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A Dissertation Submitted to The Graduate School at the University of Missouri-St. Louis in
partial fulfillment of the requirements for the degree
Doctor of Philosophy in Psychology with an emphasis in Clinical-Community Psychology

August 2017

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Abstract

Religious beliefs are an important part of daily life for many individuals; however, these beliefs are often not discussed in therapy settings. As a result, clients and clinicians may encounter barriers to treatment and be unable to harness potentially beneficial aspects of the religious belief system. The current study investigated factors influencing client willingness to discuss religious beliefs with a therapist, with the factors of interest being perceived clinician cultural humility (PCH), religious outlier status (ROS), and religious commitment (RC). Participants in the current study (N = 535) completed measures assessing RC and ROS and viewed a five-minute clip depicting a therapy session in which the clinician was either high or low in cultural humility. They then rated their perceptions of clinician cultural humility and their willingness to discuss religious beliefs with the therapist depicted in the clip. It was predicted that PCH, ROS, and RC would each separately predict willingness to discuss and would significantly contribute to a full three-factor regression model. PCH was expected to be the strongest predictor in the full model, and significant interactions were expected between PCH and ROS and between PCH and RC. Results demonstrated that PCH and ROS significantly predicted willingness to discuss when considered separately, while RC did not. In the full model, PCH was both the strongest predictor and the only significant predictor, accounting for 36% of the variance in willingness to discuss. These results emphasize the importance of clinician cultural humility in establishing an open therapeutic environment. Moreover, they suggest that clients are more willing to discuss their religious beliefs with a clinician who is high in cultural humility than one who is not, regardless of more stable client factors such as religious commitment and religious outlier status. These findings have implications for training and clinical practice, as they suggest that cultural

humility may be more important than cultural competence in some therapy situations,

particularly when working with religious clients.

Keywords: religion, religious beliefs, cultural humility, religious commitment, religious

outlier status, therapy, clinical practice

Doctrinal Dialogues: Factors Influencing Client Willingness to Discuss Religious Beliefs

Psychological investment in a religious belief system is central to the lives of many individuals. Research suggests that roughly 76% of adults in the United States are affiliated with a specific religious belief system, and for those who are affiliated, religion is not typically an intermittent or casual interest (Pew Forum on Religious and Public Life, 2014; Rosmarin, Pargament, & Robb, 2010). According to the Pew Forum on Religious and Public Life (2014), 91% of religiously affiliated adults rated religion as important in their lives. Even amongst unaffiliated adults, religion was considered important by 30% of the sample (Pew Forum, 2014). Religious beliefs can influence how individuals make sense of their experiences and structure their identities (Park, 2013; Hodge, 2013; Rosmarin, Pargament, & Robb, 2010; Shafranske, 2013). Religion can both contribute to and provide a buffer against anxiety and isolation, and in many cases, religious beliefs offer moral and ethical guidelines for day-to-day actions (Soenke, Landau, & Greenberg, 2013). Those who consider religion to be unimportant and inconsequential in their own lives have almost certainly been exposed to religion through news media and social interaction.

Religious beliefs, despite their documented influence in the lives of many individuals, are often overlooked in clinical therapeutic settings. Unless clients are seeking therapy from clergy members or clinicians who specialize in religious issues, religious beliefs may not be assessed in therapy (Frazier & Hansen, 2009; Hodge, 2013). In a national study of 1000 clinical psychologists, researchers found that while 74% of the sample considered religious and spiritual functioning to be an important part of human adjustment, less than half reported regularly assessing their clients' religious beliefs (Hathaway, Scott, & Garver, 2004). Furthermore, 58% of the sample reported assessing religious beliefs with less than 50% of

their clients, with 12% never asking about religious beliefs at all. Frazier and Hansen (2009)

also found that clinicians were not often incorporating religious beliefs into therapy. Their

survey asked 96 clinical psychologists to estimate the frequency with which they use 29

religious/spiritual psychotherapy behaviors (RSPBs) using a 5-point Likert type scale (1 =

never, 5 = very often). RSBPs included actions such as assessing clients' religious/spiritual

beliefs, integrating religious resources into treatment, and using religious/spiritual factors in

case conceptualization. The psychologists in this study reported an overall mean utilization

rate of 2.67, placing the average usage between "rarely" and "sometimes" (Frazier & Hansen,

2009). The psychologists in this study also reported discussing religious issues with only 30%

of their clients. These findings suggest that religious belief discussions are occurring less

frequently in clinical settings than might be expected when one considers the prevalence of

religious beliefs in the general population.

Consequences of Ignoring Religious Beliefs

Failing to discuss religious beliefs can both contribute negatively to the therapeutic

process and prevent clients and clinicians from harnessing aspects of the belief system that

would be therapeutically beneficial. Clinicians who are working with religious clients risk

ruptures in the therapeutic relationship, premature termination, and poor therapy outcomes if

religious beliefs are not discussed (Hodge, 2013; Owen et al., 2014; Richards & Bergin,

2000). Religion is often viewed as an important piece of client cultural identity, and the

clinician's ability to act in a culturally competent manner is weakened when the client's

religious identity is unknown (Savage & Armstrong, 2010). Additionally, religious clients

often face unique challenges in therapy.

Some religious systems, for instance, emphasize an external locus of control and suggest that followers should rely on divine intercession rather than individual action when distressed (Carone & Barone, 2001; Cragun & Friedlander, 2012; Park, Edmondson, & Hale-Smith, 2013). Many common therapeutic interventions rely heavily on increasing the client's agency and sense of empowerment. Both clinician and client may become frustrated by lack of progress if the client feels unable to act. Similarly, clinicians and religious clients may encounter conflict based on epistemological approach. Clients who maintain a strong religious identity often use a faith-based system of knowing that runs counter to the empirical approach used in the field of psychology (Desimpelaere, Sulas, Duriez, & Hutsebaut, 1999; Worthington, 1988). As such, clinicians may attempt to use observable evidence to encourage change, while the client feels blocked by unobservable, faith-based factors. Evidence also suggests that, because religion provides structure and meaning, direct challenges to religious beliefs may create existential distress and severely disrupt client identity (Furrow, King, & White, 2004; Park et al., 2013; Schimel, Hayes, Williams, & Jahrig, 2007). These conflicts, when made explicit in the context of therapy, can be used to encourage collaboration and guide treatment decisions (Hodge, 2013; Pargament, Mahoney, Shafranske, Exline, & Jones, 2013; Savage & Armstrong, 2010). However, conflicts that remain hidden or equivocal may result in broken rapport and spontaneous termination (Knox, Catlin, Casper, & Schlosser, 2005; Pargament et al., 2013).

The negative impact of ignoring religious beliefs is often amplified for clients who demonstrate a strong commitment to their religious beliefs (Worthington & Aten, 2009). Religious commitment is typically defined as the degree to which individuals feel connected to and are influenced by their religious beliefs (Worthington, 1988). Clients who score high

on measures of religious commitment (more than one standard deviation above average) tend to interpret life events using a religious lens, and they demonstrate greater sensitivity to the religious perspective of their clinicians (Worthington, 1988; Worthington & Aten, 2009). Highly religious clients report feeling threatened when they perceive their clinicians to be non-affirming, and they are more likely than less-religious clients to resist intervention or spontaneously terminate therapy (Wade, Worthington, & Vogel, 2007; Worthington & Aten, 2009). While negative clinician responses to client beliefs can weaken rapport with a broad range of religious clients, highly religious clients may take affront to both negative responses and commonly-used, neutral responses (Gockel, 2011; Knox et al., 2005).

For instance, highly religious clients are more likely than their less religious counterparts to ask directly about the clinician's religious beliefs. A common therapeutic response such as "tell me about why my beliefs are important to you" may appear evasive to highly religious clients, and they may subsequently assume that the clinician will be unsupportive (Worthington, 1986; Thurston, 2000). Similarly, general statements such as "I consider all religions to be equally important" can be perceived by highly religious clients as a sign that the clinician will not appreciate the personal weight and importance of their belief system (Worthington & Aten, 2009). Researchers have noted that, even when clinicians offer ample support of client beliefs at a later point, early therapeutic ruptures may still result in resistance or termination (Thurston, 2000; Pargament et al., 2013).

Highly religious clients risk rejection and invalidation when broaching religious topics with clinicians (Shafranske, 2013). Because their beliefs are integral to identity, these clients are more likely than their less religious counterparts to experience strong negative reactions in response to invalidating comments (Shafranske, 2013; Worthington, 1988). Many highly

religious clients reported being afraid to bring up religious beliefs in therapy, and some

reported that they would not return to therapy with a clinician who did not address religious

beliefs in some way (Gockel, 2011; Pargament et al., 2013). Thus, while religious discussions

are meaningful across most therapeutic contexts, they are often critically important for clients

who endorse high levels of religious commitment.

A common assumption in the field of clinical psychology is that clients will bring up

the beliefs that are most important to them; however, this assumption does not often hold true

for religious clients. Evidence suggests that the clients who are most likely to rate religious

beliefs as highly important are also the least likely to raise these beliefs with a therapist (Knox

et al., 2005). In turn, when religious beliefs go unnoticed, therapeutic outcomes may be

limited due to incompatible intervention approaches, tenuous therapeutic rapport, or early

termination. These therapeutic limitations and challenges could be mitigated through open

discussions of client religious beliefs in therapy.

Benefits of Religious Discussions

Discussions of religious beliefs are not only important because they can lessen the

likelihood of negative therapy outcomes. Religious discussions are also associated with a

number of therapeutic benefits such as communicating respect for client preference and

increasing rapport (Pargament et al., 2013). Clients of varying levels of religious

commitment report a preference for clinicians who integrate religious beliefs into therapeutic

dialogue (Post & Wade, 2009, 2014; Rose, Westefeld, & Ansley, 2008). They express a

desire to openly discuss religious beliefs with their clinicians, and they endorse the

importance of religious discussions in therapy (Larimore, Parker, & Crowther, 2002; Post &

Wade, 2009; Vieten et al., 2013). In 2008, for instance, researchers found that 75% of a

sample of 74 university counseling center clients reported that they would prefer to discuss religious beliefs in counseling because they were central to worldview, essential for growth and healing, or relevant to clinical problems (Rose et al., 2008).

Attending to client religious beliefs demonstrates responsiveness to client desires and reflects an open stance toward the client's perspective. Religious clients also rate clinicians as more competent when they are able incorporate religious beliefs into treatment (Savage & Armstrong, 2010; Shafranske, 2013). As such, religious discussions can build therapeutic rapport and facilitate greater trust (Hodge, 2011). Relatedly, religious discussions allow clinicians greater understanding of how clients experience reality, and research suggests that therapeutic interactions that reflect an appreciation for client perspectives can enhance buy-in and therapy outcomes (Hodge, 2013).

Religion can also serve as a powerful coping mechanism for clients by providing social and emotional support, cultivating a sense of transcendent meaning, and helping them to make sense of stressful situations (Koenig, 2013; Pargament, 2007). The religious coping literature is vast, but overall, positive religious coping has been associated with desirable mental health indicators and positive psychological adjustment to stress (Pargament, 2007). A meta-analytic study conducted by Ano and Vasconcelles (2005) revealed that individuals who used religious coping strategies (e.g. religious reappraisals, spiritual support-seeking, prayer, etc.) typically experienced "…more stress-related growth, spiritual growth, positive affect, and higher self-esteem…" (p. 473). The adaptive use of these religious coping strategies may be facilitated through therapy, and clinicians who are informed about and attentive to client religious beliefs can more easily encourage coping strategies that are congruent with client worldview (Pargament, 2007). Of course, religious coping can also be

maladaptive (i.e. I am bad, therefore God is punishing me), but the negative effects of maladaptive coping cannot be addressed unless religious beliefs are openly discussed.

