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Understanding Group Therapists' Use of Spiritual and Religious Interventions in Group Therapy, **by Marilyn A. Cornish, M.S., Nathaniel G. Wade, Ph.D., and Melissa A. Knight, B.S.**

Estimated Time to Complete this Activity: 90 minutes

Learning Objectives:
The reader will be able to:
1. Identify therapist personality and training characteristics associated with the use of religious and spiritual interventions in group therapy.
2. Identify therapist training characteristics associated with perceived barriers to attending to spirituality in group therapy.
3. Differentiate the impact of therapist spirituality versus therapist religious commitment on perceived barriers to attending to spirituality in group therapy.
4. Evaluate the practical implications of the associations between therapist characteristics and attention to religion/spirituality in group therapy.

Author Disclosures:
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Understanding Group Therapists' Use of Spiritual and Religious Interventions in Group Therapy

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ABSTRACT

The current study examined therapist characteristics that are related to the use of spiritual and religious interventions in group therapy and to perceived barriers to attending to spirituality in group therapy among a sample of experienced group therapists. Results demonstrated that greater therapist spirituality was associated with more frequent use of both spiritual and religious interventions, as well as lower perceived barriers to attending to spirituality in group therapy. Religious commitment was only uniquely related to perceived barriers, such that therapists with higher religious commitment actually perceived greater barriers. Training in religion and spirituality and comfort with spiritual discussions was also related to therapists' use of religious and spiritual interventions and perceived barriers.

To date, very little research or clinical writing has been conducted to understand the ways that religion and spirituality might be effectively integrated into the practice of group therapy, outside

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of research on groups that are explicitly religiously or spiritually themed (e.g., Cole, 2005; Richards, Berrett, Hardman, & Eggett, 2006; see Cornish & Wade, 2010, for a review). Because of the limited guidance on integrating religion and spirituality into general therapy groups, the sometimes contentious nature of religion, and social norms that mostly prohibit discussions of religion, it is possible that many group leaders may avoid this topic altogether in their groups. Yet, by avoiding the topics of religion or spirituality in group, therapists may also miss rich opportunities to help clients (Cornish & Wade, 2010) and may inadvertently contribute to early termination of clients who feel an important part of their identity is being ignored (Wade, Post, Cornish, Vogel, & Runyon-Weaver, under review). Given the recent finding that a sizable minority of group therapy clients would like to discuss religious (24%) or spiritual (47%) concerns in their group therapy work (Post, Wade, & Cornish, under review), a logical next step for this research area is the investigation of variables that are related to group therapists' beliefs and practices about intervening with religious and spiritual material in group therapy.

The terms *religion* and *spirituality* can create misunderstanding due to the various ways they are used. For this paper, we define *spirituality* as the search for the sacred, whereas *religion* is the search for the sacred that occurs within a like-minded community that has shared beliefs, rituals, and practices promoting and directing that search (Hill et al., 2000).

RELIGIOUS AND SPIRITUAL INTERVENTIONS

Most of the research on including religion and spirituality in therapy has been conducted on individual therapy through the examination of use of religious and/or spiritual interventions. A common intervention is to ask clients about their religion or spirituality during assessment, yet even this is not done routinely by most psychologists (Hathaway, Scott, & Garver, 2004). Additional interventions include using religious relaxation or imagery, incorporating prayer in session, and introducing religious concepts or sacred texts (Frazier & Hansen, 2009; Jones, Watson, & Wolfram, 1992; Walker, Gorsuch, & Tan, 2004). In general, use of re-

ligious and spiritual interventions declines as they become more explicitly tied to specific traditions or practices. Researchers have also examined therapist characteristics that help explain use of such interventions in individual therapy. Religious affiliation, religious commitment, and participation in organized religion positively correlate with use of religious interventions (Kellems, Hill, Crook-Lyon, & Freitas, 2010; Shafranske & Malony, 1990), and religious/spiritual self-identification positively predicts use of religious/spiritual psychotherapy behaviors (Frazier & Hansen, 2009).

