THE INFLUENCE OF PSYCHOLOGISTS' VALUES ON THE DISCUSSION OF SPIRITUALITY AND EXERCISE IN THERAPY

By

ANDREW N. DUNKLE

Bachelor of Science in Psychology
Texas A&M University
College Station, TX
2007

Master of Arts in Clinical Psychology
Sam Houston State University
Huntsville, TX
2009

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Dissertation Approved:

Dr. Al Carlozzi

Dissertation Adviser

Dr. Valerie McGaha

Dr. Bridget Miller

Dr. Janice Miller

Dr. John Romans

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Abstract: Previous research has provided evidence that values may direct behaviors and that psychotherapy is value laden, however, there is little known about how therapists' values influence their in session behaviors with clients. Furthermore, spirituality and exercise are topics that are not frequently addressed in psychotherapy, often due to therapists' attitudes regarding the appropriateness of including either. Trends show that not only are spirituality and exercise significant factors on individual functioning, but also that people are interested in utilizing alternative therapies as a part of their treatment. It was our goal to investigate if values are influencing therapists' decisions to give clients what they want by being client directed on their discussion of spirituality or exercise, or find out if therapists are neglecting clients' wishes by avoidance or proselytizing. Past research has been predominantly focused on attitudes and beliefs about spirituality or exercise and therapists behaviors. In the current study, the strength of therapists' values on spirituality and exercise were analyzed as they relate to the therapists specific practices regarding spirituality or exercise in session. The results of this study indicated that psychologists' spirituality values did not predict the likelihood of discussions of spirituality with their clients. However, the results did show psychologists' exercise values to be a significant predictor of discussions of exercise in psychologists' in working with clients.

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CHAPTER I

INTRODUCTION

Previous research provides evidence that values may direct behaviors and that psychotherapy is value-laden, however, there is less known about how therapists' values influence the topics they address with their clients (Bardi & Schwartz, 2003; Beutler, 1979; Bilgrave & Deluty, 2002; Feather, 1996; Kelley & Strupp, 1992; Schwartz, 1996). Despite rigorous training based on the scientist-practitioner model and evidence based practice, it has been suggested that therapists may still fail to address what could be significant factors in the lives of their clients (Delaney, Miller, & Bisono, 2007; Sheridan, Bullis, Adcock, Berlin, & Miller, 1992). Therapists' values may have more of an impact on what is addressed in therapy with clients than one might expect given the emphasis placed on objectivity in the scientist-practitioner model. The values of therapists may influence their behaviors in session, possibly putting them at risk of avoiding or neglecting certain topics that are inconsistent with their values, or overemphasizing or proselytizing about topics that are consistent with their values (Schwartz, 2003). As an

example, the formal training that therapists are exposed to often minimizes the consideration of exercise and spirituality as significant factors in the lives and experiences of clients. It has been argued that the inclusion of spirituality and exercise as areas addressed in psychotherapy is contingent upon the beliefs and attitudes that therapists' hold about such areas of human experience (Delaney, Miller, & Bisono, 2007; Hathaway, Scott, & Garver, 2004; Burton, Pakenham, & Brown, 2010).

Currently there are also growing trends that individuals seeking treatment are often relying on alternative therapies or methods of treatment in conjunction with seeing their health-care practitioner. Over 50% of clients that are seen by therapists may also be using alternative therapies which are often not discussed with their therapists (Elkins et al., 2005; Kessler et al., 2001; Knaud et al., 1999). The high utilization rates for alternative therapies by those seeking mental health care, along with the low levels of discussion about such therapies with their health care providers, clearly reflect a gap in practice where methods clients think might lead to improvements are not even discussed. Discussions regarding spirituality and exercise are often not included in therapy, since these topics are generally not included in the formal training of psychologists, and many consider them to be outside of the scope of practice for professional psychologists (Faulkner & Biddle, 2001; Folkins & Sime, 1996; McEntee & Halgin, 1996).

Nationwide polls show that 90% of the population in the United States believes in a personal God of some kind (Gallup Organization, 2005). Not only is there evidence of a belief in God, but it also appears that only about 30% of the population would be considered non-religious, meaning it is not a part of their daily lives. This is important to consider as many mental health practitioners' subscribe to a holistic view of treatment.

The Gallup Organization (1997) polls also show that the population may have a similar preference for holistic treatment as 70% of individuals reported it to be important that they have a doctor who is spiritually attuned to them. About 48% of American psychologists however, report religion to be unimportant in their lives, compared to about 15% in the general population (Bergin & Jenson, 1990; Delaney et al., 2007). Moreover, Delaney, Miller, and Bisono (2007) found that psychologists were only about half as likely as the general population to affirm that God exists. Apart from the evidence that supports a divergence of psychologists and the general population in religious beliefs, we must also consider findings that indicate although many therapists view spirituality as an appropriate topic for discussion in therapy, a much smaller percentage actually bring it up with their clients (Cornish et al., 2012; Delaney et al., 2007; Hathaway et al., 2004). These discrepancies suggest that it may be worthwhile to consider how personal values regarding spirituality may impact decisions by therapists to discuss and introduce this topic in therapy.

The effectiveness of exercise in reducing symptoms of depression and in improving well-being has been studied significantly over the past years. The interplay between physical health, exercise, and mental health has become much more understood in recent years. The rate of obesity, which has risen to over 33.8% in the general population of the United States, is the highest that it has ever been (Centers for Disease Control and Prevention, 2011). These numbers have created a growing concern within the health care community regarding the physical health risks that may be associated with obesity. In conjunction with growing physical health concerns there has also been more attention paid to the increased diagnosis of mental illness. The National Institute of

Mental Health estimates that 26.2% of the population could meet criteria for a recognized mental disorder each year and reports that depression is the primary basis for disability in the U.S. (2010). The use of exercise as a treatment for the improvement of mood has been well documented through the literature (Brown, Ramirez & Taub, 1978; Brosse et al., 2002; Blumenthal et al., 2007). However, the use of physical exercise as an integrated part of treatment planning has been underutilized in the mental health arena where practitioners routinely neglect the interplay between physical health and well-being when developing treatment plans even though clients are often seeking Complementary and Alternative Therapies (CAT) (Callaghan, 2004).

The potential implications of therapists own values on spirituality or exercise influencing their discussion of these topics with their clients must be considered. On one hand, if therapists are avoiding the discussion of these topics, they are minimizing what could be significant domains in their client's lives, thereby passing judgment on the importance of these topics in therapy. On the other hand, if therapists highly value spirituality or exercise it is likely they will address these topics with their clients. However, if they place too high a value on these areas of human experience, there may be a risk that they proselytize and become almost evangelical in addressing these topics.

Values

A general consensus on the definitions of values informs us that values can be considered motivational concepts that influence general goals across an individuals' life that are universal across time and context (Bardi & Schwartz, 2003; Beutler, 1979; Rokeach, 1973). For the purposes of this study we will adopt the comprehensive

definition provided by Schwartz and Bilsky (1987, 1990) which includes five specific features that are commonly found in values literature. A summary of this definition by Schwartz (1992) states: values (1) are composed of attitudes or beliefs, (2) "pertain to desirable end states or behaviors, (3) transcend specific situations, (4) guide selection or evaluation of behavior and events, and (5) are ordered by relative importance" (p.4). Values are often seen as similar to attitudes or beliefs; however there are some significant differences that Rokeach (1973) has brought to light. He argued that values transcend objects and situations, and that values are standards, whereas attitudes are not. Attitudes, from Rokeach's (1973) point of view are dependent on values and "values direct actions and behaviors" (p. 18). The centrality of values in an individual's self-concept, the hierarchical order of values, and the above stated differences also gives values consistency and make them more difficult to change than attitudes or beliefs (Beutler, 1979; Rokeach, 1973). This was a key departure for the current study as much of the previous research has analyzed the attitudes or beliefs of therapists rather than their value preferences.

Values Direct Behaviors. Values have been studied extensively over the past 50 years due to the potential impact that they may have on behaviors and actions (Bardi & Schwartz, 2003). Early research by Rokeach (1973) established the connection between values and actions insisting that there is an inherent need for an individual's values to be consistent with their actions. Bandura's Social Cognitive Theory (1986) provides a theoretical basis for the impact of values on behaviors and describes an individual's values as a source of internal guidance which provides a general framework for one's life. On the other hand some have come to the conclusion that values effect on behavior

is minimal and not universal (McClelland, 1985). However, there have been a number of studies that have shown a connection between values and behaviors. The relationship between values and specific measureable behaviors has been shown to be consistent in a number of real-life scenarios (Feather, 1998; Schwartz & Bardi, 2001). Feather (1988) concluded that student values were able to predict the selection of a university course. Additionally, Bardi & Schwartz (2003) were able to establish universal connections of values and behaviors beyond the specific behavioral domains that have been studied in the past. These findings are significant for the purposes of this study because of our concern with the impact of therapists' personal values on their actions in therapy. To what extent do personal values direct the behaviors of therapists in their work with clients, and more specifically do their values pertaining to spirituality and exercise affect the likelihood they will discuss these topics with their clients?

Psychotherapy as Value-Laden. Additionally, it might be worthwhile to consider how therapists' values affect the therapeutic relationship with clients. Beutler (1979) concluded that not only is there evidence to suggest that clients' values may change throughout the course of therapy, but there is reason to believe that clients actually adopt specific values of the therapist. While many therapists today may acknowledge some influence of values, there may not be as much agreement with Beutler's (1979) statements that tout therapy as a persuasive process in which the therapist changes the values of the client. Traditionally, therapists often attempt to isolate their values and provide a strictly objective method of treatment, however as Bergin (1991) states "the more open a therapist is about his or her values, the more likely the client will be able to elect responses to the value choices underlying the goals and

procedures of treatment (p.397)." Kelley & Strupp (1992) bring to the forefront the concern that discord between a therapist and client's values would undermine the formation of an appropriate therapeutic alliance and confirmed previous research that found that the values of clients and therapists impact all parts of therapy including evaluation of progress. Many training programs include culture, socioeconomic class, race, ethnicity, gender, and sexual orientation as areas of diversity already, but encouraging students to evaluate their values and become more aware of and sensitive to the values of their clients may be a worthwhile goal for the future (Kelley & Strupp, 1992; Sheridan, Bullis, Adcock, Berlin, & Miller, 1992).

Since the relationship between the therapist and the client has been shown to be more predictive of treatment outcomes than the theoretical approach that is taken; the potential influence of therapists' values on the relationship with the client may be worth considering (Lambert & Assay, 1999).

Moreover, Bilgrave and Deluty (2002) argue that not only is there evidence that therapists' may create their therapeutic approach from a number of ideological sources, but also that many of these contributing sources were rarely if ever directly discussed formally in their training. They go on to point-out evidence that therapy is value-laden and that it is possible many therapists draw upon their own spiritual or religious beliefs and that these beliefs affect their actions in therapy. In their study they found that the majority of the practitioners who participated in their study disagreed with the statement that science provides the only truths about the world, which could be viewed as undermining the scientist-practitioner model that many therapists reportedly ascribe to. This discrepancy highlights one of our current concerns, that personal values, not

necessarily science or evidence, may be more powerful in directing behaviors of therapists in their work with clients. Bilgrave and Deluty (2002) echo the sentiment of Sheridan et al. (1992) and state:

> Therapists should ask themselves regularly how their religious and political beliefs, values, and attitudes may be influencing their practice of therapy, how they see clients and their problems, how they help clients frame and understand their concerns, and how and in which direction they encourage clients to act. (p. 256)

Evidence shows that therapy is a value-laden enterprise and there is still much to learn about what effect therapists' values may have on their behaviors in therapy. We are concerned that therapists' personal spirituality and exercise values may lead to proselytizing or avoidance of these topics which are often important factors in clients' lives.

