THE RELATIONSHIP BETWEEN SPIRITUALITY AND SPIRITUAL/RELIGIOUS COPING, GOAL ATTAINMENT, AND CHANGE IN SYMPTOMS OF ADOLESCENTS IN CRISIS RESIDENCE

A Dissertation

by

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This dissertation meets the standards for scope and quality of
Texas A&M University-Corpus Christi and is hereby approved.

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ABSTRACT

Despite the increase of attention in the counseling profession to spirituality, extant literature examining spirituality and adolescent mental health is limited (Powers, 2005; Van Dyke, Glenwick, & Kim, 2009). Few studies were conducted related to the spirituality of adolescents in residential treatment settings (Dew, et al., 2008; Hawke, Hennen, & Gallilone, 2005; Taylor, 2005). In particular, no studies were conducted to determine the relationship between spirituality and goal attainment or symptom change of adolescents in crisis residence. The purpose of the study was to identify the extent to which there is a relationship between spirituality and spiritual/religious coping, change of symptoms, and therapeutic goal attainment of adolescents in crisis residence.

A correlational design was used to examine the relationship between spirituality, spiritual and religious coping, goal attainment and symptom change of adolescents in crisis residence. A canonical correlation was conducted. The two sets of variables under investigation were spirituality (as measured by the Daily Spiritual Experiences Scale and Brief Religious and Spiritual Coping Scale) and treatment outcome (as measured by the Goal Attainment Scale of Stabilization and the Target Symptom Rating Scale).

The participants in this study were adolescent clients from an acute care psychiatric facility in the southern gulf coast. Male (n = 47) and female (n = 37) adolescent participants ranged in age from 12 years to 17 years. Ethnicity and religious preference of the adolescents were reported.

Results of the study indicated that no statistically significant relationship existed between spirituality and treatment outcome for adolescents in crisis residence.

Spirituality may not be an essential component to crisis stabilization of adolescents. Rather, counselors should be aware that spirituality is a uniquely personal construct. Counselors who utilize spiritual principles as the primary tool for stabilization of adolescents may want to rethink their treatment protocols. For adolescent clients in crisis who place much importance on spiritual matters, addressing spirituality in treatment may be beneficial to attaining goals and reducing symptoms. However, adolescent clients who place no importance on spirituality may still achieve the same treatment outcomes in crisis residence. Additional studies that explore individual perceptions of spirituality, investigate the results of infusing spirituality into treatment strategies, and take into account individual diagnosis with this population would be useful.

DEDICATION

This work is dedicated to the family members and loved ones who have gone before me. The hard work and sacrifices that they made throughout their lives provided me with the opportunity to receive an education and excel in areas of my life that they only dreamed of. I thank each and every one of them for the lessons they taught me and the faith they had in the American dream.

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CHAPTER 1

Introduction

The importance of studying the role of spirituality and religion in mental health has become evident in recent years. Powers (2005) reported that the number of articles published related to spirituality and counseling consistently increased every five-year period since 1980 and each year a significantly higher number of publications in this area can be found. There are several explanations for the growth of interest in this area including the importance of being culturally sensitive when seeing clients in counseling, the recognition that religion is part of culture, and the growing body of literature that recognizes religion as a variable in mental health (Agorastos, Demiralay, & Huber, 2014; Levitt & Balkin, 2003; Shafranske & Malony, 1996). In addition, religion/spirituality "promote resilience, healing, and well-being in day-to-day living and in facing stressful events" and religiosity and spirituality are effective resiliency resources (Van Dyke, Glenwick, Cecero, & Kim, 2009; Reutter & Bigatti, 2014).

The American Counseling Association (ACA) endorsed a set of spiritual competencies created by the Association for Spiritual, Ethical and Religious Values in Counseling (ASERVIC) (Cashwell & Watts, 2010) which now includes six spiritual domains that counselors should be knowledgeable: culture and worldview, counselor self awareness, human and spiritual development, communication, assessment, and diagnosis and treatment(http://www.aservic.org/). The endorsement of these competencies by ACA demonstrates the dedication of the counseling profession to ensure that spirituality is considered and utilized for effective client care.

Spirituality and religiosity are complex, multidimensional constructs that are difficult to define (Briggs & Dixon, 2013; Richards, Bartz, & O'Grady, 2009). Some unique differences between the two terms have been described, but many times they are used interchangeably

(Richards, Bartz, & O'Grady, 2009; Stanard, Sandhu, & Painter, 2000). "Religion and spirituality are both thought to relate to the sacred, yet spirituality is usually described as a more subjective experience, and religion is defined as a set of beliefs or doctrines that are institutionalized" (Morrison, Clutter, Prichett, & Demmitt, 2009, p.184).

Religiosity was defined as "beliefs, practices, behaviors, and feelings that are expressed in institutional settings or ways associated with a denominational affiliation" (Richards, Bartz, & O'Grady, 2009, p.54). Koenig, McCullough, and Larson (2001), stated that religion referred to "an organized system of beliefs, practices, rituals, and symbols designed (a) to facilitate closeness to the sacred or transcendent (God, higher power, or ultimate truth/reality) and (b) to foster an understanding of one's relationship and responsibility to others in living together in a community" (p.18).

Myers, Sweeney, and Witmer (2000), defined spirituality as "an awareness of a being or force that transcends the material aspects of life and gives a deep sense of wholeness or connectedness to the universe" (p.252). Spirituality can also be described as "that which gives meaning to life and allows us to participate in the larger whole" (Shea, 2003, p.40).

Though the majority of studies conducted in the area of spirituality or religion focus primarily on adult clients (Dew et al., 2008; Van Dyke, et al., 2009), the benefits of utilizing spirituality with the treatment of adolescents were explored. Gollnick (2005) reported that 95 percent of adolescents from age 13-18 believe in God or a universal Spirit and 75 percent of them pray. Werner (1984) reported that the spirituality or religious beliefs of adolescents can promote the sense that adolescents have some control over their fate and can cultivate the belief that their life has meaning. Furthermore, after conducting an extensive review of the literature related to adolescents and spirituality, Kim and Esquivel (2011) reported that spirituality,

described as a longing for transcendental meaning and a search for purpose,"promotes healthy development in adolescents, enhances the ability to cope, and leads to positive outcomes in mental health, psychological well- being and academic learning" (p.755). These positive outcomes could contribute to greater success in the treatment of adolescents.

Furthermore, Davis, Kerr, and Kurpius (2003) found that greater spiritual well-being, defined as a sense of well- being related to God and a sense of purpose and life satisfaction not related to anything religious, in adolescents predicted lower trait anxiety among at-risk adolescents. Van Dyke et al. (2009) reported that positive religious coping, as measured by the Brief Religious and Spiritual Coping Scale, and daily spiritual experiences, as measured by the Daily Spiritual Experiences Scale, were significantly related to positive affect and life satisfaction while negative religious coping was significantly related to negative affect, anxiety, depression, and somatization in urban early adolescents.

Van Dyke and Elias (2007) reported that religiosity, as measured on the dimensions of transcendence (belief in a higher power), prayer and inner life (high esteem and acceptance of self and a search for meaning in the good and bad of life), relationships (openness of religious interventions by trusted individuals), values and justice (concern for less fortunate and desire to be responsible for those in need), and influence of a religious tradition (ability of religious communities to encourage religious and spiritual maturity), was positively associated with happiness, purpose, and self actualization of adolescents. An extensive review of the literature conducted by Dew et al. (2008) revealed that at least one significant relationship between religiousness (attendance in public religious activities, importance placed on religion, religious beliefs, and denomination) and better mental health existed in 92% of the 115 articles that were reviewed. Relationships between religion/spirituality and adolescent delinquency, anxiety,

depression, suicidiality, and substance use were examined. A protective factor against risky behaviors that could have negative consequences towards health outcomes was spiritual or religious connectedness. Adolescents with higher levels of spirituality or religiosity were less likely to participate in risky behavior such as sexual behavior and substance use and abuse and had better mental health outcomes (Diclemente, Santelli, & Crosby, 2009).

Considering the benefits of spirituality and mental health in adolescents, spirituality is a pertinent issue for counselors to explore with adolescents in crisis residence. However, few studies were conducted related to spirituality and crisis residence despite evidence that spirituality may have a positive influence on the mental health of those in treatment. Powel (2001) described the gains of including spirituality in the treatment of individuals in psychiatric settings as a resurgence of hope and regeneration of faith and reported a transformation of the individual can be expected when client beliefs were explored.

Lindgren and Coursey (1995) found 60% of psychiatric patients reported that spirituality (personal beliefs and practices) and religion (beliefs, practices, and rites associated with a church) impacted their illness significantly by fostering the feelings of being cared for and of not being alone. Religion and spirituality were used interchangeably throughout this study, and the term most comfortable for the participant was utilized in personal interviews. Seventy-six percent of those surveyed reported that they thought about God or other spiritual matters on a daily bases. Spirituality can be used as a tool to improve coping skills and manage mental illness. Furthermore, acknowledgement of a divine power can placate stressful life events, and possession of spiritual beliefs can provide or enhance comfort and hope so that individuals can succeed in life despite obstacles such as mental health (Snyder, 2000).

Problem Statement

Despite the increase of attention in the counseling profession to spirituality, extant literature examining spirituality and the mental well being of adolescents was limited (Dew et al., 2008; Van Dyke, Glenwick, & Kim, 2009). Currently, areas of focus in the counseling literature for adolescents and spirituality include grief care, school counseling, wellness, spiritual development of adolescent girls, and cult membership (Dobmeier, 2011; Bruce & Cockreham, 2004; Lee, 2004; Rayle & Myers, 2004; Briggs, Akos, Czyszczon, & Eldridge, 2011; Muselman & Wiggins, 2012).