Beyond providing specific coping strategies, religious beliefs can provide clients with an organizing framework for their lives that increases resilience and may reduce the harmful impact of stressful events (Pargament et al., 2013). As stated previously, some religious systems emphasize surrendering one's will to a higher power (Carone & Barone, 2001). This focus on acceptance and faith can clash with Western psychology's focus on increasing personal control, but it can also provide added benefit when the two approaches are combined. Pargament and colleagues (2013) noted that "…problems in living generally contain elements of both controllability and uncontrollability…" and "…religious and spiritual resources provide an important complement to control-oriented strategies" (p. 7). An acceptance-based framework can also provide added emotional stability to those individuals who have limited controllable resources (e.g. impoverished, elderly, ill; Koenig, 2013).

Religious beliefs are sometimes dismissed in therapy because mental illness can be effectively treated using interventions that do not incorporate religion. While there are certainly a number of very effective non-religious interventions, it is generally accepted that religiously accommodative interventions are at least as effective as secular interventions, and religious adaptations to "traditional" interventions have been shown to increase therapy effectiveness in some cases (Worthington, Hook, Davis, & McDaniel, 2011). For instance, Propst and colleagues (1992) found that religious clients being treated for depression using a religiously-accommodative CBT protocol had greater symptom reduction than religious clients being treated with "traditional" CBT. The religiously-accommodative protocol also resulted in greater improvement in adaptive behavior and self-esteem. Even when religiously-

accommodative and secular interventions are equally effective in terms of general therapy

outcome, religiously-accommodative treatments provide spiritual benefits such as increased

spiritual well-being and strengthened faith that are not present in secular approaches

(Worthington et al., 2011). Thus, understanding client religious beliefs can be especially

beneficial for clients who are highly committed to their beliefs as it has the potential to

improve spiritual outcomes that are consistent with client values (Worthington et al., 2011).

Factors Influencing the Problem

It is clear that both clients and clinicians recognize the importance of religious beliefs.

Clients want to discuss these beliefs with clinicians, and religious belief discussions can have

an important impact on therapeutic process and outcomes, particularly for clients who are

high in religious commitment. There remains, then, the question of why religious beliefs are

not regularly discussed in therapy settings. There is no single answer to this question, but the

current research focuses heavily on answers that emanate from the clinician perspective.

Research suggests many reasons that clinicians may be hesitant to talk to clients about

religious beliefs, such as lack of training in religious issues, the historical discrepancies

between religious and psychological epistemology, fears of inadvertently offending or

imposing beliefs upon clients, and the belief that religious discussions should be handled by

clergy or other religious professionals (Frazier & Hansen, 2009; Hathaway, 2013; Pargament

et al., 2013; Richards & Bergin, 2000; Russell & Yarhouse, 2006).

These factors are certainly important in clarifying the sources of clinician hesitancy,

and they provide a springboard for increasing religious training and encouraging clinicians to

assess client religious beliefs. However, these results tell clinicians very little about *how* to

appropriately bring up religious discussions.   Knox and colleagues (2005) suggested that

rapport can easily be broken if clinicians do not approach religious beliefs in a way that is

nonthreatening. It is difficult to understand how to create a nonthreatening environment

without first having a clear understanding of client perspectives.

There is a paucity of research on client perspectives regarding religious belief

discussions in therapy, and the limited client-focused research that exists is largely qualitative

in nature, using interviews to thoroughly examine the perspectives of only a few clients

(Gockel, 2011; Knox et al., 2005; Rose et al, 2008). Qualitative approaches are useful, given

the complex nature of religious beliefs, but the small, somewhat homogenous samples used in

these studies severely limit external validity. Thus, while qualitative studies can suggest

client tendencies, it is difficult to develop broad practical implications from the results. A

small number of studies have used quantitative methods, though these studies are still limited

by small sample sizes and a focus on therapeutic outcomes rather than the therapeutic process

(Owen et al., 2014; Shafranske, 2013).

The lack of empirical research on client perspectives does not allow for a full

understanding of therapy as a collaborative process. Therapy naturally requires cooperation

and input from both client and clinician. As such, it is important to understand both the client

and clinician factors that may influence the inattention to religious beliefs. Though they

express a desire to discuss their religious beliefs in therapy, clients' are frequently hesitant to

bring them up (Gockel, 2011; Knox et al., 2005; Rose et al., 2008). It would be beneficial for

clinicians to know more about why this hesitation exists. The current study seeks to address

some of the gaps in the research literature by quantitatively investigating the factors that

influence clients' willingness to introduce and discuss their religious beliefs in session. We

have already established *religious commitment* as a likely contributor to a client's overall

willingness to discuss; however, there are other important factors that should also be considered. Specifically, *perceived clinician cultural humility* and *religious outlier status* are two key factors investigated in conjunction with *religious commitment* in the current study.

Perceived clinician cultural humility. The few studies that explore client perspectives suggest that clients harbor a number of fears about disclosing their religious beliefs, many of which are related to concerns about how the clinician will perceive them as a result of their beliefs (Gockel, 2011; Goedde, 2001; Knox et al., 2005). For instance, qualitative studies have indicated that clients fear being judged for their beliefs, being misunderstood, having therapists who are insensitive to religious beliefs, being inappropriately pathologized, and having therapists who impose their own religious beliefs (Gockel, 2011; Goedde, 2001; Knox et al., 2005; Rose et al, 2008). These fears are not unfounded, given the tension that has long existed between religion and psychology, but they may be mitigated by the degree of clinician cultural humility perceived by the client.

"Cultural humility" is defined by Hook, Owen, Davis, Worthington, and Utsey (2013) as the "ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to the [person]" (p. 2). This "other orientation" includes respect for cultural differences, lack of superiority, and general attunement to client heritage (Hook et al., 2013; Owen et al., 2014). Because religion is an important part of cultural identity for many clients, a therapist who is perceived as being high in cultural humility would appear open and respectful toward a client's religious beliefs. Furthermore, it is likely that clients with culturally humble therapists would feel less fearful when disclosing religious beliefs because they would expect the clinician to be understanding without passing judgment.

Cultural humility has historically been positively associated with both working alliance and therapeutic outcomes (Hook et al., 2013; Owen et al, 2014). In a research study investigating the importance of cultural humility within a therapeutic context, participants (non-client college students) who rated a hypothetical therapist as higher in cultural humility reported greater expectations regarding therapeutic effectiveness, a higher likelihood of developing a strong working alliance with the therapist, and a higher likelihood of continuing in therapy (Hook et al., 2013). Participants in this study also rated cultural humility as more important than a clinician's specific cultural knowledge or expertise. When similar studies have been conducted using current and former therapy clients, perceptions of the therapist's cultural humility have been consistently positively correlated with high-quality alliances and perceived improvement in therapy (Hook et al., 2013; Owen et al., 2014).

These results suggest that cultural humility has a positive impact on therapy overall, and Owen and colleagues (2014) theorized that clinician cultural humility is "foundational to clients' engagement in meaningful and purposeful work" (p. 92). From these findings alone, we might hypothesize that clients would be more willing to discuss religious beliefs with a clinician who is perceived as high in cultural humility. Research findings from studies focused on client perceptions of religious and spiritual issues in therapy also lend preliminary support to this hypothesis. Client participants in a number of qualitative studies have linked clinician openness to religious and spiritual beliefs with enhanced clinician credibility, greater trust between client and clinician, personal spiritual growth, and overall satisfaction in therapy (Gockel, 2011; Goedde, 2001). Additionally, Knox and colleagues (2005) found that the majority of clients in their sample reported that religious discussions were "…facilitated by clients' perception of therapists as open, accepting, and safe." Though these studies do not

directly address clinician cultural humility, they suggest that clients likely feel greater trust and stronger alliances when clinicians embody the qualities associated with cultural humility.

Religious outlier status. Another factor of interest when investigating client willingness to discuss religious beliefs is the client's self-perceived religious outlier status (ROS). Religious outlier status is defined as the degree to which individuals feel that their religious beliefs place them outside the "mainstream" (Larsen, 2001). Specifically, individuals who classify themselves as "religious outliers" believe their faith is not widely accepted, feel discriminated against because of their religious beliefs, and feel isolated from their community because their religious beliefs are not shared by others (Larsen, 2001). Clients who are high in religious outlier status may have difficulty discussing their beliefs in therapy because they do not expect to be affirmed. An especially important consideration for these clients may be match between client and therapist beliefs.

Research on client-clinician belief match has yielded mixed results in terms of therapy outcomes, though clients have often reported feeling greater comfort when they are aware that their clinicians' beliefs are similar to their own (Post & Wade, 2009; Worthington, 1988). Client-clinician mismatch has been associated with early termination in previous studies (Gockel, 2011; Knox et al., 2005), and some religious clients "refrained from discussing religious/spiritual topics until they were certain that their therapist shared similar beliefs" (Post & Wade, 2009, p. 138). Similarly, Knox and colleagues (2005) discovered that clients who decided against bringing up their beliefs in session cited discomfort related to fears of judgment and concerns about "differences" between client and therapist. For high ROS clients who believe their beliefs are outside the "mainstream," it is unlikely that a client-clinician belief match will exist, and the low probability of finding a match may encourage

clients to hide their beliefs in session. These clients may fear that a mismatch will result in

clinicians who are either completely unfamiliar with their belief system or, in cases of

especially marginalized groups, actively biased against their beliefs. In turn, clients who are

high in religious outlier status may feel that they can protect themselves from the

consequences of client-clinician mismatch (e.g. judgment, pathologizing) by simply refusing

to discuss religious beliefs. However, as stated previously, other negative consequences can

arise when religious beliefs are ignored (Hodge, 2013; Richards & Bergin, 2000).

High ROS clients would also likely have fears of stigma and judgment that extend

beyond those associated with mismatched client-clinician belief systems. Using qualitative

interviews, Gockel (2011) found that many clients endorsed fears of being perceived as

"crazy" or "out there" if they shared their beliefs with clinicians (p. 161). These findings are

not surprising in light of the perceived tension between religion and psychology. Religious

beliefs have historically been stigmatized and pathologized within the field of clinical

psychology, and religious clients have reason to be cautious when revealing their beliefs

(Desimpelaere et al., 1999). Thus, religious clients are already aware that their beliefs may

not be "mainstream" within the field of psychology, and this awareness is amplified for high

ROS clients. Clients who believe they are religious outsiders feel separate, misunderstood,

and judged not only in the therapy room, but in society as well. The fears of judgment that

might be present for any religious client would be even more salient for religious outsiders

because they do not feel their beliefs "fit" with their clinician, their community, or their

country. As such, high ROS clients may be more motivated to protect themselves and conceal

their beliefs than low ROS clients because they have lower overall expectations for

acceptance.

Intersecting Factor Relationships

It is clear that religious commitment, perceived clinician cultural humility, and religious outlier status are relevant in the current study, and they are each likely contributors to client willingness to discuss religious beliefs. Research also suggests, however, that these factors may interact with one another in ways that uniquely influence clients' willingness over and above the expected main effects.

