to be relevant social factors when

considering how clinicians think about and treat clients (Sue & Sue, 2003). An early study examining the impact of client gender on counselor conceptualization suggested that counselor conceptualizations of men were indeed healthier than for equally symptomatic women (Broverman, Broverman, Clarkson, Rosenkrantz, & Vogel, 1970). In a follow-up study, another group of authors found that men were seen as healthier than women even when the randomly assigned vignettes were identical symptomatically (Abramowitz, Abramowitz, Jackson, & Gomes, 1973). However, in another follow-up study Gomes and Abramowitz (1976) used more rigorous experimental controls and found no significant effect of client sex on counselor clinical judgment.

Smith (1980) conducted a meta-analytic review of both published and unpublished studies examining the impact that gender of clients may have on counselor bias. Her conclusions pointed to a small bias detected in published studies (Cohen's $d = .25$) but not in unpublished studies employing a similar rigor of research methodology. In fact, her findings of the unpublished data found a small bias against men in the unpublished data leading her to conclude that, when taken together, there may be no effect of client gender on counselor conceptualization.

Still, work since that time has continued to suggest that certain clinical judgment factors are used differently for women and men. For example, in a sample consisting of trained psychologists registered in a national service provider database. Ford and Widiger (1987) indicated that a randomly assigned vignette describing a client with pervasive psychopathology was more likely to be diagnosed with histrionic personality disorder when the client was identified as female, but as having antisocial personality disorder if identified as a male.

More recent studies have indicated that counselors' biases against men may be more prevalent. In one such study the authors investigated thoughts about men and women's emotional expressiveness, finding that counselors in training rated men as more hypo-emotional and also were more often blamed for the presenting concerns when given a fictitious vignette of a heterosexual couple with ambiguous presenting concerns (Heesacker, Wester, Vogel, Wentzel, Mejia-Millan, & Goodholm, 1999). The authors discussed the possible role that non-affirming stereotypes of male emotional inhibition may play in therapists' attributions for the relationship problems. Additionally, a study examining therapists' attribution for blame among male sexual abuse survivors reported significantly more blame for male clients when therapists' views of men were less affirming (Richey-Suttles & Remer, 1997). Borrowing from this research base, perhaps non-affirming reactions toward people of faith on the part of psychologists may be related to differential conceptualizations. The historically antagonistic relationship between psychology and religion may be relevant to how current clinicians think about their religious or spiritual clients.

Evidence from heterosexism. Sexual minorities, including individuals indentifying as lesbian, gay, bisexual, transgendered, and queer/questioning (LGBTQ), have also been victims of discrimination and prejudice. These occurrences can be both overt acts of discrimination or more covert micro-aggressions such as a waitress failing to serve a table of cross-dressed persons or simply avoiding eye contact with them. The act may not overtly harm the victim physically, but when these micro-aggressions are identified by victims, the consequences may include detrimental effects on the victim's mental health (Sue, Capodilupo, & Holder, 2008).

Analogue studies have shown that counselors' attitudes toward LGBTQ clients indeed related significantly to more severe diagnostic trends as well as less optimistic prognoses with

less affirming attitudes relating to a less healthy outlook (Eubanks-Carter & Goldfried, 2006; Mohr et al., 2009). Additionally, in a study examining male counselors' conceptualizations of either a homosexual or heterosexual male, participants viewed the gay client's expression of anger as less psychologically healthy than the heterosexual client when clinicians held more traditional gender role stereotypes (Wisch & Mahalik, 1999). Together, these data indicate that pre-existing attitudes or beliefs may be an important factor in counselors' conceptualizations.

Attribution Theory and Bias

Attribution theory, from social psychological literature, may be one conceptual framework for understanding how the aforementioned biases against people from diverse cultural backgrounds may be formed. Attribution theory, as posited by Weiner (1980), is an attempt to help explain reasons why people behave as they do and the processes by which people attribute causes of varying behaviors. Specifically, Weiner indicated that human explanations of behavior tend to fall on three continuums: causality of others' behavior on a continuum from a more internal locus of control to a more external one, stability of behavior ranging from instable to stable, and controllability ranging from completely outside of a person's control to completely within a person's control. More recent collections of research have found that being familiar with and having a sense of belongingness to a given group (the "in group") tends to be associated with a positive bias for that group (Fiske, 2004). Contrarily, not being included or having a sense that one does not belong to a group (the "out group") tends to be related to more negative perceptions of that group, but not one's own out group. This model for understanding social behavior has helped researchers explain biases for or against many demographic groups (Fiske, 2004).

To extend attribution theory to areas of bias, researchers have supported this in-group/outgroup phenomena empirically. For example, one study investigating the impact of

racial stereotypes found that African-American students tended to have fewer implicit and explicit anti-African-American prejudices when compared to non-African-American students (Rudman, Ashmore, & Gary, 2001). These data support the theory that one's group membership may be an important factor when considering how attributions for behavior are made.

Brickman's study (1982) showed that attributions of causes of problems (which are important to clinical judgment) are separate from attributions for solutions to problems, hence advocating for a separation between the two types of attribution. For that reason, the current study will examine attributions of both causes of and solutions to client problems, which is consistent with Brickman's (1982) model. The Attribution of Problem Cause and Solution Scale (Stepleman, Darcy, & Tracey, 2005) was developed based on the Brickman framework for attributions. This scale has been used in counseling process and outcome research and integrates the three attributional domains of causality, control, and stability.

Clinical Judgment and Religion and Spirituality

In the studies outlined above, attitudes toward gender, race, or sexual orientation are associated with an in-group/out-group bias which favors the white male, middle-class majority, heterosexist worldview. Another area considered related to differences in counselors' clinical judgment is counselors' own religiosity, particularly when religious clients are involved. (Houts & Graham, 1986; Worthington, Kurusu, McCullough, & Sandage, 1996). Counseling researchers have found that religious clients are often suspicious of their nonreligious therapists, believing their therapists may over-pathologize them because of their beliefs (Worthington et al, 1996). Initial empirical analyses have supported the idea that religious clients tend to perceive their nonreligious counselors as having a negative bias against their religious beliefs (Gartner et al., 1990; Houts & Graham, 1986; Lewis & Lewis, 1985).

However, other work has shown that counselors' differential diagnoses between religious and nonreligious clients may not be occurring (Worthington & Scott, 1983; Reed, 1992). These mixed findings leave much to be answered in knowing the extent to which a client's religious preferences or beliefs can affect clinical judgment. One thing missing from these studies is the additional examination of clinician attitudes toward religion or spirituality in these models. Furthermore, these empirical studies have excluded Eastern and Mid-Eastern religions. The present study will advance the current understanding of the roles that client and counselor religious preferences, counselors' attitude toward religion, and interactions that these may have on clinical judgment for potential clients of either non-religious, Christian, Buddhist, or Islamic backgrounds.

Spirituality and Psychology

The U.S. was initially settled by religious pilgrims in search for the opportunity to practice their religion freely and without imposition from the majority culture at that time. Ironically, this was followed by their attempts to convert American Indians from their spiritual acts of worship to European Christianity (Gaustad & Schmidt, 2002). Today, religion remains a controversial topic within psychology partially due to the cultural violence and intolerance espoused over centuries from religious groups. However, recent developments have acknowledged the adaptive nature of the construct in the everyday lives of some clients and psychologists (Hill & Pargament, 2003).

Psychologists have long debated the value of spirituality and religion in human life. Freud (1927) and Ellis (1980), two major contributors to the field of applied psychotherapy, both maintained the idea that spirituality and religiosity were irrational and indicative of emotional instability. Ellis later qualified his initial belief by indicating that only the unmoving, devout

religious person is likely to be neurotic (Ellis, 1990) thereby presuming that a starkly religious person is by definition psychologically unhealthy to some extent. Interestingly, before he had made this statement, Ellis (1962) often used the phrase "the universe does not owe" people anything, revealing that even in his spiritual cynicism, he may have acknowledged the usefulness of engaging in spiritually-laden language for clients (p. 121). Freud (1927), on the other hand, maintained a view depicting religiosity as a "universal obsessional neurosis" revealing a regression toward primary narcissism (pp. 126-127).

Some subsequent psychoanalytic movements have since acknowledged the value of spirituality/religion in human functioning (Jung, 1938/1966). Allport and Ross (1967) were among the first psychological researchers to point out that spirituality and religion can be either detrimental or enhancing to a person's mental health. They posited that intrinsic religiosity, when commitment to religious values does not change regardless of social situation, is better related to positive mental health than religiosity in extrinsically religious people, who use religion only when beneficial for their social status or for other more peripheral concerns. Subsequent studies have confirmed their initial hypotheses (Bergin, Masters, & Richardson, 1987; Donahue, 1985; Kahoe, 1974). Since Bergin's (1980) profound challenge for psychology to accept the benefit of spiritual and religious values within psychology, the field has become more open to the idea of religion being a support for clients, but clinicians still maintain a lower level of religious practice and belief than the general population by almost 50% (Delany, Miller, & Bisono, 2007). Clearly, there is a disconnect between clinicians' and clients' worldviews when considering spiritual/religious beliefs, and the impact of this difference is yet unknown.

In a study examining counselors' training, Zinbauer and Pargament (2000) noted that the majority of practicing therapists in their sample were not trained to recognize and monitor their

value differences with their clients. Furthermore, their sample reported uncertainty as to the potential impact of their own religious beliefs on the counseling process. While this study did not specifically examine the extent to which these findings affected the counseling process, one theoretical extension might be that some practicing counselors may be at risk for imposing their value-laden spiritual worldview upon clients with different spiritual perspectives The above extension is supported by existing literature suggesting that counselor self-awareness combined with cultural training in areas of cultural diversity may help provide a buffer against biased treatment toward culturally diverse clients (Sue, 2003; Sue & Torino, 2005).

While some forms of psychotherapy have historically been described as value-free processes, Zinbauer and Pargament's (2000) study pointed to evidence that therapists' values are constantly at work within a therapy session as they related to specific therapy goals, techniques, markers of success, and session structure. Bergin (1991) pointed out that when values are deemed to be different between client and counselor, it is the counselor's responsibility to attempt to remain honest by presenting balanced content which operates within the subjective worldview of the client. As indicated in empirical research, value match of client and counselor can be an important factor in how the client perceives the counseling process (Kim & Atkinson, 2002). Given the overlap that spiritual/religious beliefs have with value systems, it is important to ensure that value alliances or mismatches are not related to differential treatment of clients, something that has been investigated very little when spiritual/religious beliefs are in question.

A non-religious therapist may, perhaps even unintentionally, be proselytizing religious clients to a secular worldview or value-system, which may violate the client's autonomy. Furthermore, this process could potentially violate the professional ethical values of non-maleficence and beneficence (APA, 2002), considering the literature supporting the positive

influence of religious or spiritual connectivity in regard to subjective well-being and physical health (Seybold & Hill, 2002). Likewise, a religious therapist who sees a religious client as having an intact spirituality may be theoretically blinded to more pathological presenting concerns which would necessitate clinical attention. One piece of evidence supporting this comes again from recent research investigating the impact of client-counselor worldview match (Kim, Ng, & Ahn, 2005). In this analogue study with Asian-American participants, the authors found that when counselors held similar worldviews as their clients, they tended to rate the working alliance as stronger. Although this intuitive finding does not necessarily indicate that counselors treated clients with mismatching values any differently, it certainly raises further questions regarding how or why the working alliances with those other clients were lower, leaving the possibility of bias against their value systems as one possibility. Additionally, the study does not provide any evidence to suggest what impact the mismatch of values had on counselors' clinical judgment.

Zinnbauer and Pargament (2000) proposed that counselors should be wary of pathologizing a client's religious and/or spiritual beliefs without clear empirical or clinical justification. However, what is clearly justifiable as pathology to a therapist with nonreligious or religiously antagonistic attitudes may be viewed as adaptive, psychologically healthy or neutral factors for a spiritual/religious therapist. This possibility, however, has yet to be fully examined with strict empirical methods. Both the affective responses and cognitive appraisals of counselors exposed to a religious client may be important factors in better understanding how clinician conceptualizations are formed and whether or not their own attitudes toward religion or spirituality are important factors in the conceptualization process. These areas are considerably important given the power that therapists have over their clients (De Varis, 1994).

Counselor spirituality, religiosity, and the impact on therapy

Social psychologists have long found that individuals tend to dislike people with grossly dissimilar values than themselves and are attracted to others with similar values (Byrne, 1971; Pinel, Long, Landau, Alexander, & Pyszczynski, 2006). Critics of psychotherapy have similarly stated that clinicians are equally vulnerable to this bias (Szasz, 1974), which may have detrimental consequences for clients with different value systems from their therapists. In a meta-analytic review of value convergence of client and therapist on process and outcome studies, Kelly (1990) found evidence suggesting that values convergence was associated with client improvement, as rated by clinicians, while no effect was found with client-reported data. However, a later study by Kelly and Strupp (1992) found that client-counselor dyads with similar values tended to be associated with greater improvement for clients, as measured by counselor, client, and objective improvement scales. Given the overlap of spiritual/religious beliefs with value systems (Richards & Bergin, 2005) it may be important to examine the effect that therapists' personal spiritual/religious ideals have when conceptualizing clients with dissimilar ideals.

Earlier work noted that psychologists reporting higher commitments to their religion tended also to report an increased sense of conflict when considering how to integrate their religious and professional beliefs together (Eckhardt, Kassinove, & Edwards, 1992; Kasinove & Uecke, 1991). Few studies have followed these trends to examine the impact of this value conflict. Likewise, the impact of client religiosity or spirituality upon a therapist's clinical judgment has not been reviewed in detail, which is surprising given the recent attention directed toward the integration of spirituality and religion into multicultural competence (Cohen, 2009; Sue, 2001a).

Houts and Graham (1986) found that, among a Christian sample, highly religious clinicians rated a nonreligious client as having more intrinsic or internal problems while the less religious clinicians gave more intrinsic problem ratings to the more religious client. This experiment revealed that there may be evidence that clinicians' pre-existing worldview may in fact color the way they view and perhaps even treat clients of varying religious backgrounds. Unfortunately, the authors only studied Christianity so it is not possible to generalize these data to clients and counselors of other faiths.

Carone and Barone (2001) posited that religious individuals would be more likely to rely upon heuristics when presented with religiously oriented stimuli. They believed that the tendency to rely on quick judgments and confirmatory biases would be more likely given the role their own religious/spiritual worldview plays in securing a sense of purpose and meaning in the world. Relying upon heuristic reasoning has been shown to lead to a plethora of cognitive biases (Dawson & Arkes, 2007; Park & Banji, 2000). In one study asking undergraduate students to rate their opinions of a product, researchers found that the sample's use of heuristics was an important factor in judgments about the product's usability (Chaiken & Maheswaran, 1994). The study revealed that even when the implications of the task were manipulated so the participants would be motivated to stay objective, they still relied up on initial heuristic reasoning. These findings support the confirmatory bias phenomena, in which people tend to cling to pre-conceived notions about a given target, even when evidence to the contrary is presented.

Taken together, these data point toward the possibility of more religious clinicians being biased to favor religious clients, simply due to the fact that they are religious. Likewise, less religious clinicians or those with antagonistic attitudes toward religion may rely upon their heuristic connections when considering the role of a client's religion or spirituality in their

presenting concerns. More empirical data is needed to determine whether these observations hold up in therapy, as well as whether the exact nature of a client's spiritual or religious traditions may be a crucial point of consideration.

Client Spirituality and Religiosity and Clinical Judgment

Sanderson, Vandenberg, and Paese (1999) found that clinicians tended to assign more pathology to religious clients whose religious practices were less common and even more pathology to clients whose religious practices were very uncommon. In essence, the less conventional the behavior, the less psychologically healthy clinicians rated the client. This finding was somewhat alarming, given the multicultural movement's emphasis on pluralism and respect for diverse expressions of oneself. One limitation of this study was that many of the very extreme religious practices were not externally generalizable to modern-day religious sects or denominations (e.g. cutting off one's own hand after stealing) which may have biased the results.

Gartner et al. (1990) found similar results. Their sample of clinicians rated two randomly assigned cases in which the client was a member of one of four possible sociopolitical ideological groups, ranging from fundamentalist Christian to anarchist atheistic beliefs. The results supported that clinicians provided qualitatively different and more severe diagnoses to clients in the more extreme ideological groups. Additionally, clinicians tended to respond with less empathy to cases when their own belief system was in opposition to the client's belief system. It should be noted that this interaction effect was only found for empathy for clients but not found for their other clinical judgment measures including ratings of clients' pathology, stress, and maturity. However, they did find evidence that the most liberal clinicians among the sample tended to rate the more right-wing client case as being less mature. Although political

ideology is not necessarily equivalent to religious belief, there is some evidence suggesting overlap between religiosity and conservatism among some Western religions (Layman, 1997).

Lewis and Lewis (1985) found evidence that counselors' rating religious and nonreligious clients based on a single audiotape were more apt to rate the religious client as needing fewer sessions but also that their spiritual beliefs were likely accounting for a more significant amount of their problems than the nonreligious client. Again, the client presented represented a Christian spiritual tradition making comparisons to other potential clients of faith more difficult. Lewis (2001) found that a sample of undergraduate students tended to view religious individuals as having less psychotic tendencies but more obsessive tendencies than identical non-religious clients.

Gerson et al. (2000) found that psychologists tended to rate a vignette of a religious client more optimistically than of a client who was not religious. This trend became stronger among those clinicians endorsing stronger personal religious beliefs. In this case, the clinicians were biased to rating the fictitious client more positively when that client was said to hold religious beliefs. This study was one of the only current (within the past 15 years) works assessing the impact that a prospective client's spiritual beliefs or practices may have on the counseling process when combined with counselor religious beliefs. However, this study is limited as a significant portion of the sample were made up of psychologists who were members of Division 36 (Psychology and Religion), whose views of spirituality/religion in psychotherapy may not generalize to other psychologists.

Furthermore, in Gerson et al.'s (2000) study 85% of respondents reported their theoretical orientation as psychodynamic or psychoanalytic which may not be a good representation of how most clinicians do therapy. It should be noted that this study did not look specifically at

psychologists, but included other mental health practitioners (counselors, social workers, and psychiatrists) whose professional roles and worldviews may not necessarily approximate those of psychologists. Additionally, the vignette was not provided in text which makes it difficult to discern precisely how the issue of spirituality or religion was presented to participants. Their results also indicated that the therapists in their sample held relatively strong religious beliefs and maintained a belief that religion should be addressed in therapy, which are findings contrary to other related studies indicating that psychologists had fewer religious beliefs and were more ambivalent about whether spiritual/religious concerns should be addressed in therapy (Eckhardt et al., 1992; Kassinove & Uecke, 1991; Shafrankske & Malony, 1990).

In response to these discrepant results, Gerson et al. (2000) stated that perhaps a shift in attitudes has taken place among psychologists as far as religion or spirituality is concerned. It is important that these data are followed up with additional empirical analyses to determine the role that both counselor and client religious and spiritual orientations may have in the counseling process. Perhaps these studies suggest that heuristic data, or pre-conceived notions about a client's worldview, may be an important factor in predicting how or why biased clinical judgments arise. It is equally important to understand which factors may act as buffers against biased clinical judgments when religious or spiritual clients are concerned.

Cultural Competence

APA's (2002) ethical code specifically states that psychologists must provide competent services to individuals of diverse cultural backgrounds and seek additional training when working within an area that is new to them (2.01; APA, 2002). Additionally, the ethical code specifically states that psychologists must refrain from discriminating against clients based on their religion (3.01) and to seek additional training, consultation, or supervision when issues

related to religion are considered essential for effective treatment. Richardson (2008) pointed out that professional ethical codes and training directly speak out against proselytizing clients to become religious converts due to the power dynamic created within the therapeutic relationship. However, these same professional standards do not speak against converting religious clients to a more secular value system in the same way that some psychotherapy theories may be more prone to doing. For instance, certain criticisms against the cognitive behavioral approach to therapy have mentioned the entire goal of the approach is essentially to convert clients to a new belief system (Proctor, 2003).

Cohen (2009) indicated that religion is one of three types of culture that are currently understudied in the field of psychology, with the other two being socio-economic status and region within a country. Cohen also suggested that although many researchers have conceptualized religion as a by-product of cultural heritage, there may be some indication that religion itself drives other aspects of culture. In this section I will outline the role that cultural competence plays in counseling, specifically the integration of spiritual/religious concerns into the cultural competency framework.

Cultural Competence and Spiritual/Religious Concerns

Both Sue (2001a; 2001b) and Abreu (2000) were quick to point out that training models promoting cultural competence should encourage counselors to acknowledge their biases about diverse people groups. However, religious and spiritual biases are not often discussed in these regards. If counselors are not trained to challenge biases against spirituality/religion, perhaps their competence for related issues would be in question. Gushue (2004) showed empirical data indicating that counselors who viewed themselves as blinded to cultural factors tended to rate an African American client as having more severe symptoms when compared to an identical

Caucasian client. The author's "shifting standard model" presupposes that more culturally competent counselors may draw from a different set of standards when conceptualizing clients with underrepresented cultural backgrounds. The present study is built upon the shifting standards' logic in order to determine if counselors with more favorable attitudes toward spirituality/religion will rate a client differently when spiritual/religious factors are present and vice versa.

Paloutzian (2006) pointed out that the field of psychology has grown to appreciate the relative importance of religion in the majority of peoples' lives. However, even though psychology has emphasized the scientific method and Aristotelian logic, humans seem to "think what we think, conclude what we conclude, and *then* construct a rationale and basis for holding it, and perhaps the meaning behind it" (p. 249). In this way, issues of spirituality and religion are subject to formative biases developed within individuals' own personal development in response to their various social, interpersonal, and intrapersonal systems. The implication then is that many people will maintain their biases for or against spiritual or religious ideals, irrespective of available evidence. However, work conducted in other areas of cultural competence may help reveal how clinicians may be able to buffer these biases for or against spiritual/religious traditions.

Helms (1994) indicated that blanket models of cultural competency may not be valid representations of specific cultural areas. Thus, she advocated for specific measures of cultural competence when examining the impact competence may have on specific cultural areas. For example, Brown (2008) discussed the importance of cultural competence when working with survivors of trauma, indicating that counselors and clients each have individual histories with various forms of culture. She went on to state that a culturally competent practitioner is aware of

his or her personal relationships to each kind of cultural construct, including spirituality and religion. She also pointed out that a therapist's lack of self-knowledge can affect the process and outcome of psychotherapy. Self-knowledge has been linked to multicultural competence in regard to racial prejudice (Sue, 2003) a theoretically related concept, lending logical support to this position

One way that psychologists have tried to promote knowledge of self and others is through projective testing techniques. Studies involving projective testing often operate with the assumption that ambiguous stimuli can act as a canvas upon which individuals project aspects of themselves (Kline, 2000). One such study using the Implicit Association Test (IAT) has found that individuals are prone to cognitive biases and implicit attitudes, particularly against racial minority groups, which actually correlate with increased discriminatory behaviors (Dovidio, Gaertner, & Kawakami, 2002; McConnell & Leibold, 2001). It is possible that clinicians' attitudes toward religious or spiritual clients are also subject to these implicit biases which, in turn, could impact their clinical decision making. Perhaps, increasing self-knowledge regarding one's heuristic biases against spirituality and religion is one step in reducing biased clinical judgments. Of course, given Spengler et al.'s (2009) finding that training or education does not produce a powerful meta-analytic effect, future research should specify how this type of training may specifically help maximize bias reduction.

As indicated earlier, spiritual and religious traditions are not always included in discussions of cultural competence (Olsen, 2007) even though multicultural theory includes these faith traditions within the concept, often acknowledging their impact on an individual's worldview (Sue, 2001a). However, cultural competence is not an easy construct to capture as an umbrella over all forms of culture. Measuring competence this way may minimize the

multidimensional aspects of culture or worldview thereby necessitating a consideration of separate components of competency. Thus, discussions of competence specific to spiritual or religious concerns may be more appropriate than overall cultural competence.

Within the last few decades, clients claiming to be "spiritually committed" were noted to under-utilize mental health services, perhaps due to their lack of trust in a process considered secular by many religions (Richards & Bergin, 2005). Support for this interpretation can be found in subsequent studies revealing that individuals committed to their spiritual beliefs tended to prefer counselors who used religious or spiritual themes during therapy (McCullough, 1999), who shared their spiritual outlook (Ripley, Worthington, & Berry, 2001), and who used spiritually-sensitive interventions in therapy (Erickson, Hecker, & Kirkpatrick, 2002).

A synthesis of these data together suggests that perhaps the field of psychology has embraced the importance that spiritual or religious matters can have within the counseling context. Remaining questions center on what impact the integration of the sacred into the counseling context has on the counseling process, particularly for therapists who are not competent in dealing with religious ideals or who have biases for or against a given religious orientation. Future research is needed to help clarify these gaps in the literature.

