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Social workers' responses to religious clients

Lisa Marie Russek

SOCIAL WORKERS' RESPONSES TO RELIGIOUS CLIENTS

A Project

Presented to the

Faculty of

California State University,

San Bernardino

In Partial Fulfillment

of the Requirements for the Degree

Master of

Social Work

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by

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ABSTRACT

The present study examined social workers' responses to religious clients. It was hypothesized that social workers would give a more negative prognosis to religious clients than to non-religious clients. Subjects randomly received one of the two survey questionnaires. One group (RG) received surveys containing three vignettes with clients making reference to a religious orientation. The other group (NRG) received surveys containing the same three vignettes, except all references to a religious orientation were removed. There were no significant differences in the prognosis given to the three clients by both groups. However, the majority of subjects from both groups indicated that religion was an important issue to address within the clinical setting, although they indicated that religion was not often addressed within their social work education.

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Introduction

Religion appears to be a taboo subject area for social work as evidenced by the scarcity of discussion of religion in social work journals and in social work curriculum. Although social work ascribes to a holistic perspective, religion and spirituality appear to be an area that social work is reluctant to address. Even though issues pertaining to race, gender, and culture are extensively explored and discussed within the literature and curriculum of social work, religion and spirituality are relatively avoided, minimized, or ignored. Yet, religious teaching and principles are at the foundation of social work practice. Religious writings and teaching have inspired social work's ethics and values (Sanzanbach, 1989). Historically, religious organizations have been in the forefront of providing services to the disadvantaged, including the neglected, the dependent, and the elderly (Joseph, 1989). For instance, in the early history of organized relief, religious institutions and religious leaders were the primary administrators of charity. Subsequently, the diligent efforts of these religious organizations were recognized by the government, which in turn passed such legislation as the Elizabethan Poor Laws, helping the church with the cost and administration of relief (Leiby, 1978). In addition, religious values have significantly influenced the values and concepts of social work and social welfare (Leiby, 1978). According to Constable (1983), the values guiding the profession are "deeply embedded in concepts of human worth which are religious in origin but which, in recent history, have lost some of the original connotations" (p. 29). In fact, historically, the traditional Christian compassion for suffering and the relief of suffering was

expressed in humanitarian reforms; helping the disadvantaged was perceived not only as a token of divine mercy, but as improving life for everyone overall (Leiby, 1978). Yet, as the social work profession progressed, religious and spiritual values diminished as recognized areas of influence and relevance to the field. This progression away from religion and spirituality in social work to an antithetical value system may be attributed to various events that have shaped the social work profession, particularly the scientific movement, the adaptation of psychology into the field, and the acceptance of secular humanism.

During the 19th century, science began to replace the religious response to societies' ills. Scientism, the belief that only science can provide the knowledge of solving all social problems, became the dominant ideology (Loewenberg, 1988). As a result, philanthropy became the accepted motivating philosophy because it was regarded as scientific (Leiby, 1978). Scientific philanthropy was considered to be "secular", "rational", and "empirical" as opposed to "sectarian", "sentimental", and "dogmatic" (Leiby, 1978, p. 91). In addition, the scientific method was viewed as capable of supplying even wisdom, thus there was no room for the practice of religion or for the experience of the supernatural (Duckro, Busch, McLaughlin, & Schroeder, 1992). Thus, relief for the disadvantaged was provided by using more scientific methods with philanthropic motives replacing religious institutions as the primary source of charity and religious values as the motivating incentive. Furthermore, since social work was comprised mostly of women and thus referred to as "social motherhood", social workers were fervent toward making social work scientific (Ehrenreich, 1985). Therefore, the social work profession embraced the

role of science in its method of practice. Consequently, Marty (1980) notes:

> "The Scientific method and a rational approach to the world is believed to be essential for a practice field that wants to be recognized as a profession. Since religion is viewed as the antithesis to science, it is best ignored" (p. 465).

Since religion was not considered rational nor scientific, social workers turned to other sources such as psychology to help legitimize the profession (Loewenberg, 1988).

Psychology provided an identifiable body of knowledge that was necessary to present social work as a legitimate profession (Ehrenreich, 1985). As theology faded, people turned toward naturalistic psychologies to deal with the emotions and morals of scientific charity which had only been understood in religious terms (Leiby, 1978). Thus, social workers adapted the theories offered by psychology to the activities and practices already established in social work. Psychanalytic theory was quite readily embraced by social workers who saw the theory as a solution to making social work professional (Ehrenreich, 1985). In conjunction with Mary Richmond's book, Social Diagnosis (1917), psychoanalysis assisted social workers by giving them a framework and a guideline to work from and also, further aligning them with the social science community in an attempt to be seen as professionals. By adopting the psychoanalytic theory, social work also adopted Freud's strong rejection of the relevance of spirituality and religion. According to Freud, religion was the epitome of the infantile, "born of the need to make tolerable the helplessness of man" (Loewenberg, 1988). Even when social workers adopted other psychological theories to replace psychoanalytic theory, the atheistic views of Freud continued to prevail. Thus, social work

continued to move further away from its religious roots and toward a secular philosophical ideology.

There is a belief that a common professional ideology and professional value set which is described as being humanistic, positivistic, and utopian (Keith-Lucas, 1971). For most contemporary authors, these social work values are based on secular humanistic values (Loewenberg, 1988). Secular humanism was developed from a number of sources such as philosophers, scientists, poets, literature, and intellectual traditions (Kurtz, 1983). Although humanism encompasses a variety of beliefs, values, and philosophies, a few of the central ideas of humanism include the following: man as self-dependent, the rejection of absolutes, the acceptance of responsibility for human life, the reliance upon human capacities and natural and social resources, and the acceptance of scientific knowledge as the most reliable means of improving welfare (Pragg, 1982). However humanism rejects all religious values, beliefs, and practices, but rather views religion as being detrimental to human beings (Kurtz, 1983). Therefore, even though many of the values of humanism coincide with social work values i.e. empowerment, equality of all human beings, and responsibility to helping others, particularly the disempowered, humanism is antagonistic to religious values. As a result, social workers may not think religion has any particular relevance for everyday professional practice. On the contrary many secular social workers, who accept the scientific superiority of atheism, believe that maturity is incongruent with religious beliefs (Loewenberg, 1988).

Literature Review

Although there is an increasing interest in the study of religion and social work, research is greatly lacking in this area. This scarcity of research is particularly evident in the area of social work direct practice. Whereas social work significantly addresses issues related to ethnicity, race, and gender, the profession has not given the same consideration to religious issues. Therefore, due to the relatively small amount of research on religion in the area of social work, the following literature review includes research from the psychology field that is applicable to the subject of social work and religion.