Cultural humility and religious commitment. As stated previously, clients' self-rated religious commitment can influence the degree of fidelity and trustworthiness that they ascribe to their clinicians, and studies have shown that level of religious commitment can interact with cultural humility to impact therapy (Owen et al., 2014, Worthington & Aten, 2009). For instance, Owen and colleagues (2014) found that while clinician cultural humility was positively associated with therapy outcomes in general, it was of greater importance when clients were high in religious commitment. Specifically, results showed that there was a strong positive relationship between clinician cultural humility and therapy outcome for clients with higher levels of religious commitment ($p = .006$). For low commitment clients, however, clinician humility was not significantly associated with outcome.

While Owen and colleagues (2014) theorized that clinician cultural humility acted as a mechanism of change in the therapy process by resonating with clients' sense of self and increasing motivation, the question of precisely how this mechanism operated was not answerable within the scope of the study. The current study seeks to focus on the therapy process by examining the relationship between perceived clinician cultural humility and religious commitment in the context of clients' willingness to discuss religious beliefs. The results of Owen and colleague's (2014) study suggest that clients who are especially

committed to their religious beliefs feel vulnerable in therapy, and they would understandably feel threatened by a non-affirming, less culturally humble clinician. Conversely, highly committed clients who perceive their clinician to be high in cultural humility would likely expect positive religious belief support and validation in a way that would not be as salient to less committed clients. Thus, highly committed clients would likely be very willing to discuss their beliefs with a culturally humble therapist and much less willing with a non-culturally humble therapist. Low commitment clients, being less bound to the importance of their religious beliefs, would likely be less sensitive to clinician cultural humility simply because their beliefs are less salient. Low commitment clients would also feel less threatened when raising their beliefs with a clinician because their beliefs are not the guiding force in their lives. While low commitment clients may still feel more comfortable when they perceive their clinician to be culturally humble, it is unlikely that they would experience a drastic difference in willingness to discuss their beliefs based on perceived clinician cultural humility.

It was expected, in the current study, that the positive relationship between perceived clinician cultural humility and willingness to discuss religious beliefs would be stronger and more pronounced among participants who are high in religious commitment as compared to those who were low in religious commitment.

Cultural humility and religious outlier status. Perceived clinician cultural humility may also interact with religious outlier status (ROS) to influence client willingness to discuss religious beliefs. In their 2014 study, Owen and colleagues noted that clinician cultural humility may play a large role for clients who identify with marginalized religious groups. Results showed that clinician cultural humility was strongly correlated with therapeutic

outcome for highly religious clients, though Owen and colleagues (2014) suggested that different "types" of highly religious clients, such as those from marginalized religious groups, might be even more sensitive to the impact of clinician cultural humility because they are more vulnerable. Additionally, Knox and colleagues (2005) found that clients' perceptions of client-clinician religious belief mismatch were less salient when clients perceived their therapists to be "open, accepting, and safe" (p. 14).

These results suggest that clinician cultural humility is more salient to high ROS clients than it is to low ROS clients. Like clients who are highly committed to their religious beliefs, clients who are high in ROS feel vulnerable in therapy settings, and this vulnerability likely heightens their awareness of clinician cultural humility. High ROS clients are aware that their religious beliefs do not match societal norms, and in turn, they are likely to expect a client-clinician mismatch in which their beliefs are neither familiar to nor accepted by the clinician. Depending on their experiences with discrimination, these clients may even expect their clinician to be actively biased against their religious belief system. Low ROS clients, believing that their religious beliefs are widely accepted, would likely experience less overt concern regarding match, familiarity, and bias, when bringing up their beliefs with clinicians.

When perceived clinician cultural humility is high, high ROS clients would likely be less focused on the potential for a client-clinician belief mismatch. Like highly committed clients, high ROS clients are likely to expect religious belief support and validation from culturally humble clinicians in a way that would not be salient to low ROS clients. High ROS clients tend to expect rejection and misunderstandings in their everyday life (Larsen, 2001), and because of this expectation, they are likely to feel especially positive toward a clinician that is perceived to be open and understanding. In turn, willingness to discuss religious

beliefs is likely to be higher than it would be for low ROS clients, who commonly expect their beliefs to be understood and accepted.

High ROS clients are also likely to withdraw more quickly than low ROS clients from clinicians who are low in cultural humility. Again, because these clients expect rejection and bias, they are likely to be sensitive to any signs that their clinician is not open to a wide variety of belief systems, and they will likely be very hesitant to discuss their beliefs with a non-affirming clinician. For low ROS clients, the threat of non-affirmation is less salient. Even if the clinician is not open to all beliefs and is perceived as low in cultural humility, low ROS clients are more likely than high ROS clients to find a client-clinician belief match and general acceptance, simply because their beliefs are more widely accepted in society. Taken together, these assumptions suggest that the positive relationship between perceived clinician cultural humility and willingness to discuss religious beliefs will be stronger and more pronounced among participants who are high in religious outlier status as compared to those who are low in religious outlier status.

Present Study

The aim of the present study is to investigate perceived clinician cultural humility, religious commitment, and religious outlier status as they relate to client willingness to discuss religious beliefs. Based on previous research and theoretical understanding, we propose the following hypotheses:

1.   Perceived clinician cultural humility, religious commitment, and religious outlier status will predict willingness to discuss religious beliefs.

    a.   When considered in a single model, perceived clinician cultural humility, religious commitment, and religious outlier status will all significantly and uniquely contribute to willingness to discuss religious beliefs.

    b.   Perceived clinician cultural humility will be the strongest predictor of willingness to discuss religious beliefs, accounting for a greater amount of variance in willingness to discuss than either religious commitment or religious outlier status.

    c.   Perceived clinician cultural humility, as a single variable, will significantly predict willingness to discuss religious beliefs.

    d.   Religious outlier status will significantly predict willingness to discuss religious beliefs.

    e.   Religious commitment will significantly predict willingness to discuss religious beliefs.

2.   There will be a significant interaction between perceived clinician cultural humility and religious commitment such that the positive relationship between perceived clinician cultural humility and willingness to discuss religious beliefs will be magnified among participants who are high in religious commitment.

3.   Similarly, there will be a significant interaction between perceived clinician cultural humility and religious outlier status such that the positive relationship between perceived clinician cultural humility and willingness to discuss religious beliefs will be magnified among participants who are high in religious outlier status.

Method

Participants

Participants were recruited through two sources: the online undergraduate research participant pool at the University of Missouri-St. Louis (SONA Systems), and advertisements posted to websites, including Craigslist and Amazon Mechanical Turk. Participants were eligible for the study if they were over 18 years of age and affiliated with a religious belief system or religious community. Participants recruited from the SONA system had the option of receiving course credit as compensation for their participation. Participants recruited from Craigslist and MTurk had the option of entering a drawing for one of five $100 gift cards. Participant identities were kept confidential, and their identities were not directly linked to their responses. Participant contact information was collected to ensure proper distribution of credit or compensation, but this information was stored in a file separate from raw data.

Measures

Demographics. Each participant completed a brief questionnaire including information concerning age, ethnicity, gender, sexual orientation, education, employment status, socio-economic status, and religious affiliation. All demographic questionnaire items are listed in Appendix A.

Religious commitment. Participants' religious commitment was measured using the Religious Commitment Inventory-10 (RCI-10; Worthington et al., 2012). The RCI-10 is a 10-item, self-report measure that assesses the degree to which individuals feel connected to and are influenced by their religious beliefs, values, and practices. Sample items include "Religious beliefs influence all my dealings in life" and "I enjoy spending time with others of my religious affiliation." A 5-point Likert-type scale (1=Not at all true of me; 5=totally true

of me) is used to rate the degree to which each statement applies to the participant. Responses

to the RCI-10 yield a full-scale Religious Commitment Score. Full-Scale scores can range

from 0 to 50, with scores of 38 or higher signifying "highly religious" participants. The RCI-

10 has been validated using large, diverse samples that include participants of varying ages,

ethnicities, and religious backgrounds. Most notably, the RCI-10 has reliably assessed

religious commitment in Christian, Hindu, Muslim, Buddhist, and Non-religious students,

suggesting that the scale may be used with participants from a variety of religious belief

systems. The RCI-10 has demonstrated good internal consistency ($\alpha = .96$), and scores on the

RCI-10 have been strongly correlated with self-rated religious commitment ($r = .84$) and

frequency of religious service attendance ($r=.74$; Worthington et al., 2012). In the current

study, RCI-10 items demonstrated a Cronbach's Alpha coefficient of $\alpha = .94$.

Perceived religious outlier status. Participants' religious outlier status was measured

using an adapted version of an unnamed 3-item scale first developed for use in a large-scale

telephone survey study conducted by Larsen (2001) in conjunction with Princeton Survey

Research Associates and the Pew Research Center's Internet and American Life Project. This

scale measures the degree to which participants feel that their religious beliefs place them

outside the "mainstream." Items on the original scale ask participants to rate their level of

agreement with statements concerning public acceptance of their religion ("I would describe

my religion or faith as widely accepted in this country"), discrimination associated with their

religious faith ("I have felt discriminated against because of my religious beliefs"), and the

presence of other individuals in the community who share their faith ("In the community

where I live, there are other people who share my religion or faith"). These 3 items were

retained in the present study; however, using prior research and theoretical understanding of

the ROS construct, 7 additional items were added to increase validity and to better capture

participant religious outlier status. The 7 additional items included questions regarding past

and current religion-based discrimination ("My religious group has been discriminated against

historically or in the past.") and perceived belief acceptance across a variety of settings ("My

beliefs make me feel like an outsider in society/my community/the therapy room.").

Response options were also adapted to create a uniform 5-point Likert-type response set. A

full list of items included on the Adapted Scale of Religious Outlier Status is included in

Appendix B.

The adapted 10-item ROS scale was pilot-tested using the first ten study participants.

Pilot-testing showed that the adapted ROS scale was internally consistent ($\alpha = .85$).

Similarly, Cronbach's Alpha for ROS items in the final sample also suggested strong internal

consistency ($\alpha = .89$). Though reliability and validity information were not available for the

original 3-item scale, all items are theoretically sound, and a number of religious experts were

consulted during survey construction (Larson, 2001).

Perceived clinician cultural humility. Perceived clinician cultural humility was

measured using the Cultural Humility Scale (CHS; Hook, Davis, Owen, Worthington, &

Utsey, 2013). The CHS measures the degree to which participants believe clinicians have the

ability to maintain an "other-oriented" interpersonal stance that is open to cultural differences.

Clinicians who are high in cultural humility are characterized by a respectful, open,

unassuming demeanor that persists even when significant cultural differences exist between

client and clinician. Using a 5-point Likert-type scale (1=Strongly Agree, 5=Strongly

Disagree), participants are asked to rate their agreement with items measuring both positive

(e.g. "I believe this counselor would be open to seeing things from my perspective") and

negative (e.g. "I believe this counselor would make assumptions about me") aspects of

cultural humility. Responses to the CHS yield a full-scale Cultural Humility Score. The CHS

has been validated using diverse samples, and the final 12-items were selected based on both

expert opinion and statistical soundness. The CHS has demonstrated adequate internal

consistency in prior research ($\alpha = .93$; Hook et al., 2013). CHS items in the current study

were also internally consistent ($\alpha = .94$).

Before completing the CHS, participants in the present study were asked to watch one

of two 5-minute clips (High or Low Cultural Humility). Both clips depicted a therapy session

in which a client and clinician discuss the client's reasons for seeking therapy. During this

discussion, the client describes concerns related to anxiety and discloses a key piece of her

cultural identity (homosexuality). Client and clinician were held constant across clips, as was

the majority of the spoken dialogue that was not associated with clinician cultural humility.