The present study will examine if counselors' impression of a client changes if that client comes from a Christian, Muslim, Buddhist, or unidentified religious orientation. The motivation for choosing the four religious groups is intentional. Most people in the United States identify as Christian, with an estimated 77% of the population endorsing some form of this religious belief system (Gallup, 2009; Richards & Bergin, 2005). This is helpful to this study for two reasons. First, when examining the construct of bias, it is helpful to understand that individuals who are part of the majority culture have the privilege of being familiar to more people in a society (Sue,

2003). Second, Christianity has come under fire by the field of psychology which may be helpful in activating certain biases that less familiar religions may be unable to activate (for review of different areas of conflict see Miller & Delany, 2004). Although studies assessing the role of client and counselor religious factors in counselors' clinical judgment are rare, those that are available have found mixed results for the role that Christianity plays in triggering bias (Gartner et al., 1990; Gerson et al., 2000; Hathaway et al., 2002; Houts & Graham, 1986; Lewis & Lewis, 1985; Reed, 1992; Worthington & Scott, 1983), providing yet another reason to include an examination of this religious identity.

In general, fewer people practice Islam and Buddhism in this country than the other Judeo-Christian religions (Richards & Bergin, 2005), making those who practice them religious minorities in the U.S. Choosing Islam and Buddhism as the other religious conditions was also due to previous work finding that counselors had less favorable impressions of clients who identified as Muslim compared to those identifying as Christian (O'Conner & Vandenberg, 2005). No studies examining this effect on Buddhist clients were identified, which is somewhat interesting given that the rates of Buddhists and Muslims in the U.S. total population are somewhat similar (Richards & Bergin, 2005). Thus, there is likely something else generating this bias against Muslim believers other than being a religious minority. Although the percentages of U.S. citizens who practice Islam and Buddhism are both relatively small compared to other religions, it is possible that the practice of Islam is seen as more pathological than Buddhism (or other less popular religions) given the past decade of media coverage emphasizing the fundamentalist practice of this religion. Along those lines, a recent Gallup poll (2010), which randomly selected over 1,000 U.S. citizens, found that 1 in 4 U.S. citizens expressed at least some feelings of prejudice against Muslims. This number almost doubled the

reported prejudices against Christians (18%), Jews (15%), and Buddhists (15%). It should be noted that the vast majority of Muslims believe that Islam does not condone terrorism (Esposito & Mogahed, 2008), indicating that these acts against civilians are representative of a small percentage of Islamic extremists, although many U.S. citizens may be unaware of this fact.

Measures of competence

Cultural competence scales have been used in recent studies to attempt to control for the effect of cultural training, however many of these scales do not include item content specific to spirituality or religious diversity. For example, in an examination of four widely used competence scales by Constantine and Ladany (2000), none of these scales included item content that related to spiritual or religious beliefs as a cultural factor. Helms (1994) mentioned that measurements of cultural competence would be more accurate if they included aspects of a specific type of culture which can reflect that individual culture. So, individual instruments aiming to assess competence related singularly to ethnicity, gender, socio-economic status, sexual orientation, and religious affiliation among others would be more appropriate to use than general multicultural competence measurements integrating all cultural areas together.

Indeed, the findings from Constantine and Ladany's (2000) study found that none of the four multicultural competence instruments assessed reflected diverse cultural groups (gender, race, religion, SES, etc.). The authors explained that, among other things, these scales seemed to assess prospective behavior rather than actual behavior and also are threatened by social desirability. To date, there have been a few more specific scales aimed to assess cultural competence with specific groups. Using a PsychInfo search, only 9 combined hits for the search terms "spiritual competence" and "religious competence" were found, with one of the nine reflecting studies in social work programming. Of these, the only scale created to measure

competence with spiritual and religious matters in psychotherapy was Parmley's (2009) dissertation. Searching through Google Scholar, two additional scales were located that were designed to specifically address spiritual competence in counseling which were also recent dissertations (Cates, 2009; Roberson, 2008). Given the above evidence of cultural competence being a theoretically important factor in reducing biases against cultural subgroups, the present study will include a specific measure of spiritual competence. If this construct operates similarly to other forms of cultural competence, it is possible that this construct may have a moderating impact on clinicians' clinical judgment ratings of spiritual/religious clients.

Summary of Literature and Rationale for Present Study

Spiritual and religious beliefs are accepted as an important cultural concern for clients; however, very little research has examined the role that both client and counselor spiritual/religious beliefs may play in shaping counselors' clinical judgment. Preliminary evidence suggests that psychologists may be more likely to assign pathology to individuals who endorsed an atypical religious belief (O'Conner & Vandenberg, 2005), yet other research demonstrated that being religious resulted in more optimistic conceptualizations from clinicians (Gerson et al., 2000). There seems to be a general lack of data addressing how clinicians' own spiritual or religious beliefs as well as their attitudes toward spiritual/religious matters relate to their conceptualization of religious clients. Even less is known when clients' religious preference is less mainstream (e.g. Muslim) when compared to Western-based belief systems.

Other specific questions yet to be answered are whether more spiritual or religious clinicians will tend to depathologize a client simply due to a shared belief system and the role that clinicians' perceived spiritual competence may play in their clinical judgment of religious clients. Research lacks in this area as no study to date has integrated experimental conditions

when examining the impact of different client spiritualities/religions and both counselors' spirituality/religion and their attitudes toward spiritual/religious matters when considering counselors' clinical judgment. Furthermore, the construct of spiritual competence in counseling is only recently emerging as a possible factor and has not been examined empirically to determine its possible effect in reducing bias in counselor clinical judgments.

Given the limited empirical support in this area, it would be helpful to examine whether or not clients from different religious orientations may be treated differently in the counseling process. Using experimental conditions, O'Conner and Vandenberg (2005) found that clinicians tended to assign more pathology to Muslim clients when compared to Christian ones but did not take counselors' attitudes or spiritual competence into consideration. Their study was one of the only ones to use experimental methods (i.e. random assignment and manipulation of an independent variable) when examining the phenomenon of interest. The present study follows up on this finding by assessing if client religious beliefs and the counselor's beliefs or attitudes, while including spiritual competence, may help shed more light in shaping counselors' clinical judgment.

Thus, the present study investigated differences in psychologists' clinical judgment in regard to a hypothetical client presenting with strong religious beliefs (Muslim, Buddhist, or Protestant-Christian) when compared with a client without reported spiritual/religious beliefs serving as a control. Counselors' level of spiritual competence, theoretically linked to their ability to conceptualize in a culturally sensitive manner, and their spiritual/religious beliefs and attitudes, conceptualized several ways, will be assessed as potential covariates. Diagnosis, prognosis, and attribution for the problem were the primary dependent constructs representing clinical judgment in the present study.

Research Questions and Hypotheses

The hypotheses were: (1) Client religious orientations will elicit different assignments of prognosis, GAF, and attribution of the problem; (2) Counselors with more affirming attitudes toward religion/spirituality will be more inclined to rate the religious clients with less responsibility, less pathology, and more optimistic prognosis; (3) Counselors with higher spiritual competence will demonstrate a shifting standards effect with religious clients, rating them with better prognoses, less pathology, and less responsibility for the problem.

Because each of these hypotheses introduces a combination of previously unexamined factors together in a single study, the direction of the differences is not well-supported. However, below are planned comparisons that have some theoretical support. A moderation analysis of counselors' spiritual competence also was assessed to determine if counselors' clinical judgment might be influenced by the interaction of counselors' spiritual competence and clients' religious background.

Planned comparisons

Given that Islam is an underrepresented religious preference in this country and the above literature on multicultural competence being key in reducing biased judgments against people from diverse groups, there may be reason to believe that the Muslim client will be assigned more pathology, more responsibility for the problem, and a worse prognosis than those in the other vignettes, irrespective of clinician religious beliefs. Secondly, I predicted that more spiritually competent and pro-religion clinicians will rate the religious clients as having less pathology, less internal responsibility, and a better prognosis than those with lower spiritual competence. Lastly, I predicted that all three religious clients would be assigned more pathology among non-religious, less culturally competent and more anti-religion clinicians than the client without

stated religious beliefs based on the familiarity effect supported in social psychology literature (Fiske, 2004; Gladwell, 2005).

Research questions

In addition to the above hypotheses, I examined whether the client vignettes and counselor factors would relate to other factors related to clinical judgment. These additional exploratory items were collected given the research on clinical judgment that supports its complexity when considering the broad areas that go into decision-making in psychotherapy (Arkes, 1981; Garb, 1996; Garb, 2005). The exploratory factors related to clinical judgment included counselor self-report of empathic response to the vignette, counselor's estimated number of sessions needed to help the client, diagnostic categories (e.g. "To what extent do you believe the client has a mood disorder?"), counselor's estimate of the client's motivation for change, counselor's estimate of his or her own ability to help the client, and counselor's own identification with client's concerns ("The client is like me").

Pilot study

A pilot study was conducted for three reasons. First, some of the measures and items have either not been updated for use in many years (Religion Scale) or were adapted specifically for the present study, including the vignettes, Spiritual and Religious Antagonism Scale (SARAS), the demographic sheet, and exploratory items). The pilot study helped provide necessary psychometrics to assess evidence for validity and reliability for the RS and SARAS scales. This was particularly important for the SARAS, given that no scale to date has been used to assess this construct and its theoretical importance in the study. Second, the pilot study and subsequent psychometric analyses aided in reducing the participant burden by revealing which items might be redundant or poor predictors of the construct measured by the SARAS. Last, the

pilot study gave prospective participants opportunities to comment on the general wording and provide feedback on typos or things that were unclear before data would be collected for the final analysis.

CHAPTER THREE

METHOD

Pilot Test and Pre-Analysis Procedures

Pilot Study

As mentioned above, the pilot study was conducted to provide empirical support for the use of the created and modified items for the four adapted vignettes, the Religion Scale (RS), Spirituality and Religious Antagonism Scale (SARAS), and the exploratory items. Participants (*N* = 51) were given paper-and-pencil surveys with these instruments as well as a demographic sheet and were asked to also include any written qualitative feedback about the surveys or individual items. The author recruited participants from classes of counseling students, faculty in psychology, and practicing psychologists.

Participants. Of the 51 total participants in the pilot study, most were female (*n* = 39, 76%). The mean age of participants was 31.90 years (SD = 12.23), and most identified as heterosexual (*n* = 44, 86%). Most participants in the pilot study were graduate students in counseling or psychology (*n* = 43, 84). Participants in the sample were mostly Caucasian (n = 44, 86%). Participants were allowed to endorse as many religious belief systems as they wanted. Most identified as Christian (*n* = 15, 29%), followed by Catholic (*n* = 12, 24%). Lastly, participants were asked their primary theoretical orientation. Most identified as person centered (*n* = 20, 39%) Of the total pilot study participant pool, most were working toward a master's degree in counseling (*n* = 29, 57%). See Table 1 for a complete list of the demographic data.

Table 1

Demographic Information for Pilot Study

	n	Percent
Gender		
Female	39	76.5
Male	12	23.5
Race		
African American	1	1.9
Asian American	4	7.8
Caucasian	44	86.3
Hispanic	1	1.9
Bi-racial	1	1.9
Sexual Orientation		
Heterosexual	44	86.3
Gay/Lesbian	3	5.9
Bi-sexual	1	1.9
Not identified	3	5.9
Religious Affiliation		
Christian (general)	15	29.4
Catholic	12	23.5
Protestant	3	5.9
Jewish	1	1.9

Table Continues

	n	Percent
Hindi	1	1.9
Buddhist	2	3.9
No Religion	5	9.8
Atheist	3	5.8
Agnostic	6	11.8
Theoretical Orientation		
Person Centered	20	39.2
Cognitive/Cognitive Behavioral	9	17.6
Behavioral	1	1.9
Existential	2	3.9
Psychodynamic	3	5.8
Interpersonal	5	9.8
Other	8	15.7
Degree Working Toward		
Masters	29	56.8
Ph.D	11	21.6
PsyD	1	1.9
Currently have terminal doctorate	8	15.7
Student Status		
Student	43	84.3
Faculty	1	1.9
Practitioner	7	13.7

Measures. The measures included in the pilot study included a demographic sheet (Appendix A), the Religion Scale (Appendix B), all four vignette conditions (Appendix D), and all clinical judgment factors (Appendices E-H). These measures were all included given that their use in previous research lacked report of vigorous psychometric analysis. Each of these measures, in addition to those used for the main analysis, is described below more comprehensively. The psychometric properties found in the pilot study will be presented below, with the factor analytic results presented in the results section to follow.

Demographic sheet. The demographic sheet included 12 questions about participants' background. It was constructed to follow APA's (2010) guidelines on reporting of demographic information in psychological research and included a list of identifying religious orientations as well as the Duke Religion Scale (DUREL; Koenig et al., 1997) for a more specific idea of participants' religious identification. The demographic sheet can be viewed in Appendix A.

*Duke University Religion Scale***.** The Duke University Religion Index (DUREL; Koenig, Patterson, & Meador, 1997) was used to more precisely evaluate participants' religious beliefs. The DUREL consists of five items assessing three dimensions of religiosity: organizational (OR), non-organizational (NOR), and intrinsic religiosity (IR). The first two items (indicative of NOR and OR) are assessed by a 6-point scale tapping into the time spent with religious activities, ranging from "never" to "more than once a week" or "more than once a day." The OR activities refer to those shared with other believers (e.g. going to a worship service), while the NOR activities refer to those which are typically private (e.g. meditation). The final three items ask participants to mark the extent to which participants' subjective experiences are influenced by their religiosity. These three items make up the IR domain and are a 5-point response scale ranging from "definitely true of me" to "definitely not true of me." The scale was specifically

designed to encompass broad definitions of religious or spiritual beliefs rooted in the theory that religiosity encompasses three main domains which are reflected in the three subscales (Koenig et al., 1997).

Hill and Hood (1999) reported that these items have been administered to over 7000 individuals between the ages of 18-90 across three different studies, although reliability information is more widely available for the last three items which comprise the intrinsic religiosity scale (Cronbach's alpha = .75), given that this subscale tends to be used more than the total scale. One study reported the DUREL's internal consistency to be good (Cronbach's alpha = .91 among managed care practitioners in the medical field, lending some support for its reliability (McCauley et al., 2005). Evidence for this subscale's validity was supported by correlations with Hodge's (1976) 10-item scale from which these items were adapted (r =.85). The three subscales have been found to correlate positively with one another lending evidence for the scale's internal validity (rs ranging from .40-.42). The OR subscale has been found to relate positively to providing social support to others, as well as negatively to depressed affect, severe medical illness, and functional impairment while the NOR has been found to relate only to increased social support indicating that NOR may be less predictive of medical and psychological problems (Koenig et al., 1997). All three scales are added to compute the total score, however given reported concerns with using the total score to predict behavior (Koenig, 2010), each subscale score were used separately for the present study.

In the pilot study, the total score had a Cronbach's alpha of .81, while the intrinsic religiosity scale had a Cronbach's alpha of .90. The organizational and non-organizational religiosity scores are represented by single items so internal consistency estimates could not be

computed. The range of responses for the OR item was 1-6 (M=4.21, SD=1.50) and the range for the NOR item was also 1-6 (M=4.35, SD=1.70).

Counselor attitudes toward religion and spirituality. Bardis (1961) created the Religion Scale (RS) to measure attitudes toward religious beliefs and worldview in three sub-domains: divinity, doctrines related to humanity, and behaviors designed to satisfy God. The scale consists of 25 Likert-type items ranging from 0 (strongly disagree) to 4 (strongly agree). Scores for all items were summed to generate a total score which can range from 0-100, with higher scores correlating with increased religious affinity. The items were derived from a pool of 200 initial items that were derived discussions with religious persons representing different faith backgrounds (Judeo-Christian and nonreligious) or from previously existing publications on religious attitudes. The 200 item test was given to 500 participants from Christian and Jewish backgrounds and a follow-up analysis was conducted with the best 46 items on a sample of 100 participants. The author compared the 10 lowest scoring surveys with the 10 highest to choose the 25 most common items in order to maximize discriminatory power.

Evidence for the RS's validity is not well-documented. In the original study, Bardis (1961) indicated that mean comparisons among pre-existing groups within his sample were statistically significant, lending support to its ability to discriminate between groups (Hill & Hood, 1999). For example, the agnostics in the study had significantly lower scores than Greek Orthodox believers (M=11.93 vs. M=67.73). Bardis (1961) also found similar trends with agnostic participants scoring lower (M=10.81) than Catholic participants (79.11). Additionally, Methodist seminary students were found to have significantly higher scores when compared to non-seminary Methodist students (M=68.83 vs. M=57.97).

Evidence of reliability for the RS can be found in the original study as well (Bardis, 1961), with the Methodist sample reporting a Spearman-Brown split-half coefficient of .74. Among the agnostic sample the reliability estimate dropped to .58. Since the original study, subsequent studies have reported higher estimates of internal consistency among the subscales ranging from .81-.98 among diverse religious and non-religious groups (Hill & Hood, 1999).

Some of the item content may be outdated because the scale was created in 1961. These items were changed to reflect changes in cultural norms but the pilot study included an analysis comparing the changed items with the original items (discussed below). Three experts in the field of measuring religious and spiritual attitudes were consulted to verify that the content validity of these items remained strong after revisions. Unfortunately, Hill and Hood's (1999) compilation review of all psychological measures of religiosity did not include a scale that simply measures attitudes toward both religion and spirituality. Because the RS better reflects attitudes toward religion than spirituality, 18 items adapted from the literature and other scales measuring general spiritual beliefs were included to tap into that domain. Also, the directions were modified to reflect the term "God" or a "higher power" to be more inclusive. Therefore, the pilot study was conducted in order to establish if these additional items allowed for a cohesive, reliable measure of attitudes toward religion and spirituality. The RS and additional items can be seen in Appendix B. Cronbach's alpha for the original RS items ($\alpha = .85$) improved ($\alpha = .90$) for the RS-Revised (RS-R), which substituted the updated items. Factor analytic data was generated for the pilot study in spite of the small sample, in order to provide some psychometric data about the underlying factor structure. The results section discusses this in more detail. However, the analysis revealed that the final RS-R had a factor structure representing both religious and

spiritual items. The total RS correlated significantly with the DUREL total score (r = .78) lending evidence for convergent validity in support of the construct for the main analysis.

Client vignette manipulation. A clinical vignette was written to reflect a possible intake summary report (see Appendix D for full description). There were four vignettes, one with a Christian background, one with a Muslim background, one with a Buddhist background, and one with no stated religious preference. The identifying information was consistent across each vignette (male, with an unidentified race, graduate student presenting for concerns related to vague depressive affect and relationship concerns). The vignette was adapted from the DSM-IV-TR case book's example of someone presenting with an adjustment disorder with mixed anxiety and mood concerns, although the details of the life and family history were changed (Spitzer, Gibbon, Skodol, Williams, & First, 1994). Additionally, the potential client in the two religious conditions is said to heavily rely on his spiritual/religious beliefs although it was written to be ambiguous as to whether this was helpful or not in order to maximize the potential projection of bias for those that have affinities for or prejudices against religious beliefs. All participants were then directed to read the client's case summary as if he was assigned to them for an individual session.

The only differences between the religious vignettes were the descriptors related to the respective religion. The religious vignettes differ from the control vignette in that the client was said to pray, fast, and read religious scriptures frequently as a way of coping whereas the client in the control condition exercises, reads, and talks to friends for support. An expert in comparative religious studies was consulted to help establish the content validity of each vignette. Additionally, two individuals identifying as spiritual clergy or scholars from Christian, Buddhist, and Muslim traditions (totaling six) were consulted to ensure that the client

descriptions are generalizable concerns for each respective religion. Counseling psychology faculty with research and teaching experience in psychopathology and counseling process and outcome also provided feedback for the vignette descriptions.

Global Assessment of Functioning (GAF). Using GAF scores has become commonplace among practicing psychologists required to diagnose their clients. The GAF is the fifth domain in the 5-Axis system of diagnosis in which clinicians are asked to "consider psychological, social, and occupational functioning on a continuum of mental health-illness" (Spitzer, et al., 1996, p.34). The instructions clearly state that clinicians are not to include estimates of environmental or physical limitations in their decision. The GAF score can range from 0-100 with higher scores indicative of higher functioning individuals. It is thought to encompass clients' overall ability to function in light of the biological, social, psychological, and interpersonal concerns. Although some studies have suggested the GAF has low inter-rater reliability estimates, there are nonetheless standardized procedures in determining a client's score which are generalizable to diagnostic practices (Spitzer, et al., 1996). The GAF is a familiar concept to counselors and psychologists trained in the DSM-IV-TR model of diagnosis. Guidelines for assigning a GAF score were provided to participants after they review the case material (Appendix E).

It should be noted that the use of the GAF in clinical settings has come under scrutiny for lacking inter-rater as well as intra-rater reliability, with levels reported to be below $r = .70$ (Hall, 1995; Jones, Thornicroft, Coffey, et al., 1995; Soderberg, Tungstrom, & Armelius, 2005). However, studies in research settings tend to show higher reliability estimates for the GAF (e.g. Hilsenroth et al., 2000 found inter-rater consistency to be .86). In one study evaluating the GAF's precursor (Global Assessment of Symptoms) researchers found that increased training may be associated with more stable GAF ratings (Dworkin, Friedman, Telschow, Moffic, &

Sloan, 1990). In the latter study, Dworkin et al. (1990) asked psychiatrists to rate eight different vignettes, and found an inter-class correlation of .81. Additionally, a comprehensive literature review by Goldman, Skodol, and Lave (1992) found the GAF to be "reasonably valid…limited in part by its modest reliability" (p. 1154).

A more recent study found that while the GAF used in research settings may have higher reliability estimates (above .85), this evidence for reliability may not generalize well to clinical uses of the scale for inpatient populations; however, having participants review the scale's directions before assigning a score helped improve reliability (Vatnaland, Vatnaland, Friis, Opjordsmoen, 2007). In their review of studies evaluating the GAF between 1999-2003, Vatnaland et al. found four of six studies suggesting the GAF had strong evidence of reliability (Cronbach's alphas = .84-.89), although there were two studies with lower estimates (Cronbach's alphas = .54 and .72). The authors did note that the studies with stronger estimates were limited in that they evaluated research contexts rather than clinical contexts. Furthermore, a small but growing interest has been reported in evaluating whether demographic considerations uniquely influence GAF ratings, with one study finding that inter-rater reliability GAF estimates were much lower when a vignette included a history of childhood trauma compared to an identical vignette without mentioning a history of trauma (Blake, Cangelosi, Johnson-Brooks, & Belcher, 2007). Keeping these concerns in mind, the GAF is a frequently used measure of psychopathology in both clinical and research contexts and provided participants with a recognizable and generalizable task. Given that the GAF is a single item, internal consistency data could not be generated for the pilot study. The range was 11-75, (M = 55.67, SD = 10.47).

Procedure

Because the RS-R and vignette were adapted specifically to fit the goals of the study, a pilot study was conducted to test the items. Counseling psychology students, faculty, and clinical professionals were recruited to take the Religion Scale original and adapted items along with the 19 created items added that address spirituality. The DUREL (Koenig, et al., 1997) was included as well, in order to evaluate evidence for convergent validity. Participants were asked to make qualitative comments about items that may be poorly worded or confusing. Additionally, these participants read the vignette and answered the diagnostic, prognostic, and attributional questions for the client. Again, they were asked to write qualitative comments about any wording issues or confusing components among any of the items. A manipulation check item was also included to ensure that participants could accurately recall the client's religious identification, gender, and race following the vignette.

Once the participants for the pilot study completed the items, psychometric properties of the RS were evaluated to ensure reliability estimates were adequate. Correlations between the original RS and the new items were evaluated for evidence of convergent validity for the RS-R. Item-to-total scale correlations, factor analysis, and qualitative comments were used to evaluate both the RS-R and the SARAS, hoping to maximize the psychometric properties of each while maintaining a parsimonious number of items for use in the main analysis.

Pilot Study Findings

The pilot study data were analyzed to ensure that the adapted items and scales had adequate psychometric properties to support their use in the study. All participants (n = 51) responded to the demographic items, reviewed one of the four possible vignettes, responded to

the clinical judgment items, and the RS, DUREL, and SARAS. Participants provided written comments for the vignette to discuss any confusing or misleading wording.

Vignette results. Three participants made a few comments on the wording of the vignette which originally discussed the client knowing that he and his ex-girlfriend were meant to be together to ensure that it was clear that the description meant the client himself rather than her new boyfriend. Four participants found a missing preposition "to" in the last paragraph so that change was made as well. Participants generally did not request other wording changes or identify other confusing wording to any of the four vignettes. The vignettes reviewed were *n*=12 Not Identified, *n*=14 Muslim, *n*=13 Christian, *n*=12 Buddhist.

