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THE RELATIONSHIP BETWEEN DAILY SPIRITUAL EXPERIENCE AND
PRACTICE, AND HEALTH, AND LIFE SATISFACTION IN DOCTORAL-LEVEL
COUNSELORS

BY

CAROL A. GERNAT

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Submitted in Partial Fulfillment
of the Requirements for the Degree
Doctor of Philosophy
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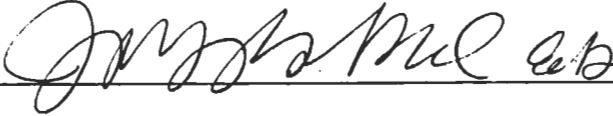
APPROVAL FOR SUCCESSFUL DEFENSE

Doctoral Candidate, **Carol A. Gernat**, has successfully defended and made the required

modifications to the text of the doctoral dissertation for the **Ph.D.** during this **Summer**

Semester **2003**.

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The mentor and any other committee members, who wish a review to recommend
revision, will sign and date this document only when revisions have been completed.
Please return this form to the Office of Graduate Studies, where it will be placed in the
candidate's file.

Abstract

The Relationship Between Daily Spiritual Experience and Practice and Health and Life
Satisfaction in Doctoral-Level Counselors

Integrating spirituality into counseling practice has become a growing area of

interest for counselors and clients alike. However, counselor training programs, in the

main, are still in the early stages of bringing spiritual issues into research, practice, and

training. Therefore, this study had two overall goals. First, doctoral-level counselors'

conceptualizations of spirituality were investigated. Second, given the evidence

supporting a relationship between spirituality and health, this study examined the degree

to which this relationship held in a sample of doctoral-level counselors. Two hundred

participants, who were selected from the Directory of the American Counseling

Association, completed the Daily Spiritual Experience Scale, a spiritual practice survey

designed for use in this investigation, the Satisfaction With Life Scale, the SF-12v2™,

and a demographic data form. According to the criteria for inclusion in the study, all

participants held a doctoral degree.

Results revealed that the majority of conceptualizations of spirituality were

multidimensional in nature. They typically included a reference to a transcendent

dimension and the experience of connection and relationship. Results concerning the

relationship between spiritual experience and health were mixed. That is, for those

counselors reporting more frequent spiritual experiences, they also reported higher levels

of mental health. In addition, there was a significant correlation between daily spiritual

experience and life satisfaction. Connection to a transcendent dimension, social

connection, and frequency of spiritual practices predicted higher levels of mental health.

In contrast, the relationship between spiritual experience and physical health was

nonsignificant. Likewise, the relationship between frequency of spiritual practices and mental health, physical health, and life satisfaction was nonsignificant. Recommendations were made for further research.

Acknowledgements

It really is true that a dissertation cannot be accomplished in isolation, and it is a daunting task to consider all the support that I have had over the course of this project. I would begin, though, with my Dissertation Committee.

First, I would like to acknowledge and thank my mentor, Dr. Shawn Utsey. When I first began my doctoral training, and for a long time, I thought that the clearest expression of my healing abilities would be in face-to-face counseling with clients. Never did I think that doing research and writing would become an important aspect of my training and career goals. Because of Dr. Utsey's enthusiasm, encouragement, and inspiration, I actually enjoy doing research from developing the ideas, to considering what it all means, to furthering exploration in new directions. From my perspective, one of his gifts as a teacher is being able to walk the fine line of freedom and structure with a student so that in this instance we brought some fringe ideas into form. Yes, I would even thank him for the major revisions he recommended along the way. I would also like to thank him for staying on as my mentor after leaving Seton Hall.

Dr. Sandra Lee extended her hand and offered to be on my committee. This alone would have been enough for which to be grateful, but Dr. Lee's expertise, openness, and interest significantly contributed to the completion and success of my dissertation. Her encouragement and recommendations for changes have also made this the work that I wanted it to be.

I would like to express my gratitude to Dr. Grace May for her contributions to my dissertation. Of these, it was most important to me that she listened to what I wanted to accomplish overall. She went through the drafts in fine detail and identified where they

could be improved, and communicated with me in a compassionate, yet direct, way. The ultimate effect of her recommendations is that this is a far better piece of work than if she had not been involved.

Dr. Jody Kulstad came to this project near the end, and I thank her for her willingness to participate on short notice and for her recommendations for changes that improved the quality of the work.

I would like to take this opportunity to thank the participants for taking the time to complete the protocols and return them. I appreciate that in light of busy schedules and competing priorities they took the time to fill out these surveys. This was crucial to the success of this project, and I am very grateful to them all.

As always, Lucy Vazquez, Department Secretary of Professional Psychology and Family Therapy, is a saint. Throughout my time at Seton Hall, she was always ready with whatever I needed, whether it was paperwork or a kind word. When I was preparing for my defense, Lucy handled the arrangements and the paperwork. Believe it or not, she even calmed me down. I do not think I can thank her enough.

I would like to acknowledge the contributions and thank the reviewers of the Spiritual Practices Survey. Dr. Guerda Nicholas, Fr. Joseph Kabali, and the anonymous reviewers provided feedback critical to the improvements of the scale.

I would also like to thank Dr. Catherine Beneteau of the Math Department at Seton Hall for her help scoring the health surveys used in this study.

Maybe it sounds trite and cliché to say that without my family I would never have been able to realize this accomplishment, but I will risk being trite. To begin with, my parents had very different views of religion and spirituality. To my father, religion is

Dedication

I dedicate this dissertation in gratitude to the memory of Sandra M. Hartley who showed me that spirituality is most importantly transformation and service; that courage is the better part of healing and teaching; that thinking outside the box is nonsense because there is no box; that sense of humor is cultivated before enlightenment; and that somehow, death is irrelevant. I also must acknowledge here that she was the one who helped me to develop my writing abilities, by her example, and to find joy and fulfillment in writing, red pen and all. In other words, editing is not so bad after all. This was no small feat in this project, in other writing projects I have been involved in during these years, and in the writing I will do in times to come.

March 31, 2003

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Chapter I

INTRODUCTION

Introduction

Examples of healing as a spiritual endeavor can be found the world over, across

time and cultures. It is natural for people to pursue health and well-being in every

domain, including that of the Spirit, and this search for spiritual healing may be extended

to contemporary mental health care settings. Cortright (1997) echoed this idea suggesting

that people with ordinary problems, who walk a spiritual path, seek therapists who not only

honor their search for the divine without minimization or impunity, but respect them as

whole beings psychologically and spiritually. Furthermore, at least 4 in 10 Americans seek

help from clergy when in personal distress; however, an analysis of 2400 studies published

in eight American Psychological Association (APA) journals revealed only four

assessments of the role of clergy in counseling (Weaver et al., 1997). It follows, then, that

there has been a disconnection between research and practice in the disciplines comprising

professional psychology and the needs of the people who seek care.

Historically, however, as Vande Kemp (1996) suggested, psychology and religion

had been inextricably intertwined. Vande Kemp pointed to the history of the roots of

psychology authored by Boring in 1929 that bolstered the view that psychology was

science. This view posited that the discipline of psychology was essentially free of the

influences of philosophy and theology. Thus, as Vande Kemp wrote, psychologists trained

in the 20th century were schooled in the new psychological paradigm in which psychology

was understood as a natural science as compared with a spiritual science. Moreover,

assessment tools largely relied upon that which can be observed or perceived by the other

senses. This, then, gave rise to the split between psychology and religion as the roots of psychology in theology and philosophy were denied. Vande Kemp believed that this view was based on false premises, and as a result, it did not present a clear and accurate picture of the origins of psychology. For example, Vande Kemp (1996) stated that "it is virtually impossible to make a clear distinction between pneuma (the spirit, or religious aspect of the person) and psyche (the soul, or the psychological)" (p. 72).

However, more recent literature has suggested a return to the integration of religion/spirituality and psychology (Chirban, 2001), and a body of research concerning spirituality as a main variable is beginning to emerge. Yet according to Chirban, this research is still in its infancy, and religious and spiritual issues are not yet part of mainstream psychology. As Chirban noted, recent works included Hill and Hood's (1999) reviews of measures of religion and a number of texts published by the American Psychological Association and other professional book publishers concerning integrating the sacred into psychotherapy (e.g., Griffith & Griffith, 2002; Hood, Spilka, Hunsberger, & Gorsuch, 1996; W. Miller, 1999a; Plante & Sherman, 2001; Richards & Bergin, 1997; Shafranske, 1996a).

Continuing this line of thinking concerning the integration, then the split, then the current, yet early reintegration of psychology and spirituality, we might consider some present day characteristics not only of psychology and spirituality, but the transformations of the physical sciences. Not only was this the era of the "quick fix," cookbook approaches, and health maintenance organizations (HMOs), it was also a time in which we saw monumental shifts in the physical sciences such that infinitesimal particles were discovered and quantum fields described. Perna and Masterpasqua (1997) drew parallels

between 20th century scientific discoveries and the human sciences, noting that behavior of subatomic particles, and human beings for that matter, cannot be predicted with certainty. In chaos theory, uncertainty and nonlinearity are embraced not pathologized as in the Newtonian model or in some schools of contemporary psychological thought. Perna and Masterpasqua noted that quantum physics and general relativity theory gave us examples that subject and object, knower and known are one, thus calling into question the closely guarded dictum that there is a certain, objective reality. Similarly, Epstein (1995), who integrated Buddhist thought and practices with psychoanalysis, recounted that the First Noble Truth of Buddhism ultimately required that we accept the uncertainties that we attempt to ignore. The new language of science and the language of spirit were becoming unified as boundaries dissolved in both camps.

Given uncertainty and co-existing realities that intermingle in the therapy hour and beyond, it followed then that spirituality, especially at the experiential level, likely affects therapeutic outcome. However, from the perspective of the counselor, there was a paucity of research concerning counselor spiritual experience and practice. As the evidence of a relationship between health and spirituality grew, it made sense to examine whether this relationship held in a sample of doctoral-level counselors. Because of the vicissitudes of the dynamics of the therapeutic encounter, the health of the counselor might be influenced by long-term, ongoing counseling interactions.

As spirituality continued to be reintegrated into the discipline of Western professional psychology, a number of considerations have arisen. For example, Sloan, Bagiella, and Powell (2001) wrote that there were ethical questions for psychologists who may be working beyond their purview. Furthermore, as Sloan et al. suggested, if the

relationship between health and spirituality continues to be supported, how do we decide when and for whom spiritual interventions would be used in psychological treatment? For these reasons, counselor spirituality warranted investigation. In fact, Tan and Dong (2001) wrote that "The health care professional must also address his or her own spiritual life to adequately and appropriately address the spiritual needs of patients" (Tan & Dong, 2001, p. 306).

In spiritual traditions, healers have been reminded to heal themselves as illustrated by the Christian "Physician, heal yourself." Shamans have undergone initiatory processes in which they experience the journey through the underworld and the accompanying transformations, the chief pathways to healing in this tradition. Similarly, precedent has been set in the psychoanalytic and marriage and family systems in which practitioners in training have undergone the processes and techniques leading to self-knowledge and wholeness. In spiritual traditions, as well as in professional psychology, practitioners have also used the tools and procedures of healing to benefit themselves. As the boundaries between spirituality and psychology have become less rigid, it is likely that oftentimes these tools and practices are spiritual in nature.

Therefore, the goals of this study were twofold. First, doctoral-level counselors' conceptualizations of spirituality were examined including whether or not they believed in a transcendent dimension and if it was personally meaningful. Second, the relationship between spirituality (operationalized as experiences and practices) and the health and life satisfaction of doctoral-level counselors was studied. Toward these ends, this chapter presents an overview of the literature in a number of relevant domains. First, the introduction continues with a deeper exploration of the concept of spirituality. The

Background of the Problem section is a discussion of the state of the research literature

with regard to spirituality, health, and life satisfaction of counselors. Statement of the

Problem presents an overview of the proposed investigation, and it is followed by

Definition of Terms, and Research Questions and Hypotheses. Finally, a summary is

presented, and the remainder of this work is introduced.

Spirituality: Common Conceptions

Conceptualizations of spirituality came in as many diverse forms as there are

people. For example, one individual may experience the sacred looking into the light in a

child's eyes, and another person may understand spirituality as praying during weekly

services with a religious community. So what did we mean by the term spirituality, and

how did we incorporate it into an empirical investigation? Spirituality was often

characterized and defined by its transcendent nature, and it may or may not have been

derived from a formal religious tradition as suggested by Plante and Sherman (2001). That

is, what were often understood as spiritual were those elements both in and beyond us that

gave meaning and vitality to life's events (Maugans, 1996). As Larson, Swyers, and

McCullough (1998) suggested, spirituality is a multidimensional space in which everyone

can be located, thus avoiding, as Miller and Thoresen (1999) clarified, taxonomies such as

spiritual or not spiritual, and more or less spiritual. Similarly, Conn (1987) defined

spirituality as self-transcendence that gives integrity and meaning to life by situating the

person within the horizon of ultimacy. Similar to the Fetzer Institute/National Institute on

Aging Working Group (1999), the distinction was made that spirituality allowed us to

transcend the boundaries of our egos and connect with a wider experience, human and

divine. Richards and Folkman (1997) summarized two characteristics through which spirituality was understood. First, a person has a deeply felt personal experience of merging with something that, prior to the experience, was considered outside the self, thus experiencing transcendence. Second, the person sensed or felt close to the presence of a higher order, force, or energy larger than him or her, but of which he or she was a part (Richards & Folkman, 1997, p. 529).

Spirit and matter are one. That is, spirituality by its very nature connects the fields of energy through the force or phenomenon that animated them and gave them vitality. Thus, connection was also often a central characteristic in definitions of spirituality. For these purposes, the definition of spirituality proposed by Griffith and Griffith (2002) was used. They suggested a simple, practical definition of spirituality that was multidimensional in its focus:

> Spirituality is a commitment to choose, as the primary context for understanding and acting, one's relatedness to all that is. With this commitment, one attempts to stay focused on relationships between oneself and other people, the physical environment, one's heritage and traditions, one's body, one's ancestors, saints, Higher Power or God. It places relationships at the center of awareness, whether they are interpersonal relationships with the world or other people, or intrapersonal relationships with God or other nonmaterial beings. (Griffith & Griffith, 2002, p. 16)

By extension, spirituality was the integration of the sacred in daily living, so the process also involved the search for the sacred (Pargament, 1997). The question here became what do we hold sacred? Thus, spirituality at this level was an orienting, motivating feature, in other words, a way of living (Hill & Pargament, 2003). When conceptualized in its wholeness, spirituality not only encompassed the transcendent dimension, but also included the grounding of the sacred in the mundane. Spirituality was then understood as the integration of the human and divine enhanced through practices including, but not limited to, ritual, prayer, meditation, and service accelerating its development. Furthermore, spirituality offered individuals a diverse set of tools for coping with the full spectrum of life experiences in addition to offering avenues for discovering and developing significance of these events. These characterizations of spirituality transcended doctrine, practices, and culture.

Religion, on the other hand, was commonly described as the institutions and doctrines that circumscribed and interpreted experience of the transcendent. In this investigation, religion was reported as a demographic characteristic as opposed to being explored as a primary variable so that doctrine and belief systems were not compared. Rather, religious affiliations were examined according to those reported in the literature concerning psychologists and related professionals and the population at large.

Religion and Spirituality in the General Population

In general, according to survey data, the American population has been described as being religious overall (Gallup, 1995; Hoge, 1996; The Pew Research Center for the People & the Press & The Pew Forum on Religion & Public Life, 2002). A 1995 Gallup

poll (Gallup, 1995) found that the overwhelming majority (96%) of Americans said they

believed in God or a universal spirit, and approximately 88% of Americans reported that

religion was important in their lives. However, as the results of the Gallup poll suggested,

over the course of three decades, there has been a 10-point decline in the percentage of

Americans who reported religion was very important to them. That is, in 1995, 60% of

Americans overall said religion was very important in their lives, whereas in 1965

approximately 70% indicated this level of salience of religion. The 1995 Gallup poll

results suggested that women were more likely to be classified as religious than men (41%

vs. 29%), and individuals over the age of 50 were more likely to self-report as religious as

compared with those younger than age 50 (42% vs. 31%). The poll found no significant

differences by education or income.

Background of the Problem

The field of professional psychology, when considering spirituality at all, has most

often focused on the belief system and practices of the client. However, this focus has not

been empirically oriented (Rose, Westefeld, & Ansley, 2001). Similarly, the research base

was not well-developed concerning the spirituality of counselors and other mental health

professionals, although there were notable exceptions (see Bergin & Jensen, 1990;

Lannert, 1992; Shafranske, 1996b, 2000, 2001; Shafranske & Malony, 1990 for examples).

Moreover, because people have most often sought psychological services in times of crisis,

transition, stress, and pain, it was important, given the transference and countertransference

dimensions of the therapeutic milieu, that counselors maintained, and sometimes restored,

their own health. There was virtually no empirical research investigating the spiritual

experiences and practices of counselors and their relationship to health and life satisfaction.

At first glance, the literature was equivocal concerning the religiousness and spirituality of psychologists. However, once spirituality and religion were teased apart as variables, the research base became clearer regarding the spirituality of psychologists and related professionals. For example, Shafranske and Malony (1990) reported findings of a study assessing religiousness and spirituality of doctoral-level counseling and clinical psychologists. Results indicated that 48% of respondents reported the salience of religion to be fairly to very important. On the other hand, a significantly larger percentage (73%) reported that spirituality was fairly to very important. Shafranske and Malony interpreted these findings to mean that the spiritual or noetic dimension was important to the most highly educated psychologists, whereas religious affiliation was not as important. These results also led the authors to conclude that doctoral-level psychologists were likely to be more similar to the general population with regard to self-reported relevance of spirituality and religion than once was thought. In addition, Lannert (1992) found that the majority of internship training directors (90%) responding to a survey reported that spirituality was personally salient to them.

Shafranske and Malony (1990) also examined the ideological orientations of psychologists. Results of these investigations indicated that approximately 40% endorsed a personal transcendent God orientation; 30% of respondents believed in a transcendent dimension present in all of nature; 26% reported that all ideologies were illusory, yet meaningful; and 2% indicated that ideologies concerning the transcendent were illusory

and irrelevant to the real world. These findings suggested that in terms of spiritual ideologies, the majority of psychologists (70%) believed in a transcendent dimension.

Interestingly, given that 73% of doctoral-level psychologists, according to Shafranske (1996b), reported that spirituality was personally meaningful, the significantly lower (below the majority) endorsement of the salience of religion raised the question of how spirituality was understood and/or experienced by doctoral-level psychologists. These findings suggested that further investigation of psychologist spirituality was warranted, particularly concerning the experiential and behavioral (i.e., practices) domains. In addition, an examination of the integration of spiritual experience and practice and their affects on health were also relevant in current research considering counselor spirituality.

Statement of the Problem

Shafranske (1996b, p.150) suggested that the clinician's personal values, beliefs, and faith commitment have entered clinical discourse, shaped technical interventions, and yielded behavioral prescriptions. He continued that it was reasonable to assume that the preprofessional experiences and ongoing personal life of the therapist were typically influential in the therapeutic process. Culture, spirituality, history, family, and so on shaped the backdrop against which counseling was conducted, sometimes in subtle, sometimes in overt ways (Shafranske, 1996b). Similarly, it was asserted that subtle influences were often covert, thus imparting significance to the experiential domain of spirituality and its likely influence as a process variable in counseling.

Counselors and other mental health workers have been in the business of promoting, preserving, and restoring health, and spirituality has been regarded as a factor

that influences health. Given that the psychotherapeutic relationship was afforded great status across theoretical orientations (Gelso & Carter, 1994), it followed that the health of the therapist was a likely variable in therapeutic outcome. Furthermore, previous work suggested that doctoral-level psychologists (70%) believed in a transcendent dimension, and approximately 73% of doctoral-level psychologists reported that spirituality was personally relevant (Shafranske, 1996b; Shafranske & Malony, 1990). It was reasonable then to question whether there was a relationship between spirituality and health in this population.

Larson et al. (1998) outlined common conceptual and methodological issues based on an extensive review of the relevant literature. For example, they suggested that there was little consensus concerning definitions of "religion," "religiousness," and "religious commitment." Not surprisingly, Larson et al. noted that this problem was compounded in attempts to study the "more nebulous concept of spirituality" (p. 4) and further exacerbated by the wide variety of assessment tools available to study religion and spirituality. Hood et al. (1996) concurred, highlighting the difficulties inherent in the empirical measurement of spiritual experience. Moreover, spirituality was sometimes conceptualized and measured in global terms such as religious affiliation, belief systems, or values often with only one or two items (Hill & Pargament, 2003). Therefore, we have not understood the mechanisms through which spirituality has affected health, although authors have attempted to glean patterns from previous research (Hill & Pargament, 2003; Levin, 2001; Thoresen et al., 2001).

Miller and Thoresen (1999) outlined a set of dimensions whereby religious/spiritual factors might be examined. This was important because findings from

the empirical evidence to date have not clearly indicated what it was about religious and spiritual factors that actually influenced health. Those dimensions included overt behaviors and subjective experiences, the two domains of spirituality investigated in the current study, in addition to beliefs and motivations, values, and goals. In any event, spiritual factors were often represented by religious involvement, and even when controlling for possible confounding variables, research has shown a link between involvement often measured as attendance at religious services and health (Levin, 2001; Thoresen et al., 2001). Simply stated, this study was an investigation of the relationship between spirituality (operationalized as experience and practices) and the health and life satisfaction of doctoral-level counselors.

It may be asserted that the counseling relationship itself is spiritual in nature, and it may be entered into, conducted, and terminated without ever using the word "God" or becoming ensnared in belief systems that may be beyond the scope of the therapeutic relationship. In addition, the danger of bias may arise in the comparison of belief systems and religious institutions. For these reasons, this investigation was a study of the experiential domain of spirituality as contrasted with belief systems and religious doctrine per se. The combination of spiritual experience and practices was postulated to be a reflection of an ongoing, grounded commitment to Spirit.

This study was correlational by design, and as a result, inferences of cause and effect were not made. Paper-and-pencil tests were administered to participants to examine the constructs hypothesized to be related to health. Underwood and Teresi (2002) developed an instrument to assess daily spiritual experiences, the Daily Spiritual Experience Scale (DSES; Underwood & Teresi, 2002), and an inventory designed as a

self-report measure of spiritual practices was created specifically to be used in this investigation. Together, these two instruments were used to examine spirituality in everyday terms. Health was operationalized as scores on the SF-12v2™ Physical and Mental Health Summary Scales (SF-12v2™; Ware, Turner-Bowker, Kosinski, & Gandek, 2002). Life satisfaction was evaluated via the Satisfaction With Life Scale (SWLS; Diener, Emmons, Larsen, & Griffin, 1985). In addition, a data form was administered to gather demographic information.

Definition of Terms

Health: As noted by Ware, Kosinski, and Keller (1994) The World Health Organization definition: A state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.

Life Satisfaction: A cognitive, judgmental process in which a person's assessment of life satisfaction is dependent upon a comparison of one's circumstances with a standard one sets for oneself. This standard is not externally imposed, and as a result, individuals impose different values upon domains associated with life satisfaction. For these reasons, life satisfaction is a global, overall assessment as compared with a summation of domains of life satisfaction (Diener et al., 1985).

Spiritual Experience: The perception of the transcendent and the perception of, interaction with, or involvement of the transcendent in life (Underwood, 1999).

Spiritual Practice: A behavior, or set of behaviors, undertaken voluntarily by an individual, grounded in a spiritual belief system.