Complementary and Alternative Therapies in Psychotherapy

For many years the field of psychology has been involved in a debate regarding the inclusion of complementary and alternative therapies in the practice of psychotherapy. Although therapists may overtly state that they do not abide by a dichotomous view of the body and the mind, the integration of alternative practices that dealt with things other than the mind and emotions specifically did not seem to be readily visible in their practices (Faulkner & Biddle, 2001). The western medical model is quite prevalent in the United States and has become a part of the landscape in regards to health care. Mental health shows no exception to this as the medical model is integral to the

infrastructure of insurance companies, medical practices, hospitals, and clinics leading to a generally dualistic approach to healthcare in which the physical body and mind are treated by separate health care providers (Bassman & Uellendahl, 2003). This system makes it difficult for practitioners to implement new treatments, utilize alternative practices, and generally provides little deviation from the norm if the practitioner hopes to seek reimbursement through insurance companies (Levin & Steele, 2001). Alternative practices are also often difficult to be studied in an empirical way, which reduces the literature available regarding the effectiveness of the treatment. Additionally, funding for research on alternative therapies is not readily available further reducing the literature available to practitioners (Bassman & Uellendahl, 2003). Complementary and Alternative Therapies (CAT) were defined by Bassman & Uellendahl (2003) as "therapeutic modalities other than psychotherapy in all its various forms and other than mainstream medical practice" (p. 264). They found that psychologists often had little training in alternative therapies, and interestingly also reported very low rates of referrals to other experts in alternative therapies (Bassman & Uellendahl, 2003). This is particularly concerning if we consider the utilization trends of alternative therapies, the polls on spirituality, and health statistics. This discrepancy illustrates the potential ethical concern of psychologists' not integrating alternative treatments that may be used to treat the presenting problem of an individual (Bassman & Uellendahl, 2003). Although the current study is focused specifically on spirituality and exercise and their inclusion in psychotherapy, it is important to understand that the climate in the mental health disciplines may mitigate the inclusion of such seemingly alternative topics in the therapeutic process. While the endorsement of a mind-body dualism in psychology is not

as prevalent as it has been in the past (Faulkner & Biddle, 2001; Rejeski and Thompson, 1993); there is still much evidence that psychologists' believe that physical and health concerns are not topics that are appropriate for psychotherapy (Baerveld & Voestermans, 1996; Faulkner & Biddle, 2001; McEntee & Halgin, 1996). If psychologists are claiming that they follow holistic treatment models, it is important that we analyze our actual practices and the extent to which we are indeed holistic in our work with clients.

Another important consideration is that of the discrepancy between a commitment to diversity and practicing from a western model of medicine. Without the willingness to discuss specific alternative therapies or non-traditional therapy topics, we are in many ways marginalizing extremely significant aspects of the client's own treatment preferences. As Bergin (1991) argues, the tendency for psychologists to not include discussions of faith and spirituality in therapy "reflects the fact that such matters have not been incorporated into clinical training as have other modern issues such as; gender, ethnicity, and race" (p. 396). The integration of alternative therapies and the discussion of non-traditional therapy topics may be of significance in the treatment of clients with different worldviews, cultural backgrounds, or those interested in a holistic treatment approach that would not be afforded to them without the opportunity to discuss these topics (Bassman & Uellendahl, 2003). Spirituality and exercise are topics that may not be utilized to their fullest treatment capabilities due to a limited view of the scope of therapeutic practice.

Spirituality

Therapists' spirituality values were measured in this study utilizing Schwartz's (1992) definition of values. One of the primary goals for this study is to better understand how therapists' spirituality values predict their discussion of spirituality in their work with clients, with the extremes being either avoidance or proselytizing. Throughout the literature there has been a distinction made between the terms religiosity and spirituality. Early researchers argue the term religiosity is often used to describe an adherence to the specific beliefs or practices of an organized religion and spirituality is more indicative of beliefs, practices, and experiences revolving around the interaction between an individual and a higher power or the universe in general (Rose et al., 2008). For the purposes of this study we will utilize the term spirituality as we are not concerned with the distinction between specific organized religions. Utilizing this definition of spirituality we are able to be more inclusive of different religions and cultural views thus gaining a wider perspective of psychologists' values.

Historically psychologists report lower levels of spirituality than social workers, licensed counselors, and the general population of the United States (Bergin & Jenson, 1990; Delaney et al., 2007; Sheridan et al., 1992). With such a discrepancy in the levels of spirituality between psychologists and the general population along with the importance that it may play in the lives and experiences of our clients, it may be worthwhile to consider the potential impact of how therapists' values are influencing the discussion of spirituality with their clients. Recent evidence shows that although therapists are now considering spirituality an appropriate topic for therapy, they are not actually discussing it with their clients (Cornish et al., 2012; Delaney et al., 2007; Hathaway et al., 2004).

There is also evidence that psychologists' behaviors and attitudes regarding religion are primarily influenced by their personal view of religion rather than by their theoretic orientation or training (Shafranske & Maloney, 1990). Psychologists should be aware of the implications of an approach based on experiences, especially considering the lower levels of spirituality reported by therapists than that of the general population. Some would argue that therapists' personal convictions matter less than their sensitivity to their clients' values (Kelley & Strupp, 1992). However, if therapists' personal religious convictions have a significant impact on their approach to religious discussions with their clients (Bilgrave & Deluty, 2002; Shafranske & Maloney, 1990), then it may be worthwhile to consider how therapists' personal values regarding spirituality may influence their sensitivity to spirituality in their work with clients.

Despite the differing beliefs between the general population and mental health professionals (Shafranske, 2000); Hathaway, Scott, and Garver (2004) found 72% of psychologists believed religiosity and spirituality to be an important area of functioning for their clients. Subsequent samples have shown the majority of psychologists believe spirituality to be an important domain in the lives and experiences of their clients (Hathaway, Scott, & Garver, 2004). In spite of these findings, the vast majority of psychologists did not assess religious functioning in their work with clients and less than 20% of psychologists reported referring to or consulting with religious professionals (Hathaway et al., 2004). While it is encouraging that therapists are acknowledging the importance of religion in their clients' lives, it appears unlikely spirituality will be a topic of discussion in their work with clients. Furthermore, if therapists felt that spirituality was important but not their area of expertise, one would expect to see a greater frequency of

consultation or referrals to religious professionals than what was reported (Hathaway et al., 2004). Cornish, Wade, and Post (2012) also found that counselors in group settings also show very high levels of endorsement for the appropriateness of discussing spirituality, however in session counselors rarely attend to topics regarding spirituality and religion in their work with clients. They concluded that counselors often attended to spirituality based on their own preferences rather than on the basis of the clients' needs (Cornish et al., 2012). The pervasive issue seems to be that spirituality receives little attention and is not often being addressed in the lives of our clients. Additionally it may be worthwhile for therapists to consider the impact of making decisions based on personal preferences rather than client needs may be harmful.

Additional evidence shows that the majority of clients believed that spirituality was not only acceptable, but that spirituality was an important domain of functioning to be addressed in therapy (Cragun & Friedlander, 2012; Rose et al., 2008). When exploring Christian clients' experiences in secular therapy it was found that even though participants did not expect the therapists to discuss spirituality, all of the participants reported that they wanted their faith to be considered in therapy because it was a significant piece of their identity. Additionally, many of the clients reported being able to sense the therapist's discomfort, often through avoidance. In Cragun and Freidlander (2012) one of the participants described their perceptions of the therapists discomfort as follows:

> I had mentioned being involved in a Christian Organization. Had she asked me if I had used the Christian Organization to help figure out my struggles or to help

> myself… had she asked, I would have told her that I do…which would have opened up an entirely different conversation. But she seemed to avoid it. (p. 384)

It may be worthwhile to consider the authors' suggestion that gaining a deeper understanding of clients' spirituality and the importance of it in their life through specific questions would be beneficial in giving clients the permission to discuss these topics in therapy and in forming a therapeutic relationship (Cragun & Freidlander, 2012). If therapists are following clients' lead on what would be beneficial to include in treatment, then it seems in-depth discussions on spirituality would not be out of the ordinary.

Spirituality may be a significant part of the lives and experiences of our clients making it worthwhile to consider potentially harmful practice of avoiding or neglecting spirituality (Cragun & Friedlander, 2012; Rose et al., 2008. However, it may also be important to consider the possibility that spirituality becomes emphasized to the point that it becomes evangelical. Psychologists, licensed counselors, and social workers all expressed concern regarding the potential pitfalls of practitioners imposing their own views of religion on clients (Sheridan et al., 1992). Furthermore, there is a concern that discussion of spirituality may lead to negative interactions within group sessions (Cornish et al., 2012). Not only is this study interested any implications there may be from practitioners who avoid spirituality in session, but also the dangers of therapists being evangelical or imposing the necessity of these topics due to the strength of their values of spirituality.

Physical Exercise

Exercise values were analyzed in this study utilizing Schwartz's (1992) definition of values. Exercise as a value: can be prioritized hierarchically, may direct goals and behaviors, transcends specific situations, and may be central to an individual's self-concept. One of the primary goals for this study is to better understand how therapists' exercise values predict their discussion of exercise in work with their clients, with the extremes being either avoidance or proselytizing. For the purposes of this study we will utilize Brosse et al., (2002) in defining exercise, which states exercise is usually able to be broken down into three different types:

> Cardio-respiratory or aerobic (e.g. walking, jogging) in which oxygen is metabolized to produce energy; muscular strength and isometric anaerobic exercise (e.g. weight lifting) in which energy is provided without the use of inspired oxygen; and flexibility exercise (e.g. yoga, stretching) that is designed to improve range of motion. (p. 745)

Conceptualizing exercise as a value is reasonable considering the importance placed on exercise through the health movement and the experiences of those "true believers" who would describe the impact of exercise in ways almost indistinguishable from how one might describe spiritual experiences (Edgley & Brissett, 1990).

With the growing health concerns, the increasing utilization of complementary therapies, and the evidence supporting the psychological and physical benefits of exercise, it seems discussing exercise as a part of treatment would be worthwhile for therapists. However, at this time it appears to be utilized rarely in the mental health field (Callaghan, 2004). Historically research on exercise as a part of therapy has been

hampered due to psychologists viewing the mind and body as separate and the lack of conceptual ties between the two (Folkins & Sime, 1982). Subsequently McEntee and Halgin (1996) supported this claim as therapists in their study reported the perceived inappropriateness of discussing exercise in psychotherapy to be the primary reason exercise was not discussed in therapy. Other reasons that were endorsed by the therapists included views that exercise was out of their scope of practice or that the prescription of exercise was too directive. However, the authors did not find any significant correlations between theoretic orientation and the likelihood that exercise would be discussed in session. McEntee and Halgin (1996) also found that the therapists most frequently spoke about exercise with clients for symptom relief, although they viewed physical and psychological issues as separate. Furthermore, the respondents reported most of their practice was self-informed by their own experiences with exercise. The authors concluded: "Many therapists simply do not see their work as pertaining to the body, and they believe that most clients come to therapy to discuss psychological ailments, not physical and exercise-related ones (p. 55)." These results seem to contradict holistic treatment models which many therapists claim to utilize.

Evidence shows that therapists who regularly engage in exercise are more likely to discuss exercise with their clients (Royak-Schaler & Feldman, 1984; Barrow et al., 1987; Burks & Keeley, 1989; McEntee & Halgin, 1996; Burton et. al., 2010). Burton et al. (2010) found that the strongest predictor for the inclusion of activity advice was if the therapist engaged in regular exercises themselves. Furthermore, the authors' state that over 80% of the respondents indicated confidence in providing general activity advice. However, less than half of the respondents reported confidence in monitoring or tailoring

activity advice to the client (Burton et al., 2010). It may be worthwhile to consider these findings when exploring the likelihood of therapists discussing specific exercise topics when working with their clients. At this juncture, being open to discussing exercise in therapy may not be sufficient considering the difficulty of implementing, adhering to, and maintaining an exercise plan.

Due to the evidence supporting a higher likelihood of exercise discussions by therapists who are exercisers, it may also be worthwhile to consider the possible harm of therapists over-emphasizing exercise in their work with clients. Edgley and Bissett (1990) illustrate this potential danger as they describe some "true believers" in exercise as "Health Nazis" because of the moral judgments these individuals have attached to health and exercise choices along with their intrusive attempts to control others' health and lifestyle choices. Therapists should consider how their own exercise values, whether strong or weak, could impact the relationship with the client. Avoiding the discussion of exercise may be equally as judgmental as imposing your personal values regarding exercise and healthy lifestyle.

Hypotheses

The following hypotheses were examined:

Hypothesis 1:

A) H_o: Psychologists' spiritual values do not predict the likelihood of engaging in discussions related to spirituality with clients that bring up the topic.

B) H_o: Psychologists' spiritual values do not predict the likelihood of engaging in discussions regarding the client's use of spirituality as a coping mechanism.

C) H_o: Psychologists' spiritual values do not predict the likelihood of engaging in discussions regarding the client's relationship with their God.

D) H_o: Psychologists' spiritual values do not predict the likelihood they will inquire about specific spiritual practices that the client thinks would be helpful.

E) H_o: Psychologists' spiritual values do not predict the likelihood that they will bring up spirituality in the course of therapy with clients who do not bring up the topic.

Hypothesis 2:

A) H_o: Psychologists' exercise values do not predict the likelihood of engaging in discussions related to exercise with clients that bring it up the topic.