In the High Cultural Humility clip, the clinician demonstrated therapy behaviors that were

consistent with cultural humility, such as openness, acceptance, and a lack of superiority. In

the Low Cultural Humility clip, the clinician demonstrated therapy behaviors that were not

consistent with cultural humility, such as making assumptions about the client's experience

and being "closed-off" with respect to the client's cultural concerns.

Perceived clinician cultural humility was a primary variable in the present study, and it

was important for the client depicted in the clips to disclose some piece of cultural identity.

Though the current study focused on religious beliefs, there was a concern that participant

responses to the dependent variable measure would be unduly influenced if the client's

religious beliefs were included in the clips. Additionally, incorporating religious beliefs into

the clips would have risked narrowing the focus of the study and altering the operational

definition of cultural humility. Instead, the clips focused on the client's sexual orientation as the major cultural focus. Like religious belief, sexual orientation is often central to a client's day to day life, cannot be assumed based on visual appearance, and must be disclosed by the client. Researchers in the present study used items from the Cultural Humility Scale to shape the clinician's responses in both the high and low cultural humility clips.

Pilot-testing was conducted to establish the validity of the high and low cultural humility clips. The first 25 study participants were sorted into High CH (n = 14) and Low CH (n = 11) groups depending on which video clip they viewed. Participants rated the degree of cultural humility demonstrated in each of the clips using the 12-item Cultural Humility Scale (CHS; Hook, Davis, Owen, Worthington, & Utsey, 2013). Group means were calculated for the High CH (M = 50.14, SD = 7.21) and Low CH (M = 40.36, SD = 10.43) groups. Mean comparison analyses conducted using a one-way ANOVA demonstrated that the mean cultural humility scores for the High CH and Low CH clips were significantly different, $F(1,24) = 7.68$, $p = .01$. Mean comparison analyses for the full sample also showed a significant difference between the mean cultural humility scores for the High CH (M = 49.41, SD = 8.16) and Low CH (M = 38.85, SD = 11.41) groups, $F(1,535) = 152.68$, $p < .001$.

Willingness to discuss religious beliefs. Participants' willingness to discuss their religious beliefs with a therapist was measured using an adapted version of the Counseling Appropriateness Check List – Religious Concerns Subscale (CACL-R; Duckro, 1978). The full CACL (Warman, 1960) consisted of 100 items and was originally designed to measure the degree to which clients rate concerns from a wide variety of domains as appropriate topics for discussion in therapeutic settings. The Religious Concerns Subscale, isolated by Duckro (1978), includes 7 items that are specific to religious concerns, and participants are asked to

rate the appropriateness of each item for discussion using a 5-point Likert-type scale (1 = Definitely Inappropriate, 5 = Definitely Appropriate). Sample items include "Have conflicts about religion" and "Differing from my family in religious beliefs." Full-scale reliability and content validity have been supported through a number of studies (Miles & McDavis, 1982; O'Brien & Johnson, 1976; Welcove & Sharp, 1971), and Cronbach's alpha estimates for the Religious Concerns Subscale range from .81 to .83. The instructions for completing the subscale were altered to better fit the purposes of the present study. The response options were also adapted to reflect "willingness to discuss" rather than "appropriateness" (1 = Definitely Unwilling, 5 = Definitely Willing).

Research suggests that it may be helpful for clinicians to understand client religious beliefs even when there are no specific religious concerns (Worthington, 1988). Thus, three items were added to the CACL-R to assess participants' willingness to discuss religious beliefs in general. These three items include the willingness to discuss "my own religious beliefs," "the ways in which religious beliefs impact my mental health," and "using religion to cope with stress." Furthermore, one item ("having religious beliefs that are not well recognized in society") was added to assess concerns related to the religious outlier status variable. Cronbach's alpha for the adapted 11-item scale was $\alpha = .95$, suggesting strong internal consistency.

Procedure

The study was completed online, and each participant received an e-mail with a link to the survey site (Qualtrics Survey Software). Upon accessing the site, participants completed an informed consent document and were randomly assigned to one of two experimental conditions (High or Low Cultural Humility) by the survey software. All

participants then completed the demographic questionnaire, the Religious Commitment Inventory, and the Scale of Religious Outlier Status. Participants then viewed either the Low Cultural Humility clip or the High Cultural Humility clip. Participants rated their willingness to discuss their religious beliefs with the therapist depicted in the clip by completing the adapted Religious Concerns subscale of the Counseling Appropriateness Check List. Finally, as a manipulation check, participants rated the degree of perceived clinician cultural humility by completing the Cultural Humility Scale and answered an open-ended question addressing their awareness of the intentions of the current study and probing for suspicion (i.e. "What was this study about?").

Results

Quantitative analyses were conducted using the Statistical Packages for the Social Sciences (SPSS). A priori power analyses (three-factor hierarchical multiple regression: $f^2 = .10$, power $= .80$, $\alpha = .05$) indicated that detection of a moderate effect would require a sample size of at least 112 participants (Cohen, 1992; Fritz & MacKinnon, 2007).

Data Screening.

Eligibility for study. A total of 729 participants accessed the study (444 from an online undergraduate subject pool and 284 from online communities, including Craigslist, N=37, and Amazon Mechanical Turk, N=248). However, many participants dropped out before completing any measures because they did not provide consent to participate in the study or they did not identify with a particular religious group or community. These participants were removed from further analyses (N=134). The sample also included 19 participants who began the survey but did not complete one or more of the survey measures presented after the cultural humility video clips (CHS and CACL-R). Because these measures

represented key independent and dependent variables, the 19 participants who did not

complete the CHS or the CACL-R were removed.

Online data collection increases the potential for participants to complete the survey

quickly, to approach items carelessly, or to take the study multiple times to increase the

likelihood of receiving compensation. Thus, the dataset was visually screened for repeated IP

addresses and for exclusively high or low response patterns that should have been prevented

by attention check items. Two response sets were found to have duplicate IP addresses (1

duplicate, 1 triplicate; 5 response sets total).   To protect response validity and reliability, all

responses with duplicate IP addresses (both original and duplicate) were eliminated. Six

participants were removed due to exclusively high or low response patterns. An additional

three participants indicated that they completed all of the measures, but they were unable to

view the video clips due to technical difficulty. Their responses were rendered invalid

because they did not view the video stimulus, and these participants were eliminated from the

final dataset.

The survey included 5 items designed to check participants' attention, and participants

were eliminated if they failed three or more of the five attention check items. Prior research

on inattentive participants has suggested that removing participants who fail a single attention

check item can improve power (Maniaci & Rogge, 2014), but it can also increase the chances

of a biased sample (Berinsky, Margolis, & Sances, 2012). Thus, it was determined that

participants would only be removed if they failed the *majority* of attention checks. Fourteen

participants were eliminated due to failed attention checks.

At this point, the eligible sample consisted of 548 total participants: 334 from the

SONA system (student sample), 18 from Craigslist, and 196 from MTurk. Because the

Craiglist sample size was very small in comparison to the MTurk sample, the Craigslist and MTurk groups were merged into a single "Online" group (N=214) before performing group mean comparisons.

Group mean comparisons. Data were collected from two distinct sources (Online and SONA). T-Test group mean comparisons were conducted to determine whether data from these two sources should be separated before conducting primary data analyses. T-Test comparisons demonstrated that the Online and SONA groups mean total scores did not differ significantly on any measures necessary for primary analysis (RCI, ROS, CHS, and CACL-R). Data from the Online and SONA samples were thus combined and analyzed concurrently.

Preliminary Analyses

Missing data strategy. With regard to missing data, listwise deletion is acceptable so long as data are missing completely at random (MCAR; Howell, 2007) or variables contain missing data on fewer than 5% of cases (Tabachnick & Fidell, 2007). In both of these instances, removing cases with missing data is unlikely to bias the sample. An item-level Missing Value Analysis was used to perform Little's MCAR test and determine whether missing data can be considered missing completely at random. This test failed to reject the null hypothesis that the missing data is random for the RCI and CACL-R data, and we can assume that the missing data for these measures is MCAR. Little's MCAR did demonstrate patterns in the missing ROS and CHS data, and we cannot assume that the missing data for these scales is MCAR. It should be noted that Little's MCAR, when run at scale-level rather than item-level, failed to reject the null hypothesis. This result suggested that there is no pattern among missing total scores for each scale when the scales are compared to one

another. Separate Variance T-Tests also suggested that missing total score data were Missing at Random (MAR).

Less than 5% of participants had missing data on any one measure (RCI = 1.1%, ROS=2.7%, CHS = 4.9%, CACL-R = 3.8%), and missing total scores on scale-level data were shown to be missing completely at random. Imputation procedures would thus have minimal effect on the analyses (Tabachnick & Fidell, 2007). Missing data points on all variables were estimated using the Expectation-Maximization Algorithm, a type of maximum likelihood estimation that is robust, even when multivariate normality assumptions are not met (Howell, 2007).

Outliers. Z-scores were generated for each measure's total score to assist in the detection of univariate outliers. Cases were removed when the absolute value of the z-score was greater than 3.29 (Tabachnick & Fidell, 2007). Two outliers were identified in relation to the ROS total score, and these cases were removed from the final sample. Boxplots were also generated for each measures total score. Nine data points (three from ROS total scores, two from RCI scores, and four from CACL-R scores) fell beyond the outer fences of the boxplots. These nine cases were selected as outliers and subsequently removed from the data set.

Mahalanobis' distances were generated for the combination of RCI, ROS, CHS, and CACL-R variables to assist in the detection of multivariate outliers. Two participants violated the criterion Mahalanobis' distance (p < .01 with three degrees of freedom, chi-square distribution). The final sample to be used for remaining preliminary analyses and all main analyses contained 535 participants.

Distribution characteristics. Inspections of skewness and kurtosis statistics, Shapiro-Wilk statistics, and histogram distributions were used to examine univariate normality. Total scores on the RCI were approximately symmetrical, ROS scores showed a slight positive skew, and scores on the CHS and CACL-R showed a slight to moderate negative skew. The total scores for the ROS, CHS, and CACL-R were approximately mesokurtic, and RCI scores were moderately leptokurtic. All skewness and kurtosis statistics fell between -1.0 and +1.0, and were considered acceptable for the purposes of multiple regression analysis (Meyers, Gamst, and Guarino, 2006).

Bivariate scatterplots suggested that all measure pairs demonstrated at least a slightly linear relationship. However, it is possible that linear analyses slightly underestimated the strength of the relationships between the RCI and CACL-R total scores and the ROS and CACL-R total scores. Plots of the standardized residuals by the standardized predicted values were examined for homoscedasticity. The plot for CHS and CACL-R total scores demonstrated slight heteroscedasticity, while all other plots were homoscedastic. Bivariate correlations for Perceived Clinician Cultural Humility, Religious Outlier Status, Religious Commitment, and Willingness to Discuss are listed in Table 1.

Table 1

Bivariate Correlations for PCH, ROS, RC, and Willingness to Discuss

Variable	*M*	SD	1	2	3	4
1. Perceived Clinician Cultural Humility	*44.26*	11.05	-			
2. Religious Outlier Status	*22.94*	8.31	-.113**	-		
3. Religious Commitment	*29.01*	10.75	.104*	.159**	-	
4. Willingness to Discuss	*41.12*	11.30	.576**	-.126*	.021	-

** Correlation is significant at the 0.01 level (2-tailed)

 * Correlation is significant at the 0.05 level (2-tailed)

Sample characteristics. Participant age ranged from 18 to 73 years old, with an

approximate mean age of 28 years. The majority of the sample (72%) identified as female

(N=385). One hundred and forty-six participants identified as male (27%). Most participants

identified as White or Caucasian (N=364, 68%), though a sizeable minority identified as

Black or African American (N = 102, 19%). The majority of the sample identified as

heterosexual (N=468, 88%). Two-hundred and fifty-seven participants identified as single or

never married (48%), and 248 identified as married/partnered (47%). The majority of

participants had at least some college education, with 228 (43%) endorsing some college, 111

(21%) endorsing an associate's degree, 94 (18%) endorsing a bachelor's degree, 25 (5%)

endorsing a master's degree, and 9 (1%) endorsing a professional or doctorate degree.