Factor analysis. Exploratory factor analysis (EFA) was conducted on the RS and the other 18 created items to ensure that the underlying factor structure was maintained as Bardis (1961) indicated. Principle components analysis with an oblique rotation was used to determine whether there was a unifying underlying construct of the original RS items and whether the 18 created items could be considered a part of or separate from that construct. Examination of eigenvectors (using values above 1.00) and the scree plot (visual inspection for the bulk of the variance) helped determine whether the underlying factor structure of the updated RS (RS-R) was consistent with the original theory posited by Bardis (1961). This analysis provided further construct validity for the RS, as no peer-reviewed articles using factor analysis could be located. It was also important to examine the SARAS items, which were created specifically for the present study, in order to establish preliminary evidence if the underlying construct was being examined. It should be noted that factor analysis using such a small sample size is discouraged given that it can produce unstable solutions (Guadagnoli & Velicer, 1988). However, it was

conducted with this caution in mind to begin to better understand the underlying factor structure in support of the construct validity for the religious worldview, measured by the RS-R.

Religion Scale. The RS (Bardis, 1961) had been constructed with 25 items almost 50 years prior to the study, so the items were updated to reflect more general and inclusive language (e.g. changing "a man" to "a person"); additionally, 8 items originally worded for education ("every school should encourage its students to attend church") were changed to reflect the work of a psychologist ("psychologists should encourage their clients to attend religious services"). The new scale items and the old scale items were both included in the pilot study in order to examine bivariate correlations of the items together. Each adapted item had a significant positive relationship to its adapted item at the $p < .05$ level; r values for the RS and RS-Revised (RS-R) substituted items ranged from .49 to .77.

The updated RS was analyzed for internal consistency using the updated items to replace the older ones. The results revealed evidence supporting good internal consistency (Cronbach's $\alpha = .89$) lending empirical support to the scale's reliability. However, there were four items with low item-to-total correlation (below .40). The item with the lowest item-to-total score was dropped and the reliability analysis was recalculated to examine if the item-to-total scores changed at all. If items were still below .40, the process was cycled through again. This process resulted in four items being dropped, with a higher overall Cronbach's alpha ($\alpha = .92$).

Then, using the 21-item scale, a principal components analysis (PCA) was conducted with the RS-R to help trim the scale of any other items that may not be good empirical representations of the construct. PCA was conducted because there had been no published exploratory works on the internal structure of the RS to date. The initial analysis resulted in four components with eigenvalues at 1.0 or above, which posed a potential issue as the original scale

was theorized to measure a single construct of religious attitudes. The first component explained 58.58% of the total variance with the other three components explaining another 6.2% and 5.2% for each of the last two; eigenvalues were 11.71, 1.25, 1.05, and 1.01, respectively. The first component included items that all represented attitudes toward religion.

The items loading on the three other component were grouped together for visual inspection. Upon reviewing them, it appeared that many of the items were those that reflected the role of a psychologist in respect to religion (e.g. "Psychologists should stress religious ideals with clients") as well as some which included more broad beliefs about the world (e.g. "We should always love our enemies"), and others which seemed related to general prejudices or biases (e.g. "Delinquency is less common among young people attending religious services regularly"). Another 4 items were eventually dropped one by one, after rerunning the PCA. These four items continued not to load on the first factor so it was decided to remove them, particularly given their slight theoretical difference from a general attitude toward religion after re-inspection.

The total variance explained by the 17 items using an oblique rotation was 60.98%, each loading on a single factor with an eigenvalue = 10.37. The PCA was run again to confirm that the deletion of these items did not significantly alter the data. Then, the calculated total RS-R score was correlated with the DUREL total score for evidence of convergent validity. The two scales were highly correlated but not redundant (r = .74), supporting the use of the RS-R for the present study. A summary of the principle components analysis (PCA) can be seen in Table 2 below.

Table 2

Principle Components Analysis for Religion Scale-Revised

Item Stem	**1**	h^2
1.	*.67*	.81
2.	*.65*	.81
3.	*.64*	.80
4.	*.57*	.75
5.	*.47*	.69
6.	*.40*	.54
7.	*.58*	.76
8.	.58	.76
9.	.47	.61
10.	.60	.77
11.	.72	.85
12.	.48	.70
13.	.60	.77
14.	.62	.79
15.	.63	.79
16.	.67	.82
17.	.49	.70

Spiritual and Religious Antagonism Scale (SARAS). The SARAS was constructed specifically for the present study after a review of existing instruments did not result in finding a scale specifically created to assess antagonistic attitudes toward spiritual and religious worldviews. Relevant literature was reviewed and academic and community experts in theologies of Christianity, Islam, and Buddhism all gave their suggestions on an initial pool of 25 items. A total of 19 items were included for the pilot study after their recommendations were taken into consideration. These items were written to reflect a general sense of antagonistic attitudes toward spiritual and religious matters each with 7 and 12 items, respectively.

Similar to the RS-R, the internal structure of the scale was initially assessed using a PCA. Although the scale contained items intending to assess attitudes toward religion and spirituality as the two main dimensions, PCA with an oblique rotation was used given that this was the first factor analysis on a new scale. The results indicated five components with eigenvalues above 1.00, explaining a total of 68.94% of the variance. Upon inspection of the items' component clusters, the items did group as expected with the 12 religious items and 7 spiritual items representing the highest two factor loadings. The third and fourth components were represented by two items each with pattern coefficient of .40 or higher each, while fifth was represented only by a single item with a pattern coefficient of .40. Each of these six items was visually inspected and there was no obvious reason that they did not load on either the spiritual or the religious factors. One by one, the item with the lowest pattern coefficent was dropped with the analysis recalculated to see if removing one item changed the data significantly. As mentioned, the fifth component had only one item with a pattern cofficient above .40. This item, when reexamined, reflected less a sense of antagonism toward religion than an idea of how to treat others. Although the item was derived from literature supporting the spiritual or religious motivation to treat

others well, the item did not clearly specify this, which likely resulted in the inconsistent factor loading. Given that it was not as consistent with the construct upon review coupled with this empirical data, it was also dropped.

To confirm that these seven items that did not cross-load on either the spiritual or religious components should be dropped, a reliability analysis was conducted with the 19 items. As expected, the item-to-total correlations of these 7 items were below .30. Procedurally, each time the item with the lowest item-to-total correlation was dropped, the overall reliability analysis was redone with the remaining items. All of the 7 originally problematic items were eventually dropped given that removing the other poor items did not increase their item-to-total correlation above the .30 threshold. Again, a total of seven of items were eventually dropped with the reliability analysis redone, until all items had item-to-total correlations above .30. This resulted in 12 final items. The overall Cronbach's α improved from .85 with the 19-item scale, to .89 for the 12-item scale. A final PCA was conducted with the 12-item scale, supporting a two-component internal structure. The first component accounted for 41% of the variance (eigenvalue = 4.94) while the second factor accounted for another 13.94% (eigenvalue = 1.67). Together, these explained 55% of the variance for the SARAS. The 12-item SARAS scale was used for the final analysis. Table 3 shows the final SARAS items with reliability and validity information. Table 3 shows the component and coefficient information for each item.

Table 3

Spiritual and Religious Antagonism, Item Stems, Components, Coefficients, and Communalities for Pilot Study (N = 51)

Item stem	*1*	*2*	h^2
1. I find myself avoiding very religious people	*-.13 (.30)*	.95 (.89)	.81
2. I often find myself becoming annoyed with spiritual interpretations	*.27(.52)*	.56 (.68)	.51
3. I tend to ignore opinions of people who are very rigid in their spirituality	*-.30 (.13)*	93 (.80)	.71
4. I like most of the religious people I know	*.12(.32)*	.44 (.50)	.26
5. Most of my friends do not embrace a traditional religion	*.29 (.44)*	.33 (.46)	.28
6. I think religion is more of a way of controlling people than freeing them	*.56 (.72)*	.35 (.61)	.62
7. If a God exists then he or she probably opposes all religions	*.54(.62)*	.18 (.43)	.42
8. I don't care much for spiritual matters	*.83 (.77)*	-.14 (.24)	.61
9. If there is a higher power I don't believe it's worth knowing	.75 (.67)	*-.15 (.19)*	.48
10. Spiritual explanations of phenomena can always be better explained by science	.79 (.82)	*.05(.41)*	.67

Table Continues

Item stem	*1*	*2*	h^2
11. Spirituality is best understood as a coping mechanism	.82 (.80)	*-.04 (.33)*	.65
12. I tend to disagree with those having strong spiritual orientations	.37 (.60)	*.50 (.66)*	.55

Main Study

Participants. Participants for the main analysis were solicited from APA listservs (Division 17), Clinical and Counseling Psychology training programs, as well as APA-accredited internship training facilities. All participants were contacted by E-mail for their participation and were either doctoral level psychologists or individuals who are in training to become doctoral level psychologists and have completed at least two semesters of practicum work. Participants were screened out if they were not doctoral level students or practitioners (n = 4).

In order to complete the moderation analysis consistent with Tabachnick and Fidell's (2007) recommendations, a sample of at least 100 participants was targeted. Additionally, a moderation analysis involved another statistical analysis, which could inflate family-wise error, increasing the likelihood of a Type I error. In order to guard against this, the alpha level was lowered, which necessitated an increased sample size. Therefore, a sample of 150 was targeted to account for the increased probability of Type II error due to the decrease in power brought on by the lower alpha level. Attempts were made to garner a diverse sample in regard to religion by targeting professional listservs related to Buddhist, Muslim, and Christian psychologists. Table 4 lists the demographic data representing the participants (N= 176) who were included in the main analysis. Participants more often identified as female (n = 130, 73.8%), Caucasian (n =

123, 69.9%), heterosexual (*n* = 150, 85.2%), Christian (*n* = 74, 26.4%), and identified Cognitive or Cognitive-Behavioral theory as their primary theoretical orientation (*n* = 61, 34.7%). Participants tended to be graduate students currently working toward a doctoral degree (*n* = 102, 58%) and the largest specialty represented was from Counseling Psychology (*n* = 69, 39.2%).

Table 4

Demographic Data for Main Analysis

	n	Percent
Gender		
Female	130	73.8
Male	40	22.7
Not Identified	6	3.4
Race		
African American	11	6.2
Asian American	15	8.5
Caucasian	123	69.9
Hispanic	9	5.1
Bi-racial	6	3.4
Other	12	6.8
Sexual Orientation		
Heterosexual	150	85.2
Gay/Lesbian	15	8.5
Bi-sexual	9	5.1
Other	2	1.1
Religious Affiliation		
Christian (general)	74	26.4
Catholic	23	13.1

Table Continues

	n	Percent
Protestant	28	15.9
Jewish	11	6.3
Muslim	3	1.7
Hindi	2	1.1
Buddhist	7	4.0
Sikh	1	0.6
No Organized Religion	25	14.2
No Religion	18	10.2
Atheist	17	9.7
Agnostic	23	13.1
Other	22	12.5
Primary Theoretical Orientation		
Person Centered	26	14.8
Cognitive/Cognitive Behavioral	61	34.7
Behavioral	9	5.1
Existential	9	5.1
Psychodynamic	29	16.5
Interpersonal	22	12.5
Feminist	3	1.7
Narrative	2	1.1
Other	15	8.5

Table Continues

	n	Percent
Highest Degree Earned	18	10.2
Bachelor's	86	48.9
Master's	45	25.6
Ph.D	19	10.8
Psy.D	8	4.5
Ed.D		
Professional Identity		
Graduate Student	102	58.0
Practitioner	74	42.0
Degree Specialty earned or working toward		
Ph.D Clinical	48	27.3
Ph.D Counseling	69	39.2
Psy.D Clinical	51	29.0
Other	8	4.5

Measures

Counselor religious identification. Although a categorical description of religious identification was collected in the demographic form, the Duke University Religion Scale (DUREL; Koenig et al., 1997) was used as well. Given that the creator of the scale recently advised against using the total score to predict behavior or attitudes related to well-being, in favor of the individual subscales (Koenig, 2010), the three individual subscale scores (described previously) were used. The organizational religiosity scale (OR) is measured by a single item

asking participants to provide a frequency estimate of the extent to which they participate in organized religious practices. The non-organizational religiosity scale, consists of a single item assessing the frequency that an individual engages in weekly religious activities (prayer, reading sacred texts, etc.). While the first two subscales deal with extrinsic behavioral manifestations of beliefs, the intrinsic religiosity subscale (IR) targets an internalized belief system or philosophy of the sacred. The total IR score was computed by adding the three remaining items together. The DUREL has evidence of reliability and validity, mentioned above in the pilot study section. Cronbach's alpha for the IR subscale in the main analysis was .78. The IR correlated significantly with both the OR ($r = .71$, $p < .05$) and NOR ($r = .75$, $p < .05$), lending support to the scale's internal consistency for the present study.

Client vignette manipulation. For the main analysis, the vignettes were updated based on feedback given by participants in the pilot study. The only differences were to clarify that the client was upset with his relationship with his ex-girlfriend and a typo. Just as in the pilot study, the only differences of the vignettes were in the religious identification of the client and the related material (e.g. the Muslim client reported reading the Koran vs. Bible for the Christian client). The vignettes can be seen in Appendix D.

Religion Scale-Revised. As mentioned in the pilot study description for the Religion Scale (Bardis, 1961), the original construction took place 50 years before the present study, the revised version updated the language of the scale to reflect more gender neutral language. In addition, the revised version included adapted items aimed more specifically for work in psychology, whereas the previous version was aimed at sociology or education. Cronbach's alpha for the RS-R was excellent for the present study ($\alpha = .96$). The RS-R score had a negative correlation with the SARAS ($r = -.63$, $p < .01$), as well as with the DUREL-OR ($r = .70$, $p < .01$),

DUREL-NOR (r =.60, p < .01), and DUREL-IR (r = .69, p < .01), lending evidence of convergent validity. The RS-R items can be viewed in Appendix B.

Spiritual and religious antagonism. After the psychometric analyses conducted in the pilot study, the Spiritual and Religious Antagonism Scale (SARAS) consisted of 12 items assessing the spiritual-religious worldview of participants. The results of the pilot study analysis confirmed that these twelve items accounted for a significant amount of the variance with two factors representing antagonism toward both spiritual and religious matters. Items were loaded on either one or both of the religious or spiritual components. Review Table 3 for results of the principle components analysis. The total SARAS score had significant negative correlations with OR (r = -.61, p < .05), NOR (r = -.58, p < .05), and RS-R (r = -.63, p < .05). It also had significant negative correlations with the RS (r = -.63, p < .01) and SCS (r = -.30, p < .05) lending evidence for convergent validity for its use. For the main study, the scale had evidence for reliability (α = .87).

Spiritual competence. Robertson's (2008) Spiritual Competency Scale (SCS) was chosen to reflect this construct. The 28-item scale was designed to cover the four target domains theoretically related to spiritual competence in counseling as described by the Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC, 1997). These areas include nine competencies that fall under the four domains of: (a) A general knowledge of spiritual phenomena; b) Awareness of one's own spiritual perspective; (c) Understanding of client's spiritual perspective; (d) Spiritually related interventions and strategies. Support for the content validity of these domains and competency areas is provided by their development coming from members of ASERVIC, a group of mental health practitioners with expertise in the areas of spirituality and religion. A panel of six experts was consulted to establish content validity for the

90 original items in the SCS. The revised SCS consists of 28 Likert-type items which were selected out of an initial item pool generated by the researcher after examining literature on the area of spiritual competence in counseling. Each item asks the participant to decide whether they agree or disagree with each statement and then to rank the intensity on a 3-point scale.

The SCS was piloted with an initial sample of 100 participants to help provide factor analytic support for dropping unreliable items (Robertson, 2008). Additionally, four graduate students in counseling were asked to provide qualitative feedback of their experiences when working on the scale. After revisions were made based on these methods, a large sample of graduate students in counseling or related fields (n = 602) was recruited across 25 religious and public universities to establish the construct validity of the scale. A cutoff of .40 was used to determine factor loading adequacy at the .05 level with items not meeting this standard being dropped. Results from a principle components (PCA) exploratory factor analysis using an oblique rotation revealed a six-factor solution for the scale with Cronbach's α levels of .89 for the revised measure and ranging from α = .72-.83 for the six underlying factors. The six factors were identified as: (a) Diagnosis and Treatment; (b) Culture and Worldview; (c) Counselor-Self-Awareness; (d) Assessment; (e) Communication; (f) Human and Spiritual Development.

Robertson (2008) found that the scale did not correlate significantly with a social desirability measure and discriminant validity was supported through a contrasted-groups approach. Students in religiously based schools tended to score higher than their public school counterparts. Scores were sensitive to religious affiliation with those identifying as more fundamentalist and "evangelical" Christians having higher total scores than the overall mean and those reporting no religious or spiritual identification with lower mean scores.

This finding is important as higher scores are thought to reflect broad spiritual competence. One facet that has not been addressed in the use of this instrument is that other research has shown a link between increased religious fundamentalist beliefs and intolerance directed toward other religions (Wrench, Corrigan, McCroskey, & Punyanunt-Carter, 2006) as well as non-affirming positions for sexual minorities (Olson, Cadge, & Harrison, 2006), attitudes that would typically be insensitive to cultural diversity. However, the scale theoretically should provide higher scores for individuals who are clearer on their own religious understanding and who have had more experiences or exposure in dealing with religious matters (Robertson, 2008). Furthermore, it is important to remember that the norming sample consisted of counselors or counselors-in-training so having an evangelical or fundamentalist belief system *and* being socialized into the counseling profession may be different from samples examining fundamentalist or evangelical belief systems in other fields. Furthermore, this scale has been endorsed by ASERVIC (2009) as the "standard" for spiritual competence in counseling. Although the Evangelical group scored higher than the other groups, no group's score was high enough to be in the desired competency range, suggesting the counselors in each of the groups were below recommended standards for spiritual competency.

Additionally, those who reported that their program of study had prepared them well for dealing with spiritual issues tended to report higher scores than those who did not. Lastly, the author found a statistically significant difference between those who said they would feel comfortable at this point in their education addressing spiritual or religious concerns in counseling and those who were not comfortable. It should be noted that the SCS is based on the author's dissertation, so has not been published in a peer-reviewed journal to date. However, the findings in the study have been used to update the ASERVIC recommendations to culturally

sensitive practices with spiritual and religious clients and the manuscript is currently under review (Robertson, personal communication, December 3, 2009; ASERVIC, 2009). Robertson has also reworked the scale based on a second wave of data collection to increase psychometric properties and decreased the scale to a 22-item instrument. She provided permission to use either version of the scale or to use additional items from the original 90-item scale which may be of interest (Robertson, personal communication, November 15, 2009). Both the 28-item and 22-item scales have been shown to have evidence for a six-factor solution accounting for approximately 60% of the variance. The estimated reliability of the 22-item total scale was assessed using Cronbach's alpha ($\alpha = .88$) and estimates for each factor were in acceptable ranges (Culture and Worldview =.73, Diagnosis and Treatment, = .73, Assessment = .84, Human and Spiritual Development = .73, Counselor Self-Awareness = .74, Communication = .65). In order to balance decreasing participant burden while not sacrificing psychometric soundness, the 22-item total scale was used. Although there is not yet a confirmatory factor analysis confirming the hierarchical factor structure, the scale's author conceptually builds a case for this (Robertson, 2008). Also, the author noted that data is being collected currently to conduct a CFA for the scale (L. Robertson, personal communication, February 2, 2010). The SCS total score had evidence of internal consistency for the present study (Cronbach's $\alpha = .90$).

Clinical judgment. In order to assess participants' clinical judgment, three important areas supported by the literature reviewed above were selected: perceived psychopathology, attribution for problem, and prognosis were each assessed. These factors have theoretical similarity in that they are a result of how a counselor thinks about the treatment process of a client. Each will be described in some detail below.

Problem attribution. In this study, attribution for the problem was assessed via the Cause and Solution Scales (Karuza, Zevon, Gleason, Karuza, & Nash, 1990). Each scale is made up of three items, with the Cause Scale assessing the extent to which the client is responsible for the concerns and the Solution Scale representing the extent to which one believes the client is responsible for solving the concerns. Items are rated from 1 (not at all) to 7 (very much) with higher total scores reflecting higher attributions of client responsibility for causing and solving the presenting concerns (range 3-21 for each subscale and 6-42 for the total score). Total scores were computed by summing the items on both scales to create one composite score for the cause of the problem and one for the solution to the problem (client's responsibility vs. forces outside the client's responsibility). Lower scores indicate a belief that the client has less responsibility for either the cause or solution of the problem and higher scores indicate an attribution for more client responsibility. See Appendix F for scale items.

Reliability estimates for the Cause Scale have ranged between .61-.87 and from .63-.74 for the Solution Scale (Bailey & Hayes, 1998; Burkhard & Knox, 2004; Karuza et al., 1990). Additionally, test-retest estimates ranged between .70-.86 after a two-week span (Bailey & Hayes, 1998). Evidence for concurrent validity was supported with a positive correlation with the Derived Cause and Derived Solution scales from the Helping Coping Orientation Measure (Michlitsch & Frankel, 1989). Furthermore, Hayes and Wall (1998) provided initial evidence for the scales' construct validity by finding that clinicians attributed less responsibility to those with PTSD when compared to those with bulimia. These items were derived from previous empirical studies examining problem attribution as a construct of clinical judgment (Karuza et al., 1990; Stepleman, Darcy, & Tracey, 2005) based in Brickman's (1982) theory of attribution. Although the scale was originally developed for clients to self-rate attribution for problems, Burkhard and

Knox (2004) successfully adapted the scale for therapist-reported attribution for client problem without sacrificing reliability estimates and the present study will use a similarly adapted version. For the present study, there was evidence of internal consistency for the Cause Scale (Cronbach's $\alpha = .81$), but the not for the Solution Scale ($\alpha = .46$).

In examining the Solution Scale, item-to-total correlations and alpha if deleted data were examined to try and determine if a single item had thrown off the data. The means of each of the three items were somewhat different (5.4, 4.8, and 4.0), perhaps explaining the low alpha level, given that Cronbach's alpha estimates the average consistency of each item tapping into, what is theorized to be, facets of the same underlying construct. However, there was no evidence to support why the differences in these items were found. Given the poor reliability of the scale, only the cause subscale was used for the final analysis.

Global Assessment of Functioning (GAF). The Global Assessment of Functioning Scale (GAF; Spitzer, et al., 1996) was included in the main analysis as an estimate of perceived overall psychopathology of the client. Given the data cited above on the GAF's inter-rater reliability, it was only one part of the assessment of clinical judgment. Given that it is a single item, internal consistency using Cronbach's α could not be computed. The range in GAF scores for the main analysis was 40-90 ($M = 61.08$, $SD = 6.84$). GAF scores were significantly correlated with prognosis total scores ($r = .20$, $p = .03$) and with solution scores ($r = .12$, $p = .04$), but not with cause scores ($r = .06$, $p > .05$).

Prognosis. On a 7-point scale, participants were asked to rate the extent to which the client would be able to improve with therapy, would improve without therapy, as well as his perceived ability to build a strong working alliance in therapy. A total of nine items made up this scale with possible scores ranging from 9-63. Lower scores indicate less confidence in the

client's ability to change and a greater impression that the clients' progress in therapy would be slow. Higher scores are more indicative of more confidence in the client's ability to work through problems.

The items were adapted from Bowers and Bieschke's (2005) study, which conceptualized counselors' judgments of client prognosis using these items. The authors pointed out that they could find no scale currently normed and developed for their specific purpose (determining clinical judgment biases based on sexual orientation). Hence, they developed their items and then checked them for face and content validity using 20 experienced clinicians, incorporating their suggestions for the final items. The authors did not report reliability information for these items, but found them to differentiate between those endorsing affirming views toward LGBT individuals and those with less affirming views for a vignette depicting a gay client. The items were adapted to include the client's name for the present study. For the present study, the prognosis scale had evidence of internal consistency, Cronbach's $\alpha = .82$.

Alternative research questions

Empathy. Participants were asked to simply rate the extent to which they felt an empathic response to the client vignette. A single item rating scale was constructed similar to single item scale indicators used in previous research studies examining clinical judgment indicators (Burkard & Knox, 2005; Gartner, et al., 1990). Because empathy can be a diffuse construct, it was primarily operationalized by an item reflecting the extent to which participants could report a sense of emotional connectedness to the client after reading the case, a component of affective and experiential empathy (Duan & Hill, 1996). The item asked participants to rate their empathic response to the vignette ranging from 1 (no empathy) to 5 (extremely empathic). Due to this item being a single item, Cronbach's alpha could not be assessed. However, it correlated significantly

with the exploratory item "the client is like me" (r =.31, p < .05) but not with the SARAS (r = .14, p >.05) lending evidence of discriminant validity.

Number of sessions. This additional factor was assessed given previous literature using it as a clinical judgment indicator (Bowers & Bieschke, 2005). The item asked participants to provide the number of sessions they believed the client in their vignette would need before feeling better. Theoretically, it could be assumed that this estimate relates to severity estimates of a client's presenting concerns. This was a single-item assessment so Cronbach's alpha could not be computed. However it correlated significantly with participants' ratings of the client's motivation for therapy (r = .31, p < .05), that the client was similar to them (r = .31, p < .05), their belief that they could help the client (r = .40, p < .05), as well as prognosis scores (r = .34, p < .05). Empathy ratings did not correlate significantly with GAF (r = .06, p > .05) or number of sessions (r = .06, p > .05), lending support for its discriminant validity.