In group therapy without a specific religious or spiritual focus, many of the explicit interventions listed above would likely be considered problematic due to the heterogeneous nature of clients' beliefs and preferences. Interventions tied to a particular faith could create significant problems in a group composed of clients from diverse backgrounds and beliefs. Yet, there may be ways religion or spirituality could be included in group therapy that are more congruent with multicultural therapy practices (Abernethy, 1998; 2002). For example, therapists might introduce the topics of religion and spirituality when discussing issues often relevant to these themes, such as identity formation or grief. This type of integration may better respect the diversity of clients' beliefs and preferences while also demonstrating to group members that religion and spirituality can be addressed if relevant to them.

BARRIERS TO ATTENDING TO RELIGION AND SPIRITUALITY IN GROUP THERAPY

Multicultural therapy guidelines (American Psychological Association, 1993) can provide a rationale for attending to religious and spiritual variables in therapy, but group therapists may be hesitant to do so for several reasons. Most clinicians receive little training regarding religion and spirituality (Brawer, Handal, Fabricatore, Roberts, & Wajda-Johnson, 2002). Therapists may also be conflicted about whether religion is appropriate to address, especially in non-religious settings (Richards & Potts, 1995) or when supervisors or senior colleagues do not address religion

and spirituality. The structure of group therapy may also result in barriers, including apprehension about conflict around religion and spirituality, worries that such discussions might derail the group's work, or concerns that some members may feel left out if religion or spirituality were introduced (Cornish & Wade, 2010). These group dynamics are possible outcomes that therapists need to consider, but using them as blanket reasons for complete avoidance of the topics may also not be helpful.

Training in multicultural issues is related to fewer perceived barriers and greater perceived competence in addressing diversity issues in therapy (D'Andrea, Daniels, & Heck, 1991). One way training may work to reduce barriers is through exploring, identifying, and working through sources of discomfort related to diversity discussions. Because religion and spirituality can be viewed as private topics that are not part of "polite" conversation, therapists may experience discomfort when religion or spirituality is raised in group therapy. By increasing therapists' comfort with spiritual discussions, perceived barriers may be reduced.

In addition, therapists' personal experiences are likely related to perceived barriers. For example, clinical psychologists' religiosity is positively related to perceived competence in knowledge and skills for addressing religion in therapy (Shafranske & Malony, 1990), and therapists' personal spirituality and spiritual experiences and training are related to self-perceived competence to counsel clients with spiritual concerns (van Asselt & Senstock, 2009).

The Current Study

The current study was designed to identify group therapist characteristics related to use of religious and spiritual interventions in group therapy, as well as perceived barriers to attending to spirituality in group therapy. We build upon previous research with this sample (Cornish, Wade, & Post, 2012) by using hierarchical regression analysis to examine several therapist characteristics while controlling for the mutual influence of each of those variables. This study also expands our previous analyses by examining characteristics associated with spiritual interventions separately from those associated with religious interventions, given

that the therapists in our previous study viewed religion differently from spirituality (Cornish et al., 2012).

We first examined predictors[1] of therapists' frequency of use of both spiritual and religious interventions in group therapy. Based on the literature reviewed above, we hypothesized that a greater degree of spirituality and religious commitment would each predict more frequent use of both spiritual and religious interventions. We also hypothesized that more training in religion and spirituality (R/S) and greater comfort with spiritual discussions would predict more frequent use of both religious and spiritual interventions even after controlling for therapists' spirituality and religious commitment. We next examined predictors of therapists' perceived barriers to attending to spirituality in group therapy. We hypothesized that a greater degree of spirituality and religious commitment would predict fewer barriers. We also expected that those with more training in R/S and more comfort with spiritual discussions would perceive fewer barriers even after controlling for spirituality and religious commitment.