Negativity toward religion and spirituality is a predominate theme within social work and in other clinical fields, and thus is reflected in the literature. Religion and religious values are viewed as being associated with rigidity and dogmatism (Ellis, 1980). Consequently, religion is seen as antagonistic toward social work values, concerns, and practices (Sanzanbach, 1989). Ellis (1980) proposes that religion, particularly devout religion, is unnecessary and is significantly correlated with emotional disturbance. In addition, religion has been seen by psychologists as not being a valid engagement of an educated mind (Duckro, et al, 1992). Thus, among many mental health practitioners, there is a high presence of non-religious and anti-religious sentiments (Jones, 1994).

Some of this negativity toward religion may be attributed to the lack of significance religion plays in the lives of most mental health professionals. Bergin and Jensen (1990) conducted a national study of mental health professionals which included marriage and family therapists, social workers, psychologists, and

psychiatrists. Although 80% of the respondents identified with some religious affiliation, more than half of them said they did not attend religious services on a regular basis. Furthermore, 20% of the group claimed to be agnostic, atheistic, or humanist. These findings reflect the belief that there are higher levels of agnosticism and atheism within the mental health profession than within the general population (Jones, 1994). Similar findings were reported in other research which indicated that mental health professionals are less committed to traditional religious affiliations than the general population (Bergin, 1980; Eckhardt, Kassinove, & Edwards, 1992; Joseph, 1988).

Yet, data shows that religion and religious beliefs play a major role in the lives of most people. In the 1991 Gallup Poll, 84% of those sampled said that religion was at least fairly important in their own lives. Also, 69% of the sample said that they belong to a church or a temple. In 1994, a U.S. News and World Report survey showed that 95% of those sampled said that they believe in God or in a universal spirit. Furthermore, 60% reported that they attended religious services regularly.

Unfortunately, the anti-religious attitude of mental health professionals is carried into the therapeutic milieu. Bergin & Jensen (1990) found that less than one third of the mental health professionals they surveyed believed that religious issues were important for treatment matters. Joseph (1988) found similar sentiments among social workers who were asked if religious considerations were important in their practice. Over half of the respondents said that religious considerations were only slightly to not at all important. As a result, religious

and spiritual issues are often not addressed or taken into account by mental health practitioners within the therapeutic setting (Denton, 1990; Duckro, et al, 1992; Joseph, 1988). Furthermore, in two different studies, social worker respondents indicated that acquiring skills to deal with religious issues with clients was not significantly important (Dudley & Helfgott, 1990; Joseph, 1988).

In some of the literature, the concern voiced is that clinicians may misunderstand, inappropriately evaluate, or have difficulty assessing the role religion plays in the lives of their clients (Braun, 1981; Denton, 1990; DiBlasio, 1993). In addition, the clinician's perception of the religious client may be impacted by the practitioner's disregard for religion, especially within the therapeutic setting. According to Abramowiz and Doketi (1977) patient values are the second most powerful predictor of clinician bias; social class being the most powerful. Research conducted by Gartner, Hohmann, Harmatz, Larson & Fishman-Gartner (1990) examined the effects of client ideology and therapist response. The results showed that clients holding an extreme ideology (religious or political) were diagnosed more negatively than those clients having no ideology mentioned. According to Gartner et al, the findings suggest that clinician's assessments and personal responses are influenced by the degree of ideological congruence between themselves and the client. However, even when religion is important in the personal life of the clinician, the clinician may not always view religion to be important or relevant when working with clients. DiBlasio (1993), in his study, found that the practitioners he surveyed who held strong personal religious beliefs were not inclined to hold more open views toward client's

religiosity.

Unfortunately, the disregard for clients' religious views by social work practitioners contradicts one of the basic, most important teachings embodied in social work practice, the "person-in-situation" perspective. Goldstein (1983) writes: "effective practice can be nurtured only within the grounds of the client's own realty...the helper is obligated to respect those characteristics that tend to mark the client as a distinct individual" (p. 268). Canada (1988) found this same sentiment voiced when he interviewed 18 social workers regarding religious perspectives and views. He found that the interviewees often stated that the client's own needs and situation must be considered most important when designing a helping approach. Yet, in actual practice, social workers do not appear to take the client's needs into consideration when it comes to religious and spiritual issues.

Bergin (1980) postulates two broad classes of values that permeate the mental health profession and that may account for the reluctance to address religious issues in the therapeutic relationship, clinical pragmatism and humanistic ideals. According the Bergin, these concepts exclude religious values and tend to clash with theistic systems of belief. Clinical pragmatism is defined by Bergin as:

> "...straightforward implementation of values of the dominant social system. In other words, the clinical operation functions within the system. It does not ordinarily question the system, but tries to make the system work. It is centered, then, on diminishing pathologies or disturbances, as defined by the clinician as an agent of the culture" (p. 98).

Thus, clinical practitioners are seen as mere agents of social control, more concerned with following the dictate set forth by the culture even when the

culture emphasized pathology. In addition, Bergin sees humanistic idealism as embracing the values of humanism such as the importance of self-exploration, self-actualization, independence, etc. Though humanistic idealism differs from clinical pragmatism, both views "maintain a relative indifference to God, the relationship of human beings to God, and the possibility that spiritual factors influence behavior" (Bergin, 1980, p. 98). Furthermore, Bergin sees these two values as completely excluding religious or theistic approaches despite the fact that most people believe in God and try to live their lives in terms of the perception of God's will.

Recent literature has recognized the neglect of research on religious and spiritual issues, indicating a need and a desire for research to be conducted in these areas (Canada, 1988 & 1989; Dudley & Helfgott, 1990; Joseph, 1988; Plenderleith, 1993). In addition, several writers have indicated the need to include religion and spirituality in clinical education, emphasizing the role of religion and spirituality in the lives of clients, the importance of addressing religious and spiritual issues in the clinical setting, and the importance of religious and spiritual sensitivity (Conway, 1989; Canada, 1988 & 1989; Dudley & Helfgott, 1990; Denton, 1990; Joseph, 1988; Jones, 1994; Shanfranske & Maloney, 1990). Spiritual sensitivity is especially needed since many counselors are generally less religious than their clients and thus, may find it more difficult to monitor the impact of their beliefs on the counseling process (Conway, 1989). Furthermore, spiritual sensitivity has been found to correlate with clinicians having a more positive view on their religious clients' prognosis (Shanfanske & Maloney, 1990).

In addition, since fundamentalist thinking is a realistic component in dealing with religious values and practices, clinical practitioners need to develop skills to deal with kind of rigidity (Joseph, 1989).