Spirituality: Spirituality is a commitment to choose, as the primary context for understanding and acting, one's relatedness to all that is. Relationships are at the center of awareness and they include one's relationship with God, other nonmaterial beings, other people, and the world (Griffith & Griffith, 2002).

Research Questions and Hypotheses

Essentially, this study asked a series of questions:

1. How did doctoral-level counselors conceptualize spirituality?

2. Did doctoral-level counselors having more frequent daily spiritual experiences also experience greater physical and mental health compared with doctoral-level counselors who reported less frequent daily spiritual experiences?

3. Were daily spiritual experiences related to life satisfaction in a sample of doctoral-level counselors?

4. Did doctoral-level counselors performing spiritual practices more frequently experience greater physical and mental health compared with doctoral-level counselors performing spiritual practices less frequently?

5. Were spiritual practices related to life satisfaction in a sample of doctoral-level counselors?

6. Did connection to the transcendent, social connection, and frequency of spiritual practices predict physical and mental health in this sample of doctoral-level counselors?

Research Hypotheses

A number of hypotheses guided this study.

H1: Counselors having more frequent daily spiritual experiences will also report significantly higher levels of physical and mental health. This difference will vary according to sex.

H2: Counselor life satisfaction will be significantly, positively related to counselor daily spiritual experience.

H3: Counselors engaging in more frequent spiritual practices will report significantly higher levels of physical and mental health as compared with counselors performing spiritual activities less frequently. This difference will vary according to sex.

H4: Counselor life satisfaction will be significantly, positively related to spiritual practices.

H5: For the entire sample of doctoral-level counselors, spirituality influences physical and mental health through connection to the transcendent, connection to other people, and frequency of spiritual practices.

Significance of the Study

As Larson and Swyers (1998) suggested, research in the field of spirituality has been plagued by conceptual, methodological, structural, and institutional barriers; however, given the value accorded spirituality by the general public and psychologists for that matter (Gallup, 1995, Lannert, 1992; Shafranske & Malony, 1990), attempts at further examination were warranted. The proposed study addressed the need to continue to evolve the research base concerning the spirituality of doctoral-level counselors and

psychologists. Spirituality was considered to be a multidimensional phenomenon; as such, it encompassed values, beliefs, experiences, and practices. However, a caveat should be mentioned here. It was antithetical to the nature of wholeness, and by extension spirituality, to reduce it to its basic elements, then to measure it using Western empirical techniques. Thus, existing measurement tools have created a false structure for the construct of spirituality. Nevertheless, given its personal relevance in the lives of psychologists, as evidenced by the extant literature, it was important to use, modify, or design measurements that have allowed us to more deeply examine this phenomenon. This investigation represented another step in the evolving exploration of the spirituality of doctoral-level counselors.

Precedent has been established for the integration of spirituality with psychological theories of human experience in the fields comprising professional psychology. In other words, theoretical stances and some seminal works in the field of psychology have incorporated Spirit and spiritual and religious perspectives into their essential themes and hypotheses. For example, Afrocentric approaches (Edwards, 1998; Myers, 1988), the work of the Transpersonalists (Jung, 1963; Maslow, 1970; Strohl, 1998), and the seminal writings of James (1994) combined spirituality with psychological theory and techniques. Currently, there has been an emerging interest in bringing spirituality into counseling from a number of different angles such as assessing client spirituality and working with clergy as adjuncts in treatment.

Counseling has been fertile ground for using spiritually-oriented techniques for self-knowledge and transformation. These techniques have harnessed the potential of the human imagination to heal and transform, thus mobilizing the healer within all of us.

However, because these techniques are powerful gifts, they must be used with great care and skill. It followed, then, that exploring the relationship between spirituality and health was warranted, because integration of spiritual techniques in psychotherapy requires practice and experience on the part of the therapist. It made sense to inquire to what degree spiritual practices were used by doctoral-level counselors and whether or not they were related to health.

The practice of psychotherapy has necessarily encompassed the relationship itself, which has been posited to be a central, if not the quintessential therapeutic factor (Gelso & Carter, 1994). Because spirituality and health have been found to be related (Fetzer Institute/National Institute on Aging Working Group, 1999; Larson et al., 1998; Levin, 2001), it followed that an examination of therapist spirituality as it related to health was warranted particularly because therapists may be susceptible to high levels of stress, burnout, and vicarious traumatization through the relational matrix of the counseling process.

The results of this investigation are likely to also have implications for the design of training programs and continuing education courses. Shafranske and Malony (1990) found that an overwhelming majority (95%) of psychologists surveyed were not formally trained in spirituality and related religious themes, and as a result, in general, counselors were likely to be ill-prepared to work with spiritual and religious material in counseling context. W. Miller (1999b) concurred suggesting that clinical training programs do little to prepare students for the diversity of religious and spiritual perspectives they may encounter in clinical work.

In 1995, spirituality competencies in four domains were identified in a meeting of scholars who had published books and or articles on spirituality in counseling. This Summit on Spirituality (G. Miller, 1999) addressed four knowledge domains in which competence was described. They were general knowledge of spiritual phenomena, awareness of one's own spirituality, understanding the client's spiritual perspective, and spiritually related interventions and strategies. Using these domains to construct a survey instrument, Young, Cashwell, Wiggins-Frame, and Belaire (2002) conducted a study of Council for Accreditation of Counseling and Related Education Programs (CACREP) liaisons. Results suggested that respondents agreed that competence in spirituality was an important aspect of professional preparation of counselors. Second, respondents felt moderately prepared to infuse spirituality competencies into teaching and supervising responsibilities. Of those who reported that they were "very unprepared," 85% indicated that more training was needed to meet the competencies. Third, respondents reported that the other faculty members in their program were generally less prepared than they were to address spirituality competencies as part of the curriculum. The current investigation was designed to add to the body of knowledge in the domain of the awareness of the counselor's own spirituality.

<div align="center">Summary</div>

Research has suggested that clients and counselors value spirituality in their personal lives, yet spirituality has not been an integral element of mainstream professional psychology training, research, and practice. Moreover, an emerging body of literature has indicated that spirituality is a factor that influences health and well-being.

This investigation examined doctoral-level counselors' conceptualizations of spirituality and the degree to which spirituality was related to health and life satisfaction in a sample of doctoral-level counselors. Toward this end, and to more clearly discern the relevance of spirituality and counselor health to the counseling process, the next chapter, Review of Related Literature, presents a blueprint whereby this connection may be established.

Chapter II

REVIEW OF RELATED LITERATURE

Introduction

The overarching goals of this chapter are threefold. First, it is relevant to locate spirituality in contemporary psychology theory and practice and to review the current literature concerning the spirituality of doctoral-level psychologists and related professionals. The second and related goal of this section is to investigate the research base regarding the relationship between spirituality and health. The third goal is to link the aforementioned concepts to propose that counselor spirituality is a process variable likely to influence therapeutic outcome.

In order to accomplish these goals, this chapter is organized in three general domains. The first segment of this chapter concerns spirituality in counseling context, and this section blends two overall themes. First, psychospiritual orientations are surveyed to set the precedents in the field for the incorporation of spirituality in psychological theory and practice. Second, to begin to construct a logical, relevant bridge between spirituality and the health and life satisfaction of counselors, the counseling relationship is explored. Next, an overview of the research concerning the spirituality of psychologists and related professionals is presented. In the third and final section of this chapter, the current research concerning the relationship between spirituality and health is examined. Specifically, the relationship between spiritual experiences, practices, and health are reviewed. This chapter combines these concepts to propose that spirituality is relevant to the health of counselors, and it likely affects the overall blueprint of contemporary counseling practice.

Spirituality in Counseling Context

A Survey of Psychospiritual Traditions

Although theorists such as James (1994), Jung (1963), Maslow (1970), Myers (1988), and Edwards (1998) have integrated spirituality into psychotherapy, in the main, we have been in the early stages of integrating soul, mind, and body in counseling context. The evolution of formally harmonizing spirituality and counseling has been following a developmental trajectory that has been almost circular in its course. Ancient traditions, such as those represented by the Afrocentric approach and Buddhist thought, as well as early theorists and writers in contemporary Western psychology (such as James and Jung) developed their ideas with spirituality at their core.

A sample of psychospiritual approaches has suggested that healing centered on the notion that the human soul is a spark of the divine (e.g., Edwards, 1998; Jung, 1963; Myers, 1988). Before obstacles to wholeness were examined in these systems, clients and their counselors honored what was already whole in the individual or group. The unalterable, constant center of the person was experienced and anchored such that further exploration proceeded. It was axiomatic in healing that the healer worked with what the client (in this context) could handle, thereby highlighting the critical importance of accurately monitoring the process and relational dynamics of counseling. Accessing this divine core took the form of exercises to open and experience the center of the heart chakra, or dream and symbol analysis, or teaching about the history and cosmology of one's ancestors. This section represents an overview of theoretical orientations that combined spiritual and psychosocial dimensions, and it was necessarily not an all-

inclusive review, but a sampling of the integration of spirituality in psychological theory and practice.

A number of conceptual threads linked psychospiritual approaches to counseling. First, they took a transcendent view of the self that might be conceptualized as an expanded entity that opened to an ever-widening phenomenology. The Self transcended the ego that was immediately experienced by the senses and included one's social collective, transcendent forces, and divine entities. Second, reality was not seen chiefly in a physical, objective sense, but in a subjective, interrelated matrix. Third, it was common to find practices that were commonly thought to be the province of religion (e.g., meditation) used to foster growth and well-being. Fourth, logic was not dichotomous, but diunital. Myers (1988), consistent with African spirituality, Jung, and the Taoists, offered that diuntial logic led to both/and conclusions, and it necessarily involved the union of opposites. Fifth, these approaches were generally not bound by ideology, but they combined elements, truths, and techniques from diverse disciplines and traditions.

Optimal Psychology

This section begins with an examination of Optimal Psychology which blends a number of the aforementioned concepts. Based in Afrocentric epistemology, the optimal world view as described by Myers (1988) was a holistic model in which connectedness transcended time, space, and external experience. Thus, harmony, peace, and wholeness were the experiential hallmarks of this perspective. If one accessed the heart of the optimal conceptual system, one would discover that this center is composed of

relationships in harmony; spirit and matter are one. Therefore, spirituality and interrelatedness constituted the core, essentially the deepest values, of the optimal conceptualization. Asante (1984) illuminated the core of optimal functioning in a discussion of transcendence. In the African mode of transcendence, Spirit was experienced always in relationships with others. According to Asante, there was no withdrawal phenomenon in African spirituality that was often found in other spiritual traditions; rather, the person became the master of his or her powers always in the midst of others, not on the mountaintop or in the valley. The African spiritual tradition was one of "remarkable encountering with others" (Asante, 1984, p.172). This harmony, as Asante asserted, expanded throughout the village and the community. Therefore, at every level, the notion of separation was foreign in this paradigm.

A number of assumptions formed the underpinning of the Myers et al. (1991) worldview conceptual system according to which Afrocentric and Eurocentric paradigms were compared. They all focused upon unity and interrelatedness, on the one hand, as contrasted with fragmentation and discontinuity on the other. In addition, this framework highlighted the differences between materiocentric and spiritually oriented models. Myers et al. posited that it was not the race or ethnicity of a given individual that defined his or her worldview, but the degree of adherence to a fragmented, self-alienating conceptual system that was the salient factor. The crux of this approach, given the centrality of spirituality, was that fragmentation of the conceptual system resulted from misalignment with Spirit, or the interconnectedness of all things, to include one's own place in the overall whole.

Fragmentation was at the root of ill health, and quality of life was improved through a process called Belief Systems Analysis (Myers, 1988). This work was centered on shifting a suboptimal conceptual system to a more spiritually oriented worldview in which the basis of all knowledge was Self-knowledge. According to Myers, the Self was understood as God manifesting, and counseling techniques were used to examine the client's belief system. Belief Systems Analysis used transcendent logic (the union of opposites to draw both/and conclusions) rooted in cultural and historical contexts to explore how one's thoughts affected one's experience. Ultimately, gradual spiritual development, which crossed ideological and religious boundaries, was the healing force in this model. In addition to the examination of conceptual systems, techniques that were thought of as spiritual practices were used to facilitate an understanding of the Self as divine. Examples included, but were not limited to, meditation, biofeedback, dream analysis, astrology, and readings in African history, religions, cosmology, metaphysics, and so on.

The Cognospiritual Model

Edwards (1998) described a "cognospiritual" model of psychotherapy which incorporated spirituality in a treatment approach. This model, which centered on the value of spirituality in African and African American beingness, drew also from Jungian, transpersonal, and cognitive orientations from which its techniques were derived. Phenomenological perspectives concerning the definition of reality were also used to address not only the psychological needs, but the spiritual and political needs of African Americans as well.

A unique component of this modality was its focus on oppression and alienation of African Americans. Edwards drew upon the work of Goldenberg (as cited in Edwards, 1998) to suggest that oppression was a way of experiencing self-in-environment such that one was limited, hopeless, helpless, and expendable. Oppression described in this way had four primary aspects, namely containment, expendability, compartmentalization, and a doctrine of personal culpability which encouraged or predisposed the interpretation of failures as evidence of personal deficit (Edwards, 1998). Alienation was understood as a multidimensional phenomenon, similar to Myers' (1988) concept of fragmentation, and alienation may be manifest in multiple levels of relationships. Beginning with alienation from the self, Edwards acknowledged Bulhan's work in which alienation expanded in scope socially to include alienation from significant others, general others, culture (one's language and history), and creative social praxis which referred to the denial or abdication of self-determining socialized and organized activity. This last form of alienation, according to Edwards, recognized the role of the oppressed in their oppression particularly as it related to the client's failure to recognize the social construction of his or her reality.

The remedy for oppression and alienation was empowerment, but it was not the power of the ego or of the material realm. In this system, the source of power was the spark or part of God within everyone (Edwards, 1998). Techniques from Western psychological approaches were used secondary to African spirituality as contrasted with using them only in the context of their own theoretical stances. For example, although as Edwards summarized, authors have suggested that Jung harbored racist attitudes, his work was applicable in the cognospiritual approach because of its focus on symbols and

transpersonal domains of experience. Likewise, techniques from cognitive behavioral therapy, such as cognitive restructuring, were effective in examining and reforming a client's belief system to transform feelings of powerlessness. Therefore, by knowing oneself as a spark of the divine, the person reclaimed his or her own creative power. This required healing feelings of powerlessness through an understanding of the roles of oppression and alienation in one's experience.

Jungian Psychology and the Transpersonalists

It was far beyond the scope of this work to fully describe Jung's landscape of the human psyche; therefore, this section represented relevant domains of Jung's work applicable to the current study. Jung's comments and theoretical perspectives concerning the therapeutic relationship are described later in this chapter in the section on the relationship itself. A central construct of Jung's psychology was the union of opposites, which included the union of the soul with God (see Jung, 1963, for a more detailed explanation of the Mysterium Conionctionis). As such, Jung's theory was inherently a spiritual one in which this union was attained through a transformational process similar to Campbell's (1972) descriptions of the journey of the hero culled from mythologies throughout the world. To oversimplify the general rhythm of this process, as might be guided by Jung (1963), it began with descent (encountering the shadow of one's psyche, or otherwise conceptualized as the descent into one's personal hell). The soul then ascended, which might be likened to emerging victorious from the struggle with one's shadow that is largely unconscious, but has now been made conscious. Finally, the second descent was the individual returning to give the gifts of his or her soul that were

discovered in this unfolding of Self-knowledge. There were various techniques that were used in this process, but by and large, they were focused on symbols and their interpretation. Symbols emerged through dreams, the transference, and techniques such as mandala drawing and other similar projective devices. Jung (1963) also referenced the use of astrology and planetary placements to more clearly conceptualize the soul's path over time.

Ulanov, a professor of theology and trained Jungian analyst, clarified a number of points relevant to this discussion of Jung's work. According to Ulanov (1999), Jung afforded great value to organized religion, but he cautioned that adherence to dogma and doctrine may be a defense against direct religious experience. Direct encounters with the divine may be overwhelming, and traditionally, as Ulanov explained (citing Jung), organized religion contained images of the divine. However, Jung believed that in the 20th century, organized religion became a weak container for the psychic energy related to the meaning that lies at the center of life (Ulanov, 1999). As a consequence, the images, archetypes, and experiences have been turned back on the psyche, according to Ulanov.

The psyche is where God or the divine is experienced, and the Self, as Ulanov (1999) highlighted, is essentially the archetypal center of the psyche. In Jung's system, according to Ulanov, the Self is an entity separate from the ego, yet the two are linked. The Self is also connected to the collective; thus it is neither fully personal, nor is it entirely beyond the individual. As Ulanov cited Jung, the Self is a larger and more authoritative presence as it is experienced from the vantage point of the ego. The Self is the organizing principle of the psyche, and healing for Jung involves revivifying the

connection to the transcendent, the center, the source (Ulanov, 1999). That is, healing occurs as the Self and ego are engaged in dialogue across the gap that separates them. Ulanov clarified that if we really became aware of the gap between the ego and the Self, we would discover our images of God.

Strohl (1998) described transpersonal psychology as the branch of psychology that studies states of consciousness, identity, spiritual growth, and levels of human function beyond those commonly accepted as "healthy and normal." Strohl also acknowledged that Jung was the first to use the term transpersonal consciousness likening it to the collective unconscious. Not only did transpersonal states transcend limits of the ego, but they were also not bound by limitations imposed by conventional time and space. Again, by definition, it was a human state of being that was inherent in all things, yet beyond finite limits. Moreover, similar to the Afrocentric world view as described by Myers (1988), and modern physics as noted by Strohl, transpersonalism illuminated the common themes of knower and known are one (all reality is subjective), the interconnectedness of all things, and harmonious unity.

Healing in this model combined dualistic and monistic approaches as Strohl (1998) suggested. Dualism proposed that polarities were complementary and harmonious, whereby the human and divine can be reconciled. Monism directed the individual's attention inward to ultimately know one's Self as divine. Although Strohl indicated that systems theory and Jung's work were essentially dualistic, the transpersonalists blended monistic and dualistic paradigms to work with the whole person such that dichotomies were transcended. Similar to the Afrocentric view, Maslow (1970), who was generally thought of as a transpersonalist, said, "As always,

dichotomizing pathologizes and pathology dichotomizes" (p. 13). These fragments, according to Maslow, were ultimately nonviable. Opposites both formed the whole and were to be integrated according to transpersonal perspectives, in contrast to mechanistic approaches in which dichotomizing has fragmented and flourished.

Maslow (1970) also wrote about transcendent experiences, for which he coined the term "peak experiences." Not only were they the basis of all the world's major religions, but as Maslow wrote, they were the province of all human beings. In fact, Maslow believed those individuals considered to be "non-peakers" did not have peak experiences because they were unable, but because they suppressed them, denied them, or pathologized them thinking themselves to be insane and out of control. Thus, Maslow posited that fully functioning human beings had peak experiences and, by definition, they experienced greater degrees of psychological health. Non-peakers, on the other hand, were more mechanistic and materially oriented, did not acknowledge mystical experiences, and were therefore less psychologically healthy than so-called "peakers." This was essentially the same underpinning as Myers' (1988) framework of optimal and suboptimal conceptual systems as discussed previously in this chapter.

The Work of William James and Current Neuroscience Research

Given the timelessness of spirituality and mystical experience, an interesting juxtaposition to consider was the ideology of William James conjoined with the findings of current neuroscience research. James, in the classic *The Varieties of Religious Experience* (1994), described mystical experience in kind and degree, thus making it the province of the common person. Furthermore, mystical experience, or direct experience

of the transcendent dimension, was commonly thought to be the result of psychotic

process or, at best, a misinterpretation of internal stimulation. As Western scientific

technology has evolved, findings from the field of neuroscience have supported human

experience of the transcendent as being "hard-wired" in the circuitry of the human brain

(Newberg, d'Aquili, & Rause, 2001), across time and cultures. Human beings, therefore,

have a need for spiritual experience. For these purposes spiritual experience was

explored, often induced through spiritual practices, through the lenses of an early writer

in the history of contemporary Western psychology and that of the most advanced

techniques that map activity in the human brain.

James acknowledged that mystical states were often discussed with reproach, and

that many took a dim view when attempting to explain them or derive meaning from

them (James, 1994). Although it was important to acknowledge the shadow side of

mystical phenomena, James, in contradistinction, focused his examinations and

descriptions of mystical experience in the context of health. To this end, he described a

spectrum of experiences of the transcendent as a matter of degree. Examples included

common everyday experiences, such as hearing a poem or piece of music one may have

heard hundreds of times in a whole new way. The next step on the "mystical ladder,"

according to James, was the nearly overwhelming feeling of having been in a certain

place before. A deeper plunge into mystical consciousness was the feeling that

everything has meaning. He cited an example in which Charles Kingsley described "a

feeling of being surrounded with truths which I cannot grasp amounts to almost

indescribable awe sometimes" (James, 1994, p. 419). A deeper state of mystical

consciousness, according to James, was characterized by a trance-like state that sweeps

over one without warning in which time, space, sensations, and other factors that were previously known to be the self were obliterated. All that remained in this state was the feeling of pure, abstract, absolute Self. Although he recognized the pathological aspect of intoxicated states, drug- and alcohol-induced states were also categorized as mystical phenomena according to James. In fact, shamanic traditions throughout the world have often used natural intoxicants, such as peyote, to bring about altered states of consciousness in their healing practices. James also recognized the power of nature to evoke mystical states. He noted that literature was replete with examples of how the beauty of nature, such as the ocean, might overwhelm one and evoke an experience of mystical union with a wider reality. Drawing from the work of R.M. Bucke, James described the highest level of mystical experience, or cosmic consciousness. This state was not simply an expansion of the self into that which we were most familiar, but a consciousness of the life and order of the universe, a sense of immortality, wholeness, and connectedness. Attempts at describing cosmic consciousness have failed; however, because this level of consciousness has existed beyond all limitations including thoughts, emotions, language, and even perception of the self as a separate, perceiving entity. It should also be noted here that, although mystical experiences were typically indescribable in words, they have an overwhelming emotional quality to them often likened to profound joy, awe, rapture, and ecstasy. At times they have involved seemingly paradoxical emotional states such as profound peace that emerged from deep, bone-chilling fear. That is, encountering the Divine may be so overwhelming that it may be experienced as sheer terror, a notion echoed by Ulanov (1999).

If we were to fast forward, so to speak, to the most recent techniques in brain-mapping, we would discover, as Newberg et al. (2001) suggested, neurobiological correlates to mystical experience. First, similar to James (1994), Newberg et al. defined the much-maligned term "mystical experience." They wrote that across spiritual traditions and time, mystical experience was simply an uplifting sense of genuine spiritual union with something larger than the self, and these states were attained through practices as diverse as drumming, pious self-denial, and ritualized sexuality. Also, similar to James and Maslow, Newberg et al. noted that mystical experience happens to all of us, citing examples such as being lost in a piece of music or falling in love, indicating neurological functions that make it happen. Newberg et al. found that when the brain's orientation area was deafferented, or deprived of neural stimulation, a limited sense of self was softened as we merge into a wider reality. Consistent with James and African traditions, rhythmic behaviors cause the orientation area of the brain to be blocked from neural stimulation to varying degrees resulting in a wide spectrum of unitary states. It was this unitary continuum, as named by Newberg et al., which linked everyday spiritual experiences with peak experiences described by mystics. They also suggested that the arousal and quiescent systems of the autonomic nervous system, in addition to the limbic system, were activated during spiritual experiences. The limbic system's involvement was significant because it integrated emotional impulses with thoughts and perceptions to produce complex emotional states (Newberg et al.).