Some research was conducted regarding spirituality and adolescents in psychiatric settings. A relationship between spirituality and depression was reported among adolescent psychiatric outpatients (Dew et al., 2008), a positive relationship between spirituality and therapeutic engagement was reported among adolescents in residential drug treatment (Hawke, Hennen, & Gallilone, 2005), and a positive relationship was found between involvement in spiritual mentoring of adolescents during residential treatment and improvement in psychological functioning and adjustment (Taylor, 2005). However, research devoted to spirituality and adolescents in crisis residence was very limited.

Therefore, despite the growth of spirituality research in the counseling literature (Powers, 2005), only a small number of researchers explored the relationship between spirituality or religious coping (the extent to which individuals utilize religion or spirituality to cope with life stressors (Pargament, Feuille, & Burdzy, 2011) and adolescent mental health. Even fewer studies were conducted related to the spirituality of adolescents in residential treatment settings. In particular, no studies were conducted to determine the relationship between spirituality and goal attainment or symptom change of adolescents in crisis residence.

Purpose of the Study

Spirituality was associated with positive psychological outcomes in adolescents, and a lack of spirituality in one's life was associated with negative psychological outcomes and behaviors (Davis, Kerr, & Kupius, 2003; Regenerus, 2003; Rew & Long, 2006). However, a lack of research currently exists in the counseling literature concerning the relationship of spirituality to the particular outcomes of adolescents in crisis residence treatment. The purpose of this study was to explore the relationship between spirituality, as measured by the Brief Religious and Spiritual Coping Scale (Pargament, Feuille, & Burdzy, 2011) and the Daily Spiritual Experiences Scale (Underwood & Teresi, 2002), and outcome of treatment, as measured by the Goal Attainment Scale of Stabilization (Balkin, 2010) and the Target Symptom Rating Scale (Barber et al., 2002) of adolescents in crisis residence. The study began to fill the gap in the counseling literature related to adolescents in crisis residence and spirituality.

Significance of the Study

Unlike traditional counseling settings, those who are treated in acute psychiatric care facilities for crisis intervention will only receive treatment for 3-7 days. During this time frame, rapid clinical stabilization of the adolescent is of utmost importance (Sharfstein, 2009). Significant changes are expected to occur within the adolescents in these facilities in a short amount of time, so counselors must have an understanding of any variable that may influence treatment.

Few factors that could influence the therapeutic goal attainment of adolescents in crisis residence have been explored. Balkin and Roland (2007) reported that a relationship between therapeutic goal attainment and mental health symptoms for adolescents in crisis residence

existed. The ability of a client to meet therapeutic goals was correlated to a decrease in client symptomology. Balkin, Leicht, Sartor, and Powell (2011) reported that a negative relationship existed between behavioral symptoms and therapeutic goal attainment, and a positive relationship existed between emotional symptoms and therapeutic goal attainment of adolescents in crisis residence. The type of symptoms exhibited by adolescents in an acute psychiatric care setting appeared to contribute to the attainment of therapeutic goals but the diagnosis of the client did not (Balkin, Leicht, Sartor, & Powell, 2011). Despite these studies, there are no current studies regarding adolescents receiving treatment in crisis residence and spirituality.

A dearth of research exists regarding spirituality and adolescents in acute psychiatric care facilities. However, several studies have been conducted concerning the usefulness of incorporating spirituality into the treatment of adults in psychiatric care facilities. The Spiritual Well-Being scale was found to be useful for measuring an individual's attributions and feelings toward God with psychiatric inpatients (Scott, Aggresti, & Fitchett, 2000). Mela, et al. (2008) determined that forensic psychiatric patients in Canada were more spiritual than the general population and that higher religiosity and spirituality of this population was associated with lower depression and anxiety scores and higher life satisfaction scores. Christmas and Van Horn (2012) introduced a model for incorporating spiritual psychoeducation into the group work of individuals in psychiatric inpatient settings. Rosmarin, Aurbach, Bigda-Peyton, Bjorgvinsson, and Levendusky (2011) developed and implemented a spirituality and cognitive behavioral therapy group in an acute psychiatric setting and reported that 90% of participants believed that spirituality was important and relevant to their treatment.

Results from this study provided counselors with additional information about adolescents who are admitted to crisis residence and the relationship between spirituality and the

outcome of their treatment, an area that was previously unexplored Counselors can use this information to aid in the stabilization of adolescents who are in treatment and to promote the therapeutic progress of adolescents in acute psychiatric care facilities.

Research Question

The following research question was examined to explore the relationship between spirituality or spiritual/religious coping and goal attainment of adolescents in crisis residence and the relationship between spirituality or spiritual/religious coping and treatment outcome of adolescent in crisis residence:

To what extent is there a relationship between spirituality, and outcome of treatment of adolescents in crisis residence?

Limitations and Delimitations

The limitations of this study include the following:

1. Participants in this study were comprised of adolescents admitted to one particular acute psychiatric care facility making generalizability of the results to other populations difficult.

2. All participants of the study were not seen by the same counselor. Any relationship discovered between the variables under investigation in this study may be attributed to differences in treatment from different counselors.

3. Spirituality and spiritual/religious coping were both measured using self-reported data from the participants. This type of data collection requires participants to be honest with their responses. Response bias may have occurred if participants were not completely honest when completing measurement scales.

4. Goal attainment and target symptom were measured by clinicians rather than clients making the presence of clinician bias a possibility.

5. The outcome of short term crisis treatment was measured in this study, making it difficult to see the long term implications of the relationship between the variables under investigation in this study.

The following delimitations were imposed on this study:

1. The population was delimited to adolescents admitted to crisis residence at a particular behavioral hospital in the southern gulf coast.

2. This study was delimited to examination of the variables of spirituality and spiritual/religious coping and their relationship to change in symptoms and therapeutic goal attainment of adolescents in crisis residence.

3. Spirituality was measured by The Daily Spiritual Experience Scale (Underwood & Teresi, 2002).

4. Spiritual/Religious coping was measured by the Religious and Spiritual Coping Scale from The Brief Multidimensional Measure of Religiousness/Spirituality (Paragmet, 1999).

5. Change in symptoms was measured by the Target Symptom Rating Scale (Barber, Neese, Coyne, Fultz, & Fongay, 2002)

6. Goal attainment was measured by the Goal Attainment Scale of Stabilization (Balkin & Roland, 2007).

Definition of Terms

Adolescent, for the purpose of this study, included individuals admitted to a behavioral hospital in the southern gulf coast between the ages of 12-17. This is a vulnerable age group that is typically admitted to the adolescent unit for inpatient treatment (Sharfstein, 2009).

GASS is an acronym for Goal Attainment Scale of Stabilization. The GASS consists of two subscales: coping and commitment to follow-up (Balkin, 2013).

DSES is an abbreviation of the Daily Spiritual Experiences Scale. The scale measures ordinary, daily spiritual experiences of individuals and how those experiences are a part of the individual's daily life (Underwood & Teresi, 2002).

Goal Attainment can be defined as "meeting specific goals related to the adolescent client's ability to address coping skills and commit to follow-up upon discharge from crisis residence (Balkin, Leicht, Sartor, & Powell, 2011). The coping skills related to goal attainment include commitment to safety, identification of problems, and process coping skills (Balkin & Roland, 2007).

RCOPE is an abbreviation of the Brief Religious and Spiritual Coping Scale. This scale was designed to "measure the myriad of manifestations of religious coping and to help practitioners better integrate religious and spiritual dimensions into treatment" (Paragment, Feuille, & Burdzy, 2011, p.54).

Religious and Spiritual Coping refers to the religious or spiritual resources that individuals utilize in their efforts to understand and deal with difficult situations in their lives (Paragment, Feulee, & Burdzy, 2011).

Spirituality is defined as "a highly individualized, ongoing, and integrative process of the self (body, mind, and soul) and, ultimately, a way to gain communion with a Higher Being" (Livingston & Cummings, 2009). For the purposes of this study, spirituality also encompasses religiosity.

TSR is an abbreviation of the Target Symptom Rating Scale. The TSR describes the variety of problems typically demonstrated by children and adolescents in intensive treatment settings (Barber et al., 2002).

Chapter Summary

In this chapter, the problem statement, purpose of the study, significance of the study, research question, limitations and delimitations of the study were described. Definitions of terms that are relevant to the study were also provided in this chapter. The following chapters will consist of a literature review, methodology, results, and discussion of the research study.

CHAPTER 2

Review of the Literature

The purpose of this literature review is to provide a framework for understanding the population under investigation and to describe the importance of exploring spirituality with this population. Adolescent development was explored to foster an understanding of the developmental milestones and concerns that influence the thought processes and worldview of adolescents in crisis residence. Counselors must be aware of the developmental concerns associated with adolescence in order to understand the issues that lead many adolescent clients to crisis residence. Treatment considerations for adolescents were defined to clarify the meaning of crisis residence and describe the reasons for residential treatment of adolescents, offering additional insight into this particular population.

To develop an argument for the necessity of examining spirituality with this population, an understanding of the role of spirituality in the counseling profession was outlined. Since much importance is placed on this construct in the profession, it is pertinent to study spirituality with all populations of clients, including adolescents. Finally, spiritual development of adolescents and spirituality of adolescents were explored to demonstrate the relevance of this construct to adolescents in general and adolescents in crisis residence specifically.

Adolescent Development

Adolescence is a period marked with many changes and opportunities for growth and learning. Developmental theorists devoted much of their time to explaining the changes and expectations that occur during adolescence. Erikson (1964) described adolescence through the lense of psychosocial development, Piaget (1958) through the lense of cognitive development, Kohlberg (1963) through the lense of moral development, Havighurst (1956) through the lense of

developmental tasks, and Bandura (1977) through the lense of social learning theory. Each of their theoretical underpinnings of adolescence give counselors an understanding of adolescent clients and their worries, concerns, stressors, goals, and priorities. In order to have the best understanding of adolescents in crisis care, it is imperative to understand adolescent development.