Purpose of the Study

Since the literature suggests that more research needs to be conducted in the area of direct practice and religious and spiritual issues, the present study conducted research on the responses of social workers to religious clients. The purpose of the study was to identify possible prejudices held by social workers toward religious clients. Since religion and spirituality are relatively unexplored areas within social work, according to the literature, there may be a propensity for social work practitioners to disregard, devalue, or negate religion and/or religious values within the therapeutic environment. As a result, this negativity toward religion may have a detrimental impact on the client and on the outcome of the client's participation in the therapeutic relationship. Using a positivist paradigm, the goal of this study was to determine if social work practitioners response to religious clients was different than the response to non-religious clients. The hypothesis was that social workers would respond more negatively to the religious client than they would to the non-religious client.

Research Design and Method

Subjects

Subjects for this study were selected from the National Association of Social Work (NASW) mailing list of members living in San Bernardino County. Systematic sampling was employed, choosing every eighth member on the list as a

subject. A total of 208 subjects were chosen. One hundred and four subjects received vignettes with religious references. This group was referred to as the Religious Group (RG). The remaining 104 surveys containing the vignettes with no religious references were also distributed to subjects. This group was referred to as the Non-Religious Group (NRG). The actual distribution of the surveys was performed by a mailing house in the Inland Empire. Forty-eight surveys were returned, however only forty three were useable. Of the surveys that were used, twenty-four were returned by the RG group and 19 were returned by the NRG group. Table 1 shows demographic information on both subject groups. The mean age of the RG group was 47 years old and the mean number of years in social work was 17 years. Within the NRG group, the mean age was 51 years old and the mean number of years in social work was 21 years.

Table 1

Demographic Information of the Religious (RG) and the Non-Religious (NRG) Group

	RG N=24		NRG N=19	
	%	N	%	N
Gender				
Male	33.3	8	47.4	9
Female	66.7	16	52.6	10
Ethnicity				
Caucasian	75.0	18	94.7	18
Mexican-American	4.2	1	0	0
Native-American	8.3	2	5.3	1
Other	12.5	3	0	0
Religious Orientation				

Catholic	37.5	9	15.8	3
Protestant	33.3	8	36.8	7
Jewish	8.3	2	26.3	5
None	8.3	2	5.3	1
Other	12.5	3	15.8	3
Clinical Orientation				
Psychodynamic	25.0	6	63.2	12
Cognitive	29.2	7	10.5	2
Rogerian	12.5	3	0	0
Behavioral	8.3	2	0	0
Existential-Humanist	4.2	1	0	0
Other	20.8	5	26.3	5
Education				
MSW	16.7	4	21.1	4
LCSW	41.7	10	20.8	5
Ph.D./DSW	20.8	5	15.8	3
MSW Student	20.8	5	5.3	1

Instrument and Data Collection

The lack of research in the area of practitioners' perceptions, attitudes, and behaviors toward religious clients prompted the author to devise a new instrument. However, ideas for constructing the instrument came from prior research on similar areas of study (Gibson & Herron, 1990; Gartner, et al, 1990; Shanfranske & Maloney, 1990).

The survey instrument consisted of two sets of three different vignettes, each one profiling a person with signs and symptoms of a possible psychiatric disorder. One set of vignettes described clients who were Christian, Jewish, and Muslim respectively (See Appendix A). References about each client's respective religious identification were contained within each vignette. For example, the first vignette had the following sentence, "Mr. K said that he is a strong Christian

and has strong beliefs about God." The other set of vignettes described exactly the same clients except all the religious references were removed (See Appendix B).

After each vignette, questions were asked pertaining to the client's diagnosis, the severity of the client's condition, the client's prognosis with treatment, and the reasons for the subject's choice of prognosis. Since both sets of vignettes provided the same descriptions of the client except for the religious identification, the responses to the prognosis would be examined to determine if religion influenced the prognostic impression given by the practitioner.

At the conclusion of the instrument, there were a series of questions asked in three different sections (See Appendix C). The first section asked questions related to the demographic information of the subjects. In the second section, subjects were asked to indicate, on a semantic differential scale, the importance of addressing ethnicity, race, religion, and gender within the therapeutic environment. In the third section, subjects were asked to indicate, on a semantic differential scale, how often ethnicity, culture, religion, and gender were addressed within their social work education.

The independent variable within the study was the religious orientation of the client. Religious orientation was defined in the measure as an affiliation to a traditionally organized religion such as Christianity, Judaism, and Islam. The religious client was identified in the vignettes by language, practices, and values associated with the religious ideology.

The dependent variable was the response of the social work practitioner. Since the prognosis is the subjective assessment of the practitioner toward the client, this study defined the response of the subject as the prognosis given to the client in each vignette. In addition, clients were asked to briefly write their reasons for the prognosis given in order to assess whether religion was a consideration for the prognosis.

Procedure

The present research study used a one shot survey design. In addition to the surveys, subjects in both groups also received an informed consent form (See Appendix D) and a stamped return envelope. In order to disguise the actual purpose of the study so as to not contaminate the results, subjects were told in the informed consent that the purpose of the study was to understand how social workers judge clinical material, taking into consideration the effects of ethnicity, culture, religion, and gender. Subjects were asked to sign the consent form and mail it back with the completed survey. Both groups were asked the same questions after each vignette pertaining to the diagnostic impression of the client, the severity of the client's condition, the prognosis of the client, and the reasons for the subject's choice of prognosis. Because the vignettes are the same except for the religious references in the RG group's vignettes, the study was able to examine if religion had any effect on the prognosis responses of the subject. Subjects in the RG group were anticipated to give the clients in their vignettes a "poor" to "very poor" prognosis. Subjects were given two weeks to return the survey. After the deadline date for the return of the surveys passed, all subjects

were sent a debriefing statement (See Appendix E) informing them of the actual purpose of the study.

Protection of Human Subjects

When the surveys were sent out, subject were sent an informed consent form to sign. The informed consent described the procedures, risks and the benefits of participating in the study. Also, the informed consent gave subjects to the name of the researcher, the name of the research advisor, and the research advisor's office telephone number in the event the subject had any questions or concerns about the study. Participation in the study posed very minimal to no risk to the subjects. Furthermore, participation was entirely voluntary, therefore subjects could choose not to participate. When the subjects returned the informed consent form and the survey, the form was separated from the survey and kept in a safe location at the researcher's home so that the subjects' anonymity and confidentiality were protected.

Although subjects were chosen from an identifiable list, the researcher never had access to the list since the mailing house randomly chose the subjects and mailed out the surveys. Thus, the only names the researcher saw were those subjects who returned the surveys. Identification numbers were given to the surveys that were returned. Thus, the surveys were only identified by a number and therefore, unrecognizable to anyone other than the researcher. Subjects in the study were only referred to by their identification number.

