The Use, Application and Integration of Religion/Spirituality in Clinical Social Service: The Case of Clinical Social Service Providers in Addis Ababa

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May 2015

Addis Ababa

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A Thesis Submitted to the School of Social Work, in Partial Fulfillment of the Requirements for the Degree of Master of Arts in Social Work

May 2015

Addis Ababa

ADDIS ABABA UNIVERSITY

SCHOOL OF GRADUATE STUDIES

MSW EXAMINING COMMITTEE

This is to certify that the thesis prepared by Serkalem Tafesse Masresha entitled: The Use, Application and Integration of Religion/Spirituality in Clinical Social Service: The Case of Clinical Social Service Providers in Addis Ababa; submitted in partial fulfillment of the requirements for the Degree of Master of Arts (School of Social Work) complies with regulation of the University and meets the accepted standards with respect to the originality and quality.

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Acknowledgement

My earnest gratitude goes to my advisor Dr Abebe Assefa Abate for his mentorship, patience and for providing insight and expertise that greatly assisted the study. He has helped me a great deal in honing my skills in quantitative research. I would also like to heartily thank the Ethiopian Society of Sociologists, Social Workers and Anthropologists (ESSSWA) for their kind cooperation to contact potential participants via email requesting them to participate in the study's web survey. Most of all, this study would not have been possible without respondents who were kind enough to take some time off from their demanding schedules to fill out the survey and share some ideas with me that served as valuable guidance.

I am very thankful to my family whose warm love and care has made everything worthwhile. My grandparents, Feleke Kabtimer & Ehetaferahu Kabtimer, my aunt and uncle, Woudnesh Kinfu & Yeshitela Kinfu -- words can't suffice to express my gratitude for your unwavering support and belief in me throughout my academic journey. The trophy sister, my better half, Selamawit Tafesse (Enqukaye), thank you for the emotional support and understanding nobody can ever show and for the deepest connection we will always share. A big Thank You goes to Frehiwot Sefiew, for listening to my tedious rants and frustrations, for always willing to see the best in me and encouraging me to see this through. Saba Getachew -- you have considered my headaches your own, getting my surveys filled, being there for me throughout the whole process and generally being a great friend, in more ways than one. Thanks for the constant questions of "you are not done yet?" that has helped me get through it all, hope our far-fetched and daring dreams come true.

Above all, I thank God for His countless blessings and the perseverance He has given me. Thank you!

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Acronyms

ANOVA	Analysis of Variance
AIDS	Acquired Immune Deficiency Syndrome
ESSWA	Ethiopian Society of Sociologists, Social Workers and Anthropologists
HIV	Human immunodeficiency virus
M	Mean
NGO	Non-governmental organization
RRSP	Role of Religion and Spirituality in Practice
SD	Standard Deviation

Abstract

This study aimed to explore the contribution religion/spirituality makes in the process of helping patients in clinical social service. Utilizing a mix of online and paper survey research, this random sample study of clinical service providers explored participants' attitude/perception as a measure of their consent or disagreement towards including these two concepts in practice and their practical use of religious/spiritually integrated interventions. The responses obtained from 67 practitioners to RRSP Likert-type scale Index of 14 interventions mostly showed indifference on the utilization of religious/spiritually integrated interventions. However, practitioners that were involved in religious establishments agreed more to the integration of religion/spirituality in practice, utilizing it in 75% of their cases as opposed to those working in secular institutions. Data collected through surveys generated results from practitioners of governmental and non-governmental institutions that are mainly engaged in three clinical fields; mental health, HIV/AIDS and child care. Results indicate that professionals in the field of child care agreed to use these concepts more than those in the field of mental health and HIV/AIDS. Practitioners' professional attitude toward the role of religion and spirituality in clinical social service was found to be the most important predictor of intervention in this sample. The study includes a review of existing literature related to religious/spirituality in health care.

Future researches should explore the actual need for religious/spiritual integrated practice in Addis Ababa and the effective use of evidence-based spiritually integrated interventions as alternative ways of coping with health problems, especially in palliative care.

Key words:

Religious/Spiritually integrated interventions, mental health, HIV/AIDS, child care, clinical social work

1 INTRODUCTION

1.1 Background to the Research

The social work profession, as depicted in different scholarly writings, originated as a result of religion and spirituality. Midgley (1977) comments that "Social work grew out of a religious philanthropic tradition of charity" (Higham, 2006, p. 20) By the same token, Zastrow (2009) in his book *Social Work and Social Welfare* reiterates that the earliest social welfare agencies opened their doors to service users in the 1800s with the "initiation of the clergy and other religious groups" (p. 111). The author further elaborates that it is not until after the early 1900s that service provision saw the involvement of workers other than members of the clergy. Correspondingly, Jeffrey Clark (2000) states that Ethiopia witnessed its first organized form of social work practice through international NGOs in collaboration with local church-affiliated agencies during its disastrous famine crises of 1973–74 and 1984–85.

Although attributed for the origin of social work, religion and spirituality were not widely integrated into social work practice for an extensive period of time. Loewenberg (1988) and Marty (1980) mention that the introduction of concepts such as "secularization and professionalization" in social work practice following the nineteenth century, led to religion and spirituality being considered as unnecessary and irrelevant (Canda, 2012, p. 45) The inclusion of religion and spirituality as an intervention method gained recognition once again in recent times. The 1980s has been highlighted by Canda & Furman (2010) as a time when different publications emerged calling for the return of the social work profession to its "historic commitment to spirituality" (p. 112) with the trend persisting until the mid-1990s. The Society for Spirituality and Social work was established in 1990 to draw together "scholars and practitioners of diverse spiritual perspectives for the enhancement of the profession" (Canda &

Furman, 2010, p. 113) The two concepts were further introduced into the profession as a means of embracing the holistic approach in practice in view of the fact that it is the ideal way of addressing clients from different cultural and social backgrounds. Payne (2005) implies that the resurgence of the two concepts came into the spotlight once more in Western societies, because of the "need to respond to ethnic and cultural minorities" (Nolan & Holloway, 2013, p. 153).

In practice, religion and spirituality have demonstrated great purpose in the field of clinical social work that involves health, palliative care and mental health among other aspects. Consequently, social work practitioners began integrating religion and spirituality in cases that were inadequately handled by biological interventions. "The importance of religion and spirituality among patients with advanced disease as a central component of physical and psychological wellbeing is increasingly recognized by professionals (Cooper, 2006, p. 182).

A professor and Dean of Social Work at Wilfrid Laurier University, Francis J. Turner (2005) states in his book *Social Work Diagnosis in Contemporary Practice,* that religion and spirituality can be utilized to empower clients and enhance the path to recovery. In order for this to be realized and become more mainstream, the perception and attitude of social workers towards the inclusion of these two concepts in practice plays a fundamental role. Canda (1988) claims that "the religious viewpoints of social workers may be reflected in their approaches to professional practice" (Crisp, 2012, p. 27) However, insufficient knowledge exists on the perception and attitude of social work practitioners towards the inclusion of religion and spirituality in clinical service provision and the impact it has on their practice in the specific context of Addis Ababa. The implication proposed by Canda, can be identified through assessing the perception and attitude of clinical social work practitioners in Addis Ababa versus their

actual professional practice towards the inclusion of these two concepts in their interventions with clients cases.

1.2 Statement of the Problem

Clinical social service provision should aim to address and support individuals' path to recovery through methods suitable to them. As clients seeking help from health practitioners come with different dimensions of coping mechanisms to deal with their illness, practitioners should optimize their knowledge, perception as well as practice to attain the desired result in helping clients. Drawing attention to the different perceptions individuals may possess in framing their problems and the solution to overcome them, Dorfman (2013), describes his expression in the following manner:

> There is a tremendous variety in what individuals perceive to be problems or symptoms, their view of causality and the best way to fix it (or accept it) and their relationship with a healer. In many cases, these perceptions are rooted in cultural values, beliefs and traditions. (p. 63)

Religion and spirituality take center stage among the numerous coping mechanisms that clients opt for especially in terminal illnesses and those with no biological cure. Ergo, clinical interventions should be centered on a biopsychosocial approach to address these different dimensions. However, in the context of Ethiopia, there is inadequate literature that establishes the perception of clinical service providers on religion and spirituality and to what extent they incorporate it in practice. Understanding these concepts will help practitioners identify ways of utilizing religion and spirituality especially in illnesses where the accomplishments of biomedicine fail to be reliable.

1.3 Significance of the Study

The study is significant because it demonstrates the extent of clinical service providers' use of religion and spirituality in caring for their clients. It navigates and discovers clinical social

service practitioners' perception towards integrating religion and spirituality and how it affects their practice. This in turn will reveal if these service providers are providing a culturally competent practice. It is inevitable that they need to be able to respond appropriately to the needs of all service users, including those for whom religious and spiritual beliefs are very vital. A culturally competent practice, accordingly, depends among other things on an understanding and acknowledgment of the impact of faith and belief. The author of "Culture, theory and narrative: The Intersection of meanings in practice", Saleebey, describes a culturally competent practice as "an intersection where the meaning of the worker (theories), the client (stories and narratives), and culture (myths, rituals and themes) meet" (Greene, 2009, p.38). Therefore, this study is significant as it identifies the current prospects in Addis Ababa on the inclusion of religion and spirituality and recognizes to what extent service provisions respect clients' diversity and different views thereby, upholding the true essence of social work in helping people. Another reason is the relevance of religion and spirituality in palliative care. Greene (2009) argues that including religion and spirituality as part of clients' assessment helps to identify the appropriate intervention method and hasten their path to recovery. In light of this fact, this study is significant as it explores how religion/spirituality is being exploited among clinical service providers in Addis Ababa as a form of dealing with illnesses in palliative care and other diseases with no tangible biological cure. Furthermore, the study is significant as it focuses on the concept of religion and spirituality which hold a distinguished place in Ethiopia. The Ethiopian population is highly intertwined with religious beliefs, in view of the fact that a substantial number of individuals identify themselves with one religion or another. As depicted in table 1, the latest population census conducted by the Central Statistical Agency of Ethiopia in 2007 indicates that, out of the entire Ethiopian population,43.5% are Orthodox Christians, 33.9% are

Muslim, 18.6% are Protestant Christians, 0.7% are Catholic, 2.6% are followers of traditional religions, while 0.7% fall under the 'other' religion category.

Table 1.Addis Ababa Population by Religion and Sex, 2007 Census

Sex	Orthodox	Protestant	Catholic	Islam	Traditional	Other	Total
Female	1,087,268	115,477	6,726	212,623	593	11,477	1,434,164
Male	958,177	97,430	6,476	231,402	784	11,118	1,305,387
Both Sexes	2,045,445	212,907	13,202	444,025	1,377	22,595	2,739,551

Source: Adapted from the Central Statistical Agency, Census report (2007)

Be that as it may, research conducted on this issue in the specific context of Addis Ababa, are minimal. Consequently, this study is inherently substantial in exploring the role of these two concepts in clinical service provision in Addis Ababa.

1.4 Objective of the Study

Through a quantitative study design, this study seeks to understand how clinical social service providers in Addis Ababa, Ethiopia, perceive the concept of religion and spirituality as an intervention method and the extent to which they embrace it to address the religious and spiritual dimensions of their clients. It also seeks to provide a modest contribution to the literature on spirituality and religion in clinical social work in Addis Ababa.

The study's overall objectives are to explore the following main points:

- The impact of clinical service practitioners' personal factors (gender, age, education, years of experience, religious affiliation, and training on religion/spirituality) on their practice and attitude towards including religion and spirituality in their intervention methods with clients.
- The impact of type of organization (governmental/non-governmental) and work setting (religious/secular) on practitioners' practice and attitude towards including religion and spirituality in their intervention methods with clients.

Integration of Religion/Spirituality in Clinical Social Service

- The attitude and practice difference among professionals across various clinical service types in the inclusion of religion and spirituality.
- The relationship between practitioners' attitude and practice in the inclusion of religion and spirituality in helping clients.