B) H_o: Psychologists' exercise values do not predict the likelihood that they will tailor a physical activity program to clients' individual needs.

C) H_o: Psychologists' exercise values do not predict the likelihood they will monitor ongoing physical activity levels.

D) H_o: Psychologists' exercise values do not predict the likelihood they will problem solve barriers to physical activity with client.

E) H_o: Psychologists' exercise values do not predict the likelihood that they will bring up exercise in the course of therapy with clients who do not bring up the topic.

CHAPTER II

METHODS

Participants

A total of 122 individuals of various professional backgrounds participated in the current study. Participants were required to meet the inclusion criteria of providing therapy for one year of greater at the time of study participation and have completed a doctoral degree in the field of psychology. Surveys were sent to American Psychological Association Division 17, Counseling Psychology, and Division 29 Psychotherapy, Division 38, Health Psychology, Division 42, Psychologists in Independent Practice, and Division 47, Exercise and Sport Psychology. Of the 122 responses, 4 were excluded from data analysis due to failure to respond to more than ten percent of the survey questions and 14 were for failure to meet the educational requirements. The final sample consisted of 104 psychologists who met inclusionary criteria. Of the respondents there were 27 males (26%) and 77 females (74%). See Table 1 for demographics of this sample.

The majority of the participants indicated their age to be from 35 to 44 years (n = 31; 30%), 29 were 22-34 years of age (28%), 21 were 45 to 54 years of age (20%), 18 were 55-64 years of age (17%), and 5 were 65 years and above in age (5%). The average number of years of therapy provided was 12.83 years (SD = 11.04, range = 1-42). The primary work setting for respondents, when given 6 choices, were: university counseling center, 5 respondents (5%), faculty, 8 respondents (8%), inpatient setting, 4 respondents (4%), outpatient setting, 8 respondents (8%), private practice, 36 respondents (35%), medical setting, 42 respondents (41%); 1 participant did not respond to this item. Of the sample, 7 were members of Division 17 (7%), 11 were members of Division 29 (11%), 47 were members of Division 38 (47%), 32 were members of Division 42 (32%), 14 were members of Division 47 (21%), 21 members of multiple division (21%), and 3 participants did not respond. Furthermore, 4 participants identified as Asian (4%), 2 identified as Black or African American (2%), 3 identified as Hispanic or Latino (3%), 87 identified as Non-Hispanic White (87%), 3 identified as biracial (3%), 1 identified as multiracial (1%), and 4 participants did not report racial identity.

Instruments

Demographic Questionnaire. Participants were asked to respond to a uniform demographic questionnaire that collected information on the following variables: gender, age, state or territory of residence, years worked as a psychologist, highest degree completed, primary work setting, APA division membership, and racial identity.

Specific Value Rating Measure (SVRM). A new questionnaire was created for this study due to the specific variables of interest and the lack of an existing brief

measure. The questionnaire was primarily based on past research on values research and the Schwartz Values Survey (SVS) (Schwartz, 1992; Schwartz, 2009). The SVS was not utilized for this survey because the purpose of the measure does not meet the needs of this study. The SVS includes 56 values that are then rated based on importance in the participant's life, however it is meant to measure the universality of 10 value types across cultures. Our measure utilizes Schwartz' (1992) definition of values, which states: values (1) are composed of attitudes or beliefs, (2) "pertain to desirable end states or behaviors, (3) transcend specific situations, (4) guide selection or evaluation of behavior and events, and (5) are ordered by relative importance," to direct the items that were used to rate the strength of spirituality and exercise as values in the participant's life (p.4). An initial item pool was developed by the researcher and subsequently reviewed by a panel of doctoral students who have provided therapy for at least one year and taken at least one course in psychometrics and statistics as well as one faculty member of the researcher's home institution. The final questionnaire was narrowed to 8 items; removing questions that were not directly related to the above stated definition of values and questions that were redundant, based on feedback from the review panel. The purpose for the questionnaire is to be: a brief self-report measure of therapists spiritual and exercise values, which can be administered quickly and provide a reliable measure of psychologist's values. The response format is a 1-11 scale in which the participant will mark the number that best describes their agreement with the statement with 1 being "never" and 11 being "all of the time." Two subscales were created to measure the two values of interest. These subscales include: Spirituality (four items; e.g., "My spirituality is a guiding principle in my life") and Exercise (four items; e.g., "Physical exercise is a

guiding principle in my life"). Each item is scored using the points indicated in the response. The scores from each of the four items on the spirituality subscale were used to create an average that was then used as the spirituality values composite. The spirituality values composite score was used as the predictor variable in hypotheses 1. The scores from each of the four items on the exercise subscale were also used to create an average that was then used as the exercise values composite score. The exercise values composite score was used as the predictor variable in hypotheses 2. Increased scores on the subscales of the SVRM will provide us with an indicator of the strength of spirituality and exercise values based on the composite of scores. Higher scores on the SVRM indicate stronger spirituality or exercise values.

A pilot study was completed with a sample of graduate student peers and internal consistency reliability was established. The spirituality values subscale consisted of 4 items ($\alpha = .98$) and the exercise values subscale consisted of 4 items ($\alpha = .97$) and each subscale shows high levels of internal consistency. The results indicate excellent levels of internal consistency and show no need to remove any items. Although we are seeking high levels of reliability, there may be some redundancy in the measure. However, due to the brief nature of the measure and the additional value of subsequent analysis of the items, it was decided that all items be included.

Psychologists' Treatment Practice Items (PTPI). Another scale was developed to measure the presence of specific behaviors in therapy. Again an initial item pool of 20 practice items was created and reviewed by graduate students and faculty members of this researchers' home institution. Two subscales were created to measure specific behaviors related to spirituality and exercise in session. The two subscales are:

Discussion of Spirituality (five items; e.g., "A client wants to include spirituality as a part of treatment, I will inquire about specific spiritual practices that the client thinks would be helpful"), and Discussion of Exercise (five items; e.g., "A client wants to include exercise as a part of treatment, I will tailor a physical activity program to the client's individual needs"). Individual items were used to understand therapists' specific behaviors, with higher scores indicating a higher frequency of engaging in the behavior. The response format for the PTPI is a 1-11 scale in which the participant will mark the number that best describes their agreement with the statement with 1 being "never" and 11 being "all of the time". Each of the behaviors described in the Discussion of Spirituality subscale items were utilized as the outcome variables for hypotheses 1. Furthermore, each of the behaviors described by the Discussion of Exercise subscale items were utilized as the outcome variables for hypotheses 2. Increased scores on the PTPI show a greater willingness to discuss spirituality and exercise in therapy.

Design and Procedures

A web-based self-administered survey was constructed by the researcher through the Qualtrics online survey platform and was utilized for this exploratory research due to the ability to reach a large and potentially diverse sample of psychologists who have provided therapy for at least one year. The survey was approved by the Oklahoma State University Institutional Review Board (IRB) and participants were recruited through a non-random convenience sampling technique. IRB-approved recruitment scripts were sent to potential participants via five different division listservs which are all part of the American Psychological Association.

The IRB-approved recruitment script provided general information about the study, introduced the researcher, specified the eligibility requirements, provided the contact information for the researchers involved, and included instructions for consent and participation. Participants were prompted to access a website through a link in the email. Upon reaching the site, consent to participate, confidentiality, anonymity, and general inclusion guidelines were presented. By clicking web link the individual acknowledges they meet the study criteria and are providing informed consent to participate in the study. The participant then completed the demographic questionnaire and the values questionnaire and the therapy practices items. Following the completion of the questionnaire participants were thanked for their participation and were given the opportunity to provide a valid email on a separate webpage, in order to maintain privacy, to be entered into a drawing for one of four $25.00 Amazon gift cards. In total 86.5% of study participants (n = 90) decided to enter into the optional drawing. Four randomly chosen participants were notified of their winnings and the Amazon gift cards were mailed electronically to the email address that the participant chose to provide.

The Statistical Package for Social Sciences (SPSS) version 20.0 for Windows was used to complete all of the statistical analysis. Internal consistency reliabilities were measured for the spirituality values composite subscale consisted of 4 items ($\alpha = .98$) and the exercise values composite subscale ($\alpha = .97$). These alpha scores indicate that the items that comprise the spirituality values composite subscale and the exercise values subscale items show reliability producing similar scores. The results indicate excellent levels of internal consistency and show no need to remove any items, but may indicate some redundancy in the measures.

CHAPTER III

FINDINGS

Descriptive Statistics

Descriptive information on each of the predictor variables and criterion variables are presented in Table 2. The spirituality values composite scores (M = 6.34; SD = 2.68) were slightly greater than the exercise values composite score (M = 5.84; SD = 2.29) which indicates that overall participants reported higher levels of spirituality values than exercise values.

The spirituality variables measured in this study indicated that the participants were generally likely to discuss spirituality when clients want to include spirituality as a part of treatment. Participants reported a willingness to discuss spirituality when a client brings it up (M = 9.98; SD = 1.55), a willingness to discuss the use of spirituality as a coping mechanism when a client wants to include spirituality as a part of treatment (M = 9.47; SD = 2.30), a willingness to discuss the client's relationship with his or her God when the client wants to include spirituality as a part of treatment (M = 9.22; SD = 2.46), and a willingness to inquire about specific spiritual practices that the client thinks would

be helpful when a client wants to include spirituality as a part of treatment (M = 9.64; SD = 1.82). However, participants were less likely to bring spirituality during the course of therapy with a client who does not speak about spirituality during therapy (M = 5.02; SD = 2.04).

The exercise variables that were measured in this study indicate that psychologists were generally willing to discuss exercise when working with clients. Participants reported a strong likelihood of engaging exercise discussions nearly all of the time when clients want to discuss exercise (M = 10.20; SD = 1.55), a willingness to monitor ongoing physical activity with clients who want to include exercise as a part of treatment (M = 8.12; SD = 3.05), and a willingness to problem solve barriers to physical activity with a client who wants to include exercise as a part of treatment (M = 9.99; SD = 1.66). Participants generally indicated a slightly lower likelihood that they would tailor a physical activity program to the client's individual needs when a client wants to include exercise as a part of treatment (M = 7.81; SD = 3.05) and that they would bring up exercise during the course of therapy if a client does not bring it up (M = 7.19; SD = 2.50).

Primary Analysis

Simple linear regression analyses were conducted to assess the extent to which spirituality values were predictive of psychologists' discussion of spirituality in their work with clients. The predictive nature of exercise values on psychologists' discussion of exercise in their work with clients were also assessed through simple linear regression. One linear regression analyses was conducted for each criterion variable, for a total of ten

regression analyses. The Spirituality Values Composite score was the predictor variable utilized for hypothesis 1 and was derived by combining the four items related to spirituality values on the SVRM. The Exercise Values Composite score was the predictor variable utilized for hypothesis 2 and was derived by combining the four items related to exercise values on the SVRM.

Hypotheses 1: Spirituality

1. A) H_o: Psychologists' spiritual values do not predict the likelihood of engaging in discussions related to spirituality with clients that bring up the topic?

Simple linear regression analysis determined that the likelihood that psychologists engage in discussions of spirituality with clients who bring up the topic did not vary as a function of the psychologists' spiritual values. Overall, the spirituality values predictor was not significant and accounted for less than 0.40% of the variability in the discussion of spirituality with clients' who bring up the topic, $F(1, 102) = .53$; $p > .05$.

1. B) H_o: Psychologists' spiritual values do not predict the likelihood of engaging in discussions regarding the client's use of spirituality as a coping mechanism?

Simple linear regression analysis determined that the likelihood that psychologists engage in discussions regarding the client's use of spirituality as a coping mechanism did not vary as a function of the psychologists' spiritual values. Overall, the spirituality values predictor was not significant and accounted for 1.50% of the variability in the discussion of client's use of spirituality as a coping mechanism, $F (1, 102) = .22$; $p > .05$.

1. C) H_o: Psychologists' spiritual values do not predict the likelihood of engaging in discussions regarding the client's relationship with their God?

Simple linear regression analysis determined that the likelihood that psychologists engage in discussions regarding the client's relationship with their God did not vary as a function of the psychologists' spiritual values. Overall, the spirituality values predictor was not significant and accounted for less than 0.00% of the variability in the discussion of client's relationship with their God, $F(1, 102) = .22$; $p > .05$.

1. D) H_o: Psychologists' spiritual values do not predict the likelihood they will inquire about specific spiritual practices that the client thinks would be helpful?