Summary

Upon examination, these aforementioned psychospiritual traditions combined psychological theory with spiritual experience and practices. This suggested that spiritual experiences, along a continuum, have had their place not only in contemporary psychological thought and the advances of neuroscience, but they have been important in the history of Western psychology. This was principally because spiritual experience was grounded in human experience and, as recent neuroscientific research has found, the human brain is wired for spiritual experience. Moreover, a critical dimension these approaches shared was that they related spirituality, regardless of religious doctrine, to health, particularly mental health. In some of these traditions, however, health considerations also encompassed the physical body and the wider social network. Precedents have been established in professional psychology to draw upon spirituality in theory and practices to transform the health of a client. These assertions open into the next segment concerning the counseling relationship, because counseling was not a mere application of techniques absent a context. Rather, it has been widely recognized in the field of professional psychology that the relationship itself heals.

The Therapeutic Power of the Counseling Relationship

Gelso and Carter (1985, 1994) proposed a tripartite model of the counseling relationship that crossed ideological boundaries. The three components were the real relationship, the transference/countertransference dynamics (the "unreal" relationship), and the working alliance. To begin to modify the transference/countertransference

domain, Orange (1994) proposed the notion of co-transference, given the history of considering countertransference as a distortion, or a negative phenomenon. Countertransference traditionally, at the least, was to be reduced in the therapeutic relationship. The concept of co-transference recognized that analytic work, or the counseling relationship for that matter, was a system of mutual influence. Counselor and client were whole participants, and both were transformed by the experience.

It was important for the purposes of Western empiricism to delineate components of the counseling relationship so that they may be studied and described; however, in a seemingly off-hand remark, Gelso and Carter (1985) noted that something "mystical" happened in the context of the counseling relationship. That is, there existed other elements of the relationship itself that defied description or definition. Thus, if we took this remark completely out of context and expanded it, modified it by using Jungian conceptions of transference and countertransference, and further integrated intersubjectivity theory, we could propose a model that might more closely approximate the complexity of what occurred in the therapy hour and beyond.

Jung (1954) described the transference/countertransference matrix, most notably for these purposes, in terms of its intensity and the interaction of the patient's maladjustment with the doctor's mental health. Concerning intensity, Jung agreed with Freud that the infantile conflict persisted with all its intensity and was projected onto the analyst in kind. Jung suggested that the bond created by this intense transference could almost be called a combination. Likewise, when two chemical substances were combined, both were altered, according to Jung. Moreover, the transference influenced the therapist to the extent that the therapist's mental health might suffer in that the

therapist assumes the suffering of the patient and shared it with him or her. Yet, as Jung noted, this was a risk the therapist ran in the nature of the therapeutic milieu. The transference relationship, then, in this framework was an instinctive energy interchange. Jung described it as being instinctive on the part of the patient in that projection was the key underlying mechanism, and as such, it cannot be demanded or controlled as a requisite of treatment. However, given the combination of the analyst and patient, similar to a chemical combination, the therapist was also involved in this energy interchange, much of the contents and process of which come straight from the unconscious which housed potentials for good or ill (Jung). It was these contents that Jung wrote "flit about from patient to doctor" (Jung, 1954, p. 24). Therefore, it was conceivable that one or both individuals in the therapeutic relationship may become overwhelmed by them.

Sucharov (1994), integrated concepts from Kohut's self psychology and quantum theory and proposed a number of points that de-mechanized the analytic relationship. These points may be transferred to other formats of counseling practice. Intersubjectivity theory, similar to quantum theory, posited that the observed and the observer constituted one indivisible unit, or one quantum domain that existed within other quantum domains. In other words, all energy exists in an interrelated whole. Energy is discontinuous in quantum theory giving rise to the discovery of the wave and particle features of matter. In addition, it is impossible to measure with any degree of certainty the position and momentum of any particle which is known as the Heisenberg uncertainty, as Sucharov acknowledged. According to Sucharov, the wave feature in analysis was likened to the potential of the intersubjective field, while the particle feature referred to the actualization of a potential at the moment of observation. It should be noted here that

whereas in mechanical systems past and future are determined, a quantum system is an ever-evolving series of potentialities shaped and reshaped by the distinctive qualities of its irretrievable past (Sucharov). Empathic interactions, by actualizing potentialities of the intersubjective field, create new potentialities by generating new sets of possibilities, according to Sucharov. It was this empathic dialogue that both "illuminates and transforms." Sucharov also emphasized that the wave feature of a quantum system reflected wholeness in the broad sense, such that waves may combine with other waves to create new wholes in addition to the self-transforming qualities of the system itself. Thus, context cannot be removed from phenomena, and the system cannot be reduced to the sum of its parts. Not only were therapist and client unified in this paradigm, but cognition and affect were inseparable as well.

Whether it was called the intensity of the transference or the potentiality of a quantum system, the psychotherapeutic relationship can bring about stress reactions in counselors thereby negatively influencing health and life satisfaction. This was particularly evident in the field of trauma counseling in which counselors have experienced vicarious traumatization, compassion fatigue, and burnout (Arvay & Uhlemann, 1996). Vicarious traumatization describes the symptoms of trauma that therapists experience as a direct result of working with clients who have been traumatized. According to Figley (1995), these symptoms mirrored those of posttraumatic stress disorder (PTSD), including intrusive thoughts, impaired sleeping and eating habits, sadness, depression, irritability, anger, and hyperarousal. When practitioners experienced burnout, according to McCann and Perlman (1991), they experienced the same numbing, distancing, and avoidance that resulted from the inability

to process the traumatic material. They also suggested that stress and burnout were cumulative. A particular danger was the loss of empathy and attachment that counselors brought to the therapeutic relationship, thus rendering them ineffective at best.

So far, we have seen that spirituality has been an important ingredient in some approaches to mental health, and that spiritual experiences, along a wide spectrum, were innate in human beings. For counselors, descriptions of the therapeutic relationship have typically suggested that there were unnamed components to the relationship, most notably that the relationship was a combination in which both participants were transformed. Therefore, spirituality, given its focus on the interrelatedness of all things, was likely to be a process variable; however, spirituality was not limited to belief systems per se, but it also encompassed experience and presence. The next section then explores the research base concerning the salience of spirituality for psychologists and related professionals.

Counselor Spirituality

The empirical literature concerning counselor spirituality and religiousness was underdeveloped at best. Conceptually speaking, counselor spirituality has primarily been explored in the psychological domain. That is, beliefs, attitudes, and values have been investigated by Shafranske (1996b, 2000, 2001), Shafranske and Malony (1990), Lannert (1992), and Bergin and Jensen (1990). The method most often used to collect data from psychologists concerning their spirituality has been the survey approach that was used by the above-noted authors.

Results of relatively more recent research projects (Bergin & Jensen, 1990; Shafranske, 1996b, 2000, 2001; Shafranske & Malony, 1990) contradicted earlier notions that psychologists did not value spirituality and religion to the degree to which the general population revered these traditions. In fact, research findings indicated that psychologists were more similar to the general population than once was thought. This section is an examination of the research literature concerning the spirituality and religious affiliations of psychologists and related professionals. It represented an exploration of the cognitive, emotional, valuing domains of counselor spirituality in contrast to the spiritual experiences and practices of doctoral-level counselors. Because the research base concerning the spirituality and religious affiliations and commitments of counselors and related professionals was evolving, this section was subdivided by author.

The Work of Shafranske and Colleagues

The work of Shafranske and colleagues has accomplished a number of goals in the pursuit of describing the spirituality and religiousness of doctoral-level psychologists. First, they made the distinction between spirituality and religion. This was an important step in eliciting the finding that, although psychologists valued spirituality as a salient dimension of living, they did not hold religion in as high of a regard. This distinction was significant in drawing conclusions that a majority of psychologists actually did value spirituality and considered it to be personally meaningful and relevant.

Shafranske and Malony (1990) examined the nature of clinical psychologists' religiousness and spirituality, their attitudes toward religiousness, their utilization of

religiously oriented interventions in therapy, and their training regarding religiousness and spiritual issues. They drew a random sample of 1000 clinical psychologists from the 1987 membership of Division 12 (Division of Clinical Psychology) of the American Psychological Association (APA), and they mailed a 65-item questionnaire to each prospective participant. This survey contained sections related to (a) demographics; (b) an ideology orientation scale (measuring degrees of belief in a personal God); (c) external, internal, and quest scales (which measured dimensions of religiousness); (d) items that assessed attitudes toward religion and psychology and clinical training experiences; (e) a scale that inquired about attitudes and practices concerning specific counseling interventions; and (f) a case study that examined clinician bias with regard to a depiction of a religious client. To assess the degree to which the sample represented the population, Shafranske and Malony also sent a brief, non-participant survey in each packet of test materials.

According to Shafranske and Malony (1990), of the 409 participants, 26% were females, 73% were males, and 1% did not respond to the gender item. In addition, 96% of respondents held a doctoral degree, the vast majority (93%) were from APA accredited training programs. Theoretical orientation was assessed through a forced-choice item; 33% were psychoanalytic, 30% cognitive, 17% learning theory, 12 % humanistic, and 7% gave multiple responses and were designated as "eclectic" (Shafranske & Malony).

A note should be made here, as Shafranske and Malony (1990) acknowledged, that the results of the survey were skewed in the direction of a positive bias toward spirituality and religion; therefore, findings should be interpreted with caution. This bias was discovered through analysis of the differences between the responses to the 65-item

survey and the 6-item brief non-participant questionnaire. Nevertheless, Shafranske and Malony reported significant results in the domains of ideology, affiliation with organized religion, dimensions of religiousness, religious interventions, clinical practice and training, and bias as revealed in responses to the case vignette.

According to Shafranske and Malony (1990) the domain of ideology was assessed by asking the respondent to choose among six positions concerning the transcendent that ranged from the notion of illusion to a belief in a personal God. Results suggested that the vast majority of the clinical psychologists surveyed believed in a real and salient transcendent dimension as evidenced by 40% who endorsed a personal God orientation and an additional 30% who chose the orientation that affirmed the presence of the transcendent in all of nature. Of the remaining participants, 26% endorsed the position that all ideologies were illusion, yet meaningful, and 2% held the position that all ideologies were illusion and irrelevant in the real world (Shafranske & Malony).

Two other findings concerning ideological orientation were relevant to the current investigation. First, Shafranske and Malony (1990) found that 65% of those responding reported that spirituality was personally relevant. Second, the authors reported that 53% of this sample rated having religious beliefs as desirable for people, 14% endorsed religious beliefs as undesirable, and 33% selected a neutral position. Furthermore, affiliation with organized religion was examined, and the authors found that, although 97% of those surveyed were raised within a particular religion, approximately 71% reported a current affiliation. This number fell to 41% when regular involvement was measured. The average attendance at worship services was less than two times per month, and 49% reported no attendance. A small percentage of this sample reported

disdain and negativity toward religion. Of particular significance was the finding that only 18% of the participants agreed that organized religion was the primary source of their spirituality, and 51% of respondents characterized their spiritual beliefs and practices as an "alternative spiritual path that is not part of any organized religion" (Shafranske & Malony, 1990, p. 74).

External, internal, and quest scales were selected to measure dimensions of religiousness. Shafranske and Malony (1990) adapted the work of Batson and Ventis (as cited in Shafranske & Malony, 1990) who developed a three-dimensional model of religiousness. These three perspectives—means, ends, and quest—when measured yielded a dominant dimension of the ways in which one was oriented toward religion. The means dimension considered the degree to which social and environmental factors shaped one's religiousness, and the ends orientation referred to the function of religion in providing answers to ultimate concerns of living, such as death. The quest orientation referred to the degree to which an individual's religiousness involved an open-ended dialogue with existential issues. According to Shafranske and Malony, a full 28% of respondents were not assessed in this domain because of missing data; however of those assessed, 45% were found to be predominantly in the quest dimension, 32% within the means dimension, and 23% within the ends dimension.

Items that assessed attitudes toward religion and psychology and clinical training experiences yielded significant findings concerning the spirituality of psychologists. First, according to Shafranske & Malony (1990), 74% of those surveyed believed that spiritual and religious matters fell within the scope of psychotherapeutic work. Second, the authors found that approximately 60% of respondents reported that clients often

expressed their experiences in religious or spiritual language, and a significant proportion of the sample (approximately 50%) estimated that a substantial proportion of their clients brought religious or spiritual material to therapy. In addition, Shafranske & Malony found that 52% of participants reported that spirituality was relevant in their professional lives, and 67% believed that psychologists possessed the necessary knowledge and skills to work with spiritual and religious material in therapy. In light of these findings, it was surprising that only approximately one third of respondents expressed personal competence in counseling clients with regard to spiritual or religious matters (Shafranske & Malony).

Shafranske & Malony (1990) used a scale inquiring about attitudes and practices concerning specific counseling interventions to assess respondents' views of their clients' religion and spirituality. These findings were significant in that the overwhelming majority (87%) of psychologists included in this sample reported that it was appropriate to know the religious backgrounds of their clients, and approximately 64% believed that the client's religious background affected the course and outcome of counseling. On the other hand, the majority (55%) agreed that it was inappropriate for a psychologist to use religious texts and Scripture in the course of therapy, and 68% believed it was inappropriate to pray with a client in therapy (Shafranske & Malony).

Shafranske and Malony (1990) also used a case study to examine clinician bias with regard to a depiction of a religious client. According to the authors, case material was presented with different perspectives held by the client that presented her as religious or nonreligious. Participants randomly received the religious or nonreligious client case. Although differences were found between the religious client group and the nonreligious

client group for the estimated number of sessions it would take for substantial progress to occur, a modest, yet significant correlation ($r = .14$) was found between psychologists' attitudes toward religious issues and an estimate of the likelihood of the client's progress in therapy (Shafranske & Malony, 1990).

Shafranske and Malony (1990) also examined education and training opportunities. A salient finding was that only 5% of respondents reported that religious and spiritual issues were presented in their training. Although not covered in training, approximately 54% of those surveyed indicated that the psychology of religion was desirable in training, and 62% of the participants rated the handling of spiritual and religious matters in clinical supervision and training as desirable.

More recently, Shafranske surveyed other mental-health professionals, including psychiatrists (Shafranske, 2000) and rehabilitation counselors (Shafranske, 2001), concerning religious affiliation and involvement in addition to the salience of spirituality. Results of these investigations were similar to those reported earlier concerning psychologists. For example, of the 111 psychiatrists who responded to the survey, 73% reported that they believed in God or a Universal Spirit (Shafranske, 2000). Approximately 81% of this random sample of psychiatrists reported that spirituality was fairly or very important to them, whereas only 57% of the sample endorsed the salience of religion as fairly or very important (Shafranske, 2000). Shafranske (2001) also examined the religiousness and spirituality of rehabilitation psychologists ($N = 121$). Approximately 80% reported that spirituality was fairly or very important. The same percentage self-identified as moderately or very spiritual; however, this figure dropped to 50% when the question concerned religiousness. Shafranske (2001) concluded that the

spirituality of psychologists tended to be less institutionally derived, and it was likely more private.

The Work of Bergin and Jensen

Bergin and Jensen (1990) conducted a study that compared the religiousness of four distinct groups of therapists. The data were gathered in 1985 from a national sample of 425 participants representing the mental health professions of clinical psychologists, psychiatrists, marriage and family therapists, and clinical social workers. According to the authors, the sample was demographically and geographically comparable to national statistics describing these groups. Approximately half of the sample had more than 16 years of professional experience.

Bergin and Jensen (1990) assessed therapist religiousness through two means. The first method was to query participants concerning their religious preferences. The vast majority (80%) reported some religious preferences with "Protestant" being the most common (38%), and the second largest group (20%) self-identified as agnostic, atheist, humanist or none. On the other hand, regular attendance at religious services was endorsed by 41% of the sample, whereas occasional attendees and non-attendees together summed to 59%. According to Bergin and Jensen, 91% of the public reported having a religious preference, slightly higher than the mental health professional total of 80%. Moreover, Bergin and Jensen found that approximately 77% of therapists tried to live according to their religious beliefs as compared with 84% of the public. Finally, 68% of the respondents endorsed an item that asked "Seek a spiritual understanding of the universe and one's place in it" (Bergin & Jensen, p. 6).

A second mode of examining therapist religiousness was through the Religious Orientation Scale (ROS) developed by Allport and Ross (as cited in Bergin & Jensen, 1990) which yielded two subscale scores, namely an intrinsic score and an extrinsic score. Bergin and Jensen used the ROS to categorize the respondents as intrinsically religious (100), extrinsically religious (28), pro-religious, which referred to high in both intrinsic and extrinsic scores (102), and non-religious which indicated low intrinsic and extrinsic scores (89). Approximately one fourth of the sample did not respond to these items, and the authors assumed that they "did not like the traditionally religious content of the items" and thus were categorized as "non-religious" (Bergin & Jensen, 1990, p.4).

The Bergin and Jensen (1990) study was limited by a number of constraints. First, it did not distinguish between religion and spirituality. In fact, the authors suggested that a more acceptable measure of religious commitment was attendance at services as compared with preference. This measure of commitment did not examine the involvement of those mental health professionals who valued spirituality but not necessarily religion. In addition, the results reported were limited to percentages with no statistical analysis such as tests of significance or chi square. For example, no correlation between the ROS (Allport & Ross, 1967) and measures of religiousness were reported. The ROS was used primarily to classify respondents into categories such as intrinsically or extrinsically religious.

Lannert's Study of Internship Directors' Spirituality and Religiousness

Lannert (1992) investigated the personal and professional backgrounds, attitudes, beliefs, and practices of training directors at psychology internship sites concerning

religion and spirituality. In addition, Lannert examined these training directors'
perceptions of the policies, procedures, and practices internship sites had toward spiritual
and religious issues regarding staff, supervisors, and clients.

Using a six-page survey instrument, Lannert (1992) randomly selected training
directors through the directory of the Association of Psychology Internship Centers ($N =$
79). Lannert reported characteristics of the sample as follows: 68% were male and 32%
were female; the range of ages were from 31 to 66 years with a mean age of 45.6 years
and a standard deviation of 9.5; all held doctoral degrees, 92% of whom held a Ph.D., 6%
held a Psy.D., and 1% held an Ed.D.; the mean number of years they were training
directors at their current sites were 5.6; and 94% currently practiced psychotherapy. The
most frequently endorsed theoretical orientation was eclectic/integrative (32%), followed
by neo-Freudian/psychodynamic (28%), and cognitive/behavioral (18%). All other
orientations composed less than 10% each of the total orientations endorsed. Christian
was the most frequently endorsed religious orientation (35%), followed by Jewish (22%).
Approximately 23% considered themselves to be agnostic, while 7% stated they were
atheist.

A number of findings of Lannert's (1992) study were relevant to the current
investigation. Results revealed that approximately 72% of those surveyed identified with
or participated in an organized religion, whereas only 6% responded that they had a
negative reaction to religion. This finding was inconsistent with other studies that
showed a markedly lower identification with organized religion. On the other hand,
Lannert found that approximately 91% of the participants indicated that spirituality was
personally relevant, and 35% noted that their spirituality involved religion in some way.

Lannert found a significant, positive correlation between training directors'

acknowledgement of relevance of spirituality and professional orientation and openness

to spiritual and religious issues in the clinical setting ($t = 5.6, p < .05$). In addition, there

was a significant, positive relationship between the acknowledgement of the relevance of

spirituality and reading professional journal articles addressing spirituality and

religiousness in psychotherapy ($t = 2.59, p < .05$). Approximately 79% of Lannert's

sample noted that they have used counseling interventions with clients presenting with

spiritual or religious issues, and 71% stated that they were comfortable examining

transference and countertransference issues with spiritual or religiously oriented clients.

Given that the data were presented in summary format, it was not clear from the

presentation if the training directors used spiritual interventions or if they worked

primarily within the purview of psychological theory.

Summary

To this point in the discussion, it has been established that spirituality has had a

place in psychological theory and practice. Furthermore, there were dimensions of the

counseling relationship itself that indicated that there were unseen, and as yet unnamed,

forces at work. These so-called forces were also often alluded to in descriptions of

spiritual and mystical experiences. Thus, the context itself of counseling was one in

which spirituality likely played a significant part. The aforementioned research

suggested that doctoral-level psychologists and related professionals held spirituality to

be personally salient. In fact, research conducted to date indicated that they held

spirituality to be more personally relevant than religion. For these reasons, and because

the work of counseling necessarily involved a focus on health, the next section explored the relationship between spirituality and health.

Spirituality and Health

Considerations in Spirituality Research

Prior to introducing an overview of the current state of the research base examining the relationship between spirituality and health, it is appropriate to present general considerations, though often understood as barriers according to Larson et al. (1998), to conducting research in this area. These limitations were imposed by Western scientific method itself, or it may have been necessary for the researcher to choose parameters that made exploration of spiritual experiences, beliefs, and behaviors possible.

Studying the relationship between spirituality and health was confounded not only by definitions of spirituality, but also by primarily Western conceptualizations and valuing processes relative to health (McCullough, Larson, & Worthington, 1998). McCullough et al. illustrated their point by noting that in Western, individualist social orders, autonomy was prized as a chief component in mental health, whereas this may not be assumed for collectivist societies in which community was held as the ideal.

In terms of methodology, three concerns dominated the extant literature on spirituality and religion, as noted by Larson et al. (1998). First, it was difficult to establish appropriate control groups. Similar to Miller and Thoresen (1999), persons were not randomized as spiritual and nonspiritual. Second, it was difficult at best to control for confounding spiritual factors such as holding prayer constant by those outside of the sample in investigations of the affects of intercessory prayer on health (Larson et

al., 1998). Third, Larson et al. suggested that experimenter bias was a significant confound in that studies may have been skewed as a consequence of expectations of results inherent in research designs. Moreover, structural barriers, such as the prohibition against the use of public funds to study religious or spiritual processes, in addition to institutional impediments, such as the belief that science and religion/spirituality do not mix, served to limit the development of investigations concerning spirituality (Larson et al., 1998).

Spirituality and Health Research Findings

Despite the limitations of studying spirituality and its relationship to health, research was warranted particularly given the reported personal relevance of religion and spirituality in the population, in general, and for psychologists and related professionals (Gallup, 1995; The Pew Research Center for the People & the Press & The Pew Forum on Religion & Public Life, 2002; Shafranske, 2001). Recently, panels have been convened to examine spirituality and religion as variables related to physical and mental health (Fetzer Institute/National Institute on Aging Working Group, 1999; Larson et al., 1998). Larson et al. acknowledged that the work of the Fetzer Group formed the underlying structure upon which their work was built. The Fetzer Institute/National Institute on Aging Working Group (1999) identified twelve domains through which spirituality/religion was related to health outcomes. Those domains were (a) daily spiritual experience, (b) meaning, (c) values, (d) forgiveness, (e) private spiritual practices, (f) commitment, (g) religious/spiritual coping, (h) beliefs, (i) religious support, (j) organizational religiousness, (k) religious/spiritual history, and (l) religious preference.

This panel produced a multidimensional measure of religiousness/spirituality to be used in healthcare research which may be used in its entirety, or according to selected domains.