1.5 Research Questions and Hypothesis

The following central research questions and their corresponding hypotheses guided this study:

1. Is attitude towards the inclusion of religion and spirituality in clinical social work practice in Addis Ababa associated with personal factors such as gender, age, education, years of experience, religious affiliation, and training on religion/spirituality?

   Hypothesis 1: Attitude towards the inclusion of religion and spirituality in clinical social work practice in Addis Ababa is associated with personal factors such as gender, age, education, years of experience, religious affiliation, and training on religion/spirituality.

2. Does attitude towards the inclusion of religion and spirituality in clinical social work practice differ by type of organization (governmental/non-governmental) and work setting (religious/secular)?

   Hypothesis 2: Attitude towards the inclusion of religion and spirituality in clinical social work practice differs by type of organization (governmental/non-governmental) and the work setting (religious/secular) the practitioner is engaged in.

3. Does attitude towards the inclusion of religion and spirituality differ by clinical service type?

   Hypothesis 3: Attitude towards the inclusion of religion and spirituality differs by clinical service type.

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4. Is the inclusion of religion and spirituality in the practice of clinical social work in Addis Ababa associated with personal factors such as gender, age, education, year of experience, religious affiliation and training on religion/spirituality?

   Hypothesis 4: The inclusion of religion and spirituality in the practice of clinical social work in Addis Ababa is associated with personal factors such as gender, age, education, years of experience, religious affiliation and training on religion/spirituality.

5. Does the inclusion of religion and spirituality in social work practice differ by type of organization (governmental/non-governmental) and work setting (religious/secular)?

   Hypothesis 5: The inclusion of religion and spirituality in social work practice differs by type of organization (governmental/non-governmental) and work setting (religious/secular).

6. Does the inclusion of religion and spirituality in social work practice differ by clinical service type?

   Hypothesis 6: The inclusion of religion and spirituality in social work practice differs by clinical service type.

7. Is there a relationship between attitude and practice in the inclusion of religion and spirituality?

   Hypothesis 7: The more positive practitioners' attitude is towards religion and spirituality, the more they incorporate them in practice.

2 REVIEW Of RELEVANT RESEARCH AND THEORY

The purpose of this chapter is to present the concepts that are fundamental to clinical social work practice in the health care setting where the biopsychosocial/spiritual approach remains the basis for which all intervention strategy rests.

2.1 The Concept of Religion and Spirituality

Various scholarly writings shade light on the concept of religion and spirituality reiterating that these two ideals represent guidance to one's worldly life. Sheridan (2000) defines spirituality as "the search for meaning, purpose and connection with self, others, the universe, and ultimate reality however one understands it. This search may or may not be expressed through religious forms or institutions" (Sheridan, 2000, p.20). According to Sheridan, religion is identified as a controlled, prearranged set of beliefs and rituals shared by a group of people associated with spirituality. In a similar token, Hay (1998) defines spirituality, as "awareness that there is something greater than the course of everyday events" in our lives, events such as birth, death, sadness, love, joy and special occasions are related to this definition" (Tirri, 2006, p. 8). A religious studies scholar, Smart (1998), identified religion as "a human activity related to rituals, including prayer, worship and meditation" (Nelson, 2009, p. 6). Religion demonstrates a structured way of believing and worshiping a divine power. As Dhillon (2011) puts it "religion is order, religion is law. Religion represents the individual's internal law to which obedience must be given if that individual's life is to live in accordance with a Divine law." (p. 26). The definitions featured above demonstrate that religion and spirituality are both centered on creating meaning of life to individuals and that there is a greater power than all that must be respected.

Religion and spirituality, although two sides of the same coin, exhibit quite a considerable difference in the way they are reflected among believers and followers of the two

concepts. Stifoss–Hansenn (1999) stated that religion and spirituality share some similar characteristics, but they possess "their own areas of interest" (Tirri, 2006, p.9) The definitions that exist in various literatures portray religion as a collection of rituals to express one's belief in a divine power while spirituality is more connected to seeking a meaning to life in forms that may or may not involve rituals. To highlight the demarcation between the two, Thoresen (1998) operationalized religion as "an organized system of beliefs, practices, rituals and symbols" while spirituality was defined as one's transcendent relationship to some form of higher power (Ambrose, 2006, p. 207). This leads us to believe that religion is a concept centered on traditions and shared experiences among believers of a certain religion while spirituality is inclined towards an individual's experience of seeking meaning to life. As opposed to religion, spirituality may or may not involve the worshiping of a supreme figure. Winarsky's 1991 definition cited in Frame (2003) emphasizes this argument:

> It may be an inner generated, thoughtful, sometime skeptical search – a process rather than a product – for universal connections, with no quid pro quo from a higher power sought or intended. People who consider themselves to be spiritual may or may not participate in organized religion. Some may find solace in readings, discussion groups and the like. (p.3)

Generically summarized, religions may be seen as "organizational dealing with rituals and ideologies while spirituality may be seen as affective, experiential and thoughtful and may involve meaning, unity, connectedness and transcendence" (Ambrose, 2006, p. 206) Despite these differences, religion and spirituality exhibit a very strong relationship. Sheridan (1986) cited in Ambrose (2006) describes the strong association between religion and culture as nearly indistinguishable.

In terms of purpose to human beings in general, both religion and spirituality seem to serve corresponding functions. Gollnick (2005) states that "religion is a transitional space which helps people meet challenges of the external world" (p.18). He further highlights the role religion

plays in individuals' life as a concept that alleviates anxiety, isolation and sense of remorse. In a similar indication, Jernigan (2001) explains the functions of spirituality as the "organization (centering) of individual and collective life around dynamic patterns of meanings, values and relationships that are trusted to make life worthwhile (or at least, livable) and death meaningful" (Nelson, 2009, p. 9).The human life passes through rigorous transitions that involve good and bad situations for which individuals constantly search support for, where religion and spirituality plays a vital role. Johansen (2009) supports this argument:

> For some, religion can be a source of comfort and healing. Many individuals find religion and spirituality in times of crisis and adversity. And people sometimes use them to resolve trauma or other life challenges. Generally speaking religion and spirituality can be life enriching in countless ways. (p. 46)

Plante and Boccaccini (1997) cited inEubanks (2006) established that the stronger the religious faith an individual possesses, the better his/her perception of life and optimism would be while simultaneously reducing anxiety and depression.

2.2 The Holistic Approach

A holistic foundation means that healthcare providers will assess and respond to each client's physical, emotional, mental and spiritual dimensions (Koopsen& Young, 2009). Outlining the concept of the holistic approach, Lishman (2007) comments that:

> The holistic approach builds on the social model of disability that seeks blocks to independence arising from social attitudes, disabling systems and environments. The approach also stresses the need for attention to people's ethnicity, culture and history because together they form their identity and influence life options (p.103).

This indicates that the concept of illness, in this approach, finds its expression in the evaluation of the entire personality, the individual's reaction to the illness and the ability of bodily functions to work well again implying that health in a holistic sense signifies wellbeing physically as well as psychologically. Holloway & Moss (2010) in their book *Spirituality and Social work* wrote that in social work, the holistic approach generally entails a "whole person

approach" to assessments, which implies to the practice of covering all areas of a person's life. Brand Reith and Statham (2005a) claim that the goal of a holistic assessment is to enhance an individual's welfare in terms of health, academic performance or living environment. An all rounded focus with regard to the personal, social and economic conditions of the client is the main feature of social work (Lishman, 2007, p. 103)

Social work as a profession that seeks to help people, demonstrates its uniqueness in the fact that it encompasses different approaches to assist clients in their path to wellness. Hutchison (1999) asserts that the unique focus of social work as "a profession is its person-in-environment perspective, which provides a holistic, ecological assessment and intervention framework for practice." Lloyd (2000) argues that social work can maintain its original purpose of helping people only when it is able to address different dimensions of an individual's life. From the arguments mentioned above, we can deduce that, the main goal of social work is enhancing the overall wellbeing of individuals and in order to manifest this objective, the profession must exhaust every option available to ensure the welfare of its clients, thereby helping it retain its true distinct value of existence and integrity as a profession that works for the good of humanity. In favor of this idea, Holloway et al. (2010) remark that:

> A holistic approach to individuals and families which continuously shapes itself in response to prevailing social and policy dynamics is the only way for social work to hold onto its core professional and ethical identity in the managerial and market-driven climate of contemporary health and social care (p. 103)

Equally important to helping maintain social work's uniqueness as a profession, the holistic approach serves the purpose of helping social work practitioners to comprehend clients' problems from different perspectives prior to implementing predetermined intervention methods. In assessments, Dorfman (2013) discusses that the intricacy of a client's problems is more evident to practitioners through a holistic assessment. Consequently, Greene & Lee (2011) argue

that a holistic framework enables social workers to devise an approach and treatment technique best suitable for a client's case subsequent to conducting an assessment. As Burkhardt& Nagai-Jacobson (2005) described it, a social worker will be better informed about the nature and meaning of suffering for a particular person if he/she has an insight of the client's personality, culture, religious traditions and family background which are in the inclusion spheres of the holistic approach (Koopsen & Young, 2009) Dziegielewski (2003) places an increased emphasis on the argument of using the holistic approach in treating clients as she states "health care social workers are encouraged to approach this type of service delivery seriously. It can provide a viable and necessary way for health care social workers to provide clinical service" (p. 104) Accordingly, one can infer that rather than focusing on a client's internal matters alone, a social worker should put into consideration the different facets and relationships in an individual's life along with their interaction, as they may have a great impact on his/her wellbeing.

Sometimes termed as a bio-psycho-social-spiritual model in social work, the holistic approach transcends the boundaries of biological intervention methods to address clients' spiritual and psychological dimension. As an illustration of how the holistic framework directs both the assessment and intervention processes to surpass biological interventions in substance abuse, Forte (2006) articulates that although addiction to substances has powerful biological bases, "holistic theories consider also psychological dimensions, social systems, and other factors" (p. 265).

Among the different dimensions of an individual's life, lies the aspect of his/her religion and spirituality. DeLaune & Ladnes (2006) assert that "spiritual care is a part of holistic care" (Cyndie Koopsen and Caroline Young, 2009).An individual's perception on what could be the right way to tackle a problem he faces in his life varies tremendously. While one person may

consider spirituality and religion as an ideal way, others opt for a different choice. Drawing attention to the different perceptions individuals may possess in framing their problems and the solution to overcome them, Dorfman (2013), describes his expression in the following manner:

> There is a tremendous variety in what individuals perceive to be problems or symptoms, their view of causality and the best way to fix it (or accept it) and their relationship with a healer. In many cases, these perceptions are rooted in cultural values, beliefs and traditions. (p. 63)

In light of this, social workers should be receptive to using spirituality and religion as one form of intervention in their clients' cases. Micozzi (2006) notes that "the blending of spirituality with the tenets of alternative, complementary and integrative therapies provides individuals with a means of understanding how they contribute to the creation of their illness and to their healing" (Koopsen et al., p.32).

Therefore, it's a foregone conclusion that the holistic approach in assessment and intervention is an effective method of practice in social work as it holistically conceptualizes the person (bio-psycho-social-spiritual) in environment.

2.3 Bio-Psycho-Social/Spiritual Model

Social work service programs that exist to extend support to clients should exhibit resilience in embracing cultural competence and be entirely client and patient centered. This includes addressing the psychological, social and spiritual dimensions of a client's problem. The Biopsychosocial model is one means of addressing this need, as it is a scientific model constructed to take into account the missing dimensions of a biomedical model. Engel (1977) first proposed that "the biopsychosocial model assumes that biological, psychological and social influences comprise a complex system of interactions which determine an individual's health, vulnerability to disease and reactions to disease" (Bennett, Weinman & Spurgeon, 1990, p. 129) The model fundamentally argues that an individual's health is affected by numerous factors that

basically center on psychological, biological and social aspects in interaction. "The biopsychosocial/spiritual model acknowledges that all persons have many aspects and that these aspects all interact" (Winiarski, 1997, p. 6).