Subjects were mailed a debriefing letter after the return deadline date had passed. The debriefing letter described the actual purpose of the study and once

again, gave the researcher's name, the research advisor's name, the name of the school, and a phone number to call if the subjects had any questions or concerns.

Results

The present study hypothesized that social workers would respond more negatively to religious clients than to non-religious clients. The response was measured through the prognosis given to the clients by the subject. A Chi square analysis was used on the three vignettes to determine if a relationship existed between the religious orientation of the client and the prognosis given.

No significant relationship was found between the RG group and the NRG group's prognosis for Client One. Client One was given a prognosis of "Fair" most frequently by both groups (See Table 2). Contrary to the prediction of the hypothesis, 31.6% (N=6) of the subjects in the NRG group indicated a "Poor/Poor-to-Fair" prognosis, while 12.5% (N=3) of the subjects in the RG group gave a "Poor" prognosis. In response to the question asking subjects to give the reasons for the prognosis they gave, the most frequent reason given by both groups was that Client One was resistant and/or lacked motivation for treatment.

Table 2

Clinical Information on Client One from Religious Group (RG) and Non-Religious Group (NRG)

	RG N=24		NRG N=19	
	%	N	%	N
Diagnostic Impression				

BiPolar Disorder	29.2	7	15.8	3
Chemical Dependency	4.2	1	10.5	2
Stress Disorder	4.2	1	0	0
Schizoaffective	0	0	5.3	1
Personality Disorder	20.8	5	36.8	7
Mood Disorder	0	0	5.3	1
Delusional Disorder	4.2	1	0	0
Paranoid/Delusional	0	0	5.3	1
Anxious/Paranoid	4.2	1	5.3	1
Recommend to R/O Several Diagnosis	16.7	4	10.5	2
Recommend to R/O One Diagnosis	8.3	2	5.3	1
No Diagnosis Given	8.3	2	0	0
Severity of the Condition				
Moderate	79.2	19	73.7	14
Severe	16.7	4	26.3	5
No Response Given	4.2	1	0	0
Prognosis				
Poor	12.5	3	26.3	5
Poor-to-Fair	0	0	5.3	1
Fair	58.3	14	36.8	7
Fair-to-Good	0	0	5.3	1
Good	16.7	4	21.1	4
Very Good	4.2	1	0	0
No Prognosis Given	8.3	2	5.3	1

Five (20.8%) of the subjects in the RG group indicated a reference to religion in the reasons for the prognosis given. One of the subjects saw Client One's church association as a social connection. Three of the subjects' responses pointed to Client One's religious beliefs and church association being used in the treatment intervention, i.e., "...treatment through a Christian counselor..." and enlisting Client One's "strong Christian beliefs" in treatment. Only one subject referred to religion as being negative; "...religiosity will get in the way of any therapy."

In addition, Table 2 shows the frequencies of clinical responses for Client One. A more severe diagnosis was given to Client One by the NRG group than by the RG group. The NRG group's most frequent diagnosis was Personality Disorder, 36.8% (N=7), whereas the RG group more often diagnosed Client One with a Bipolar Disorder, 29.2% (N=7). Both groups indicated very little difference in the severity of Client One's condition. Client One's condition was seen as primarily moderate by the two groups.

A Chi square analysis on prognostic responses for Client Two indicated no significant differences between the RG group and the NRG group. 62.5% (N=15) of the subjects in the RG group and 78.9% (N=15) of the subjects in the NRG group gave Client Two a "Good" prognosis (See Table 3). Neither group indicated a "Poor" prognosis for Client Two. The reason most frequently given by subjects in the RG group for the prognosis they indicated was that Client Two had support systems in her life. Whereas subjects in the NRG group indicated that Client Two's symptomatic reaction was normal considering her circumstances as the most prevalent reason given for their prognosis.

Table 3

Clinical Information on Client Two from Religious Group (RG) and Non-Religious Group (NRG)

	RG N=24		NRG N=19	
	%	N	%	N
Diagnostic Impression				

Major Depression	37.5	9	31.6	6
Depression w/ Anxiety	33.3	8	10.5	2
Grief Reaction	8.3	2	15.8	3
Stress Disorder	4.2	1	0	0
Mood Disorder	0	0	5.3	1
Adjustment Disorder	8.3	2	26.3	5
Recommend to R/O Several Diagnosis	0	0	5.3	0
Recommend to R/O One Diagnosis	4.2	1	0	0
Bereavement w/ some Personality Disorder	0	0	5.3	1
No Diagnosis Given	4.2	1	0	0
Severity of the Condition				
Mild	4.2	1	0	0
Moderate	62.5	15	73.7	14
Severe	29.2	7	26.3	5
No Response Given	4.2	1	0	0
Prognosis				
Fair	29.2	7	10.5	2
Fair-to-Good	4.2	1	0	0
Good	62.5	15	78.9	15
Very Good	4.2	1	10.5	2

Eight (33.3%) of the subjects in the RG group made reference to religious affiliation, religious beliefs, and/or religious activities in their responses to reasons given for the prognosis. Three of the subjects indicated the church or spiritual beliefs as being a support system in Client Two's life, although one of the subjects indicated that Client Two's religious beliefs would need "some reframing" in order for them to be a source of support. Another subject indicated that Client Two's religion "may provide her with strength." One subject suggested "utilizing counsel from her temple" in order to assist Client Two with treatment. Two subjects responses indicated religion as a negative in Client Two's life. One subject stated "...Mrs. S's (Client Two) perception of her religious

constructs may hinder her from giving up her 'need to suffer'." The other subject indicated "...Her religious beliefs can stop her from getting better...."

Table 3 shows the similarity of the RG group and the NRG group in regards to diagnostic impression and severity of the condition. 37.5% (N=9) of the subjects in the RG group and 31.6% (N=6) of the subjects in the NRG group diagnosed Client Two most often with Major Depression. In addition, subjects in both groups indicated the severity of the condition as most often being moderate.

A Chi square analysis found no significant difference in the two groups; response to Client Three's prognosis. However, a wider range of prognosis was indicated by subjects with this client (See Table 4). In addition, subjects in the RG group were less optimistic about Client Three's prognosis than subjects in the NRG group. The most frequent prognosis given by subjects in the RG group was "Fair" (45.8%, N=11). Whereas, the most frequent prognosis given by subjects in the NRG group was "Good" (47.4%, N=9). Also, 12.5% (N=3) of the subjects in the RG group gave Client Three a "Very Poor" or "Poor" prognosis, while only 5.3% (N=1) gave the client a "Poor" prognosis. Subjects in both groups indicated that Client Three was motivated for treatment as their most frequent reason for the prognosis given.