METHOD

Participants

Participants were 242 clinical, associate clinical, or adjunct members of the American Group Psychotherapy Association (AGPA). A slight majority of participants were women (55.4%) and most were European American (88.7%). The average participant was 58 years old (*SD* = 11.3; range = 31–86) with 25 years of mental health experience (*SD* = 11.2; range = 2–50). The most frequent R/S worldviews were Judaism (21.7%), Protestant Christianity (17.9%), Buddhism (12.3%), Catholicism (12.3%), and agnosticism (9.4%). Participants were trained primarily in social work (31.2%) or clinical (28.7%) or counseling (15.2%) psychology.

1. We use terms like "predictors" and "predict" because it is common language for regression analyses (i.e., the independent variables are termed predictor variables). It is important to note, however, that because all variables were collected simultaneously, the results demonstrate statistical prediction rather than temporal prediction.

Most participants worked in private practice (69.8%) and conducted process-oriented groups (84.3%).

Procedures

This was an online questionnaire study approved by the researchers' institutional review board and implemented through AGPA. E-mail invitations to complete the questionnaire online were sent to members of the above AGPA categories. Definitions of group therapy, spirituality, and religion were provided (Cornish et al., 2012), and participants were asked to consider only their experiences in groups without a specific R/S theme when answering the questions.

Measures

Frequency of Spiritual and Religious Intervention Use. Participants rated on a 1 (*never*) to 6 (*almost always*) scale how frequently they used various spiritual and religious interventions in group therapy (Cornish et al., 2012). Two separate measures were created from ten of these items: frequency of spiritual interventions and frequency of religious interventions. Each measure had five items: (1) Bringing up the topic of spirituality [religion]; (2) Facilitating a discussion of spirituality [religion] after a group member brings it up; (3) Asking group members about their spiritual [religious] beliefs; (4) Self-disclosing one's own spiritual [religious] beliefs; and (5) Using spiritual [religious] language or concepts. Cronbach's alphas were .85 for spiritual interventions and .80 for religious interventions.

Barriers to Addressing Spirituality. Participants responded to 11 statements on potential barriers to or hesitations about addressing spirituality in group therapy (Cornish et al., 2012). Sample items included, "I worry that conflict among group members might arise if spiritual issues were discussed in group therapy" and "I have enough training to effectively address spirituality in group therapy" [reverse scored]. Participants used a 1 (*completely untrue*) to 6 (*completely true*) scale. Higher scores indicate greater perceived barriers. Cronbach's alpha was .85.

Comfort with Spiritual Discussions. Participants rated how they generally feel during a group therapy session if/when a client

brings up issues related to spirituality (Cornish et al., 2012). Each item had polar descriptors (e.g., tense/relaxed, hesitant/sure) anchored at 1 and 7 on a numerical scale. Higher scores indicate greater comfort. Cronbach's alpha was .84.

Therapist Spirituality. The Spiritual Transcendence Index (STI; Seidlitz et al., 2002) was used to assess participants' degree of spirituality. Questions include "My spirituality helps me to understand my life's purpose" and "I try to strengthen my relationship with God." Cronbach's alpha for the total scale was .97 among a community sample (Seidlitz et al., 2002) and .95 for the current sample.

Therapist Religious Commitment. The Religious Commitment Inventory—10 (RCI; Worthington et al., 2003) was used to assess participants' degree of religious commitment. Questions include, "My religious beliefs lie behind my whole approach to life" and "I enjoy working in activities of my religious organization." The RCI has an average Cronbach's alpha of .95 (Worthington et al., 2003) and was also .95 in the current sample.

Demographic Information. Participants provided demographic information and information regarding their clinical training and experiences. A question on amount of training in religion/spirituality (R/S) included 12 training activities and experiences related to R/S in therapy (e.g., reading books, attending a conference or seminar, receiving supervision). The training activities selected by participants were summed to create the "R/S Training" variable. Participants were also asked whether they had ever conducted a group with a focus on R/S issues. For correlation and regression analyses, this "R/S Group" variable was dummy coded (0 = have not conducted an R/S issues group; 1 = have conducted an R/S issues group).