Results of numerous studies have indicated a consistent relationship between spirituality and health, mental and physical (Hill & Pargament, 2003; Larson et al., 1998; Levin, 2001; Thoresen et al., 2001). Surprisingly, as Larson et al. noted, a review of the literature yielded largely unexplored and unacknowledged findings concerning the relationship between spirituality/religion and health outcomes. These findings were relegated to notes sections or were culled largely from tables, leading Larson et al. to conclude that this body of research was "found" as compared with "emerged" given the detective skills used in its discovery. Nevertheless, a number of salient findings were relevant in the domains of mental health and physical health respectively, and the following sections examine the evidence suggesting a relationship between spirituality and mental health and physical health.

Spirituality and Mental Health

Given previously noted limitations in this field of inquiry, reviews and summaries of the research have suggested that some forms of spirituality and religiousness, such as greater frequency of church attendance, affected mental health in the following ways (a) they were related to greater subjective well-being, life satisfaction, and marital satisfaction; and (b) they were related to reductions in mental health symptoms such as depressive symptoms, suicide, delinquency, and alcohol and drug use (McCullough et al., 1998; Plante & Sharma, 2001). McCullough et al. noted that these findings were largely

gleaned from cross-sectional studies; however, the relationship between spirituality and mental health held in well-designed, longitudinal studies. On the other hand, Thoresen et al. (2001) summarized that other researchers found that some religious/spiritual factors had a negative affect on mental health outcomes, such as increased stress, depressive symptoms, and suicidality. These factors were religious strain, lack of ability to forgive God, and "negative" religious coping styles.

Plante and Sharma (2001) summarized the research concerning the relationship between spiritual and religious factors and depressive symptoms. They reported that intrinsic religiosity, maternal-offspring concordance of religiosity, and church attendance have been factors that reduced depressive symptoms. They also indicated that religious coping has assisted in buffering the affects of and reducing the susceptibility to depression in caregivers, the terminally ill, and bereaved individuals. Similarly, Lee and Waters (2003) found that 47% of the variance in trauma symptoms in an adult college student population was predicted by spiritual well-being and stressful life events, suggesting that spirituality may be a buffer between stressful life events and traumatic stress. Holistic forms of treatment for depression that integrated spiritual and religious aspects were promising in reducing depression. Contrariwise, some spiritual/religious practices sometimes were positively associated with depression, according to Plante and Sharma.

Research findings have suggested that for some individuals, spiritual and religious factors reduced anxiety, yet for others, they increased anxiety (Plante & Sharma, 2001). For example, Plante and Sharma reported that the research to date has indicated that positive mental health outcomes have been found in individuals who have used spiritual

and religious coping mechanisms, for those who were intrinsically religious, and for those who have participated in religiously or spiritually oriented treatment. In contrast, Plante and Sharma summarized that negative outcomes were found for those individuals who had strict religious upbringings and for those with obsessive-compulsive disorder.

Reviews of the research have suggested that evidence supported that spirituality affected outcome in other specific conditions. For example, Miller and Bennett (1998) reported that there is strong evidence for a number of assertions made by a panel examining the literature concerning the relationship between spirituality and alcohol and substance abuse. Strong evidence meant that findings were drawn from appropriate research designs with multiple replications. They asserted that (a) religious/spiritual involvement predicted less use of and fewer problems with alcohol, tobacco, and illicit drugs; (b) involvement with Alcoholics Anonymous (AA) was associated with better outcomes after outpatient treatment; (c) there were significant denominational differences in risk for substance abuse; and (d) meditation-based interventions were associated with reduced levels of alcohol/drug use and problems (Miller & Bennett, 1998, p. 70).

Spirituality and Physical Health

Authors have also found that spirituality likely affects physical health; however, research to date has suggested that these influences were likely explained by multiple factors (Matthews, Koenig, Thoresen, & Friedman, 1998). For example, based on an extensive review of the literature, Levin (2001) suggested that belief systems influence health outcomes. Levin proposed that proscriptions and prescriptions often found in religious and spiritual traditions were links in a chain through which systems are linked

holistically. In addition, social affiliation, such as connections to spiritual and religious communities, also influenced health and longevity (Levin, 2001; Spiegel, 1993). Levin suggested that social support was significant even when harmful behaviors were taken into account. Spiritual practices and interventions such as meditation, covered in detail below, have been associated with lowering blood pressure and reducing chronic pain (Kabat-Zinn, 1990; Matthews et al., 1992; Orme-Johnson, 2002). Similarly, spirituality has been a mechanism for coping with chronic and terminal illness (Matthews et al., 1998; Pargament, 1997; Spiegel, 1993).

Spiritual Experience and Health

Underwood (1999) described the domain of daily spiritual experiences and its relationship to health outcomes. Based on investigation of reports of spiritual experiences combined with interviews of individuals representing diverse spiritual traditions, Underwood developed a measure of the dimension of everyday spiritual experiences. A number of commonalities in reports of ordinary, daily experiences individuals had of the Divine were discovered via these interviews. First, connection emerged as a central aspect of spiritual experience. In collectivist cultures, such as African and Eastern traditions, conceptualizations of the self emphasized a sense of unity in that they include others, ancestors, divine entities, and all of life. Underwood suggested that Western spirituality stressed a personal connection with God and other people. A number of other core elements of spiritual experience were understood to flow from experiences of connection, unity, and integration. For example, Underwood discovered through the interview process that forgiveness, compassion, gratefulness, and

awe were common to diverse spiritual traditions. Moreover, deep inner peace, harmony, and wholeness in addition to merger phenomena through which the self was transcended evolved from the essential core of connection. These experiences were thought to lift one out of daily concerns and trials. Similarly, individuals frequently reported feelings of strength and comfort derived from experience of the divine.

Underwood and Teresi (2002) proposed a model that had an integrative core and four different life dimensions, namely the vital (physical and emotional), functional (intellectual and physical), interpersonal (social and cultural) and the transcendent. According to Underwood and Teresi, the model was an examination of how we interact socially to shape and, in turn, be shaped by others integrated with influences such as our physical hardware, our environment, emotional disposition, and orientation to the transcendent. Underwood and Teresi drew from this model to develop the Daily Spiritual Experience Scale (DSES), which measured features that can affect physical and mental health, social and interpersonal interactions, and functional abilities. On the other hand, as the model suggested, the above-noted life dimensions can also influence daily spiritual experience. This model, then, was a fully integrative, dynamic, interactive map of human experience that included orientation to the transcendent.

Underwood (1999) summarized that little empirical work linked day-to-day spiritual experience directly to health outcomes, despite the plethora of anecdotal evidence supporting the connection between health and daily spiritual experience. One aspect of daily spiritual experience was studied by Oxman, Freeman, and Manheimer (1995) who found reduced mortality following cardiac surgery for those patients who received comfort and support from their religion or spirituality. Although subjective

spiritual experience was recognized as a domain of spirituality, it has not figured prominently, as Underwood found, in research exploring the link between spiritual and religious factors and health.

Hood et al. (1996) summarized the work of James and Boisen who indicated that religious (or spiritual) experience was the resolution of a previously experienced uneasiness. According to Hood et al., what separated the great personal disharmony of religious experience from pathological experience was the outcome. In religious experience, the resolution was successful in that a limit had been transcended in a meaningful way (Hood et al., 1996). Therefore, religious or spiritual experience was generally conceptualized as positive; there was significantly less focus on negative spiritual experiences or negative outcomes of spiritual experience. This idea may also have been related to the comfort and strength domains often ascribed to spiritual experience.

Often, experience and practice were linked in the literature. This was particularly evident in the meditation research base where physiological and neurological correlates to experience were generally examined. Hood et al. (1996) concurred noting that it would be unusual to think of experience without action. Hardy (as cited in Hood et al., 1996) categorized triggers of spiritual experience. They included natural beauty, sacred places, prayer, meditation, music, sexual relations, physical activity, despair, crisis, and anticipation of death. It made sense, then, to assume that spiritual experience and spiritual practices were strongly, positively correlated.

Levin (2001) suggested that spiritual experience influenced health through altered states of consciousness. This point was supported by the meditation research which

indicated that physiological indicators of stress were reduced through practice of

Transcendental Meditation ™ (TM), for example (Orme-Johnson, 2002). In TM and

other forms of meditation, such as Zazen, it has been well-established that there is a

change in brain waves in practitioners (Hood et al., 1996). In the case of TM, Orme-

Johnson (2002) summarized that markers of stress, such as an increase in cortisol

production, were typically reduced through practice; thus practice altered consciousness.

It may be posited, then, that practices, such as meditation, influenced health through

experience as compared with practices themselves having had a direct affect on health.

That is, it was likely that it was not the frequency, duration, or kinds of practices alone

that were significant but the changes in experiential markers that were salient influences

on health.

Spiritual Practices and Health

There was a robust and growing body of evidence that spiritual practices and

interventions, most notably meditation and prayer, were related to health. Research

findings have also indicated that attending worship services had a positive impact upon

physical and mental health (Levin, 2001). The terms "spiritual practices" and "spiritual

interventions" are used interchangeably in this section. In a discussion of measurement

issues concerning private spiritual practices, Levin (1999) summarized that items

assessing these practices performed outside religious contexts were typically frequency of

prayer, reading religious material, and watching or listening to religious broadcasts on

radio or television. Levin noted that these items constituted 75% of a well-fitting

measurement model confirmed in a national probability sample of African Americans for

use with older adults. The scale Levin (1999) developed included these items and added an item addressing praying or saying grace before meals.

However, consistent with Thoresen et al. (1998), a number of spiritually oriented techniques and interventions, in addition to prayer and meditation, were available and were likely to influence health outcomes. For the most part, the techniques mentioned in this section were applicable across spiritual orientations and traditions. These techniques included but were not limited to forgiveness, release, religious/spiritual dance or other "moving meditations" (e.g., Tai Chi, Yoga), and ritual. Furthermore, Miller and Bennett. (1998) recommended additional spiritual practices/interventions for drug and alcohol abuse. Most notable among these were abstinence, invocations, quest experiences (which included retreats, pilgrimages, and shamanic work), sacrifice, suffering, worship and Twelve-step fellowships.

Thoresen et al. (1998) summarized the "state of the science" concerning the relationship between spiritual practices and physical and mental health. By and large, the most convincing evidence for a relationship between spirituality and health was derived from the body of work investigating the effects of meditation on physiological and psychological processes, according to Thoresen et al. This work is examined in depth later in this section. We turn now to the relevant literature on spiritual practices and health first by suggesting that spiritual experience and spiritual practices have been linked. Thoresen et al. noted that existing interventions that had spiritual aspects have focused on a number of areas. These areas included (a) feelings of connectedness with others including God, a higher power, or spirits; (b) encouragement of love, compassion, and forgiveness of self and others; (c) sources of meaning, direction, and purpose in one's

life; and (d) clarification of what was vital as contrasted with what was trivial in one's life. These foci were consistent with those domains cited by Underwood (1999) and Underwood and Teresi (2002) as elements of daily spiritual experience suggesting that there is likely a direct, positive relationship between spiritual experience and spiritual practice.

Thoresen et al. (1998) described some of the methodological limitations of the research base investigating spiritual interventions and practices. First, and most notably, according to Thoresen et al., with the possible exception of the meditation research, the evidence for the effectiveness of spiritual practices and interventions was largely theoretical as contrasted with empirical. In addition, some evidence was based on single or small case studies. Therefore, generalizability of findings was limited. However, as Thoresen et al. suggested, an abundance of articles and books have appeared describing spiritual approaches to therapy. Second, many of the claims of clinical effectiveness were based on research findings culled from studies that were not well-controlled (Thoresen et al.). For example, as the authors suggested, because controls were not implemented, it was unknown whether participants benefited from spiritual interventions per se or if the intervention was more or less effective than standard treatment.

Consistent with previously mentioned conceptualizations of spirituality and with the model of spiritual experience proposed by Underwood (1999), a major goal of ritualized behavior has been the transcendence of the self, and the blending of the self into some larger reality (Newberg et al., 2001). Newberg et al. went so far as to say that at the root of human rituals was the neurobiological need of all living things to escape the limiting boundaries of the self (Newberg et al. 2001, p.85). Although all rituals were not

religious or spiritual, Newberg et al. wrote that all rituals contained elements of rhythm and repetition, and these were common in human and animal rituals suggesting a biological, evolutionary hard-wiring. An outcome of ritualized behavior, consistent with the notion of merger beyond the limited scope of self, according to Newberg et al., was the reduction of conflict and aggressiveness in social groups thereby establishing and maintaining strong connections. Because ritual had an evolutionary base, by definition it was involved with survival, and survival and health-physical and mental-were inexorably linked. Therefore, it was reasonable to assume that ritual and health were related, yet there was virtually no empirical literature that explored this relationship.

The Meditation Research

Research findings clearly suggested a relationship between meditation and physical and mental health. Prior to examining these findings, it is appropriate to describe and define meditation which was often used as a catch-all term to describe an interrelated set of cognitive and physiological processes. For example, according to Shafii (1985, pp. 90-91), meditation, although primarily a cognitive activity, immersed the whole person in a psychophysiological experience that may be conceptualized as "active passivity" and "creative quiescence." Although seemingly paradoxical, these terms made the distinction between meditation, which was a self-directed practice, and mere "spacing out." Because much of the evidence suggesting a relationship between meditation and health used Transcendental Meditation™ (TM) procedures, the technique was defined by its founder Maharishi Mahesh Yogi (1967) as

…turning the attention inwards towards the subtler levels of a

thought until the mind transcends the experience of the subtlest

state of the thought and arrives at the source of the thought. This

expands the conscious mind and at the same time brings it in

contact with the creative intelligence that gives rise to every

thought. (p. 470)

Meditation, as summarized by Thoresen et al. (1998) was often practiced in two

basic forms. In concentration or fixed meditation, the individual fixed his or her mind on

an internal or external object such as a sound, image, word, bodily sensation, and so

forth. In mindfulness, another general form of meditation, the meditator focused alertly,

yet nonjudgmentally, on all processes that passed though the mind (Goleman, 1988;

Kabat-Zinn, 1990). Although, as Thoresen et al. suggested, meditation was most

commonly thought to be associated with Eastern religions, it has transcended worldview

differences. For example, meditation or contemplative practices have been part of

Western religions for centuries, and secular science has also embraced meditative

practice which has become known as the "relaxation response" given its relationship to

biofeedback techniques, progressive muscle relaxation, and guided imagery (Carrington,

1993). Furthermore, meditative practice has transcended doctrine in that the object the

meditator fixed his or her mind upon may or may not be a religious figure per se, but may

be an image, sound, vibration, and so forth of one's choosing.

Meditation, in different formats, has been widely investigated particularly to study

its power to reduce the effects of psychological and physical stress (Benson, 1996).

Results of these studies, as summarized by Thoresen et al. (1998), revealed that

meditation, in its variety of forms and disciplines, produced similar physiological and psychological changes. Many of the more recent studies, as Thoresen et al. indicated, focused on the use of meditation as an adjunct therapy to address heart disease, depression, pain, and alcohol and substance abuse. In terms of methodology, they have used Transcendental Meditation ™ Program techniques and Buddhist techniques, such as Mindfulness, to study meditation interventions to treat psychological and psychiatric problems.

Results of a study conducted by Alexander, Langer, Newman, Chandler, and Davies (1989) revealed that the health benefits of meditation may go beyond alleviating the effects of stress. In a four-group randomized study, Alexander et al. researched the question of whether meditation actually extended the life span and reversed age-related decline in physical health. Participants were residents of eight nursing homes for the elderly ($N = 73$) who were randomly assigned to the following groups: Transcendental Meditation ™ (TM), Mindfulness (MF or guided attention), relaxation (low mindfulness), and a control group that received no treatment. Participants were assessed after 36 months on measures of cognitive and behavioral flexibility, mental health, systolic blood pressure, aging, and treatment response. The TM group improved the most, followed by the MF group, the relaxation group, and the control group. Survival was assessed as well; the TM group rate was 100%, while the MF group survival rate was 87%. The survival rate was 65% for the relaxation group and 62.5% for the control group.

Orme-Johnson (2002) compiled and summarized more than 500 studies investigating the affects of TM on physical and psychological health. According to

Orme-Johnson, the research findings have yielded consistent results across research methodologies using different measures of physiological, psychological, and sociological function. Overall, findings indicated that TM practice exerted a positive affect on health and well-being in a number of domains. Orme-Johnson suggested that the TM technique produced a physiological state of restful alertness that, with regular practice, broadened to states outside of meditation as well. This state was also labeled transcendental consciousness, or the experience of one's higher self and, over time, it became a stable internal reference even during dynamic activity (Orme-Johnson, 2002). This was a significant conceptualization of this level of consciousness because, as Orme-Johnson alluded to, as the physiology relaxed, the autonomic nervous system became more integrated. It was then better able to cope with the effects of stress, and brain function became more orderly. Therefore, a robust body of research findings has consistently supported the efficacy of this meditative practice and its health benefits for a variety of conditions across samples with differing characteristics.

It was useful here to examine the findings of a study conducted by Eppley, Abrams, and Shear (1989) who performed a meta-analysis of the effects of relaxation techniques on trait anxiety. Trait anxiety was selected as the dependent variable because, as the authors acknowledged the work of Sarason and Speilberger, a large segment of the population experienced high trait anxiety which has been shown to be associated with health and behavioral problems. In addition, it was stable over time, highly correlated with behavioral and clinical measures, and, using one outcome measure, reduced the effects of confounding variables (Eppley et al., 1989). The authors reported that studies were selected in the following categories (a) relaxation techniques that included

progressive relaxation (22 studies), (b) various forms of meditation including TM (70 studies), and (c) electromyographic biofeedback (17 studies). Consistent with Orme-Johnson's (2002) summary and Alexander et al. (1989), Eppley et al. found that TM consistently produced significantly larger effects compared with other relaxation techniques used to reduce trait anxiety, and they posited that these effects were due, at least in part, to a greater degree of effortlessness in TM training and practice. That is, relaxation techniques involving concentration were not as effective in reducing trait anxiety. This significance also held when the demand characteristics of TM were examined (Eppley et al., 1989). TM training and practice had been hypothesized by the authors to have possible effects on the effect size; however, they found that this was not the case as the effects of TM grew over time. Had demand characteristics in the form of expectations of the practitioner and trainer influenced the effect size, the size of the effect would have diminished over time (Eppley et al., 1989).

<div style="text-align:center">Spirituality and Life Satisfaction</div>

There was little empirical evidence that linked spirituality with life satisfaction. According to Pavot and Diener (1993), life satisfaction was the cognitive component of subjective well-being. It was a global evaluation, and the criteria for judgment were those chosen by the person; therefore, many factors may have influenced life satisfaction. Because religion and spirituality were important in the general population and to the subset of mental-health professionals, it followed that spirituality and life satisfaction were related to some degree. Sink (2000) studied spiritual experiences, religious beliefs, and life satisfaction and positive affect in samples of graduate students ($N = 227$, mean

age = 46 years) and employees at a large treatment center (N = 287, mean age = 42 years). Life satisfaction and positive affect were considered to be measures of optimal development through midlife. Findings, according to Sink, revealed a significant relationship between spirituality and subjective well-being. Spiritual transcendence was correlated with life satisfaction (r = .23), and a factor "spirituality" was correlated with a factor of "optimal well-being" (r = .29). Spiritual experience was found to account for approximately 10% of the variance in subjective well-being. When specific test items describing more intense spiritual experience were extracted from the test instruments, these items correlated with measures of well-being at higher rates (r = .32 to .38), and they accounted for approximately 15% of well-being. These findings suggested that although spiritual experience was significantly related to life satisfaction, the correlations tended to be low.

Summary

This chapter presented an examination of the current literature in a number of relevant domains. It began by setting the stage for examining the integration of spirituality and contemporary psychological theory and practice. This chapter then moved to a discussion of the healing power of the relationship in the therapeutic encounter. The presentation then shifted to the spirituality of counselors themselves. Finally, the current research suggesting a relationship between spirituality and health was reviewed.

This chapter presented evidence concerning the integration of spirituality and contemporary counseling practices, particularly along two lines. First, the interest in

spirituality in this field was not new by any means, and further, the spirituality of psychologists mirrored that of the general population. Therefore, the so-called reintegration of spirituality in psychology was an idea whose time has come, not only for clients who, as research suggested, would like to bring spiritual concerns into counseling, but for counselors as well. A question, then, has arisen from this presentation so far. If spirituality was personally salient for psychologists, then how was it understood, experienced, and practiced? Second, a robust and growing research base has suggested a relationship between spirituality and health, both physical and mental. To continue this line of inquiry, does this relationship hold for doctoral-level counselors as well? The next chapter, Methodology, describes the participants, instruments, and procedures used to test this relationship.

Chapter III

METHODOLOGY

Introduction

The methodology of the current investigation is described and reported in this chapter. The basic nature of the research design of this study is characterized as between-subjects correlational. That is, all participants completed the same set of measures one time each. The primary dependent variables under consideration were spirituality, health, and life satisfaction. The dependent variables of spirituality and health were further subdivided to allow for multiple levels of analysis. First, spirituality was examined in its dimensions of experience and practice. Second, health was composed of physical and mental domains.

This chapter is composed of four general areas. First the participants are described according to their demographic characteristics including sex, age, marital status, race/ethnicity, and annual income. Professional characteristics are described next including highest degree and domain, settings in which they worked, and number of years working as a professional counselor. In addition, participants' religions are also reported along with data indicating belief in a transcendent dimension and whether or not this belief was personally meaningful. A tabular format aids in presenting the data clearly. Next, the instruments selected to measure the variables under consideration in this investigation are presented with particular attention devoted to the psychometric properties of each one. Third, procedures for data collection are described in depth. This

section also includes safeguards for participant rights, well-being, and confidentiality.
Fourth, the planned data analysis strategy is specified.

Participants

This sample was composed of 200 participants who were selected from the directory of the American Counseling Association who returned completed test materials (see Table 1 for an overview of demographic characteristics of the sample). According to the criterion for inclusion in the study, all of them held doctoral degrees. Of the 428 protocols that were mailed, 200 were returned and useable, and 11 were completed but not included because the respondents did not hold a doctoral degree. The completed test materials represented a response rate of 47%. Approximately 40% were males ($n = 81$), and 60% were females ($n = 119$). The mean age was 54 ($SD = 9.37$, range was 30 to 81 years). Most of the participants were married ($n = 139$, 69.8%), and the vast majority of the participants were White ($n = 181$, 90.5%). The average annual income was $72,547 ($SD = $39,692$).

Data were gathered concerning professional characteristics of the participants (see Table 2). As previously indicated, all participants held doctoral degrees; some held more than one doctorate. In the overall sample, 132 participants (66%) held a Doctor of Philosophy (Ph.D.), and 52 (26%) held a Doctor of Education (Ed.D). There were 6 participants (3%) holding a Doctor of Ministry (D. Min.), and there were 5 (2.5%) respondents holding a Doctor of Psychology (Psy.D.). The remaining participants (1 in each of the following categories or .5%) held the following doctoral degrees:

D.Min./Ph.D., Doctor of Pastoral Counseling (DPC), Ed.D./D.Min., MD/JD,

Ph.D./DM/Doctor of Divinity (DD).