Table 4

Clinical Information on Client Three from Religious Group (RG) and Non-Religious Group (NRG)

RG N=24	NRG N=19

	%	N	%	N
Diagnostic Impression				
Obsessive-Compulsive Disorder	79.2	19	94.7	18
Anxiety Disorder	4.2	1	0	0
Hypochondriasis w/ Major Depression	4.2	1	0	0
Phobia	4.2	1	5.3	1
Recommend to R/O One Diagnosis	4.2	1	0	0
No Diagnosis Given	4.2	1	0	0
Severity of the Condition				
Moderate	41.7	10	36.8	7
Moderate-to-Severe	4.2	1	0	0
Severe	54.2	13	63.2	12
Prognosis				
Very Poor	4.2	1	0	0
Poor	8.3	2	5.3	1
Poor-to-Fair	0	0	5.3	1
Fair	45.8	11	42.1	8
Fair-to-Good	4.2	1	0	0
Good	33.3	8	47.4	9
Very Good	4.2	1	0	0

Seven (29.2%) of the subjects in the RG made reference to religion within the reasons given for the prognosis. One of the subjects just made reference to the idea that there were variables, i.e., religion, that needed to be factored in when considering the prognosis. Another subject indicated that the religious component should not be of concern since it "may be an accepted religious practice of Muslims." Two subjects suggested that interfacing with leaders within Client Three's religion or using counsel from the Muslim faith would be helpful. Finally, three of the subjects regarded Client Three's religion and his religious practices as a hindrance to overcoming his condition.

Table 4 shows a similarity of responses by subjects in the RG group and the NRG group in regards to the diagnostic impression of Client Three and to the severity of his condition. 79.2% (N=19) of the RG group and 94.7% (N=18) of the NRG group indicated Obsessive-Compulsive disorder as Client Three's diagnosis. Also, subjects in both groups indicated Client Three's condition as being severe as their most frequent response.

Responses to the question asking subjects to indicate the importance of addressing ethnicity, culture, religion and gender are shown in Table 5. In regards to religion, subjects in both groups indicated that religion was an important issue to address in the clinical setting. However, 37.5% (N=9) of the subjects in the RG group indicated that addressing religion was "Very Important," whereas only 21.1% (N=4) of the subjects in the NRG group indicated "Very Important."

Table 5

Importance of Addressing Ethnicity, Culture, Religion, and Gender in Clinical Setting

	RG N=24		NRG N=19	
	%	N	%	N
Ethnicity				
Very Important	41.7	10	31.6	6
Important	45.8	11	31.6	6
Average Importance	12.5	3	36.8	7
Culture				
Very Important	66.7	16	52.6	10

Important	33.3	8	31.6	6
Average Importance	0	0	15.8	3
Religion				
Very Important	37.5	9	21.1	4
Important	50.0	12	47.4	9
Average Importance	4.2	1	31.6	6
Unimportant	8.3	2	0	0
Gender				
Very Important	37.5	9	31.6	6
Important	37.5	9	31.6	6
Average Importance	20.8	5	36.8	7
Unimportant	4.2	1	0	0

Table 6 shows subjects' responses to the question asking them the frequency ethnicity, culture, religion, and gender were addressed within their social work education. Both the RG group and the NRG groups' responses were very similar. 58.3% (N=14) of the subjects in the RG group and 52.6% (N=10) of the subjects in the NRG group indicated that religion was "Sometimes" addressed in their social work education. In addition, religion was the most rarely addressed topic of the four mentioned within the survey for both groups.

Table 6

Frequency Ethnicity, Culture, Religion, and Gender Were Addressed Within Social Work Education

	RG N=24		NRG N=19	
	%	N	%	N
Ethnicity				
Very Often	25.0	6	21.1	4
Often	50.0	12	31.6	6

Sometimes	25.0	6	47.4	9
Culture				
Very Often	25.0	6	10.5	2
Often	50.0	12	42.1	8
Sometimes	20.8	5	47.4	9
Rarely	4.2	1	0	0
Religion				
Often	8.3	2	10.5	2
Sometimes	58.3	14	52.6	10
Rarely	33.3	8	36.8	7
Unimportant	8.3	2	0	0
Gender				
Very Often	25.0	6	5.3	1
Often	33.3	8	26.3	5
Sometimes	25.0	6	47.4	9
Rarely	16.7	4	15.8	3
Never	0	0	5.3	1

Discussion

The present study found that there was no significant difference between the responses of subjects who received the religious vignettes and the responses of subjects who received the non-religious vignettes. Religion did not appear to have a significant affect on subjects' prognosis for the clients. Overall, the prognosis given to the clients in both groups appeared to be the same.

However, the data indicates that religion was an issue for subjects in the RG group when deciding the client's prognosis. Within the reasons given by subjects in the RG group for the prognosis chosen, 20 of the responses contained a reference to religion. Over half of the responses indicated that religion was a positive source in the client's life. A few of the positive responses indicated that the client's religious affiliation provided a support, strength, or social outlet to the

client. Other positive responses suggested the possibility of interfacing or employing the assistance of a religious leader, a counselor who shared the same faith, or a support group within the religious organization to help the client. These responses suggest that social workers do recognize the importance of religion in a person's life as well as the importance of incorporating a person's religious beliefs and practices into the treatment plan.

In addition, religion may have been a positive influence on the diagnostic impression given by subjects, particularly with Client One. Of the three clients, Client One appeared to have the most varied diagnosis; possibly because the described symptomology was more unclear for Client One than for the other two clients. Yet, Client One was diagnosed with a less severe disorder by subjects in the RG group than by subjects in the NRG group. Client One was predominantly diagnosed with a bipolar disorder by subjects in the RG group. However, Client One was most often diagnosed with various personality disorders, including paranoid and borderline personality disorders, by subjects in the NRG group. Given that both vignettes were the same, except for the religious references, religion may have influenced the subjects' perception of Client One's symptoms, and subsequently, his diagnosis.

Furthermore, religion may have had an influence on the subjects' participation in the study. Theoretically, since the surveys were randomly distributed to the subjects, both groups should demographically appear to be the same. Yet, the demographic data reveal that the two groups are very different. For instance, two-thirds of the RG group were females, whereas the NRG group

had an almost equal amount of males and females. Also, although both groups show a high percentage of Protestants, the RG group had a higher percentage of Catholics than the NRG group. On the other hand, the NRG group had a higher number of Jewish subjects. Furthermore, over 50% of the subjects in the NRG group are, clinically, psychodynamic, whereas only 25% of the subjects in the RG group have a psychodynamic clinical orientation. The subjects in the RG group predominant clinical orientation was cognitive. In addition, there were no African-American or Asian-American respondents, and only one Mexican-American subject within the entire study.