Clinical social workers need to develop an understanding of what their clients' problem is from different outlooks prior to proceeding with treatments. Frankel, Quill & McDaniel (2003), state that the clinical social worker gathers all information deemed relevant with regard to the client's background and environment to better comprehend the nature of the client's problem and relieve them from it.

The relevance of the biopsychosocial model is more evident in palliative care which is usually in practice to deal with diseases such as diabetes, Parkinson's disease, multiple sclerosis, HIV/AIDS, cancer and in severe mental illnesses among others. "In recent years, the model has been of special interest in the treatment of psychosomatic conditions such as chronic pain, where it has proved effective" (Fagan, 2004, p. 7) In the case of HIV/AIDS for instance, the importance of this model surpasses all others as current medical interventions have failed to provide a cure for the disease. Bennett et al. (1990), emphasize that the model is mainly imperative because the health and sense of well-being of people living with HIV is not exclusively confined to the accomplishments of biomedicine. As Pierson (2008) describes it, people living with diseases that involve chronic pain such as cancer and HIV/AIDS experience problems that are far from being limited to physical problems and the biopsychosocial model proves to be very helpful in these cases as it "includes a conceptualization and suggests treatment strategies that address the multidimensional nature of the problems experienced by the patient (p. 38). The author further asserts that Biopsychosocial treatments for chronic pain attempt to lessen stress that may arise during the process of being ill simultaneously enhancing patients functioning. The benefits of a

bio-psycho-social assessment, particularly in the case of people living with HIV/AIDS, are reflected beyond the idea of taking care of their personal wellbeing to reducing risk of infection among other people. "For persons with HIV and AIDS, a thorough and a biopsychosocial assessment has far reaching implications not only for competent and coordinated care but also for adherence to medical treatment and risk reduction, as well as public health "(Gorman, 2007, p. 61).

Pierson (2008) believes that the integration of a biopsychosocial model to help clients should be frequented and incorporated into general clinical practice to become an effective method of treatment. In the case of people living with HIV/AIDS, social work services that fail to address the bio-psycho-social-spiritual need of a client can be termed as having fallen short of providing a comprehensive support. Ambrosino, Heffernan, Shuttlesworth & Ambrosino (2011), affirm that "Service programs should be culturally competent, linguistically appropriate, and client and patient centered" (p. 243).

Correspondingly, in the case of mental illness, the problems are believed to be the outcome of "the interplay among the biological, psychological and social factors that affect the lives of the individual" (Rosenberg, Weissman & Wong, 2014, p. 56) Incorporating bio-psycho-social assessment and treatment therefore goes further than alleviating the mental distress of the client alone. Concerning the youth that suffer from mental illness, Steele (2006) explains that "Multimodal therapies are meant to address not only to address and resolve the underlying issues of presenting clinical problems, but also to teach more socially adaptive skills to maintain the youth in their homes, schools and communities." (p. 135)

2.4 Strength Based Approach

The strength based approach draws attention to a client's vital assets that can be used as a means to deal with problems in the client's life. McQuaide and Ehrenriech (1997), describe strength as:

> The capacity to cope with difficulties, to maintain functioning in the face of stress, to bounce back in the face of significant trauma, to use external challenges as a stimulus for growth, and to use social supports as a source of resilience. (Greene & Lee, 2011, p. 10)

Rippe (2013) comments that, "a strength-based approach aims to capitalize on things that patients are already doing well that can contribute to improvements and well-being" (p. 56). Similarly, Rosenberg et al. (2014) accentuates that as opposed to focusing on a person's weakness and problems, the strength based model is aware of the client's needs, aims, aspirations and hopes as well as working on his or her internal and external resources to accomplish his or her goals. In light of this idea, it is recommendable to design and implement clinical interventions on the basis of the client's strong coping mechanisms, once identified, rather than building a whole new method to help clients. The coping mechanism of a client may display a clear distinction from others; while one's strong asset may center on family relationships for instance, others may look upon their religion and spirituality as a support mechanism to pass through the troubles of life. Cashwell (2005) outlines that "the spiritual beliefs and values of clients can be a resource for strength-based approaches such as wellness" (p. 37). Doka (2011) remarks that spiritual beliefs and practices can be significant foundations for clients' strength (Reese, 2013). A similar argument is raised by Ashman & Hull (2008), who forward the idea that a "client's spirituality may be a great source of strength" (p. 72) Furness & Gilligan (2009) reiterate that social workers should recognize religious and spiritual beliefs as an important resource and to use it as an intervention method. As put forward by Lee (2009), the strength based approach will empower clients to deal with their problems and also lessen their

dependency on professionals in search of solutions. The author further elaborates the strength based approach from a spiritual aspect stating that "utilizing spirituality in human existence therefore goes beyond solving the problems at hand but expands the client's life horizon and brings the prospect of achieving personal growth and transformation" (p. 196).

This implies that given the fact that religion and spirituality is found to be a client's one form of strength when carrying out an assessment, the social work practitioner should proceed to include these two concepts to help the client and hasten his/her recovery.

2.5 Religion and Spirituality in Clinical Social Work Practice

Numerous incidents in a person's life may require the intervention of religion and spirituality to cope with and prevent the incident from becoming a reason to disrupt the individual's entire life. In some occasions, these incidents may include clinical cases. According to Speck, cited in Lyall (2001) circumstances that necessitate spiritual and religious issues comprise of severe distress connected with mental illness or substance abuse, resentment towards God or lack of the sense of God which may result from the passing away of a loved one and a sense of guilt or shame because of a certain phenomenon in a person's life among other matters. In addition to this aspect, Healy (2014) claims that spirituality and religion is particularly important in palliative care. Clinical social work practitioners may regularly encounter clients that present issues they think is best handled by religion or spirituality. In this case, Canda (2012) states that even though the practitioner recognizes the need for a religious or spiritual intervention, he or she may perceive that it is inappropriate to address, considers them irrelevant or may lack knowledge on how to handle them. This leads to an intervention that lacks all roundedness, neglecting an important aspect of clients' cases. Edwards (2002) argues that "attending to the religious and spiritual needs of service users is a key dimension of holistic care"

(p.83) Healy (2014) supports this claim restating that an understanding of spiritual and religious beliefs and practices is also important to culturally sensitive practice. Practitioners, therefore, should be aware of how their clients frame their problems and be willing to bring spirituality and religion to the table whenever the need arises. Outlining the role of the social worker in spiritual care, Koopsen et al. (2009) wrote in their book "Integrative Health: A Holistic Approach for Health Professionals", "Social workers may assist in the spiritual care process in many ways, from helping families organize their care support system to guiding the client and family in meeting their emotional, spiritual, psychological, and bereavement needs" (p.52). From the outset, a social work practitioner should gather information on the client's religious or spiritual background prior to implementing any sort of interventions. Doka (2011) highlights that, understanding the client's belief system allows the social worker to gear interventions toward the client's point of view.

> The social worker will want to inquire about religious background and current affiliation with organized religions, any rituals or practices that the client or family members want integrated into the care plan, and any religious leaders or supports that the client would like to be involved. This is necessary in order to respond in a manner that is appropriate to the client's needs and may be an important source of comfort. (Reese, 2013, p. 129)

Correspondingly, Lee, Siu-Man, Leung, Chan & Leung (2009) argue that workers need to reveal their spiritual values and beliefs in order for them to recognize any potential assumptions, prejudice, strengths or limitations that could arise during the helping relationship and to identify how these values and beliefs may have impacted their own practice.

As a form of religious and spiritual intervention, various practices are exercised in the form of prayers or meditations, touching clients for healing purposes, recommending spiritual writings or books, recommending forgiveness, amends or peace, helping clients clarify religious values and performing exorcism in some instances. Recommending religious or spiritual forgiveness, amends, or peace can serve a great purpose in creating a tranquil mental state among

clients. For example, in the case of people living with HIV/AIDS, developing forgiveness is considered as a significant part of the acceptance process.

> Forgiveness is a prominent issue not only in the interpersonal context of how the infection was acquired but also in relation to subsequent relationships, especially in response to negative attitudes of family and friends who may be perceived as abandoning the PLWHA. (McCullough, 2001, p. 56)

In support of this argument, Reese (2013) forwards the idea that "clients may have a need to ask for forgiveness from others or may need to forgive someone else for a past hurt. Forgiveness releases pain, guilt, shame and anger toward the self or other" (p. 138)

Prayer or meditation is also used as a different means of intervention in clinical social work. In fact, Trivieri& Anderson (2002) claim that prayer is "the most common form of spiritual practice" (Koopsen et al., 2009, p. 43) Collins, Jordan & Coleman(2009), state that "Spiritual rituals such as prayer and meditation or the support of a spiritual or religious community can provide strength during difficult times" (p. 156) Reese (2013) recommends meditation, keeping a diary and discussing dreams and drawings, as one way of finding meaning. Evidently, prayer can strongly influence a client's healing process. Religious practices such as participating in a worship ceremony and prayer has great positive impact on the physical and emotional health of individuals. Taylor (2002) states that "although experimental evidence of prayers curative effect is inconclusive, there have been several correlational studies that demonstrate relationships between prayer and psychological health benefits" (Koopsen et al., 2009, p.43) However, this type of method is deemed suitable for cases in which the client is comfortable with the concept of praying or meditating. "If it is an area that we and the client are comfortable exploring, and if it is something we can call upon to aid in our intervention with clients, then prayer can be an appropriate technique" (Turner & Rowe, 2013, p. 332). Aside from helping clients through prayers, the social worker is also encouraged to use the client's belief

system and clarify their religious values to find means of coping with the problems they face in their lives. In doing so, the practitioner must be careful not to impose his/her own religious and spiritual beliefs upon the client. Hugen& Scales (2008) mention that "as long as workers are not imposing spiritual convictions, they are merely facilitating client self-determination, helping clients make their own decisions" (Barsky, 2009, p. 36).

Religious rituals are also mentioned among interventions that can make the path to recovery considerably speedy for clients. Helping clients develop a spiritual ritual as a clinical intervention such as houseblessing and visiting graves of relatives among other practices is considered vital in the healing process. Turner et al. (2013) explains that rituals can be a source of comfort to clients. The author elaborates on the advantages of rituals as practices that can nurture a sense of security, make the client feel empowered to own the whole helping process and participate in it while also supporting him/her to create his/her own identity. Reese (2013) encourages clients to develop their own rituals, whether religious or specifically developed for the client's case, to find a resolution for distressing experiences in individuals' lives. "In some cases religious ritual may help the client to resolve guilt, if the client is interested, the social worker should make a referral to the appropriate religious leader" (Reese, 2013, p. 138).

In a research conducted on the inclusion of religion and spirituality by clinical social workers in Virginia, Bullis (2013) found out that social workers and their clients placed great emphasis on the two concepts dominantly using four intervention methods that are exploring a client's spiritual background, exploring the client's religious background, clarifying the client's spiritual values and recommending participation in spiritual programs. He further concluded that there were three interventions used most infrequently which comprised of performing exorcisms, touching clients for healing purposes, and reading scriptures with clients.

Integration of Religion/Spirituality in Clinical Social Service

The advantages of religion and spirituality are not only aiding the client to his/her path to recovery but providing solid support even when recovery is not the anticipated end result.

> The implications of effective spiritual care are that, even where the source of the problem, pain or oppression cannot itself be removed, the service user is able to transcend the situation such that it no longer has a problematic, painful or oppressive impact. (Holloway & Moss, 2010, p. 101).