Psychosocial Development

Erik Erikson (1964) believed that each human being goes through eight stages from birth to death before reaching his or her full development that he referred to as The Eight Ages of Man. The period of adolescence described by Erikson was the developmental stage of identity vs. role confusion. A relationship to the world of skills and tools is established and puberty begins, marking the end of childhood. During this stage, adolescents question the sameness and continuities that were relied upon in earlier stages because of the rapid body growth that is similar to that of early childhood and because of the addition of genital maturity in the stage. Individuals are faced with a physiological revolution within themselves and with the adult tasks that lay ahead of them. Because of this, the adolescents may be more concerned with out they appear from others' perspectives, as opposed to their own perspective (Erikson, 1964). They are also preoccupied with the question of how to connect the roles and skills they cultivated in earlier stages with the new occupational roles of their day (Erikson, 1964).

Individuals in identity vs. role confusion are searching for a new sense of continuity and sameness, so they are required to fight many of the same battles of their earlier years. In order to accomplish this, "they must artificially appoint perfectly well-meaning people to play the roles of adversaries; and they are ever ready to install lasting idols and ideals as guardians of a final identity" (Erikson, 1964, p. 261).

Role confusion is the danger of this stage. A strong previous doubt as to one's sexual identity can lead to role confusion. Furthermore, delinquent episodes and psychotic episodes are not uncommon in this stage. However, if diagnosed and treated in the proper manner, incidents such as psychosis and delinquency do not have the same long-lasting consequences that they do at other ages. In most instances, the inability to determine an occupational identity is the factor that disturbs individual adolescents in this stage of development (Erikson, 1964).

Cognitive Development

Piaget (1958) described cognitive development as occurring through four stages. The final stage, formal operations, transpires during adolescence. In this stage of development, the adolescent reverses the direction of thinking between reality and possibility. In previous stages of development, theory was derived from empirical data. Formal thought begins when the adolescent draws conclusions based on hypotheses that are later empirically verified. When an adolescent is faced with a problem, a general theory of all factors that may influence the outcome is utilized to deduce specific hypotheses that may occur. The adolescent then systematically construes the hypotheses to determine the truth status of each and to discover which hypotheses do in fact occur in the real world. Problem solving begins with possibility and proceeds to reality, or problem solving is hypotheticodeductive (Piaget, 1958).

Furthermore, propositional logic occurs during this stage of development (Piaget, 1958). Adolescents now have the ability to assess the logical validity of verbal statements, even if they refer to hypothetical scenarios rather than events that take place in the real world. Adolescents no longer compare or evaluate the logic of a statement by comparing it against evidence in the real world (Berk, 2007). This type of logic provides adolescents with access to knowledge that could not be cultivated before. For example, higher math can now be understood by an adolescent in

this stage of cognitive development. Also, "the adolescent is able to analyze his own thinking and construct theories" from this point on (Erikson, 1958, p. 340).

Developmental Tasks

Havighurst (1956) attributed development to a set of tasks that must be completed by all individuals and can be defined as "a task which arises at or about a certain period in the life of the individual, successful achievement of which leads to his happiness and to success with later tasks, while failure leads to unhappiness in the individual, disapproval by society, and difficulty with later tasks" (Havighurst, 1956, p.215). Three sources contribute to the creation of these tasks for a particular group of people: physical maturation, individual aspirations or values, and the expectations of society (cultural pressure). Schoeppe, Haggard, and Havighurst (1953) reported that performance on a developmental task at one age is positively correlated to performance of the same task at a later age. Once an individual has mastered a developmental task, the individual will always master the task.

Although developmental tasks are more powerful and motivating than social roles, a developmental task can be a social role that is expected of the majority of people in a society and which the greater part of individuals come to anticipate for themselves (Havighurst, 1956). Five developmental tasks for adolescents were reported and include: learning an appropriate sex role, achieving emotional independence of parents or other adults, developing conscience, morality and a set of values, getting along with age mates, and developing intellectual skills.

Moral Development

Moral development, originally postulated by Piaget (1932) and then researched by Kohlberg (1963), "represents the transformations that occur in a person's form or structure of thought" (Kohlberg & Hersh, 1977, p.54). Through the study of moral development, Kohlberg

identified how individuals solve problems related to their social world through the analysis of developing structures of moral judgment (Kohlberg & Hersh, 1977). The study of progression through the stages was considered to be a cognitive-behavioral approach to moral reasoning because active thinking about moral issues and decisions was stimulated in the child or adolescent and moral development saw the aim of moral education as the succession through several stages (Kohlberg & Wasserman, 1980). Each stage was a structural whole, movement through the stages always moves forward, never backward, and thinking at each stage included lower stage thinking (Kohlberg & Wasserman, 1980).

Kohlberg (1963) described moral development as occurring across time and through a series of six stages represented across three levels. The second level, conventional morality, was most often seen in adolescents. At this level, the individual makes moral decisions based upon meeting the expectations of family members, an important group, or society in general despite possible consequences. Decisions made at this level are based upon loyalty and support of personal expectations and social order as well as identification of the individual with the group. Conformity is important to individuals operating from the conventional stage of moral development (Kohlberg & Hersh, 1977).

Two stages of the model are seen at this level: stage 3 (good boy-nice girl orientation) and stage 4 (law and order orientation). Stage 3 was described as "orientation to approval and to pleasing and helping others" (Rest, Turiel, & Kohlberg, 1969, p.225). Individuals in this stage conform to stereotypes of the natural behavior of the majority and judge moral decisions based upon the intention or motive behind a behavior (Kohlberg & Hersh, 1977; Rest et al., 1969). Stage 4 was explained as an "orientation toward authority, fixed rules, and the maintenance of the social order" (Kohlberg & Hersh, 1977, p.55). Individuals operating from this stage wish to

show respect for authority and maintain the predetermined social order. Furthermore, they hold high regard for the earned expectations of others (Rest, et al., 1969).

Social Learning Theory

Bandura (1977) outlined the theoretical underpinnings of Social Learning Theory. The view of interaction from this standpoint was described as a process of reciprocal determinism, behavior, other personal factors, and environmental factors. Each of these factors functions as intertwined determinants of each other. The influence of each of these aspects differs in physical settings and for different behaviors. Additionally, from this theoretical perspective, individuals are "not driven by inner forces nor buffeted by environmental stimuli" (Badura, 1977, p. 11). Instead, psychological functioning can be understood in terms of a continuous reciprocal interaction of personal and environmental determinants. Learning through observation, modeling, and symbolic activities play a prominent role in Social Learning Theory. Self-regulatory capacities are also of utmost importance in this theory. "By arranging environmental inducements, generating cognitive supports, and producing consequences for their own actions, people are able to exercise some measure of control over their own behavior" (Bandura, 1977, p.13).

According to the social learning perspective, human nature is characterized as occurring through direct and vicarious experiences that take on a variety of forms within biological capacities. The level of development, biologically and socially, of each individual determines what knowledge can be acquired at a given time (Bandura, 1977). Most important is the significance that is placed on human agency in this theory (Bandura, 2002). Individuals can intentionally make things happen by their actions, including their functioning and life

circumstances (Bandura, 2001; Bandura, 2002). There are four key features to human agency: intentionality, forethought, self-reactiveness, and self-reflectiveness.

Intentionality refers to the idea that humans have a say in their behaviors and they choose to take a specific course of action. Individuals can exercise self-influence to determine whether they behave in an accommodating manner. Intentions are self-motivators that affect the likelihood of actions to be taken at a future time (Bandura, 2001). Forethought is an exercise that allows individuals to motivate themselves and guide their actions in expectancy of future events. A perspective of forethought allows an individual to provide coherence, direction, and meaning to life. Throughout the progression of life, the forethoughtful person will plan ahead, reorder priorities, and structure aspects of life accordingly. "In this form of anticipatory self-guidance, behavior is motivated and directed by projected goals and anticipated outcomes rather than being pulled by an unrealized future state" (Bandura, 2001, p.7).

Self-reactiveness refers to the ability of individuals to make way for appropriate courses of action and to regulate and motivate the execution of those courses. This is a self-regulatory process that links a person's thoughts to actions. "By making self-evaluation conditional on matching personal standards, people give direction to their pursuits and create self-incentives to sustain their efforts for goal attainment. They do things that give them self-satisfaction and a sense of pride and self-worth, and refrain from behaving in ways that give rise to self-dissatisfaction, self-devaluation, and self-censure" (Bandura, 2001, p.8).

Furthermore, individuals are not only agents of action, but also self-examiners of their individual functioning. The capability of an individual to reflect upon himself and the adequacy of his thoughts or actions describes the aspect of self-reflectiveness. "Through reflective self-consciousness, people evaluate their motivation, values, and the meaning of their life pursuits. At

this higher level of self-reflectiveness individuals address conflicts in motivational inducements and choose to act in favor of one over another" (Bandura, 2001, p.10). Individuals also use self-reflection to verify the soundness of their thinking. People can judge the accuracy of their thinking (predictive and operative) against the outcome of individual actions, the effects that the actions of others produce, the beliefs of others, conclusions from established knowledge, and what follows from that knowledge (Bandura, 2001). The most important mechanism of personal agency is this belief that individuals are capable to exercise a degree of control over their personal functioning and environmental events (Bandura, 1997).