One hundred and sixty-four participants (31%) endorsed full-time employment status,

166 (31%) endorsed part-time, and 135 (25%) identified as students. Though most

participants reported that they were not currently in therapy (N=481, 90%), almost half

endorsed a therapy history (N=239, 45%). With regard to religious affiliation, the sample was

quite varied. Though the majority of participants could be categorized under the umbrella of

"Christianity" (N=407, 76%), they endorsed a variety of denomination-specific affiliations

(e.g. Roman Catholic, Baptist, Church of Christ, etc.). Non-Denominational Christian was the

most frequently endorsed affiliation (N=105, 26%), followed closely by Roman Catholic

(N=92, 17%). Please see Table 2 for a detailed description of sample demographics.

Table 2
Sample Demographics

Demographic Characteristic	Sample	
Gender	*N*	%
Male	146	27
Female	385	72

	N	%
Transgender	1	<1
Prefer to Self-Identify	3	<1
Race/Ethnicity	*N*	*%*
Caucasian/White	364	68
Black/African American	102	19
Native American/ American Indian	2	<1
Asian/Asian American/ Pacific Islander	18	3
Hispanic/Latino	21	4
Biracial/Multiracial	16	3
Prefer to Self-Identify	8	2
Sexual Orientation	*N*	*%*
Heterosexual	468	88
Homosexual	23	4
Bisexual	26	5
Unsure	5	1
Prefer Not to Say	3	<1
Prefer to Self-Identify	9	2
Marital Status	*N*	*%*
Single/Never Married	257	48
In a Relationship	143	27
Married/Partnership	105	20
Widowed	4	1
Divorced	17	3
Separated	3	<1
Level of Education	*N*	*%*
Some High School	3	<1
High School Diploma	58	11
Some College	228	43
Vocational Training	7	1
Associates	111	21
Bachelors	94	18

	N	%
Masters	25	5
Professional/Doctorate	9	1
Employment Status	*N*	*%*
Full-Time	164	31
Part-Time	166	31
Unemployed	22	4
Student	135	25
Retired	10	2
Unable to Work	5	<1
Other	28	5
Therapy History	*N*	*%*
Prior Therapy	239	45
No Prior Therapy	295	55
Current Therapy	*N*	*%*
Currently in Therapy	52	10
Not Currently in Therapy	481	90
Religious Affiliation	*N*	*%*
Nondenominational Christian	105	26
Roman Catholic	92	17
Baptist	55	11
Church of Christ	29	5
Lutheran	27	5
Church of God	23	4
Muslim	19	4
Buddhist	17	3
Pentecostal	13	2
Reform Judaism	13	2
Secular Humanism	12	2
Christian Science	12	2
Unitarian Universalism	8	1.5
Episcopal	8	1.5
Evangelical Christian	8	1.5

Covariates. Age, gender identity, race/ethnicity, sexual orientation, marital status, education level, employment status, therapy history, and religious affiliation were all examined for their impact on the primary dependent variable (CACL-R totals; willingness to discuss religious beliefs). Because age was a continuous variable, a bivariate Pearson correlation was used to investigate the relationship between age and willingness to discuss. For all categorical demographic variables, one-way between subjects ANOVAs were used to determine whether they should be included as covariates in the main statistical analyses. Additionally, confidence intervals were generated for each potential covariate to add clarity to the ANOVA results. Please see Table 3 for a full list of confidence intervals.

Pearson correlations between age and CACL-R total scores, r = .076, p = .081, were not significant, and age was not used as a covariate. Similarly, confidence interval comparisons and one-way between-subject ANOVAs were not significant for gender identity, F (1,529) = .007, p = .931, race/ethnicity, F (1,530) = .004, p = .950, sexual orientation, F (1,530) = .581, p = .446, marital status, F = (1,503) = 1.226, p = .269, education level, F = (2,532) = 1.375, p = .254, therapy history, F (1,532) = 0.264, p = .608, and religious affiliation, F (2,532) = .504, p = .604.

Employment status had a significant impact on CACL-R scores, F (2,518) = 4.44, p = .012. For this analysis, employment status categories were recoded to combine categories with few participants. Participants identifying as students remained coded as students (N = 135). Participants endorsing full-time or part-time employment were recoded into a combined "currently employed" category (N = 334). Participants identifying as unemployed, retired, or unable to work were recoded into a combined "currently unemployed" category (N=50). Participants who selected "other" were recoded into the appropriate category as specified by

their comments. Participants who selected "other" were left uncoded if they could not be

placed definitively into a single category. Comparison of group means revealed that

participants who were currently students or currently working (full-time, part-time) were

significantly less willing to discuss their religious beliefs than participants who were not

currently working (unemployed, retired, unable to work). Employment status was used as a

covariate for all analyses using CACL-R total scores. Mean comparisons, standard

deviations, and confidence intervals for all covariate analyses are listed in Table 3.

Table 3
Mean Comparisons and Confidence Intervals for Demographic Variables

Variable	*M* (SD)	95% CI
Gender Identity		
Male	*41.21* (10.37)	[39.51, 42.91]
Female	*41.12* (11.64)	[39.95, 42.28]
Race/Ethnicity		
White	*41.40* (11.76)	[40.19, 42.62]
Non-White	*40.52* (10.26)	[38.97, 42.07]
Sexual Orientation		
Heterosexual	*44.49* (10.77)	[43.51, 45.47]
Homosexual	*42.88* (12.99)	[39.64, 46.13]
Marital Status		
Single	*40.57* (11.92)	[39.11, 42.04]
Married/Partnered	*41.68* (10.49)	[40.37, 42.99]
Level of Education		
HS/Vocational	*41.69* (11.42)	[38.92, 44.45]
Some College/Associates	*40.52* (11.30)	[39.32, 41.73]
Bachelors or Higher	*42.40* (11.22)	[40.43, 44.36]
Employment Status		
Student	*41.00* (10.62)	[39.19, 42.81]
Working	*40.28* (11.63)	[39.03, 41.53]

Nonworking	*45.38* (10.69)	[42.34, 48.42]
Therapy History		
Prior Therapy	*40.81* (11.80)	[39.31, 42.32]
No Prior Therapy	*41.32* (10.88)	[40.07, 42.57]
Religious Affiliation		
Catholic	*42.17* (10.76)	[39.96, 44.39]
Protestant	*40.85* (11.00)	[39.63, 42.07]
Non-Christian	*40.85* (12.48)	[38.64, 43.06]

Experimental group comparisons. The main variable manipulation in this study involved participants viewing either a high or low cultural humility clip and rating their willingness to discuss their religious beliefs with the clinician depicted therein. This manipulation resulted in two randomly assigned experimental groups labeled High CH and Low CH, though the perceived cultural humility variable could be construed as either continuous or categorical, depending on the hypothesis in question. As the primary research questions in this study focused on the participants' perceptions of cultural humility rather than the clips themselves, main analyses were conducted using a continuous variable model. However, it was important to establish the effectiveness of the variable manipulation and the validity of the video clips, as this research may be useful for practical purposes, such as training and education, in the future.

Participants completed the CHS to check the validity of the cultural humility variable manipulation. A one-way between-subjects ANOVA was used to compare mean CHS scores for the High CH (M=49.41) and Low CH (M=38.85) groups. Results showed a significant difference between these mean scores, $F(1,535) = 152.68$, $p < .001$, suggesting that participants who viewed the high cultural humility clip, rather than the low cultural humility

clip, rated the clinician as more culturally humble on average. A one-way ANOVA was also used to compare the mean CACL-R scores for the High CH, M=43.73, and Low CH, M=38.54, groups. Results demonstrated a significant difference between the mean CACL-R scores, $F(1,535) = 29.98$, $p < .001$, suggesting that participants who viewed the high cultural clip were more willing to discuss their religious beliefs with the clinician than participants who viewed the low cultural humility clip. Overall, these mean comparisons demonstrate the validity of the high and low CH clips, and suggest that the variable manipulations were effective. Because this study emphasized participant perceptions of cultural humility as a construct, the main statistical analyses were conducted using a continuous PCH variable.

Main Analyses

Hypothesis 1a: Perceived clinician cultural humility, religious commitment, religious outlier status, and willingness to discuss. It was hypothesized that, when considered in a single model, perceived clinician cultural humility, religious commitment, and religious outlier status would all significantly and uniquely contribute to the willingness to discuss religious beliefs. SPSS regression analysis procedures were used to conduct a multiple regression including CHS, ROS, RCI, and CACL-R total scores with employment status included as a covariate. Results of the regression indicated that perceived clinician cultural humility had a significant and unique impact on the model, $\beta = .58$, $t = 15.67$, $p < .001$, as did the employment status covariate, $\beta = .07$, $t = 2.06$, $p = .040$. The four predictor model was able to account for approximately 34% of the total variance in willingness to discuss religious beliefs, $R^2 = .34$, $F(4,530) = 84.66$, $p < .001$. Thus, Hypothesis 1a was partially supported. Coefficients for Hypotheses 1a and 1b are included in Table 4.

Hypothesis 1b: Perceived clinician cultural humility as a key predictor of

willingness to discuss in full regression model. It was hypothesized that perceived clinician

cultural humility would be the strongest predictor of willingness to discuss religious beliefs,

accounting for a greater amount of variance in willingness to discuss than either religious

outlier status or religious commitment. Neither religious outlier status, β = -.08, t = -1.61, p =

.108, nor religious commitment, β = -.03, t = -.81, p = .421, contributed significantly to the

model. In the full regression model, perceived clinician cultural humility accounted for

approximately 32% of the variance in willingness to discuss religious beliefs (R^2 Adj = .318),

while religious outlier status (R^2 Adj = .004) and religious commitment (R^2 Adj = .001) each

accounted for less than 1% of the variance. Thus, hypothesis 1b was supported. Coefficients

for Hypotheses 1a and 1b are included in Table 4.

Table 4

*Regression Analysis Summary for Variables Predicting Client Willingness to Discuss
Religious Beliefs*

Variable	B	$SE\ B$	β	t	p
Employment Status	1.05	.51	.07	2.06	.040
Perceived Clinician Cultural Humility	0.58	.04	.57	15.67	.000
Religious Outlier Status	-0.08	.05	-.06	-1.61	.108
Religious Commitment	-0.03	.04	-.03	-0.81	.421

Note. R^2 = .34 (N = 529, p < .001)

Hypothesis 1c: Perceived clinician cultural humility and willingness to discuss. It

was hypothesized that perceived clinician cultural humility (PCH) would significantly predict

participant willingness to discuss religious beliefs. This hypothesis was tested using a

stepwise linear regression including CHS and CACL-R total scores, with employment status

included as a covariate. Results indicated that PCH predicted a significant portion of the total

variance for willingness to discuss religious beliefs when accounting for employment status, F

(1,532) = 255.21, $p < .001$. PCH and employment status predicted approximately 34% of the

variance in willingness to discuss (R^2 Adj = .335). PCH alone predicted approximately 32%

of the variance in willingness to discuss (R^2 Adj = .318). Thus, hypothesis 1c was supported.