Simple linear regression analysis determined that the likelihood that psychologists inquire about specific spiritual practices that the client thinks would be helpful did not vary as a function of the psychologists' spiritual values. Overall, the spirituality values predictor was not significant and accounted for 1.60% of the variability in the likelihood that psychologists will psychologists inquire about specific spiritual practices that the client thinks would be helpful, $F(1, 100) = .20$; $p > .05$.

1. E) H_o: Psychologists' spiritual values do not predict the likelihood that they will bring up spirituality in the course of therapy with clients who do not bring up the topic?

Simple linear regression analysis determined that the likelihood that psychologists will bring up spirituality in the course of therapy with clients who do not bring up the topic did not vary as a function of the psychologists' spiritual values. Overall, the spirituality values predictor was not significant and accounted for 0.70% of the variability in the

likelihood that psychologists will bring up spirituality in the course of therapy with clients who do not bring up the topic, $F(1, 102) = .38$; $p > .05$.

Hypotheses 2: Exercise

2. A) H_o: Psychologists' exercise values do not predict the likelihood of engaging in discussions related to exercise with clients that bring it up the topic?

Simple linear regression analysis determined the likelihood that psychologists engage in discussions related to exercise with clients that bring it up the topic did not vary as a function of the psychologists' exercise values. Overall, the exercise values predictor was not significant and accounted for 2.20 % of the variability in the likelihood that psychologists engage in discussions related to exercise with clients that bring it up the topic, $F(1, 101) = .13$; $p > .05$.

2. B) H_o: Psychologists' exercise values do not predict the likelihood that they will tailor a physical activity program to clients' individual needs?

Simple linear regression analysis determined the likelihood that psychologists engage in discussions related to exercise with clients that bring it up the topic varied as a function of the psychologists' exercise values. Overall, the exercise values predictor was significant and accounted for 5.50 % of the variability in the likelihood that they will tailor a physical activity program to clients' individual needs, $F(1, 100) = .02$; $p < .05$. Exercise values contributed significantly to the prediction of the likelihood that they will tailor a physical activity program to clients' individual needs $t (100) = 2.41$; $p < .05$.

2. C) H_o: Psychologists' exercise values do not predict the likelihood they will monitor ongoing physical activity levels?

Simple linear regression analysis determined the likelihood that psychologists will monitor ongoing physical activity levels did not vary as a function of the psychologists' exercise values. Overall, the exercise values predictor was not significant and accounted for 0.90 % of the variability in the likelihood that psychologists will monitor ongoing physical activity levels, $F (1, 101) = .33$; $p > .05$.

2. D) H_o: Psychologists' exercise values do not predict the likelihood they will problem solve barriers to physical activity with clients?

Simple linear regression analysis determined the likelihood that psychologists will problem solve barriers to physical activity with clients did not vary as a function of the psychologists' exercise values. Overall, the exercise values predictor was not significant and accounted for 0.70 % of the variability in the likelihood that psychologists will problem solve barriers to physical activity with clients, $F (1, 101) = .39$; $p > .05$.

2. E) H_o: Psychologists' exercise values do not predict the likelihood that they will bring up exercise in the course of therapy with clients who do not bring up the topic?

Simple linear regression analysis determined the likelihood that will bring up exercise in the course of therapy with clients who do not bring up the topic varied as a function of the psychologists' exercise values. Overall, the exercise values predictor was significant and accounted for 12.1 % of the variability in the likelihood that they will bring up exercise in the course of therapy with clients who do not bring up the topic, $F(1, 101) = .000$; $p < .05$. Exercise values contributed significantly to the prediction of the

likelihood that they will bring up exercise in the course of therapy with clients who do not bring up the topic $t(101) = 3.73$; $p < .05$.

CHAPTER IV

DISCUSSION

The findings from this study indicate that psychologists in general were willing to discuss spirituality with their clients when the client brings it up and were mixed in their willingness to bring spirituality up with client who did not speak about it initially. This appears to contradict previous studies that suggested that therapists may fail to address what could be significant factors in the lives of their clients (Delaney et al., 2007; Sheridan et al., 1992). However, the varied responses from participants in this study when asked if they would bring up spirituality appears to be consistent with research that has shown that although many therapists view spirituality as an appropriate topic for discussion in therapy, a much smaller percentage actually bring it up with their clients (Cornish et al., 2012; Delaney et al., 2007; Hathaway et al., 2004). Furthermore, the findings reflect a strong likelihood that psychologists will discuss exercise in therapy and bring up the topic with clients. These findings are not consistent with previous findings

That showed many psychologists considered exercise topics to be outside of the scope of practice for professional psychologists (Faulkner & Biddle, 2001; Folkins & Sime, 1996; McEntee & Halgin, 1996). As a whole these results show that the psychologists who participated in the study have a strong willingness to discuss spirituality and exercise in therapy, which may reflect a change in views regarding topics that that should be included in treatment.

Hypotheses 1. This appears to be the first study that has investigated psychologist's spirituality values and exercise values as predictors of their discussion of these topics in their work with clients. The findings from the first hypotheses showed that psychologist's spirituality values were not significant predictors of the likelihood that they would discuss spirituality with their clients. These results do not lend support to previous research showing values to be a predictor of behaviors (Feather, 1998; Schwartz & Bardi, 2001; Schwartz, 2003). Furthermore, these findings also appear to contradict research that indicates therapy is a value-laden enterprise, where beliefs and attitudes of the therapists had an influence on their work with clients (Bergin, 1991; Beutler, 1979; Bilgrave & Deluty, 2002; Kelley & Strupp, 1992; Sheridan et al., 1992). Additionally, these findings are not supportive of previous research that suggests the inclusion of spirituality as a topic in therapy is contingent on the therapists' attitudes and beliefs (Delaney, Miller, & Bisono, 2007; Hathaway, Scott, & Garver, 2004). Although it appears psychologists continue to be varied on the likelihood they would bring up spirituality with clients who do not; the findings from this study provide evidence that psychologist's personal spirituality values are not influencing their discussion of spirituality in their work with clients.

Hypotheses 2. When considering the findings from hypotheses two, it appears that although psychologists exercise values were not predictive of three of the criterion variables tested (Hypotheses: 2A, 2C, 2D); exercise values could be seen as significant predictors of the likelihood that psychologists will tailor a physical activity program to clients' individual needs and the likelihood that psychologists will bring up exercise in the course of therapy with clients who do not bring up the topic. These results support previous research that showed values to be a predictor of behaviors (Feather, 1998; Schwartz & Bardi, 2001; Schwartz, 2003). Additionally, these findings also support research that indicates therapy is a value-laden enterprise, where beliefs and attitudes of the therapists had an influence on their work with clients (Bergin, 1991; Beutler, 1979; Bilgrave & Deluty, 2002; Kelley & Strupp, 1992; Sheridan et al., 1992).

The insignificant findings between psychologists exercise values and three of the outcome variables appear to contradict findings that have shown psychologists often do not utilize exercise as a part of treatment and view exercise as outside of their scope of practice (Callaghan, 2004; McEntee & Halgin, 1996). This may indicate that psychologists who participated in the studied are utilizing a holistic treatment approach some of the time.

Previous research has shown that less than half of psychologists are confident in monitoring or tailoring activity advice with their clients (Burton et al., 2010) and this study shows that psychologist's exercise values were not predictive of their willingness to monitor activity advice. However, hypothesis 2B was confirmed and psychologist's exercise values were a significant predictor of their willingness to tailor a physical activity program to clients' individual needs. These results show that exercise values

become particularly relevant when considering the discussion of more specific tailoring of activity advice compared to more general exercise discussions. These findings may also support the necessity of a deeper understanding of psychologists competencies in order to avoid potential ethical dilemmas.

Although previous research has shown that therapists who engage in exercise regularly was strongly related to the likelihood that therapists will discuss or include exercise in work with clients (Royak-Schaler & Feldman, 1984; Barrow et al., 1987; Burks & Keeley, 1989; McEntee & Halgin, 1996; Burton et. al., 2010), by confirming hypothesis 2E, this study appears to be the first to show psychologist's exercise values to be a predictor of the likelihood they will discuss exercise with clients' who do not bring up the topic. These findings are particularly relevant, considering the previous research that has shown exercise to be an effective treatment for mood improvement, as they show that psychologist's personal exercise values are predictors for the likelihood that they will bring exercise up with clients. This provides information regarding what influences psychologists to discuss or not discuss exercise when working with clients. Additionally, these findings provide some indication that psychologist's values may be related to the likelihood that they will avoid discussing exercise or impose their views of exercise on their clients.

Implications for Practice

The mixed results of this study provide some support for previous theories related to the relationship between values and behaviors. Spirituality values were not shown to have any significant influence on psychologists' discussion of spirituality with their

clients. While these results contradict previous values research, it appears that even considering the generally lower rates of religiosity in psychologists than other professions, their spirituality values did not have a significant impact on their work with clients.

Findings indicated a statistically significant relationship between psychologists exercise values and the likelihood that they would tailor a physical activity program to a client's needs and bring up exercise with a client who does not bring it up. These results support previous research related to the influence of values on behaviors. Exercise has been well supported as a treatment for mood improvement, understanding that psychologists exercise values influence their inclusion of exercise as a treatment option in their work with clients provides support for the need to include formal training experiences related to exercise biases and the inclusion of exercise discussion in work with clients.

The findings from this study may also provide some support for the potential for psychologists to proselytize about exercise due to the relationship between exercise values and the likelihood that psychologists would bring up the topic with a client who does not bring it up. Psychologists working with clients must be aware of how their personal exercise values may influence them to exercise more often, possibly imposing their exercise beliefs on their clients. The influence of values on the discussion of specific topics with clients may have an impact on the relationship with the client if exercise discussions are avoided or overemphasized. The findings of this study may provide a platform warranting more discussions regarding exercise values among psychologists.

Psychologists should consider how their personal exercise values, whether strong or weak, could impact the relationship with the client. Considering the support for exercise as a treatment for mood, avoiding the discussion of exercise may be equally as detrimental as imposing your personal values regarding exercise and healthy lifestyle.

Limitations and Directions for Future Research

The study utilized the SVRM to measure psychologists' spirituality and exercise values which was a newly created instrument. Exercise values have not been previously measured in this way and although our definition of values provided by Schwartz (1992) can be applied to exercise as a construct, participants may not have considered exercise to be a value prior to responding to this survey and may have made responding to each of the exercise values items difficult. Similarly spirituality values as a construct has been more frequently utilized in values ranking research, rather than behavioral research, which may have led to some participants to have difficulty responding to the spirituality values items in accordance with the operational definition that was provided. Subscales on the SVRM did show good reliability, however as new instruments construct validity was not well established.

The PTPI measure was used to measure specific behaviors related to psychologists' discussion of spirituality and exercise with their clients and was also a newly created instrument with little validity established. Although, the PTPI did provide information on the behaviors identified on the Spirituality Practices and Exercise Practices subscale, the items on these subscales may have only identified a narrow range of behaviors. The PTPI may benefit from increased specificity regarding the behavior of

discussion spirituality and exercise topics, as well as a wider range of practice items. Additionally, 8 of the 10 items on the PTPI were worded in a way that the client "wanted to include spirituality or exercise as a part of treatment." The wording of these items may have had an influence on the response if the psychologist was concerned with not doing what the client is requesting. These items reflect a client initiative to discuss spirituality or exercise in therapy. A possible alternative to these items may start with "A client mentions…" rather than the direct statement utilized for this study. Additionally, theoretical orientation of the psychologists may have influenced the response of the participants to items that show the client's desire to discuss these topics. Collaborative and non-directive psychologists may have been more apt to respond that they would discuss these topics more frequently because of the client's intentions. Future studies may consider including a wider number of therapist practices, including items that are not prefaced by a client's initiation of the topic.

Furthermore, the self-report format of the SVRM and the PTPI should also be considered as a potential limitation as social desirability and response bias effects may have influenced the psychologists' responses. Due to the sensitive nature of the items related to psychologists' behaviors while working with clients, there is a possibility that the participants wanted to be viewed in a favorable light, thus influencing them to respond as they perceive other psychologists might (Krumpal, 2013). Additionally, utilizing self-report responses to measure behaviors in therapy may not be as accurate as observational data from session videos or recordings. Future studies should consider including observational data to any self-report to improve upon the results that were found in this study.