Developmental Issues of Adolescents

Adolescents face challenges and situational stressors that are unique to their stage of development. Decisions are based on conformity, looking good in the eyes of others, perceived social roles, and personal agency (Bandura, 1997; Erikson, 1964; Havighurst, 1956; Kohlberg, 1963). Because this is an age where individuals are searching for their own identity and attempting to separate from their parents to become their own person, experimentation and risk-taking behaviors are prominent. Risk-taking is thought to be a normative element of adolescence, but many times risk-taking behaviors are a cause of concern for parents, teachers, researchers, and clinicians. Frequently, adolescents engage in health-endangering and problematic behaviors including tobacco and alcohol use, drug experimentation, unsafe sexual activities, poor eating habits, and delinquent actions (Sullivan & Terry, 1998). Many of these risk-taking behaviors are the cause of adolescent admission to acute crisis care facilities (Gosselin, DeMaso, & Sharfstein, 2009). The biopsychosocial model provides a framework for understanding the risk-taking behaviors of these adolescents.

Additionally, adolescents place tremendous importance on social relationships. These relationships play a significant role in decision making, mental health, and behaviors of adolescents. Understanding how social relationships impact the behaviors and well being of adolescents is important for counselors when working with adolescents in acute crisis care facilities and can offer an explanation to problematic adolescent behaviors.

Biopsychosocial Model

The biopsychosocial model of risk taking takes into account social and environmental factors as well as existing biological and psychological predispositions of adolescents to provide a framework for understanding adolescent risk-taking behaviors. This model considers all aspects of a client's life to give counselors an understanding of how to identify potential stressors and possible preventative interventions for adolescents. It is especially suitable for use in acute crisis care because of its emphasis on "the reality of the client's life outside of the treatment center" (Mosey, 1974, p. 139). Knowledge of everything that could contribute to problem behaviors is helpful not only for developing treatment strategies for clients but also for gaining insight as to what brings adolescents to acute crisis care facilities.

The biopsychosocial model "integrates the relationship of biological development to psychosocial processing during adolescence, and the relationship of risk-taking behaviors to psychosocial correlates of these behaviors" (Sales & Irwin, 2009, p.42). The psychological portion of the model focuses on "normal growth and development and deficits in the maturation process" (Mosey, 1974). The timing of maturation from a biological standpoint has a direct influence over four areas of psychosocial functioning: cognition, perception of self, perception of social environment, and personal values. According to the model, variables related to biology,

psychology, and environment of the adolescent are mediated by perceptions of risk and peer-group characteristics to predict adolescent risk taking (Sales & Irwin, 2009).

Early Maturation and Social Relationships

Socialization is a key component to the maturation of adolescents. This period is marked by a heightened self-consciousness that leads to increasing preoccupation with other people's judgments of their thoughts, actions, and appearance (Choudhury, Blakemore, & Charman, 2006). Interpersonal relationships that play on the emotions of an adolescent are the primary tool for teaching cultural patterns, expectations, and rewards for conforming to those expectations as adolescents transition from child to adult (Schoeppe, 1953). For this reason, adolescents become emotionally involved with members of the social groups to which they belong. They learn to imitate group members in social situations and, in either positive or negative ways, identify with parents, teachers, older youth, other influential people in their lives, and peers. Through identification with or emulation of these social groups, the adolescent "expedites his solution to many dilemmas of socialization which might otherwise be very difficult of solution" (Schoeppe, 1953, p. 175). The social environment of adolescents can contribute to levels of depression, use or non use of substances, mental health problems such as traumatic stress, anxiety and suicidal thoughts, self-esteem, school adjustment and socially adaptive behaviors, and healthy adjustment of adolescents in general (Barret & Turner, 2006; Colarossi & Eccles, 2003; Demaray, Malecki, Davidson, Hodgson, & Rebus, 2005; Mason, Schmidt, Abraham, Walker, & Tercyac, 2009; Reedy& Saunders, 2013; Reuger, Malecki, & Demary, 2010).

A primary developmental task of adolescence entails individuation from the family and identification with a peer group (Diclemente, Santelli, & Crosby, 2009). During early adolescence, adolescents spend more time with their age mates and place a tremendous amount

of importance on relationships with peers (Brown and Larson, 2009; Furman & Buhrmester, 1992). Also, during this time, youth place more emphasis on the intimacy and loyalty of friendship. Relationships with peers now require more sophisticated social skills as compared to previous stages of life when just participating in enjoyable activities together was the main aspect of friendship (Mounts, 2011).

Because of this period of separation from the family, parental impact on risk-taking may decline as peer influence increases throughout adolescence (Diclemente, et al., 2009). Jessor and Jessor (1977) reported that a greater influence of peers compared to parents was associated with a greater likelihood toward problem behaviors. Furthermore, the predominance of peer influence over parental influence predicted the use of marijuana, problematic drinking, and early sexual encounters. Lashbrook (2000) reported that in an attempt to avoid negative emotions, older adolescents may participate in risky behaviors with peers. The strongest predictor of delinquent behavior in adolescents was deviant peer affiliation when compared to variables such as school, family, and community characteristics (Elliot & Menard, 1996).

Peer relationships, however, are not the only social relationships that play a part in the well being and development of adolescents. Stewart and Suldo (2011) found that teacher support was a predictor of externalizing symptoms of adolescents, and in regards to academic achievement, adolescents with a higher perception of parental social support were associated with lower levels of externalizing symptoms such as rule breaking behavior and aggressive behavior. Additionally, parental support was associated with fewer internalizing symptoms and higher life satisfaction in adolescents (Rosario, Salzinger, Feldman, & Ng-Mak, 2008; Suldo & Huebner, 2004).

Treatment Considerations for Adolescents in Crisis

Because the transition from childhood to adulthood is marked by significant developmental, social, and psychological changes, adolescents sometimes have difficulty coping. The struggles associated with the developmental tasks and cognitive maturation of adolescence may cause significant stress and increase the vulnerability of adolescents to participate in risky behaviors or experience psychological crisis (Goldbeck, Schmitz, Besier, Herschbach, & Henrich, 2007). A crisis occurs when an adolescent presents a threat of harm to self or others (The American Academy of Child and Adolescent Psychiatry, 1996). This can include suicidal threats or attempts, homicidal threats or attempts, violent tendencies, or other self-destructive behaviors.

Treatment Options

Multiple treatment options are available for adolescents who are experiencing a crisis. The selection of an appropriate program "depends on the early history of the adolescent upset, the diagnostic configuration of the pathologic response, emotional and financial resources available in the family, and resources available in the community" (Feinstein & Uribe, 1985, p.603). The most common form of treatment for adolescents is outpatient therapy (Burns, Hoagwood, & Maultsby, 1998). Outpatient care is offered for individuals, families, or groups and usually takes place in a clinic or private practitioner's office (Burns, et al., 1999).

Partial hospitalization, also referred to as day treatment, is another form of outpatient treatment. This treatment option is more intense than individual, family, or group counseling. All of the treatment services offered in a psychiatric hospital are provided, but the adolescent returns home each evening (Burns, et al., 1999; The American Academy of Child and

Adolescent Psychiatry, 2008). Sometimes, however, outpatient treatment is not the best option for an adolescent.

Psychiatric inpatient services are utilized when clarification of a diagnosis is needed and/or when a safe or contained environment is necessary for protection of the adolescent or others in times of crisis, suicidality, or escalated behavioral problems (Gosselin, DeMaso, & Sharfstein, 2009). Hospitalization of adolescents may be required if outpatient alternatives are not effective, are refused by the family, or when the adolescent is overtly or potentially posing a threat to self or others. Hospitalization is also considered if an adolescent's behaviors are self-destructive or if the individual manifests behaviors such as repetitive running away, promiscuity, violence, truancy, extreme mood swings, social isolation, psychosomatic dysfunction or psychosis (Feinstein & Uribe, 1985).

The most common form of psychiatric hospitalization for adolescents is acute care or crisis residence. Short term crisis intervention and treatment occur in this setting, and treatment usually lasts less than 15 days. Adolescents in crisis residence receive 24-hour per day supervision with the focus of treatment being stabilization (American Academy of Child and Adolescent Psychiatry, 2008; King, Hovey, Brand, & Ghaziuddin, 1997). A client is stable when able to verbalize the intention to no longer harm oneself or others, achieve therapeutic goals that are in line with those intentions, and demonstrate a decrease in symptoms (Balkin & Roland, 2007). Several variables have been explored to determine what factors may influence the outcome of treatment for adolescents in crisis residence (Balkin, Casillas, Flores, & Leicht, 2011; Balkin, Leicht, Sartor, & Powell, 2011; Balkin & Roland, 2005). Spirituality is not one of those variables. However, the significance that spirituality plays in the lives of clients and the importance that is placed on spirituality in the counseling profession necessitates an

understanding of spirituality and its role in the profession along with the influence of spirituality in adolescence.

Spirituality in Counseling

Mental health professionals have often viewed spirituality as a basis for problems rather than as a source of solutions, but the majority of individuals who look to their faith for support find it helpful and many people are sustained and supported in their daily lives as well as in stressful times through involvement in regular religious practices. Through the lens of spirituality, the characteristics of problems can change and solutions can appear. Individuals begin to see their lives in a broad, transcendent viewpoint, discern deep truths in ordinary or extraordinary experiences, and find timeless values that offer grounding and direction during changing times and uneasy circumstances (Pargament, 2007).

History of Spirituality in the Profession

Frank Parsons' and Jesse Davis' works in vocational counseling and guidance played a tremendous role in the development of contemporary professional counseling (Kelly, 1995). Their perspectives' of spirituality and religion were mostly positive and varied greatly from the predominant, negative view of spirituality and religion in the origins of science based psychology (Kelly, 1995). Parsons (1909) affirmed the possible positive value of spirituality and religion for personal development and Davis (1914) saw a fundamental connection between occupational success and the moral qualities of individual workers and between moral qualities and positive religious influences.