Table 1

Demographic Characteristics of Participants

Characteristic	*n*	% of Sample
Sex		
Female	119	60
Male	81	40
Marital Status		
Married	139	69.5
Single	23	11.5
Partnered	8	4.0
Separated	2	1.0
Divorced	23	11.5
Widowed	4	2.0
Missing Data	1	.5
Race/Ethnicity		
American Indian	2	1.0
Asian/Pacific Islander	3	1.5
Black	5	2.5
Hispanic	4	2.0
White	181	90.5
Other	5	2.5

Table 2

Professional Characteristics of Participants

Domain of Doctoral Degree	*n*	% of Sample
Clinical Psychology	15	7.5
Counseling	74	37.0
Education	12	6.0
Human Resources Dev.	3	1.5
Marriage & Family	12	6.0
Psychology	8	4.0
Rehabilitation	7	3.5
Religion	8	4.0
Social Psychology	1	.5
Other	11	5.5
Missing Data	49	24.5
Total	200	100.0
Primary Work Setting		
Academic		
College/University	8	4.0
Counseling Center		
Higher Education	33	16.5

Table 2 (continued)

	n	% of Sample
K – 12	9	4.5
General	7	3.5
Business	6	3.0
Church/Religious	10	5.0
Community Mental Health Center	6	3.0
Group Practice	2	1.0
Medical	10	5.0
Not for Profit Agency	3	1.5
Private Practice	98	49.0
Retired	2	1.0
Other	5	2.5
Missing Data	1	.5
Total	200	100.0

The most frequently reported domain of the doctoral degree was counseling (*n* = 74, 37%), which was composed of the specialty areas of counseling psychology, counselor education, and counseling and guidance. The mean number of years participants worked as professional counselors were 20.09 (*n* = 196, *SD* = 8.984, range was 2 to 45 years), and the most frequently reported primary work setting was private practice (*n* = 98, 49%). Approximately 21% of the participants reported a second work setting, and of these, the most frequently cited was private practice (*n* = 14).

Religious and Spiritual Characteristics of the Participants

Participants were queried about religion (see Table 3 for an overview of religious affiliations), and results indicated that this was a predominantly Christian sample ($n = 128$, 64 %). Although the data were collapsed into categories, the most frequently reported individual religious preference was Catholic ($n = 30$, 15%) followed by Methodist ($n = 26$, 13%) and None ($n = 24$, 12.0%). Sixteen participants (8%) self-identified as Jewish. Data were missing in 7 cases (3.5%).

Participants were asked if they believe in a transcendent dimension (see Table 4), and 79.5% ($n = 159$) of the sample reported that yes, they did believe in a transcendent dimension. Approximately the same percentage of the sample ($n = 158$, 79%) reported that this belief was personally relevant. There were 18 cases of missing data, or 9% of the sample did not respond or responded with a question mark. Approximately 82.7% ($n = 62$) of males answering this question reported that they believed in a transcendent dimension, and for 81% ($n = 61$) of them it was personally relevant. Approximately 90.7% ($n = 97$) of females responding to the question of belief in the transcendent endorsed this belief, and this belief was personally relevant for 100% of them. These results were unusual in that it would make sense that the belief percentages would be higher than the salience percentages; however they were nearly identical.

Table 3

Religious Affiliations of Participants

Denomination	*n*	% of Sample
Buddhist	4	2.0
Christian – General	19	9.5
Christian – Evangelical Protestant[a]	6	3.0
Christian – Mainline Protestant[b]	71	35.5
Christian – Not Protestant[c]	32	16.0
Cross-religious Belief[d]	2	1.0
Jewish	16	8.0
Other/Miscellaneous[e]	19	9.5
None	24	12.0
Missing Data	7	3.5
Total	200	100.0

Note. [a]Assemblies of God, Born Again Believer, Church of God, Evangelical Protestant. [b]Baptist, Congregationalist, Episcopalian, X-Episcopalian, Lutheran, Methodist, Presbyterian, Reformed. [c]Catholic, Eastern Orthodox and Orthodox. [d]Interfaith and Judeo-Christian. [e]Agnostic, Diest, Mormon (Latter Day Saints), Non-denominational, Quaker (Society of Friends), Spiritual, Unitarian/Universalist, Unity, Yes.

Table 4

Belief in and Personal Salience of a Transcendent Dimension by Sex

	Belief			Salience		
	Yes	No	Total	Yes	No	Total
Females	97	10	107	97	10	107
Males	62	13	75	61	14	75
Total	159	23	182	158	24	182

Participants were asked how close they felt to God (see Table 5). Overall, the vast percentage of participants felt some degree of closeness to God ($n = 180$, 90%). The majority of participants, 55% reported that they felt "very close" to God. On the other hand, approximately 9% reported that they did not feel close to God at all, and there were 3 participants who did not answer the question.

Table 5

How Close Participants Feel to God

Degree of Closeness	n	% of Sample
Not at all	17	8.5
Somewhat close	50	25.0
Very close	110	55.0
As close as possible	20	10.0
Missing Data	3	1.5
Total	200	100.0

Instruments

This section described the instruments administered to all subjects to measure the dependent variables under consideration: spirituality, life satisfaction, and health. Spirituality was assessed by The Daily Spiritual Experience Scale (DSES; Underwood & Teresi, 2002), and a survey of spiritual practices developed specifically for this investigation. Physical and mental health was measured by the SF-12 Physical and Mental Health Summary Scales (SF-12v2™; Ware et al., 2002). Life satisfaction was explored through the Satisfaction With Life Scale (SWLS; Diener et al., 1985). In addition, a demographic data form was administered. Each instrument was described in the following sections which included reliability and validity data.

The Daily Spiritual Experience Scale (DSES; Underwood & Teresi, 2002)

The Daily Spiritual Experience Scale (DSES; Underwood & Teresi, 2002) was a 16-item self-report instrument that measured an individual's perception, involvement, and interaction with the transcendent (i.e., God, the Divine, etc.). There was also a 6-item brief version of the DSES that was incorporated into the Brief Multidimensional Measure of Religiousness/Spirituality (Fetzer Institute/National Institute on Aging Working Group, 1999). In contrast to other measures that purported to measure intense or mystical experiences, the DSES assessed day-to-day, relatively ordinary spiritual experience individuals may have, which may be evoked in religious context or by other events in daily life. The DSES was developed in response to recommendations of the National Institute on Aging and the Fetzer Institute Working Group which convened in 1995. Anecdotal evidence suggested that daily spiritual experience was important in the

lives of individuals, and thus likely had implications for health and well-being. However, no measures existed to examine this dimension of spirituality.

A paper-and-pencil measure, the DSES was easily administered and scored. As noted in the instructions to the scale, a number of items used the term "God." Respondents were instructed that "if this word is not a comfortable one for you, please substitute another idea which calls to mind the divine or holy for you." Participants responded to positively worded items in Likert-type format from 1 (many times a day) to 6 (never or almost never). There were no negatively worded items because, according to Underwood and Teresi (2002), it became clear that negatively worded items measured something other than the concept being assessed, alienation, for example. With the exception of the value marked for item 16 (In general, how close do you feel to God?), which was evaluated according to a different metric, scores were summed to arrive at a scale score. Lower scores indicated more frequent daily spiritual experience. Therefore, caution was exercised in interpreting results of this measure given that the scaling was counterintuitive.

The authors emphasized that the greater number of spiritual experiences one had did not make one "better" in spiritual terms. The mean was reported by sex in two studies (Underwood & Teresi, 2002). In the first study, the mean scale score for females was 46.45 ($n = 74$, $SD = 13.48$), and the mean scale score for males was 48.65 ($n = 46$, $SD = 14.41$). In a second study, in which all participants were female, the mean was reported to be 46.87 ($n = 233$, $SD = 18.69$).

Given the lack of prior attention to measuring spirituality in day-to-day life, Underwood engaged in a number of activities to gather data across cultures and

religious/spiritual ideologies to conceptualize the basic framework of the DSES (Underwood & Teresi, 2002). These endeavors included a review of the relevant literature concerning spiritual experience, focus groups, and in-depth personal interviews. Once the prototype instrument was designed, semistructured interviews with individuals from diverse backgrounds were conducted to examine individual interpretation of the items, leading to further refinement of the instrument. Every effort was taken to ground the questions in specifics while keeping them broad enough to include a variety of circumstances. For example, individual, open-ended interviews were conducted to confirm the meanings of the items with those suggested in the semistructured interview format. Finally, the instrument was reviewed by representatives of a number of spiritual orientations to include agnostic, atheist, Buddhist, Christian, Hindu, Jewish, and Muslim, and feedback was incorporated into the scale.

Based on the aforementioned exploratory procedures, the DSES was designed to assess nine underlying dimensions of daily spiritual experience according to Underwood and Teresi (2002). These domains were (a) connection, (b) interaction with the transcendent, (c) transcending the difficulties of present physical ills or psychological situations, (d) a sense of wholeness and internal integration, (e) awe, (f) gratefulness, (g) compassionate love, (h) mercy, and (i) spiritual longing (Underwood & Teresi, 2002).

Reliability

Reliability estimates for the DSES (Underwood & Teresi, 2002) were based on two studies. The first study was The Study of Women Across the Nation (SWAN) which contributed 233 cases using the 16-item format of the DSES. All participants were

female, 60% were White. The reported religious preferences were 53% Catholic, 18% Protestant, 21% Baptist, and 8% other. The mean reported age was 46.76 ($SD = 2.74$). Second, the full 16-item DSES was administered to 122 individuals from the University of Chicago area. Of these, 58% were full-time students, 51% female, 49% male, 72% White, 28% Non-white, Catholic 49% and non-Catholic 51%. The mean age was 27.7 ($SD = 13.4$).

Reliability estimates were derived from data from the two aforementioned studies, and Underwood and Teresi (2002) reported adequate reliability for the DSES. Cronbach's alphas for the DSES were calculated at .94 and .95 for the 16-item version, suggesting a highly internally consistent instrument. With the exception of two items, corrected item-total correlations ranged from .60 to .80. Those two items ("I feel a selfless caring for others." and "I accept others even when they do things I think are wrong.") were correlated in the .20s with all other items. According to Underwood and Teresi, test-retest reliability was currently being examined for the full 16-item DSES.

Validity

Underwood and Teresi (2002) presented a preliminary estimate of construct validity of the DSES. The Study of Women Across the Nation (SWAN) was a multisite, multiethnic, multifactorial study of the midlife experience. The sample size for the SWAN study was 233. The results of The SWAN study revealed that African American women scored lower on the DSES than did Caucasian women. This finding was significant in that lower mean scores indicated a greater degree of daily spiritual experiences. Underwood and Teresi stated that this finding was consistent with findings

of the General Social Survey (GSS) in addition to other studies which found higher

degrees of religiousness among African American women based on subjective rating and

religious involvement.

Summary

The DSES (Underwood & Teresi, 2002) was chosen to explore spiritual

experience in the current investigation for a number of reasons. First, the DSES

examined grounded, and arguably ordinary, day-to-day spiritual experiences that were

considered to be common across cultural, religious, and socioeconomic boundaries.

Second, the DSES was not constrained by religious or cultural ideology; rather, it was

designed to examine universal human experience with the transcendent. Third, the DSES

possessed adequate psychometric properties for these purposes. That is, although there

were currently a limited number of studies in which the DSES was used, preliminary

reliability and validity estimates were promising. Fourth, because the test packets were

sent to participants through the mail, it was necessary that the measures be brief. In the

case of the DSES, the estimated time of completion was approximately 2 minutes. Fifth,

it has been postulated that daily spiritual experience was related to health outcomes. It

followed, then, that the DSES was an appropriate measure to use in the current

investigation in which the relationship between spirituality and health and well-being was

examined. Finally, this instrument was used in research context, and no clinical decisions

were made based on individual responses to this measure. It should be noted here,

however, that taken as an aggregate, the studies used to validate the measure mainly

reflected the spiritual experiences of a largely White, Catholic, female, middle-aged

cohort. Consequently, descriptive statistics and reliability and validity estimates may vary in samples representing other cultural groups and men. Therefore, the psychometrics, while promising, were interpreted with caution.

Spiritual Practices Survey

A survey to measure spiritual practices (see Appendix A) was developed specifically for the current investigation for a number of reasons. First, a review of the literature revealed a limited selection of instruments designed to gather data concerning spiritual practices in general. For example, a collection of tests of religiosity (Hill & Hood, 1999) included a section of instruments that were purported to measure religious beliefs and practices. Of these 21 scales, only one, the Structure of Prayer Scale developed by Luckow et al. (as cited in David, 1999) was a measure of practices. These practices were limited to six types of prayer (confession, petition, ritual, meditation-improvement, habitual, and compassionate petition). Second, it was typical to find one or two items in measures of spirituality or religion that queried respondents as to the frequency of spiritual practices that were again often limited to prayer, meditation, and attendance at worship services. Miller and Thoresen (1999) suggested that frequency counts alone of spiritual practices were meaningless. Third, Hill and Hood (1999) wrote that the psychology of religion reflected a decidedly Western, Christian bias. Because a vast majority of psychologists considered their spirituality to be personally relevant, as compared with religious affiliation, it followed that measures of practices that were limited to largely religion-based activities may not have adequately assessed doctoral-

level counselors' spiritual practices. Therefore, it made sense to create a measure that would address the aforementioned shortcomings in the assessment of spiritual practices.

A number of procedures were used in the construction of the Spiritual Practices Survey. First, a review of the literature concerning spirituality was conducted with the aim of extracting practices that were common across spiritual traditions. Second, based on this review of literature and anecdotal evidence from individuals representing different spiritual traditions, a list of approximately 40 items was generated. Third, a Likert-type scale was constructed that was similar to the scale used by Underwood and Teresi (2002) for use in the Daily Spiritual Experience Scale (DSES). Fourth, evaluation and feedback was solicited from individuals having expertise in scale construction, research in spirituality and psychology, and/or integration of spirituality in psychological practice. Finally, a number of revisions were made to the original prototype based on responses to requests for feedback addressing appropriateness of items, additions and/or deletions of items, clarity of instructions, and utility of the Likert-type scale itself. In addition, the reviewers were asked specifically to examine the prototype for evidence of bias.

The Spiritual Practices Survey was a 32-item, paper-and-pencil self-report measure of spiritual practices. Of these items, 30 of them were activities that may or may not have been used for spiritual reasons, and one item was an open-ended query entitled 'Other' in which respondents were asked to designate one practice they performed for spiritual reasons that was not otherwise listed. Practices included but were not limited to prayer, meditation, ritual, attendance at worship services, dance for spiritual reasons, music, surrender, community service, and being out in nature. Based on feedback on the original prototype, an open-ended item was added that asked respondents to briefly

define spirituality in their own words. This recommendation was rooted in two basic perceptions of the original scale. First, without this item, it appeared that the list of spiritual practices was without context, and asking for a brief definition would focus the participant's attention on the relevance of the activities to spirituality. Second, because spirituality was difficult to operationalize, it made sense to ask doctoral-level counselors about their personal construals of spirituality.

Respondents were instructed to use a Likert-type scale to indicate how often they performed each activity for what they considered to be spiritual reasons. They were asked to focus on practices they had done over the past year, and to mark all items, leaving no space blank. The six-point Likert-type scale was anchored on one end by 0 (*Not at all*) and 5 on the other end (*More than once a day*). Thus, the scale was an inversion of the scale constructed by Underwood and Teresi (2002). As a result, although a significant, positive relationship between spiritual experience and practice was hypothesized, correlations between the authors' recommended scoring of the DSES and Spiritual Practices Survey were likely to be opposite by virtue of the construction of the respective scales.

Properties of the Spiritual Practices Survey

Exploratory factor structure of the Spiritual Practices Survey. As previously indicated, the Spiritual Practices Survey was developed according to theoretical bases for spiritual practices and interventions. The original prototype was subjected to an expert review, and it was revised to include additional practices as recommended by the

reviewers. As a result, it included 30 activities and an open-ended item inquiring about other practices one might have engaged in for spiritual purposes.

An exploratory factor analysis was performed on the 31 items that composed the scale to assess its dimensionality. Results of a principal components analysis revealed seven interpretable factors with eigenvalues greater than 1.0; however, a scree test suggested that as many as two factors were interpretable. Next, additional exploratory factor analyses were conducted for two components using oblique and orthogonal rotations. Of these two extractions, the orthogonal rotation yielded the most interpretable extraction. The first component (eigenvalue = 9.7), which was composed of 12 items, accounted for 31.4% of the common variance. The second component (eigenvalue = 3.2), consisting of 11 items, accounted for 10.4% of the common variance. Item loadings, means, standard deviations, and communalities were displayed in Table 6. In addition, items were retained with component loadings greater than .35. Given that this criterion was met, a second criterion required that the item loaded on only one factor. As a result, eight items were eliminated from the scale given the selection criteria.

Preliminary estimates of psychometric properties were calculated for the Spiritual Practices Survey. Early reliability estimates were promising as evidenced by Cronbach's alpha for this sample which was calculated for the entire scale to be .90; for the religious factor alpha was calculated to be .88; alpha for the spiritual/secular based factor was .86. Calculations were performed to test for preliminary evidence toward convergent validity. The Daily Spiritual Experience Scale (DSES; Underwood & Teresi, 2002) measured day-to-day, thus seemingly ordinary, spiritual experiences. For example, items include "I feel deep inner peace or harmony," and "I find strength in my religion or spirituality." It was

expected a priori that a correlation between the DSES and the Spiritual Practices Survey would be significant and positive. A Pearson product-moment correlation was calculated, and the results suggested a strong, significant relationship between The Daily Spiritual Experience Scale and the Spiritual Practices Survey ($r = .71, p < .01$). Therefore, preliminary evidence toward convergent validity was established for the Spiritual Practices Survey. However, because of the strength of this correlation, there is likely overlap between the two scales.

Table 6

Items, Component Loadings, Means, Standard Deviations and Communalities of The Spiritual Practices Survey

Item #	Item	Factor 1	Factor 2	M	SD	h^2
1	Attend instruction	.80	.00	1.04	1.08	.64
2	Attend workshops	.57	.17	1.12	.72	.35
3	Attend worship services	.78	-.16	1.58	1.1	.63
7	Donations	.57	.11	1.82	.94	.34
9	Holding office	.74	.00	.96	1.62	.54
10	Invocations	.58	.24	1.28	1.63	.40
15	Music	.53	.31	1.68	1.54	.38
17	Prayer	.68	.27	3.21	1.69	.53
18	Radio/television	.54	.00	1.09	1.29	.29
19	Reading	.66	.33	2.26	1.40	.54

Table 6 (continued)

Item #	Item	Factor 1	Factor 2	M	SD	h^2
22	Sacrifice	.53	.29	.59	1.05	.36
23	Social gatherings	.76	.14	1.49	1.11	.59
4	Being out in nature	.00	.52	2.52	1.21	.27
5	Community Service	.20	.40	2.07	1.14	.20
6	Dance	.24	.51	.28	.58	.31
8	Energy management	.00	.75	.89	1.43	.56
13	Meditation	.34	.59	2.09	1.49	.47
14	Movement	.00	.63	1.16	1.35	.40
26	Use herbs	.14	.56	1.10	1.60	.33
27	Use sacred objects	.32	.56	1.06	1.47	.41
28	Visualization	.15	.84	1.70	1.60	.71
29	Work with dreams	.16	.80	1.31	1.50	.66
30	Writing	.34	.57	1.27	1.32	.44

Other practices noted by participants. A number of participants ($n = 38$, 19%) indicated spiritual practices other than those listed in the Spiritual Practices Survey. Of these 38 additionally reported spiritual practices, nearly half of them (47%) had social themes. These practices included mentoring, spiritual counseling, making love, teaching and leading children in worship, spending time with one's children in ways that are meaningful, being a spiritual director, having spiritual conversations with others, being

connected to family, being part of a faith community or support group, and attending Twelve Step meetings. To extend the theme of connection to include nature, an additional 3 (8%) participants indicated connection to plants, animals, or nature in general. Work and service was noted by four participants (11%). A contemplative theme was evidenced by 3 (8%) participants' responses including pondering one's place in the universe and attending to Inner Wisdom. Gratitude was also mentioned as a spiritual practice by two respondents (5%). Specific rituals were indicated by three respondents or 8%, and they included communion and observing the Sabbath. Finally, seven participants (18%) indicated miscellaneous practices such as listening to music, chanting, racquetball, using Tarot/Angel cards, and listening to audiotapes about spirituality and spiritual practices.

Recommendations made by participants. A small number of participants ($n = 4$) made comments about the utility of the scale used for the Spiritual Practices Survey, yet an additional 15 respondents either wrote weekly or monthly next to several items to clarify their responses. One participant modified the scale by extending it to $6 =$ weekly and $7 =$ monthly. The comments were summarized as illustrated by the following quote by a participant: "The scale doesn't work well for everything on the list – ex. I go to church once a week if I'm in town. I make out my check for my pledge once a month." For these reasons, the scale itself required revision given the comments, modifications, question marks, and explanatory notes indicated by several participants.

SF-12v2™ Physical and Mental Health Summary Scales (SF-12v2™; Ware, et al., 2002)

Overview

The SF-12v2™ Physical and Mental Health Summary Scales (SF-12v2™; Ware et al., 2002) was a brief measure of health status that took approximately 2 minutes to complete. Based on the longer SF-36 Health Survey (SF-36; Ware et al., 1994), the advantages of the shorter version included time of administration, thus making the SF-12v2™ the instrument of choice for surveys requiring brief measures of health status. It made sense to use the SF-12v2™ rather than the SF-36 in the context of the current investigation for two reasons. First, interpretations of group data were made on what was anticipated to be a healthy population as compared with making individual decisions in clinical situations where higher reliability estimates would be preferred over ease of administration (Ware, Kosinski, & Keller, 1998). Second, because a test packet was mailed to prospective participants, the short version was likely to be appealing to more individuals. Thus, a higher response rate was expected relative to the SF-36 which had a longer administration time and made the test packet itself larger (i.e., five pages as compared to two).

In this section, the original instrument is described in depth including its psychometric properties. Next, the SF-12v2™ in terms of its development and relationship to the longer instrument is presented. Finally, reliability and validity coefficients are detailed to further support the use of the SF-12v2™ in this study.

SF-36 Health Survey (SF-36; Ware et al., 1994)

The SF-36 Health Survey (SF-36; Ware et al., 1994) was a multidimensional measure of health representing eight of the most important health concepts incorporated in many widely used health surveys. It also included a measure of transition in general health relative to status one year prior. The authors noted that the SF-36 was a generic measure because it assessed health concepts associated with basic human values relevant to functional status and well-being. Therefore, the SF-36 has been used to assess health status of individuals, ages 14 and above, with chronic conditions as well as those sampled from the general population (Ware et al.). It was primarily a self-administered paper-and-pencil instrument; however, the manual provided instructions for other administration formats. The SF-36 was composed of 36 items scale-scored such that higher scores indicated a better health state.

According to Ware et al. (1994) the eight multi-item subscales, containing between 2 and 10 items each, were compiled into two summary measures, the Physical Health and Mental Health Scales. Included in the Physical Health Summary Scale were the following subscales along with a brief description of each (a) Physical Functioning (PF) was a 10-item scale which measured the degree to which activities were performed without physical limitations, (b) Role-Physical (RP) was a four-item scale that assessed problems with work or daily activities because of physical health, (c) Bodily Pain (BP) was a two-item scale that measured the degree to which one experienced physical pain and its accompanying limitations, and (d) General Health (GH) was a five-item scale evaluating personal health. The Mental Health Summary Scale was composed of the

following subscales (a) Vitality (VT) was a four-item scale that assessed energy level; (b) Social Functioning (SF) was a two-item scale that evaluated performance of social activities and possible physical and/or emotional limitations; (c) Role-Emotional (RE) was a three-item scale measuring problems with work or daily activities because of emotional factors; and (d) Mental Health (MH), a five-item scale that at its extremes measured nervousness and depression or peace, calm, and happiness. The final scale was a one-item general measure that assessed changes in general health status compared with health one year ago.