Another limitation of the current study would be the utilization of convenience sampling techniques rather than a random sampling technique. The use of convenience sampling may affect the generalizability of the data, due to the lack of randomization, control, and manipulation, which may be present if random sampling techniques were utilized. An additional factor that may limit generalizability due to sampling technique was the use of APA division listservs. While recruiting from these listservs provided an appropriate sample size, we must acknowledge that these listservs are not exhaustive collections psychologists and up to 45% of APA members do not belong to any divisions. It also possible that gender may have influenced the results of this study as 74% of the participants were female and 26% were male. Although an experimental design with random sampling techniques may not be feasible for a study of this nature, in the future researchers may be able to utilize some randomization and improve the generalizability of their findings.

Additionally, pre-existing groups as identified by division membership may have influenced the results as 79% of the participants identified as members of the Health Psychology Division 38 or the Psychologists in Independent Practice Division 42. Furthermore, 76% of the participants identified their primary work setting as a medical setting or independent practice which may also have an impact on the generalizability of our findings. In the future, it may be important to obtain a better representation from diverse work settings.

Cultural and racial factors should also be considered as 87% of the respondents identified as Non-Hispanic White indicating a racially homogeneous sample. Cultural and racial groups may vary significantly on views of spirituality or exercise and it may be

worthwhile for future researchers to explore other methods of obtaining a more diverse sampling of psychologists.

Furthermore, we must consider the limits to the conclusions we are able to make as simple linear regression was the primary analyses utilized. While we may be able to confirm predictions regarding the influence of spirituality and exercise values on psychologists' behaviors, we will not be able to make cause-effect conclusions

In acknowledging these limitations regarding the sample demographics, instruments, sampling techniques, and the results of this study may still provide worthwhile information on the influence of psychologists' values on their discussion of spirituality or exercise when working with clients.

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APPENDICES

Appendix A

Review of the Literature

Values

Rokeach's (1973) work on values has provided much of the foundation for the decision to focus on the impact of values in our study. It may be useful to consider what functions values serve in humans and expand on what Rokeach's work has given us. One of the functions that Rokeach (1973) highlights is that values can be viewed as standards that provide a compass for our ongoing activities and goes on to outlines seven different ways that values can influence human conduct as follows: values 1) inform the positions we take on social issues, 2) predispose us to view a particular ideology over another, 3) direct how we present ourselves to others, 4) provide a standard for people to evaluate and judge, 5) are central to our comparisons of self with others and 6) "They are, moreover, standards employed to persuade and influence others, to tell us which beliefs, attitudes, values, and actions of others are worth challenging, protesting, and arguing about, or worth trying to influence or to change" and 7) give people a way to rationalize beliefs, attitudes, and behaviors that would otherwise be unacceptable (p. 13). In

considering the nature of values as standards Rokeach (1973) suggests we consider how values may then be employed as standards of actions, judgment and evaluation, and to rationalize behaviors and in what situations these standards are employed. In this study we hope to gain a better understanding of the ways in which therapists values are employed as standards of action when working with their clients.

It may also be helpful to establish a deeper understanding of the differences between values and other concepts. Attitudes in particular have been measured frequently throughout the literature and have at times been viewed as synonymous with values. While some may view this lack of clarity as of little importance, we believe it would be helpful to distinguish between the two as our study focuses solely on values rather than attitudes. Rokeach (1973) outlines important aspects of how they differ. One of the distinctions made between the two is that values can be considered standards while an attitude is not a standard. Another distinction would be the centrality of values makes them determinants of both attitudes and behaviors. For this study is helpful to consider idea that attitudes are based on pre-existing values. While we can explore the influence of values on directing behaviors, we are unable to make these types of connections with attitudes because they would be considered secondary characteristics. Additionally, values are concerned with a transcendent end-state or a specific mode of behavior while an attitude describes an organization of specific beliefs in reference to certain objects or situations.

Values Direct Behaviors. The predictions for this study are based on the view that values can direct behaviors. By understanding therapists values we would hope to make some predictions regarding how they will behave in work with their clients.

Rokeach (1973) devotes a chapter to reviewing the literature supporting a link between values and behaviors and included domains such as civil rights, religion, politics, war, interpersonal conflict, behavior in counseling, academic pursuits, lifestyle, and occupational choices. He found that values often significantly related to general and specific behaviors across a number of contexts. Albert Bandura (1986) included values as a part of his social cognitive theory because of the significant role values may have as a guide for an individual's trajectory throughout life and states "Human behavior is partly governed by value preferences and evaluative standards. It is through this internal source of guidance that people give direction to their lives and derive satisfactions from what they do" (p. 73). Bandura's theory has been subsequently supported by research showing the ability to predict behavior in specific situations from one's values. Feather (1988) measured student values and the value they ascribed to specific subjects then compared these to enrollment decisions that were made. Their results provide more evidence between personal values, subjective values, and actions or outcomes. Many of these early studies analyzed the impact of values on specific measurable behaviors and found significant connections. Evidence from Feather (1988) shows support for the argument that values influence choice-situations. However, in everyday life many of our behaviors do not begin with conscious consideration of values that influence our choices. People do not often stop to consider their values in the midst of a conversation or before every action throughout the day. Bardi and Schwartz (2003) chose to explore values in a way to see if values influence more behaviors than the small subset of choice-situation behaviors. In their study they analyzed ten universal values and behaviors that do not require or involve much consideration. The authors hypothesize that all values and

behaviors will show relationships with one another, more specifically, behaviors that show a positive relationship with values are the most compatible with that value and behaviors that show an inverse relationship with values would indicate incongruence between behaviors and values. Bardi and Schwartz (2003) administered their surveys to three different samples. One sample was of individuals who only rated themselves, the second sample included a self and an intimate partner rating, and the final sample included a self and peer response. Due to the nature of the study and the correlational analyses utilized, the researchers were unable to make a causal claim; however there were positive correlations between values and corresponding behaviors. A limitation of Bardi and Schwartz' (2003) study is their reliance on self-report and the respondent's memory to answer questions regarding their behaviors. This research provides a promising foundation for the current study on the influence of therapists' spirituality and exercise values on the likelihood they will engage in discussion on specific spirituality and exercise topics in their work with clients.

Psychotherapy as Value-Laden. Beutler (1979) argues that psychotherapy is very much a persuasive process, more specifically that it is a process in which the client develops beliefs base on those of the therapist. He begins by building a case for his argument by citing research that shows that a positive outcome in therapy is correlated with the amount of attitude or value change experienced by the client. Beutler (1979) subsequently addresses the question of whether the client is acquiring a better set of values for themselves or if they are in fact acquiring the values of his or her therapist. Although he points out some mitigating factors, he makes a strong case for the belief that clients do in fact acquire the values of their therapist. He then provides evidence that

therapy may fall under many of the same parameters as social persuasion including citations on persuasion theories and compatibility variables. Beutler (1979) concludes that values, attitudes, and beliefs, change in psychotherapy and that "there also seems ample reason to suggest that patients acquire the specific values and attitudes of their therapists rather than simply a more mature or adaptive set of values" (p. 438). For the purposes of our study, Beutler's (1979) review provides some rationale for the possible implications of therapists who have high or low values regarding spirituality or exercise. However, due to the foundations of psychology in a medical model historically, therapists often still use language that reflects objectivity and a scientific approach to treatment rather than attending to their own values and the possible influence of them (Wampold, Ahn, & Hardin, 2001). The reliance on a medical model and perceived objectivity often encourages therapists to be aware of their values and isolate them in attempts to provide a standardized or technical treatment in which therapists values are not considered. Interestingly, Bergin (1991) provides evidence that mental health professionals report their values to influence their approach in working with clients and cautions therapists against attempting to take an objective approach. Bergin (1991) states an objective approach to therapy is not effective because "it often amounts to taking a value position in that silence may be viewed as consent for certain actions, and one subtly communicates one's inclinations as critical points essentially involuntarily…" (p. 397). We hope to analyze how this values position may impact therapists work with their clients.

One of the possible detriments of not considering the potential influence of therapists' values in their work with clients would be on the formation of the therapeutic

relationship. If therapists' and their clients' values do not match or if the therapists' actions create a judgment based on these values, there is a potential that the therapeutic relationship would be undermined (Kelley & Strupp, 1992). We consider this to be a worthwhile area of interest as the therapeutic relationship has been shown to have a significant role in the outcome of therapy (Lambert & Assay, 1999). There is evidence that shows the relationship between the client and the therapists may be the most significant factor therapeutic factor, contributing to up to 30% of the outcomes clients' experience. We suggest that the possible impact of therapists' values on the therapeutic relationship provides us with a strong rationale for our current study.

Bilgrave and Deluty (2002) conducted a study that included 233 psychologists from various APA divisions in effort to understand how religious and political ideologies influenced their theoretical orientations and their practice of psychotherapy. More specifically they hypothesized that Eastern religious beliefs and political liberalism would predict humanistic orientations and that Christian beliefs and conservatism would predict cognitive behavioral therapies. The psychologists in their study reported lower endorsement of spiritual beliefs than the American public. However, 63% of the psychologists reported religious beliefs to be a moderate influence on their practice of therapy. Bilgrave and Deluty (2002) were able to confirm their first hypothesis that Eastern religious beliefs and political liberalism could predict a humanistic orientation toward therapy. Interestingly, they were unable to confirm their second hypothesis that Christian beliefs and conservatism would predict cognitive behavioral therapies. Through further analysis they did find that Christian beliefs were able to predict cognitive behavioral therapies, but not conservative political views. The implications of these

findings give us reason to question the relevance of a scientist-practitioner model when many psychologists apparently utilize a number of cultural resources other than science to inform their work with clients. Additionally Bilgrave and Deluty (2003) conclude that the training of practice of psychologists should be more sensitive to the ideologies and assumptions that psychologists are relying on to guide their work with clients. The evidence supports our suggestion that attention should be given to therapists values and how it may influence their actions in psychotherapy.

Complementary and Alternative Therapies in Psychotherapy

The growing utilization trends and possible potential to provide more culturally inclusive treatment options for their clients suggest it may be worthwhile to include discussions of CAT in psychotherapy. Research by Knaudt, Connor, Weisler, Churchill, and Davison (1999) concluded that over half of their sample of psychiatric outpatient had used alternative therapies, often without telling their health care providers and of the sample approximately 75% reported that they believed the alternative therapies had contributed to symptom relief. As stated previously, there is not a significant amount of literature supporting or validating the use of alternative therapies; however, with such high rates of perceived symptom improvement by clients we cannot deny the potential impact of CAT. Similar findings were also evident in work by Kessler et al., (2001) who found over 56% of their sample with an anxiety disorder and over 53% with a diagnosis of depression utilized alternative therapies in the prior year, again with low levels of discussion with healthcare providers. Of the participants who were engaged in a traditional treatment for their diagnosis, over 65% reported they had used some kind of alternative therapy as a part of their treatment (Kessler et. al, 2001). A more recent study

of psychotherapy clients by Elkins, Marcus, Rajab, and Durgam (2005) showed that 64% of their sample reported using at least one alternative therapy during the year prior to the study. In line with previous research a low level of discussion of these alternatives was found, as only 34% of those utilizing alternative therapies reported discussing them with their therapist. The high utilization rates for alternative therapies by those seeking mental healthcare along with the low levels of discussion with their health care providers clearly indicates a gap in practice where methods believed by clients to lead to improvements are not even discussed.

Spirituality

As the previously cited polls have indicated, an overwhelming majority of the population in the United States believes in a personal God of some kind and report that spirituality has a significant impact on their daily functioning (Gallup Organization, 2005). These recent polls require us to consider the relevance of the discussion of spirituality within our treatment models.

Shafranske & Maloney (1990) conducted a study with a sample of members of the Division 12 of Clinical Psychology exploring the connections between religious orientations and their actions in therapy. They were able to obtain data from 409 participants on spiritual ideology, dimensions of religiousness, attitudes towards religion and psychology, and attitudes regarding specific interventions in counseling. One of the purposes of their study was to understand therapists' attitudes towards religious clients through the use of a case vignette. This sample was found to report a higher level of spirituality than had been reported in previous studies by Ragan and Maloney (1980) but

they appeared to show similar levels of involvement in institutionalized religion. Shafranske & Maloney (1990) found that the psychologists' behaviors and attitudes regarding religion were primarily influenced by the personal view of religion of the individual rather than by their theoretical orientation or training. These results indicate that the navigation of religious issues in therapy was most influenced by personal experience and not the clinical training experiences. It was also reported by participants that 60% of their clients often used religious language during therapy to describe personal experience (Shafranske & Maloney, 1990). The authors conclude that the majority of the psychologists viewed clients as presenting with concerns that could include religious issues and that the lack of professional training experiences regarding religion in psychotherapy direct the field to reflect upon this discrepancy. While Shafranske & Maloney (1990) provides evidence that personal experiences are directing behaviors regarding religion rather than clinical training or theoretical approach; Kelley & Strupp (1992) conducted a study analyzing the relationship between therapist and client values and concluded that "matching of patients with therapist by religious orientation would involve not so much the therapists' personal religious convictions as their ability to understand and deal sensitively with their patients specific values" (p. 39). This conclusion provides a dilemma when considered with the findings of Shafranske & Maloney (1990) which found that therapists' personal convictions were the primary factor in how they approached religious topics rather than the sensitivity therapists have for religious beliefs in their clients.