RESULTS

Descriptive statistics and correlations for the measures are presented in Table 1. The average number of training experiences in religion and spirituality was 3.2, with 9.9% reporting no training in this area. Most participants had never conducted an R/S issues group (79%), 16.3% had conducted one in the past, and 4.2% were conducting one at the time of the questionnaire.

Table 1. Means, Standard Deviations, and Correlations Among Study Measures and Selected Demographic Variables

	Variable	*M*	*SD*	1	2	3	4	5	6	7	8	9
1	Spiritual Intervention Use	14.0	4.8	—								
2	Religious Intervention Use	11.9	4.1	.80**	—							
3	Barriers	27.4	8.8	-.38**	-.30**	—						
4	Comfort	33.9	6.1	.26**	.22**	-.49**	—					
5	STI	32.6	11.3	.53**	.42**	-.35**	.21**	—				
6	RCI	22.1	11.4	.32**	.36**	-.05	.11	.61**	—			
7	R/S Training	3.2	2.4	.40**	.40**	-.27**	.16*	.35**	.31**	—		
8	Age	57.8	11.3	-.07	-.06	.02	.08	-.09	.00	-.11	—	
9	Sex			.01	-.12	.08	-.12	.14*	.02	.001	-.06	—
10	R/S Group			.34**	.35**	-.19**	.15*	.27**	.25**	.33**	.04	.04

Note: $N = 235$ to 242. *$p < .05$. **$p < .001$. STI = Spiritual Transcendence Index. RCI = Religious Commitment Inventory. Sex: 0 = male, 1 = female. R/S Group: 0 = have never led an R/S issues group, 1 = have led an R/S issues group.

Predictors of Spiritual Intervention Use

We conducted a hierarchical linear regression analysis to examine the hypothesized predictors of frequency of spiritual intervention use. We first entered as a control variable the R/S Group dichotomous variable indicating whether or not participants had conducted an R/S issues group. This model was significant, $R^2 = .118$, $F(1, 228) = 30.53$, $p < .001$ (see Table 2 for results at each step). Adding the personality variables in Step 2 resulted in significantly more variance accounted for, $\Delta R^2 = .211$, $F(2, 226) = 35.57$, $p < .001$. Finally, adding the training and comfort variables in Step 3 also resulted in a significant increase in variance accounted for, $\Delta R^2 = .050$, $F(2, 224) = 8.96$, $p < .001$. In the final model, having led an R/S issues group, greater spirituality, more training in R/S, and greater comfort with spiritual discussions were all associated with more frequent use of spiritual interventions. Religious commitment was not a significant predictor.

We found that the final regression model had significantly skewed residuals, with a slight bias toward over-predicting use. We therefore ran the same model using a square root transformation of the frequency of spiritual intervention use variable, which resulted in normally distributed residuals. The conclusions using this transformed outcome variable did not differ from the original analyses.

Predictors of Religious Intervention Use

We next examined the same predictors for religious intervention use. The model at Step 1 was significant, $R^2 = .117$, $F(1, 228) = 30.22$, $p < .001$ (see Table 2 for results at each step). Adding the personality variables in Step 2 provided a significant increase in variance explained, $\Delta R^2 = .129$, $F(2, 226) = 19.31$, $p < .001$. Finally, including the training and comfort variables in Step 3 also resulted in a significant increase in variance explained, $\Delta R^2 = .052$, $F(2, 224) = 8.30$, $p < .001$. In the final model, having led an R/S issues group, greater spirituality, and more training in religion and spirituality were all associated with more frequent use of religious interventions. Religious commitment and comfort were only marginally significant positive predictors in the final model.