Despite Parson's and Davis' views of the importance of religion and spirituality in the counseling profession, for many years religion and spirituality were dismissed from the profession. Frame (2003) reported that historically, most mental health professionals held a

negative view of religion and spirituality. One explanation for this opposition from mental health professionals was the influence of some of the prominent psychology scholars such as Freud, Elis and Skinner on the profession (Young, Wiggins-Frame, & Cashwell, 2007). Freud (1927) viewed religious beliefs as a source of mental problems and fantasies. Another explanation for "excluding religion and spirituality from clinical work came from the conflict between the scientific, objective perspective of psychology and the transcendent, subjective aspects of religion" (Young, et al., 2007, p.47).

Jung's View of Spirituality

Carl Jung was among the first clinicians to determine that religion was an important component of psychology. Jung described the goals of the counselor and the client to be "directed towards that hidden and as yet unmanifest 'whole' man, who is at once the greater and the future man" (Jung, 1953, p.434). He regarded popular psychology as being compartment psychology which did not focus on the whole picture but instead on small pieces of the whole man. Jung believed that the idea that Christianity led to arrested development was false and said that religion should not be blamed for something that was due mainly to human incompetence.

Jung (1953) argued that "religion excels all rationalistic systems in that it alone relates to the outer and inner man in equal degree" (p.436). However, the superficialities and misunderstandings of Christianity by individuals or by society lead to the objectification of worship, which prevented the spiritual "from reaching down into the depths of the soul and transforming it into wholeness" (Jung, 1953, p. 437). In other words, Christianity or religion itself was not the problem; instead the misunderstanding by man of what Christianity really was prevented individuals from experiencing the benefits of developing and exalting the inner man.

Allport's View of Spirituality

Gordon Allport (1950) questioned the disinterest in religion throughout the field of psychology. He argued that religion should be included in psychology and psychological treatment of individuals because "religious sentiments of mankind-whatever the fate of institutional religion may be-are very much alive and will perhaps always remain alive, for their roots are many and deep" (Allport, 1950, p.3). Contrary to the psychological view of his time that described religion as being irrational, Allport explained that subjective religion was a blend of reason and emotion, of feeling and meaning. He expressed disappointment that psychology did not have a term to "designate this cognitive-affective fusion" (p.18) which he described as a state of mind that fuses emotion and logical thinking.

Furthermore, Allport (1950) elucidated that the sentiment of religion was a personal one, which led to special significance in each individual's life. The mainstream view of religion by social scientists at the time, however, was that the function of religion was to produce social stability. Allport (1950) believed that psychology and social science would benefit if they began to understand the truth that there was no single explanation for the religious experiences of individuals, instead they must be understood in the context of each individual. Allport was also one of the first psychologists to distinguish a difference between childhood or adolescent religious interpretation and that of adults. He stated that belief in a higher power develops across three stages: a period of raw credulity, a period of doubts, and a period of evolving our beliefs with our values and sentiments.

Allport asserted that what an individual believes is to a large extent the determinant of mental and physical health and "religious belief, simply because it deals with fundamentals often turns out to be the most important belief of all" (Allport, 1950, p.89). An individual, who

possesses a mature religious sentiment, cannot be categorized as an escapist or evasive. Rather, Allport called psychotherapists to recognize the similarities of religion and psychotherapy in that they both recognize the needs of a healthy mind. He described religion as being based on love and fulfilling man's need for loving attachment. The focus of psychology on hostile, negative phenomena, reactive conditions, such as, aggression, compulsive sexuality, fear, and hate, meant psychologist were placing their attention on the pathological conditions that manifested due to love deprivation, or lack of religion or belief. "Love of God is needed in order to make life seem complete, intelligible, right" (p.93). In other words, religious sentiment served an important function in the personality of the individual.

ASERVIC- Current View of Spirituality in Counseling Profession

The groundwork that was laid by these theorists in the areas of spirituality and religion has influenced the counseling profession as a whole. A great deal of attention is now placed on the effect that spirituality has in client's lives. The Association of Spiritual, Ethical, and Religious Values in Counseling (ASERVIC) has transformed through the years to become the central force of spirituality in the counseling profession. In a period from 1961 to 1977 the association evolved from three organizations (The Catholic Counselors, the founders of the *Catholic Counselor*, and the National Conference of Guidance Counselors) to become the National Catholic Guidance Conference, a division of the American Personnel and Guidance Association. Later, the name changed to the Association of Religious and Value Issues in Counseling to represent the ideal that the organization was no longer comprised solely for Catholic professionals but for "examining counseling in terms of its religious and values issues" (Bartlett, Lee, & Doyle; Miller, 1999, p.498). In 1993, the name of the organization evolved one final time into the Association of Spiritual, Ethical, and Religious Values in Counseling as the

result of a decision by the American Counseling Association to include the words *spiritual* and *ethical* in the title. *Religion* alone did not fully encompass the priorities of the association (Miller, 1999).

Because the focus of ASERVIC is spirituality, the association plays a tremendous role in the American Counseling Association's commitment to diversity in counseling, including spirituality (Miller, 1999). In recent years, the importance of spirituality in client care has been recognized by the American Counseling Association (ACA). The ACA endorsed a set of spiritual competencies created by ASERVIC (Cashwell & Watts, 2010; Miller, 1999), which now includes six spiritual domains that counselors should be knowledgeable of: culture and worldview, counselor self awareness, human and spiritual development, communication, assessment, and diagnosis and treatment. Additionally, a survey completed by a random sample of 600 ACA members yielded results that counselors perceived the spiritual competencies to be of high importance (Young, Frame, & Cashwell, 1998). The endorsement of the spiritual competencies by the ACA and agreement among professional members of the organization that the competencies are of high importance demonstrates the influence that ASERVIC has on the counseling profession and validates the importance of the inclusion of religion and spirituality into client care.

Spiritual Development of Adolescents

Spiritual development during adolescence is just as important to consider as any other area of development. Good and Willoughby (2008) reported that the most sensitive period for exploration and development of spirituality and religion is adolescence. This is a period when adolescents begin to experience apprehension about their beliefs, question individual beliefs, and take on beliefs that are most compatible with their budding personal world view (Magaldi-

Dopman & Park-Taylor, 2010). Furthermore, the formal-operational stage of development, as described by Piaget (1958), allows adolescents to begin to "understand abstract concepts, see interrelationships, draw high-level conclusions, and think in terms of general principles such as goodness and evil (Gollnick, 2005, p.68). Paloutzian (1996) reported that during this stage of development, adolescents experience a time of increased questioning about all things, including religion.

For the first time, adolescents possess the capability to think about abstract concepts such as religion or spirituality, understand the relationship between God or a Higher Power and themselves, develop their own conclusions about religious ideology, and apply the principles of goodness and evil to those conclusions. Furthermore, the ability to think hypothetically in this stage of development allows adolescents to begin to envision a number of possibilities related to beliefs, identity, behavior, and attitudes, to conceptualize the basic ideas of religion and value systems, and to compare and assess those ideas and possibilities. Because of this, a major aspect of religion during adolescence is to question religious ideas, values, and beliefs that have been established by family (Gollnick, 2005).

Religious conversion is most likely to take place during adolescence (Spika, Hood, Hunsberger, & Gorsuch, 2003). At this time in an individual's life, spiritual beliefs and values are considered from multiple perspectives, leading adolescents to determine their own personal spiritual, religious, agnostic, or atheist identity (Magaldi-Doopman & Park-Taylor, 2010).

Fowler (1981) outlined a comprehensive model of spiritual development that is referred to as Faith Development. Fowler used the word faith rather that religion because he believed religion was the outward, cultural expression of an individual's faith. His definition of faith was closely aligned with modern definitions of spirituality (Parker, 2011). He described faith as "the

most fundamental category in the human quest for relation to transcendence" (Fowler, 1981, p.14). Fowler believed that faith was a universal feature of all humans and was an orientation to the whole person. Faith gave purpose and goals to an individual's hopes and strivings, thoughts and actions (Fowler, 1981).

The structures that were used to develop the stages of faith were based on the works of Piaget, Kohlberg, Erickson, Selman, and Fowler's own contributions (Fowler, 1981; Parker, 2011). The model described one pre-stage and six stages of faith development: Infancy and Undifferentiated Faith, Stage 1. Intuitive-Projective Faith, Stage 2. Mythic-Literal Faith, Stage 3. Synthetic-Conventional Faith, Stage 4. Individuative-Reflective Faith, Stage 5. Conjunctive Faith, and Stage 6. Universalizing Faith. The model also addressed typical developmental crises and transitions between the stages (Fowler, 1981).

Although each individual may progress through the stages at different times, the stage thought to be most common among adolescents is stage 3: Synthetic-Conventional Faith. In this stage, faith provides a basis for identity and outlook and synthesizes values and information. This stage is a conformist stage because individuals focus on the expectations and judgments of those they hold in high regard. Individuals in this stage do not have a firm grasp of their own identities or posses autonomous judgment to form and uphold a personal perspective of faith.

At this stage, an individual "has an "ideology," a more or less consistent clustering of values and beliefs, but he or she has not objectified it for examination and in a sense in unaware of having it" (Fowler, 1981, p.173). During this stage, a personal myth emerges that describes an individual's developing identity and faith beliefs. This myth incorporates the past and anticipated future of the individual to portray the ideal environment and characteristics of

personality that the individual hopes to attain. Folwer (1981) described the dangers or deficiencies in this stage:

> The expectations and evaluations of others can be so compellingly internalized (and sacralized) that the later autonomy of judgment and action can be jeopardized; or interpersonal betrayals can give rise either to nihilistic despair about a personal principle or ultimate being or to a compensatory intimacy with god unrelated to mundane relations. (p. 173)

Several factors contribute to the breakdown of this stage as well as to readiness for transition. An individual may experience major contradictions between valued sources of authority or may be confused by changes in sanctioned or religious leaders or policies and practices that were formally considered sacred and unbreachable. Furthermore, an individual in this stage may encounter experiences or perspectives that cause critical reflection on how his or her own beliefs or values were formed or have changed and how those beliefs and values align with the individual's cultural group or background. Finally, the experience of leaving home to become independent either emotionally or physically can lead to "the kind of examination of self, background, and life-guiding values that gives rise to stage transition at this point" (Folwer, 1981, p.173).