Coefficients for hypothesis 1c are included in Table 5.

Table 5

*Regression Analysis Summary for Perceived Clinician Cultural Humility and Client
Willingness to Discuss Religious Beliefs*

Variable	*B*	*SE B*	β	*T*	*p*
Employment Status	1.04	.51	.07	2.03	.043
Perceived Clinician Cultural Humility	0.58	.04	.57	15.98	.000

Note. R^2 = .34 (N = 529, $p < .001$)

Hypothesis 1d: Religious outlier status and willingness to discuss. It was

hypothesized that religious outlier status would significantly predict participant willingness to

discuss religious beliefs. SPSS regression analysis procedures were used to conduct a simple

stepwise linear regression including ROS and CACL-R total scores, with employment status

included as a covariate. Results of the regression indicated that perceived religious outlier

status predicted a significant portion of the total variance for willingness to discuss religious

beliefs when accounting for employment status, F (1,532) = 8.83, p = .003. Religious outlier

status and employment status predicted approximately 4% of the variance in willingness to

discuss (R^2 Adj = .035). Perceived clinician cultural humility alone predicted approximately

2% of the variance in willingness to discuss (R^2 Adj = .018). Thus, hypothesis 1d was

supported. Coefficients for hypothesis 1d are included in Table 6.

Table 6

Regression Analysis Summary for Religious Outlier Status and Client Willingness to Discuss Religious Beliefs

Variable	B	$SE\ B$	B	t	p
Employment Status	2.01	.61	.14	3.28	.001
Religious Outlier Status	-0.17	.06	-.13	-2.97	.003

Note. $R^2 = .04$ ($N = 529$, $p < .001$)

Hypothesis 1e: Religious commitment and willingness to discuss. It was

hypothesized that religious commitment would significantly predict participant willingness to

discuss religious beliefs. This hypothesis was tested using a stepwise linear regression

including RCI and CACL-R total scores, with employment status included as a covariate.

Results of the regression indicated religious commitment did not predict a significant portion

of the total variance for willingness to discuss religious beliefs when accounting for

employment status, $F (1,532) = 0.214$, $p = .644$. Religious commitment and employment

status predicted approximately 2% of the variance in willingness to discuss (R^2 Adj = .019).

Religious commitment alone predicted less than 1% of the variance in willingness to discuss

(R^2 Adj < .001). Thus, hypothesis 1e was not supported. Coefficients for hypothesis 1e are

included in Table 7.

Table 7

Regression Analysis Summary for Religious Commitment and Client Willingness to Discuss Religious Beliefs

Variable	B	$SE\ B$	B	t	p
Employment Status	2.00	.62	.14	3.24	.001
Religious Commitment	0.02	.05	.02	0.46	.644

Note. $R^2 = .02$ ($N = 529$, $p = .005$)

Hypothesis 2: Perceived clinician cultural humility and religious commitment. It

was hypothesized that there would be a significant interaction between perceived clinician

cultural humility and religious commitment such that the positive relationship between

perceived clinician cultural humility and willingness to discuss religious beliefs would be

magnified among participants who were high in religious commitment. SPSS regression

analysis procedures were used to conduct a hierarchical multiple regression (Block 1:

Employment covariate; Block 2: Perceived clinician cultural humility, religious commitment,

and perceived religious outlier status; Block 3: Perceived clinician cultural humility x

religious commitment interaction term). Before conducting the hierarchical multiple

regression, mean-centered variables were computed for perceived clinician cultural humility,

religious commitment, and the PCH x RC interaction term. Results of the hierarchical

multiple regression indicated that the interaction term did not contribute significantly to the

model $F(1,529) = .006$, $p = .940$. Hypothesis 2 was not supported. Coefficients for

hypothesis 2 are included in Table 8.

Table 8

Hierarchical Regression Analysis Summary for Variables Predicting Client Willingness to Discuss Religious Beliefs

Variable	R^2	ΔR^2	β	t	p
Step 1	.02**	.02**			
Employment Status			.14	3.24	.001
Step 2	.34***	.32***			
Perceived Clinician Cultural Humility			.57	15.67	.000
Religious Outlier Status			-.06	-1.61	.108
Religious Commitment			-.03	-0.81	.421
Step 3	.35***	.003			
PCH x ROS Interaction			.06	1.63	.104

$** p < .01.$ $*** p < .001.$

Hypothesis 3: Perceived clinician cultural humility and religious outlier status. It

was hypothesized that there would be a significant interaction between perceived clinician

cultural humility and religious outlier status such that the positive relationship between

perceived clinician cultural humility and willingness to discuss religious beliefs would be

magnified among participants who were high in religious outlier status. SPSS regression

analysis procedures were used to conduct a hierarchical multiple regression (Block 1:

Employment covariate; Block 2: Perceived clinician cultural humility, religious commitment,

and perceived religious outlier status; Block 3: Perceived clinician cultural humility x

religious outlier status interaction term). Before conducting the hierarchical multiple

regression, mean-centered variables were computed for perceived clinician cultural humility,

religious outlier status, and the PCH x ROS interaction term. Results of the hierarchical

multiple regression indicated that the interaction term did not contribute significantly to the

model $F(1,529) = 2.656$, $p = .104$. Hypothesis 3 was not supported. Coefficients for

hypothesis 3 are included in Table 9.

Table 9

*Hierarchical Regression Analysis Summary for Variables Predicting Client Willingness to
Discuss Religious Beliefs*

Variable	R^2	ΔR^2	β	T	p
Step 1	.02**	.02**			
Employment Status			.14	3.24	.001
Step 2	.34***	.32***			
Perceived Clinician Cultural Humility			.57	15.67	.000
Religious Outlier Status			-.06	-1.61	.108
Religious Commitment			-.03	-0.81	.421
Step 3	.34***	.000			
PCH x RC Interaction			-.003	-0.08	.940

** $p < .01$. *** $p < .001$.

Discussion

The present study investigated the influence of perceived clinician cultural humility, religious outlier status, and religious commitment on clients' willingness to discuss their religious beliefs with a therapist. The study was motivated by a desire to ease and encourage religious belief discussions in therapy, thus improving communication and potentially avoiding the negative consequences that can arise when such discussions are neglected. Although this desire is not entirely new to the field (Pargament, 2007; Pargament et al., 2013), the existing literature concerning how best to facilitate religious belief discussions is inadequate. There is a dearth of research in this area, and studies are often limited by clinician-centered research questions, exclusively qualitative methods, and small samples. The present study makes a substantial contribution to the literature by focusing on client perspectives, relying heavily on quantitative analyses, and recruiting a large sample.

This study also examined perceived clinician cultural humility in a new context. To the author's knowledge, this study is the first of its kind to investigate the importance of perceived clinician cultural humility as it relates to the process of approaching religious beliefs in therapy. Additionally, this study included a previously unexamined three-factor model that assessed perceived clinician cultural humility in conjunction with religious commitment (a heavily researched, commonly cited variable) and religious outlier status (a newly-defined, but theoretically supported variable). Investigating these three factors in a single model offers an understanding of a broad range of client perceptions including the strength of personal religious beliefs (religious commitment), religious beliefs as they relate to society (religious outlier status), and religious beliefs as they might relate to a therapist (clinician cultural humility).

Full Regression Model

The combined three-factor model that included perceived clinician cultural humility, religious outlier status, and religious commitment was found to significantly predict participant willingness to discuss their religious beliefs. As expected, perceived cultural humility was the strongest predictor in the model, but it was also the only significant predictor. In the full model, religious outlier status and religious commitment did not influence willingness to discuss.

Perceived Clinician Cultural Humility

Perceived clinician cultural humility was found to significantly predict participant willingness to discuss religious beliefs with a therapist. Specifically, participants who rated the therapist as more culturally humble tended to be more willing to discuss their beliefs. This finding was expected, and it complements other findings from the cultural humility literature (Hook et al., 2013; Owen et al., 2014; Owen et al., 2016). Client perceptions of therapist cultural humility have been positively associated with strong working alliances and enhanced therapy outcomes (Hook et al., 2013; Owen et al., 2014), and it has been suggested that cultural humility helps clients and clinicians "form, maintain, and repair social bonds" (Hook et al., 2013, pg. 359). Owen and colleagues (2016) also found that clients who had culturally humble therapists reported fewer missed opportunities to discuss cultural issues in-session. Collectively, these data suggest that cultural humility plays an important role in both cultural communications between client and clinician and therapy outcomes.

Prior studies have investigated client perceptions of clinician cultural humility while clients were attending therapy or after termination (Owen et al., 2014; 2016). Because the present study used brief video vignettes and asked participants to rate their perceptions of a

previously unknown therapist, the results illustrate the importance of cultural humility from the earliest stages of therapy, when clients would typically assess the fit between client and clinician. Participants in this study only observed a five minute interaction between a client and therapist, and yet they were able to perceive subtle differences in cultural humility that predicted their willingness to discuss religion with that therapist. It is likely, then, that clinicians can communicate a stance that is culturally open and nonjudgmental within the first therapy session. In turn, clients who believe their therapist will be open to exploring cultural beliefs without making assumptions or judging will likely feel more comfortable disclosing potentially relevant cultural beliefs. Establishing this open cultural stance early could aid clinician understanding of client presenting concerns, increase trust and rapport, and reduce the risk of culture-based alliance rupture. High perceived clinician cultural humility might also accelerate the rate at which some clients progress through therapy, as cultural issues can raise barriers to treatment when left undiscussed (Hodge, 2013; Richards & Bergin, 2000; Tan, 1996).

Culture has been discussed generally up to this point, but the present study centered on client religious beliefs as a specific, key piece of cultural identity. All participants in the study identified with a religious belief system or community, and because cultural humility was such a strong predictor of client willingness to discuss religious beliefs, cultural humility may play an especially important role for religious clients. As stated previously, though many clients endorse a desire to discuss their religious beliefs with clinicians, they often harbor fears of being judged, pathologized, or misunderstood because of their beliefs (Gockel, 2011; Rose, Westefeld, & Ansley, 2008). The present study suggests that cultural humility may provide a path to reducing these fears. In a qualitative study, Knox and colleagues (2005)

noted that religious discussions were most easily facilitated when clients felt that their

therapists were open, accepting, and respectful toward religious beliefs. Results of the present

study support this statement; however, participants in the present study did not view a

religious beliefs discussion in the clip. They were required to make decisions based on

assumptions about how the clinician *might* respond to their religious beliefs. Results suggest

that participants made these decisions, in part, by assessing the clinician's cultural humility.

Culturally humble clinicians embody the qualities of openness, acceptance, and respect

toward all cultural differences, including religious beliefs. Thus, it may not be necessary for

clinicians to convey a specific acceptance of religious beliefs in order to facilitate religious

belief discussions. The present study indicates that a general sense of openness toward other

cultures can facilitate religious belief discussions and alleviate some fears of judgment, even

when clients have no prior knowledge of the clinician's stance toward religious beliefs.

The significance of cultural humility in the present study also has implications for

clinical training. In training new clinicians, the field of clinical psychology has placed a

strong emphasis on multicultural competency. This emphasis is appropriate, given that

clinicians will undoubtedly be working with clients from many different cultures and the APA

code of ethics prioritizes respect for cultural differences (APA, 2002). However,

multicultural competency training can create some unhelpful assumptions and practices if

culture-specific knowledge and skills are taught without an appreciation for cultural humility.