Table 2. Results of Hierarchical Linear Regressions Predicting Frequency of Use of Spiritual and Religious Interventions

	Spiritual Interventions						Religious Interventions					
Predictor	R^2	ΔR^2	*B*	*SE*	β	*t*	R^2	ΔR^2	*B*	*SE*	β	*t*
Step 1	.118**	.118**					.117**	.117**				
R/S Group			4.15	.75	.34	5.53**			3.51	.64	.34	5.50**
Step 2	.329**	.211**					.246**	.129**				
R/S Group			2.68	.69	.22	3.91**			2.44	.62	.24	3.94**
STI			.213	.03	.49	7.06**			.10	.03	.27	3.63**
RCI			-.01	.03	-.03	-0.36			.05	.03	.15	1.99*
Step 3	.379**	.050**					.298**	.052**				
R/S Group			1.95	.69	.16	2.84*			1.79	.62	.17	2.88*
STI			.18	.03	.42	6.07**			.07	.03	.20	2.67*
RCI			-.02	.03	-.04	-0.61			.05	.03	.13	1.78
R/S Training			.41	.12	.20	3.34**			.37	.37	.21	3.40**
Comfort			.10	.04	.12	2.27*			.08	.04	.11	1.92

Note: $N = 230$. *$p < .05$. **$p < .001$. STI = Spiritual Transcendence Index. RCI = Religious Commitment Inventory. R/S Group: 0 = have never led an R/S issues group, 1 = have led an R/S issues group.

We found that the final regression model had significantly skewed residuals, with a slight bias toward over-predicting use. We therefore ran the same model using a square root transformation of the frequency of religious intervention use variable, which resulted in normally distributed residuals. This model using the transformed outcome variable resulted in both religious commitment and comfort becoming significant positive predictors, compared to the marginally significant results in the untransformed model. No other conclusions differed.

Predictors of Barriers to Attending to Spirituality

To examine the hypothesized predictors of therapists' perceived barriers to attending to spirituality in group therapy, we conducted a hierarchical linear regression analysis with the barriers measure as the criterion variable. For consistency across analyses, we again used the R/S Group variable as a control variable. This model was significant, $R^2 = .039$, $F(1, 234) = 9.50$, $p = .002$ (see Table 3 for results at each step). Adding the personality variables at Step 2 provided a significant increase in variance explained, $\Delta R^2 = .160$, $F(2, 232) = 23.12$, $p < .001$. Adding the training and comfort variables in Step 3 also resulted in a significant increase in variance explained, $\Delta R^2 = .171$, $F(2, 230) = 31.17$, $p < .001$. The residuals in the final model were normally distributed. Having led an R/S issues group was not a significant predictor of perceived barriers in the final model. As hypothesized, higher spirituality, comfort, and R/S training were associated with lower perceived barriers to attending to spirituality in group therapy.

Contrary to expectations, however, greater religious commitment actually predicted greater perceived barriers. Because of this unexpected finding, we conducted a post-hoc regression analysis that included the previous predictors and an RCI × STI interaction term in order to determine whether religious commitment interacted with spirituality to predict barriers. This interaction effect was not significant.

Table 3. Results of Hierarchical Linear Regression Predicting Barriers to Attending to Spirituality

Predictor	R^2	ΔR^2	*B*	*SE*	β	*t*
Step 1	.039*	.039*				
R/S Group			-4.32	1.40	-.20	-3.08*
Step 2	.199**	.160**				
R/S Group			-3.02	1.34	-.14	-2.25*
STI			-.40	.06	-.51	-6.80**
RCI			.23	.06	.30	4.07**
Step 3	.370**	.171**				
R/S Group			-1.25	1.24	-.06	-1.01
STI			-.31	.05	-.39	-5.66**
RCI			.22	.05	.29	4.34**
R/S Training			-.49	.22	-.13	-2.26*
Comfort			-.58	.08	-.40	-7.37**

Note: N = 236. *p < .05. **p < .001. STI = Spiritual Transcendence Index. RCI = Religious Commitment Inventory. R/S Group: 0 = have never led an R/S issues group, 1 = have led an R/S issues group.