Adolescent Spirituality

The influence of spirituality in the life of adolescents has not been overlooked in the counseling profession. Scales and Leffert (2004) reported that adolescents with stronger religiosity were less likely to engage in delinquent activities and risky behaviors and more likely to participate in altruistic or pro-social behaviors. Adolescents who placed a high importance on prayer and personal religion had low levels of cigarette and alcohol use and high levels of self-

esteem (Resnick, et al., 1997). Religiosity contributed to lower levels of drug use, risky sexual behaviors, hostility, and aggression (Bullock, Nadeau & Renaud, 2012) and was reported to be a protective factor against conduct problems (Pearce, Jones, Schwab-Stone, & Ruchkin, 2003).

Religion and spirituality were reported to serve as protective factors that inhibit negative outcomes such as depression and substance use and promote positive outcomes such as subjective well-being in adolescents (Koenig, McCullough, & Larson, 2001). This may be explained by the role that a religious or spiritual community has in being gatekeepers of mental health and well being (Bullock, Nadeau, & Renaud, 2012). Additionally, religiosity or spirituality have been reported to be factors contributing to resilience in adolescents (Crawford, Wright, & Masten., 2006; Van Dyke & Elias, 2007; Werner, 1984).

Corwyn (2002) found that religiosity did not relate to the likelihood that an adolescent would not engage in substance use. Furthermore, several studies have concluded that the protective factor of religiosity on anti-social or risky behaviors is negated when negative peer influence is present (Brenda & Corwyn, 1997; Chadwick & Top, 1993; Grier & Gudiel, 2011; Mason & Windle, 2002). Possible harmful effects of religion or spirituality including negative religious coping or spiritual struggles have been associated with poor psychological adjustment (Ano & Vasconcelles, 2005). Some spiritual beliefs can lead adolescents to manage problems through avoidant coping, escape, or denial in which an adolescent absolves oneself from any responsibility (Callaghan & Irwin, 2003).

Chapter Summary

In this chapter, and extensive review of the literature related to the study under investigation was conducted. Adolescent development, developmental issues, history of spirituality in the counseling profession, spiritual development, adolescent spirituality,

developmental concerns and treatment options were explored in the literature. Each of these areas combine to achieve a thorough understanding of adolescents and the role that development and spirituality play in shaping their thought process, coping mechanisms, and socialization. Furthermore, developmental theories and spirituality provide a framework for understanding how adolescents in crisis residence view the world around them, themselves, and other people in their lives. This understanding aids in the process of learning what influences adolescents in crisis residence to engage in behaviors that lead to hospitalization and understand possible variables that may influence their treatment. The following chapters will consist of results, and discussion of the research study.

CHAPTER 3

Method

The following are presented in this chapter: research questions, research design, description of the participants, instrumentation, procedures for data collection, and statistical procedures for data analysis.

The purpose of this study was to explore the relationship between spirituality, spiritual and religious coping, symptom change, and goal attainment of adolescents in crisis residence. This study began to fill the gap in the counseling literature related to adolescents in crisis residence and spirituality.

The following research question was examined to explore the relationship between spirituality or spiritual/religious coping, goal attainment, and change of symptoms of adolescents in crisis residence: To what extent is there a relationship between spirituality and outcome of treatment of adolescents in crisis residence?

Research Design

A correlational research design (Dimitrov, 2010) was utilized for this study to explore the relationships between spirituality of adolescents in crisis residence and goal attainment, spirituality of adolescents in crisis residence and symptom change, spiritual/religious coping of adolescents in crisis residence and goal attainment, and spiritual/religious coping of adolescents in crisis residence and symptom change. The criterion variables in this study were therapeutic goal attainment and symptom change. The predictor variables in this study were spirituality and spiritual/religious coping. Goal attainment was measured by the Goal Attainment of Stabilization Scale (Balkin & Roland, 2007) and symptom change was measured by the Target Symptom Rating Scale (Barber, Neese, Coyne, Fultz, & Fongay, 2002). Predictor variable data

was collected through use of the Brief Spiritual and Religious Coping Scale (Paragment, 1999) and The Daily Spiritual Experience Scale (Underwood & Teresi, 2002).

A correlational research design was determined to be the best strategy for this study because the variables under investigation were simply being observed as they exist and no attempt was made to control or manipulate any variables in the study, a key element of correlational research (Gravetter & Wallnau, 2007). Also, the research question focused on measuring or describing the relationship between the variables in the study rather than on comparing scores of different groups, another characteristic of correlational research (Gravetter & Wallnau, 2007).

Setting

Data for this study was collected from adolescent patients and their counselors at an acute care psychiatric facility in the southern gulf coast. Patients were admitted to the hospital for suicidal ideations or attempts, homicidal ideations or attempts, aggressive or violent behavior, or inability to function due to psychosis or other psychological symptoms. The average length of stay for adolescents in the unit was 7 days, with some patients staying fewer days and some staying more days.

The treatment varied for each individual, but all adolescents in the unit attended group therapy, activity/recreational therapy, and a psychoeducational/nursing educational group once per day. Furthermore, the unit schedule was utilized as an intervention in itself. Patients completed certain tasks at certain times, providing a sense of structure that is often lacking in their daily lives. Interventions utilized by individual clinicians included existential questioning, rational emotive behavioral therapy, cognitive behavioral therapy, dialectical behavioral therapy, motivational interviewing, solution focused therapy, and narrative therapy.

In addition, each adolescent participated in a minimum of one family therapy session prior to discharge. The session was primarily solution-focused within a family systems framework. The following questions were processed from each family member's perspective: (1) What was the reason for your (or your child's) admission to the hospital? (2) What are the underlying causes of those behaviors? (3) What are you willing to do to make change for the future?

Participants

The Institutional Review Board of Texas A&M University-Corpus Christi and the adolescent unit of an acute care psychiatric facility in the southern gulf coast granted approval for participants to volunteer for the study. Participants were adolescent clients (N = 85) ages 12-17 (M =14.92, SD = 1.45) admitted to an acute care psychiatric facility in the southern gulf coast for crisis residence. Female to male ratio was 44% (N = 37) to 56% (N = 47), respectively. One participant did not report an age. Over 34% of the participants identified their religion as Christian, 20% as Catholic, 5.9% as Baptist, 1.2% as Presbyterian, 1.2% as Morman, 2.4% as Agnostic, 2.4% as Satanist, 7.1% as Atheist, 1.2% as Jehovas Witness, 18.8% as none, and 5.9% did not answer. Over 50% of the participants reported their ethnicity as Hispanic, 29.4% as Caucasian, 8.2% as Mixed Heritage, 2.4% as African American, 2.4% as Native American, and 5.9% did not answer. Every adolescent admitted to the hospital was invited to participate in the study. Adolescents who provided assent after the legal guardian provided consent completed the study.

The sampling method used for this study is referred to as convenience or non-probability sampling because an intact group that was readily available for use by the researcher was utilized

(Cohen & Swerdlik, 2010). Convenience sampling is common in social science research because of the need for informed consent and/or assent.

Participants were recruited during intake at the behavioral hospital. The intake packet that is given to guardians upon admission of adolescents to the hospital included an informed consent form for guardians to complete. Only adolescents whose guardian agreed to informed consent were given an assent form, and only adolescent who agreed to assent participated in the study.

Tabachnick and Fidell (2007) reported that a 10:1 ratio for interpreting one canonical variate was appropriate to determine the number of participants needed for a study. Each subscale utilized in the study was a variable. In the case of this study, a total of 7 subscales were used: follow up and coping (GASS), positive and negative coping (RCOPE), behavioral and emotional problems (TSR), and daily spiritual experiences (DSES). In keeping with the guidelines of a 10:1 ratio for determining an appropriate sample size, a target sample size for this study was 70.

Measures

Goal Attainment of Stabilization Scale

The GASS is a 25 item scale that is completed by the clinician and used to rate specific goals that are related to two subscales: coping skills and commitment to follow-up (Balkin, 2013). The coping subscale "measures a client's ability to (a) commit to safety, (b) identify problems, and (c) process coping skills" (Balkin, Leicht, Sartor, & Powell, 2011). Sample items from this coping subscale include, "The client worked towards identifying personal strengths to encourage coping and decrease stress," "The client is not longer a danger to self or others," and "The client understands how his/her behavior may have contributed to the problem." The

commitment to follow-up subscale measures "the client's ability to identify resources and commit to use the resources beyond hospitalization" (Balkin, Leicht, Sartor, & Powell, 2011, p.35). Sample items from this subscale include, "The client agrees to attend follow-up services," "The client has access to support outside the immediate home environment," and "Appropriate services/resources were identified by the client."

Upon discharge, each client is rated on a scale from -2 to +2 for each item. A score of -2 denotes the least favorable outcome and indicates that the client was below attainment of the stated goal. A score of -1 means the outcome is less than desired or expected and indicates that the client is slightly below the attainment of the stated goal. A score of 0 means the client attained the desired or expected outcome and indicates that the client attained the stated goal. A score of +1 means that the outcome is more than desired or expected and indicates that the client was slightly above attainment of the stated goal. A score of +2 denotes the most favorable outcome and indicates that the client was above expected attainment of the stated goal (Balkin, 2013).