When comparing psychologists with social workers and licensed counselors, Sheridan, Bullis, Adcock, Berlin, & Miller (1992) found psychologists reported the

lowest levels of spiritual beliefs, engagement in spiritual practice, and affiliation with an organized religion. They also reported all groups were not satisfied with the level of training they had received regarding religious issues in therapy. Further evidence can be seen in Bilgrave & Deluty (2002) as the majority of the sample indicated that their personal religious beliefs had an impact on their practice of therapy. Again we must consider what the implications of the samples' religious beliefs, or lack thereof, may have on the treatment for clients especially when such a high level of spirituality is reported in the general population.

More recently psychologists have shown an increased in importance placed on religion and spirituality in the lives of their clients. Hathaway et al., (2004) conducted a small study including 25 psychologists from what they considered best practice settings. Of this sample 72% endorsed items congruent with the belief that spiritual functioning is an important part of their clients' lives and 56% believed that their work with clients impacted the spirituality or religious functioning of their clients. The authors do note that this small sample appeared to be more religious than the other studies have shown psychologists to be. Hathaway et al., (2004) then completed a nationwide survey through the APA that included 333 participants in which 51% endorsed items indicating a strong belief that spiritual functioning is a significant part of the lives and experiences of their clients. Interestingly 80% of this sample reported that they never or rarely make referrals to religious professionals or seek consultation regarding religious or spiritual concerns in their work with clients. Additionally the authors found that the majority of psychologists do not regularly assess religious functioning when working with clients (Hathaway et al.,

2004). It seems odd that psychologists would not explore a domain that they have endorsed as a significant part of the lives and experiences of their clients.

It may be helpful to understand how therapists in group setting may differ in their view or preferences regarding the discussion of spirituality in the lives and experiences of their clients. In recent research Cornish, Wade, and Post (2012) investigated how group counselors attend and approach religion and spirituality in group counseling by surveying 251 members of the American Group Psychotherapy Association. The results indicated that 97% of the sample felt it appropriate to discuss spirituality after group members brought it up. The authors also found that as spirituality or religious invention became more explicit or active, the appropriateness ratings declined. While this appears understandable for working in a group setting, it is interesting that even though the ratings for appropriateness of discussion were high the results showed that the therapists did engage in even basic interventions or discussions of spirituality or religion in group counseling sessions. The results also indicated a significant positive correlation between the religious commitment and spirituality of the counselors and their responses regarding the appropriateness of specific religious or spiritual interventions. This provides more evidence that in regards to spirituality and religion, it is the therapists' personal views that influence their attention to these topics in the lives and experiences of their clients. Additionally we must consider the potential impact of therapists making decisions not based on client needs.

Client Preferences. While the polls indicate spirituality and religiosity are important to a great majority of the U.S. population of the U.S. (Gallup Organization, 2005), it may be helpful for us to gain a better understanding of client expectations

regarding discussions about spirituality in therapy. Rose et al., (2008) analyzed the preferences of clients regarding discussions of spirituality, and the appropriateness of such discussions in secular therapy. The sample consisted of 74 individuals seeking therapy within a number of different settings. The sample showed lower religious affiliations than the general population with about 40% reporting no religious affiliation. However the majority of the sample still did express current religious affiliations. The results indicated that the majority of clients believed that spirituality was appropriate for discussion in therapy and about 27% reported that discussing spirituality would be an important part of their healing process. Rose et al. (2008) found a number of the participants held this view and one client summed it up by stating "What you believe spiritually or religiously can help with solving problems. If the counselors don't know what you believe, how can they help" (p. 28)? One of the limitations of their study is the possibility for response bias due to the selection procedures of the participants. These findings show that from clients' perspective it may be helpful to consider the discussion of spirituality in counseling.

Additionally Cragun and Friedlander's (2012) mixed-methods study contributed to our understanding of client preferences by exploring Christian clients' experiences in secular therapy. Some of the participants did not expect religious content to be approached in therapy, however all of the participants reported that they wanted their faith to be considered in therapy as it was a significant piece of their identity. Furthermore, the participants reported it would have been helpful to receive encouragement to engage in specific religious behaviors such as praying, going to church, and reading the Bible. The participants also reported that therapists often did not go into

depth when discussing spirituality, which left the participants feeling as though the therapists did not really understand the significance of their beliefs. Cragun and Friedlander concluded that:

> If clients discuss faith, it seems important to follow up with specific questions in order to gain a deep understanding of a client's faith and its role in her or his life. In addition to providing information about the client, this questioning would convey to clients that they are allowed to talk about their faith and that the topic is relevant. (p. 388)

These conclusions give our study reason to consider how not asking follow-up questions regarding spirituality may give clients the perception therapists do not believe that spirituality is an important or appropriate topic for therapy.

Due to the divergent spiritual beliefs between psychologists and the general population, and the evidence that therapists' personal spiritual beliefs direct their discussion of this topic when working with clients, it may be worthwhile for therapists to consider how their own values regarding spirituality, whether strong or weak, could impact the relationship with the client. Neglecting the discussion of spirituality may be equally as judgmental as imposing your personal values regarding spirituality. Through the proposed study we hope to gain a better understanding of the influence of therapists' values regarding spirituality on the likelihood of discussing spirituality when working with clients.

Physical Exercise

It may be worthwhile explore the potential impact of utilizing exercise as a part of treatment. The significant increases in diagnosis of mental disorders and of obesity along with the holistic view of treatment endorsed by many therapists create the stage for exercise to be an integrated part of treatment. Kessler, Chiu, Demler, & Walters (2005) estimate that 26.2% of the population could meet criteria for a recognized mental disorder each year and that roughly 46.4% of Americans will meet criteria for a neuropsychiatric disorder at some point in their lifetime. Mood disorders (Major Depressive Disorder, Dysthymic Disorder, Depressive Disorder Not Otherwise Specified, Bipolar I Disorder, Bipolar II Disorder, and Cyclothymic Disorder) are of particular interest as in any given year 9.5% of the population meets criteria for a mood disorder and over the lifespan 20.8% of the population meets criteria for a mood disorder (Kessler, Chiu, Demler, & Walters, 2005). The prevalence of mental health disorders and mood disorders is significant throughout the population. Paying attention to alternative therapies may be worthwhile considering the high rates of individuals seeking treatment for mental illness and obesity.

While the elevated rates of mood disorders alone are worthy of note, the toll taken by these disorders is equally as important as mood disorders can be debilitating to the individual who is experiencing symptoms and those close to them. The impact of this toll is significant as the National Institute of Mental Health (NIMH) identified Neuropsychiatric Disorders, at 28.5%, as the highest percent of total disability-adjusted life years DALYs observed in the U.S. and Canada (2010). Disability-adjusted life years are a unit used by the World Health Organization (WHO) to measure the burden of a particular disease on the population. According to the WHO website:

> DALYs represent the total number of years lost to illness, disability, or premature death within a given population. They are calculated by adding the number of years of life lost to the number of years lived with disability for a certain disease of disorder (World Health Organization, 2011).

The burden of Neuropsychiatric Disorders is over twice that of Cardiovascular Disease which is the second highest for burden of disorder with a percentage of 13.9% (NIMH, 2011). When the Neuropsychiatric Disorders category is broken down further, Unipolar Depression, which is included within mood disorders, emerges as the most significant contributor making up the highest percent of total DALYs at 10.3% (NIMH, 2011).

While an individual may meet the criteria for diagnosis for a mood disorder, the observable symptoms may appear unlike those seen in an individual with the same diagnosis. Feelings of sadness may be seen contextually as isolation from others and reduced contact with support. Suicidal ideation and thoughts of dying are also commonly reported and can be categorized as active or passive thoughts. Hopelessness is one of the significant risk factors for suicidal ideation and suicide attempts (DSM-IV-TR, 2000). Insomnia is the most prevalent disruption for individuals during a major depressive episode; however, at times hypersomnia may also be identified as a symptom (DSM-IV-TR, 2000). The expansiveness of the effects on the quality-of-life of an individual experiencing a mood disorder and illustrates the significance on physical and mental health. The ultimate impact on quality of life is represented by data indicating approximately 90% of those who complete or attempt suicide meet criteria for a mental illness diagnosis (Moscicki, 2001). The comorbidity of suicide and mental illness is

startling. In CDC data from 2007 published by the NMHI (2011), suicide was reported as the number four cause of death in the U.S.

Background on the Use of Exercise in Treating Depressive Symptoms. The increased diagnosis and attention to mood disorders have instigated a growing body of research for empirically validated treatments over the past years. The most prevalent and utilized treatments at this time are pharmacotherapy and psychotherapy. Pharmacological treatments include: tricyclic antidepressants (TCAs), monoamine oxidase inhibitors (MAOIs), selective serotonin reuptake inhibitors (SSRIs), and serotonin norepinephrine reuptake inhibitors (SNRIs), with the most commonly prescribed being SSRIs which block the reuptake of the neurotransmitter serotonin leaving more available in the synaptic cleft (Brosse et al., 2002). The use of psychotherapy has also been well supported, particularly cognitive behavioral therapies (CBT), which are more research friendly due to their ability to be standardized more so than others. Unfortunately, it is recognized that due to the complexity of the etiology of mood disorders, there is not one treatment is effective everyone. It appears that it would be worthwhile to consider exercise as a supplementary or adjunctive treatment for mood disorders (Blumenthal et al., 2007).

Brown, Ramirez, and Taub (1978) were among the first to recommend that exercise be prescribed by physicians as a valuable way to improve symptoms of depression. At the time of their study, they could not clearly explain why exercise resulted in the reduction of symptoms, but they were able to report significant results between exercise and non-exercise groups, especially for those who jogged consistently three days per week for ten weeks. In the second phase of the study over 600 university

students were included as participants, 100 of which were determined to be clinically depressed. The groups with no exercise prescribed, had similar pre and post test scores throughout over the period of ten weeks. However, the depressed and non-depressed exercise groups showed in their scores on the post-test (Brown, Ramirez & Taub, 1978). Brown et al., (1978) provide evidence for the correlations between movement and mood and make conclusions about the types of exercise used, biological benefits, and the role of a physicians' in the prescription of exercise. The study appears to support the potential benefit of using exercise as a viable treatment modality for depression. One of the potential caveats to the study is the effect that being a part of a treatment group may have had on the participants. There may have been an expectation of improvement, held by patients, for those assigned to exercise groups. Furthermore, while acknowledging that prescribing or encouraging an individual to exercise more may be helpful, Brown et al. (1978) provide little direction for the implementation of prescribing exercise for depression.

Since Brown et al. (1978), a number of mechanisms of action have been proposed as the facilitating factors in the reduction of depressive symptoms through exercise. Physiological mechanisms proposed include the balance of irregularities in central monoamine systems, the correction of imbalances in the hypothalamic-pituitary-adrenal (HPA) axis, which is involved in stress reactions, and the release of endogenous opioids in the form of endorphins as a response to exercise (Brosse et al., 2002). Each of these mechanisms independently shows evidence of physiological changes during exercise resulting in improved mood. Unfortunately, these changes are difficult to study in humans, are not present in all individuals who reported improvements, and in some cases

may only account for short-term improvement in mood. In addition to physiological support for the reduction of symptoms through the use of exercise, there are also theories that attribute the changes to psychosocial mechanisms, including: improvement of self-evaluations, self-esteem, body image, distraction from negative emotion, and behavioral activation (Brosse et al., 2002). Clarifying the mechanisms contributing to the reduction of depressive symptoms reported in the literature is critical in documenting the etiology of these changes. We must ask if knowledge of the etiology necessary for the use of exercise in treating depressive symptoms to become a comparable treatment to those currently being used?