Reliability. Ware et al. (1994) reported internal consistency, test-retest, and alternate forms reliability estimates over a range of studies for the full scale and for each of the subscales. The full scale reliabilities were reported here first. Cronbach's alpha coefficients indicating internal consistency ranged from .62 to .96. The range of test-retest reliabilities, expressed as correlations, were between .43 and .90. Alternate forms reliability, for the Mental Health subscale only, was reported to be .92.

Reliabilities were reported for each subscale. The Physical Functioning reliability estimates were .81 to .94 internal consistency, and test-retest ranges were .81 to .90. Role-Physical subscale reliabilities were .76 to .96 internal consistency, and .60 to .69 test-retest. Bodily Pain reliabilities were reported to be .79 to .88 internal consistency, and .43 to .78 test-retest. Internal consistency was found to range from .80 to .95 for the General Health subscale, and test-retest estimates were reported to be between .80 and .83. Vitality subscale Cronbach's alphas ranged from .62 to .96, and test-retest estimates were .68 to .80. Internal consistency alphas ranged from .63 to .85 for the Social Functioning subscale, and test-retest correlations were reported to be .60 over two

studies. Role-Emotional Cronbach's alphas were .80 to .96, and test-retest correlations ranged from .60 to .63. Finally, Mental Health subscale internal consistency reliabilities were reported to be .67 to .95, and test-retest correlations were .75 to .80.

Validity. Validity of the SF-36 was well-established using a number of different procedures to determine content, construct, and criterion validity (Ware et al., 1994). First, content validity was assessed by determining health states associated with the highest and lowest possible scores. These descriptions were presented in the manual so users may make content-based interpretations of the scales. This was accomplished, according to Ware et al. by plotting responses to a given item across the levels of the scale containing that item. For example, as Ware et al. found, at a score of 75 on the Physical Functioning scale, approximately 90% of the population can walk one block without limitations. This percentage dropped to approximately 32% if they score 45 on the Physical Function scale. Content-based interpretation, the authors found, appeared to be particularly useful for the Physical Functioning, Vitality, and General Health scales.

Criterion validity was tested through comparisons of the SF-36 with measures that met the following selection criteria (a) they were clinically and socially relevant, (b) they represented plausible outcomes of variations of function and well-being, and (c) they were measured through independent scales (Ware et al., 1994). Results were reported for six of the subscales in addition to the health transition item. Physical Functioning (PF) and ability to work were examined in relation to each other ($N = 2192$). Findings suggested that at all 10 levels of measurement of the PF scale, ability to work correlated in the expected direction with physical function. Similarly, when Bodily Pain (BP) and ability to work were compared ($N = 2187$), large increases in disability were observed at

the three lowest levels of measurement. In addition, according to Ware et al. (1994), a perfect ordering of disability rates was observed in the 4th through the 10th levels of the BP scale. The General Health (GH) indicator was found to be directly related to utilization of health care services such as hospitalizations, annual office visit rates, and prescriptions per visit.

Large differences in Mental Health (MH) scale scores were observed across four levels of the Role-Emotional (RE) scale as hypothesized by Ware et al. (1994). From these results, the authors concluded that the RE scale defined substantial differences in mental health burden. With regard to the MH scale, Ware et al. examined the relationship between clinically undesirable outcomes such as dissatisfaction with life, depressive symptoms, diagnosis of depression, suicide ideation, outpatient mental health care, and mental health specialty care. Results revealed that without exception, percentages of independent criteria studied to date had been monotonically related MH scale scores and response categories. The average prevalence rates decreased by approximately 10 percentage points from level to level. In addition, the intercorrelation between the MH scale and the Medical Outcomes Study Mental Health Scale was .96. Ware et al. reported that changes in the health transition item were associated with measured changes in health status over a 1-year period.

Finally, the authors correlated the General Health (GH) scale with the SF-36 scales and the widely used quality of life rating from the General Psychological Well-being measure developed by Dupuy (as cited in Ware et al., 1994). Results indicated that all correlations were significant and positive. Correlations between the SF-36 and the GH ranged from a low of .43 for the RE scale to .69 for the PF and RP scales.

Correlations between the quality of life rating and the GH scale were reported to be between .19 for the PF scale and .60 for the MH scale.

Empirical approaches such as factor analysis were used, according to Ware et al. (1994), to test construct validity of the SF-36 which was constructed to measure two major dimensions of health, physical and mental. Therefore, according to the authors, they extracted two factors and performed an orthogonal rotation to determine factor loadings of the subscales. This two-factor orthogonal solution accounted for 82.4% of the variance (Ware et al., 1994). The subscales loaded on the principal factors in the hypothesized direction. The Physical Functioning, Role-Physical, and Bodily Pain subscales were strongly associated with the physical component (r = .88, .78, and .77, respectively) and weak associations were found with the mental component (r = .04, .30, and .24, respectively). Similarly, the Mental Health Role-Emotional, and Social Functioning subscales were strongly associated with the mental component (r = .90, .81, and .71, respectively). The Mental Health (MH) and Role-Emotional (RE) subscales showed similar patterns as the previously noted scales that primarily loaded on the physical component. The MH and RE subscales were strongly associated with the mental component and weakly related to the physical health dimension (r = .12 and .19, respectively). The Social Functioning subscale was moderately correlated with the physical health factor as hypothesized (r = .44). As hypothesized a priori, the Vitality and General Health Perceptions subscales demonstrated moderate to substantial correlations with both factors. The Vitality subscale was associated with physical health (r = .59) and mental health (r = .57) and the General Health Perceptions subscale was

more strongly associated with the physical component ($r = .68$) than it was to the mental component ($r = .32$) (Ware et al., 1994, p. 9:19).

Psychometric Properties of the SF-12v2™

According to Ware et al. (2002), several criteria guided the development of the SF-12v2™. The first objective was to reproduce the SF-36 mental and physical health summary measures using one or more items to represent all eight domains of health. Ware et al. noted that this was content validity representation. Second, Ware et al. included a rating of general health item given its widespread use. Third, items were included that assessed psychological well-being and distress, and an "energy" item was selected from the Vitality scale to raise the "ceiling." Finally, two items each from the role functioning scales because they were relatively coarse given their reliance on dichotomous response choices (Ware et al., 2002, p. 28). For these reasons, according to Ware et al., independent attempts to predict physical and mental health summary scale scores were consistent with fewer items. This section presents the psychometric properties of the SF-12v2™ in terms of reliability and validity estimates.

Similar to the SF-36 (Ware et al., 1994), the SF-12v2™ was scored such that a higher score represented a better health state. After data entry, items and scales were scored using a scoring algorithm with the following general procedures (a) recode four items that required recoding, (b) computed scale scores by summing items for each scale, (c) transformed raw scores to a $0 - 100$ scale (Ware et al., 2002).

Reliability. According to Ware et al. (2002), reliability estimates were calculated based on data sets from general population surveys in the United States in 1998 and 2000.

Reliability coefficients ranged from .73 to .87 across the eight scales of the SF-12v2™.

Estimates for the Physical Component Summary (PCS-12) and the Mental Component

Summary (MCS-12) were .89 and .86 respectively according to Ware et al. Nunnally and

Bernstein (as cited in Ware et al., 2002) suggested that reliability coefficients above .70

were generally adequate for scales used in group-level analyses. Therefore, the reliability

coefficients observed in these analyses suggested that the SF-12v2™ summary scales

were reliable measures of physical and mental health and were applicable for the

purposes of the current investigation.

Validity. Ware et al. (2002) reported that validity of the SF-12v2™ corresponded

favorably with that of the SF-36 which had been shown to measure frequently studied

health concepts. In a four-group study, validity in discriminating among four groups was

calculated. The four groups according to Ware et al. were (a) individuals who were well,

(b) individuals with one or more physical condition except depression, (c) individuals

with depression and no other physical condition listed, and (d) individuals with

depression and one or more chronic conditions. In all cases, validity of the PCS-12 and

the MCS-12 were compared with validity of the summary measures of the SF-36. The

authors reported that the PCS-12 yielded the same statistical results as the physical health

summary scale for the SF-36 in that they both discriminated between physical conditions

and the other groups listed above. Likewise, the MCS-12 performed about the same as

the MCS-36 in measuring mental health conditions as compared with the other groups

listed above.

The Satisfaction With Life Scale (SWLS; Diener et al., 1985)

The Satisfaction With Life Scale (SWLS; Diener et al., 1985) was a five-item measure of global (as compared with domain-specific) life satisfaction. The SWLS was a paper-and-pencil instrument in which the participant responded to the items according to a 7-point Likert-type scale with the end points being 1 (*strongly disagree*) and 7 (*strongly agree*). Scores were summed, ranging from a low of 5 to a high of 35, and higher scores indicated greater satisfaction with life. Pavot and Diener (1993) noted that a score of 20 was the neutral point on the scale indicating that the person was equally satisfied and dissatisfied. They also reported score ranges whereby scores may be interpreted in absolute or relative terms as follows: Scores between 21 and 25 represented slightly satisfied with life, while scores between 15 and 19 represented slightly dissatisfied with life. More extreme scores, such as scores ranging from 26 to 30, represented satisfied, while those scores falling between 5 and 9 represented extreme dissatisfaction with life. Pavot and Diener noted that most groups' means fell between 23 and 28, indicating slightly satisfied to satisfied. The reading level required to complete the SWLS was at the 6th to 10th grade levels.

The development of the SWLS centered around two main objectives. First, the measure was designed to be a global measure of life satisfaction. This was to allow respondents to weight the various domains associated with life satisfaction according to their own criteria. For this reason, the SWLS was used across cultural groups given that domains of satisfaction were not imposed on the respondent by the researcher. Second, the SWLS was constructed to measure the cognitive component of subjective well-being. Pavot and Diener (1993) summarized previous research suggesting that subjective well-

being was composed of two broad aspects, an affective component and a cognitive component, that appeared to behave differently over time. In addition, these two components seemed to have different relationships with other variables. Given that a number of measures of the affective aspect of well-being had already been developed, according to Pavot and Diener, the SWLS was designed to measure the conscious, cognitive, judgmental domain of well-being, otherwise known as life satisfaction.

The construction of the SWLS involved a number of procedures according to Diener et al. (1985). First, 48 items were generated that related to satisfaction with one's life, and they included positive and negative affect items. Preliminary factor analysis resulted in three factors: positive affect, negative affect, and satisfaction. Next, the affect items, in addition to satisfaction items with a factor loading of less than .60, were removed leaving 10 items. Of these remaining items, five were dropped because they were thought to be too similar in terms of language. The resulting instrument, the SWLS, contained five items, all related to satisfaction.

Reliability

Internal consistency reliability, expressed as Cronbach's alpha, and test-retest reliability were reported for the SWLS (Diener et al., 1985; Pavot & Diener, 1993). For the initial validation study ($N = 176$), Cronbach's alpha was .87 and item-total correlations ranged from .57 to .75. The 2-month test-retest reliability was .82 ($n = 76$). Item-total correlations for the third segment of the initial validation study ($n = 53$) ranged from .61 to .81. Pavot and Diener summarized internal consistency and test-retest reliabilities for studies conducted subsequent to the initial work on the SWLS.

Cronbach's alphas ranged from .79 to .89 and test-retest reliabilities ranged from .50 (10-week interval) to .84 at a 1-month interval.

Validity

Evidence of construct and discriminant validity was presented for the SWLS (Diener et al., 1985; Pavot & Diener, 1993). In the initial validation study, a battery of tests, including subjective measures of well-being, were administered to two samples of undergraduates ($n = 176$, $n = 163$). In addition, the second sample was given measures of self-esteem, social desirability, and a symptom inventory. Results revealed that the SWLS was not correlated with social desirability ($r = .02$), and correlations with the other measures of subjective well-being were in the expected direction. For example, for sample one, correlations ranged from .50 to .75 and for sample two, correlations were reported to be between .47 and .66. According to the authors, as hypothesized, given the one-factor solution for the SWLS, a measure of emotional intensity was uncorrelated with the SWLS. A measure of negative affect was inversely related to the SWLS, although the correlations were low ($r = -.37$ for sample one and $r = -.32$ for sample two). In a third sample in the initial validation of the SWLS, 53 older adults (mean age = 75) were interviewed about their lives for approximately 1 hour by a pair of trained interviewers. They also completed the SWLS and the Life Satisfaction Index developed by Adams (as cited in Diener et al., 1985). The interviewers rated each participant independently according to a 7-point scale with regard to global life satisfaction. These ratings correlated .73, and they were summed to create a rater life satisfaction composite judgment. This value correlated .43 with the SWLS, and the LSI and the interviewer

composite were correlated .68. The SWLS and the LSI were correlated .46. Furthermore, Pavot and Diener (1993) stated that the SWLS has been correlated negatively with measures of clinical distress such as the Beck Depression Inventory ($r = -.72$) based on a study conducted by Blais et al. (as cited in Pavot & Diener, 1993). Pavot and Diener also noted that the SWLS was found to be positively correlated with extraversion and inversely correlated with neuroticism.

Summary

Because of several features of the SWLS (SWLS; Diener et al., 1985), it was chosen to assess life satisfaction in the current investigation. First, consistent with the other measures included in this study, the SWLS was not based on assumptions associated with any given cultural group or perspective. Rather, it was a global measure that allowed the respondent to weight the domains that constitute life satisfaction according to his or her own criteria. Second, the SWLS possessed adequate psychometric properties. Third, the SWLS represented a measure of the participant's cognitive appraisal of life satisfaction. As one of the measures of well-being included in this study, (the SF-12v2™ was the other), it was important that the SWLS measured the cognitive component of life satisfaction given that the SF-12v2™ included items that measured affect. Taken together, the SWLS and the SF-12v2™ presented an adequate picture of well-being.

Demographic Form

An information form was included in the packet of test materials to collect

demographic data (see Appendix B). This data was categorized in three overall groups,

namely demographics, professional information, and religious/spiritual information.

Procedures

Doctoral-level counselors were selected from the directory of the American

Counseling Association using a Table of Random Numbers. The directory listed contact

information including the highest degree held, and this information was presented in

three-column format on each page. The table was randomly entered at the top, left-hand

corner, as was often done according to Witte (1993), and the five-digit numbers listed in

the table were first divided. The first three digits were used to identify the page number

from which the prospective participant was chosen. Next, because the inclusion criterion

was that the individual hold a doctorate in psychology or a related field, the fourth and

fifth digits were used to determine eligibility by virtue of the position of the person's

contact information on the randomly selected page. For example, using the digit 46162,

the prospective participant was drawn from page 461. Then, the contact information for

the sixth individual from the top of each column was examined until an individual

holding a doctoral degree was identified. If the sixth listing from the top yielded no

results, the information for the sixth individual from the bottom of each column was

examined. Then the listings for the second individual were assessed using the same

procedures, until a prospective participant was selected from page 461. In all, 428 prospective participants were selected for inclusion in the sample.

Once identified, contact information was entered into a master data base. Contact information was limited to the prospective participant's name and address. For tracking purposes, this master list also included the unique alphanumeric code assigned to the test materials mailed to each prospective participant. This five-character code allowed for the test materials for each respondent to be kept together in the event of any untoward circumstances in addition to preventing duplicate mailings being sent. Moreover, each stamped self-addressed envelope was encoded to ensure confidentiality of responses. Each code was logged from the envelope and the contact information was removed from the mailing list prior to opening the envelope. For the first mailing, the code was read as A101 for the first packet sent, A102 for the second and so forth until all materials were encoded. For the subsequent mailing, the alphabetic code changed to B to indicate that it was a second mailing.

A packet of test materials was mailed, via first class mail, through the United States Postal Service to each randomly selected prospective participant. The materials were sent in a 9" X 12" brown kraft envelope with the University's and department's return address. The prospective participants were unknown to the researcher, and at the time of the mailing, the Postal Service warned the public not to open mail from unknown senders. Therefore, a postcard (see Appendix C) was sent to all prospective participants approximately 1 week prior to the mailing. No details about the study were provided in the postcard, it merely was an announcement that dissertation research materials would be arriving in a brown 9 X 12 envelope.

Each packet contained (a) a letter to participants (see Appendix D) which provided information concerning completion and return of the instruments, confidentiality of responses, contact names for questions or comments, assurance of no untoward consequences, informed consent; (b) one copy each of the research instruments; and (c) a stamped self-addressed envelope to be used to return the completed tests. The measures were counterbalanced to reduce error associated with the order in which the instruments were presented. This was especially salient, given the fact that response-set error was likely to occur because the Likert-type scales used for the DSES and Spiritual Practices Survey respectively appeared to be similar, yet were opposites of each other.

The following measures were implemented to safeguard confidentiality of responses: (a) informed consent was assumed by completion and return of the test materials; (b) completed test packets were returned to the researcher anonymously and were kept in a locked file; (c) the master tracking list that matched the participant's contact information, test packet code, and dates the test materials were sent and returned was destroyed at the conclusion of this study; (d) the participants were informed of a confidential means of contacting the researcher with any questions or concerns; and (e) results were reported in summary format only, so that any individual's response could not be associated with that individual.

Participants completed the same set of instruments one time only, and upon receipt of the completed test materials, a number of procedures were conducted. First, the code numbers were recorded in a separate log, and the completed test packets were set aside until a minimum of 25 were received for data entry to ensure confidentiality of response. Because a second mailing was indicated, the separate log of returned packets

was used to remove the contact information from the mailing list of those participants who responded to the first mailing so that a duplicate was not sent. Second, after receiving a minimum of 25 completed sets of test materials, data were entered in an SPSS 11.0 model on a secure computer.

Planned Data Analysis Strategy

This section described the planned techniques that were used to analyze the data. First, descriptive statistics were reported with regard to the demographic data, with results presented in tabular format. Second, the data were examined to test for assumptions such as homogeneity of variance, normal distribution, and outliers. Third, to empirically test relationships between dependent variables, Pearson product-moment correlations were calculated. Fourth, a themes analysis was performed on the respondents' brief definitions of spirituality.

To test the main hypotheses of this study, a number of procedures were used. This section represented a restatement of each hypothesis and the planned data analyses associated with each one.

H1: Counselors having more frequent daily spiritual experiences will also report significantly higher levels of physical and mental health. This difference will vary according to sex. Use one standard deviation above and below the mean as cut points to create more and less frequent daily spiritual experience groups (Multivariate analysis of variance).

H2: Counselor life satisfaction will be significantly, positively related to counselor daily spiritual experience (Correlation).

H3: Counselors engaging in more frequent spiritual practices will report significantly higher levels of physical and mental health as compared with counselors performing spiritual activities less frequently. This difference will vary according to sex. Use top third and bottom third as cut points to create groups of those who perform spiritual practices more frequently and those who practice less frequently (Multivariate analysis of variance).

H4: Counselor life satisfaction will be significantly, positively related to spiritual practices (Correlation).

H5: For the entire sample of doctoral-level counselors, spirituality influences physical and mental health through connection to the transcendent, connection to other people, and frequency of spiritual practices. Connection to the transcendent was operationalized as combined scores on items 1, 2, 8, 9, 15 on the Daily Spiritual Experience Scale. Connection to other people was operationalized as combined scores on items 2, 10, 13, 14 on the Daily Spiritual Experience Scale. Frequency of Spiritual Practices was represented by the subscale scores on the Spiritual Practices Survey (Multiple regression).

Limitations of the Study

Investigations of spirituality in the main have been limited by a number of factors, the current investigation included. As Larson and Swyers (1998) suggested, there were no commonly accepted definitions of "religion," "religiousness," and "religious commitment." Spirituality, as Larson and Swyers noted, was even more difficult to study given that it was conceptually more "nebulous" than religion. Examinations of

spirituality were further complicated by the wide variety of assessment tools available to study the related constructs of religion and spirituality (Larson & Swyers, 1998).

There was an inherent limitation in collapsing constructs into component elements. This notion was consistent with Asante's (1984) assertion that studying holistic phenomena with traditional Western means was by definition a limitation. In other words, categorization and fragmentation necessarily imposed limits. The overarching construct of spirituality was highly complex and multidimensional. For example, although difficult to operationalize, spirituality was often conceptualized as inclusive of, though not limited to, a number of dimensions such as beliefs, meaning, values, experiences, practices, and institutional affiliation. This study measured spirituality in two domains; thus, it did not capture the phenomenon in its wholeness. Moreover, spirituality was correlated with other constructs such as social support. It was difficult at best to delimit the relationship between spirituality and social support, thereby influencing the relationship between spirituality and health. This, then, limited the internal consistency of this study. Therefore, because a central variable under investigation in this research was spirituality, the aforementioned boundaries circumscribed the current study.

There were limitations in the generalizability of the findings of this study based on research design characteristics. First, the study was descriptive and correlational. As a result, cause and effect relationships could not have been demonstrated. Rather, relationships between variables were tested for significance and described. Second, the study was cross-sectional, so it was a snapshot in time. Therefore, it did not consider longitudinal individual and/or relational dynamics over time. A cross-sectional design

did not capture temporal influences on doctoral-level counselors' experiences, nor did it assess the complexities of the development and transformation of spiritual experience and practices over time. In addition, it did not examine other factors known to be related to health such as cigarette smoking, medical history, diet, exercise, and so on.

Limitations were inherent in the use of self-report measures to gather data. For example, for reasons such as social desirability, a respondent may "fake good." In addition, follow-up surveys or alternate measures to assess the variables under consideration, such as reports of significant others or clinical observation, were not administered. However, given the likelihood of diverse experiences of the population under consideration, self-report measures represented an effective method of addressing the elements of this investigation.

Finally, the research instruments chosen for the study were developed and normed for English-speaking populations. Although the SF-12v2™ and SWLS have been translated into languages other than English, for the purposes of this investigation, the translated versions of the research measures were not used. Therefore, this study did not examine the experiences of respondents who do not speak English as a first language, or at all. These individuals are by definition culturally different than those who speak English.

Chapter IV

RESULTS

Introduction

This chapter is a presentation of the results of the current investigation. First, preliminary data analysis is described. Next, descriptive statistics related to the dependent measures are calculated, and tests of significance are performed on the hypotheses. Finally, the results of self-reported definitions of spirituality are presented and analyzed according to general themes.

Preliminary Data Analysis

Prior to conducting the main data analysis the data were screened for accuracy, and procedures exploring normality, linearity, and homoscedasticity were undertaken. Results of these procedures revealed that there were no unusual occurrences in the data, and assumptions of normality, linearity, and homoscedasticity were adequately met. In addition, means and standard deviations of the dependent measures were calculated and reported in Table 7, and scale intercorrelations are displayed in Table 8.

In the current study, the mean of the DSES (Underwood & Teresi, 2002) was 39.21 ($n = 200$, $SD = 15.8$) for the full sample. The mean for females in the current study was 38.17 ($n = 119$, $SD = 16.14$), and the mean for males was 40.74 ($n = 81$, $SD = 15.27$). On average, this sample of doctoral-level counselors scored approximately 29 on the Satisfaction With Life Scale (SWLS; Diener et al., 1985), and according to the authors' guidelines for interpretation, the participants were satisfied with life. Furthermore, in this

sample, on average, participants reported higher levels of physical and mental health as compared with the general population (M = 52.97 and 53.03 respectively).