In support of this argument and in the specific context of spiritual practice for healing purposes, Matthews and Clark (1998) clarify that every human is mortal and not every illness is followed by a recovery but even when physical recovery seems unattainable, some level of improvement is frequently observed in facing a serious illness or disability when spiritual interventions are integrated as one method in clients' cases. (Koopsen et al., 2009, p.43)

Conversely, some scholars argue that religion and spirituality as opposed to being a source of strength for clients, occasionally present themselves as a major source of distress in some individuals' cases, creating what is termed as a psychospiritual problem. Bullis (2013) defined this concept as "Psychospiritual problems are experiences that a person finds troubling or distressing and that involve that person's relationship with a transcendent being or force" (p. 17). For this reason, social work practitioners must take the proper precautions prior to introducing religion and spirituality as an intervention method in clients' cases given that the outcome may take a negative turn.

> Religion may encourage magical thinking as people pray for and expect physical healing as if God were a giant genie at the beck and call of every human whim. Then, if physical healing does not come immediately, the person may be disappointed and disheartened, claiming that the prayer was not answered and that God does not care, or worse, that the illness was sent by an angry, vengeful God as punishment (Koenig, 2007, p. 109)

Adjacent to this argument, Koenig (2007) in his book *Spirituality in Patient Care* further elaborates that the effort people make to go in accordance with a "prescribed lifestyle" by their religious group worsens their state of being as these lifestyles may entail "self-sacrifice,

nonparticipation in certain kinds of activities, or avoidance of certain kinds of people". According to this author, failing to abide by these usually high standard values, such as "sexual morality, honesty, generosity, forgiveness, humility or kindness", causes feelings of self-resentment, remorse and depression.

The negative effects of religion and spirituality are also reflected in patients' refusal to incorporate biomedical and religious/spiritual interventions simultaneously. Koenig, King & Carson (2012) state that "with good intentions, religious persons make seek to rely on their faith, trust in God, and prayer rather than medicine, when dealing with a medical condition" (p. 63). The authors continue to elaborate that religious individuals may not comprehend and realize that medicine is a "gift from God" and that religion and medicine can work well jointly.

3 RESEARCH METHODS

This study plans to examine the attitude and use of religious/spiritually integrated interventions of clinical service providers in Addis Ababa. Based on the literature review, the study seeks to discover what practitioners' perception is towards religious/spiritual interventions and whether they report that they make frequent use of it with clients that seek spirituality or religion in their recovery. The methods are described here.

3.1 Research Design

This study is based on positivist approach which bases on the idea that there is an objective 'reality' which can be accurately measured, and which operates according to natural laws that can be 'discovered' by rigorous, objective research (Marlow, 1998). Accordingly, this study used quantitative cross sectional research design, with descriptive, explanatory and predictive function. It is descriptive because it presents detailed picture of the specific situation which has been highly developed in previous works; taking explanatory role, it answers why things are the way they are; and it is also predictive because the regression analysis forecasts outcomes.

3.2 Sampling Plan

3.2.1 Units of analysis

This research takes as its primary unit of analysis individual clinical social service providers in Addis Ababa. Individuals that have been characterized in terms of membership in clinical service providing organizations and have been active in the field for at least a year have been considered as a subject.

3.2.2 Recruitment and sampling frame

The sampling frame for this research initially included members of the Ethiopian Society of Sociologists, Social Workers and Anthropologists (ESSSWA). The population of interest was members engaged in clinical services. ESSSWA is an association with more than 500 members, but not all of them are engaged in a clinical/direct social service. A list of members and their email addresses was procured from the association following the approval of its president. From a list of 500 identified members, a letter of invitation and a web link was emailed to potential participants requesting them to participate in the web survey. Out of the 500 potential participants, only 46 filled the online survey. I tried to resolve the issue of inadequate number of samples by approaching clinical service providers in different institutions randomly. Finally, sixty-seven clinical service providers participated in the current study.

3.2.3 Inclusion criteria

In order to be included in the study, participants had to meet the following criteria: Clinical service providers (clinical social workers, nurses, psychiatrists, psychologists, health officers); currently working or has actively worked with clients with health issues for at least one year of their professional practice in Addis Ababa; had face to face contact with patients during their practice.

3.3 Operational Definition

The operational definitions of key terms used for the study are described below.

Religion/spirituality: Religion is defined as an organized, structured set of beliefs and practices shared by a community related to spirituality. Spirituality is defined as the search for meaning, purpose and connection with self, others, the universe, and ultimate reality however one understands it. This search may or may not be expressed through religious forms or institutions.

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Respondents self-reported if they have a religious/spiritual affiliation or not and it was coded as 1 for Yes and 0 for No.

Clinical social service/work: Clinical social service/work is a healthcare profession based on theories and methods of prevention and treatment in providing behavioral healthcare (mental health and substance use disorder) services, with special focus on bio-psychosocial problems and disorders.

Clinical social service providers: In this study, Clinical social service providers are professionals that are engaged in counselling their clients for the prevention, diagnosis, and treatment of mental, behavioral, and emotional disorders in individuals, families, and groups. Their goal is to enhance and maintain their patients' physical, psychological, and social function.

Attitude of practitioners: Respondents selected if they agree or don't agree towards integrating religion/spirituality in dealing with clients' physical and psychological health problems. This is a 14 item Likert type scale.

Practice: Clinical social service providers selected the number of times they integrate religion/spirituality in their practice on a scale of 0-100%. This is a 14 item scale measure.

Type of organization: respondents described if they work in a governmental, non-governmental or private institution and they were coded 1, 2 and 3 respectively.

Type of work setting: participants described if they work in a religious or secular work place. Religious work place was coded as 1 while a secular one was coded as 2.

Primary work setting: participants selected from a list provided their area of specialization such as mental health, family and children, substance abuse, HIV/AIDs and self-reported their work setting in cases that are not included in the list.

3.4 Instrumentation

3.4.1 The data collection Instrument

The instrument for this study is a three part questionnaire, incorporates the "Role of Religion and Spirituality in Practice" Scale (RRSP) developed by Sheridan (2000) and a demographic section. They are described briefly here.

3.4.2 The "Role of Religion and Spirituality in Practice" Scale (RRSP)

The RRSP is designed "to measure professional attitudes toward the role of religion and spirituality in social work practice" (Sheridan, 2000, p.2). The RRSP contains 14 Likert-type scaled items asking practitioners' views about the appropriate role of religion or spirituality in social work practice. "The possible range in scores is 14 to 70, with higher score indicating more positive attitudes towards the role of religion and spirituality in practice" (Sheridan, 2000, p.2). To evaluate the extent of the inclusion of religion and spirituality in professionals' practice, the same 14 item scale was used containing percentage indicators for each item (0-10%, 11-20%, 21-30%, 31-40%, 41-50%, 51-60%, 61-70%, 71-80%, 81-90%, 91-100%). If a respondent used a particular intervention with at least 10% of his or her clients, the response was coded with a "1". If the use of intervention exceeded to 20%, the response was coded with a "2". The coding continued as such sequentially until "10", meaning the practitioner used a particular intervention with 100% of his or her clients. If, on the other hand, a respondent indicated that he or she used a particular intervention with less than 10% of his clients, his or her response was coded "0"

meaning he or she does not use the intervention. The higher the score is from 0-100%, the more it proves the inclusion of religion and spirituality in practice.

The RRSP Scale has been used in previous studies with relatively high reliability and demonstrates internal consistency, with alpha coefficients ranging from .81 to .91 (Heyman, et al., 2006). A second study (Quattlebaum, 2002) found similar results for the RRSP, with an internal consistency of .80. The scale "possesses good face and content validity" as reported in Sheridan's (2004) study with practitioners.

Results of my study conducted with a sample of 67 respondents indicated the RRSP has an internal consistency of .79 to .88.

Table 2.Instrument Characteristics and Reliability Coefficients

Instrument and Example Items	Response Format	# of Items	Cronbach's *Alpha*
Role of Religion and Spirituality in Practice (RRSP): general attitudes about the role of religion and spirituality in clinical social service - *Recommending religious or spiritual forgiveness, amends or peace, recommending participation in a religious or spiritual program, gathering information on the client's religious or spiritual background*	Likert type	14	.81 to .91 (.79)
Role of Religion and Spirituality in Practice (RRSP): Extent of religion and spirituality inclusion in individual practice - *helping clients develop a spiritual ritual as a clinical intervention (houseblessing, visiting graves of relatives), sharing their own religious or spiritual beliefs or views, praying or meditating with a client*	Percentage scale	14	.81 to .91 (.88)
Demographic survey - *age, gender, year of experience*	Check from a list and fill in the blank	10	

Integration of Religion/Spirituality in Clinical Social Service

The survey included an introduction informing participants that the purpose of the study was to better understand social workers' opinions and practices regarding the role of religion and spirituality when working with children and adolescents. The following definitions were provided to assist participants in answering the survey questions based on Sheridan (2004). Both of these definitions have been consistently used in the social work literature.

- Spirituality was defined as "the search for meaning, purpose, and connection with self, others, the universe, and ultimate reality, however one understands it. This may or may not be expressed through religious forms or institutions."
- Religion was defined as "an organized set of beliefs and practices shared by a community related to spirituality."

3.4.3 Background Questionnaire

The Background Questionnaire is a 10-item survey designed to obtain routine demographic data. This questionnaire comprised the first part of the survey and took approximately five minutes to complete. Information such as age, gender, religious affiliation, level of education, professional background, religion/spiritual training acquired, work and practice setting were obtained.

3.5 Data Collection

3.5.1 Data Collection procedure

The overall design approach for this quantitative study of clinical service providers' attitude and religious based practices was to collect data using Qualtrics, a web-based survey research tool. Qualtrics is an online survey software and insight platform that provides a process for building a database or online survey and has an intuitive interface for collecting and validating data that is downloadable to common statistical packages such as SPSS. Respondents

were able to complete the survey online, thus reducing the costs, time limitations, and travel and scheduling issues of both the respondents and researcher. Once logged on, the database did not collect any identifying data about the participants. The research participants were asked to fill out two separate instruments, including a background questionnaire. The overall estimated time for instrument completion was 20 minutes.

3.6 Data Analysis

Since the data collected was quantitative, it was analyzed using univariate, bivariate and multivariate data analysis. Data was analyzed using Statistical Package for Social Science (SPSS) Version 20 computer application program.

3.6.1 Univariate Analysis

Categorical variables such as gender, education, religious orientation, type of organization, type of work setting, major service type and training received on religion/spirituality were measured at nominal level and analyzed using absolute frequency and percentage. Those continuous variables like years of work experience and the major research variables attitude and practice of professional service providers were measured at ratio level and univaritely analyzed using measure of central tendency (mean) and measure of variability (standard deviation).

3.6.2 Bivariate Analysis

In order to analyze the association and causality of variables, a bivariate analysis was conducted. It involved looking at if the variables such as gender, type of organization, type of work setting, training received on religion/spirituality contributed to the attitude of practitioners towards religion/spirituality and their practice via the use of an independent samples t-testTo explore the difference in attitude and practice of practitioners in utilizing religion and spirituality

as an intervention method among different major service types (HIV/AIDS, mental health and child care), a one way ANOVA between groups was performed. The outcome variable was the attitude and practice of clinical service providers. A Pearson's correlation was also computed to explore the strength and direction of the relationship between attitude and practice among clinical service providers.

3.6.3 Multivariate Analysis

A multivariate analysis was also conducted in cases where there are more than two variables. Linear regression analysis was conducted with personal factors such as age and year of experience to determine the two variables contribution in predicting attitude and practice.

3.7 Ethical Considerations

Informed consent of participants has been obtained before involving them in the study (see Appendix A). Members of the sample group have not been subjected to coercion in any way. Privacy of the research participants have also been ensured, so that no personal data were collected form respondents. Research participants have been debriefed about aims and objectives of the study before the primary data collection process. I initially had no plans to provide incentives to participants and involvement in the study fully rested on their good will. However, upon the request of some respondents, 50 ETB was given to 14 participants each for filling a questionnaire. I have witnessed that accepting compensation in exchange for information is becoming a thriving trend particularly among HIV/AIDS caregivers.