Also, unlike previous studies (Bergin & Jensen, 1990; Jones, 1994) where the finding showed a large percentage of clinicians identify as atheist, agnostic, or humanist, the present study found only three subjects who indicated no religious orientation. In addition, more subjects responded to the religious vignettes than to the non-religious vignettes. In agrement with Shanfranske and Maloney's study (1990), these findings suggest that subjects who responded may be more sensitive to religious and spiritual issues than social workers in general, and thus may have self-selected to participate in this study.

Thirty percent (N=6) of the respondents referred to religion as a negative influence. Subjects giving these responses seemed to indicated that the religious beliefs or practices would hinder the client's treatment progress or may get in the way of therapy. Fifty percent (N=3) of these negative responses were made toward Client Three, who was identified as a Muslim and had references made within the vignette to an Islamic religious practice, i.e. praying several times per

day. It is possible that the high percentage of negative references to this client are due to the respondents' own religious identification or familiarity with certain religions. Since most of the subjects in the RG group identified themselves as Catholic or Protestant, subjects may not be familiar with or comfortable with Muslim religious practices because these practices differ from their own. Furthermore, since most people living in the United States are exposed to Judeo-Christian religious beliefs and practices, other types of religious practices, that are not similar, may be perceived as negative.

According to the date from this study, the need for social work to address religion and spirituality within the literature, the curriculum, and the profession is apparent. In response to the question asking subjects how important it is to address religion within the clinical setting, the majority of subjects in both groups indicated that addressing religion was important. Yet, according to the data, most of the subjects had little exposure or training on religious issues within their social work education. Whether religion is perceived as positive or negative, religion is a consideration with social workers when working with clients. If social workers are taught that a fundamental practice principle when working with clients is to consider the person-in-environment, how effectively can social workers operate from this principle if they lack in knowledge within an area as significant to their clients as religion and spirituality? Consequently, when social workers are not given the necessary training or skills to work with issues such as religion and spirituality, they inadvertently negate a large portion of the client's environment.

In addition to neglecting a client's religious values or spirituality, social workers may be unable to recognize their own religious or spiritual biases. Since social workers are not given any training in religious or spiritual sensitivity, they may not be aware of how their own religious and spiritual values influence the way they view a client's religious and spiritual values. This lack of awareness is particularly evident when a client practices a religion that may be unfamiliar to the social worker. The negative reasons given for Client Three's prognosis by subjects in the RG group are an example of possible religious bias that exists with clients who practice a religion unfamiliar to the social worker. Consequently, social workers who are not aware of their religious or spiritual biases may wrongly attribute the beliefs and practices of the religion as being part of a client's pathology. In addition, social workers who are not sensitive to religion and spirituality may overlook the positives that the client's faith may have on treatment outcome.

One implication of this study is that the social work curriculum needs to include religion and spirituality. Teaching religion and spirituality does not mean proselytizing or advocating one religious view over the other. But rather, religion and spirituality need to be treated with the same sensitivity and importance as ethnicity, culture, and sexual orientation. Social work curriculum can discuss the role of religion and spirituality within society and within people's lives. Also, the curriculum can expose and educate social workers on various types of religions, spiritual philosophies, beliefs, and practices. Furthermore, social work curriculum needs to address religious and spiritual sensitivity as well as increasing social

workers' awareness on their own religious values and beliefs and how these values may affect their work with both religious and non-religious clients.

In addition to including religion and spirituality in social work education, the profession needs to conduct more research within the area of religion and spirituality. Social work should continue to study how religion and spirituality impact social work practice, particularly in the area of direct practice. The greater the amount of knowledge and information social workers can obtain in the area of religion and spirituality, the better equipped they are to work with all clients.

In conclusion, although this study found no significant differences between the prognostic responses of social workers to religious and non-religious clients, the data clearly indicate the need for the social work profession to recognize religious and spiritual issues as an important diagnostic and treatment issue in social work practice. As America becomes more diverse, this need to recognize the significance of religion and spirituality becomes increasingly relevant to social work practice.

Appendix A

Religious Vignettes

I. The following are a series of vignettes describing an intake session. Please read the vignettes and answer the question after each vignette as accurately and honestly as possible.

Client One

Mr. K is a 37 year old male who works for a manufacturing company. He is married and has two children. He was referred to counseling by his employer for erratic behavior at work, including an inability to control his temper and verbally violent outbursts toward co-workers and customers.

Mr. K appeared very uncomfortable in the initial interview. His eyes were constantly darting around the room, he had difficulty maintaining eye contact, and his speech was pressured and rapid. He verbalized feelings of anger for having to attend counseling. The only reason for coming to counseling, he said, was because his employer threatened to terminate his job if he did not come. Mr. K stated that he does not believe in therapy. He said God was his personal therapist. Mr. K said that he is a strong Christian and has strong beliefs about God.

When asked abut the reason his employer referred him to counseling, Mr. K said it was because his boss doesn't like him and is jealous of his work abilities. Mr. K stated that referring him to counseling was just one of his boss' ways of making him look bad.

Besides the church, his other recreational outlet is painting. Mr. K stated that when he is painting, he can stay up all night working on his art. He considers himself a great artist and said he has created some magnificent pieces of art. Mr. K verbalized frustration that local galleries will not display his works. He believes that the curators are unable to appreciate the depth of his art.

1. Given the above information, please give your diagnostic impression of Mr. K.

_____

_____

2. Circle the number that corresponds to the severity of his condition.

   1 Mild
   2 Moderate
   3 Severe

3. Circle the number that corresponds to the prognosis you would give to Mr. K with treatment.

   1 Very poor
   2 Poor
   3 Fair
   4 Good
   5 Very Good

4. Briefly give your reasons for the prognosis you gave to Mr. K in Item Three.

_____

_____

_____

Client Two

Mrs. S is a 48 year old woman, recently widowed, who works in the field of education. She has three adult children and two grandchildren. She was referred by her family physician after he found no physical reasons for her complaints of chest pains, breathing difficulties, and sporadic instances of feeling light-headed and dizzy. Her doctor was also concerned about her recent rapid weight loss and her request for sleeping pills because of her difficulty sleeping for more than 3 or 4 hours per night.

Mrs. S stated that her husband died suddenly seven months ago, leaving a large amount of debts behind. She was unaware that they were so severely in debt. She said she may have to file bankruptcy and, in the process, will lose her home of 28 years. She explained that she was trying to find a second job but was having a difficult time because she was always so tired. She said she does not want to die, however she would like to go to sleep for a very long time. Except for occasional tearfulness, Mrs. S's affect was emotionless. She described her situation in a very matter-of-fact tone of voice.