Diagnosis. Participants were asked to select among diagnostic options that they believed best fit the vignette. They were instructed to select from a list of disorders with instructions asking which type of disorder would be most suited to this client (options include psychotic disorder, adjustment disorder, mood disorder, anxiety disorder, personality disorder, no diagnosis) and the extent to which they believe the client exhibited symptoms consistent with each disorder. Again, this assessment method was designed to highlight external validity as psychologists frequently are asked to decide how to classify presenting symptoms for managed care situations. Participants were also given a more generalizable open-ended response option for diagnosing the client on each of the 5 DSM-IV TR scales (Spitzer et al., 1996). In addition, a question was asked, "How confident are you in the diagnostic ratings that you've given?" This was rated on a 5-point rating scale from 1 (not at all confident) to 5 (very confident).

These items were assessed independently to examine the extent to which participants might endorse more consistent vs. less consistent diagnostic categories when rating the different client vignettes. The descriptive data, including a frequency analysis, is reported in the results section.

Procedure

All participants were contacted via an E-mail invitation to the study with a link to the online survey hosted by Psychdata.com. They were informed that their participation is voluntary and that after completing the survey they could enter a raffle to win one of three $50 drawings or, if they preferred, they were told that after completion of their survey $1 would be donated to one of three charities, which they could choose (domestic violence shelter, homeless shelter, or Red Cross) for up to 100 participants. Additionally, participants were given the opportunity to be sent the study results for their participation. Furthermore, participants in doctoral training programs were contacted through listservs by asking training directors for their help in passing on the research request. In order to help keep track of those that view the study's invitation but declined to participate, two links were embedded in the invitation email, one which read "I agree to participate, take me to the survey" and another that read "I do not wish to participate." This way a response rate was be estimated (3 of 295 selected that they did not wish to participate while another 42 simply did not advance the survey past the invitation screen). The response rate is not likely representative of the actual numbers, given that the survey was sent to total of 189 different listserv managers in counseling and clinical psychology training programs for both students and faculty, as well as internship training facilities for both interns and staff to review. Purposeful sampling procedures included contacting individuals through groups of psychologists such as the Society for Christian Psychology and Crescent Life (a group of Muslim mental health

providers). Time taken to complete the survey was recorded as well, with the average time recorded for the entire survey taking 27 minutes and 40 seconds (*SD*= 214 seconds). This is noteworthy in that the description of the study indicated that it would likely take participants between 15-25 minutes to complete the study.

After the initial screen informed them about the particulars of the study, participants read one of the four randomly assigned case vignettes. They then were asked to rate the client on a number of factors related to clinical judgment including diagnostic factors and the GAF (APA, 2000), attribution for the problem (Karuza et al., 1990), and predicted prognosis (Bowers & Bieschke, 2005). In addition to the clinical judgment items, participants filled out surveys assessing their spiritual competence (Robertson, 2008), personal religiosity and spiritual beliefs (Koenig et al., 1997), attitudes toward religion (Bardis, 1961), the Spiritual and Religious Antagonism items, as well as demographic items including their religious identification and belief system. Given the dearth of literature examining these constructs together, the analysis explored the relationships among the constructs using a quasi-analogue methodology and mixed experimental and correlational designs.

A total of 295 participants initially agreed to review the survey description and invitation page; however, a smaller subset completed the entire survey (n = 141). A number of participants (n = 35) had some missing data but completed enough of each survey that their responses could be included (the criterion used was for missing items to comprise no more than 10% of the scale; Tabachnick & Fidell, 2007). One hundred nineteen participants were removed from the analysis because they had significant amounts of missing data (> 10%; n=102), for not passing the manipulation check (n = 6), or due to univariate (n = 7) or multivariate (n = 4) outliers.

As recommended by Tabachnick and Fidell (2007), a correlation matrix was computed to determine if those who skipped or missed items had any discernable demographic or attitudinal differences from those who did not. Pearson correlation coefficients were both calculated given the inclusion of categorical variables which were dummy-coded (gender, race, religion). There were no significant correlations from the incomplete surveys and complete surveys on areas of gender, race, religion, income, or theoretical orientation (all p-values > .05). Additionally, no statistically significant relationship was found among item skipping and any of the explored variables in the study (all coefficients were not significant; $p > .05$). Item means were used as substitutes for missing data on items so long as the missing data comprised only 10% or less of the total number of items for each scale; only 35 cases with missing data met this criteria, resulting in a final of sample of 176 participants for the analyses.

Exploratory analysis. In order to examine these exploratory dependent constructs, one-way MANCOVA, including the independent variable with four levels (Muslim, Christian, Buddhist, and non-religious), was assessed on participants' ratings of the two single item dependent constructs (empathy and number of sessions). For the diagnostic ratings, a separate MANCOVA was computed with each of the four possible diagnostic conditions as dependent variables and the item asking them their confidence levels of their diagnostic ratings was inserted as an additional covariate. The categorical ratings were recorded for a frequency analysis to determine what diagnoses participants tended to consider more frequently among each condition.

Therefore, in addition to the main analysis, three exploratory dependent variables were included in the survey including measures of participants' empathy for the client vignette, the number of sessions they believe the client needed to reach improvement, as well as additional diagnostic information. These factors are other ways of conceptualizing clinical judgment based

in the literature cited above. The primary aim of the study was determining whether the factors of client religion, counselor religiosity, and counselor spiritual competence would affect counselors' estimates of these other three conceptualizations of clinical judgment. Ideally, these constructs would be included in the main analysis, but due to the discrepancy in how to best conceptualize clinical judgment and the anticipated difficulties in recruiting participants, fewer dependent constructs were selected for the main analysis. Exploratory items can be viewed in Appendix H.

Power analysis. In order to run the analysis with an intended power of .95, using a p = .05 significance level and an estimated a small-to-medium effect size of $f^2(V)$ = .15 based in the available literature examining the effect of bias on clinical judgment, a sample size of 66 was needed for the MANCOVA using seven predictors (including four levels of the independent construct and six covariates) and interaction term of spiritual competence by vignette, for a total of eight predictors run in two separate analyses (Erdfelder, Faul, & Buchner, 1996; Tabachnick & Fidell, 2005). In order to run the moderation analysis consistent with Tabachnick and Fidell's (2005) recommendations, a sample of at least 100 participants would be appropriate. Additionally, a moderation model involves examining possibly small effect sizes, threatening to inflate Type II error. However, because this study included multiple analyses which could inflate Type I error, a sample of 150 was targeted to account for these threats (Aiken & West, 1991). After data cleaning procedures resulted in screening out cases due to missing data or failing the manipulation check (n = 115) and univariate and multivariate outliers (n = 4) the final sample included 176 participants for the main analysis.

CHAPTER FOUR

RESULTS

Preliminary Analysis

All participant surveys with one or more measure missing data on 10% or more of that measure were removed from the analysis and the remaining responses were assessed for missing data points. SPSS 17 Missing Values Analysis indicated no detectable pattern for the missing responses. The existing data were used to compute means in order to substitute for those missing data points after excluding any participant leaving 10% or more of the total scale blank (Tabachnick & Fidell, 2007).

Following this analysis, descriptive statistics were examined for each of the observed constructs (means, standard deviations, and reliability coefficients) which can be seen in Tables 5 and 6. Skewness and kurtosis statistics were examined for all constructs as well to ensure that the data were all normal. All reliability estimates were computed using Cronbach's alpha (α). Because the CSS-Solution scale's Cronbach's alpha was below .70, the scale was dropped for use in study, given that the value indicated very poor internal consistency. Before dropping the scale, the possibility of dropping one of the items from the subscale to see if the internal consistency might change was assessed. This resulted in even poorer estimates (in all two-item combinations, the highest alpha was .46). Because this evidence suggested that, at least for the present sample, these three items did not share enough empirical variance (i.e. they were not internally consistent) to be considered an adequate reflection of the CSS-Solution construct, they were dropped from the analysis. Ultimately, using any one of the three items did not make theoretical sense over any of the others. Thus, given that nothing could be done to improve the reliability of this subscale, given that deleting items only depressed the value and because the

score was so low. Therefore, the attribution for the problem's solution was not included in the final analysis.

Table 5

Descriptive Statistics and Cronbach's Alphas

	Mean	Standard Deviation	Cronbach's Alpha	Skewness	Kurtosis
GAF	61.34	6.53	-	.14	1.69
Prognosis	48.71	5.70	.77	-.79	.69
Attribution-Cause	11.14	3.07	.83	-.15	-.34
Attribution-Solution	14.34	2.55	.45	-.52	.93
Duke-Organized Religiosity	4.40	1.59	-	-.69	-.70
Duke-Non-Organized Religiosity	4.51	1.71	-	-.70	-.99
Duke-Intrinsic Religiosity	9.42	4.06	.92	-.04	-1.34
Religion Scale	41.93	14.13	.95	.51	-.48
Spiritual Competence	96.52	14.20	.90	-.47	.01
Spiritual/Religious Antagonism	36.21	9.37	.87	.08	-.38

Table 6

Descriptive Statistics for Dependent Variable by Group

	Mean	Std. Deviation
Prognosis	48.71	5.70
Not Identified	49.78	5.88
Christian	47.87	5.22
Muslim	48.34	6.21
Buddhist	49.21	5.47
Causal Attribution	11.14	3.07
Not Identified	11.02	2.98
Christian	11.40	2.90
Muslim	10.70	3.27
Buddhist	11.37	3.24
GAF	61.34	6.53
Not Identified	60.96	6.83
Christian	61.91	6.82
Muslim	60.92	6.55
Buddhist	61.50	5.88

Statistical Assumptions

All data were inspected to ensure that statistical assumptions for MANCOVA were met. Specifically, estimates of normality were determined by examining skewness and kurtosis outputs and univariate outliers. Case with normality statistics outside an acceptable ranges (i.e.

Z-scores > 3.5), were deleted. Additionally, reflected and square root transformations were computed for the SCS and Prognosis scales which were both negatively skewed. The skewness critical ratios improved from -4.33 (Prognosis) and -3.50 (spiritual competence) to 1.31 and .97, respectively. All other variables had normality statistics within acceptable limits (Tabachnick & Fidell, 2007).

In order to retain the ability to make meaningful interpretations from the data, the transformed constructs were used with standardized scores being used to make comparisons. In addition, although not all correlations among the three dependent variables were statistically significant (only GAF and prognosis were significantly related) and some of the correlations between covariates and dependant variables were not all significant (prognosis scores did not correlate with the SARAS or DUREL scores; GAF did not correlate with RS scores; Cause of problem did not correlate with the SCS or the RS), the theoretical rationale built above was used to keep the variables in place. Additionally, each covariate and dependent variable correlated with at least one other construct in the analysis at the $p < .05$ level.

Furthermore, the assumption of multivariate outliers was checked as MANCOVA is sensitive to these. Checking Mahalanobis' distance against the respective critical value (alpha = .001), four cases which fell above the critical value for multivariate outliers were deleted. In addition, the three dependent constructs were inspected to ensure that they were correlated, which is another assumption of MANCOVA. The results can be seen in Table 7. Only GAF and prognosis scores were significantly correlated; however, because the three dependent constructs are theoretically linked to clinical judgment, they were still included in a MANCOVA rather than conducting a separate ANCOVA with cause of problem.

Table 7

Bi-variate Correlations among Clinical Judgment Variables and Covariates

	1.	2.	3.	4.	5.	6.	7.	8.	9.
1. SARAS	1	-	-	-	-	-			
2. SCS	-.25*	1							
3. RS-R	.62**	.37*	1						
4. Duke-OR	-.60**	.36**	.70**	1					
5. Duke-NOR	-.58**	.36**	.60**	.75*	1				
6. Duke-IR	-.64**	.40**	.68**	.71*	.71	1			
7. Prognosis	-.06	.29**	.10	-.09	-.02	-.11	1		
8. CSS-Cause	.04	.04	.14	-.15*	-.20*	-.21	.03	1	
9. GAF	.07	.17*	-.06	-.11	-.01	.03	.25*	.06	1

Note. *p < .05; **p < .01; SARAS=Spiritual and Religious Antagonism Scale; SCS= Spiritual Competence Scale; RS-R=Religion Scale; OR=Organizational religiosity; NOR=Non-organizational religiosity; IR= Intrinsic religiosity; CSS-C=Attribution of Problem Cause and Solution Scale

Linearity and multicollinearity were examined using correlation matrices and scatter plots. Because three of the spiritual/religious constructs share theoretical variance, multicollinearity estimates were conducted using a tolerance cutoff of .20 and a VIF level cutoff of 4.0. No two variables were correlated above .75, so none were dropped from the analysis (Tabachnick & Fidell, 2007).

Although respondents were predominantly female (70%) and there were slightly unequal group sizes among the four levels of the independent variable, the results of Levene's and Box's M tests were both not significant ($p > .05$) indicating that homogeneity of variance was not violated for each of the three dependent constructs. Additionally, statistics from Wilk's lambda

and Pillai's trace were identical for the MANCOVA results; therefore Wilk's lambda was used when reporting results of the MANCOVA in the main analysis (Tabachnick & Fidell, 2007).

In order to ensure that the demographic constructs of gender, race, and religious orientation were not confounding constructs, a one-way multivariate analysis of variance (MANOVA) was conducted with these factors and the dependent constructs of interest (GAF, prognosis, attribution for the problem). The overall omnibus test was significant using the Wilk's criteria, $F(12,163) = 12.13$, $p < .01$, $\eta^2 = .11$; Results of these analyses can be found in Table 8.

Table 8

Parameter Estimates of MANOVA with Demographic Variables

	B	Std. Error	*t*	Sig	η^2
Gender	2.81	1.20	8.60	.02	.03
Catholic	-3.47	0.99	-3.50	.60	.00
Christian(Protestant)	-.04	.06	-.59	.55	.00
Christian(Other)	.09	.03	3.01	.00	.05
Buddhist	.31	.43	.73	.47	.00
Jewish	-1.03	.39	-2.66	.01	1.79
Muslim	.404	.19	2.12	.04	.03
No organized religion	-.02	.05	-.44	.66	.00
Atheist/Agnostic	-.25	1.14	-.22	.82	.00
Sikh	-2.53	1.17	-2.17	.03	.03
Hindu	-1.50	1.24	-1.21	.23	.01
Not Identified	-	-	-	-	-

The MANOVA showed that men and women did not differ in ratings of prognosis or attribution for the problem but that men's mean GAF score (M = 57.02, SD = 2.31) was significantly lower than the mean scores from women (61.08, SD = .91; t = 4.79, p = .05). There were no detectable differences across race in the sample (p >.05). Because there were very few non-Western religious orientations, the religious identity variable was dummy coded into Christian (broadly defined), non-Christian religious (which included Muslim, Buddhist, Jewish, Pagan, and other belief systems), and Agnostic/Atheist belief systems were combined in a single group given their theoretical overlap. The only significant difference was found for GAF score with participants endorsing either atheist or agnostic views tending to report a higher GAF score (M = 62.90, SD = 1.04) than those who endorsed any other form of religious orientation (M = 60.95, SD = .55). Thus, both gender and religious identification were entered into the MANCOVA as additional covariates to the counselor attitudes and beliefs (organizational, non-organization, and intrinsic religiosity, religious worldview, spiritual/religious antagonism) as well as spiritual competence.

Hypothesis Testing.

To test the overall multivariate effects, a one-way between-subjects MANCOVA was performed on three dependent variables including eight total covariates for the main analysis. Overall, the MANCOVA tested the impact that four levels of an independent variable (client religious orientation [not identified, Christian, Muslim, or Buddhist]) would have on three constructs theorized to be related to a counselor's clinical judgment (GAF score, prognosis, and causal attribution for the problem). Additionally, therapist factors were included based on theoretical rationale (1-antagonism toward spirituality and religion, 2-organizational religiosity, 3-nonorganizational religiosity, 4-intrinsic religiosity, 5-religious attitudes/beliefs, and 6-spiritual

competence) as well as the empirical results found in the preliminary analysis (7-gender and 8-religious orientation).

The overall intention of the study was to investigate the impact that client religious tradition combined with counselor religious and spiritual factors would have on counselors' clinical impressions of a case. The hypotheses were that client religious identity (Hypothesis 1) together with counselor religious identity and attitudes (Hypothesis 2), combined with counselor spiritual competence (Hypothesis 3), would relate to different clinical impressions for each of the four vignettes. Specifically, the hypotheses were (1) Client religious orientations will elicit different assignments of prognosis, GAF, and attribution for the problem; (2) Counselors with more affirming attitudes toward religion/spirituality will be more inclined to rate the religious clients with less responsibility, less pathology, and more optimistic prognosis; (3) Counselors with higher spiritual competence will demonstrate a shifting standards effect for religious clients, rating them with better prognoses, less pathology, and less responsibility for the problem.

The following narrative will outline the overall multivariate effects of the final model, separated by each hypothesis as it applies to the multivariate impact of clinical judgment (prognosis, causal attribution for problem, and GAF score). Then, a description of the results of each of the three hypotheses as they relate to the relevant univariate effects on each dependent construct will be presented. Lastly, a discussion of the moderation analysis, using spiritual competence will follow.

Although the final model showed that the variables included significantly accounted for a large portion of the variance in clinical judgment $F(3, 162) = 390.42$, $p < .01$, $\eta^2 = .47$, observed power = 1.0, client religious orientation did not significantly impact the combined dependent constructs using the Wilks' criteria, $F(9, 162) = 1.06$, $p > .05$, $\eta = .02$, observed power = .44.

This finding does not support the first hypothesis that client religious orientation was related to different clinical judgment factors of prognosis, problem attribution, and GAF score. Due to the low observed power, the findings are, at best, inconclusive. However, upon examining the other covariates, the results were significant for gender, $F(3,162) = 4.43$, $p < .01$ (men: M = , SD =; women: M =, SD =), $\eta^2 = .08$, observed power = .87; spiritual antagonism, $F(3,162) = 3.81$, $p = .01$, $\eta^2 = .07$, observed power = .81; organizational religiosity, $F(3,162) = 3.00$, p = .03, $\eta^2 = .05$, observed power = .70; non-organizational religiosity, $F(3,162) = 3.84$, p = .01, $\eta^2 = .07$, observed power = .81; and intrinsic religiosity, $F(3,162) = 2.92$, p = .03, $\eta^2 = .05$, observed power = .69. These findings lend partial support for the second hypothesis. Non-significant multivariate effects were found for religious worldview, $F(3,162) = 1.41$, p = .24, $\eta^2 = .03$, observed power = .37 and counselor religious orientation $F(3,162) = 1.99$, p = .11, $\eta^2 = .04$, observed power = .51. Again, due to low observed power, these findings cannot be interpreted conclusively.

Spiritual competence also had a significant and sizable main effect, $F(3,162) = 4.43$, $p < .01$, $\eta^2 = .08$, lending initial support for the third hypothesis. Overall, the model accounted for 45.0% of the variance in clinical judgment, as measured by the three dependent variables (prognosis, attribution for problem cause, and GAF), which would be considered a very large effect. However, it should be noted that eta squared can have an upward bias in estimating population effects (Tabachnick & Fidell, 2007).

Results for the effect on each dependent variable by each significant variable were also examined. For prognosis, the combined variables resulted in a significant finding $t(3, 165) = 8.78$, $p < .05$, $\eta^2 = .32$, a large cumulative effect, observed power = .99. Individual effects can be viewed in Table 9. The variables also had a significant effect on attribution for cause of the

problem, $t(3, 165) = 3.85$, $p < .00$; $\eta^2 = .08$, a moderate cumulative effect, observed power = .83. Table 10 shows the individual effects. Lastly, the variables also had a significant impact on GAF scores, $t(1, 165) = 9.04$, $p < .00$, $\eta^2 = .33$, a large cumulative effect, observed power = .99. Individual effects can be seen in Table 11.

Table 9

Parameter Estimates for MANCOVA on Prognosis

	B	Std. Error	*t*	Sig	Partial Eta^2	Obs. Power
Gender	.07	.02	3.6	.00*	.07	.95
S/R	.00	.01	.49	.61	.00	.66
Antagonism						
SCS	.00	.00	-3.06	.00*	.05	.86
OR	.00	.01	.49	.62	.00	.08
NOR	.02	.01	2.94	.00*	.05	.83
IR	-.01	.00	2.13	.04*	.03	.56

Note. S/R=Spiritual/Religious; OR=Organizational religiosity; NOR=Non-organizational religiosity; IR= Intrinsic religiosity; RS=Religion Scale

Table 10

Parameter Estimates for CSS-Cause

	B	Std. Error	*t*	Sig	η^2	Power
Gender	.17	.56	.30	-.94	.00	.06
S/R Antagonism	.12	.04	3.26	.00*	.06	.90
SCS	-.02	.02	-1.13	.02*	.01	.20
OR	.00	.24	.20	.84	.01	.05
NOR	.34	.22	1.61	.12	.01	.34
IR	.20	.11	1.88	.06^	.02	.46

Note. S/R=Spiritual/Religious; OR=Organizational religiosity; NOR=Non-organizational religiosity; IR= Intrinsic religiosity; RS-R=Religion Scale

Table 11.

Parameter Estimates for GAF scores

	B	Std. Error	t	Sig	η^2	Power
Gender	-.29	1.21	-.24	.80	.00	.06
S/R Antagonism	.06	.08	.76	.45	.00	.12
SCS	.08	.04	2.24	.03*	.03	.61
OR	1.56	.52	3.01	.00*	.05	.85
NOR	-.24	.47	-.50	.61	.00	.08
IR	-.13	.23	-.57	.57	.00	.09

Note. S/R=Spiritual/Religious; OR=Organizational religiosity; NOR=Non-organizational religiosity; IR= Intrinsic religiosity; RS-R=Religion Scale; SCS=Spiritual Competence

Hypothesis 1. The first hypothesis predicted that both the vignette and counselor religious orientation would account for variance in prognosis, GAF, and attribution for the problem. As mentioned above, none of the vignette conditions were related to the combined clinical judgment constructs in the multivariate test when taking the covariates into consideration. Given that the multivariate effect was not significant, examination of univariate differences would be inappropriate (Tabachnick & Fidell, 2007).

Hypothesis 2. The second hypothesis indicated that counselor religious attitudes would relate to different ratings of pathology, prognosis, and attribution for the problem. As mentioned above, the multivariate effects for four of the six attitudinal covariates studied were significant at the $p < .05$ level: spiritual/religious antagonism, organizational religiosity, non-organizational religiosity, and intrinsic religiosity. Religious worldview was not significant. Upon further review, the between subjects results indicated how the religious/spiritual attitudes were related to specific clinical judgment factors. Table 12 shows the univariate effects for each of the 5 attitudinal covariates for each of the three dependent variables.

Table 12.

Between Subjects Effects of Attitudinal Covariates

	df	F	sig	Partial η^2	Power
Prognosis					
S/R Antagonism	1	.25	.45	.00	.08
OR	1	.24	.62	.00	.08
NOR	1	8.66	.00*	.05	.83
IR	1	4.54	.04*	.03	.56
RS-R	1	5.15	.66	.00	.05
Casual Attribution					
S/R Antagonism	1	10.62	.00*	.06	.90
OR	1	.04	.99	.00	.05
NOR	1	2.24	.12	.01	.34
IR	1	3.51	.06^	.02	.46
RS-R	1	.61	.44	.00	.12
GAF					
S/R Antagonism	1	.57	.45	.00	.12
OR	1	9.04	.00*	.05	.85
NOR	1	.25	.62	.00	.08
IR	1	.28	.60	.00	.09
RS-R	1	3.27	.07^	.02	.44

*Indicates significance at $p < .05$; ^Indicates marginal significance S/R=Spiritual/Religious; OR = Organizational religiosity; NOR = Non-organizational religiosity; IR = Intrinsic religiosity; RS-R = Religion Scale

Spiritual antagonism only had a significant impact on attribution for cause $F(1,165) = 10.70$, $p < .01$, $\eta^2 = .06$ with those endorsing increased antagonism tending to attribute the problem's cause more likely to be the client's responsibility. Organizational religiosity ("How often do you attend church or other religious meetings?") only had a significant impact on GAF scores and in a positive direction, $F(1,165) = 9.18$, $p < .01$, $\eta^2 = .05$, meaning those that tended to endorse increased participation in organizational religion also tended to provide higher GAF scores. Non-organizational religiosity ("How often do you spend time in private religious activities, such as prayer, meditation, or Bible study?") had a significant negative impact on prognosis, $F(1,165) = 7.01$, $p < .01$, $\eta^2 = .04$ but a positive one on attribution for cause, $F(1,165) = 2.60$, $p < .05$, $\eta^2 = .02$ meaning an increased non-organizational religiosity was associated with a tendency to project a less optimistic prognosis for the client and put responsibility on the client for the cause of his problem. Intrinsic religiosity had a significant main effect on prognosis with those reporting increased religiosity also rating the client with a better prognosis, $F(1,165) = 4.50$, $p < .05$, $\eta^2 = .03$. Religious attitudes had a marginally significant effect on GAF, such that those endorsing more religious attitudes tended to assign lower GAF scores $F(1,165) = 3.26$, $p = .07$, $\eta^2 = .02$.