4 FINDINGS

This chapter reports the findings of this quantitative study. Demographic descriptive about the sample and statistical data on the "Role of Religion and Spirituality in Practice" (RRSP) Scale used in the study will be presented and discussed.

4.1 Univariate Analysis

This survey had a total of 67 respondents, of which 22 were mental health practitioners, 23 are involved in HIV patient care and 22 are engaged in family and child care. More than two quarters (58.2%) of the respondents who participated in this survey were female, while the remaining 41.8% were male. The participants' age range from 24 to 56 years (M=34.60, SD=7.70). Their work experience period extends from one year to fifteen years (M=5.63, SD=3.14) in social services related to mental health, HIV patient care and child care. A little more than half (53.7%) of the respondents worked in Non-governmental institutions while 44.8% were from government institutions. The remaining 1.5% were from privately owned organizations. More than a third quarter (83.6%) of the participants worked in secular organizations while the rest (16.4%) were from religious establishments. 43 respondents (64.2%) identified "Bachelor's Degree" as their highest education level; 12 respondents (17.9%) indicated their highest education level to be "Diploma" while the remaining 12 participants (17.9%) held a "Masters Degree and above".

With regard to acquiring formal and non-formal training on religion and spirituality, 58.2% of the respondents had non-formal training on the two concepts while 41.8% had attended formal training. In terms of religious affiliation and spiritual orientation, all of the respondents (100%) claimed to have been affiliated with one religion or another. More than half (56.7%) of

the service providers were Christian Orthodox, 28.4% were Evangelical Christian, 7.5% were Christian Catholic, 6.0% were Muslim, and 1.5% were Jehova's witness.

Table 3. Demographic characteristics of the respondents

Variables		Frequency	Percent
Gender	Male	28	41.8
	Female	39	58.2
Education	Diploma	12	17.9
	Degree	43	64.2
	Masters Degree& above	12	17.9
Religious Affiliation	Christian Orthodox	38	56.7
	Muslim	4	6.0
	Evangelical Christian	20	29.9
	Christian Catholic	5	7.5
Type of organization	Governmental	30	44.8
	Non-governmental	36	53.7
Type of work setting	Religious	11	16.4
	Secular	56	83.6
Major Service type	Mental Health	22	32.8
	Child care	22	32.8
	HIV/AIDS	23	34.3
Training Received on Religion/Spirituality	Formal	28	41.8
	Non-formal	39	58.2

The attitude possessed by social service providers towards religion and spirituality reveals that they agree about initiatives related to *recommending religious or spiritual forgiveness, amends or peace* (M=3.99, SD=0.977), *recommending participation in a religious or spiritual program* (M=3.73, SD=1.024), *gathering information on the client's religious or spiritual background* (M=3.69, SD=1.047), *referring clients to a religious or spiritual counselor* (M=3.66, SD=1.109), *praying privately for a client* (M=3.61, SD=1.243) and *using or recommending religious or spiritual books or writings* (M=3.57, SD=1.076).

Table 4. Item by item analysis of attitude towards religion and spirituality

Items	N	Min	Max	Mean	Std. D
Recommending religious or spiritual forgiveness, amends, or peace	67	1	5	3.99	0.977
Recommending participation in a religious or spiritual program	67	1	5	3.73	1.024
Gathering information on the client's religious or spiritual background	67	1	5	3.69	1.047
Referring clients to a religious or spiritual counselor	67	1	5	3.66	1.109
Praying privately for a client	67	1	5	3.61	1.243
Using or recommending religious or spiritual books or writings	67	1	5	3.57	1.076
Using religious or spiritual language or concepts with a client	67	1	5	3.48	1.185
Helping clients clarify their religious or spiritual values	67	1	5	3.39	1.205
Helping clients develop a spiritual ritual as a clinical intervention (houseblessing, visiting graves of relatives)	67	1	5	3.33	1.260
Sharing your own religious or spiritual beliefs or views	67	1	8	3.00	1.557
Praying or meditating with a client	67	1	5	2.81	1.171
Performing exorcism (expelling evil spirits)	67	1	5	2.72	1.241
Participating in client's rituals as a clinical intervention	67	1	5	2.61	1.086
Touching clients for healing purposes	67	1	5	2.54	1.105
Overall attitude to religion and spirituality	67	31	67	46.10	8.396

As revealed in Table 4, the practitioners exhibited an indifferent outlook, in terms of attitude, towards *using religious or spiritual language or concepts with a client*(M=3.48, SD=1.185), *helping clients clarify their religious or spiritual values* (M=3.39, SD=1.205), *helping clients develop a spiritual ritual as a clinical intervention (houseblessing, visiting graves of relatives)* (M=3.33, SD=1.260), *sharing their own religious or spiritual beliefs or views* (M=3, SD=1.557), *praying or meditating with a client* (M=2.81, SD=1.171), *performing exorcism (expelling evil spirits)* (M=2.72, SD=1.241), *participating in client's rituals as a clinical intervention* (M=2.61, SD=1.086) and *touching clients for healing purposes* (M=2.54, SD=1.105).

As indicated in Table 5, in practice, the participants implied the frequent use of *recommending religious or spiritual forgiveness, amends or peace* (M=5.46, SD=3.59) more than any other religious and spiritual intervention methods integrating it in a little more than half

of their clients' cases. *Gathering religious or spiritual background information from clients* was also more prominently used in a slightly over half of clients' cases as compared to other methods (M=5.27, SD=3.91). In third place, *intervention methods such as recommending participation in a religious or spiritual program* (M=4.19, SD=3.31) and *recommending religious or spiritual books or writings* (M=3.52, SD=3.17) were exercised in close to 40% of the interventions with clients.

Table 5.Item by item analysis of religion and spirituality integrated practice

Items	N	Min	Max	Mean	Std. D
Percent of clients the professional recommended religious or spiritual forgiveness, amends, or peace.	67	0	10	5.46	3.59
Percent of clients the practitioner gathered religious or spiritual background information from	67	0	10	5.27	3.914
Percent of clients the professional recommended to participate in a religious or spiritual program	67	0	10	4.19	3.318
Percent of clients the practitioner recommended religious or spiritual books or writings	67	0	10	3.52	3.174
Percent of clients the practitioner prayed privately for	67	0	10	3.46	3.513
Percent of clients that were handled using religious or spiritual language or concepts	67	0	10	3.19	2.432
Percent of clients helped to develop a spiritual ritual as a clinical intervention (house blessing, visiting graves of relatives)	67	0	10	3.19	3.163
Percent of clients helped to clarify religious or spiritual values	67	0	10	2.96	2.931
Percent of clients the practitioner shared his/her own religious or spiritual beliefs or views with	67	0	10	2.58	2.996
Percent of clients the practitioner touched for healing purposes	67	0	10	1.84	2.428
Percent of clients' rituals the professional participated in as a clinical intervention	67	0	9	1.79	2.39
Percent of clients the practitioner prayed or meditated with	67	0	10	1.78	2.066
Percent of clients the professional performed exorcism (expelling evil spirits) for	67	0	5	0.97	0.816
Overall attitude to religion and spirituality	67	0	100	44.40	25.860

Integration of Religion/Spirituality in Clinical Social Service

In close to 30% of clients' cases, practitioners opted for the practice of *praying privately for clients* (M=3.46, SD=3.51), *using religious or spiritual languages or concepts* (M=3.19, SD=2.43), *helping clients develop a spiritual ritual as a clinical intervention (house blessing, visiting graves of relatives)* (M=3.19, SD=3.16), clarifying religious or spiritual value (M=2.96, SD=2.93), and *sharing their own religious or spiritual beliefs or views with clients* (M=2.58, SD=2.99). *Touching clients for healing purposes* (M=1.84, SD=2.42) and *participating in clients' rituals as a clinical intervention* (M=1.79, SD=2.39) were implemented by practitioners in close to 20% of their cases. *Praying or mediating with clients* is exercised in less than 20% of the cases handled by the social service providers (M=1.78, SD=2.06). *Performing exorcism (expelling evil spirits)* was the least used intervention method in practice (M=0.97, SD=0.81) with practitioners in favor of applying it in less than 10% of the cases they encounter.

4.2 Bivariate Analysis

This section of the data analysis involved conducting an independent samples t test and a Pearson's correlation to discover the association and causality of variables. The independent samples t test was conducted to determine the influence of variables such as gender, age, type of organization, type of work setting and formal/non-formal training of religion and spirituality on the attitude and practice of clinical social service providers in incorporating religion and spirituality as intervention methods when dealing with clients' issues.

With the assumption that gender might contribute to the attitude and practice of practitioners, I conducted an independent t test. As shown in table 4 above, there was no significant mean difference in attitude; $t(65)=.767$, $p> 0.05$ between male (M=47.04, SD=6.936) and female (M=45.44, SD=9.335) service providers. With the understanding that attitude and practice go together I did an independent samples t test for practice. There is no statistically

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This section of the data analysis involved conducting an independent samples t test and a Pearson's correlation to discover the association and causality of variables. The independent samples t test was conducted to determine the influence of variables such as gender, age, type of organization, type of work setting and formal/non-formal training of religion and spirituality on the attitude and practice of clinical social service providers in incorporating religion and spirituality as intervention methods when dealing with clients' issues.

With the assumption that gender might contribute to the attitude and practice of practitioners, I conducted an independent t test. As shown in table 4 above, there was no significant mean difference in attitude; $t(65)=.767$, $p> 0.05$ between male (M=47.04, SD=6.936) and female (M=45.44, SD=9.335) service providers. With the understanding that attitude and practice go together I did an independent samples t test for practice. There is no statistically

mean difference in both the practice percentage of the use of religion and spirituality t(65)=-.250, p> 0.05. The result obtained indicated that both male (M=43.46, SD=24.306) and female (M=45.08, SD=27.214) practitioners used religion and spirituality in their practice in less than 50% of the time.

Table 6.An independent samples t test of predicting factors on attitude and practice

Independent Variable	Value	Dependent Variable	N	Mean	Std. D	Std. Error Mean	t	p
Gender	Male	Attitude	28	47.04	6.936	1.311	.767	.446
	Female		39	45.44	9.335	1.495		
	Male	Practice	28	43.46	24.306	4.593	-.250	.803
	Female		39	45.08	27.214	4.358		
Type of Organization	Governmental	Attitude	30	44.50	5.057	.923	-1.354	.181
	Non-governmental		36	47.31	10.362	1.727		
	Governmental	Practice	30	40.37	16.859	3.078	-1.171	.246
	Non-governmental		36	47.89	31.599	5.267		
Type of work setting	Religious	Attitude	11	56.00	6.753	2.036	4.990	.000
	Secular		56	44.16	7.271	.972		
	Religious	Practice	11	75.09	25.022	7.544	5.038	.000
	Secular		56	38.38	21.524	2.876		
Training Received on Religion/Spirituality	Formal	Attitude	28	48.25	8.614	1.628	1.802	.076
	Non-formal		39	44.56	7.993	1.280		
	Formal	Practice	28	49.54	27.767	5.247	1.386	.170
	Non-formal		39	40.72	24.090	3.857		

I have also conducted an independent-samples t-test to compare the attitude and practice of social work providers in the inclusion of religion and spirituality with practitioners that are active in governmental institutions and practitioners who work in non-governmental establishments. There was no statistically significant mean difference in attitude; t(65)=-1.354, p> 0.05 among both governmental (M=44.50, SD=5.057) and non-governmental (M=47.31, SD=10.362) organization employees. To discover if practice had a similar or opposite implication, I did an independent samples t-test for practice. There is no statistically mean difference in both the practice percentage of the use of religion and spirituality t(65)=-1.171,

$p>0.05$. The result obtained indicated that both governmental ($M=40.37$, $SD=16.859$) and non-governmental ($M=47.89$, $SD=31.599$) institution practitioners used religion and spirituality in their practice in less than 50% of the time.