Exercise vs. Pharmacotherapy Treating Major Depressive Disorder. When assessing the possible effectiveness of alternative treatments, the alternative is regularly tested against accepted treatment options. Blumenthal et al. (2007) investigated the use of exercise and pharmacotherapy as treatment options for Major Depressive Disorder (MDD). Their study consisted of 202 patients who met criteria for MDD, one of the largest to date, who were randomly assigned to one of the four groups which consisted of one of the following: supervised exercise in a group setting, home-based exercise, an SSRI antidepressant medication, or a placebo pill, for 16 weeks. Heart-rate was used to monitor the desired level of aerobic training in the exercise treatment groups. Participants in the group exercise treatment condition were supervised for 30 minutes of walking, three times a week, at a pace in which their heart rates were in the 70% to 80% range of the maximum heart rate reserve. Those in the home-based exercise group condition were given the same prescription and trained in their homes on how to use appropriate self-monitoring techniques. When the study concluded, after four months, the results showed

that all groups had lower depression scores on the Hamilton Depression Rating Scale (HAM-D) than when the study began. The data also revealed that the individuals in active treatment groups did not differ significantly from individuals in the placebo group. However, the active treatment groups did all show better outcomes than those of the placebo group, although not in the significant range. The authors acknowledge the high placebo levels as a limitation to their findings and suggest that it could be due to patients' expectations of treatment, continued attention and monitoring by healthcare professionals, and nonspecific factors that were present throughout all groups. While this initially appears to discredit the efficacy of the exercise as a treatment for depressive symptoms, Blumenthal et al. (2007) conclude that patients who were in exercise treatment groups appear to have comparable outcomes to those who received antidepressant medications. The use of SSRIs is widely accepted and often an initial step in the treatment process for individuals diagnosed with MDD. Even though the study did not produce significance in the findings, the comparable outcomes for exercise treatment and standard pharmacological treatment must be acknowledged when considering treatment options.

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exercise treatment groups appear to have comparable outcomes to those who received antidepressant medications. The use of SSRIs is widely accepted and often an initial step in the treatment process for individuals diagnosed with MDD. The comparable outcomes for exercise treatment and standard pharmacological treatment must be acknowledged when considering treatment options.

Mind-Body Connection. Historically the roots of the field of psychology were based on a medical model of treatment separating the physical body and the mind as different entities to be treated. In 1972 Eaker pointed out a fundamental philosophical issue in the field of psychology regarding mind-body dualism and the view of man through a dualistic lens separating the two. When working with clients, therapists' techniques, actions, roles (collaborator, director), and expectations are often based upon a theoretical orientation with which they most closely align. Intuitively it would appear that this may influence therapists consideration of the use of exercise as a part of treatment, however McEntee and Halgin (1996) quantitative study's results indicate there was not a relationship between the theoretical orientation and the likelihood that exercise would be brought up with the client. This finding may not account for the growing number of therapists considered to be integrative rather than purists of one specific theory. What was found was that a percentage of therapists perceived exercise to be an inappropriate action in the therapeutic relationship. Most of the support for this stems from the belief that clients are coming in to work on psychological problems and not physical issues (McEntee & Halgin, 1996). Furthermore, Faulkner and Biddle (2001) found that treatment through exercise is not typically included in psychologists' training. One of the participants clearly stated the need for qualitative research to address the gap between the

evidence of exercise and the mentioning of it in a therapeutic setting (Faulkner & Biddle, 2001). Treatment practices based on a dualistic model, separating the mind and body, were viewed by all participants as a false dichotomy. However, this false dichotomy provides the foundation for a clinical model focusing on disease and illness being separate from other parts of the person. Faulkner and Biddle indicated that some participants view the role of psychologists as dealing with the mind. Holistic approaches of treatment are more widely accepted in effort to dispel this notion of a mind-body dualism, while in clinical practice it appears a focus on treating mental illness through psychological methods is the standard for many psychologists (Faulkner & Biddle, 2001).

The study by Faulkner and Biddle (2001) was conducted to redress the discrepancy between research supporting the use of exercise as a part of treatment for mood and the fact that is rarely used as a form of treatment. They approached this issue through an idiographic methodology and provided training directors of clinical psychology doctoral programs the opportunity to talk about their perceptions of the use of exercise in treatment. The general perceptions of the training directors indicated that about half had positive views of the effects of exercise on mental-health while others believed it was better used as a normalizing strategy to promote activity and socialization. Those interviewed reported that it is rare to see exercise used as an adjunctive treatment for depression, despite the significant research supporting the benefits. Faulkner and Biddle (2001) also found that the nature of an individual's training appears to play a large part in the use of exercise as a treatment option. The interviews showed that many of the training directors were not aware of the literature supporting the use of exercise in treatment which to some meant that there must not be much evidence in the first place. It

may be worthwhile to consider a theme that was explored by Faulkner and Biddle (2001) that was derived from participants' responses concerning the perceived illegitimacy and de-professionalization that may occur if exercise were utilized as a specific treatment in therapy. Two of the training directors interviewed described the use of exercise in treatment as being "almost too simple" and were concerned there was a "fear of being involved with something that isn't psychological enough" (Faulkner & Biddle, 2001, p.441). The participants' also argue that due to the years of training in therapeutic techniques and the value placed on one's own expertise there may be resistance to discussions regarding something as simple as exercise. Furthermore, training directors felt exercise would not be welcomed into psychotherapy "because in a sense it gives people back control over their own problems" and would not require much specialization or training to implement (Faulkner & Biddle, 2001, p. 441) The view of exercise being too simple to be discussed with clients may be related to how psychologists view their role in therapy. To hold such a view is concerning if we consider the possible benefits of exercise for clients seeking treatment for mood improvement (Blumenthal et al., 2007; Brosse et al., 2002). Fortunately, some training directors described the difficulty in helping clients and the need for flexibility to use whatever method works, especially if it is based on firm evidence (Faulkner & Biddle, 2001).

Faulkner and Biddle (2001) was the only qualitative study found regarding the inclusion of exercise into therapy. While it provides useful information regarding the experiences of clinical directors, the use of clinical directors rather than those engaged in full-time practice leaves the literature with gaps regarding the experiences of those in full-time practice. Furthermore, the majority of those providing direct care to clients are

bachelors or masters level practitioners. With more evidence and clearly defined training regimens mental health practitioners may show an increased level of confidence in their ability to provide adequate exercise treatment plans. When it begins to become more widely implemented research regarding the adherence to exercise prescriptions will become vital. Making available trainings regarding each of these issues would also be a benefit to the mental-health field. The use of exercise in the treatment of depressive symptoms could potentially benefit millions of individuals world-wide. Exercise has the potential to supplement current treatments and provide an alternative for those who have not responded well to current treatment approaches should not be neglected. We should be asking why therapists are not integrating exercise into treatment.

Royak-Schaler and Feldman (1984) sampled Division 29 (psychotherapy) psychologists and found that those engage in health-promoting behaviors were more likely to recommend them to their clients. Of this sample about half of the psychologists reported that the discussion of physical health to be a topic that should be included in therapy. These results indicated many psychologists did not see physical health and exercise to be important things to consider in therapy. In another study, Barrow, English, and Pinkerton (1987) found similar results finding about 53% of their sample occasionally recommending exercise to their clients. In their sample of therapists 97% reported exercising at least two times per week which they report as being much higher than the general population leading to cautionary interpretation due to possible response bias (Barrow et al., 1987). Even with a sample of exercising psychologists there were still a large number of those who did not address exercise with their clients. To build upon previous research Burks and Keeley (1989) analyzed the types of exercise and diet

recommendations that therapists made and what the likelihood of these recommendations was based on. They found that of the life-style variables measured; exercise and diet recommendations were made less frequently that those regarding drug use, alcohol consumption, sleeping habits, and family medical history. This result shows that while there is some consideration of more traditional physical health and lifestyle factors, exercise and diet are still not often priority when therapists are working with clients. Burks and Keeley (1989) also found that 56% of their participants reported exercising at least 20 minutes three times per week. More recently, Burton, Pakenham, and Brown's (2010) research also provides evidence that psychologists are willing to promote exercise as component of treatment.

The use of exercise as an effective method for improving mood has been well documented through comparison trials, self-reports, and physiological mechanisms over the past forty years (Blumenthal et al., 2007; Brosse et al., 2002; Brown, Ramirez, & Taub, 1978). However, even with a relatively significant amount of literature supporting the positive effects of exercise, it is currently under-utilized in mental health care settings and non-existent in training programs (Callaghan, 2004; Faulkner & Biddle, 2010). For these reasons, it may be worthwhile to consider therapists' values regarding exercise, whether strong or weak, could impact the discussions of exercise as a part of treatment with clients. Neglecting the discussion of exercise may be equally as judgmental as imposing your personal values regarding spirituality. Through the proposed study we hope to gain a better understanding of the influence of therapists' values regarding exercise on the likelihood of discussing exercise when working with their clients.

Conclusion

Spirituality and exercise may be relevant topics in the lives and experiences of our clients. If therapists hope to provide the best possible treatment to their clients, then we suggest that the potential implications of therapists own values on spirituality or exercise influencing their discussion of these topics with their clients must be considered. Therapists may attempt to provide value-free or non-judgmental feedback in their work with clients, but if therapists are avoiding the discussion of these topics, they are minimizing what could be significant domains in their client's lives, thereby passing judgment on the importance of these topics in therapy. Furthermore, if therapists place too high a value on these areas of human experience, there may be a risk that they proselytize, again passing judgment. A better understanding of the influence of therapists' values regarding exercise and spirituality on the likelihood of discussing these topics when working with their clients may provide information on the importance of considering these values in training and in therapists work with clients.

Appendix B

Demographic Questionnaire

Please indicate the most appropriate response.

Gender:
[ ] Male
[ ] Female
Not Listed (open ended response)

Age:
[ ] 21 and Under
[ ] 22 to 34
[ ] 35 to 44
[ ] 45 to 54
[ ] 55 to 64
[ ] 65 and Over

Location: (State drop-down)

Years Working as a Psychologist: (Years drop-down 1-60)

Highest Degree Completed:
[ ] Doctoral degree
[ ] Master degree
[ ] Bachelor degree

Primary Work Setting:
[ ] University Counseling Center
[ ] Faculty
[ ] Inpatient Hospital or Residential Treatment Setting
[ ] Outpatient Mental Health or Community Setting
[ ] Private Practice
[ ] Student

Please Indicate the APA division or divisions that you are a member of.

Division 17 - Counseling Psychology
Division 29 - Psychotherapy
Division 38 - Health Psychology
Division 42 - Psychologists in Independent Practice
Division 47 - Sport and Exercise Psychology
Other

Please indicate your racial identity.

Asian

Black or African American

- Hispanic or Latino
- Native American
- Native Hawaiian or Pacific Islander
- Non-Hispanic White
- Biracial
- Multiracial

Appendix C

Specific Value Rating Measure

For the purpose of this study **spirituality** is described as beliefs, practices, and experiences revolving around the interaction between myself and a higher power or the universe in general.

Therapists' value of spirituality

My spirituality directs my goals.
1----------2----------3----------4----------5----------6----------7----------8----------9----------10----------11
NEVER ALL OF THE TIME

My spirituality influences my behaviors and actions.
1----------2----------3----------4----------5----------6----------7----------8----------9----------10----------11
NEVER ALL OF THE TIME

My spirituality influences my attitudes and beliefs
1----------2----------3----------4----------5----------6----------7----------8----------9----------10----------11
NEVER ALL OF THE TIME

My spirituality is a guiding principle in my life.
1----------2----------3----------4----------5----------6----------7----------8----------9----------10----------11
NEVER ALL OF THE TIME

Therapists' value of exercise

Physical exercise directs my goals.
1----------2----------3----------4----------5----------6----------7----------8----------9----------10----------11
NEVER ALL OF THE TIME

Physical exercise influences my behaviors and actions
1----------2----------3----------4----------5----------6----------7----------8----------9----------10----------11
NEVER ALL OF THE TIME

Physical exercise influences my attitudes and beliefs
1----------2----------3----------4----------5----------6----------7----------8----------9----------10----------11
NEVER ALL OF THE TIME

Physical exercise is a guiding principle in my life.
1----------2----------3----------4----------5----------6----------7----------8----------9----------10----------11
NEVER ALL OF THE TIME

Appendix D

Psychologists' Treatment Practices Items

Therapists' willingness to discuss spirituality

A client wants to discuss spirituality; I will engage in discussions related to his or her spirituality.
1----------2----------3----------4----------5----------6----------7----------8----------9----------10----------11
NEVER ALL OF THE TIME

A client wants to include his or her spirituality as a part of treatment; I will discuss the use of spirituality as a coping mechanism.
1----------2----------3----------4----------5----------6----------7----------8----------9----------10----------11
NEVER ALL OF THE TIME

A client wants to include his or her spirituality as a part of treatment; I will discuss the client's relationship with his or her God.
1----------2----------3----------4----------5----------6----------7----------8----------9----------10----------11
NEVER ALL OF THE TIME

A client wants to include spirituality as a part of treatment; I will inquire about specific spiritual practices that he or she thinks would be helpful.
1----------2----------3----------4----------5----------6----------7----------8----------9----------10----------11
NEVER ALL OF THE TIME

A client does not speak about his or her spirituality during session; I will bring it up during the course of therapy.
1----------2----------3----------4----------5----------6----------7----------8----------9----------10----------11
NEVER ALL OF THE TIME

Therapists' willingness to discuss exercise

A client wants to discuss exercise; I will engage in discussions related to exercise.
1----------2----------3----------4----------5----------6----------7----------8----------9----------10----------11
NEVER ALL OF THE TIME

A client wants to include exercise as a part of treatment; I will tailor a physical activity program to the client's individual needs.
1----------2----------3----------4----------5----------6----------7----------8----------9----------10----------11
NEVER ALL OF THE TIME

A client wants to include exercise as a part of treatment; I will monitor ongoing physical activity levels.
1----------2----------3----------4----------5----------6----------7----------8----------9----------10----------11
NEVER ALL OF THE TIME

A client wants to include exercise as a part of treatment; I will problem solve barriers to physical activity with the client.
1----------2----------3----------4----------5----------6----------7----------8----------9----------10----------11
NEVER ALL OF THE TIME

A client does not speak about exercise during session; I will bring it up during the course of therapy.
1----------2----------3----------4----------5----------6----------7----------8----------9----------10----------11
NEVER ALL OF THE TIME

Appendix E

Informed Consent

Greetings! My name is Andrew Dunkle and I am recruiting psychologists who have provided individual or group therapy for one or more years to participate in this study. This study is designed to explore the influence of values on psychologists' decisions related to work with their clients. It is hoped that findings from this research will contribute to the field of psychology, especially in the areas of values, spirituality, and exercise.