DISCUSSION

The Impact of Therapist Spirituality and Religious Commitment

The current study provided evidence that selected therapist characteristics do influence perceptions and practices regarding spirituality and religion in group therapy. Therapists with higher self-reported spirituality use both spiritual and religious interventions more frequently. Religious commitment had less of an impact, as it was only marginally predictive of frequency of religious intervention use (but was significant in the transformed model) and did not influence spiritual intervention use. These results suggest that therapists may use the personal importance they place on spirituality—and possibly religion—as a guide, whether implicit or explicit, to determine the extent to which they attend to religion and spirituality in group therapy. Among therapists who largely ignore or avoid the topic of religion and spirituality, highly spiritual or religious clients may find that an important part of their lives is being neglected in treatment, and clients may

miss out on opportunities to explore how religion and spirituality have impacted their lives.

On the other hand, if some highly spiritual or religious therapists use religious or spiritual interventions frequently, clients may feel uncomfortable with the level of attention paid to these topics, especially those who are not religious or spiritual or who have beliefs that do not match the interventions integrated into the therapy process. Following Sue's (2001) model of cultural competence, it is important for therapists to increase their awareness of how their own beliefs and preferences influence the attention paid to religion and spirituality in group therapy (and other types of therapy, for that matter). Supervision, consultation, or personal therapy may be helpful for therapists who find their own beliefs or experiences negatively impact their therapy work as it relates to religion and spirituality.

Therapist spirituality and religious commitment were also related to perceived barriers to attending to spirituality in group therapy. As expected, greater spirituality was associated with fewer perceived barriers. The finding that greater religious commitment predicted greater perceived barriers, however, was unexpected. The zero-order correlation between religious commitment and barriers was not significant and close to zero (-.05), providing evidence that a therapist's religious commitment per se does not predict greater perceived barriers to attending to spirituality in group therapy. It is instead commitment to organized religion after controlling for one's level of spirituality that was associated with greater perceived barriers. It is important to acknowledge that few people consider themselves to be religious but not spiritual (Zinnbauer, 1997). Still, it is possible to be committed to one's religious organization without having a strong sense of spirituality connected to that commitment. This might be especially so for individuals whose religion provides more of a sense of cultural identity rather than a religious one. For example, Judaism is a religion with strong ties to cultural identity, and there is a wide range of religious observance among those with a very strong sense of Jewish identity (Schlosser, 2006). Given that our sample was one-fifth Jewish, this may have contributed to the unexpected result.

Another possibility is that some clients who are highly religious may have a negative reaction to the concept of spirituality. This may be particularly true in more conservative Christian traditions, in which spirituality has at times been conflated with new age movements. This, combined with the often negative reactions to New Age philosophies (Saliba, 1999), might influence some highly religious Christian therapists to reject the notion of "spirituality" despite their own beliefs and practices that fit with how we defined spirituality in this study.

The Impact of Training and Comfort

Therapists who have conducted R/S issues groups utilized both spiritual and religious interventions in their group work more frequently, but they did not perceive fewer barriers to attending to spirituality in group therapy. Despite our request that participants rate the frequency of spiritual and religious interventions in groups *without* a specifically religious/spiritual focus, it is possible that some participants reflected on their work in their R/S issues groups when answering the intervention questions. This is one reason we chose to include it as a control variable. However, it is also possible that some of this predictive relationship is because therapists who have conducted such groups find religion and spirituality to be important to attend to and have found it helpful to use spiritual and religious interventions in their other groups.

We also found that both training in religion and spirituality and comfort with spiritual discussions predicted more frequent use of spiritual interventions, more frequent use of religious interventions (with comfort only marginally significant in the untransformed model), and fewer perceived barriers to attending to spirituality in group therapy. Of course, therapists may seek out training in this area to the extent that they themselves are religious or spiritual. However, training was a unique predictor even after accounting for therapists' religious commitment and spirituality. This has implications for group therapy training, in that providing training specifically on religion and spirituality might reduce barriers to attending to this topic of diversity. Graduate programs could include religion in their multicultural therapy

courses, as well as their group therapy courses. Therapists who have finished their training might benefit from continuing education seminars or workshops related to religion and spirituality in therapy. Such training opportunities could better ensure multiculturally competent therapists in this area.