With the hypothesis that the kind of work setting (religious or secular) practitioners' are engaged in influences their attitude, I also carried out an independent samples t-test for attitude. The result gained showed that there was a statistically significant mean difference in attitude $t(65)=4.990$, $p< 0.01$. Practitioners in religious institutions on average agreed to the idea of using religion/spirituality ($M=56$, $SD=6.753$) while those in secular institutions ($M=44.16$, $SD=7.271$) showed an indifferent stand. Assuming that there is a positive relation between attitude and practice, I also conducted an independent samples t test for practice. The result revealed that there was a statistically significant mean difference in practice $t(65)=5.038$, $p< 0.01$. Clinical service providers in religious institutions ($M=75.09$, $SD=25.022$) integrated religion/spirituality in 75% of their clients' cases while practitioners in secular institutions ($M=38.38$, $SD=21.524$) utilized the two concepts in less than 40% of the time.

With the assumption that practitioners' attitude may vary based on the kind of training they have acquired on Religion/Spirituality (formal or non-formal), I did an independent samples t test. The result obtained showed that there was no statistically significant mean difference in attitude $t(65)=1.802$, $p> 0.05$ among practitioners that have acquired formal ($M=48.25$, $SD=8.614$) and non-formal ($M=44.56$, $SD=7.993$) training. Similarly there was no statistically significant mean difference for practice $t(65)=1.386$, $p>0.05$. however, clinical service providers that have received formal training ($M=49.54$, $SD=27.767$) used religion/spirituality in almost 50% of the time while those who received non-formal training ($M=40.72$, $SD=24.090$) used it in less than 50% of the time.

Table 7.Correlation between attitude and practice

		Attitude	Practice
Attitude	Pearson Correlation	1	
Practice	Pearson Correlation	.698***	1

**. Correlation is significant at the 0.001 level (2-tailed).

With the assumption that there is a positive relationship between attitude and practice of social service providers towards the inclusion of religion and spirituality in practice, a Pearson correlation coefficient was computed. As indicated in the table above, the Pearson's correlation, ($r=0.698$, $p<0.001$) reveals that there is a statistically significant positive and strong correlation between practitioners' attitude and their practice. This implies that 99.9% of the time, as the value for attitude for the inclusion of religion and spirituality in social service provision increases; the practice variable also increases in value. Similarly, as the attitude of practitioners towards including religion and spirituality in their practice becomes less favorable, they show a reduced amount of flexibility towards including it in their practice.

4.3 Multivariate Analysis

Multivariate analysis was conducted to explore cases such as the association of personal factors (age and year of experience) with attitude and practice. The difference in attitude and practice of professionals in utilizing religion and spirituality as an intervention method is also presented and discussed in this section.

4.3.1 Practitioners' attitude and practice by service type

In terms of attitude, the descriptive statistics indicated that on average those in child care(M=49.59, 10.308), agreed on the use of religion and spirituality in practice while practitioners in the field of mental health (M=45.45, 6.131) and in the field of HIV/AIDS (M=43.39, 7.341), both showed an indifferent attitude towards religion and spirituality.

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In practice, on average 49% of the time, practitioners in childcare responded that they include religion and spirituality in interventions. In the field of mental health, service providers on average incorporated religion and spirituality 42% of the time. In HIV/AIDS, practitioners used the two concepts in 41% of clients' cases.

Table 8.Practitioners' attitude and practice by service type

Please identify your primary work setting		Attitude	Practice
Mental Health	Mean	45.45	42.36
	N	22	22
	Std. Deviation	6.131	20.643
Child care	Mean	49.59	49.50
	N	22	22
	Std. Deviation	10.308	31.867
HIV/AIDS	Mean	43.39	41.48
	N	23	23
	Std. Deviation	7.341	24.310
Total	Mean	46.10	44.40
	N	67	67
	Std. Deviation	8.396	25.860

To determine if there is any difference in attitude and practice among practitioners between different types of work setting (mental health, HIV/AIDS and child care), I conducted a one-way ANOVA between groups.

As indicated in the table below, one way ANOVA indicated that at least two of the groups (the mean difference between the two groups) is statistically significant for attitude $F(2, 66) = 3.393$, $p < 0.05$. But when it comes to practice, there is no statistically significant mean difference between the three groups $F(2, 66) = 0.636$, $p > 0.05$.

Table 9.A one way ANOVA between groups

		Sum of Squares	Df	Mean Square	F	Sig.
Attitude	Between Groups	446.018	2	223.009	3.393	.040
	Within Groups	4206.251	64	65.723		
	Total	4652.269	66			
Practice	Between Groups	859.789	2	429.895	.636	.533
	Within Groups	43276.330	64	676.193		
	Total	44136.119	66			

I had to do a post hoc analysis to locate where the difference lies among the three groups. Therefore I conducted Bonferoni analysis. The post hoc analysis showed that there is a mean difference between HIV/AIDS (M=43.39, SD=7.341) and child care (M=49.59, SD=10.308).

Table 10. Post hoc analysis for service type (HIV/AIDS, mental health & Child care)

(I) Primary work setting	(J) Primary work setting	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
Mental Health	Child Care	-4.136	2.444	.286	-10.15	1.87
	HIV/AIDS	2.063	2.418	1.000	-3.88	8.01
Child Care	Mental Health	4.136	2.444	.286	-1.87	10.15
	HIV/AIDS	6.200*	2.418	.038	.26	12.14

*. The mean difference is significant at the 0.05 level.

4.3.2 Linear regression analysis for age and year of experience predicting attitude

With the assumption that age and year of experience might have a relationship with the attitude of a practitioner towards the application of religion and spirituality, I did a simple linear regression. As indicated in the table below, both age (β=.060, $p>0.05$) and year of experience (β=-.544, $p>0.05$) were not found to be significant predictors of attitude.

Table 11.Linear regression analysis for age and year of experience predicting attitude

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	47.085	4.884		9.641	.000
	Age	.060	.167	.055	.361	.720
	Number of years as a social service provider.	-.544	.408	-.204	-1.331	.188
	R^2		.031			

a. Dependent Variable: Attitude

The result obtained showed that 31% of change in attitude is attributed to change in age and year of experience. When looking at the percentage, it was not found to be statistically significant. The unstandardized coefficient for age (β=.060) and year of experience (β=-.544) means that for every year increase in age of the professional, there is a 0.60 point increase in attitude. For every year increase in work experience, there is -.544 point decrease in attitude.

Table 12.Linear regression analysis for age and year of experience predicting practice

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	59.415	15.042		3.950	.000
	Age	-.282	.513	-.084	-.549	.585
	Number of years as a social service provider.	-.934	.126	-.113	-.742	.461
	R^2		.031			
	F		.001			

a. Dependent Variable: Practice

4.3.3 Linear regression analysis for age and year of experience predicting practice

With the assumption that age and year of experience might have a relationship with the practice of clinical social service providers incorporating religion and spirituality, I did a simple linear regression. As indicated in table 10, both age (β=-.282, p>0.05) and year of experience (β=-.934, p>0.05) were not found to be significant predictors of practice. The result implies that

31% of change in practice is attributed to change in age and year of experience. When we look at the percentage, it was not found to be statistically significant. The unstandardized coefficient for age (β=-.282) and year of experience (β=--.934) means that for every year increase in age of the professional, there is a -.282 point increase in practice. For every year increase in work experience, there is -.934 point decrease in practice.

In addition, a multiple regression was run to determine the inclusion of religion and spiritual concepts in practice from the attitude of practitioners. The R value is .698 which demonstrates a slightly high degree of correlation. TheR^2 value indicates that there is a 48.7% variation in practice that can be explained by the change of attitude possessed by practitioners.

4.3.4 Multiple regression analysis for attitude predicting practice

Table 13.Multiple regression analysis for attitude predicting practice

Model	Unstandardized Coefficient		Standardized Coefficient	t	Sig
	B	Std .Error	Beta		
1(Constant)	-54.650	12.826		-4.261	.000
Attitude	2.148	.274	.690	7.848	.000
R^2		.487			

a. Dependent Variable: Practice

b. Predictors: (Constant), Attitude

The table above indicates that the regression model predicts the dependent variable, which is the inclusion of religion and spirituality in social service provision (practice), significantly well. The statistical significance of the regression model that was run shows that $p<0.0005$, which is less than 0.05, and indicates that, overall, the regression model statistically significantly predicts the outcome variable.

5 DISCUSSIONS AND CONCLUSIONS

5.1 Discussion of Major Findings in the Context of Previous Literature

This study constitutes three main parts. The demographic survey, the attitude survey and the practice survey. The demographic survey is designed to determine factors that could influence respondents' choice of answers and entail information about gender, educational qualification, current area of work and institutional work setting. The attitude survey was included to assess the outlook held by social service providers in terms of incorporating religion and spirituality as one form of intervention in clients' cases. The last one, the practice survey, reviews the extent to which social service providers embrace religion and spirituality as one method of helping clients in practice. The surveys provide answers to the research questions raised.

5.1.1 Major Descriptive Findings

A total of 67 respondents participated in the survey. The demographic data revealed that the professionals who responded to this survey were predominantly female accounting for more than half of the clinical service providers. This could be an indication that a profession in social service provision is more preferred by women. With respect to age, the finding reveals that organizations that provide clinical social service are staffed with adults. Almost half of the respondents comprised of people between the ages of 30-40. The overall respondents age range from 24 to 56. Close to half of the respondents have been serving as a clinical service provider for 5 to 8 years. This suggests that the considerable year of experience observed provides practitioners the opportunity to develop essential skills for a good social service provider. Although both age and year of experience were not found to be significant predictors of attitude, the result obtained showed that 31% of change in attitude and practice is attributed to change in

age and year of experience. For every year increase in age of the professional, there is a 0.60 point increase in attitude and -.282 point increase in practice. This may be a result of the inherent human nature to grow more religious or spiritual as one's age increases which is in turn reflected in their attitude. "Research to date seems to support the common-sense observation that inclination to spiritual matter increases with advancing age" (Moody, 2006, p.2). On a different note, the study's finding shows that for every year increase in work experience, there is -.544 decrease in attitude and -.934 point decrease in practice. This suggests that clinical service providers have the tendency to strictly follow a secular model as they stay longer in clinical service programs rather than accommodate religion and spirituality as an intervention method.

All of the participants of the survey claimed to have a specific religious orientation. This finding suggests that clinical service providers in Addis Ababa have evident attachment to organized form of religion than merely describing themselves as spiritual. In terms of education, 43 respondents (64.2%) identified "Bachelor's Degree" as their highest education level; 12 respondents (17.9%) indicated their highest education level to be "Diploma" while the remaining 12 participants (17.9%) held a "Masters Degree & above". This reveals that most practitioners in Addis Ababa may not feel the need to advance their studies beyond first Degree and hence do not specialize in one particular subject. The prospects of advancing to a higher education such as masters or doctoral degree, seems to be limited among service providers leaving room for an outdated knowledge in the field. More than a third quarter (83.6%) of the participants worked in secular organizations while the rest (16.4%) were from religious establishments. This implies that the number of sectarian institutions as clinical service providers is small when compared to secular organizations in Addis Ababa. Although a more consolidated study is required to assert this claim since this finding could be a result of the study's sampling method. With regard to

acquiring formal and non-formal training on religion and spirituality, 58.2% of the respondents had non-formal training on the two concepts while 41.8% had attended formal training. This is an indication that education provided to health professionals does not adequately address the issue of religion and spirituality in formally organized courses. Accordingly, clinical service providers have limited exposure to formal training on the two concepts which may lead to lack of proper knowledge on how to handle the issue and force them to refrain from engaging in these sorts of interventions.