Participation is completely voluntary and will require 10-15 minutes of your time. Participants may be entered into a drawing for a chance to win one of four $25.00 Amazon gift cards offered by the primary investigator. Once the survey has been completed, you will be directed to a new page and be given the option of providing your e-mail address for entry into the gift card drawing. The gift cards will be sent to the winners through the email that has been provided.

Completing the survey and submitting your responses indicates both your consent to participate and that you have provided counseling/psychotherapy for at least one year. If you choose to participate, you will be asked to provide basic demographic information and to complete questionnaires related to your view of values and behaviors related to work with clients. Individual responses will remain unidentifiable. Though you are strongly encouraged to complete all questionnaires and demographic questions, you may choose to withdraw your participation at any time by exiting the survey. All collected data was stored in a confidential, secure location for the duration of the study up to 3 years.

All inquiries regarding this research can be addressed to the primary researcher, Andrew Dunkle, M.A., of Oklahoma State University, at adunkle@okstate.edu and/or advisor, Al Carlozzi, Ed.D. of Oklahoma State University, at al.carlozzi@okstate.edu. If you have questions about your rights as a research volunteer, you may contact Dr. Shelia Kennison, IRB Chair, 219 Cordell North, Stillwater, OK 74078, 405-744-3377 or irb@okstate.edu.

https://okstatecoe.qualtrics.com/SE/?SID=SV_cvzAtXbIaIUJ3Vj

Tables

Table 1
Sample Demographics

Characteristic	*M*	*SD*	Range
Years Worked as Psychologist	12.83	11.04	1-42
	N		Percentage
Gender			
Male	27		26%
Female	44		74%
Age			
22 to 34 years	29		28%
35 to 44 years	31		30%
45 to 54 years	21		20%
55 to 64 years	18		17%
65 years and older	5		5%
Primary Work Setting			
University counseling center	5		5%
Adjunct or full-time faculty	8		8%
Inpatient hospital or residential treatment setting	4		4%
Outpatient mental health or community setting	8		8%
Private practice	36		35%
Medical setting	42		41%
APA Division Membership			
Division 17 - Counseling Psychology	7		7%
Division 29 - Psychotherapy	11		11%
Division 38 - Health Psychology	47		47%
Division 42 - Psychologists in Independent Practice	32		32%
Division 47 - Sport and Exercise Psychology	14		14%
Other	21		21%
Race/Ethnicity			
Asian	4		4%
Black or African American	2		2%
Hispanic or Latino	3		3%
Native American	0		0%
Native Hawaiian or Pacific Islander	0		0%
Non-Hispanic White	87		87%
Biracial	3		3%
Multiracial	1		1%

Table 2

Descriptive Statistics for Independent and Dependent Variables

Variable	N	Range	*M*	*SD*
Independent Variable				
Spirituality Values Composite			6.34	2.68
Spirituality directs my goals	104	1-11	5.78	2.82
Spirituality influences my behaviors	104	1-11	6.36	2.72
Spirituality influences my attitudes	104	1-11	6.88	2.72
Spirituality is a guiding principle in my life	104	1-11	6.33	2.95
Exercise Values Composite			5.84	2.29
Exercise directs my goals	103	1-10	5.66	2.34
Exercise influences my behaviors	103	1-11	6.24	2.39
Exercise influences my attitudes	104	1-11	6.01	2.42
Exercise is a guiding principle in my life	104	1-11	5.41	2.69
Dependent Variables Spirituality				
General Discussions	104	4-11	9.98	1.55
Discussion of Spirituality as Coping Mechanism	104	1-11	9.47	2.30
Discussion of Relationship with God	104	1-11	9.22	2.46
Inquire about Specific Spiritual Practices	102	3-11	9.64	1.82
Bring up Spirituality if Client Does Not	104	1-11	5.02	2.40
Dependent Variables Exercise				
General Discussions	103	4-11	10.20	1.26
Tailor Physical Activity Program	102	1-11	7.81	3.05
Monitor Ongoing Activity	103	1-11	8.12	2.93
Problem-Solve Barriers to Activity	103	3-11	9.99	1.66
Bring up Exercise if Client Does Not	103	1-11	7.19	2.50

Table 3
Regression Coefficients

Model	B	SE B	Beta	Sig.	t
(Constant)	10.21	.392		.000	26.043
Spirituality Values Composite	-.036	.057	-.062	.533	-.625

a. Dependent Variable: General Discussions of Spirituality

Table 4
Regression Coefficients

Model	B	SE B	Beta	Sig.	t
(Constant)	8.81	.580		.000	15.21
Spirituality Values Composite	.104	.084	.121	.221	1.23

a. Dependent Variable: Discussions of Spirituality as Coping Mechanism

Table 5
Regression Coefficients

Model	B	SE B	Beta	Sig.	t
(Constant)	9.285	.625		.000	14.85
Spirituality Values Composite	-.010	.091	-.011	.912	-.111

a. Dependent Variable: Discussion of Relationship with God

Table 6
Regression Coefficients

Model	B	SE B	Beta	Sig.	t
(Constant)	9.081	.468		.000	19.42
Spirituality Values Composite	.087	.068	.128	.201	1.29

a. Dependent Variable: Inquiry about Specific Spiritual Practices

Table 7
Regression Coefficients

Model	B	SE B	Beta	Sig.	t
(Constant)	4.528	.608		.000	7.45
Spirituality Values Composite	.078	.088	.087	.382	.88

a. Dependent Variable: Bring up Spirituality of Client Does Not

Table 8
Regression Coefficients

Model	B	SE B	Beta	Sig.	t
(Constant)	9.727	.339		.000	28.72
Exercise Values Composite	.082	.054	.149	.134	1.51

a. Dependent Variable: General Discussion of Exercise

Table 9
Regression Coefficients

Model	B	SE B	Beta	Sig.	t
(Constant)	5.99	.810		.000	7.395
Exercise Values Composite	.313	.130	.234	.018	2.41

a. Dependent Variable: Tailor Physical Activity Program

Table 10
Regression Coefficients

Model	B	SE B	Beta	Sig.	t
(Constant)	7.39	.796		.000	9.28
Exercise Values Composite	.125	.127	.097	.327	.984

a. Dependent Variable: Monitor Ongoing Activity

Table 11
Regression Coefficients

Model	B	SE B	Beta	Sig.	t
(Constant)	9.63	.451		.000	21.34
Exercise Values Composite	.062	.072	.085	.391	.862

a. Dependent Variable: Problem-Solve Barriers to physical activities

Table 12
Regression Coefficients

Model	B	SE B	Beta	Sig.	t
(Constant)	4.97	.640		.000	7.77
Exercise Values Composite	.381	.102	.348	.000	3.73

a. Dependent Variable: Bring up Exercise if Client Does Not

Oklahoma State University Institutional Review Board

Date:	Thursday, March 28, 2013
IRB Application No	ED1346
Proposal Title:	The Influence of Psychologists' Values on the Discussion of Spirtuality and Exercise in Therapy
Reviewed and Processed as:	Exempt

Status Recommended by Reviewer(s): Approved Protocol Expires: 3/27/2014

Principal Investigator(s):

Andrew Dunkle
434 Willard
Stillwater, OK 74078

Al Carlozzi
MH 2415, 700 N. Greenwood
Tulsa, OK 74106

The IRB application referenced above has been approved. It is the judgment of the reviewers that the rights and welfare of individuals who may be asked to participate in this study will be respected, and that the research will be conducted in a manner consistent with the IRB requirements as outlined in section 45 CFR 46.

☒ The final versions of any printed recruitment, consent and assent documents bearing the IRB approval stamp are attached to this letter. These are the versions that must be used during the study.

As Principal Investigator, it is your responsibility to do the following:

1. Conduct this study exactly as it has been approved. Any modifications to the research protocol must be submitted with the appropriate signatures for IRB approval. Protocol modifications requiring approval may include changes to the title, PI, advisor, funding status or sponsor, subject population composition or size, recruitment, inclusion/exclusion criteria, research site, research procedures and consent/assent process or forms.
2. Submit a request for continuation if the study extends beyond the approval period of one calendar year. This continuation must receive IRB review and approval before the research can continue.
3. Report any adverse events to the IRB Chair promptly. Adverse events are those which are unanticipated and impact the subjects during the course of this research; and
4. Notify the IRB office in writing when your research project is complete.

Please note that approved protocols are subject to monitoring by the IRB and that the IRB office has the authority to inspect research records associated with this protocol at any time. If you have questions about the IRB procedures or need any assistance from the Board, please contact Dawnett Watkins 219 Cordell North (phone: 405-744-5700, dawnett.watkins@okstate.edu).

Sincerely,

Shelia Kennison

Shelia Kennison, Chair
Institutional Review Board

Oklahoma State University Institutional Review Board

Date:	Thursday, April 18, 2013	**Protocol Expires: 3/27/2014**
IRB Application No:	ED1346	
Proposal Title:	The Influence of Psychologists' Values on the Discussion of Spirtuality and Exercise in Therapy	
Reviewed and Processed as:	Exempt **Modification**	

Status Recommended by Reviewer(s) **Approved**

Principal Investigator(s):

Andrew Dunkle
434 Willard
Stillwater, OK 74078

Al Carlozzi
MH 2415, 700 N. Greenwood
Tulsa, OK 74106

The requested modification to this IRB protocol has been approved. Please note that the original expiration date of the protocol has not changed. The IRB office MUST be notified in writing when a project is complete. All approved projects are subject to monitoring by the IRB.

☐ The final versions of any printed recruitment, consent and assent documents bearing the IRB approval stamp are attached to this letter. These are the versions that must be used during the study.

The reviewer(s) had these comments:

Minor revision to include snowball sampling recruitment methods.

Signature :

Shelia Kennison, Chair, Institutional Review Board

Thursday, April 18, 2013
Date

VITA

Andrew Nathan Dunkle

Candidate for the Degree of

Doctor of Philosophy

Thesis: THE INFLUENCE OF PSYCHOLOGISTS' VALUES ON THE DISCUSSION OF SPIRITUALITY AND EXERCISE IN THERAPY

Major Field: Counseling Psychology

Biographical:

Education:

Completed the requirements for the Doctor of Philosophy in Counseling Psychology at Oklahoma State University, Stillwater, Oklahoma in July, 2014.

Completed the requirements for the Master of Arts in Clinical Psychology at Sam Houston State University, Huntsville, Texas in 2009.

Completed the requirements for the Bachelor of Science in Psychology at Texas A&M University, College Station, Texas in 2007.

Experience:

Will complete APA Accredited Pre-Doctoral Internship July 2014.
Wilford Hall Ambulatory Surgical Center, Lackland AFB, Texas
Training Director: Ann S. Hryshko-Mullen, Ph.D.

Professional Memberships:

American Psychological Association