Table 7

Means and Standard Deviations of the Dependent Measures

Instrument	n	M	SD
Daily Spiritual Experience Scale	200	65.44	15.81
Survey of Spiritual Practices	200	40.58	21.85
Religious Practices Subscale	200	18.08	10.21
Spiritual/Secular Practices Subscale	200	15.42	9.70
Satisfaction With Life Scale	199	28.63	4.42
SF-12 v 2			
PCS (Physical Summary Scale)	197	52.97	8.30
MCS (Mental Summary Scale)	197	53.03	6.19

Correlations were calculated between the dependent measures, and the full results are displayed in Table 8. A number of highlights are presented in this section. First, as previously reported, the Daily Spiritual Experience Scale (DSES; Underwood & Teresi, 2002) was recoded such that higher scores reflected more frequent daily spiritual experiences. With the exception of physical health, daily spiritual experience was significantly, positively related to spiritual practices (the full scale and the two subscales), life satisfaction and mental health. Similarly, mental health was significantly positively correlated with the dependent measures studied with the exception of secularly oriented

spiritual practices (the correlation was nonsignificant). The summary scales of the SF-12v2™ (SF-12v2™; Ware et al., 2002) measuring physical health and mental health respectively were inversely correlated r (197) = -.23, p < .01. This correlation with mental health was the only significant correlation with physical health in this study. The two subscales of the Spiritual Practices Survey were significantly, positively correlated to a moderate degree r (200) = .45, p < .01.

Table 8

Scale and Subscale Correlations

	1	2	3	4	5	6	7
1. DSES[a]	-	.71**	.68**	.52**	.18**	-.07	.26**
2. SPS[b]	.71**	-	.85**	.83**	.10	-.07	.12
3. RPrac[c]	.68**	.85**	-	.45**	.06	-.07	.15*
4. SPrac[d]	.52**	.83**	.45**	-	.07	-.04	.01
5. SWLS[e]	.18**	.10	.06	.07	-	.11	.37**
6. PH[f]	-.07	-.07	-.07	-.04	.11	-	.23**
7. MH[g]	.26**	.12	.15*	.01	.37**	-.23**	-

Note. [a]Daily Spiritual Experience Scale; [b]Spiritual Practices Survey

[c] Religious Practices Subscale; [d] Spiritual/ Secular Practices Subscale

[e] Satisfaction With Life Scale; [f] SF-12v2™ Physical Health

[g] SF-12v2™ Mental Health

* $p < .05$ level, 2-tailed. ** $p < .01$ level, 2-tailed.

Main Data Analysis

Hypothesis Tests

H1: Counselors having more frequent daily spiritual experiences will also report significantly higher levels of physical and mental health. This difference will vary according to sex.

To test this hypothesis, a 2 x 2 between-subjects multivariate analysis of variance (MANOVA) was performed on two dependent variables, physical health and mental health. Independent variables were sex (male and female) and daily spiritual experience (low and high). The criterion for inclusion in the high spiritual experience group was a score greater than or equal to one standard deviation above the mean on the DSES, and participants scoring less than or equal to one standard deviation below the mean on the DSES were in the low spiritual experience group.   Significant differences were found between the two levels of daily spiritual experience on the dependent measures, Wilks' Λ = .77, $F(2, 56) = 8.24$, $p < .001$, $n = 61$. The multivariate η^2 based on Wilks' Λ was .23. According to Tabachnick and Fidell (2001), η^2 represents the strength of the association, or effect size, and .23 would be considered modest. The means and standard deviations for the dependent variables are provided in Table 9.

Table 9

Means and Standard Deviations on the Dependent Variable for the Two Spiritual

Experiences Groups By Sex

	High Spiritual Experiences		Low Spiritual Experiences	
	M	SD	M	SD
Physical Health				
Female	54.05	6.16	55.55	6.59
Male	52.08	8.67	56.43	4.71
Mental Health				
Female	55.93	3.36	51.34	7.06
Male	57.28	2.79	50.05	5.60

Analyses of variances (ANOVA) on each dependent variable were conducted as follow-up tests to the MANOVA. The ANOVA on the mental health scores was significant, $F(3, 57) = 5.73$, $p < .002$, $\eta^2 = .23$, $n = 61$. More specifically, main effect of the spiritual experience groups on mental health was significant $F(1, 57) = 16.54$, $p < .001$, $\eta^2 = .23$, $n = 61$. The main effect of sex and the interaction effect of sex and spiritual experience on mental health were nonsignificant. The ANOVA on the physical health scores was nonsignificant, $F(3, 57) = .92$, $p > .05$, $n = 61$, $\eta^2 = .05$. Post hoc tests were not performed on either of the independent variables because they both had fewer than three groups.

A supplemental analysis was conducted to examine main effects and interaction effects with age entered as a covariate. Significant differences were found between the

two levels of daily spiritual experience on the dependent measures, Wilks' $\Lambda = .78$, F (2,

55) $= 7.82$, $p < .001$, $n = 61$. The multivariate η^2 based on Wilks' Λ was .22.

Analyses of variances (ANOVA) on each dependent variable were conducted as

follow-up tests to the MANOVA. The ANOVA on the mental health scores was

significant, F (4, 56) $= 5.37$, $p < .001$, $\eta^2 = .28$, $n = 61$. More specifically, main effect of

the spiritual experience groups on mental health was significant F (1, 56) $= 15.69$, $p <$

.001, $\eta^2 = .22$, $n = 61$. The main effects of sex and age were nonsignificant as was the

interaction effect of sex and spiritual experience on mental health. The ANOVA on the

physical health scores was nonsignificant, F (4, 56) $= .86$, $p > .05$, $n = 61$, $\eta^2 = .06$.

Means and standard deviations of the dependent measures were the same as those

reported in Table 9.

H2: Counselor life satisfaction will be significantly, positively related to

counselor daily spiritual experience.

To evaluate this hypothesis, a Pearson correlation was calculated. This

correlation was significant, yet low, r (200) $= .18$, $p < .01$. This result suggests that for

this sample of doctoral-level counselors, daily spiritual experience was directly related to

life satisfaction.

H3: Counselors engaging in more frequent spiritual practices will report

significantly higher levels of physical and mental health as compared with counselors

performing spiritual activities less frequently. This difference will vary according to sex.

To test this hypothesis, a 2 x 2 x 2 between-subjects multivariate analysis of

variance (MANOVA) was performed on two dependent variables, physical health and

mental health. Independent variables were sex (male and female) and religious practices

(low and high) and spiritual/secular practices (low and high). Low and high spiritual practices groups were determined by those scoring in the top third on the spiritual practices subscales (i.e., religious practices and spiritual/secular practices) were in the high practices groups, and those scoring in the bottom third were in the low practices groups. This method was chosen because the sample size was adequate for analysis compared with the one standard deviation above and below the mean procedure. The results of the multivariate tests were nonsignificant. For sex, Wilks' $\Lambda = .99$, $F(2, 91) = .7$, $p > .05$, $n = 100$. For religious practices Wilks' $\Lambda = .98$, $F(2, 91) = .83$, $p > .05$, $n = 100$. For spiritual/secular practices Wilks' $\Lambda = 1$, $F(2, 91) = 0$, $p > .05$, $n = 100$. No interaction effects were significant.

H4: Counselor life satisfaction will be significantly, positively related to spiritual practices.

A correlation was performed to examine the strength of the relationship between life satisfaction and spiritual practices in this sample of doctoral-level counselors. This correlation $r(199) = .10$, $p > .05$, was nonsignificant, suggesting that life satisfaction was not related to spiritual practices in this sample of doctoral-level counselors. Two additional correlations were computed using the two subscales of the Spiritual Practices Survey, and these relationships were also nonsignificant. For Religious Practices $r(199) = .06$, $p > .05$, and for Spiritual/Secular Practices $r(199) = .07$, $p > .05$.

H5: For the entire sample of doctoral-level counselors, spirituality influences physical and mental health through connection to the transcendent, connection to other people, and frequency of spiritual practices.

Because the relationships among these variables were assumed to be linear, a pair of multiple regression analyses were performed to assess the explanatory and predictive power of this proposed model. Moreover, these relationships were not assumed to be mutually causal or reflexive in any way. In other words, this model was suggested as a simple linear model.

For both equations, the independent variables were (a) connection to the transcendent as measured by seven items extracted from the Daily Spiritual Experience Scale (DSES; Underwood & Teresi, 2002), (b) connection to other people as measured by three items extracted from the DSES, and (c) frequency of spiritual practices which was the two subscale scores computed for the Spiritual Practices Survey.

First, a multiple regression analysis was conducted to examine the aforementioned model using physical health as the dependent variable, and R^2 was .01. Moreover, this model was nonsignificant $F(4) = .41, p > .05$. Therefore, connection to the transcendent, connection to other people, and frequency of spiritual practices did not predict or explain physical health status in this sample.

A second multiple regression analysis was performed to examine the relationships of the independent variables to the dependent variable of mental health. This model produced R^2 of .08 and Adjusted R^2 of .06. This model was significant $F(4) = 4.06, p < .01$. Thus, the independent variables accounted for 8% of the variance in the dependent variable of mental health. Correlations between variables were displayed in Table 10.

Table 10

Correlations between Regression Equation Variables

	1	2	3	4	5
1. CT[a]	-	.62*	.73*	.52*	.21*
2. SC[b]	.62*	-	.44*	.37*	.24*
3. RP[c]	.73*	.44*	-	.45*	.18*
4. SP[d]	.52*	.37*	.45*	-	.01
5. MH[e]	.21*	.24*	.18*	.01	-

Note. [a]Connection to the Transcendent. [b]Social Connection.

[c]Spiritual Practices (Religious). [d]Spiritual Practices (Spiritual/Secular)

[e]Mental Health.

*p < .01.

The only independent variable that contributed significantly to prediction of mental health was social connection ($t = 2.05$, $p < .05$). According to Tabachnick and Fidell (2001), the semipartial correlations, when squared, represented the amount R^2 would be reduced if an independent variable were omitted from the equation. The contribution of social connection to R^2 was calculated ($sr_i^2 = .02$). Therefore, the variables connection to the transcendent, religious practices, and spiritual/secular practices together contributed another .06 in shared variability. A summary of the regression analysis is presented in Table 11.

Table 11

Summary of Regression Analysis for Variables Predicting Mental Health

Variable	B	SE B	β
Connection to the Transcendent	0	.07	.11
Social Connection	.35*	.17*	.19*
Religious Practices	0	.05	.10
Spiritual/Secular Practices	0	.04	-.16

Note. $n = 184$.

*$p < .05$.

Secondary Data Analysis: Brief Conceptualizations of Spirituality

In order to investigate the research question inquiring about how doctoral-level counselors define spirituality, a number of procedures were followed to generate categories describing participants' conceptualizations of spirituality. Overall, this process involved developing categories from the data and from common dimensions of spirituality found in the literature. The data were drawn from an open-ended item that asked participants to briefly define spirituality.

Although this was not qualitative research, techniques for category development were borrowed from Berg (2001). First, a set of dimensions of spirituality were gleaned from the literature. For example, the literature suggested that spirituality referred to a

transcendent dimension that may be described as a Higher Power, God, the Creator, Allah, divine spirits, a force, or energy larger than oneself of which one is a part (Richards & Folkman, 1997). In addition, the research suggested that connection and relationship were central to understanding spirituality (Griffith & Griffith, 2001). Existing conceptualizations of spirituality also alluded to the notion that it was a multidimensional construct encompassing the physical, mental, emotional, and spiritual domains (Miller & Thoresen, 1999). Similarly, spirituality was internally or externally oriented. Often, the understanding or description of spirituality made reference to the self in terms of experiencing the self as it opens to an ever-widening phenomenology.

The next phase of category development involved comparing the data with the aforementioned categories. In most instances, the data refined the category listing derived from the literature by adding or deleting characteristics of spirituality. The codes, supercategories, and subcategories are shown in Table 12 with examples from the data. In essence, this chart represents the overall set of rules for coding the data, and because it was derived from the literature and the data, both were linked in the coding structure. The coding structure was designed such that as much data as possible would be captured for analysis. As a result, only six definitions were excluded. They included two value assessments of spirituality, two allusions to the difficulty in describing spirituality in words, one definition focused on being, and one reference to the vagueness of the term. Data were missing in 13 cases, or 6.5% of the sample.

Codes, according to the framework described in Table 12, were assigned to each definition. Each code was then translated into a 0 or 1 format and entered into a Statistical Package for the Social Sciences (SPSS) 11.0 document. For example, those

Table 12

Coding Structure for Conceptualizations of Spirituality

Code	Supercategory	Subcategories	Examples
1	Involved or referred to a transcendent dimension	God; Higher Power; the Creator; the Divine, sacred or holy; Jesus Christ; the Holy Spirit; Allah; Buddha; Spirit Guides; Light; Energy; Force; Transcendent, greater than or beyond ourselves; The oneness	Jesus is my Savior and Lord and Best Friend; …being held by something greater;
2	Connection or relationship	Connection with God, other people, nature, the universe, the cosmos, all things; Friendships; Being in Community; Unity; A "close walk with"	Extent to which Nature and I are one
3	Referred to the self	Process through which one comes to know oneself; Remembering, transcending, enhancing/improving oneself; Power from within	Inner positive "essence" of self

Table 12 (continued)

Code	Supercategory	Subcategories	Examples
4	Emotional Domain	Love; Comfort; Gratitude; Balance; Harmony; Peace; Compassion;	Inner Peace
5	Cognitive Attributes	Personal beliefs; Philosophy of life; Meaning; Purpose; Awareness; Insight; Guidance; Faith; Religious dogma;	Core beliefs concerning faith
6	Behavioral/Practice Component	Meditation; Prayer; Movement; Service; Work at it every day	Meditation regularly – Unitarian – Buddhist- Humanistic

definitions of spirituality describing a personal relationship with God were assigned a code of 1 for Code 1 and a 1 for Code 2 with 0 entered for the remaining four codes. In this way, frequencies of codes were reported and cross tabulations were examined for combinations of concepts indicated in definitions. It should be noted here that participants were instructed to "briefly define spirituality in your own words." Therefore it was assumed that these definitions reflected those aspects of spirituality most central to respondents.

Results revealed that 64.5% (n = 129) of the sample made reference to a

transcendent dimension in their brief descriptions of spirituality. Most of these

respondents named the transcendent God; however, many made direct references to Jesus

Christ, the Creator, or a Higher Power. Approximately two thirds of the males

responding (n = 50, 66.6%) made reference to the transcendent, and approximately 70.5%

(n = 79) of females responding included a reference to the transcendent in their brief

definitions of spirituality. The second most frequently reported dimension of spirituality

indicated in these brief definitions was that of connection/relationship as evidenced by

the self-reports of 57% (n = 114) of those responding. Connection to God

(or another named divine entity) was frequently cited; however, many brief definitions

contained references to other people, nature, all things, or the universe. A cross

tabulation of these two dimensions of spirituality revealed that 69.8% (n = 90) of those

who referred to a transcendent dimension also alluded to relationship/connection as an

aspect of spirituality. Approximately 54.7% (n = 41) of males responding included

connection in their brief definitions, and approximately 65% (n = 73) of females

responding referred to connection in their conceptualizations. The third most frequently

cited domain of spirituality was its cognitive attributes as represented by the responses of

41% (n = 82) of respondents. Cognitive attributes were often reflected in responses such

as beliefs, or in some cases, participants reported that awareness or insight was relevant

in their definitions. A cross tabulation revealed that 55 participants (27.5%) who made

reference to a transcendent dimension also included cognitive attributes in their brief

conceptualizations. However, of those who referred to the transcendent, a greater

number of participants (n = 74, 37%) did not also refer to cognitive elements. In this

sample, a relationship with the transcendent superceded beliefs in the transcendent as being central elements in the conceptualization of spirituality.

Three other dimensions of spirituality were coded in this analysis; however, they were not as noteworthy as those mentioned previously. Of these dimensions, 45 (22.5%) participants indicated emotional experience was an aspect of their spirituality. This concept was most often reported as love, compassion, comfort, or other similar experience. It should be noted here that no one reported negative emotional experiences such as punishment or fear as aspects of spirituality. Emotional references suggested a conceptualization of a benevolent, caring Supreme Being and were overwhelmingly suggestive of a supportive divine aspect. The next most frequently reported minor domain of spirituality was that it made reference to the self ($n = 27$, 13.5%). For example one participant defined spirituality as "Remembering who I really am, and accepting myself and others as we are," or another illustration was "Belief in your <u>own</u> higher power." Other examples of this kind involved references to the transcendence of consciousness. Finally, the least frequently reported aspect of spirituality was a behavioral component which was reported by 26 (13%) of participants. Illustrations often included references to meditation and prayer to enhance experience or to bring spirituality to daily living. For example, one participant defined spirituality as "the practice of being mindful of the presence of God in all things at all times daily, no matter what life brings to me."

Thirty percent ($n = 60$) of the brief conceptualizations were coded with three or more codes. Of these, all but eight of them made reference to a transcendent dimension. For those definitions coded with four categories ($n = 17$), all referred to a transcendent

dimension and all but one included connection in conceptualizing spirituality. The vast majority (76%) of these conceptualizations included a cognitive attribute. This finding suggested a multidimensional understanding of spirituality that typically centered on connection to the transcendent and included a set of beliefs concerning this connection. Further, just over half included an emotional component, and the remainder was references to the self or had a behavioral component. The following examples illustrated a multidimensional understanding of spirituality. One participant defined spirituality as "a connection and appreciation of God, finding God's presence and being continually thankful – a knowledge of touching more than I can see in my life." Another participant stated,

> Spirituality is being aware that I exist in a spiritual as well as
>
> physical dimension. Because of this I try to see the good in myself
>
> and in others; I try to enrich myself spiritually through worship and
>
> prayer both in an organized way and privately, 10% monthly.
>
> Spirituality is not about being "religious."

Incidentally, six participants directly stated that spirituality is not religion. For example, one participant wrote, "Spirituality is not organized religion engined. It's a conscious partnership with one's soul."

The findings for those conceptualizations coded with three categories ($n = 40$) were similar to those reported above in that for the most part, the definitions made reference to a transcendent dimension ($n = 32$), and to connection ($n = 29$). Examples of conceptualizations of spirituality that did not include a transcendent dimension, yet were multidimensional included the following "The interconnectedness between my inner

feelings and thoughts and my environment. This includes loved ones, people in general and nature." Another participant illustrated the point in this way, "a sense of peaceful harmony with myself, my life, and the world."

Summary

The findings of the current study were presented in this chapter. First, the primary data analyses were conducted including testing the hypotheses, and the chapter concluded with an examination of the brief conceptualizations of spirituality reported by the participants. The next chapter examines the conclusions of the study, implications for counseling, and recommendations for further research.

Chapter V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

The current study had two overall goals. The first was to investigate the

conceptualizations of spirituality of doctoral-level counselors. Second, the relationship

between spirituality and health and life satisfaction in doctoral-level counselors was

examined. Paper-and-pencil instruments were used to measure daily spiritual experience

(DSES; Underwood & Teresi, 2002), spiritual practices (the Spiritual Practices Survey),

health (SF-12v2™; Ware et al., 2002) and life satisfaction (SWLS; Diener et al., 1985).

A demographic data form was also administered. Participants were selected from the

directory of the American Counseling Association (ACA) published in 2000, and a

packet containing an informed consent letter and the test materials was mailed to each

participant via first class mail through the United States Postal Service.

A note should be made here about the timing of the study. This research was

conducted in the latter half of 2001, a time during which many individuals sought

comfort, strength, and meaning from religion and spirituality to cope with the events of

the September 11 terrorist attacks in the United States. On the other hand, others

questioned their faith and the existence of an omnipotent, just, and merciful God. In fact,

one of the participants noted on the protocol that it was likely that history affected the

results of this study. Indeed this was likely, and in a series of polls conducted by The

Pew Research Center for the People and the Press and The Pew Forum on Religion and

Public Life (2002), trends indicated that the public's view that the influence of religion

on American life was increasing spiked at 78%. It fell only slightly in December, 2001 to

71% as suggested by a Gallup poll cited by the The Pew Research Center for the People and the Press and The Pew Forum on Religion and Public Life. Previously, this figure was 37% in March 2001, and by March 2002, the percentage of Americans who believed that the influence of religion on American life was increasing rebounded to pre-September 11 levels at 37% (The Pew Research Center for the People & the Press and The Pew Forum on Religion & Public Life, 2002).

Participants were mostly White (91%), with females (60%) outnumbering males (40%). The mean age was approximately 54, and the majority of participants were married. Moreover, this was an experienced group of doctoral-level counselors who worked mostly in private-practice settings. Their doctoral degrees were in a range of specialty domains, and the most frequently cited was counseling and related fields such as counselor education. Approximately 84.5% of participants endorsed a religious affiliation, and of the total sample, approximately 64% were Christian. Nearly 80% of the sample reported that they believed in a transcendent dimension, and it was personally relevant; however, approximately 9% of the participants did not answer the question or marked it with a question mark. On the other hand, only approximately 9% of the sample reported that they did not feel close to God. Overall, participants in the current study reported having more frequent daily spiritual experiences than the comparison groups previously studied by Underwood and Teresi (2002). On average, participants scored approximately 29 on the SWLS, and according to the authors' interpretation, the participants were satisfied with life. Participants reported higher levels of physical and mental health as compared with the general population (M = 52.9703 and 53.0301 respectively).

Participants were asked to briefly define spirituality in their own words, and three overriding themes emerged in the analyses of these data. First, results revealed that 64.5% ($n = 129$) of the sample referred to a transcendent dimension in their brief conceptualizations of spirituality. Most of these respondents named the transcendent God; however, many made direct references to Jesus Christ or a Higher Power. Second, connection/relationship was cited in the definitions of 57% ($n = 114$) of those responding. Connection to God (or another named divine entity) was frequently cited, yet many brief definitions contained references to other people, nature, all things, or the universe. Third, beliefs played an important role in the spirituality of these participants as evidenced by 41% mentioning beliefs or other cognitive elements in their brief conceptualizations. Similar to Hill and Pargament (2003), spirituality was not absent a context, and spiritual contexts were often related to belief systems. Other dimensions of spirituality were mentioned such as emotional experiences or practices; however, in this sample, they were not as salient as references to a transcendent dimension, the role of connection/relationship, or the cognitive aspects of spirituality. Those participants who reported believing in a transcendent dimension conceptualized a Supreme Being as a benevolent, supportive, and loving entity. It was noteworthy that participants did not describe a fearsome, punishing God, nor were there references to the overwhelming nature of the Divine.

The main statistical analyses yielded mixed results. On the one hand, statistical significance was achieved in those analyses that examined the relationship between spiritual experience and mental health. Most importantly, on average those doctoral-level counselors who reported more frequent daily spiritual experiences also reported higher

levels of mental health compared with those having less frequent daily spiritual experiences. Further, daily spiritual experience was related to life satisfaction in this sample; however, the strength of this relationship was low. This finding was consistent with Sink's (2000) finding. Finally, a model was posited suggesting that mental health was predicted by connection to the transcendent, connection to other people, and frequency of spiritual practices. Statistical analysis found that this model was significant although the predictive power of these variables on mental health was low. However, this finding was salient given that connection to a transcendent dimension, other people, and the world is considered to be a core component of conceptualizations of spirituality (Fetzer Institute/National Institute on Aging Working Group, 1999; Griffith & Griffith, 2002; Richards & Folkman, 1997).

On the other hand, the quantitative analyses concerning the relationship between spirituality and physical health produced nonsignificant results. For example, on average those counselors who reported more frequent daily spiritual experiences did not also report higher levels of physical health. Similarly, those counselors who performed spiritual practices more frequently also did not report greater physical health. In addition, a model was posited suggesting that connection to the transcendent, connection to other people, and frequency of spiritual practices would predict physical health, and statistical analysis did not support this hypothesis. Finally, spiritual practices were not related to mental health or life satisfaction in this sample.