The GASS had an overall reliability of .96 from the scores on the normative sample and reliability coefficients were strong, r = .97 for the coping subscale scores and r =.96 for the commitment to follow up subscale scores (Balkin, Leicht, Sartor, & Powell, 2011; Balkin & Roland, 2007; Balkin & Roland, 2005). Strong convergent and discriminant evidence were noted for the GASS (Balkin, Leicht, Sartor, & Powell, 2011).

Eighteen items on the GASS are associated with coping and 7 items are related to commitment to follow-up. Evidence of internal structure was assessed for each subscale using a Modified Multitrait-Multimethod Matrix method. Intercorrelations for items associated with problem identification ranged from .83-.86. Intercorrelations for items associated with

processing coping skills ranged from .62 to .90. Intercorrelations for items associated with commitment to follow-up ranged from .47 to .83 (Balkin, 2013).

Discriminant validity evidence was obtained for the GASS by examining intercorrelations of the subscales to ensure that each subscale measured a separate construct. Originally, three subscales were analyzed: problem identification, commitment to follow-up, and processing coping skills. The intercorrelations for the subscales were $r = .58$ (problem identification and commitment to follow-up), $r = .62$ (processing coping skills to commitment to follow-up), and $r = .86$ (problem identification to processing coping skills). Commitment to follow-up had distinctive qualities from problem identification and processing coping skills. Problem identification and processing coping skills, however, were highly correlated and statistically the items were more difficult to differentiate meaning only two subscales were present for the instrument: commitment to follow-up and coping skills (Balkin, 2013; Balkin, Leicht, Sartor, & Powell, 2011; Balkin & Roland, 2007).

Daily Spiritual Experience Scale

The DSES is a self-report measure consisting of sixteen items. The instrument was designed to measure every day, ordinary spiritual experiences and how they are a part of the individual's daily life (Underwood & Teresi, 2002). Sample items from the scale include, "I feel God's presence", "I feel comfort in my religion or spirituality", and "I feel a selfless caring for others", The first 15 items of DSES are measured on a 6-point Likert-type scale*: many times a day, every day, most days, some days, once in a while, and never or almost never*. Item 16 is measured on a 4-point scale: *not close at all, somewhat close, very close, as close as possible.* Lower scores on the scale indicate more frequent daily spiritual experiences (Underwood & Teresi, 2002).

Evidence of validity was established for the DSES through in depth interviews and focus groups with individuals from a variety of religious backgrounds and through reviewing other scales and theological, spiritual, and religious writings (Underwood & Teresi, 2002). Correlations among the items of the DSES were moderate to high ranging from $r = .60$ to $r = .80$. Internal consistency reliability estimates for the scores from the normative sample were high, $r = .94$.

Several exploratory factor analyses (EFA) were conducted for the DSES. First, an exploratory principal factor analyses was performed to examine the dimensionality of the DSES. The item set was unidimensional for this sample set (Underwood & Teresi, 2002). Next, an EFA with oblique rotation was conducted. Nearly all items loaded highly on the first factor, with loadings ranging from .69 to .93. Two items loaded at .33 and .27, but only accounted for 8% of explained variance (Underwood & Teresi, 2002). Two additional EFAs were performed with the dichotomization of items at two different points. The second dichotomization- the combination of *never, once in a while,* and *somedays* versus *most days* to *many times a day*- yielded results more similar to those with continuous response format and performed more consistently. The internal consistency for this version of the scale scores was .93 (Underwood & Teresi, 2002).

Target Symptom Rating Scale

The TSR consists of 13 ratings of symptoms that describe the variety of problems typically demonstrated by children and adolescents in intensive treatment settings. Clinicians who utilize the scale are asked to "rate each symptom based on your knowledge of the youth as compared with *normal* same-age peers. Rate for the time period of the *most recent seven days*" (Barber et al., 2002, p.191). Symptoms are numbered and five responses are available for the clinician to use to rate the adolescent. For example, "1. Family Conflict: *1.No significant family*

conflict; minor conflicts are resolved without distress 2. Minor conflict only, which are resolved within the family 3. Moderate conflicts which family cannot resolve independently, causing distress in one or more family members 4. Serious conflicts, causing significant distress in family members. 5. Severe conflicts which escalate and become out of control without external intervention" (Barber et al., 2002, p.191).

The scale was developed through the review of structured admission interviews conducted with adolescent patients and their parents to extract common presenting problems. Then, 5-point example-anchored scales were developed for each of the common presenting problems and were reviewed by senior clinicians (Barber et. al, 2002).

Evidence of validity of the scale was assessed through a survey of experienced child and adolescent clinicians. Each of the 13 items of the scale was rated on four dimensions: Relevance to Inpatient Settings, Relevance to Residential Settings, Relevance to Outpatient Settings, and Clarity of Anchor Definitions. The respondents ranked each item on a 5-point scale ranging from 1 (*very poor*) to *5* (excellent) as well as rated the extent to which the entire scale was representative of the problems seen in their clinical work with children and adolescents. The mean score for Inpatient Relevance was 4.27, for Residential Relevance was 4.27, and for Outpatient Relevance was 4.33. The overall mean rating for clarity of item anchors was 4.08. For the question regarding whether the items as a whole were representative of the kinds of problems seen in clinical work, the mean score was 4.40 (Barber, et. al, 2002).

An exploratory principal components analysis was conducted on the 13-item scale. A two-factor solution was utilized for the scale. The subscales were labeled "Emotional Problems" (depression, anxiety, psychosomatic problems, suicdality, and psychotic symptoms) and "Behavior Problems" (family conflict, peer relationship problems, school difficulties, self-

destructive/dangerous behaviors, aggression, substance abuse, runaway, out of control problems, and impulsivity) (Barber, et. al, 2002). Eigenvalues for the first factor across informants and assessment points (primary clinician at admission and discharge, family therapists, patient self-report, parent reported problems) ranged from 3.00 to 5.23 and for the second factor, ranged from 1.46 to 2.44. The two factors accounted for 38% to 52% of the variance (Barber, et. al, 2002). The internal consistency of the scale was examined. Coefficient alphas for the scores on the Behavioral Problems subscale ranged from .65 to .85, with a median of .76. Coefficient alphas for the scores on the Emotional Problems subscale ranged from .56 to .76, with a median of .70.

Religious and Spiritual Coping Scale

The Brief Religious and Spiritual Coping Scale is used to measure the extent to which individuals utilize religion or spirituality to cope with life stressors. A short form (7-item) or long form (14-item) version of the assessment may be utilized. For this study, the short form will be used. Sample items for the scale include, "I think about how my life is part of a larger spiritual force", "I look to God for strength, support, and guidance", and "I wonder whether God has abandoned me" (Fetzer Institute, 2003, p.87) Individuals use a 4-point Likert scale (*0 not at all* to *3 a great deal*) to indicate the extent to which they use methods of religious or spiritual coping to deal with a critical life event. Previous empirical studies and existing religious coping scales were utilized to determine the items for the RCOPE as well as interviews with individuals who were relying on religious and spiritual beliefs to cope with current life stressors (Pargament, Feuille, & Burdzy, 2011).

The Brief RCOPE is a condensed version of the original RCOPE. Two subscales were identified: Positive Religious Coping and Negative Religious Coping. Each subscale consisted of

3 items. Positive religious coping methods were "those that rest on a generally secure relationship with whatever the individual may hold sacred" and negative religious coping methods were "those that are reflective of tension, conflict, and struggle with the sacred" (Pargament, Feuille, & Burdzy, 2011, p.54).

Confirmatory factor analyses were conducted indicating that the two factor solution provided a reasonable fit for the data (Pargament, Feuille, & Burdzy, 2011). Positive religious coping methods scores lead to greater spiritual growth after dealing with a stressor and fewer psychosomatic symptoms. Negative religious coping scores correlated to increased signs of psychological distress, poorer quality of life, and greater callousness towards other people (Pargament, Feuille, & Burdzy, 2011).

Scores from the normative sample of the Brief RCOPE demonstrated good internal consistency. The alpha for scores of the Positive Religious Coping Scale ranged from .67 to .94with a median alpha of .92. The alpha for scores of the Negative Religious Coping Scale ranged from .60 to .90 with a median alpha of .81 (Pargament, Feuille, & Burdzy, 2011).

Data Collection Procedures

Clinicians at the data collection site were trained in the use of the GASS and TSR to ensure interrater reliability before data collection began. Study packets were provided by the researcher to the hospital. Each study packet included a guardian consent form, client assent form, attending clinician Target Symptom Rating Scale (TSR) pre-assessment, client Demographic Information Sheet, client Daily Spiritual Experience Scale (DES), client Religious and Spiritual Coping Scale (RCOPE), attending clinician TSR post assessment, and attending clinician Goal Attainment Scale (GASS) stapled together.

Participants for this study were derived through the assistance of staff at the hospital. Guardians of adolescents were contacted by hospital staff. Upon admission to the hospital, guardians were asked to complete a consent form for the study. Once consent was obtained from the guardian, the entire packet was given to the attending clinician for each adolescent. The packet was stored in a secure, locked location and was kept in the client chart. The attending clinician attained assent from the adolescents whose guardians consented to study participation. After assent was obtained, the attending clinician completed the TSR pre-assessment and provided the client with the Demographic Information Sheet, DSES, and the RCOPE for completion. It took approximately 15 minutes for the adolescents to complete the combined scales (Demographic Information Sheet, DSES, and RCOPE). The adolescents completed each of the scales on their own, and only completed the scales one time. No incentives were offered to the adolescents or the attending counselors who participate in the study.

When the client was discharged from the hospital, the attending clinician completed the TSR post assessment and the GASS. No more than 10 minutes were needed for completion of each form. All consent and assent forms were unstapled from the packets and placed in a folder separate from the remainder of the packet documents. This provided a blinded copy of the test packets to the researcher and allowed for anonymity in the study. No information related to the study was kept by the hospital as part of the patient's permanent medical file.