Hook (2014) states that, in addition to self-awareness, cultural competency relies on

"knowledge about the various cultural groups that comprise the clients [we] work with… and

counseling skills for working with clients from various cultural groups" (pg. 277). Culture-

specific knowledge and skills may give trainees an idea of the cultural considerations that

may come up in therapy, but relying heavily on group-level cultural understanding can easily

lead to biased assumptions about an individual from that cultural group. It is imperative that

trainees are also taught that exploration and understanding of the client's individual cultural

perspective are, in many cases, more valuable to clinicians than culturally-specific

knowledge. Cultural humility may be more valuable to clients as well. For instance, in a

2013 study, Hook and colleagues found that client perceptions of cultural humility explained

a moderate amount of the variation in therapeutic alliance over and above client perceptions

of cultural competency. In essence, while cultural competence can establish foundational

knowledge, cultural humility can establish the framework for client-clinician communication.

This competence-humility distinction is especially important for cultural categories

like religion that 1) include a plethora of subcategories and 2) receive very little attention in

most multicultural psychology classes. It is well-established that a number of clinicians do

not feel comfortable entering into religious belief discussions because they did not receive

specific religious training and do not feel competent to address religion (Frazier & Hansen,

2009). Additionally, in a 2006 survey, only 35% (49/135) of APA-accredited internship sites

reported offering any type of didactic training in the areas of religion and spirituality (Russell

& Yarhouse, 2006). Of those 49 sites, roughly half only offered training once a year. Thus, it

is no surprise that clinicians do not feel religiously competent. Even if training was offered

more frequently, it would be very difficult to feel competent with regard to every religious

denomination. Increased training in cultural humility would help clinicians at a process level,

allowing them to feel confident in the way they approach religious clients, even if they lack

religion-specific knowledge or skills. Results of the present study show that religious clients

respond well to clinician openness and respect, even when the clinician does not convey any specific religious knowledge.

Religious Outlier Status

Religious outlier status was also found to predict client willingness to discuss religious beliefs when considered as a single variable. Participants who felt that their religious beliefs were discriminated against, unaccepted in society, and/or unfamiliar to other people were less willing to discuss their religious beliefs with the therapist depicted in the clip. This result was expected, though religious outlier status has not been extensively researched. Findings from prior qualitative studies have suggested that clients feel more comfortable when they are aware that their beliefs match the beliefs of their clinician, and some clients refuse to discuss their religious beliefs until they are sure there is a client-clinician belief match (Post & Wade, 2009). If we can assume that belief match would increase the willingness to discuss religious beliefs, then it follows that high religious outlier status might be associated with a decrease in willingness to discuss because a belief match would be less likely. Similarly, clients who are religious outliers because they have experienced religious discrimination would likely be even less willing to discuss their religious beliefs. Experiences of discrimination can create expectations for future discrimination (Gockel, 2011; Post & Wade, 2009). In turn, clients who are high in religious outlier status may approach clinicians with caution because their expectations for acceptance and understanding are low.

Religious outlier status, contrary to expectations, did not add unique predictive value to the full three-factor model (PCH, ROS, & RC). While perceived clinician cultural humility was a strong predictor in the full model, religious outlier status accounted for less than 1% of the variance in willingness to discuss religious beliefs. This finding suggests that religious

outlier status is most important when it is the only factor under consideration. ROS becomes

less relevant when it is considered in conjunction with perceived clinician cultural humility.

Practically speaking, religious outlier status may be most influential before a client enters

therapy and during the earliest therapy sessions, before the client has time to fully assess the

clinician's degree of cultural humility.

Religious outlier status may influence basic help-seeking behaviors before clients ever

consider formal therapy. In a national survey (n=8098), Wang, Berglund, and Kessler (2003)

found that 23% of participants who sought treatment for mental illness did so from clergy

members. Furthermore, one quarter of those seeking help from clergy were suffering from

serious mental illness. While seeking counseling from clergy members may be beneficial for

religious clients with mild mental illness, very few clergy members have the appropriate

training to treat moderate to severe mental illness (Yarhouse & Johnson, 2013). Given the

risk associated with improperly treated severe mental illness, it is important to ask how we

might encourage more of these severely ill religious clients to consider seeking help from

mental health practitioners. Understanding religious outlier status may help us answer that

question. Though the present study did not investigate help-seeking behaviors, it is possible

that those seeking help from clergy members sometimes do so because they expect

psychologists to misunderstand or condemn their religious beliefs (high ROS). If clinicians

can assess ROS and determine which religious groups are most likely to feel marginalized and

isolated, they may be able to engage in outreach efforts that would reduce stigma and connect

potentially high ROS individuals with mental health service providers.

Once a religious client begins attending formal therapy, it may be beneficial to assess

ROS quickly in order to retain the client while a culturally humble foundation is being built.

Certainly, the present study demonstrates that clients can gain a "first impression" regarding

clinician cultural humility that can influence their willingness to talk about their beliefs, but

prior research suggests that introducing a culturally open stance is only the first step to

facilitating cultural conversations (Owen et al., 2014; 2016). Cultural humility is, in some

ways, an ongoing process rather than an endpoint to be achieved, and it may take several

sessions for religious clients to feel secure in the cultural humility of their clinicians. It is

during these first several sessions that religious outlier status may be most pertinent. If

clinicians are able to assess religious outlier status early, they can work to prevent ruptures

and early terminations that might occur when high ROS clients feel threatened (Post & Wade,

2009).

One way that clinicians might begin to assess ROS is through the frequently cited

"two-tier" approach to religious assessment (Josephson & Peteet, 2004; Pargament &

Krumrei, 2009; Richards & Bergin, 2000; Shafranske, 2013). This approach involves

assessing the saliency of religion or religious beliefs for the client (first tier) and, if religion is

important, exploring the content of the client's beliefs and the impact of these beliefs on

worldview, behavior, and identity (including ROS; second tier).   This two-tier approach can

be incorporated into standard assessment procedures and used to increase clinician awareness

of client ROS very early in therapy. This awareness can then be used to retain high ROS

clients until cultural humility can be firmly established. For instance, when working with a

high ROS client, the clinician may wish to include a discussion of religious acceptance when

determining the client's expectations for therapy. This type of religion-focused conversation

may be less crucial for a low ROS client who has historically experienced religious

acceptance.

In the present study, religious outlier status was only significant until cultural humility was included in the model. Thus, the present study findings suggest that once rapport has been established and the clinician has had multiple opportunities to demonstrate high cultural humility, ROS will likely require less active monitoring. ROS is a trait that clients bring with them to the first session. Cultural humility, however, must be conveyed by the clinician over time. It makes sense, then, to work with a religious client where they are with regard to ROS while working to demonstrate the qualities of cultural humility.

Religious Commitment

Contrary to expectations, religious commitment did not significantly predict willingness to discuss religious beliefs either as a single variable or as part of the full three-factor model. This finding is unusual, as prior research has linked religious commitment with a variety of client perceptions and behaviors (Walker et al. 2011; Worthington, 1988). Prior studies have also emphasized the importance of understanding and assessing religious commitment in order to work effectively with religious clients (Thurston, 2000; Wade, Worthington, & Vogel, 2007; Worthington, 1988). However, it is important to note that the findings regarding how religious commitment might affect client perceptions have been somewhat mixed across studies. For instance, Worthington (1988) suggested that clients above the 85th percentile in religious commitment might be hesitant to discuss their religious beliefs with a secular clinician. Walker and colleagues (2011), however, found that the desire to discuss religious beliefs in therapy is positively correlated with religious commitment, such that those who are highly committed have a strong desire to discuss their beliefs with both secular and non-secular clinicians.

The relationship between religious commitment and willingness to discuss may have been nonsignificant in the present study because religious commitment does not always lend itself well to generalized group-level conclusions.   The lack of consistent findings in prior research and lack of significance in the present study seem to suggest that religious commitment may be most useful when understood through an individual client's perspective. For instance, it is possible that clients with the same level of religious commitment could be either high or low in willingness to discuss depending on their perceptions of therapy. Clients who are high in religious commitment may be high in willingness to discuss because their beliefs are central to their identity, or low in willingness to discuss because they fear judgment and identity disruption (Hodge, 2013; Knox, 2005; Shafranske, 2013). Clients who are low in religious commitment may be high in willingness to discuss because there is minimal risk of identity disruption or low in willingness to discuss because they do not believe religion is relevant to their treatment (Gockel, 2011; Shafranske, 2013). Thus, we cannot assume that two clients will respond to religious discussions in similar ways, simply because they are both highly committed to their faiths.

Cautioning clinicians against making assumptions based on a client's level of religious commitment does not negate the overall importance of assessing and understanding religious commitment. The results of the present study do, however, highlight the *challenge* of understanding client religious commitment. The present study suggests that religious commitment, as a construct, cannot always help us predict client perception. Therefore, it may be beneficial for clinicians to closely monitor their assumptions about both high and low RC clients. Knowing a client's level of religious commitment is unlikely to provide much specific information about how clinicians should approach religious belief discussions. It is

important to note that other therapy factors, like clinician cultural humility, may ultimately be more useful in facilitating religious discussions.

It was expected that religious commitment would make a unique, significant contribution to the full three-factor model of willingness to discuss religious beliefs. This hypothesis was not supported. Like religious outlier status, religious commitment was not found to be a significant predictor of willingness to discuss, and this lack of significance is likely due to the strength of the cultural humility variable. Cultural humility far outweighed religious commitment in terms of predictive power, and this finding suggests that cultural humility may be more useful in facilitating religious belief discussions than religious commitment. Using a client's level of religious commitment to guide the clinician's approach to religious belief discussions often requires the clinician to be reactive or work from assumptions. Clinicians assess religious commitment, use that data to determine how the client is likely to approach religious discussions, and react accordingly. This approach leaves room for error, particularly given that clients who share the same level of commitment could approach religious discussions very differently. Using clinician cultural humility to facilitate religious belief discussions allows the clinician to be proactive. Clinicians can embody the qualities of cultural humility beginning in the first session, and it is not necessary for clinicians to base behavior on the strength of client beliefs.

Interaction Terms

It was originally expected that there would be a significant interaction between perceived clinician cultural humility and religious commitment such that the positive relationship between perceived clinician cultural humility and willingness to discuss religious beliefs would be magnified among participants who are high in religious commitment.

Cultural humility was a dominant predictor of willingness to discuss religious beliefs, and as such, this hypothesis was not supported. This finding was surprising given prior research evidence. Owen and colleagues (2014) found a significant interaction between clinician cultural humility and religious commitment such that clinician cultural humility was more influential for high RC clients than low RC clients. Specifically, therapy outcomes were significantly better for high RC clients when the clinician was high in cultural humility and significantly worse when the clinician was low in cultural humility.   For low RC clients, clinician cultural humility was unrelated to therapy outcomes. Results of the present study do not support these findings, given that the PCH x RC interaction was not significant.

One possible explanation for this discrepancy between findings is the difference in study scope. Owen and colleagues (2014) investigated perceptions of therapy effectiveness (therapy outcomes) in a clinical population, while the present study asked non-client participants to rate their willingness to discuss religious beliefs with a hypothetical clinician (therapy process). It is possible that the combination of religious commitment and cultural humility becomes more important when considering therapy progress over time. There are multiple steps between a client's initial assessment of a clinician and a client's final assessment of therapy effectiveness, and the salience of religious commitment could certainly change over the course of therapy.