This research attempted to look at practitioners' attitude towards religion and spirituality as a potential predictor of their practice. Respondents filled out Sheridan's 14 item instrument using "Strongly agree", "agree", "neither agree nor disagree", "disagree" and "strongly disagree". The descriptive data indicated that practitioners agreed to the use of interventions such as *recommending religious or spiritual forgiveness, amends or peace, recommending participation in a religious or spiritual program, gathering information on the client's religious or spiritual background, referring clients to a religious or spiritual, praying privately for a client and using or recommending religious or spiritual books or writings.* This could be for the reason that interventions such as *gathering information on the client's religious or spiritual background* is mandatory in some clinical services. This finding supports the existing literature and a study conducted by Bullis (2013) "The interventions rated by the highest percentage of respondents as being professionally ethical and personally comfortable included exploring the client's spiritual background". The rest of the intervention methods mentioned above (*recommending religious or spiritual forgiveness, amends or peace, recommending participation in a religious or spiritual program, referring clients to a religious or spiritual, praying privately for a client and using or recommending religious or spiritual books or writings)* are more utilized than others perhaps for

the main reason that they do not require an in-depth knowledge of religion or spirituality from the practitioners side. They are mostly centered on recommendations and would not create any inconveniences and make professionals feel that they are exercising beyond their area of expertise.

Practitioners had an indifferent attitude towards practices such as *using religious or spiritual language or concepts with a client, helping clients clarify their religious or spiritual values, helping clients develop a spiritual ritual as a clinical intervention (houseblessing, visiting graves of relatives), sharing their own religious or spiritual beliefs or views, praying or meditating with a client, performing exorcism (expelling evil spirits), participating in client's rituals as a clinical intervention and touching clients for healing purposes.* The need for a profound knowledge and understanding of religion and spirituality prior to engaging in these intervention methods may have prohibited practitioners from employing them at all as they have limited formal training on the concepts.

The outcome variable in the study was the practice of clinical service providers. To assess this variable, respondents filled out Sheridan's 14 item instrument using percentages (0-10%, 11-20%, 21-30%, 31-40%, 41-50%, 51-60%, 61-70%, 71-80%, 81-90%, 91-100%) that expressed the frequency of religious/spiritual intervention implementation in clients' cases. In this case, the most prominently used interventions were found to be *recommending religious or spiritual forgiveness, amends or peace* (M=5.46, SD=3.59), *gathering religious or spiritual background information from clients* (M=5.27, SD=3.91), *recommending participation in a religious or spiritual program* (M=4.19, SD=3.31) and *recommending religious or spiritual books or writings* (M=3.52, SD=3.17). Interventions such as *touching clients for healing purposes, participating in clients' rituals as a clinical intervention, praying or mediating with*

clients and *performing exorcism (expelling evil spirits) (M=0.97, SD=0.81)* were found to be the least used interventions. This research's finding is consistent with a study conducted by Bullis (2013) on Virginia clinical social service providers. The study has revealed that the four most frequently used interventions are *exploring a client's spiritual/religious backgrounds*, *clarifying the client's spiritual values* and *recommending participation in spiritual programs*. The three interventions used most infrequently are *performing exorcisms*, *touching clients for healing purposes* and *reading scriptures with clients*.

5.1.2 Testing the Hypothesis

A. Personal factors in influencing attitude and practice

The study's first and fourth research questions attempt to uncover if any of the personal factors (gender, age, year of experience, training on religion and spirituality, type of religion and education) are associated with a practitioner's positive or negative attitude towards the inclusion of religion and spirituality in the process of helping clients and including these two concepts in practice. Findings highlight that there is no strong correlation between personal factors (gender, age, education, year of experience and type of religion) and practitioners' attitude and practice in including religion and spirituality in their interventions with clients. An independent samples t test shows that although there is no statistically significant mean difference among practitioners that have attended formal training and those who attended non-formal training, those who have taken part in formal training integrate religion and spirituality in practice more than professionals who have had non-formal training. This could be as a result of a formal training being more potent since it is a scientifically proven way of teaching about spirituality and religion. A considerable number of professionals may think that religion and biological interventions in medicine may not go hand in hand but when affirmed through academic training, they become

more convinced. When it is non-formal training however, practitioners may feel like they are tress passing a medical border and be hesitant to include religion/spirituality in interventions.

B. Attitude and practice by institutional work setting

My second and fifth research questions seek to discover whether the attitude towards the inclusion of religion and spirituality in social work practice differs by institutional work setting (religious or secular and governmental or non-governmental). This hypothesis supposes that the attitude of practitioners towards these two concepts and their practice is determined by their institution's work setting. According to my finding, in cases where the practitioners are active in governmental or non-governmental establishments, no significant difference has been observed in terms of attitude and practice. Professionals in both settings had an indifferent attitude towards the two concepts and they utilized them in less than 50% of their cases. This suggests that the extent to which clinicians agreed on the use of religion and spirituality as a helping method with clients does not show a big variation regardless of the institutions work setting (governmental or non-governmental). Conversely, there was a noticeable difference in the attitude and practice among employees of religious versus secular organizations. Social service providers in religious establishments agreed towards using religion and spirituality while those in secular establishments were indifferent about the concept. There was also a substantial difference in practice as professionals in secular organizations utilized religion and spirituality in more than 75% of the cases they encounter while those in secular establishments implemented the two concepts in less than 50% of the time. This may be a result of the philosophy of religious institutions being more resilient to religious interventions and the very same motive of their foundation in what drives them to help people. The Encyclopedia of Social Work states that sectarian agencies' are often affiliated with particular religious denominations and therefore are

flexible to different ways of addressing clients' problems. "Many religious organizations are not bound by red-tape and can easily experiment with new methods of care." (The Encyclopedia of Social Work, p. 441) Another explanation for this finding could be the nature of clients that come seeking help. People who come to religious institutions in search of cure are mostly aware of the organization's underpinning motive for establishment. With that understanding in mind, they may solicit for a religious or spiritual based intervention and have the acceptance towards practitioners' incorporating the two concepts in the helping process. It could also be that religion and spirituality is usually utilized following a request by the client himself/herself rather than with the practitioners' own initiation. This provides service providers a less challenging situation to introduce religion and spirituality in supporting clients given that there will be no resistance from the client's side. In addition, practitioners' engage in intervention methods based on the client's area of strength. If religion and spirituality are found to be the client's area of strength, the service provider will proceed in implementing it. According to Zastrow, 2009, in working with clients, social service providers focus on the resources and strengths of the clients to help them resolve their difficulties while he also asserts that "religious and spiritual organizations can be the source of support for clients because they can provide a sense of belonging, safety, purpose" (Zastrow 2009, p. 313) A supplementary argument is the predisposition of religious organizations to hire people that exhibit behavior consistent with the religious practices of the institution which in turn will influence their practice.

In secular institutions however, even when the practitioners have a positive attitude towards the two concepts, they can't incorporate it because of the organization's setting and policies to be free of any religious biases. Ergo, the result from research hypothesis two revealed that institutional work setting (religious or secular) do indeed significantly predict practitioners'

attitude towards the inclusion of religion and spirituality. This suggests that clinical social service providers' attitude is highly adhered to the condition of their work environment. A supportive and reassuring work environment, to incorporate religion and spirituality in intervention, or lack thereof poses an impact on the attitude of social service providers. Therefore, we can infer that regardless of the practitioners view, the institution's philosophy is a determinant factor in practitioners' decision to use religious/spiritual interventions.

C. Attitude and practice by service type

My third and sixth research questions raise the issue of difference in attitude and practice of clinical social service providers in integrating religion/spirituality in helping clients by service type. Findings from my survey indicate that practitioners' attitude did not show any variation regardless of the service type. However, in the specific case of integrating religion and spirituality in practice, professionals in the field of child care agreed to use these concepts more than those in the field of mental health and HIV/AIDS. In line with this finding, a substantial body of research suggests religion and spirituality play an important role in the lives of children than adolescents. One perspective proposes that "spirituality is based on sensory experience and that childhood, in particular, is a unique time of enhanced spiritual awareness" (Hay, Nye, & Murphy, 1996; Levine, 1999; Nye & Hay, 1996).

In the specific case of mental health, religion is either the answer or the problem. Mental health practitioners' indifferent attitude towards using religion and spirituality in practice may have emanated from the reason that religion and spirituality are sometimes the causes of psychological distress in some clients rather than serving as a solution. This goes in line with Koenig's (2009) statement that religion does not always promote better mental health and stronger social relationships. Koenig who has done researches on how religion affects mental

health and well-being for twenty years believes that religion may "restrict personal growth by promoting rigid thinking or may foster an attitude of self-righteousness. Religion may be used maladaptively or neurotically to block therapeutic interventions, and may even discourage professional help altogether." In other instances, mentally ill people believe that they possess some sort of divine power making interventions using religion and spirituality unimaginable. This goes to show that while there has been relatively consistent support for a positive relationship between well-being and intrinsically motivated religious or spiritual intervention, the outcome is not always positive. An additional argument could be the impairment of mentally ill people's ability to think logically. Clients with these kinds of cases could be rarely capable enough to understand and interpret the benefits of religion and spirituality.

In the field of HIV/AIDS, practitioners have shown an indifferent attitude even more than those in mental health. This suggests that although spirituality and religion are often central issues for patients dealing with a chronic illness like HIV/AIDS, a growing awareness about the disease on how people can cope with it using antiretroviral drugs may have altered the society's view of the disease in general and its coping mechanisms. Moreover, practitioners are less favorable towards religion and spirituality intervention probably for the fear that patients may deviate from taking their antiretroviral drugs and solely focus on religious interventions like the Holy water or group prayers. Religious leaders encourage patients to adhere to religious interventions only, as balancing biological interventions with religious ones simultaneously shows lack of faith. In addition, clients may not be open to religious and spiritual interventions as it may be a cause of discomfort to them rather than support. Koenig, 2009 argues that "Religion may induce excessive guilt, shame and fear with its prohibitions against unacceptable behavior. It can foster social isolation and low self-esteem in activities sanctioned by the religious

community." Intervention methods may also generally be influenced by the client's attitude towards religion and spirituality and the integration of these two concepts may be based on the initiation of clients.

Looking at it from the practitioners' perspective in general, they may have tended to feel uncomfortable or unqualified to address issues of religion and spirituality with clients.

D. Relationship between attitude and practice

The relationship between professionals' attitude and their practice was the focus of my seventh research question. My findings highlight that the more positive a practitioner's attitude is towards religion and spirituality, the higher his/her integration of the concepts in practice was. This suggests that attitude is a predictive factor of practitioner's behavior. My finding is parallel to the results of three investigations made by Heyman et al., 2006, Murdock, 2005 and Sheridan 2004 which suggested that "positive practitioner attitudes toward the role of religion and spirituality in social work were predictive of higher intervention use (Heyman et al., 2006; Murdock, 2005; Sheridan, 2004)."

5.2 Limitations of the study

Findings of this study must be interpreted from the point of its limitations. These limitations primarily involved sampling issues, data-collection methods, and scales used. First, the study utilized a stratified random sampling of clinical practitioners. The very fact that there are no established groups of clinical service providers posed a challenge as to where to get a good enough sample to draw acceptable participation. The study relied on the membership of ESSSWA and randomly identified practitioners in Addis Ababa. Therefore, the sample was a small predominantly female and Orthodox Christians, mostly from secular organizations. Among the different clinical service types, this study's data emerged from practitioners in the field of

HIV/AIDS, mental health and child care. As such, the respondents are not representative of all clinical service providers in Addis Ababa, Ethiopia.

Secondly, the use of Qualtrics online survey, employed to gather data may have impaired detail understanding of the questions posed. This limitation was partly addressed at a later stage of my data gathering as I switched to pen-and-paper survey which provided me to have face to face conversations with respondents. The online survey also prevented me from identifying respondents that are from Addis Ababa.

Thirdly, the instrument used in this study, the "Role of Religion and Spirituality in Practice" Scale (RRSP), did not cover the aspect of number of cases that require religious/spiritual interventions in Addis Ababa. This would have provided a more definite view of the disparity between the need for religious/spiritual interventions and the existing practice. Furthermore, a pretest was not conducted to evaluate the suitability of this research's instrument to the Ethiopian context.