She believes that it is God's intention for her to suffer. She believes that just as her people, the Jewish people, were punished for their disobedience and made to wander in the desert for 40 years, she too is being punished for her disobedience. Therefore she feels she needs to just accept her situation and get on with her life. She feels that talking about it will not change anything. When asked what brings her pleasure in her life she said going to Temple and spending time with her grandchildren.

5. Given the above information, please give your diagnostic impression of Mrs. S.

_____

_____

6. Circle the number that corresponds to the severity of her condition.

1 Mild
2 Moderate
3 Severe

7. Circle the number that corresponds to the prognosis you would give to Mrs. S with treatment.

1 Very poor
2 Poor
3 Fair
4 Good
5 Very good

8. Briefly give your reasons for the prognosis you gave to Mrs. S in Item Seven.

_____

_____

_____

Client Three

Mr. F is a 25 year old male who is a full-time student at a local university. He is single and works only part-time on weekends at a grocery store. He is seeking counseling on his own because of concern over some reoccurring thoughts that are interfering with his academic performance and attendance at school. He stated that he is constantly worried about catching a fatal disease, especially AIDS. He is aware of the ways AIDS and other diseases are spread, and even though he is not engaged in any of the activities that make a person susceptible to contracting AIDS, he continues to think about it constantly. He stated that he is afraid to be around people because of this fear and engages in other behaviors to reduce his anxiety, such as repetitive hand washing and numerous showers.

Mr. F stated that he had experienced these feelings of fear since he was in high school, however he said they've become more intrusive and disruptive to his life over the past couple of years. He went on to give an account of his average daily routine:

Mr. F, who is also a devout Muslim, gets up at 5:00 AM and prays. Then he takes a shower, eats his breakfast after thoroughly washing his already clean silverware and dishes. He cleans up after eating, washes his hands, cleans up the house, washes his hands again and then attempts to go to school. He said he sits away from other students to the extent possible, but if he can't, he runs to the bathroom immediately after class and tries to wash his hands and face. At noon, he goes to his dorm, prays, eats lunch and takes another shower before returning to school. Mid-afternoon, he prays again and goes to his last class. He takes another shower before he starts his homework. He prays once again before dinner and then follows the same pattern of cleaning his dinnerware before eating. He cleans up the dishes, washes his hands and face, prays one last time and goes to bed. He stated that he gets upset and distraught if his routine is changed. He said he can't take living like this much longer.

9. Given the above information, please give your diagnostic impression of Mr. F.

_____

_____

10. Circle the number that corresponds to the severity of his condition.

    1 Mild
    2 Moderate
    3 Severe

11. Circle the number that corresponds to the prognosis you would give to Mr. F with treatment.

    1 Very poor
    2 Poor
    3 Fair
    4 Good
    5 Very good

12. Briefly give your reasons for the prognosis you gave to Mr. F in Item Eleven.

_____

_____

_____

Appendix B

Non-Religious Vignettes

1. The following are a series of vignettes describing an intake session. Please read the vignettes and answer the questions after each vignette as accurately and honestly as possible.

Client One

Mr. K is a 37 year old male who works for a manufacturing company. He is married and has two children. He was referred to counseling by his employer for erratic behavior at work, including an inability to control his temper and verbally violent outbursts toward co-workers and customers.

Mr. K appeared very uncomfortable in the initial interview. His eyes were constantly darting around the room, he had difficulty maintaining eye contact, and his speech was pressured and rapid. He verbalized feelings of anger for having to attend counseling. The only reason for coming to counseling, he said, was because his employer threatened to terminate his job if he did not come. Mr. K stated that he does not believe in therapy. He said God was his personal therapist. Mr. K said that he is a strong Christian and has strong beliefs about God.

When asked abut the reason his employer referred him to counseling, Mr. K said it was because his boss doesn't like him and is jealous of his work abilities. Mr. K stated that referring him to counseling was just one of his boss' ways of making him look bad.

Besides the church, his other recreational outlet is painting. Mr. K stated that when he is painting, he can stay up all night working on his art. He considers himself a great artist and said he has created some magnificent pieces of art. Mr. K verbalized frustration that local galleries will not display his works. He believes that the curators are unable to appreciate the depth of his art.

1. Given the above information, please give your diagnostic impression of Mr. K.

_____

_____

2. Circle the number that corresponds to the severity of his condition.

   1 Mild
   2 Moderate
   3 Severe

3. Circle the number that corresponds to the prognosis you would give to Mr. K with treatment.

   1 Very poor
   2 Poor
   3 Fair
   4 Good
   5 Very Good

4. Briefly give your reasons for the prognosis you gave to Mr. K in Item Three.

_____

_____

_____

Client Two

Mrs. S is a 48 year old woman, recently widowed, who works in the field of education. She has three adult children and two grandchildren. She was referred by her family physician after he found no physical reasons for her complaints of chest pains, breathing difficulties, and sporadic instances of feeling light-headed and dizzy. Her doctor was also concerned about her recent rapid weight loss and her request for sleeping pills because of her difficulty sleeping for more than 3 or 4 hours per night.

Mrs. S stated that her husband died suddenly seven months ago, leaving a large amount of debts behind. She was unaware that they were so severely in debt. She said she may have to file bankruptcy and, in the process, will lose her home of 28 years. She explained that she was trying to find a second job but was having a difficult time because she was always so tired. She said she does not want to die, however she would like to go to sleep for a very long time. Except for occasional tearfulness, Mrs. S's affect was emotionless. She described her situation in a very matter-of-fact tone of voice.

She believes that it is God's intention for her to suffer. She believes that just as her people, the Jewish people, were punished for their disobedience and made to wander in the desert for 40 years, she too is being punished for her disobedience. Therefore she feels she needs to just accept her situation and get on with her life. She feels that talking about it will not change anything. When asked what brings her pleasure in her life she said going to Temple and spending time with her grandchildren.

5. Given the above information, please give your diagnostic impression of Mrs. S.

_____

_____

6. Circle the number that corresponds to the severity of her condition.

   1 Mild
   2 Moderate
   3 Severe

7. Circle the number that corresponds to the prognosis you would give to Mrs. S with treatment.

   1 Very poor
   2 Poor
   3 Fair
   4 Good
   5 Very good

8. Briefly give your reasons for the prognosis you gave to Mrs. S in Item Seven.

_____

_____

_____

Client Three

Mr. F is a 25 year old male who is a full-time student at a local university. He is single and works only part-time on weekends at a grocery store. He is seeking counseling on his own because of concern over some reoccurring thoughts that are interfering with his academic performance and attendance at school. He stated that he is constantly worried about catching a fatal disease, especially AIDS. He is aware of the ways AIDS and other diseases are spread, and even though he is not engaged in any of the activities that make a person susceptible to contracting AIDS, he continues to think about it constantly. He stated that he is afraid to be around people because of this fear and engages in other behaviors to reduce his anxiety, such as repetitive hand washing and numerous showers.