Hypothesis 3. The third hypothesis, that participants' spiritual competence would lead to different ratings of clinical judgment factors among the vignettes, was supported by the overall MANCOVA $F(3, 162) = 116.68$, $p < .0$, $\eta^2 = .68$, observed power = 1.0. Spiritual competence did have a significant effect on the clinical judgment variables $F(3,162) = 4.43$, $p < .01$, $\eta^2 = .08$. Closer analysis of the between subjects results indicated that spiritual competence had a significant effect on prognosis, $t(1,162) = 9.08$, $p < .01$, $\eta^2 = .05$, attribution for the problem, $t(1,162) = -1.27$, $p = .02$, $\eta^2 = .01$, as well as GAF, $t(1,162) = 4.91$, $p < .05$, $\eta^2 = .03$. In these

findings, higher spiritual competence tended to relate to more positive prognosis and GAF scores. Higher spiritual competence was also associated with a decreased assignment of responsibility to the client, $t(1,162) = 2.24$, $p < .03$, $\eta^2 = .03$.

In order to assess the moderation effect, a second MANCOVA was conducted including spiritual competence and counselor religious orientation together as an interaction term in the model. Whereas the previous MANCOVA did not test for interactions among variables, in order to test the third hypothesis this follow-up MANCOVA tested for the effect of spiritual competence on the relationship between the religious conditions for clients and the dependent variables. All other covariates (as specified in the previous model) remained intact. Although the overall model was significant (see previous paragraph) there was no evidence of statistical significance for an interaction effect of spiritual competence on the relationship between clients' religious identification and counselor clinical judgment using the moderation analysis procedure. Using the Wilks' criterion, the relationship of client religious condition on the combined dependent variables was not significantly impacted by the interaction of spiritual competence when taking the 6 covariates into account $F(9, 164) = .98$ $p = .46$, partial eta squared = .02, observed power = .40. Based on these data, there was not significant evidence to support the idea that spiritual competence moderated the relationship between client religious background and clinical judgment factors, however the power estimate was significantly below the intended limit of .80, possibly masking a significant effect. Therefore, the test was essentially inconclusive. Similar to the main analysis, client religious orientation did not produce a significant multivariate effect $F(9, 164) = .98$ $p = .46$, partial eta squared = .02, observed power = .40. However, spiritual competence did have a significant multivariate effect, $F(3, 169) = .6.32$ $p < .01$, partial eta

squared = .10, observed power = .96. Univariate effects of spiritual competence were found on GAF as well as prognosis

Because the multivariate effect of the interaction was not significant, no further univariate analysis was indicated. However, given the limitations in power, inspection of the results may provide directions for future research so graphs were provided. Graphs including the means for each group can be seen in Figures 1-3. Table 13 shows the parameter estimates for spiritual competence in the moderation analysis.

Table 13

Moderation Analysis Parameter Estimates, (n = 176)

	B	Std. Error	*t*	*p*	η^2	Power
GAF						
SCS	.07	.03	2.15	.03	.03	.57
Prognosis						
SCS	0.02	.00	-4.17	.00*	.09	.98

*Indicates significance at $p < .05$; GAF = Global Assessment of Functioning, SCS = Spiritual Competence

Analysis of Research Questions

Exploratory clinical judgment indicators of experienced emotional reaction of participant to the case, number of sessions predicted for the client to achieve goals, and alternative pathology items (how likely is that the client has a psychotic/mood/adjustment/anxiety disorder)

were used in the same one-way MANCOVA format as the main analysis. These constructs were included given their theoretical relevance to the clinical judgment construct. In order to better assess their relevance to the factors examined, the exploratory constructs were investigated in a secondary analysis in which the original dependent constructs representing clinical judgment (prognosis, GAF score, and attribution for the problem) were replaced with the relevant exploratory ones. In order to determine which of the exploratory constructs might be most appropriate for the analysis, they were entered first in a correlation matrix (see Table 15) to determine which would maximize the efficacy of the MANCOVA.

Table 14

Bivariate Correlations for Exploratory Items

		1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.
1.	Empathy	1										
2.	Session Number	.06	1									
3.	Depressive Disorder	-.07	-.02	1								
4.	Anxiety Disorder	.07	.07	.02	1							
5.	Adjustment	.18*	-.12	.05	.05	1						
6.	Psychotic	-.03	-.05	-.02	.26*	-.02	1					
7.	IR	.23	.08	.05	-.03	.07	.02	1				
8.	Religious Attitudes	.09	-.04	-.02	.08	.05	-.02	-.69*	1			
9.	S/R Antagonism	-.11	.00	-.06	-.02	-.14	.07	.64*	-.63*	1		
10.	SCS	.24*	-.11	-.10	.07	.16*	.02	.40*	.37*	-.26	1	
11.	OR	.18*	.05	-.07	.03	.10	.11	.71*	.70*	-.61*	.36*	1
12.	NOR	.20*	.08	-.08	.00	.11	.03	.75*	.60*	-.58	.36*	.71*

Note. * Significant at $p < .05$ level; S/R=Spiritual/Religious; OR=Organizational religiosity; NOR=Non-organizational religiosity; IR= Intrinsic religiosity; RS-R=Religion Scale

Upon inspection, the emotional empathy item and likelihood of an adjustment disorder were the only two exploratory items to have a significant bivariate correlation with one another (r = .18). Additionally, these two items were the only ones to correlate with any of the covariates. Thus, only these two items were entered as dependent variables in the exploratory MANCOVA. This included the same independent variable (client religious orientation), the same covariates (counselor religious orientation, religious attitudes, organization religiosity, non-organizational religiosity, intrinsic religiosity, spiritual/religious antagonism, and spiritual competence), but with two different dependent constructs (emotional empathic reaction and rated likelihood that the client meets criteria for an adjustment disorder) from the main analyses.

The exploratory dependent variables (emotional empathy and likelihood of an adjustment disorder) each adequately met assumptions for MANCOVA (Tabachnick & Fidell, 2007). Using the Wilk's criteria , there was not evidence for a significant multivariate effect of client religion on the combined dependent variables , $F(6, 170) = 1.35$, $p > .05$. Table 15 shows the multivariate impact of the covariates in the model. Of note, only spiritual competence had a statistically significant multivariate effect, with a small-to-medium effect size. Religious worldview (RS) was also marginally significant. Because these were the only two variables significant related to the exploratory dependent variables, their respective univariate effects will be presented below.

Table 15

Exploratory Dependent Variables Multivariate Results

N = 176

	df	F	*p*	η^2
Gender	2	1.41	.25	.02
Atheist/Agnostic	2	.08	.92	.00
S/R Antagonism	2	1.37	.26	.02
SCS	2	3.42	.04*	.04
OR	2	.66	.52	.01
NOR	2	.20	.82	.01
IR	2	2.34	.10	.03
RS-R	2	2.65	.07^	.03
Client Religion	6	1.36	.23	.03

Note. *Indicates significance at $p < .05$; ^Indicates marginal significance. S/R=Spiritual/Religious; OR=Organizational religiosity; NOR=Non-organizational religiosity; IR= Intrinsic religiosity; RS-R=Religion Scale Revised

Univariate results of spiritual competence and religious worldview on each dependent variable can be seen in Table 16. Spiritual competence scores had a significant impact on the exploratory empathy score, $t(1,166) = 2.34$, $p < .05$, $\eta^2 = .01$, meaning increased spiritual competence scores were related to increased reports of empathy after reading the vignette. However, this effect is small. Conversely, religious worldview scores were related to lower reports of empathy $t(1,166) = -2.22$ $p > .05$, $\eta^2 = .03$, indicating those endorsing more a religious worldview had lower self-report empathic responses to the vignettes. Neither covariate was related to the adjustment indicator.

Table 16

Univariate Results for Exploratory Dependent Variables

	B	Std. Error	t	*p*	η^2
Empathy					
Agnostic/Atheist	.06	.13	.40	.70	.00
Gender	-.18	.13	-1.33	.18	.01
S/R Antagonism	.00	.01	.14	.89	.00
SCS	.01	.00	2.34	.02*	.03
OR	-.07	.06	-1.14	.26	.01
NOR	.01	.05	.132	.90	.00
IR	.049	.03	1.91	.06^	.02
RS-R	-.01	.01	-2.22	.03*	.03
Vignette					
Buddhist	-.09	.15	-.61	.55	.00
Christian	-.38	.16	-2.38	.02*	.03
Muslim	-.14	.17	-.86	.39	.01
Not Identified	-	-	-	-	-
Adjustment					
Agnostic/Atheist	.06	.35	3.37	.00*	.07
Gender	-.36	.29	-1.23	.22	.01
S/R Antagonism	-.03	.02	-1.61	.11	.01
SCS	.01	.01	1.53	.13	.03

Table Continues

	B	Std. Error	t	*p*	η^2
OR	.04	.13	.30	.77	.00
NOR	.07	.11	.59	.56	.00
IR	-.04	.06	-.72	.47	.00
RS-R	-.01	.01	-.96	.34	.01
Vignette					
Buddhist	-.13	.34	-.37	.71	.00
Christian	.16	.34	.48	.63	.00
Muslim	.10	.36	.28	.78	.00
Not Identified	-	-	-	-	-

Note. *Indicates significance at $p < .05$; ^Indicates marginal significance. S/R=Spiritual/Religious; OR=Organizational religiosity; NOR=Non-organizational religiosity; IR= Intrinsic religiosity; RS-R=Religion Scale

In exploring the frequency of open-ended diagnoses, Axis I disorders were grouped into the major DSM-IV-TR (Spitzer, et al, 2000) categories of Mood disorder, anxiety disorder, adjustment disorder, psychotic disorder, none, V-code diagnosis, or mixed. The vignette included both mood and anxiety symptoms, but not enough to meet criteria for either a mood or anxiety disorder. The "mixed" category was given if participants rated the vignette with more than one of the major diagnoses listed (e.g. Mood Disorder and Psychotic Disorder). Table 17 reveals the frequency of these categories among each of the four vignette conditions. The percentages are more telling than the total numbers given the unequal cell sizes for each vignette group. The Christian group was given the highest percentage of adjustment disorders (46%) while the Muslim group was given higher Mood disorders (56%). In examining ratio differences, the

largest difference was that the Muslim group percentage of “two or more” diagnoses was at least twice as high as any other group.

Table 17

Frequency Analysis of Open-Ended Diagnoses

Disorder	Not Identified (n=51)	Christian (n=50)	Muslim (n=37)	Buddhist (n=38)
Mood	19 (37%)	21 (42%)	21 (56%)	19 (50%)
Anxiety	1 (2%)	0 (0%)	0 (0%)	0 (0%)
Adjustment	18 (35%)	23 (46%)	10 (27%)	15 (39%)
Psychotic	0 (0%)	0 (0%)	0 (0%)	1 (3%)
No diagnosis	3 (6%)	2 (4%)	2 (7%)	1 (3%)
V-Code	3 (6%)	2 (4%)	0 (0%)	0 (0%)
Two or more of the above	3 (6%)	2 (4%)	4 (11%)	1 (3%)

CHAPTER FIVE

DISCUSSION

The present study allowed for investigation of how a prospective client's religious orientation, combined with doctoral-level therapists' religious orientation, spiritual/religious attitudes, as well as spiritual competence would relate to therapists' self-reported clinical judgment indicators of a written intake summary. Clinical judgment was measured by prognosis, GAF score, and causal attribution for the client's presenting concerns. Due to poor reliability estimates, the fourth dependent construct, attribution for solution to the problem, was dropped from the analysis. After preliminary analyses were run on the demographic factors, gender also was included as a covariate.

The three main hypotheses for the study were: (1) Client religious orientations will elicit different assignments of prognosis, GAF, and attribution for the problem; (2) Counselors with more affirming attitudes toward religion/spirituality will be more inclined to rate the religious clients with less responsibility, less pathology, and more optimistic prognosis; (3) Counselors with higher spiritual competence will demonstrate a shifting standards effect for religious clients, rating them with better prognoses, less pathology, and less responsibility for the problem. While the first hypothesis was not supported, the second two hypotheses were at least partially supported by the analysis, although no single construct accounted for variance in each of the three dependent variables. To address the third hypothesis more precisely, a moderation analysis was conducted examining the interaction of the four client vignettes with counselor spiritual competence. Additionally, exploratory dependent variables representing other forms of clinical judgment were assessed for possible differences.

Hypothesis 1

The first hypothesis stated that a potential client's religious identity would impact a counselor's initial impressions of that client. The four possible client conditions (Christian, Buddhist, Muslim, or Not identified) were written identically except for material pertaining to religious identity of the client. The results indicated that, even when entering the religious identity of the counselor (Atheist/Agnostic vs. any other identified religion) as a covariate, there was not an overall multivariate effect for client religious background on the clinical judgment factors studied.

The idea of prognosis presumes a type of forecasting into the future, or predicting behavior in response to treatment, whereas the other two measures of clinical judgment were about the client in his present situation (for the GAF score), and thinking about past circumstances for casual attribution for the problem. A "better" prognosis in this study is indicative of clinicians' perception that a client will respond favorably to the treatment process and will require less intensive interventions.

Counseling process and outcome research has confirmed that a therapists' impression of what a client needs at the outset of therapy can affect the ensuing process. Theorists have noted that therapist expectations can steer the direction of therapy toward a negative outcome if they are different from client expectations (Duncan, Sparks, & Miller, 2000; Greenberg, Constantino, & Bruce, 2006) and empirical data have confirmed the importance of this congruency in treating psychological concerns in counseling (Clinton, 1996). Additionally, when prognosis was conceptualized as expected number of sessions needed to address the problem, one study found that therapists' expectancy for the sessions needed for treatment of a new client's presenting concern was a significant predictor of the actual number of sessions attended by clients (Mueller

& Pekarik, 2000). The presumption of a poorer prognosis at the beginning of therapy is, therefore, an important construct to consider when exploring process and outcome for psychotherapy. In the case of the current study, finding no differences among the four different client religious conditions indicates that, among the present sample, simple categorical differences in a client's religious orientation either did not elicit biases for or against those religions or the study was not able to detect these biases if they did exist. Perhaps this finding supports the positive trend that training programs and professional organizations have done to discuss the realistic benefits and costs of spiritual and religious beliefs.

Christian Vignette

As mentioned in the literature review, Christianity specifically has a tumultuous past with professional psychology. Hodges (2006) reviewed literature listing content analyses of how mental health field publications and general media have supported unfavorable views of conservative Christianity. Although the vignette used in the present study was only identified as "Christian," it is possible that this label activated a set of negative schemas in regard to clinicians' personal understanding of Christianity, but this bias, if it exists, was not directly investigated. This effect would have some empirical basis in that previous research has shown that professionals in psychology have reported ill feelings, and in some cases behaviors, toward more conservative Christians due to perceived or real differences in value systems (Neumann, Thompson, & Woolley, 1991; Neumann, Thompson, & Woolley, 1992). The results of the present study seem to indicate that a client's religious orientation alone was not able to attract biases related to prognosis, pathology, or attribution for the problem's cause.

Buddhist Vignette.

At the time of the present study, little research in professional psychology has discussed stereotypes related to impressions of Buddhism. Eckell (1996) theorized that Eastern religions, as a group, may tend to be associated with being more flexible and connected to nature. Buddhist philosophers have championed ideas related to the practice of self-discovery and basic humanistic tenets of the basic capacity for humankind to love (Ferguson, 2004). However, there is really no research available discussing mental health practitioners' biases for or against Buddhism. This is one area of future research needed to make more meaningful conclusions about the present study. Although the present study did not directly assess participants' own affinity for Buddhism specifically, the "third wave" of psychological clinical theories has emphasized elements of Buddhist thought (Hayes, Luoma. Bond, Masuda, & Lillis, 2006). Future studies may explore whether a Buddhist orientation is viewed as more of a psychological strength than other belief systems more explicitly.

Not Identified Vignette

The "not identified" vignette, served as the control comparison for the present study. The coping behaviors listed for both the not identified and the religious vignettes were matched except for the reliance on prayer as a coping strategy for the religious conditions (the not identified vignette described talking to a friend as a comparable coping strategy). The study did not directly assess the qualitative process behind participants' interpretation of these coping strategies. In all, the not identified case was very similar to the others in presentation and was rated similarly on the dependent constructs.

Muslim Vignette

Not finding a statistically significant multivariate effect for religious traditions is perhaps most surprising given the inclusion of Muslim faith. The socio-political climate since the September 11th, 2001 terrorist attacks has resulted in increased hostility toward the Muslim faith (McMorris-Santoro, 2010). The results of the present study indicated that there was no clear difference in how participants rated the Muslim client compared to the other groups. Again, the hope is that religious tolerance and appreciation for the client in the larger context helped reduce biases. However, this was not directly investigated.

Therapist Religious Identity

The second component of the first hypothesis was that therapist religious orientation would significantly influence clinical judgment scores. Due to a fairly low representation of diverse religious orientations (see Table 2 for breakdown within sample), the only two variables used were dummy-coded variables, Christian vs. non-Christian and atheist/agnostic vs. non-atheist/agnostic were the two groups used. After seeing that only the agnostic/atheist group significantly correlated with the dependent constructs, the Christian vs. non-Christian construct was dropped from the analysis. Therapists' religious identity was assessed by dummy coding a variable collapsing both atheistic and agnostic beliefs into one group and placing all other religious orientations into another group. Although there was not a significant main effect found, ($p = .11$) the observed power (.51) indicates that the findings can be considered inconclusive. The other measures of clinician religiosity revealed more meaningful differences.

The Hunsberger et al. (1994) study may be important in understanding this finding when coupled with other research (Spengler & Strohmer, 1994) indicating that counselors in their study tended to be prone to increased biases when their thinking was less complex about a given

client in his or her situation. Perhaps the combination of the client being religious and being in psychological distress triggered a different bias within religious therapists than nonreligious therapists but participants' ability to think carefully and comprehensively about the case superseded any potent biases. This is not to say a religious counselor is any more or less capable of employing the same level of cognitive complexity as a non-religious counselor, but perhaps highlights one area where future researchers may investigate whether religious counselors may be more prone to relying on heuristics or other biases when they are less likely to think about an individual with a high level of cognitive complexity.

Also, some evidence suggests that religious persons may be more likely to be more critical of other religious persons who seek psychological help (Hathaway, 2005; King, 1978). Although one would hope that this effect would not remain significant for those trained in psychotherapy, relatively little investigation of this exists with a sample of mental health practitioners. Although the sample in the present study was comprised of individuals who are trained to understand the benefit of counseling, the extent to which these religious counselors believe therapy is viewed as a "weakness" or indicative of spiritual pathology of some kind was not assessed. Existing research indicates that clinician biases can adversely influence the treatment process (Al-Issa, 1995; Rosenthal & Berven, 1999; Strakowski et al., 1997; Whaley, 1997) but biases of therapists' beliefs about whether mental health is a weakness was not the focus of the present study. However, these data may point to the importance of follow up research further verifying the quantitative and qualitative aspects of this broad area.

Hypothesis 2

The second hypothesis indicated that therapist religious attitudes would significantly affect clinical judgment factors (prognosis, pathology, and attribution of the problem) among the

four client conditions. Gender was included as a covariate given its significant relationship with the dependent constructs found during the preliminary analysis. The different religious attitudes studied included organizational religiosity, non-organizational religiosity, intrinsic religiosity, antagonism toward spirituality/religion, as well as religious worldview. Results for each covariate will be discussed below.

Gender

The covariate of gender was added to the main analysis given its significant correlation with prognosis found in the preliminary analysis. When entered with the other variables in the study, gender maintained its significant main effect which was completely accounted for by the impact on prognosis. The data indicated that female clinicians tended to provide a more optimistic prognosis than men. A search for peer-reviewed studies found older research on this topic. Jones and Zoppel (1982) found that male therapists tended to use less "socially desirable" language when discussing their impressions of mock client concerns presented via vignettes compared to their female colleagues (p.259). They also found that female therapists tended to endorse more positive terms than their male counterparts when discussing their impressions of the clients.

Because prognosis is a difficult variable to study, few studies have been able to pinpoint gender differences in prognostic ratings among clinicians. The data may suggest that examining gender may be an important point of consideration when thinking through what a clinician expects when given an intake summary report. The results of this study also supplement the meta-analytic finding that a small bias against men may exist in therapists' clinical judgment (Smith, 1980), in that men were more critical of the male client than women were.

One might presume that prognosis entails a certain ability to determine how likely a client is to respond to treatment. Aside from stereotypes, it is difficult to think of a strong rationale for a gender effect on prognosis. Even more puzzling is why the effect arose for prognosis, yet not the other two dependent variables. The fact that the others were not statistically significant perhaps speaks against the idea that the men in the sample happened to be agitated or pessimistic thereby more critical of the client; if that were the case, one might expect more negative reviews for the other constructs as well.

One thing to keep mind would be the research suggesting that women tend to be more comfortable in expressing spirituality and relying on it for strength in times of duress than men (Gallup & Lindsay, 1999). In fact, one study found that men the U.S. actually report fewer spiritual or religious beliefs overall when compared to women. The stereotypical masculine perspective could encompass spiritual beliefs as a type of weakness for men, whereas it may be more often viewed as a strength for women, which may have influenced these gender differences. As mentioned earlier, qualitative data assessing these interpretations were not collected, so these are mere speculations. Future researchers are implored to investigate this further.

Another important factor in the interpretation of these data is that the client was identified as a male. Again, the in-group/out-group biases may be at play in this finding. The existing research in this area suggests that women would be more likely to have a better prognosis for other women, but these data show an opposite effect. Women rated the prognosis for the male client more optimistically than men. Perhaps the finding in the present study reflects literature and theory supporting that women are socialized to be more affirming of others' self-worth and capacity for good (Book, 2000; Rosner, 1995).

Organizational Religiosity (OR)

Organizational religiosity refers to an individual's tendency to view religion as a means of staying socially connected to other like-minded individuals by participating in group experiences of religion such as attending a service, prayer group, or study group (Hill & Hood, 1996;Koenig et al., 1997). Less often, organizational religiosity is associated with the positive or protective factors that spirituality/religiosity have been found to predict when examined apart from other forms of religiosity (Koenig et al., 1997). It also has been considered to reflect a type of extrinsic religiosity, known as an enterprising form of religiosity, that people use for external benefit (recognition from others, positive reputation, etc..; Allport & Ross, 1967; Koenig, 2010). In the present study, organizational religiosity was significantly related to a decreased GAF score but not to the other two dependent variables. This finding was consistent with the findings mentioned above regarding religious persons giving a less optimistic prognosis. It is important to note that the findings examining religious orientation do not speak to the strength of that commitment in any way, only an affirmative affiliation or not. Whereas, an attitudinal measure on a continuous rating scale, like the OR and the others included, provide a more precise level of information about the quality of the religiosity in question. Still, finding that those who attend religious services more also report a lower GAF overall is interesting, and should implore future research to employ follow-up investigations to determine why or how increased organizational religious participation would be associated with providing more severe GAF scores among psychotherapists.

One possibility may be rooted in social psychological literature. Tajfel's (1982) social identity theory posits that people tend to show favoritism toward those deemed to be akin to them in some specific way, or in their "in-group." In this case, there was evidence to suggest

that this did not occur among trained clinicians in psychology, assuming religious clinicians felt similar to the religious clients. However, one extension of this theory, dubbed the "black sheep effect" (Marques, Yzerbyt, & Leyens, 1988), indicates that sometimes an in-group member may rate another in-group member less favorably when that in-group member is thought to be different in some other important way. In the case of the vignettes, perhaps those clinicians scoring higher on organizational religiosity felt that the clients, though similar in some ways, were more different from them than the clinicians who scored lower on organizational religiosity.

Non-organizational Religiosity (NOR)

Non-organizational religiosity refers to an individual's practice of private religious behavior or ascribing to personal religious beliefs independent of the social context or direct external reward. This may include reading sacred scriptures, prayer, meditation, memorizing scriptures, etc. There may still be a motivating reward for an individual's piety, but it is not a social reward from other believers. Rather, it is more likely anticipation of God's favor or blessing, or a belief that the activities are morally right; these motivations can be either externally or internally driven (Allport & Ross, 1967). The important distinction is that these are not necessarily the same motivations related to engaging in public practices of religiosity as there would be with organizational religiosity, which could be surrogate for other forms of well-being such as social connectedness (Hall, Meador, & Koenig, 2008). However, non-organizational religiosity can be conceptualized as a form of dogmatic adherence to traditional religious beliefs (Allport & Ross, 1967; Koenig et al., 1997) or the expression could be more connected to a spiritual understanding, or nurturance for oneself (Hall et al., 2008).