Results of the present study suggest that clinician cultural humility, above all other study variables, plays a key role in the initial "first impression" stages of therapy, when clients are assessing their level of comfort with a clinician. Perhaps, as religious clients progress through therapy and begin engaging in religious belief conversations with their clinicians, highly religious clients rely more on a continued sense of clinician cultural

humility than less religious clients. It is possible that both high RC and low RC clients are willing to discuss their religious beliefs in session if they initially sense that clinicians are open to those discussions. For low RC clients, the accuracy of this initial impression may not matter simply because their religious beliefs are not important to them.   For high RC clients, therapy may improve over time if their initial impressions are shown to be correct, but it may begin to suffer if they were inaccurate. Thus, while the interaction of religious commitment and perceived clinician cultural humility does not appear to influence client willingness to discuss their beliefs with a clinician, it may still prove to be important to the level of success in therapy.

It was also expected that there would be a significant interaction between perceived clinician cultural humility and religious outlier status such that the positive relationship between perceived clinician cultural humility and willingness to discuss religious beliefs would be magnified among participants who are high in religious outlier status. This hypothesis was also unsupported. In the present study, client perceptions of clinician cultural humility outweighed the impact of other variables to such an extent that significant interaction effects were unlikely. It is possible that, similar to the interaction between religious commitment and perceived clinician cultural humility, the interaction between religious outlier status and perceived clinician cultural humility could become more relevant as a client progresses through therapy.   Based on the definition of the ROS construct, high ROS clients are likely to expect others to misunderstand, be unfamiliar with, or discriminate against their religious beliefs (Larsen, 2001). While both low and high ROS clients might be willing to discuss their religious beliefs if a clinician initially appears culturally humble, it stands to reason that having an ongoing relationship with a culturally humble clinician would be

especially valuable to high ROS clients, as it would allow them an opportunity to be understood and accepted. High ROS clients may be more engaged, more motivated, and ultimately more successful in therapy if there is a continued sense of clinician cultural humility throughout therapy, but it is difficult to draw conclusions about potential relationships between ROS and PCH without testing the relationship at different stages of the therapy process.

The lack of significant interaction terms in the present study was not consistent with the proposed hypotheses; however, it underscores the powerful influence of clinician cultural humility and the responsibility clinicians have in either facilitating or hindering communication regarding religious beliefs. Religious outlier status and religious commitment are both client-driven variables that are established before a client first encounters a clinician. They cannot be influenced by the clinician's behavior. Perceived clinician cultural humility, the most powerful variable in the current study, is established through client-clinician interaction, and it is possible for a clinician to purposefully adopt a culturally humble stance. Thus, even the lack of interaction effects can provide some information about client-clinician religious belief discussions. In the early stages of therapy, clinicians can be proactive in creating an environment that supports these discussions. Clinicians need not necessarily be prepared to respond to specific levels of client-driven religious variables (e.g. religious commitment and religious outlier status). Instead, they can proactively adopt a uniformly humble stance that supports all of these variables. Clinicians may then be able to enter into religious discussions with confidence and reduce common fears associated with a lack of training or lack of religious competence.

Limitations

The present study contains several limitations. The study asked participants to rate their willingness to discuss religious beliefs with a clinician presented in a video clip; however, the content of the clips focused on sexual orientation, rather than religion, as the key piece of client cultural identity to avoid priming participants. Sexual orientation was selected because it shares some cultural qualities with religious belief (e.g. relative invisibility, necessity of client disclosure), but it is possible that discussing sexual orientation in the clips could have influenced participant responses in a different way. It is common knowledge that religious belief systems, depending on their content, are sometimes at odds with sexual minority groups. Thus, a highly religious participant could have perhaps been *more* willing to discuss their beliefs with the *less* culturally humble clinician because the clinician was less open toward a client who identified as a sexual minority. This response by the clinician could have indicated an increased likelihood of a participant-clinician religious belief match. Because willingness to discuss religious beliefs was not significantly influenced by either religious affiliation or religious commitment, it seems unlikely that the choice of cultural identity had an undue influence on results. Nevertheless, it may be useful to address this limitation in future studies by choosing a cultural identity that does not conflict as easily with religious belief.

It is also possible that the race and gender of the client and clinician depicted in the video clips could have influenced participant responses. The clips used in the present study depicted a white, female clinician and a white, female client. It is possible that participants of the same race and/or gender might have been more willing to discuss religious beliefs while participants of different races or genders might have been less willing. Again, neither race

nor gender was a significant covariate in this study, but that does not preclude the existence of individual differences in response style. Future research may wish to examine the influence of these cultural variables on religious belief discussions.

The present study also used both simulated therapy clips and non-client participants whose responses may be less informed than those of clients who are currently enrolled in therapy. These methods increased overall sample size and experimental control, but they may limit the external validity of the study. It should be noted that 48% of the sample endorsed prior therapy or counseling experience, thus strengthening generalizability. Additionally, the large sample size and quantifiable measures used in the present study provide a solid foundation for future research.

Finally, religious commitment did not significantly predict participant willingness to discuss religious beliefs. As stated previously, this result can likely be explained by the mixed findings regarding religious commitment in the existing literature, but the lack of significance violates the assumptions of hierarchical multiple regression and makes it challenging to test the fit of the full three-factor regression model. Fortunately, hierarchical regression is generally robust to these types of violations and the powerful impact of clinician cultural humility as a predictor is unlikely to have been significantly influenced by the violation (Meyers, Gamst, and Guarino, 2006). Future researchers may wish to consider this limitation when developing new hypotheses regarding religious commitment and clinician cultural humility, but the results of the current study are robust, despite the violation of assumptions.

Future Research

The present study provides insight into the importance of clinician cultural humility, particularly as it pertains to religious clients. However, both cultural humility and client religious beliefs are relatively new topics of study in the field of psychology, and there are several questions that could be investigated as a result of this research. We do not yet know how clinician cultural humility interacts with other religious variables over the course of therapy. The present study focuses on early client perceptions, and previous research has looked at client perceptions of therapy outcomes (Owen et al., 2014, 2016). It would be useful to know if client perceptions of the importance of cultural humility change over the course of therapy, depending on other religious variables. Future studies could help clarify how clinicians can maintain cultural humility once it has been established and continue to work effectively with religious clients over time.

Additionally, future research may wish to focus on clinical training as it relates to cultural humility. The current study suggests that, when considering religious clients, cultural humility may be more important than cultural competency early in therapy. But clinical training is frequently competency-focused and religious diversity is rarely covered in depth due to time constraints. Thus, future research could begin to determine the most direct, efficient way to incorporate cultural humility into training programs by identifying concrete behaviors that convey cultural humility to clients. Future research could also identify the characteristics and behaviors of culturally humble clinicians that are most useful in facilitating communication with clients. These results could help determine the skills that are most important to teach, even when time is limited or when humility and competency are taught simultaneously.

Conclusions

The present study investigated the effects of perceived clinician cultural humility, religious outlier status, and religious commitment on client willingness to discuss religious beliefs. Perceived clinician cultural humility and religious outlier status both independently predicted willingness to discuss, but when considered in a full, three-factor model, clinician cultural humility was both the most powerful predictor and the only significant predictor within the model. These results provide support for the importance of clinician cultural humility in facilitating religious belief discussions in the early stages of therapy. Future studies should focus on determining the impact of cultural humility on religious clients' experiences throughout therapy and identifying behavioral characteristics of cultural humility to facilitate clinical training.

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Appendix A

Demographic Questionnaire

Gender: Female   Male   Transgender   Prefer to Self-Identify_____

Age: _____

Ethnicity:

- Caucasian/Non-Hispanic White
- Black/African American
- Native American/American Indian
- Asian/Asian American/Pacific Islander
- Hispanic/Latino
- Prefer to Self-Identify: _____

Sexual Orientation:

- Heterosexual
- Homosexual
- Bisexual
- Unsure
- Prefer Not to Say
- Prefer to Self-Identify: _____

What is your highest level of education?

- 8th grade or less
- Some high school, no degree
- High school graduate, diploma or GED
- Some college credit, no degree
- Vocational training
- Associate's degree
- Bachelor's degree
- Master's degree
- Professional degree
- Doctorate degree
- Other (please explain): _____

Current Marital Status:

- Single/Never married
- Married/Domestic partnership
- Widowed
- Divorced
- Separated

Current Employment Status:

- Full-Time Employment
- Part-Time Employment
- Unemployed
- Student
- Retired
- Unable to Work
- Other (please specify): _____

In which region of the country do you currently live?

- Midwest - IA, IL, IN, KS, MI, MN, MO, ND, NE, OH, SD, WI
- Northeast - CT, DC, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VT
- Southeast - AL, AR, FL, GA, KY, LA, MS, NC, SC, TN, VA, WV
- Southwest - AZ, NM, OK, TX
- West - AK, CA, CO, HI, ID, MT, NV, OR, UT, WA, WY

In which region of the country did you live before age 18?

- Midwest - IA, IL, IN, KS, MI, MN, MO, ND, NE, OH, SD, WI
- Northeast - CT, DC, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VT
- Southeast - AL, AR, FL, GA, KY, LA, MS, NC, SC, TN, VA, WV
- Southwest - AZ, NM, OK, TX
- West - AK, CA, CO, HI, ID, MT, NV, OR, UT, WA, WY
- I lived in more than one of these regions before age 18
- I am not originally from the United States – please specify country of origin
- Other (please specify): _____

Have you ever attended therapy or counseling?

- Yes
- No

Are you currently attending therapy or counseling?

- Yes
- No

Are you currently affiliated with a religious denomination or community?

- Yes
- No

If yes, which of the following denominations do you most closely affiliate with?

- African Methodist Episcopal (A.M.E.)
- Assembly of God
- Bahai
- Baptist (non-Southern Baptist)
- Buddhism
- Christian Science
- Church of Christ
- Church of God
- Eastern Orthodox
- Episcopal
- Evangelical Christian
- Hinduism
- Jainism
- Jehovah's Witness
- Lutheran
- Methodist
- Mormon
- Muslim
- Neo-Pagan
- New Age
- Non-Denominational Christian
- Non-theist
- Orthodox Judaism
- Paganism
- Pentecostal
- Presbyterian
- Quaker
- Reform Judaism
- Roman Catholicism
- Scientology
- Secular Humanism
- Seventh-Day Adventist
- Sikhism
- Southern Baptist
- Taoism
- Unitarian Universalist
- Wiccan
- Other: _____

Have you always been affiliated with your current belief system?

- Yes
- No

If no, with which other denominations have you been previously affiliated (check all that apply)?

- Same list as above

Is your current faith system the same as the faith system held by your family of origin (i.e. parents or caregivers)?

- Yes
- No

Where did you learn about this study?

- SONA System (UMSL)
- Craigslist
- Facebook
- Other (please specify)

Appendix B
Revised Pew Forum Scale of Religious Outlier Status

Please rate your level of agreement with the each of the following statements.

1	**2**	**3**	**4**	**5**
Strongly Agree	**Agree**	**Neutral/Don't Know**	**Disagree**	**Strongly Disagree**

1. I would describe my religion or faith as widely accepted in this country.

2. There are many people in the community where I live that share my religion or faith.

3. I have felt discriminated against because of my religious beliefs.

4. My religious group has been discriminated against historically or in the past.

5. My religious beliefs make me feel like an outsider in society.

6. My religious beliefs make me feel like an outsider in my community.

7. I believe my religious beliefs would make me feel like an outsider in therapy.

8. There are few people in my community who share my religious beliefs.

9. I have been treated unfairly because of my religious beliefs.

10. I have been treated with less respect because of my religious beliefs.