Conclusions

General Conclusions

Spirituality in this investigation was isolated as a variable. In other words, myriad variables affect physical and mental health and life satisfaction, and none of them were studied here. Therefore, that there was any significance afforded the relationship between spirituality and mental health in this population added to the significance of the findings. More specifically, two domains of spirituality were examined, namely experience and practice. This was in contrast to previous research which primarily investigated beliefs and values mental-health professionals held concerning religion and spirituality (Bergin & Jensen, 1990; Lannert, 1992; Shafranske, 1996b, 2000, 2001; Shafranske & Malony, 1990).

This study represented somewhat of a starting point in the dimensions of spiritual experience and practice whereby the relationships between spirituality and health and life satisfaction may be investigated further. In an effort to shed light on the complex, and as yet unclear, relationship between religious/spiritual factors and health, Thoresen et al. (2001) suggested a model such that spiritual and religious factors interacted with other variables to influence health. These variables included but were not limited to sociodemographic and cultural influences in addition to personal attributes such as health behaviors and social and emotional support. Therefore this model would suggest, similar to that posited by Underwood and Teresi (2002), that a holistic model of health with its mutual and multiple determinants included spiritual and religious aspects in complex interplay with other features. Clearly, connection, which also may be termed support,

was an integral characteristic of any model examining the pathways through which this relationship might be explained.

Spirituality was considered to be a multidimensional construct (Fetzer Institute/National Institute on Aging Working Group, 1999; Larson et al., 1998; Miller & Thoresen, 1999). Given the difficulty in operationalizing spirituality in the overall sense, the findings of this investigation assisted in the ongoing research concerning the mechanisms through which spirituality influences health. In other words, because the domains of spiritual experience and practices were extracted from the overall construct of spirituality in this study, the findings add to the growing, yet early, evidence of specific influencing affects of spirituality on mental health.

Levin (2001) summarized that religious involvement, measured as attendance at religious services and other forms of participation, was significantly related to health and well-being over time. Levin went on to posit that it was the social support inherent in attending worship services and other activities that explained the relationship between religious participation and health. Interestingly, in the current study, analyses concerning traditionally religious practices (e.g., attending worship services, reading religious/spiritual material) and their relationship to health were nonsignificant, yet connection emerged as a significant explanatory factor of mental health. Thus, this finding does not contradict the mass of previous research, but it suggests that for those not religiously involved, spiritual involvement outside of organized religion may have similar buffering effects. This emerged as an area that warrants further investigation.

Taken together, the major findings of this study suggested a number of implications for counselors concerning their spiritual experiences and practices.

Doctoral-level counselors valued spirituality, and nearly 85% endorsed a religious affiliation. A vast majority (80%) believed in a transcendent dimension that was personally relevant. They reported having more frequent daily spiritual experiences than other groups studied to date, and frequently endorsed spiritual practices were composed of both spiritual/secular and religion based activities. Alternatively, 9% of participants reported that they did not feel close to God. Therefore, it was concluded that regardless of religious affiliation or involvement, this was a spiritual group of people who expressed their spirituality in traditionally religious and secular ways.

The power of connection in spirituality, particularly as it related to mental health, must be acknowledged. This statement was supported by the general findings from the analysis of the brief conceptualizations of spirituality in addition to the main statistical analysis concerning the relationship between daily spiritual experiences and practices and mental health. More specifically, once connection as an influencing factor on mental health was extracted, a significant predictive, explanatory relationship was revealed. These points formed the backbone of the significance of this study given that research concerning spirituality and doctoral-level counselors and related professionals has focused on beliefs and values. The findings of the current study then supported and extended the ongoing description of doctoral-level psychologists' spirituality. Doctoral-level counselors integrated spirituality in their lives, and this integration was related to their mental health.

Specific Findings Concerning Spiritual Experience

Findings of this investigation suggested that the frequency of daily spiritual experiences was directly, significantly related to mental health and life satisfaction. Therefore, it was important to reiterate here how daily spiritual experience was conceptualized and measured. The instrument selected to measure spiritual experience, the Daily Spiritual Experience Scale (DSES; Underwood & Teresi, 2002) assessed day-to-day, relatively ordinary spiritual experience individuals may have, which may be evoked in religious context or by other events in daily life. Therefore, spirituality, although it may encompass religious contexts, may be understood as not being bound by any one ideology. That is, a sense of wholeness may be derived from everyday life events, and it was not contingent upon religious commitment or involvement. This definition of spirituality may describe the experiences of individuals across belief systems. This scale measured a number of domains thought to compose spirituality. These domains were as follows (a) connection, (b) interaction with the transcendent, (c) transcending the difficulties of present physical ills or psychological situations, (d) a sense of wholeness and internal integration, (e) awe, (f) gratefulness, (g) compassionate love, (h) mercy, and (i) spiritual longing (Underwood & Teresi, 2002). Thus, the results of this investigation indicated that this overall experience of internal integration and connection (which included God, other people, all things, and nature) was significantly related to mental health and life satisfaction in this population. Interestingly, though not at all surprising, spirituality was described for the most part as a comforting, positive, loving experience. Other forms of spirituality, such as those focusing on transformation,

for example, may relate to health through other pathways. In other words, working to

effect change as a function of a deeply held spiritual perspective likely carries health

implications that may not be readily discernable using traditional research methodologies.

This is an assertion that warrants further investigation, an idea echoed by Hill and

Pargament (2003) who suggested that spiritual well-being be explored as an outcome

variable as compared with mental or physical health.

Specific Findings Concerning Spiritual Practices

The findings of this investigation suggested that spiritual practices were not

directly related to physical or mental health or life satisfaction. However, spiritual

practices were found to be positively, significantly related to daily spiritual experience

which was related to mental health and life satisfaction in this sample. This finding was

consistent with findings from the meditation research suggesting that meditative practice

altered consciousness and it was this change that affected health (Kabat-Zinn, 1990;

Levin, 2001; Orme-Johnson, 2002). It may be that spiritual practices influenced health

and life satisfaction indirectly through spiritual experience. This was a hypothesis that

warrants further investigation particularly because there has been discourse concerning

how to work with spiritual interventions in counseling context. Spiritual interventions

and practices are synonymous in that they form the behavioral domain of spirituality.

Implications for Counseling Theory, Practice, and Training

This study enhanced the literature concerning psychologist spirituality and its

relationship with health and life satisfaction in a number of ways. For example,

spirituality was conceptualized in terms of experience and practices in this investigation, whereas past research examined beliefs and values. Therefore this research added another dimension to the descriptions of the spirituality of doctoral-level counselors, which led to another contribution of this study to the existing literature. That is, when spirituality was examined, it was usually relevant to the client's experience. The findings of the current study suggested that spirituality, particularly in terms of experience, was related to mental health in doctoral-level counselors. Previous research has suggested that clients often seek counselors with similar religious beliefs, or clergy may be adjuncts in care. The findings of this study suggested that in addition to the importance of belief system congruence, it is likely that doctoral-level counselors also integrated spirituality into everyday life in ways that directly influenced mental health. This, then, may introduce the opportunity for experiential and practical consistency as it related to spirituality in the counseling relationship. Another finding of this study was the role of social connection in spirituality. With some exceptions, definitions of Western spirituality found in the literature typically focused on the relationship of the individual to the transcendent dimension. The findings of this study highlighted the idea that spirituality necessarily involved social and other types of connection such as to nature. The significant relationship found between spirituality and mental health also carried implications for coping with demands of the work in order to maintain or restore mental health.

An examination of the details of the Council for the Accreditation of Counseling and Related Education Programs (CACREP, 2001) competency areas for training in spirituality were consistent with this study's overall rationale and findings. For example,

in the understanding of spiritual phenomena domain, CACREP standards called for counselors to explain how the varieties of spiritual phenomena are understood from diverse perspectives. This was also an idea advanced by W. Miller (1999b). The majority of participants in this research were White and Christian, and for the most part they believed in a transcendent dimension that was personally relevant. They also reported more frequent spiritual experiences than other groups studied by Underwood and Teresi (2002). Although great care was taken to select instruments that would be applicable across religious and spiritual groups, the instruments themselves likely imposed limits on conceptions of spirituality. Consequently, they may not have captured its essence or relevance for all respondents or prospective participants. Ongoing discourse concerning spiritual experience and phenomena must consider spiritual experiences that may not have been encountered by mainstream mental-health professionals. This is likely to be a challenge given that uncommon spiritual experience has often been pathologized in the fields of professional psychology.

In addition, CACREP (2001) counselor competencies for spirituality in counseling required that counselors be able to describe the research, theoretical, and clinical evidence indicating a relationship between spiritual phenomena and mental health. Evidence of this relationship in doctoral-level counselors was revealed in the findings of the current research. Finally, CACREP standards required that counselors be able to describe their own spiritual perspective and be able to conceptualize oneself given the evidence of the relationship between spiritual phenomena and mental health. This investigation asked doctoral-level counselors to briefly describe their spirituality in their own words in addition to completing paper-and-pencil instruments measuring spiritual

experience and practices. Thus taken together, the overall research design, rationale, and findings were relevant to current competency standards for integrating spirituality in counseling.

Generalizability of the Findings

Similar to Shafranske and Malony (1990) the results of this investigation are to be interpreted with caution given its positive bias toward religion and spirituality. First, the mean of the Daily Spiritual Experience Scale (DSES; Underwood & Teresi, 2002) in this study was lower than that reported by Underwood and Teresi, thus indicating more frequent spiritual experiences, according to the scaling of the instrument. Moreover, many participants offered support and encouragement as evidenced by their comments. In fact several respondents directly wrote "God bless you" or similar statement of good wishes on the protocol. There was only one respondent who questioned the possible underlying assumptions of the study and thus its scholarship, and another participant who perceived that it was not relevant enough to the Christian experience. It was expected that in a mailing to more than 400 doctoral-level counselors, more than two respondents would have had overall negative reactions to the research itself. It may therefore be posited that possible participants not holding spirituality or religion in high regard spoke through their lack of response.

This sample of participants was a group of volunteers, and Borg and Gall (1989) noted that a well-developed body of research existed suggesting that volunteers typically were characterized by sets of attributes. A number of these characteristics were relevant to the current study, particularly those findings suggesting that volunteers tended to be

more interested in religion, more sociable, more self-disclosing, and less conformist than non-volunteers. In terms of demographics, volunteers were more often female and married than non-volunteers. In addition, an overwhelming majority of the sample self-identified as White, suggesting that cultural mistrust may have been a factor in participating in this research. There may have also been a form of spiritual or religious mistrust that was perceived by possible participants who understood and experienced spirituality in ways other than those suggested by the measurement tools used in this study. Taken together, these attributes of the sample limited the generalizability of the study's findings.

Generalizability of the results of this research was also limited by possible confounding variables that affected health. Examples included risk factors for serious health conditions such as smoking, inactivity, and obesity that were not assessed in this research. Physical health history including trauma and illnesses was also not assessed, and these factors also influenced current physical health. Finally, stress levels were not measured, and they would be important in research of this kind given their well-established affects on physical and mental health.

Recommendations for Future Research

Overall Research Plan

The results of this investigation indicated a number of avenues to be pursued as this research base is developed further. First, a replication of the study is in order particularly given the historical milieu in which it was conducted. As previously noted, data were gathered in the fall of 2001 following the terrorist attacks in the United States.

Surveys suggested that religion and spirituality were in high focus during this time (The Pew Research Center for the People & the Press and The Pew Forum on Religion & Public Life, 2002). A replication of the study may aid in determining the degree to which timing was a confounding factor in this study. Second, as suggested by researchers in the field, the interaction of spirituality with other factors warrants further investigation (Thoresen et al., 2001). Because connection emerged as being a critical aspect of spirituality in this study, consistent with Levin's (2001) summary of findings concerning social support, religious and spiritual factors and health, future examinations might concentrate on this relationship in particular. In addition, studying age as a variable in future investigations is recommended. For example, Lee and Waters (2003) found that age, in addition to spiritual well-being and stressful life experiences, was a significant predictor of the variance in trauma symptoms. Koenig (2001) also discussed the changes in spirituality and religious involvement and their affects on mental health with age. Similarly, it makes sense to examine time as it relates to spirituality. For example, Hill and Pargament (2003) reported that when spirituality and religion are studied, cross-sectional designs are typical. Thus, religion and spirituality were considered to be stable, enduring constructs. Hill and Pargament noted that future research designs might capture spiritual and religious dynamics that change across time and situations.

An unusual and contradictory finding in this study concerned the relationship between spirituality and physical health. The extant research suggested a relationship between spirituality and physical health that was not supported by the results of this investigation, possibly because of the measurement of physical health as mentioned previously. The SF-12v2™ (SF-12v2™; Ware et al., 2002) measured current physical

and mental health over the "past four weeks," and the physical and mental health scales in this research were inversely related r (197) = -.226, $p < .01$. As a result, it was consistent with this measurement tool that the findings concerning the relationship between spirituality and physical and mental health would yield opposite results.

Alternate health measures and/or research designs may produce findings different from those reported here. In addition, and as suggested previously, the mechanisms through which spiritual practices influence health warrant further examination. Finally, future studies might investigate causal pathways describing the relationships among spirituality, health, and life satisfaction by including sociodemographic variables, professional characteristics, and a different positioning of health and life satisfaction relative to the aforementioned variables.

A primary conclusion of this research was that the daily spiritual experience of counselors was related to mental health. It may be assumed that given the demands of contemporary counseling practice, it was possible that counselors relied on their spirituality to maintain mental health. Because the relationship between spirituality and health was examined in a sample of doctoral-level counselors, further research might explore these same variables in master's-level counselors and other mental-health professionals. In addition, it makes sense to investigate the degree to which spirituality is a coping mechanism, how it is used for coping, and what other tools and techniques are also used.

Results of this investigation revealed a significant relationship between day-to-day, and arguably ordinary, spiritual experiences and mental health. As the discourse continues regarding how spiritual phenomena may be understood and measured, further

investigation is warranted concerning the relationship between more intense spiritual experiences and mental health and life satisfaction, similar to Sink (2000).

The Spiritual Practices Survey

The Spiritual Practices Survey was constructed specifically for this investigation given the paucity of available instruments to examine spiritual practices. Measures used previously included frequency counts of prayer, attendance at religious services, and reading religious materials and sacred texts. Advantages of this scale included its ease of administration and scoring in addition to a brief conceptualization of spirituality. Preliminary analyses suggested that this scale had a two-factor structure, namely a religiously oriented factor and a spiritual/secularly based factor. Moreover, initial reliability estimates were promising with Cronbach's alpha calculated to be .90 for the full scale; for the religious factor alpha was calculated to be .88; alpha for the spiritual/secular factor was .86. It was therefore a useful alternative to collect information concerning religious and spiritual practices in clinical and research settings. As a result, further validation studies are warranted.

Although this full scale and its two subscales were strongly correlated with the Daily Spiritual Experience Scale (DSES; Underwood & Teresi, 2002), the Spiritual Practices Survey offered an option through which to assess the practice dimension of spirituality. The results of the current investigation suggested that the two components of spirituality as measured by the DSES and the Spiritual Practices Survey yielded dissimilar results. That is, spiritual experience was significantly related to health and life satisfaction, whereas spiritual practices were not. This finding suggested that the two

scales were likely measuring different underlying constructs. Findings from the meditation research suggested that it was the change in consciousness and not meditative practice in and of itself that influenced health outcome (Kabat-Zinn, 1990; Levin, 2001; Orme-Johnson, 2002). It may be that in the current investigation, spiritual practices influenced health indirectly through spiritual experience.

Although preliminary analyses were promising, revisions to the scale were indicated. For example, practices shown in this and previous investigations to be performed most frequently, most notably meditation and prayer, may be more detailed in terms of type and how often they are practiced in group or individual formats. In addition, those participants who indicated practices other than those listed often noted spiritual activities of a social nature. Revisions of the scale may include items such as "mentoring" and "working with youth groups" as spiritual practices. Another item to be considered for inclusion is "making love" as suggested by two participants and Hood et al.'s (1996) summary of triggers for spiritual experiences. Revisions to the scaling were also in order. Options included two possible alternatives. First, the scale itself might be extended to include the options of weekly, monthly, and bimonthly. On the other hand, instructions might be given to use "some days" for weekly and bimonthly, and "once in a while" for monthly.

Summary

As evidenced by the evolving competency standards for counselor education advocated by accrediting bodies such as CACREP, in addition to clients' and counselors' interests in spirituality, the conclusions of this study were relevant to contemporary

counseling theory, research, and practice. Results supported the relationship between spiritual experience and mental health, and they have extended the understanding of the experiential and practice domains of counselor spirituality. This investigation also continued inquiry concerning the relationship between spirituality and health and how counselors conceptualized their own spirituality. In other words, given that in this sample of doctoral-level counselors spiritual experience was related to mental-health, how would this be integrated in counseling practice and training? How might spiritual practices or interventions be used? More importantly however, discourse must continue particularly concerning the varieties of spiritual experience and how they relate to mental health in addition to continuing the development of ethical guidelines for using spiritual interventions in counseling.

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Appendix A
Spiritual Practices Survey

Spiritual Practices Survey

In your own words, please briefly define spirituality. _____

_____

INSTRUCTIONS: Below you will find an inclusive, though not exhaustive, list of spiritual practices. In the space provided, please use the following scale to indicate how often you perform each activity for what you consider to be spiritual reasons. In answering, focus on practices you've done during the past year. Please answer all questions, leaving no space blank.

0= Not at all   1= Once in a while   2= Some days   3= Most days   4= Every day
5= More than once a day

_____ 1. Attend ongoing spiritual/religious instruction (e.g., Bible classes)
_____ 2. Attend workshops/seminars/lectures
_____ 3. Attend worship services
_____ 4. Being out in nature
_____ 5. Community service
_____ 6. Dance for spiritual purposes
_____ 7. Donations of money or other goods to a church or other religious/spiritual organization
_____ 8. Energy management (e.g. work with Kundalini, chakras, meridians, chi, vibration, light, sound)
_____ 9. Holding office in a spiritual or religious community (e.g., deaconess, elder, minister, priest, rabbi, etc.)
_____ 10. Invocations
_____ 11. Keep dietary laws (including fasting)
_____ 12. Libations
_____ 13. Meditation
_____ 14. Movement (e.g., Tai Chi, exercise, Yoga)
_____ 15. Music (e.g., singing, playing music for spiritual reasons, chanting, drumming, etc.)
_____ 16. Pilgrimage or visit to sites you consider sacred
_____ 17. Prayer
_____ 18. Radio/television programs
_____ 19. Reading (e.g., sacred texts or writings, inspirational; myths, stories or other spiritually oriented fiction; etc.)
_____ 20. Retreat
_____ 21. Ritual
_____ 22. Sacrifice
_____ 23. Social gatherings
_____ 24. Surrender
_____ 25. Teaching (spiritual or religious subject matter)
_____ 26. Use herbs
_____ 27. Use sacred objects
_____ 28. Visualization
_____ 29. Work with dreams and/or images for spiritual purposes
_____ 30. Writing (e.g. journal, poetry)
_____ 31. Other   please specify: _____

Appendix B
Demographic Information Sheet

Demographic Information Sheet

1. Gender: _____ Male _____ Female

2. Age: _____

3. Race/Ethnicity:

   _____ American Indian _____ Asian /Pacific Islander
   _____ Black _____ Hispanic
   _____ White, not Hispanic
   _____ Other, Please specify _____

4. Annual Income: _____

5. Marital Status: _____

6. Religion: _____

7a. Do you believe in a transcendent dimension? _____ Yes _____ No
   b. Is it personally meaningful to you? _____ Yes _____ No

8. Please specify Highest degree and domain (e.g., Ph.D., Marriage and Family
   Therapy; Psy.D., Clinical Psychology, Ed.D. Counseling Psychology).

   _____

9. Number of years you have been a professional counselor or psychotherapist: _____

10. Type of setting you currently work in: _____

Appendix C
Postcard Text

POSTCARD TEXT

Dear Prospective Participant,

I am a doctoral candidate in Counseling Psychology at Seton Hall University. In about

a week, you will be receiving a packet of questionnaires in a brown 9 X 12 envelope.

This is my dissertation research, and I would appreciate it if you would take about 10

minutes of your time to complete these surveys and return them to me.

Thank you in advance for your consideration.

Carol Gernat, M.A.

Appendix D
Letter to Participants

Carol A. Gernat, M.A.
c/o Seton Hall University
Department of Professional Psychology and Family Therapy
400 South Orange Avenue
South Orange, NJ 07079
973-471-9850
e-mail: gernatca@shu.edu

Dear Prospective Participant,

I am a doctoral candidate in Counseling Psychology at Seton Hall University, and I am studying the relationship between spiritual experiences and practices and health and life satisfaction of counselors. It is hoped that this project will assist in furthering the research literature concerning the spirituality of counselors and the degree to which spirituality and health are associated in this population.

This study involves filling out five questionnaires that all together take approximately 10 minutes to complete. The Daily Spiritual Experiences Scale (DSE) is an inquiry of day-to-day spiritual experience. The SF-12v2™ asks questions about your physical and mental health. The Satisfaction With Life Scale is five questions that ask you about your overall satisfaction with life. A survey of spiritual practices asks about spiritual activities you may be involved in. Finally, there is a form that asks you for general information about yourself.

These surveys should not cause you any discomfort. If they do, talk with a friend, a mental-health professional, or someone else you trust, or you may contact me confidentially at 973-471-9850 or via e-mail at gernatca@shu.edu.

Your participation in this study is purely voluntary. You may stop participating at any time, or you may decide not to be involved at all. Your participation, or decision not to participate, will not affect you in any way.

Your answers to the written tests will be private, confidential, and anonymous. Your name will not appear on any of the answer forms. I will not give your private answers to anyone, and every effort is being taken to ensure your confidentiality, anonymity, and well-being. Results will be reported in summary form and presented in a general way so that your answers cannot be associated with you.

Return of the completed questionnaires in the enclosed stamped self-addressed envelope means that you have read this letter and agree to the terms of your participation in this study. Your informed consent is thereby assumed.

This project has been reviewed and approved by the Seton Hall University Institutional Review Board (IRB) for Human Subjects Research. The IRB believes that the research procedures adequately safeguard your privacy, welfare, civil liberties, and rights. The chair of the IRB may be reached through the Office of Grants and Research Services. The telephone number is 973-378-9809.

I appreciate your time and attention to this study, thank you.

Sincerely,
Carol Gernat

Appendix E
License Agreement to Use SF-12v2™

QualityMetric
INCORPORATED

LICENSE AGREEMENT

License No.
PF-041102-01

This License Agreement is entered into, by, and among QualityMetric Incorporated (the "Licensor"), 640 George Washington Highway, Lincoln, RI 02865, and Carol Gernat (the "Licensee"), 52 Rockhill Road, Clifton, NJ 07013.

Carol Gernat is the only licensed user, under this License Agreement, of the SF-12® and/or SF-12v2™ Health Surveys.

This license covers the use of the above-mentioned survey(s) in US English.

This license cannot be transferred to other third parties, nor can it be used by Carol Gernat to obtain data for studies other than "Counselor Daily Spiritual Experiences and Practices: Implications for Health and Life Satisfaction."

Licensor has the exclusive commercial rights to the US English version of the above-mentioned survey(s) and licenses the survey items, scoring algorithms, and normative data for the Licensed Survey(s) (the "Intellectual Property") to organizations wishing to use these surveys as part of their product or service offerings.

Trademark and Copyright Reproduction

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