In the present study, non-organizational religiosity was significantly linked to prognosis in a negative direction. That is to say, individuals reporting more non-organizational religiosity also provided a less optimistic picture of the client's future. Unlike organizational religiosity, non-organizational religiosity deals with an individual's internal sense of duty, obligation, and responsibility to a higher power. Again, perhaps the black sheep effect is possibly at work here. An individual who engages in more behaviors related to non-organizational religiosity may also be more critical of a religious (or even nonreligious) individual who engages or reports immoral behavior (in the case of the vignette, coercing the ex-girlfriend for sex may have activated this effect). It is possible that an individual that engages in more private expressions of religiosity may have less respect for an individual that professes similar values and subsequent behaviors, but also reports falling short morally.

Again, non-organizational religiosity deals with an individual's self-imposed religious expectations for present and future behavior. Perhaps, individuals who tend to report more non-organizational religiosity were less optimistic about the religious client's prognosis given that the intake summary reported that the client was still engaging the religious behaviors of reading sacred texts, praying, and fasting, but was presenting with significant distress. The landmark study related to cognitive dissonance (Festinger & Carlsmith, 1959) indicated that an individual who is faced with data contradicting something they believe is faced with the decision to either adjust their own beliefs or their impression of the other person. An individual who engages in more non-organizational religiosity behaviors out of a sense of those being the "morally right" way to live may have more difficulty thinking through how an individual who engages in the same pious behaviors lives in psychological distress or who engages in morally repulsive behavior.

Intrinsic Religiosity (IR)

Koenig (2010) refers to intrinsic religiosity, a term coined by Allport and Ross (1967), as the practice of religion due to heartfelt valuing of faith without regard to external benefit. Unlike either organizational religiosity or non-organizational religiosity, which are assumed to be externally motivated, intrinsic religiosity is rooted in an internal reward or satisfaction. This type of religiosity does not bring a sense of pressure or external expectation, but is adhered to by an individual due to his or her genuine sense of internal peace or satisfaction that the activity or belief elicits. In the present study, intrinsic religiosity was found to be a significant predictor of prognosis in a positive direction. This finding provides a stark contrast to the non-organizational religiosity findings where the relationship was a negative one.

Perhaps individuals reporting more intrinsic religiosity were more likely to see hope and optimism in the client's progress in therapy due to their own subjective construction of what religion is for them. Individuals who are more in tune with their own intrinsic religiosity may be more likely to see a spiritual or religious background as potential for growth or support in an individual. This possibility could be helpful for therapeutic progress, as many studies have shown religious orientations and spiritual beliefs to be a psychological resource (Bergin, 1980; Koenig & Larson, 2001). However, it may be equally possible that individuals with higher intrinsic religiosity may assume their clients who identify as religious to mean that they have components of intrinsic religiosity when, in fact they may be religious only in title or for some other extrinsic benefit. It is important for therapists who identify themselves as being more intrinsically religious to think through how this bias may exist in both directions, for better or worse, in regard to a client's prognosis for therapy.

Spiritual and Religious Antagonism

Spiritual and religious antagonism (SARA) is a construct that has not been examined in the counseling process and outcome literature to date. Although some studies have pointed out that general feelings of discomfort or appreciation for religious traditions or spirituality may be related to political attitudes (Layman et al., 1997), racism (Hunsberger & Jackson, 2005), or death anxiety (Harding, Flannelly, Wheaver & Costa, 2005), no studies have shown how therapists' feelings about religious and spiritual matters may affect how they conceptualize a client. The present study found that clinicians endorsing greater spiritual/religious antagonism tended to assign more responsibility to the client for the presenting concerns. This is interesting because spiritual and religious antagonism was the only factor, aside from spiritual competence, that was specifically found to have a significant impact on casual attribution for the problem of the nine variables studied. As mentioned earlier, attribution for the problem's cause relates better to a therapists' belief about the etiology of the presenting concerns, or past behaviors, which is different from GAF (estimation of the present) and prognosis (estimation of the future).

When conceptualizing attribution of responsibility for the cause of the client's problem, it may be helpful to be reminded of the research regarding racist attitudes cited earlier. Recent evidence has supported that when counselors' attitudes toward racial differences represents a non-affirming respect for those differences (e.g. increased colorblindness), counselors may tend to blame a client for responsibility of his or her problem significantly more when the client was a person of color (Burkard & Knox, 2004; Gushue, 2004). Finding that antagonistic attitudes toward spirituality/religious led to a tendency to blame the client for the problem's cause approximates the findings mentioned above to a certain extent, although this effect was found

across the different religious groups, indicating that the antagonistic attitude may not have been specific to religion or spirituality.

Attribution for the cause of the problem is a slightly different construct than either GAF, a measure of global psychopathology in the present time, or of prognosis, which deals with the factors related to a client's future improvement. Whereas the other two dependent variables deal with issues of the present and future respectively, causal attribution deals with the past events that have lead up the present. In a way, this variable may reflect a counselor's conceptualization of the presenting concerns better than either GAF or prognosis given its logical tie to theoretical conceptualization of problem formation. Attributing responsibility to a client for his or her presenting concerns can be both freeing and dismissing. Peck (1993) discussed the freedom and responsibility that go hand in hand with a client acknowledging how his or her contribution to the presenting concern can be a major step for clients understanding the road to improved symptoms. However, the reverse is that blaming clients for things that they may not have control over or which have a clear environmental etiology (e.g. racism, sexual assault, traumatic experiences, etc.) may promote unhealthy psychological consequences and counterproductive feelings of guilt, shame, or anger (Constantine & Sue, 2007; George & Martinez, 2002). Many pleas have been made for therapists and training programs to understand the complex person-situation interaction that can lead to psychological distress (Mintz et al., 2009). However, the data from the present study indicate that, individuals who endorse less affirming attitudes toward spiritual and religious ideals, also tended to attribute the client, across all four vignettes, with more inherent responsibility for the development of the presenting concerns.

Spiritual perspectives often include a sense that humankind is part of something much greater in the universe, and some more traditional belief systems even advocate that a higher

power, or fate, ultimately controls or predestines the unfolding of the present. This may include dealing with mental health issues. In Christianity, some have interpreted writings from the apostle Paul suggesting that his own unidentified personal struggle was something which originated from God to keep Paul humble (Mullins, 1957). Likewise, in the Jewish worldview, one common interpretation from the book of Job is that God allowed Job to experience suffering, externalizing the responsibility Job had in bringing on an onslaught of physical and psychological losses (Hartley, 1988). The tendency of some religious persons to, at the very least, entertain the possibly of spiritual or other factors leading to the presence of suffering may be one extraneous factor explaining these data. Many traditional humanists and proponents of cognitive therapy emphasize the responsibility that a person has in the subjective experience of his or her own life (Beck, 1979;Yalom,1980). This will be discussed more in the limitations section.

These findings should be interpreted with caution given that the SARAS, which was used to measure the construct of spiritual and religious antagonism, was created specifically for the present study. All psychometric estimates along with evidence of reliability and validity are supported only by the present study. In time, perhaps this instrument may prove a useful tool for identifying antagonistic attitudes toward spiritual and/or religious matters. But at the time of the present study, it has only been used once for this purpose. Researchers and clinicians should continue to investigate the scale's utility.

Religious Worldview (RW)

Lastly, religious worldview was assessed using the RS-R, an updated version of the RS (Bardis, 1961); this instrument measures the extent to which an individual endorsed beliefs reflecting a religious understanding of the way society and people "should" function. This factor

was marginally related to GAF scores and not statistically associated with either prognosis or causal attribution. The statistical trend found for the GAF score was in the negative direction such that individuals reporting a stronger religious worldview tended to give clients lower GAF scores overall. As mentioned, this effect did not quite meet statistical significance (p = .07) and had a small effect size too, η^2 = .02, limiting the extent to which interpretations can be made. The RS was one of the scales that was slightly skewed, though not above problematic cutoffs (Tabachnick & Fidell, 2007), perhaps not using a transformation on the variable may have masked an effect that actually existed.

The marginal effect of an increased religious worldview being associated with lower GAF scores is consistent with the effect of organizational religiosity, which also had a negative relationship with GAF scores. Theoretically, one could argue for a significant overlap between a religious worldview (the way the external world should be) and organizational religiosity, using one's religiosity for external gain or social validation. However, there are also differences in the constructs. A religious worldview extends beyond the constraints of external expectations to include expectations for oneself to be in the moral right. Additionally, this construct taps into one's concept of how humanity *should* respond to the existence of a deity more explicitly than organizational religiosity. Organizational religiosity more closely reflects public behavioral associations to religion. The religious worldview scale more directly measures a belief in the way things *should* be. This effect is further complicated in that the OR and RS-R scales were significantly and positively correlated (r = .70). Understanding how these two scales are different is likely the key to interpreting these results. The question still remains, why would an individual with a stricter or stronger religious worldview be more inclined to view a client's presenting concerns with more disparagement?

Perhaps this is not the best question when interpreting the data. Instead, perhaps a more fruitful question is, why would those engaging in more organizational religiosity be more inclined to rate a client with a more pessimistic GAF score? One factor left unstudied was the subjective importance of piety, or an individual's attempt to live a righteous life. Perhaps those who consider themselves to be pious or who strive for piety are also less tolerant of others who they deem to be struggling in this regard.

A recent review of literature has also linked religiosity with an increased ability to self-regulate or to practice self-control (McCullough & Willoughby, 2009). Once again, if religious participants who also happen to value the practice of more rigid self-control unconsciously had an "out-group" heuristic activated by reading that a client was having difficulty in self-regulating, perhaps this could have led them to think that the client was having more distress than those with a weaker religious worldview.

Hypothesis 3

The third hypothesis specified that a counselor's spiritual competence would significantly predict differences in counselor's clinical judgment across four different client vignettes. It was partially supported by finding that higher spiritual competence was associated with a more optimistic prognosis and higher GAF scores, independent of vignette condition assigned. The effect size for the interaction found was in the small range ($\eta^2 = .02$). This effect was assessed during the MANCOVA analysis in which the continuous SCS score was entered as one of the covariates for the analysis. The commonality in these two effects may be a trend toward optimism in general. The present study did not explore the presence of personality constructs such as optimism. Due to the overlap of spirituality and well-being within recent psychological theory, it is possible that professionals seeking out training experiences in spiritual competence

may also be more optimistic than others in the field. One must first be optimistic that an existing bias can be reduced to explore meaningful ways of reducing those biases. Noting that one can improve in one's ability to reduce cultural biases could reasonably be associated with an increase in spiritual competence scores, albeit an extraneous variable in doing so. This will be discussed further in the limitations section to follow.

Shifting Standards Effect

The Gushue (2004) "shifting standards" model posits that clinicians who have higher cultural competency may use a different set of cognitive standards when evaluating clients from the specific cultural backgrounds in which those clinicians maintain that competence. In this case, higher spiritual competency tended to relate to more optimistic prognoses and GAF scores across all the vignette conditions. The data from the MANCOVA analysis pointed to the possibility that this effect may exist for spiritual competence. A follow-up moderation analysis was used to examine this in more detail. The findings revealed limited support for the shifting standards effect as it applied across the different religious vignettes assigned. Another possibility is that the construct of spiritual competence may not have been a factor in this study due to adequate cultural training among the sample. Training in cultural competence, either broadly defined or specific to spiritual and religious diversity, was not assessed. Perhaps existing training in cultural competence acted as a buffer toward biases related to religious or spiritual concerns. While the observed power was not high enough to conclude this to be the case, it is another possibility.

A moderation analysis was used to examine whether client's religious orientation (all three religious vignettes vs. the not identified vignette) and counselor level of spiritual competency (continuous total scores) could more specifically shed light into the effect. The only

detectable effect for the interaction term was a marginal one for prognosis ($p = .10$), such that higher spiritual competence scorers tended to also provide more optimistic prognoses than those with lower levels of spiritual competence only when the client was religious.

Because there was not a statistically significant effect for GAF scores and attribution for the problem, the moderation analysis only partially supported the third hypothesis via a marginal *p*-value on prognosis scores. All in all, the mean scores across groups varied relatively little, suggesting spiritual competence did not have much effect on clinical judgment impressions for participants across the vignettes, although it did account for a significant amount of variance in both GAF and prognosis irrespective of client religious factors. In fact, covariates of spiritual and religious antagonism, organizational religiosity, non-organizational religiosity, and gender maintained stronger effects on the dependent variables than the interactional effect of spiritual competence, with some effect sizes in the moderate to large range.

The trends for the moderation analysis on each dependent variable can be viewed graphically in Figures 1-3. Although due to the non-significant findings coupled with low power, interpretations from these data are inconclusive at best. Still, future researchers may be interested to have a visual aid in examining the means for the groups in the analysis. Although the vignette was written from the perspective of an adjustment disorder in terms of actual symptoms presented, it did leave some ambiguity about the client's previous mental health concerns. Among this sample, the trend was for increased spiritual competence to be associated with a more optimistic prognosis, irrespective of religious background.

Summary of Findings

All in all, the present study may have sequestered answers to the questions regarding how or when biases against religious clients may impact clients from different religious backgrounds

due to inadequate power for the vignette comparisons coupled with the non-significant findings. However, the study also provided more questions related to this topic area. The findings support Koenig's (2010) call to measure the three facets of religiosity separately, given that organizational religiosity was negatively related to GAF, non-organizational religiosity was negatively related to prognosis, and intrinsic religiosity was positively related to cause of the problem. Each of these three types of religiosity, though overlapping in some ways, were connected to distinct areas of case conceptualization.

Although there was not support for the shifting standards effect across the religious vignettes, spiritual competence more consistently predicted the clinical judgment variables than the other construct studied. Higher spiritual competence was associated with a more optimistic prognosis, less severe estimates of pathology, and a tendency to blame the client less for causing his concerns. This effect did not change when the client's religious was not identified, Christian, Buddhist, or Muslim. Unfortunately, no vignette depicted a client who was antagonistic to religious or spiritual matters, which may have been an important factor in better determining how the spiritual competence construct may function. Based on these data, there is not enough evidence to conclude the shifting standards effect was either applicable or irrelevant here. Further refinement of the method and increasing statistical power in future research may help answer this question.

The construct of spiritual/religious antagonism had moderate-to-large effect on cause of the problem, with those endorsing more antagonism toward spiritual/religious matters also assigning more responsibility to the client for causing the presenting the concerns. Because this study developed this scale to assess this construct and no other peer-reviewed studies seemed to discuss this construct, future research is greatly needed before clear statements can be made.

Still, there was adequate power to detect this effect so, among this sample, spiritual and religious antagonism seemed be related to a trend to blame clients more for their problems overall, irrespective of the client's religious identification. The consequences of this trend cannot be determined by this study, however to put ourselves in clients' shoes, it may be that individuals maintaining a spiritual worldview are justified in their hesitance to seek counseling from an individual that is less willing to examine situational or external factors that lead to pathology. The strongest interpretation of this finding is that spiritual and religious antagonism may bias clinicians view toward a belief that clients are more responsible for their problem than more affirming clinicians. This makes some logical sense of individuals who are more antagonistic deny the spiritual or other invisible qualities may have impact upon human behavior. The problem is that roughly nine out of ten U.S. citizens tend to endorse a belief in the existence of a higher spiritual power (Gallup, 2008). Psychological research and training programs have begun to take strides to address spirituality as an important cultural factor, psychological and counseling theories, at least within secular training programs, having tended not to address this. Together, these findings should motivate researchers, clinicians, and faculty to consider the impact that their own spiritual and religious values and beliefs may have on a public who demonstrates different levels of those same values and beliefs.

Lastly, while no formal statistical tests were conducted on the frequency analysis of diagnoses, future research may explore whether religious or spiritual affiliation would influence assignment of diagnostic labels differently. One other possibility would be to see how other within group factors such as race, gender, sects or denominations, may relate to differences in how clinicians conceptualize a case or diagnose a client from a given religious background.

Strengths and Limitations

Methodology

The present study had methodological strengths and weaknesses throughout, which could have played a significant role in the results reported above. Procedurally, the process was an analogue to a real-life counseling scenario. Generally speaking, analogue methods can protect against threats to a study's internal validity, but in doing so, reduce the external validity (Heppner, Wampold, & Kivlighan, 2008). Participants understood that the client was not going to be on their case load and this may have impacted their concentration and attention to the task. This could be a benefit to the study as it was aimed at garnering heuristics and initial impressions constructed after reading a case summary, maximizing the potential for biased judgments to arise. Participants did not have access to the case summary for the diagnostic information in order to ensure that participants used their initial impressions of the case to guide their clinical judgment. The strengths for analogue designs could have limited the study's generalizability to real life scenarios where participants can refer to a diagnostic manual, a colleague, or additional data from the client before establishing impressions for a diagnosis, conceptualization of the problem, or prognosis. The vignettes are also not necessarily generalizable to clinical practice. In this case, practitioners often would not need to commit to a diagnosis based on an intake summary. This artificial condition should be taken into consideration. An analogue design also helped refrain from impinging on actual clients' confidentiality, which could have been an issue if this study used therapists with their actual clients.

Furthermore, participation for the study was incentivized. Unlike many other available incentives, the present study allowed participants to choose to either enter to win something personally (a raffle drawing for a $50 gift card) or have $1 donated to one of three charities. The

novelty of being able to choose between two types of incentive may have attracted individuals to participate in the study who may have done so based on the topic description. However, having an incentive at all biases the sample somewhat, as not all practitioners necessarily are motivated to participate in research and, even among those that are, many may not be enticed by incentives to participate.

The use of an analogue counseling situation also allowed for experimental control of the independent variable and situational control, in that all participants essentially saw identical presentations for each of the vignettes. Although experimental controls of manipulation of the independent variable, having a "control condition" (the not identified vignette), and random assignment were used to reduce threats to the study's internal validity, there were other design factors which decreased experimental control of the study. First, each of the covariates were constructs that were not able to be manipulated by a researcher (e.g. gender, religious orientation, etc.). While it is a strength to be able to include these constructs which have some theoretical support for inclusion in the analysis, their inclusion reducing experimental control over the variability of the constructs, which is a threat to the internal validity of the study. This loss of control over the covariates means that variance within a given construct could be accounted for by some extraneous variable. For example, scores in spiritual competence could actually be a function of an individual's professional training, which was not accounted for in this study. The attempt to include a large number of variables related to spirituality and religiosity was done to help account for the possibility of extraneous variables. However, there were a number of factors (e.g. personality, affect, etc.) that were not measured which may be important in a study such as this.

The nature of the study did not lend itself to a longitudinal analysis due to the cost and time involved. Rather, it was a cross-sectional, time-limited view into a single point in history. A more precise determination of the impact of participants' religiosity or spirituality might involve tracking participants' subjective experience of their faith to determine if their treatment of clients changes when there are feeling more or less fulfilled by their faith. Additionally, the study only included three, somewhat vague, religious orientations. Ideally, it would have been preferable to include more specific and inclusive labels for client religions, but this would have made meaningful comparisons difficult as it would impact statistical power. Also, the length of time taken to complete the surveys was about 27 minutes. Because the invitation sheet stated that it would take between 15-25 minutes, it is possible that some participants were frustrated and either quit the survey prematurely or whose negative affect impacted their responses later in the survey. Lastly, the participants were not randomly selected from the population of doctoral-level psychologists. They were solicited online largely through APA-accredited doctoral training program and internship listservs, as well as groups psychologists representing spiritual and religious diversity. Even in the latter attempt to garner a diverse sample, there were very few participants representing less popular religious orientations in the United States, which limits the study's generalizability. Similarly, the main analysis sampling procedures did not return the intended religious and spiritual diversity. While having the majority of religious participants identify as some form of Christian may be more generalizeable to the U.S. landscape, having so few Buddhist, Muslim, or other faith groups represented may have skewed the results.

The pilot study was sensitive to a number of methodological weaknesses. As mentioned earlier, although principle components analysis was only one of three tools in preparing the SARAS and the RS, general recommendations have indicated that small sample sizes like this,

are subject to instability, and therefore possibly unreliable results. Additionally, experts were consulted in each of the religious areas studied, but only 2 per faith tradition. There could be many more perspectives on how a client from one of the three religious orientations would realistically present. Lastly, the participants for the pilot study were mostly students, many of whom were only starting out with their clinical work, which could have biased the results for the items to be unrepresentative of more advanced clinicians and students.

There were also several strengths and weaknesses included in the statistical analyses conducted. First, transforming variables to increase linearity can also make interpretations non-meaningful or else very difficult draw conclusions from, but retaining the original skewed or kurtotic data in an analysis decreases power of the analysis, possibly masking significant effects (Tabachnick & Fidell, 2007). The decision to retain the transformed data was informed by the caution that some have given for researchers to utilize transformations to maximize significance of statistical tests at the possible expense of losing the ability to interpret the results. Although the philosophical rationale to transform skewed data is often generally practiced and accepted among social science research, the limitations of this methodology are equally consistent, in that transformations for the sake normality, can obscure an attempt to make meaningful sense out of the result, particularly as the common methods of data transformation ultimately bend the data into a curvilinear shape. However, it is also true that transformed data can be meaningfully interpreted when the standardized values are used. Therefore, interpretations related to spiritual competence were based on standardized values.

For the MANCOVA, bivariate correlations among dependent variables (GAF and Attribution for the problem) and some covariates with dependent variables were not all significant. However, there was theoretical rationale for including the three dependent constructs

together as an index of "clinical judgment" given the previous literature which has used these factors correlate with RS scores; Cause of problem did not correlate with the SCS or the RS). However, each covariate correlated with at least one other dependent variable. Given the theoretical rationale for including each construct, and to conserve power and reduce experiment-wise error, the constructs were included together in a single MANCOVA. Once again, this decision increased the likelihood of making a type II error, possibly masking significant effects. The inflations in type II error were combated by reporting marginal effects found in the study (*p*-values between .05-.10), many of which may represent real effects. Also, Fisher's least significant difference test (LSD) was used for planned comparisons rather than the more conservative Bonferroni adjustment.

Although statistical significance was found in the simple differences for the first hypothesis (worse prognosis for Christians than either Buddhist of not identified groups), using Fisher's LSD method could have overestimated the effect. When using a Bonferroni adjustment, statistical significance was lost for both comparisons, $p > .05$. Given the criticisms with Bonferroni comparisons being used in a single study with multiple hypotheses on a single set of data, it is difficult to determine how meaningful these data might be. As Perneger (1998) suggested, Bonferroni adjustments do help decrease inflation of Type I error, however, that effect also increases the likelihood of increasing Type II error. Given the aforementioned threats to Type II error inflation, Bonferroni adjustments were not used. When multiple comparisons are rooted in exploratory hypotheses, such as those for the present study, using Bonferroni adjustments may mask effects that, with more refined theory and research, could be better researched and documented in future studies (Perneger, 1998). Given that no study to date has combined these four religious conditions experimentally while simultaneously exploring

therapist religious identification, using Bonferroni corrections may have provided too conservative an estimate for the effects. In combination with lower power for many of the comparisons, Bonferroni corrections to p-values could have suppressed a significant effect as well, making Bonferroni adjustments even more of a threat to masking significant effects. These decisions were ultimately made in order to balance the inflation of both Type I and Type II errors. Previous work in counseling process and outcome have utilized similar procedures to work through this balance (Hill, Roffman, Stahl, Friedman, Hummel, & Wallace, 2008).

Variables Studied

One important point when interpreting these data is that the prognosis scores have not been generalized to "real life" scenarios, but were developed by previous researchers (Bowers & Bieschke, 2005) to study variables that may influence a therapist's impressions of a client. Finding that higher scores of spiritual competence related to prognosis perhaps encourages more questions than answers. Theoretically, there is not evidence to suggest this should be the case.

As far as the moderation analysis of spiritual competence and client religious orientation, there was not statistically significant evidence for the mean differences between either GAF scores or attribution for the problem (cause), however due to the limitations of the study's procedures it is possible that the effect was suppressed. Again, retaining the original variable scores for the GAF and prognosis scores could have suppressed effects given that these dependent constructs were skewed and kurtotic data respectively. The strength of retaining the original data is that the results can be interpreted and applied in a more generalizable fashion, however the statistical analysis is sensitive to these assumptions so could mask particularly small effects that may exist (Tabachnick & Fidell, 2007). Also, the moderation analysis was conducted by constructing two variables somewhat artificially. The first was religious/non-religious

therapists, which seemed to have the best empirical connection to the clinical judgment factors. However, as mentioned elsewhere, this label may not be very meaningful without additional qualitative information, given the wide variance within a label of "religious" or "non religious." The spiritual competence scale is relatively new in the field and has undergone scant empirical investigations. Along those lines, the SCS total score was used given the theoretical reasoning for its use; however a confirmatory factor analysis has not yet been conducted to verify the hierarchical factor structure of the scale. Conducting a CFA on these data was beyond the scope of this project, but will be used in combination with the author of the SCS for on-going data collection to support a future CFA for the total scale. Because the empirical construct evidence, at least at this time, does not support use of the total score, implications drawn from this construct should be done with caution. One additional point is that social desirability was not controlled in the present study due to a previous study finding that the spiritual competence scale was not sensitive to social desirability (Robertson, 2009). However, due to the nature of the present study's use of the spiritual competence construct, it may have been possible that socially desirable responding influenced participants' ratings of the vignettes.