5.3 Conclusion

Sixty-Seven clinical social service providers working in Addis Ababa responded to a questionnaire that explored two areas – attitude towards religion and spirituality and the use of religious or spiritually integrated interventions. Findings from this study revealed that these professionals' outlook on and the use of spiritually integrated interventions are mostly indifferent. However, practitioners in religious/faith based establishments mostly agreed to the use of religion/spirituality in practice, utilizing it in 75% of their cases as opposed to those working in secular institutions. With regard to service type, religion/spirituality were practiced more by practitioners in childcare program than in the field of HIV/AIDS and mental health. Results from the data analysis clearly identified practitioners' professional attitudes toward the

role of religion and spirituality in social service as the most important predictor of intervention in this sample.

6 SOCIAL WORK IMPLICATIONS

This study has various implications in terms of research, practice, education and policy. Researches that probe into the effects of religion/spirituality in clinical social service to treat illnesses among the population in Ethiopia can never be considered enough. Data in this area need to be consolidated greatly to help meet public health demands and ensure optimal care delivery for those whose health issues are best addressed through these interventions. In this regard, this study has provided a clear description of clinical social service providers' perception with regard to religion and spirituality. It has also revealed the extent in which these two concepts are integrated in practice in the field of HIV/AIDS, mental health and childcare in Addis Ababa. The reasons for the presence, or lack thereof, of these interventions in dealing with clients have also been discussed in the study. With regard to its *research implications*, the findings of this study could serve as a spring board for future researches that seek to ask for anecdotal experiences of clients who have requested for religious/spiritually integrated interventions from practitioners to answer decisive questions such as: Is religion/spirituality an effective tool in clinical service provision in Addis Ababa? Which clinical service requires the support of these interventions? How can ethical issues and boundaries be addressed in the process of helping clients using religion and spirituality? Furthermore, in terms of methods, the study provides a clear picture of what religious/spiritual interventions involve in Addis Ababa, through the list of interventions incorporated in the instrument used to collect data.

According to the scale used for this study, clinical service practitioners in Addis Ababa seem to demonstrate a low utilization of religious/spiritually-integrated interventions. This

finding contradicts to some extent with Collins, Jordan and Coleman (2009) among the many writers that claim spirituality and religion are particularly important in aiding patients' path to recovery. Furness & Gilligan (2010) also asserted that "those affected by ill health and life crises may turn to religious or other belief systems as ways to support and comfort them in times of need, especially when conventional health treatment has failed to cure or aid recovery" (p. 37).Consequently, this study has *practice implications* suggesting that it would be difficult and inefficient for clinicians to provide a holistic service without taking the religious or spiritual convictions of clients into account. In addition, it is a way of empowering clients in the helping process. This implies that there should be a continued emphasis on person centered planning, interventions and outcomes in clinical service provision in Addis Ababa.

This study also has *educational implications*. The study revealed that most (58.2%) clinical service providers have not had any formal training on the topic of religion and spirituality. However, although not statistically significant, practitioners that have had formal training have utilized religion and spirituality more in practice as compared to professionals who had non-formal training. This could be for the reason that non-formal training does not equip them to work adequately with spirituality. This research's findings indicate that consolidated courses on religion and spirituality as an intervention method should be offered to clinical service providers during their academic stay. Alternative healing practices are more likely to address the patient's spiritual orientation and what is of ultimate importance to them. Therefore, incorporating courses on religion and spirituality can lead to a more enhanced knowledge on how to keep a holistic perspective as a clinical service provider and function competently in the required range of clients' settings. Education provided to would be practitioners should also include aspects of culturally competent practice.

Integration of Religion/Spirituality in Clinical Social Service

Findings of the study express that although there is no disparity seen in governmental and non-governmental organizations in terms of perception and attitude among service providers, there was a statistically significant difference among sectarian versus religious institutions. Workplace setting affects practitioners' attitude and practice. As a *policy implication*, this is suggestive of the fact that organizations that provide clinical services should modify their rules and regulations to be more receptive to the notion of incorporating religion and spirituality in practice and allow their practitioners the liberty to exercise this method. This will help to address the issues of patients that mostly rely on their religious/spiritual conviction.

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APPENDICES

Appendix A: Consent Form

Addis Ababa University

Research Information and Consent for Participation in Social Work Research

Research Title: The Use, Application and Integration of Religion/Spirituality in Clinical Social Service: The Case of Clinical Social Service Providers in Addis Ababa

Introduction and Purpose of Study:

My name is Serkalem Tafesse. I am a graduate student of Social Work at the Addis Ababa University. The survey that I am conducting is about the use, application and integration of religion and spirituality in clinical social service, specifically the inclusion of these interventions by health practitioners to assist the recovery process of clients. The survey will last for about 15 to 30 minutes. It includes two parts with the first part assessing the perception of health service providers and the second focusing on the respondents' actual practice. Demographic data will also be asked to establish a profile of practitioners. The information you share will be kept strictly confidential. Nothing with your name or other identifying information will be cited in the results. Once I have analyzed the survey and written the final results of this study, I will destroy the filled surveys.

By signing this consent form, I am indicating that I have had all of my questions about the survey answered to my satisfaction and that I understood the agreement of this consent form.

Participant's name and Signature:

_____

Date: _____

Researcher's name and Signature:

_____

Date: _____

Appendix B: Data Collection Instruments

The following questions are the first 14 items of the Role of Religion and Spirituality in Practice Scale (RRSP) developed by Sheridan (2000) to investigate social workers' beliefs on the use of religious/spiritual interventions with clients. Contents focus on the attitude and perception of social workers towards religion and spirituality.

For the purposes of this study, the definitions for religion and spirituality have been taken from this study's research instrument (Sheridan, 2000). Spirituality is defined as "the search for meaning, purpose and connection with self, others, the universe, and ultimate reality however one understands it. This search may or may not be expressed through religious forms or institutions" (Sheridan, 2000, p.20). Religion is defined as "an organized, structured set of beliefs and practices shared by a community related to spirituality" (Sheridan, 2000, p.20).

Part I

1. Please choose the extent to which you agree or disagree with the appropriateness of the following activities in individual therapy and fill in the table.

Gathering information on the client's religious or spiritual background

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
○	○	○	○	○

Using or recommending religious or spiritual books or writings

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
○	○	○	○	○

Praying privately for a client

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Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
○	○	○	○	○

Praying or meditating with a client

ngly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
○	○	○	○	○

Using religious or spiritual language or concepts with a client

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
○	○	○	○	○

Helping clients clarify their religious or spiritual values

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
○	○	○	○	○

Recommending participation in a religious or spiritual program

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
○	○	○	○	○

Referring clients to a religious or spiritual counselor

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
○	○	○	○	○

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Recommending religious or spiritual forgiveness, amends, or peace

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
○	○	○	○	○

Performing exorcism (expelling evil spirits)

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
○	○	○	○	○

Touching clients for healing purposes

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
○	○	○	○	○

Helping clients develop a spiritual ritual as a clinical intervention (houseblessing, visiting graves of relatives)

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
○	○	○	○	○

Participating in client's rituals as a clinical intervention

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
○	○	○	○	○

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Sharing your own religious or spiritual beliefs or views

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
○	○	○	○	○

Part II

The following questions are the second part of the 14-item Role of Religion and Spirituality in Practice Scale (RRSP) developed by Sheridan (2000) to investigate social workers' beliefs on the use of religious/spiritual interventions with clients. Contents focus on the practice of social workers with the inclusion of religion and spirituality as one form of intervention.

1. Please choose and underline the extent to which you engage in the following activities from the percentage provided.

hat percent of clients have you gathered religious or spiritual background information from?

0-10%, 11-20%, 21-30%, 31-40%, 41-50%, 51-60%, 61-70%,
71-80%, 81-90%, 91-100%, Not applicable

What percent of clients have you used or recommended religious or spiritual books or writings for?

0-10%, 11-20%, 21-30%, 31-40%, 41-50%, 51-60%, 61-70%,
71-80%, 81-90%, 91-100%, Not applicable

What percent of clients have you prayed privately for?

0-10%, 11-20%, 21-30%, 31-40%, 41-50%, 51-60%, 61-70%,
71-80%, 81-90%, 91-100%, Not applicable

What percent of clients have you prayed or meditated with?

0-10%, 11-20%, 21-30%, 31-40%, 41-50%, 51-60%, 61-70%,
71-80%, 81-90%, 91-100%, Not applicable

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What percent of clients have you used religious or spiritual language or concepts with?

0-10%, 11-20%, 21-30%, 31-40%, 41-50%, 51-60%, 61-70%,
71-80%, 81-90%, 91-100%, Not applicable

What percent of clients have you helped to clarify religious or spiritual values?
0-10%, 11-20%, 21-30%, 31-40%, 41-50%, 51-60%, 61-70%,
71-80%, 81-90%, 91-100%, Not applicable

What percent of clients have you recommended to participate in a religious or spiritual program?
0-10%, 11-20%, 21-30%, 31-40%, 41-50%, 51-60%, 61-70%,
71-80%, 81-90%, 91-100%, Not applicable

What percent of clients have you referred to a religious or spiritual counselor?

0-10%, 11-20%, 21-30%, 31-40%, 41-50%, 51-60%, 61-70%,
71-80%, 81-90%, 91-100%, Not applicable

What percent of clients have you recommended religious or spiritual forgiveness, amends, or peace?
0-10%, 11-20%, 21-30%, 31-40%, 41-50%, 51-60%, 61-70%,
71-80%, 81-90%, 91-100%, Not applicable

What percent of clients have you performed exorcism (expelling evil spirits) for?
0-10%, 11-20%, 21-30%, 31-40%, 41-50%, 51-60%, 61-70%,
71-80%, 81-90%, 91-100%, Not applicable

What percent of clients have you touched for healing purposes?
0-10%, 11-20%, 21-30%, 31-40%, 41-50%, 51-60%, 61-70%,
71-80%, 81-90%, 91-100%, Not applicable

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What percent of clients have you helped develop a spiritual ritual as a clinical intervention (house blessing, visiting graves of relatives)?
0-10%, 11-20%, 21-30%, 31-40%, 41-50%, 51-60%, 61-70%,
71-80%, 81-90%, 91-100%, Not applicable

What percent of clients' rituals have you participated in as a clinical intervention?
0-10%, 11-20%, 21-30%, 31-40%, 41-50%, 51-60%, 61-70%,
71-80%, 81-90%, 91-100%, Not applicable

What percent of clients have you shared your own religious or spiritual beliefs or views with?
0-10%, 11-20%, 21-30%, 31-40%, 41-50%, 51-60%, 61-70%,
71-80%, 81-90%, 91-100%, Not applicable

Please feel free to use this space to comment on your thoughts about the issue of religion and spirituality in practice in Addis Ababa.

_____

_____

_____

_____

_____

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Part III

Demographic Questions

1. Please identify your gender. _____
2. Please indicate your age. _____
3. Please state the type of organization you work in. (Governmental, non-governmental, private) _____
4. Please identify the type of work setting your organization practices. (Religious, secular)
5. Please identify the number of years you have worked as a social worker. _____
6. Please identify your primary work setting. (Community Mental Health Center, Education setting, Hospital, Justice Agency, Private practice, Substance abuse agency, Family and children,

Other (Please specify _____

7. Please identify and circle your social work training around religion and spirituality, if applicable.
   a. Took course in graduate course on religion/spirituality
   b. Idea of religion and spirituality was weaved into courses in graduate school
   c. Had significant coursework on religion and spirituality at graduate level
   d. Have attended training on the two concepts
   e. Have read about the topic
   f. None
8. Currently, do you have a religious affiliation or spiritual orientation? (Yes, No, other). If other, please specify. _____
9. If yes, please describe your current relationship to organized religion or spiritual support group.
10. Please choose the religion(s) or spirituality (ies) you may have identified with or currently identify with.

Christian Orthodox Muslim

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- ○ Christian Catholic
- ○ Evangelical Christian
- ○ Jehovah's Witness
- ○ Other