Mr. F stated that he had experienced these feelings of fear since he was in high school, however he said they've become more intrusive and disruptive to his life over the past couple of years. He went on to give an account of his average daily routine:

Mr. F, who is also a devout Muslim, gets up at 5:00 AM and prays. Then he takes a shower, eats his breakfast after thoroughly washing his already clean silverware and dishes. He cleans up after eating, washes his hands, cleans up the house, washes his hands again and then attempts to go to school. He said he sits away from other students to the extent possible, but if he can't, he runs to the bathroom immediately after class and tries to wash his hands and face. At noon, he goes to his dorm, prays, eats lunch and takes another shower before returning to school. Mid-afternoon, he prays again and goes to his last class. He takes another shower before he starts his homework. He prays once again before dinner and then follows the same pattern of cleaning his dinnerware before eating. He cleans up the dishes, washes his hands and face, prays one last time and goes to bed. He stated that he gets upset and distraught if his routine is changed. He said he can't take living like this much longer.

9. Given the above information, please give your diagnostic impression of Mr. F.

_____

_____

10. Circle the number that corresponds to the severity of his condition.

    1 Mild
    2 Moderate
    3 Severe

11. Circle the number that corresponds to the prognosis you would give to Mr. F with treatment.

    1 Very poor
    2 Poor
    3 Fair
    4 Good
    5 Very good

12. Briefly give your reasons for the prognosis you gave to Mr. F in Item Eleven.

_____

_____

_____

Appendix C

Survey of Demographic Information

II. Please answer the following questions pertaining to you by circling the appropriate number of filling in the blanks.

13. **Gender**

1 Male
2 Female

14. **Age:** _____ years

15. **Ethnicity**

1 Caucasian
2 African American
3 Mexican American
4 Asian American
5 Native American
6 Other Latino (Non-Mexican)
7 Other Specify _____

16. **Religious Orientation**

1 Catholic
2 Protestant
3 Jewish
4 Muslim
5 None
6 Other Specify _____

17. **Level of Education**

1 No formal degree
2 BSW
3 MSW
4 LCSW
5 Ph.D. or DSW
6 BSW Student
7 MSW Student

18. **How long have you been employed in social work?** _____ years

19. **What is your main clinical orientation?**

1 Psychodynamic
2 Cognitive
3 Rogerian
4 Gestalt
5 Behavioral
6 Existential Humanist
7 Other _____

III. Please indicate the importance to you of addressing each of the following items within the therapeutic environment by circling the appropriate number.

20. **Ethnicity**

1 Very important
2 Important
3 Average importance
4 Unimportant
5 Very unimportant

21. **Culture** (norms and values of an ethnic group)

1 Very important
2 Important
3 Average importance
4 Unimportant
5 Very unimportant

22. **Religion** (practices and beliefs of organized religion)

1 Very important
2 Important
3 Average importance
4 Unimportant
5 Very unimportant

23. **Gender**

1 Very important
2 Important
3 Average importance
4 Unimportant
5 Very unimportant

IV. Please indicate how often the following items were addressed within your social work education. Circle the appropriate number.

24. **Ethnicity**

1 Very often
2 Often
3 Sometimes
4 Rarely
5 Never

25. **Culture**

1 Very often
2 Often
3 Sometimes
4 Rarely
5 Never

26. **Religion**

1 Very often
2 Often
3 Sometimes
4 Rarely
5 Never

27. **Gender**

1 Very often
2 Often
3 Sometimes
4 Rarely
5 Never

APPENDIX D

INFORMED CONSENT

The study in which you have been selected to participate in is designed to understand how social workers judge clinical material, taking into consideration the effects of ethnicity, culture, religion, and gender. This study is being conducted by Lisa Russek under the supervision of Dr. Morley Glicken, Professor of Social Work at California State University, San Bernardino. This study has been approved by the Institutional Review Board of California State University, San Bernardino.

In this study you will read a series of vignettes and will be asked to answer questions pertaining to the content in the vignettes. After all the vignettes have been read and the subsequent questions answered, you will be asked to answer questions in Section B. The survey should take you approximately 10-15 minutes to complete.

Please be assured that any information you provide will be held in strict confidence by the researcher. At no time will your name be reported along with your responses. All data will be reported in aggregate form only. A contact phone number will be provided at the end of this consent form if any questions or concerns should arise.

It is hoped that the results of this study will improve the practice competency of social workers. Your participation will be helpful in attaining this goal. However, please understand that your participation is totally voluntary and you are under no obligation to respond. Furthermore, you have the right to withdraw from participation at any time without penalty.

If you do participate, please sign this consent and return it with your completed survey in the return envelope provided. **Please return the survey by February 13, 1995.**

I acknowledge that I have been informed of and understand the nature and purpose of this study. I freely consent to participate. I acknowledge that I am at least 18 years of age.

_____ _____

Participant's Signature **Researcher's Signature**

Lisa Russek, MSW Candidate

Dr. Morley Glicken, Ph.D., Research Advisor (909) 880-5557

APPENDIX E

DEBRIEFING STATEMENT

The purpose of the study in which you participated examined how social workers judge clinical material, taking into consideration the effects of ethnicity, culture, religion, and gender. Specifically, the study is interested in how social workers respond to religious clients. Since religion and spirituality are seldom addressed within social work literature or curriculum, social workers are not equipped with the necessary skills to work with religious or spiritual issues. Thus, there may be a propensity for social workers to disregard, devalue, or negate religion or religious values within the therapeutic environment. Negativity or ambivalence toward religion may have a detrimental impact on the client and on the outcome of the client's participation in the therapeutic relationship. It is important for social workers to be aware of any potential effects certain values, such as religious values, have upon their relationship with their clients. Once aware of these effects, social workers can then take the appropriate measures to address them.

If you have any questions or concerns about your participation in the study, or you would like to obtain the results of the study, you may contact the researcher named below or her research advisor. In addition, if you have experienced any harm or injury due to your participation in this study, the person named below or the School of Social Work at California State University, San Bernardino may be contacted.

Since the results of the study rely on participants being unaware of the actual purpose of the study, your cooperation in not revealing the nature of the study to other potential subjects will be appreciated.

Thank you for your assistance and participation this project.
For further information, contact:

Lisa Russek, MSW Candidate
Morley Glicken, Ph.D., Research Advisor

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5500 University Pkwy.
San Bernardino, CA 92407
(909) 880-5500

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