The pilot study was intended to strengthen the psychometric properties of the Religion Scale (Bardis, 1961) as well as to provide preliminary estimates of the usefulness that the Spiritual and Religious Antagonism Scale (SARAS) might hold for use in the present study. Part of the pilot study procedures involved factor analysis using a very small sample (n=51). Although it is generally not recommended to base decisions related to scale development on factor analytic work on samples fewer than 100 participants, the criticism is due to the effect that adding to the sample size could cause items to flip from factor to factor. For this reason, factor analysis was not the only tool utilized to make decisions about the items and scales. Reliability

coefficients, item-to-total correlations, and reliance upon 6 experts in the areas of theology and religion (of Christian, Catholic, Muslim, and Buddhist backgrounds) also helped make the decisions to pair the scales down.

Lastly, while there were many spiritual/religious constructs examined in the present study, it was not possible to include all constructs. Follow up studies might investigate constructs such as spiritual quest, which has been associated with increased tolerance and flexibility in thought, on clinical judgment. Likewise, literature exploring the attachment to God construct, is only beginning to burgeon as it applies to the counseling relationship. Counselor and client attachments to spiritual or religious figures or beliefs was not directly assessed, and certainly not in a way consistent with the attachment framework (see Kirkpatrick, 1997 for an introduction).

Counseling Implications

Overall, the cumulative effects of these data ranged from small-to-moderate, with the majority of the data pointing toward a difference related solely to participants' prognostic ratings of the vignettes. Apart from the intended purpose of the study, these data also revealed an unintended effect of gender on clinical judgment. While a great deal of literature has explored gender and gender role beliefs related to conceptualization of differently gendered clients, the integration of spiritual and religious factors has seldom been included. Furthermore, there was surprisingly little research exploring how the gender of a therapist might specifically relate to clients' prognosis. The finding in these data revealed a moderate effect size among of the effect of gender on prognosis (Eta squared =.07), which was among the strongest effect sizes among the other factors. Counselors and researchers alike may explore whether the finding in the present study is worth exploring for training or clinical purposes. Some have noted that women are socialized to be warmer and more nurturing than men, attending more often to enhancing

others' self-worth (Book, 2000; Rosner, 1995). However, it seems very little has been done to explore whether these differences in gender role or sex may impact clinical judgment among doctoral-level therapists. A such, counselors are encouraged to examine the impact that their own cultural understanding of what it means to be a man or a woman as it relates to their clinical work. While this study is limited in its ability to clearly expand on reasons for the gender difference found, counselors should simply note that, among this limited sample, preliminary evidence indicated that women tended to provide more optimistic prognoses for the clients, irrespective of the clients' religious orientation, their own spiritual/religious orientation and beliefs, or their spiritual competence.

There are three main counseling implications related to the planned hypotheses of the present study. Counseling implications can be made from these results in these areas: (1) Counselors should become aware of their own spiritual/religious beliefs; (2) Counselors should be prepared to more critically evaluate the extent to which their own belief systems and behaviors related to spirituality/religiosity may impact their clinical practice; and (3) Counselors are encouraged to explore the constructs of spiritual competence, religious worldview, and spiritual/religious antagonism when exploring their understanding of clinical judgment, particularly as it relates to religious clients.

Clinician Self-Awareness

The first point relates to conceptualizations of spirituality and religiosity. In the present study, simplistic identifications as Christian for example, did not have robust effects on the clinical judgment factors. With the exception of the dummy-coded religious orientation factor for participants (religious belief system vs. no religious beliefs system) on prognosis ($\eta^2 = .03$), categorical beliefs of counselors were not a significant factor for this sample. Rather, more

precise explorations of spirituality and religiosity were found to relate to the participants' clinical judgment. Specifically, spiritual/religious antagonism had a significant and negative effect on the combined clinical judgment factors (η^2 =.07), which was driven entirely by the univariate effect on causal attribution for the client's problem (η^2 = .06), so increased antagonism was associated with blaming the client more for responsibility for the cause of the problem. Spiritual competence also had a significant impact on the combined clinical judgment factors (η^2 = .08), which was driven by the significant univariate effects on GAF (η^2 = .03), indicating that increased spiritual competence related to higher GAF scores, and prognosis (η^2 = .05), where higher spiritual competence was associated with more optimistic prognosis. Organizational religiosity also had a unique main effect on clinical judgment (η^2 = .05), driven by the univariate impact on GAF scores, suggesting that increase participation in organizational religion was associated with higher GAF scores (η^2 = .05). Nonorganizational religiosity also had a significant main effect on clinical judgment (η^2 = .06), accounted for by the negative association with prognosis (η^2 = .04). Intrinsic religiosity, or the practice of religion without extrinsic motivation, was also significantly related to the clinical judgment factors (η^2 = .05), which was accounted for by a significant and positive association with prognosis (η^2 = .02) and a marginally significant negative effect on causal attribution, such that increased intrinsic religiosity trended toward conceptualizing the problem to be more under the control of the client. Although religious worldview did not have significant main effect on clinical judgment, it did have a marginally significant negative impact on GAF scores, with those reporting an increased religious worldview tending to assign lower GAF scores across vignettes (η^2 = .05).

None of the effect sizes for individual variables were in the "large" range, with the highest effect of .08 (spiritual competence). Still, these findings should implore clinicians to

consider the number of ways that a person's spiritual or religious beliefs can be represented and how each of those representations may lend itself to a different lens through which a client's treatment may be viewed. Trends in training programs have tended to emphasize the benefit of acknowledging existing cultural factors among clinicians, and how those factors (and the associated beliefs or attitudes) might impact the counseling process. The present study reveals some evidence to say that, a counselor's personal religious or spiritual belief systems, practice of those systems, and comfort integrating spirituality in the therapy room, may have implications in how that person forms clinical impressions of that client.

Awareness of Client Context

The second point expands on the first, emphasizing that not only should counselors be self-aware of their own spiritual/religious beliefs , practices, and comfort integrating spirituality in therapy, but become more aware of how those realities may impact (or not impact) that counseling process. As others have pointed out, clinicians who reduce client concerns and simplify the context surrounding the client's issues may be more inclined to misjudge a client (Spengler & Strohmer, 1994). These data specifically point to implications this might have on a client's historical process (causal attribution for the problem), present distress (GAF), or future response to treatment (prognosis). Counselors are encouraged to engage in introspection and thoughtful reflection on how their own impressions of religion and spirituality may influence their understanding and treatment of clients with and without spiritual backgrounds, for better or worse. Theoretically, it is through this type of experiential exercise that implicit bias can move from our unconscious awareness, where they are difficult to change, into our conscious awareness, where they may be more reasonable to be changed (Bermudez, 1997). Comparisons based on racial/ethnic biases have found more contemporary courses, injected with experiential

activities, to actually improve learning outcomes in courses focused on pluralistic psychology (Hansen & Williams, 2003). Clinical supervisors, training directors, and academic programs may consider using these techniques to help reduce the impact cultural biases related to religion and spirituality may have.

Competence

The third and final recommendation is that counselors should explore three relatively novel constructs used in the present study which had either significant or marginal effects on the clinical judgment indicators. First, the construct of spiritual competence has recently been presented as one culturally-specific factor of importance for culturally sensitive counseling. As Helms (1994), global cultural competence is an insufficient construct when exploring specific effects on specific cultures. The instrument used for spiritual competence (SCS; Robertson, 2009) is the only of its kind in peer-reviewed studies and those clinicians who appreciate the benefit of scholarship on clinical practice may be rewarded by reviewing this instrument and the construct it represents. This study suggests that individuals with higher levels of spiritual competence may particularly be able to more readily engage in the "shifting standards" effect posited by Gushue (2004), whereby the more spiritually competent individual is more ready, and theoretically more accurately, to associate the client's spiritual beliefs, practices, and/or worldview with psychological strengths.

Spiritual and religious antagonism was connected with a tendency to assign blame to the client rather than an environmental or external stimulus. Counselors are encouraged to monitor the extent to which they hold antagonistic views toward spirituality and religion. An honest reflection of these biases is the first step, but they are also encouraged to consider how their conceptualization of a client's presenting concerns might be impacted by their own spiritual or

religious antagonism. Perhaps skeptics of spirituality or religion are also skeptical of extraneous influences on clients' development of psychological distress. While this study does not investigate this directly, future researchers and clinicians are encouraged to follow up on this finding to determine whether it holds any ecological validity in non-experimental contexts.

Furthermore, religious worldview had a marginally significant negative trend for GAF scores. That is, those who hold a more strict religious worldview, or understanding of how the world should be as a result of their religious beliefs, also tended to rate the client vignettes with lower GAF scores. Clinicians who find themselves with more rigid understandings of how their own religion may relate to their beliefs about themselves, others, and the world around them are encouraged to monitor whether they may be more prone to a harsher judgment of individuals professing psychological disturbance or individuals professing non-pious behaviors who present for services. Biased GAF scores may be one way for some clinicians to engage in a micro-aggression against an individual perceived to be either a "black sheep," holding similar beliefs yet engaging in behavior that contradicts those beliefs, or a more pure "out group" label for individuals who profess different beliefs. Further research on this construct is needed, particularly as it applies to clinical judgment of counselors.

Coupled with the data suggesting that a more optimistic prognosis was also positively influenced by spiritual competence and negatively by both intrinsic and non-organizational religiosity, practitioners are encouraged to reflect deeply and broadly about the impact that a client's religious identification coupled with their own religious labels and beliefs might hold for their own clinical practice. These data are quantitative in nature, so they do not provide the qualitative, "between-the-cracks" information that can be discovered during thoughtful reflection and discussion with colleagues and clients. Clinicians are encouraged to examine themselves

carefully to determine in what way their own spiritual beliefs, values, and practices may influence their impressions of their clients.

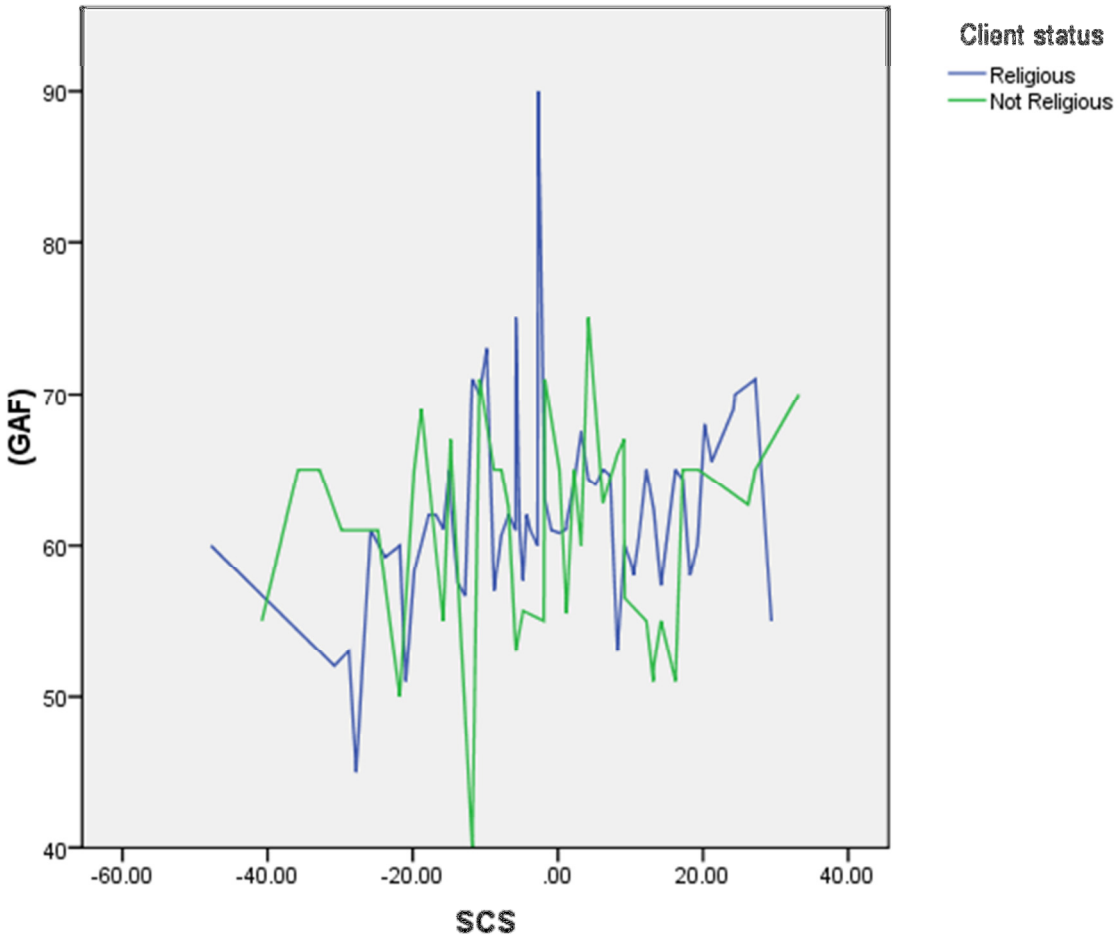

Figure 1. *Moderation Analysis for GAF*

SCS = Spiritual Competence Score

GAF = Global Assessment of Functioning

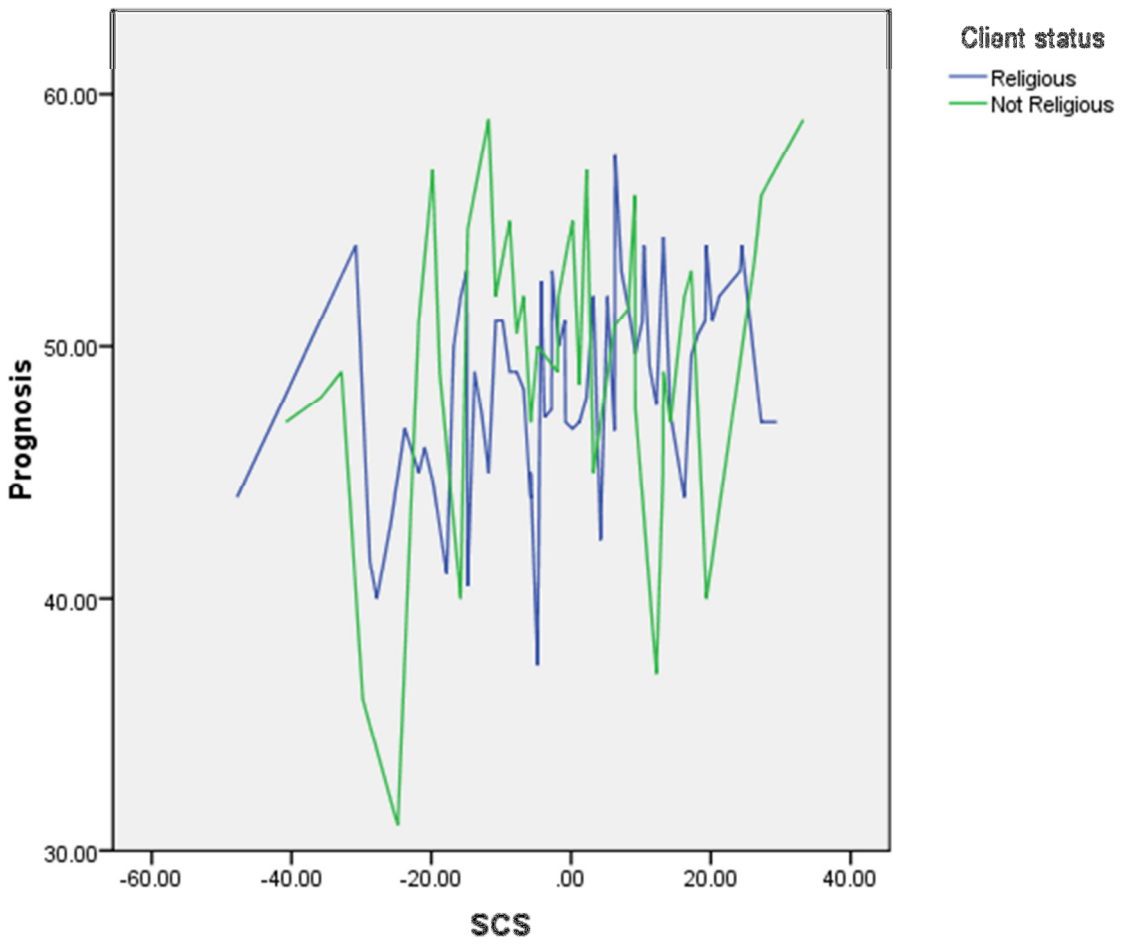

Figure 2. *Moderation Analysis for Prognosis*

SCS = Spiritual Competence Score

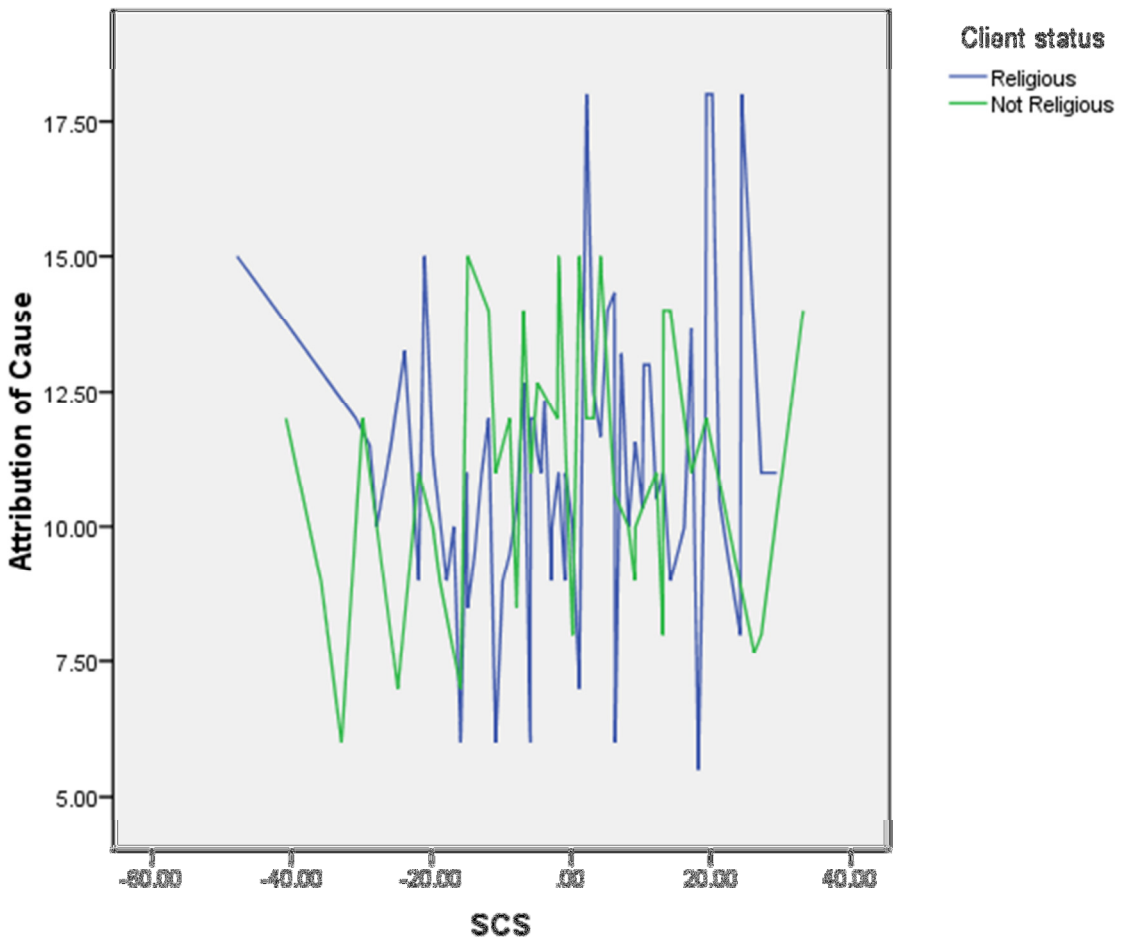

Figure 3. *Moderation Analysis for Attribution for Problem (Cause)*

SCS = Spiritual Competence Score

APPENDIX A

DEMOGRAPHIC QUESTIONNAIRE

Please answer the following questions as directed.

1. Age___

2. Gender___

3. Sexual Orientation____

4. Race/Ethnicity_____

5. Student___ or Licensed Psychologist___ or Other (please specify)_____

6. Years of clinical work (including practicum and internship)_____

7. Highest degree earned PhD, PsyD, etc.)_____

8. Degree working toward (PhD, PsyD, M.A., Ed. D)____

9. Most recent Primary Clinical Setting seeing clients____

College counseling center__

Hospital__

Private practice__

Community Mental Health Center__

Other (specify)__

10. Estimated number of clients seen per week___

11. SES (annual household income) *Circle one.*
0-10,000
10,000-20,000
20,000-30,000
30,000-50,000
50,000-75,000
75,000-100,000
100,000+

12. What is your religious preference? (select as many as you need)

1. Catholic

2. Protestant
3. Other Christian (please specify)_____
3. Jewish
4. Muslim
5. Hindi
6. Buddhist
7. Sikh
8. No *organized* religion
9. No religion
10. Atheist
11. Agnostic
12. Other, please specify_____

13. What is your primary theoretical orientation? (select one).

1. Person Centered
2. Cognitive or Cognitive-Behavioral
3. Behavioral
4. Existential
5. Psychodynamic or psychoanalytic
6. Interpersonal
7. Feminist
8. Other (specify)

APPENDIX B

DUKE RELIGION INDEX

Directions: Please answer the following questions about your religious beliefs and/or involvement. Please indicate your answer with a checkmark.

1. How often do you attend church or other religious meetings?

    1. More than once a week
    2. Once a week
    3. A few times a month
    4. A few times a year
    5. Once a year or less
    6. Never

2. How often do you spend time in private religious or spiritual activities, such as prayer, meditation, or Bible study?

    1. More than once a day
    2. Daily
    3. Two or more times/week
    4. Once a week
    5. A few times a month
    6. Rarely or never

The following section contains 3 statements about religious belief or experience. Please mark the extent to which each statement is true or not true for you.

3. In my life, I experience the presence of the Divine (i.e. God, Allah, Jehovah, etc.)

    1. Definitely true of me
    2. Tends to be true
    3. Unsure

4. Tends not to be true

5. Definitely not true

4. My religious or spiritual beliefs are what really lies behind my whole approach to life.

1. Definitely true of me

2. Tends to be true of me

3. Unsure

4. Tends not to be true

5. Definitely not true

5. I try hard to carry my religion or spirituality over into all other dealings in life.

1. Definitely true of me

2. Tends to be true of me

3. Unsure

4. Tends not to be true

5. Definitely not true

APPENDIX C

RELIGION SCALE (Bardis, 1961) AND REVISION

Directions: Below is a list of issues concerning religion. Please read all the statements very carefully and respond to all of them on the basis of your own true beliefs, without consulting any other persons. Do this by reading each statement and then writing in the space provided at its left, only one of the following numbers: 0,1,2,3,4. The meaning of each of these figures is:

0=strongly disagree
1=disagree
2=undecided
3=agree
4=strongly disagree

*Original items are listed with altered items in italics below the original item.

Please note: God refers to any reference of a higher power that you may believe in. Please substitute your personal name for God in these items if that makes it more applicable to you (Allah, Jehovah, Goddess, Great Spirit, etc.)