It is likely that training on religion and spirituality increases comfort with the topic, but comfort was also a unique predictor even after accounting for amount of training. Comfort with these discussions might come from experiences other than formal training. For example, comfort can be elicited by social norms, models, or exemplars. Therapists might feel more comfortable with religion and spirituality in group therapy if they see others who are confidently and competently attending to religion and spirituality in their groups or if they are actively encouraged to be aware of religious and spiritual themes by supervisors or peers.

Although we believe reducing therapists' perceived barriers to addressing spirituality in group therapy as conceptualized by the barriers measure (Cornish et al., 2012) would be beneficial, it is less clear whether training should be utilized to increase the use of religious and spiritual interventions in group therapy. The interventions included in this study are less explicitly tied to any particular religious or spiritual traditions than many of the interventions examined in individual therapy. Still, this study did not explore the impact these interventions have on individual group members or the group as a whole. For example, some clients may appreciate a therapist who brings up the topic of spirituality or religion, whereas other clients may perceive that therapist to have a religiously motivated agenda. Client factors may impact this perception, but the manner in which therapists bring up the topic may also impact perceptions. Similarly, self-disclosure of religious or spiritual beliefs by a therapist may inadvertently align the therapist with some clients while alienating others holding differing beliefs (Chen, Kakkad, & Balzano, 2008). Therefore, additional empirical and clinical work should be conducted on the potential beneficial and deleterious effects of utilizing religious and spiritual interventions in group therapy. Training can then be tailored to ensure ethical and competent use (or avoidance) of these potentially sensitive interventions.

Limitations and Future Research

Because of the lack of scales on religion and spirituality in group therapy, several of the measures were developed for this study. They were created utilizing previous research and literature, internal consistency was acceptable, and an expert panel found the measures to have good content validity (Cornish et al., 2012). Still, these measures have not been subjected to rigorous reliability and validity testing. Therefore, the conclusions utilizing these measures should be considered tentative until the measures can be further validated.

The low level of average religious commitment in this sample is another limitation. Although psychologists overall have lower levels of religious commitment compared to the general population (Delaney, Miller, & Bisonó, 2007), having a sample that is skewed toward lower religious commitment may have limited the predictive ability of that measure. Future researchers may want to engage in sampling that allows for a wider range of religious commitment. In addition, the regression analysis predicting perceived barriers suggested there may be something about religious commitment not tied to a high sense of spirituality that is related to greater perceived barriers to attending to spirituality. This population of therapists should therefore be further examined using qualitative and/or quantitative methods to explore how they respond to clients who are spiritual but not religious or those who wish to discuss spirituality as a part of their group therapy work. In doing so, a sample with a wider range of religious commitment will be helpful to rule out possible spurious results due to the restricted range found in this sample.

Similarly, the regression models for use of spiritual and religious interventions had skewed predictive ability. Follow-up analyses with transformed outcome variables demonstrated the same (for spiritual interventions) or similar (for religious interventions) results as were found with the untransformed variables. We reported the untransformed version of the results because it is likely that use of religious and spiritual interventions is skewed among group therapists. Still, this statistical issue must be taken into consideration when interpreting the results.

Another limitation of this study is that all data was collected concurrently. Causal relationships can therefore not be established despite the exploration of statistical prediction used in the regression analyses. Longitudinal research would need to be conducted to further test the temporal validity of these predictive relationships. Similarly, we only examined self-reported use of religious and spiritual interventions. Future research could examine factors that predict actual use of such interventions in group therapy sessions.

Finally, as mentioned above, additional research is needed to examine the impact of therapists' use of religious and spiritual interventions. The impact is likely complex due to the various beliefs and preferences of group members. Training for group therapists should address this complexity if and when the potential use of religious and spiritual interventions is explored.

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