__1. A sound religious faith is the best thing in life

__2. Every school should encourage its students to attend church
**Psychologists should encourage their clients to attend religious services*

__3. People should defend their religion above all other things

__4. People should attend church once a week if possible
**People should attend religious services once a week if possible*

__5. Belief in God makes life more meaningful

__6. Every person should give 10 percent of his income to his church
**Every person should financially support his or her religious organization*

__7. All people are God's children

__8. People attending church regularly develop a sound philosophy of life
**People attending church or religious services regularly develop a sound philosophy of life*

__9. We should always love our enemies

__10. God rewards those who live religiously

__11. Prayer can solve many problems

__12. Every school should have chapel services for its students
**Every counselor education program should expose its students to spiritual/religious matters*

__13. There is life after death

__14. People should read the Scriptures at least once a day
**People should read religious texts at least once a day*

__15. Teachers should stress religious ideals in class
**Psychologists should stress religious ideals with clients*

__16. Young people should attend Sunday School regularly
**Psychologists need more exposure to religious teachings*

17. People should pray at least once a day

__18. A religious or spiritual wedding ceremony is better than a civil one

__19. Religious people should try to spread the teachings of the Scriptures
**Religious people should try and spread the teachings of their belief system*

__20. People should say grace at all meals

__21. When a person is planning to be married, he should consult his minister, priest, or rabbi
**When a person is planning to be married, he/she should consult a minister, priest, rabbi, imam, or other religious expert of his/her faith tradition*

__22. Delinquency is less common among young people attending religious services regularly

__23. What is moral today will always be moral

__24. Children should be brought up religiously

__25. Every person should participate in at least one church activity
**Every person should participate in at least one religious or spiritual activity.*

APPENDIX D

SPIRITUAL AND RELIGIOUS ANTAGONISM SCALE (SARAS)

Below is a list of issues concerning religion and spirituality. Please read all the statements very carefully and respond to all of them on the basis of your own true beliefs, without consulting any other persons. Do this by reading each statement and then writing in the space provided at its left, only one of the following numbers: 0,1,2,3,4. The meaning of each of these figures is:

0=strongly disagree
1=disagree
2=undecided
3=agree
4=strongly disagree

Pilot test items

1. I find myself avoiding very religious people
2. I am interested to hear what religious fundamentalists have to say
3. It is easy for me to be in the company of those with conservative religious values
4. I often find myself becoming annoyed with spiritual interpretations of social or scientific realities
5. I tend to ignore opinions of people who are very rigid in their spiritual beliefs or practices
6. I go out of my way to learn about faith traditions different from my own
7. I value deep explanations of spiritual or religious matters
8. I like most of the religious people I know
9. Most of my friends do not embrace a traditional religion
10. I think religion is more of a way of controlling people than freeing them
11. If a God exists then he (or she) probably opposes all religions
12. I don't care much for spiritual matters
13. If there is a higher power I don't believe it's worth knowing
14. I find it difficult to believe that we are all spiritually connected
15. Spiritual explanations of phenomena can always be better explained by science
16. Spirituality is best understood as a coping mechanism
17. In my experience, firm religious beliefs are often more indicative of psychopathology than mental health
18. Society should encourage more commitment to spirituality than is currently the norm
19. I tend to ignore or disagree with people with strong spiritual orientations

SARAS 12-item version

1. I find myself avoiding very religious people
2. I often find myself becoming annoyed with spiritual interpretations of social or scientific realities
3. I tend to ignore opinions of people who are very rigid in their spiritual beliefs or practices
4. I like most of the religious people I know
5. Most of my friends do not embrace a traditional religion
6. I think religion is more of a way of controlling people than freeing them
7. If a God exists then he (or she) probably opposes all religions

8. I don’t care much for spiritual matters
9. If there is a higher power I don’t believe it’s worth knowing
10. Spiritual explanations of phenomena can always be better explained by science
11. Spirituality is best understood as a coping mechanism
12. I tend to ignore or disagree with people with strong spiritual orientations

APPENDIX E

VIGNETTE DESCRIPTIONS

Please read the intake report below as if you were assigned to work with this client for individual therapy. Following the report, you will be asked to respond to a series of questions about your impressions of this case. You will not be able to return to the description after you advance to the next screen.

Control Vignette

Abe, a 22 year-old graduate student at a local university, has been assigned to you for therapy. His intake counselor provided the data below for you to review prior to your first session.

Demographic Data
Abe is in his first year of a graduate program in creative writing. He left the race/ethnicity item blank. He grew up with his mother in an urban environment and described their SES as low-middle class. His father left the family when Abe was 9 years-old. He described his father as distant and cold through his childhood. He worked his way through his undergraduate education and was recently (6 months ago) awarded a prestigious fellowship to support his first year of graduate education. In an open-ended prompt for his sexual preference he wrote "strongly heterosexual."

Presenting Concerns
He was referred to therapy by a concerned friend due to a recent change in his affect and behavior including a noticeable increase in irritability, a discussion of guilty feelings, and loss of appetite. Abe said that he has he has not been living his life the way he wants to live and has numerous regrets including "pushing away" a romantic interest during his last year of college by constantly nagging her to engage in sexually intimate behavior knowing she wanted to wait until marriage. He reported brief suicidal ideation about eight months ago, which included a vague plan to "escape this hell," in reference to his girlfriend breaking up with him. He explained that he feels most guilty about treating his ex-girlfriend "like trash" and now that she is dating another man he is starting to lose sleep, now down to only 4-5 hours a night from his normal 8 hours. Abe's distress level has increased recently because he had a sudden realization that he and his ex-girlfriend are "meant to be together."

Social Context
Abe graduated from college about six months ago and started his new graduate program this week. His father also attempted to reconcile with him after he started his current graduate program, which Abe believes is simply a selfish act on his father's part. He repeatedly stated that he wished his dad would just "go away" and leave him and his family alone. He has lived with one friend for the past two years who he described as his "closest" friend; this is the person who referred Abe to counseling. (no spiritual interpretation)

Family Background
Abe reported that before his father left his mother 13 years ago, his family was somewhat chaotic. His father had "unrealistic expectations" for the family and his parents often fought about his mother's desire to work outside of the home. He recalled several times hearing his

father belittling his mother after they had gone to bed. He said he was glad that his father left even though it made his mother unhappy because of the financial strain. He reported good relationships with his mother and sister currently, although he reported some guilt for "not being a good son and brother" to them. He clarified this by saying he does not visit or call them as much as he believes they would like.

Medical History
Abe had no significant medical history to report. He reported no history of physical or sexual abuse in his family. He is currently not taking any medications and has never seen a mental health clinician before.

Sources of Support
Although his contacts with several of his sources of social support (e.g., mother and sister) has diminished recently, Abe said that he still spends time with friends, particularly his roommate, several times a day and that he often feels better after these occurrences, but not always. He also exercises regularly because he believes that it will make him a stronger person, which he expressed with the phrase "no pain, no gain." He is also an avid reader and spends lots of time reading works by his favorite authors.

Goals for Therapy
Abe wants to better understand why he is so irritable and how to become "happy," something his ex-girlfriend accused him of being "incapable" of. He believes his guilty feelings are appropriate for his past behavior toward his ex-girlfriend and he expressed that while the feelings are preoccupying his thoughts, he does not want to get rid of them in order to be a better person in the future ("I deserved to be punished for being such a jerk"). He also expressed thinking that being remorseful may be the only way to get his girlfriend back. Lastly, he would like figure out how to be a better son and brother to his mother and sister.

Christian Vignette

Abe, a 22 year-old graduate student at a local university, has been assigned to you for therapy. His intake counselor provided the data below for you to review prior to your first session.

Demographic Data
Abe is in his first year of a graduate program in creative writing. He left the race/ethnicity item blank. He grew up with his mother in an urban environment and described their SES as low-middle class. His father left the family when Abe was 9 years-old. He described his father as distant and cold through his childhood. He worked his way through his undergraduate education and was recently (6 months ago) awarded a prestigious fellowship to support his first year of graduate education. In an open-ended prompt for his sexual preference he wrote "strongly heterosexual." He identified a strong religious identification as Christian.

Presenting Concerns
He was referred to therapy by a concerned friend due to a recent change in his affect and behavior including a noticeable increase in irritability, a discussion of guilty feelings, and loss of

appetite. Abe said that he has he has not been living his life the way he wants to live and has numerous regrets including "pushing away" a romantic interest during his last year of college by constantly nagging her to engage in sexually intimate behavior knowing she wanted to wait until marriage. He reported brief suicidal ideation about eight months ago, which included a vague plan to "escape this hell," in reference to his girlfriend breaking up with him. He explained that he feels most guilty about treating his ex-girlfriend "like trash" and now that she is dating another man he is starting to lose sleep, now down to only 4-5 hours a night from his normal 8 hours. Abe's distress level has increased recently because he had a sudden realization that he and his ex-girlfriend are "meant to be together" and believes God told him this during a recent prayer time.

Social Context
Abe graduated from college about six months ago and started his new graduate program this week. His father also attempted to reconcile with him after he started his current graduate program, which Abe believes is simply a selfish act on his father's part. He repeatedly stated that he wished his dad would just "go away" and leave him and his family alone. He has lived with one friend for the past two years who he described as his "closest" friend; this is the person who referred Abe to counseling.

Family Background
Abe reported that before his father left his mother 13 years ago, his family was somewhat chaotic. His father had "unrealistic expectations" for the family and his parents often fought about his mother's desire to work outside of the home. This conflict was based on their different interpretations of the Bible. He recalled several times hearing his father belittling his mother after they had gone to bed. He said he was glad that his father left even though it made his mother unhappy because of the financial strain. He reported good relationships with his mother and sister currently, although he reported some guilt for "not being a good son and brother" to them. He clarified this by saying he does not visit or call them as much as he believes they would like.

Medical History
Abe had no significant medical history to report. He reported no history of physical or sexual abuse in his family. He is currently not taking any medications and has never seen a mental health clinician before.

Sources of Support
Although his contacts with several of his sources of social support (e.g., mother and sister) has diminished recently, Abe said that he still prays regularly, several times a day, and that he often feels better after these occurrences, but not always. He also fasts (gives up eating but still drinks fluids) a few days a month, which he believes makes him a stronger person internally. His motto is "No pain gain." Lastly, he said that he spends lots of time reading the Bible.

Goals for Therapy
Abe wants to better understand why he is so irritable and how to become "happy," something his ex-girlfriend accused him of being "incapable" of. He believes his guilty feelings are appropriate for his past behavior toward his ex-girlfriend and he expressed that while the feelings are

preoccupying his thoughts, he does not want to get rid of them in order to be a better person in the future ("I deserved to be punished for being such a jerk"). He also expressed thinking that being remorseful may be the only way to get his girlfriend back. Lastly, he would like figure out how to be a better son and brother to his mother and sister.

Muslim Vignette

Abe, a 22 year-old graduate student at a local university, has been assigned to you for therapy. His intake counselor provided the data below for you to review prior to your first session.

Demographic Data
Abe is in his first year of a graduate program in creative writing. He left the race/ethnicity item blank. He grew up with his mother in an urban environment and described their SES as low-middle class. His father left the family when Abe was 9 years-old. He described his father as distant and cold through his childhood. He worked his way through his undergraduate education and was recently (6 months ago) awarded a prestigious fellowship to support his first year of graduate education. In an open-ended prompt for his sexual preference he wrote "strongly heterosexual." He identified a strong religious identification as Muslim.

Presenting Concerns
He was referred to therapy by a concerned friend due to a recent change in his affect and behavior including a noticeable increase in irritability, a discussion of guilty feelings, and loss of appetite. Abe said that he has he has not been living his life the way he wants to live and has numerous regrets including "pushing away" a romantic interest during his last year of college by constantly nagging her to engage in sexually intimate behavior knowing she wanted to wait until marriage. He reported brief suicidal ideation about eight months ago, which included a vague plan to "escape this hell," in reference to his girlfriend breaking up with him. He explained that he feels most guilty about treating his ex-girlfriend "like trash" and now that she is dating another man he is starting to lose sleep, now down to only 4-5 hours a night from his normal 8 hours. Abe's distress level has increased recently because he had a sudden realization that he and his ex-girlfriend are "meant to be together" and believes Allah told him this during a recent prayer time.

Social Context
Abe graduated from college about six months ago and started his new graduate program this week. His father also attempted to reconcile with him after he started his current graduate program, which Abe believes is simply a selfish act on his father's part. He repeatedly stated that he wished his dad would just "go away" and leave him and his family alone. He has lived with one friend for the past two years who he described as his "closest" friend; this is the person who referred Abe to counseling.

Family Background
Abe reported that before his father left his mother 13 years ago, his family was somewhat chaotic. His father had "unrealistic expectations" for the family and his parents often fought

about his mother's desire to work outside of the home. This conflict was based on their different interpretations of the Koran. He recalled several times hearing his father belittling his mother after they had gone to bed. He said he was glad that his father left even though it made his mother unhappy because of the financial strain. He reported good relationships with his mother and sister currently, although he reported some guilt for "not being a good son and brother" to them. He clarified this by saying he does not visit or call them as much as he believes they would like.

Medical History
Abe had no significant medical history to report. He reported no history of physical or sexual abuse in his family. He is currently not taking any medications and has never seen a mental health clinician before.

Sources of Support
Although his contacts with several of his sources of social support (e.g., mother and sister) has diminished recently, Abe said that he still prays regularly, several times a day, and that he often feels better after these occurrences, but not always. He also fasts (gives up eating but still drinks fluids) a few days a month, which he believes makes him a stronger person internally as he can train his body. His motto is "no pain no gain." Lastly, he said that he spends lots of time reading the Koran.

Goals for Therapy
Abe wants to better understand why he is so irritable and how to become "happy," something his ex-girlfriend accused him of being "incapable" of. He believes his guilty feelings are appropriate for his past behavior toward his ex-girlfriend and he expressed that while the feelings are preoccupying his thoughts, he does not want to get rid of them in order to be a better person in the future ("I deserved to be punished for being such a jerk"). He also expressed thinking that being remorseful may be the only way to get his girlfriend back. Lastly, he would like figure out how to be a better son and brother to his mother and sister.

Buddhist Vignette

Abe, a 22 year-old graduate student at a local university, has been assigned to you for therapy. His intake counselor provided the data below for you to review prior to your first session.

Demographic Data
Abe is in his first year of a graduate program in creative writing. He left the race/ethnicity item blank. He grew up with his mother in an urban environment and described their SES as low-middle class. His father left the family when Abe was 9 years-old. He described his father as distant and cold through his childhood. He worked his way through his undergraduate education and was recently (6 months ago) awarded a prestigious fellowship to support his first year of graduate education. In an open-ended prompt for his sexual preference he wrote "strongly heterosexual." He identified a strong religious identification as Buddhist.

Presenting Concerns

He was referred to therapy by a concerned friend due to a recent change in his affect and behavior including a noticeable increase in irritability, a discussion of guilty feelings, and loss of appetite. Abe said that he has he has not been living his life the way he wants to live and has numerous regrets including "pushing away" a romantic interest during his last year of college by constantly nagging her to engage in sexually intimate behavior knowing she wanted to wait until marriage. He reported brief suicidal ideation about eight months ago, which included a vague plan to "escape this hell," in reference to his girlfriend breaking up with him. He explained that he feels most guilty about treating his ex-girlfriend "like trash" and now that she is dating another man he is starting to lose sleep, now down to only 4-5 hours a night from his normal 8 hours. Abe's distress level has increased recently because he had a sudden realization that he and his ex-girlfriend are "meant to be together" during an intense meditation session when he heard the Buddha saying this.

Social Context
Abe graduated from college about six months ago and started his new graduate program this week. His father also attempted to reconcile with him after he started his current graduate program, which Abe believes is simply a selfish act on his father's part. He repeatedly stated that he wished his dad would just "go away" and leave him and his family alone. He has lived with one friend for the past two years who he described as his "closest" friend; this is the person who referred Abe to counseling.

Family Background
Abe reported that before his father left his mother 13 years ago, his family was somewhat chaotic. His father had "unrealistic expectations" for the family and his parents often fought about his mother's desire to work outside of the home. This conflict was based on their different interpretations of the Buddhist tradition. He recalled several times hearing his father belittling his mother after they had gone to bed. He said he was glad that his father left even though it made his mother unhappy because of the financial strain. He reported good relationships with his mother and sister currently, although he reported some guilt for "not being a good son and brother" to them. He clarified this by saying he does not visit or call them as much as he believes they would like.

Medical History
Abe had no significant medical history to report. He reported no history of physical or sexual abuse in his family. He is currently not taking any medications and has never seen a mental health clinician before.

Sources of Support
Although his contacts with several of his sources of social support (e.g., mother and sister) has diminished recently, Abe said that he still prays and meditates regularly, several times a day, and that he often feels better after these occurrences, but not always. He also fasts (gives up eating but still drinks fluids) a few days a month, which he believes makes him a stronger person internally as he can train his body. His motto is "No pain no gain." Lastly, he said that he spends lots of time reading Buddhist texts and philosophy.

Goals for Therapy
Abe wants to better understand why he is so irritable and how to become "happy," something his ex-girlfriend accused him of being "incapable" of. He believes his guilty feelings are appropriate for his past behavior toward his ex-girlfriend and he expressed that while the feelings are preoccupying his thoughts, he does not want to get rid of them in order to be a better person in the future ("I deserved to be punished for being such a jerk"). He also expressed thinking that being remorseful may be the only way to get his girlfriend back. Lastly, he would like figure out how to be a better son and brother to his mother and sister.

Manipulation Check

Please select the best answer (select only one).

What was Abe's sexual orientation?
- Gay/Lesbian
- Heterosexual
- Strongly Heterosexual
- Bi-sexual
- Not identified

What was Abe's gender?
- Male
- Female
- Transgender

- Not identified

What was Abe's Religion?
- Christian
- Muslim
- Buddhist
- Not identified

What was Abe's Ethnicity?
- African-American
- Latino/Hispanic
- Caucasian
- Asian-American
- Not identified

APPENDIX F

ATTRIBUTION OF PROBLEM CAUSE AND SOLUTION SCALE

Please rank on a scale of 1 (*not at all*) to 7 (*very much*).

1. To what extent do you believe the client is personally responsible for the cause of his problems? __

2. To what extent do you believe the client could have controlled the cause of his problems? __

3. To what extent do you believe the client could have avoided the problems he has? __

4. To what extent do you believe the client is personally responsible for creating a solution to his problems? __

5. To what extent do you believe the client can overcome his problems by himself? __

6. To what extent do you believe the client can control the solution to his problems? __

APPENDIX G

COUNSELING PROGNOSIS ITEMS

Please rate on a scale of 1 (not at all) to 7 (very much).

1) How likely is it that Abe will improve with individual therapy?

2) How likely is it that Abe's relationship problems will improve with individual therapy?

3) How likely is it that Abe will require hospitalization during the course of individual therapy?

4) How likely is it that Abe will become actively suicidal during the course of individual therapy

5) How comfortable would you be if you were working with Abe in individual therapy?

6) How interested would you be to work with Abe in individual therapy?

7) I am confident the client will improve with therapy

8) I believe the client would improve without therapy

9) I believe I would be able to build a strong working alliance with this client

APPENDIX H

EXPLORATORY ITEMS

Diagnostic Questions

1. What would be your Axis I diagnosis?_____

2. What would be your Axis II diagnosis?_____

3. Axis III:_____

4. Axis IV:_____

5. To what extent do you believe Abe has a: Depressive Disorder

(definitely not) 1 2 3 4 5 6 7 (definitely sure)

6. To what extent do you believe Abe has an: Anxiety Disorder

(definitely not) 1 2 3 4 5 6 7 (definitely sure)

7. To what extent do you believe Abe has an: Adjustment Disorder

(definitely not) 1 2 3 4 5 6 7 (definitely sure)

8. To what extent do you believe Abe has a: Psychotic Disorder

(definitely not) 1 2 3 4 5 6 7 (definitely sure)

9. How confident are you in your diagnostic factors?

(definitely not) 1 2 3 4 5 6 7 (definitely sure)

Empathy

10) Please rate your sense of emotional connectedness to Abe after reading this vignette

1	2	3	4	5
None	Marginal	Moderate	Significant	Extremely connected

Sessions

11) How many sessions would you predict Abe needs to resolve his difficulties? ____

Other Clinical Judgment Indicators

1) This client is motivated for change

(definitely not) 1 2 3 4 5 6 7 (definitely sure)

2) This client is like me

(definitely not) 1 2 3 4 5 6 7 (definitely sure)

3) I believe I can help this client

(definitely not) 1 2 3 4 5 6 7 (completely)

APPENDIX I

E-MAIL TO LISTSERV COORDINATORS AND TRAINING DIRECTORS

Email Participation

Dear Dr. _____

My name is Dominick Scalise, and I am a doctoral candidate in the Counseling Psychology program at the University of Missouri-Kansas City. My adviser is Dr. LaVerne Berkel. I am seeking your assistance with recruiting participants for my dissertation. My study is assessing client and therapist cultural effects on therapists' conceptualizations of clients from different cultural backgrounds. This study has been approved by the UMKC Social Science Institutional Review Board (IRB# X100315).

If you would be willing to forward my complete email invitation to your student program's listserv I would be grateful! Please let me if this would be possible and I will forward you the official recruitment email.

Thanks very much,

Dominick Scalise
Counseling Psychology Doctoral Candidate
University of Missouri - Kansas City
5100 Rockhill Road Kansas City, MO 64110-2499

Email Recruitment for APA and Professional Listservs

Greetings Listserv Members,

My name is Dominick Scalise, and I am a doctoral candidate in the counseling psychology program at the University of Missouri-Kansas City. My adviser is Dr. LaVerne Berkel. I am seeking your assistance with my dissertation study by inviting you to participate in a study assessing therapists' conceptualizations of clients from different cultural backgrounds. This study has been approved by the UMKC Social Science Institutional Review Board (IRB# _____).

While a great of literature has examined the topic, there are still many questions about how clinicians with different perspectives of the counseling process may any given client. As many case conference discussion show, many times clinicians are not in agreement on a client's diagnosis, prognosis, and conceptualization of the problem. This study aims to explore both client and therapist factors involved in influencing therpists' decisions.

You are eligible to participate in this study if you (a) are 18 years of age or older, (b) are either a current licensed psychologist OR in a doctoral training program. Your participation would involve a 20-25 minutes of your time in reading an intake report and then answering several questions about your perception of the client followed by questions asking you about your own personal values and demographic indicators.

Participation in this study is completely voluntary, and you may discontinue participation at any time without penalty. Each participant will be able to enter a raffle drawing to win one of 3 $50 gift cards or chose to have $1 donated to a charity for his or her participation.

If you choose to participate in this study, you will make a significant contribution to research that may enhance counselor training and professional practice with prospective clients from different cultural groups. Your contribution may enable psychologists to develop and apply more effective methods for training students to work effectively with clients. There are no known risks or benefits to participating in the study.

If you are interested in participating in the study, please go to my website at _____

If wish to decline this invitation please click on the following link so I can track these data: _____

Please feel free to forward this email to any early career psychologists or graduate students who may be appropriate for this study.
If you'd like to contact me directly to ask questions about the study, please email me at dase54@umkc.edu or my dissertation chair, Dr. LaVerne Berkel, at dase54@umkc.edu. Thank you very much for your interest.

Sincerely,

Dominick Scalise, M.A.
Counseling Psychology Doctoral Candidate
University of Missouri - Kansas City
5100 Rockhill Road Kansas City, MO 64110-2499

APPENDIX J

IRB APPROVAL LETTER

Study 100315X: Assessing the roles of client religion, counselor religiosity and spiritual competence in counselors' clinical judgment

andermansh@umkc.edu [andermansh@umkc.edu]

Sent: Tuesday, June 01, 2010 12:35 PM

To: Scalise, Dominick A.

Cc: Anderman, Sheila H.; Anderman, Sheila H.; Berkel, LaVerne A.

June 1, 2010

Dominick Scalise
Department of Counseling and Educational Psychology
615 E. 52nd Street SOE RM 215
Kansas City, MO 64110

Dear Investigator:

Your research protocol IRB #100315X entitled, "Assesing the roles of client religion, counselor reigiosity and spiritual competence in counselors' clinical judgement" has been classified as exempt in accordance with exemption criteria #2 in the Federal Guidelines 45 CFR Part 46 as follows: "Research involving the use of educational tests (cognitive, diagnostic, achievement) survey procedures, interview procedures or observation of public behavior, unless: (i) information obtained is recorded in such a manner that subjects can be identified, directly or through identifiers linked to the subjects; and (ii) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation."

It is our understanding no identifiers will be used to link the patients with data collected.

Reapproval is also required and you are asked to submit a progress report before 4/6/11 if your project continues beyond this date. If your project is terminated earlier, a final report to the Review Board is required within 90 days.

Should you require additional information, please contact me at 816-235-5370.

Sincerely,

Sheila Anderman, CIP, CIM
Research Protections Program Manager
Social Sciences Institutional Review Board

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VITA

Dominick A. Scalise was born April 29, 1982 in San Luis Obispo, California. His family relocated to Owensville, Missouri in 1991 and after graduating high school in 2000, he accepted athletic and academic scholarships, playing football at Truman State University. In 2004, he earned a Bachelor of Arts in Communication: Journalism and a Master of Arts in Counseling: Community Counseling in 2006. After completing a graduate thesis exploring how cultural and developmental factors relate to counseling outcomes, he continued his graduate training by pursuing a Ph.D. in Counseling Psychology at the University of Missouri-Kansas City, working under the tutelage of Dr. LaVerne Berkel, who shared his interest investigating spiritual and religious factors as they relate to the counseling process. Altogether, he completed practica in six different settings including inpatient work with children and adults, university counseling centers, and outpatient work with veterans.

During his graduate training, he earned two publications and presented his research at conferences across the nation. He was supported by various fellowships, scholarships, assistantships, and grant monies during this time. Mr. Scalise completed his pre-doctoral internship at Texas A&M University's Student Counseling Service during the 2010-2011 academic year, completing his doctoral requirements in August of 2011. He accepted a position as a staff psychologist at the University of Maryland-College Park beginning in August of 2011, allowing him to practice counseling and psychotherapy, provide training and supervision to beginning counselors, and continue his research pursuits.