Adolescents obtained normal treatment during the course of the study. No additional interventions were utilized by clinicians.

Data Analysis

The Statistical Package for the Social Sciences (SPSS) software (SPSS, 2007) was used to perform a canonical correlation analysis to acquire the needed information to answer the research question for this study. Model assumptions, including normality, homoscedasity, and linearity were verified prior to performing the canonical correlation (Tabachnick & Fidell, 2007).

A canonical correlation was conducted to determine the relationship between spirituality, religious and spiritual coping, goal attainment, and symptom change of adolescents in crisis residence. A canonical correlation is used to analyze the relationships between two sets of variables. Canonical correlation is an exploratory technique rather than a confirmatory procedure (Tabachnick & Fidell, 2007).

For the purpose of this study, the two sets of variables under investigation were spirituality (as measured by the DSES and RCOPE) and treatment outcome (as measured by the GASS and TSR). A canonical correlation offered a statistical analysis for this study in which spirituality was measured on three variables and treatment outcome was measured on four variables to inform the researcher if and how the two sets of variables related to each other (Tabachnick & Fidell, 2007). Spirituality variables were positive religious coping, negative religious coping, and daily spiritual experiences. Treatment outcome variables were emotional problems, behavioral problems, commitment to follow-up, and coping.

Chapter Summary

In this chapter, I described the research questions, research design, description of the participants, instrumentation, procedures for data collection, and statistical procedures for data analysis for the study. A correlational research design (Dimitrov, 2010) was utilized in this study to gather the appropriate data to answer the research questions. Four instruments were

utilized throughout the study: DSES, RCOPE, GASS, and TSR. Participants were adolescents in crisis residence at an acute care psychiatric facility in the southern gulf coast. A canonical correlation was utilized to analyze the data for this study (Tabachnick & Fidell, 2007), and SPSS software (SPSS, 2007) was used to conduct the canonical correlation.

CHAPTER 4

Results

The following are presented in this chapter: preliminary analysis, reliability coefficients and results of the study.

A correlational research design (Dimitrov, 2010) was utilized to explore the relationship between spirituality and outcome of treatment for adolescents in crisis residence. Spirituality was measured by daily spiritual experiences and spiritual/religious coping. Outcome of treatment was measured by change of symptoms and therapeutic goal attainment. The research question under investigation was: To what extent is there a relationship between spirituality and outcome of treatment of adolescents in crisis residence?

Preliminary Analysis

A total of 94 participants completed the study. Nine of the participation packets were missing data for at least one complete scale. A listwise deletion, the most common method for handling missing data in social science research, was used to remove the results of the nine participants from the data set leaving a total of 85 cases to be analyzed (Tabachnick & Fidell, 2001). Fourteen individuals were missing data for one item from one scale. Mean item imputation was utilized to compute values for the missing items. The missing values for these items were replaced with the mean of the variable for the data set (Tabachnick & Fidell, 2001).

Model assumptions for canonical correlation were addressed through analysis of normality, linearity, and homoscedasity. Box plots and Q-plots revealed that a normal distribution of the variables for each scale was present in the study. Linearity was analyzed through the use of scatter plots, which revealed that the assumption of linearity was met for this study. Scatter plots were also utilized to determine that the model assumption of homoscedasity

was met. Outliers were present but did not appear to affect normality, so the integrity of the data set was maintained (e.g. outliers were not removed).

Reliability

Reliability was measured for each scale using Cronbach's Alpha. Reliability coefficients for the scores on the GASS were strong, r = .87 for the commitment to follow up subscale scores and r = .94 for the coping subscale scores. These scores were slightly lower than those reported for the normative sample published for the GASS, r = .97 for the coping subscale and r = .96 for the commitment to follow-up subscale (Balkin, 2013; Balkin, Leicht, Sartor, & Powell, 2011; Balkin & Roland, 2007; Balkin & Roland, 2005). The scores on the DSES appeared to have excellent internal consistency, r = .94. Reliability coefficients for the DSES were identical to the estimates that were published for this scale (Underwood & Teresi, 2002).

Reliability coefficients for the TSR were good, r = .79 for the behavioral problems subscale scores and r = .73 for the emotional problems subscale scores. Reliability coefficients for this study were consistent with those published for the TSR where coefficient alphas for the scores on the Behavioral Problems subscale ranged from .65 to .85 and coefficient alphas for the scores on the Emotional Problems subscale ranged from .56 to .76 (Barber, et. al, 2002).

The internal consistency reliability estimates for the RCOPE scores were acceptable, r = .84 for positive religious coping and low, r = .58 for negative religious coping scores. Scores from the normative sample of the Brief RCOPE demonstrated good internal consistency. The Cronbach's alpha coefficient for scores on the Positive Religious Coping Scale ranged from .67 to .94. The Cronbach's alpha coefficient for scores of the Negative Religious Coping Scale ranged from .60 to .90 (Pargament, Feuille, & Burdzy, 2011).

Results

Descriptive statistics and intercorrelations were examined for the subscale scores utilized in this study (see Table 1). The scores on the positive RCOPE were strongly correlated to the scores on DSES, but a negligible correlation was evident between scores on the negative RCOPE and the DSES. Despite being from the same measure, the scores of the positive and negative subscales of the RCOPE were correlated rather weakly. This is consistent with results from the validation study for the RCOPE in which an orthogonal relationship was reported among the positive and negative subscales, and no significant associations were found between the two subscales in a variety of populations (Pargament, Feuille, & Burdzy, 2011). The coping subscale and commitment to follow-up subscale scores of the GASS were strongly correlated. This is consistent with previous research (Balkin, 2013; Balkin & Roland, 2007; Balkin & Roland, 2005). Neither of the GASS subscales scores were correlated to the TSR subscales, which is inconsistent with past research (Balkin, Leicht, Sartor, & Powell, 2011).

A canonical correlation analysis was performed between spirituality (Brief RCOPE subscales and DSES scale) and outcome of treatment (GASS subscales and TSR subscales). An alpha level of .05 was utilized. Cutoff correlations of .30 were used for interpretation of the canonical variates (Tabachnick & Fidell, 2001). A statistically significant relationship was not found between spirituality and outcome of treatment. The first canonical root was not significant $\lambda = .95$, F (12, 206) = .33, $p = .983$, accounting for 3% ($r_c = .18$) of the overlapping variance. Shown in Table 2 are the correlations and standardized canonical variate coefficients for the RCOPE subscales, the DSES, the GASS subscales, and the TSR subscales as they relate to the first canonical variate.

Table 1.

Summary of Intercorrelations, Means, and Standard for Scores on the Brief RCOPE, DSES, GASS, and TSR Subscales

Scale	1	2	3	4	5	6	7	M	SD
RCOPE									
1. Positive	-	.19	-.75*	.03	.04	.01	.03	7.66	2.91
2. Negative		-	-.13	-.01	-.09	-.25	.08	8.38	2.61
3. DSES			-	-.05	-.05	-.08	-.08	35.29	20.61
GASS									
4. Coping				-	.75*	.13	-.03	.01	8.67
5. Follow-up					-	-.04	-.11	.86	3.11
TSR Change									
6. Emotional						-	.59*	4.31	3.12
7. Behavioral							-	7.41	4.88

*p < .01, n = 85

Table 2.

Correlations and Standardized Canonical Variate Coefficients on the RCOPE, DSES, GASS, and TSR for the First Canonical Variate

Scale	COR	COE
RCOPE		
Positive	-.01	.01
Negative	.96	.99
DSES	.15	.28
GASS		
Coping	-.12	.88
Follow-up	-.56	-1.17
TSR Change		
Emotional	-.26	-.83
Behavioral	.73	.73

Note. **COR = correlations to the canonical variate. COE = standardized canonical variate coefficient.**

Chapter Summary

In this chapter, the preliminary analysis of the data set, reliability of the instruments, and results of the study were reported. A listwise deletion and mean imputation were utilized to address missing data (Tabachnick & Fidell, 2011). A canonical correlation was performed to answer the research question under investigation. A statistically significant relationship was not found between spirituality and outcome of treatment. The remaining chapter will focus on discussion of the results.

CHAPTER 5

Discussion

The purpose of this study was to explore the relationship between spirituality and outcome of treatment for adolescents in crisis residence. The construct of spirituality was measured across two scales (RCOPE and DSES) and the construct of outcome of treatment was measured across two scales (GASS and TSR). The RCOPE measured positive and negative religious coping and the DSES measured daily spiritual experiences. Scores from the two instruments were utilized to measure the degree that spirituality was important for each individual. Adolescents who scored higher on spirituality measures indicated that spirituality was important to them, and adolescents who scored lower on spirituality measures indicated that spirituality was not important in their lives. The GASS measured therapeutic goal attainment and the TSR measured symptom severity. Scores from these measures were utilized to measure outcome of treatment for each individual. Lower scores on the TSR indicated that adolescents demonstrated more successful treatment outcomes, and higher scores on the GASS indicated more successful treatment outcomes.

Results of the Study

The results of the study indicated that there was no relationship between spirituality and outcome of treatment for adolescents in crisis residence. Scores on the spirituality measures did not affect the scores on treatment outcome measures. Some adolescents who scored high on spirituality measures also scored high on measures of treatment outcome. Some adolescents who scored high on spirituality measures scored low on measures of treatment outcome. Conversely, some adolescents who scored low on the measures of spirituality also scored low on measures of treatment outcome, and some adolescents who scored low on the measures of spirituality scored

high on the measures of treatment outcome. Because of this, no evidence was present to determine that spirituality positively or negatively related to treatment outcome of adolescents in crisis residence.

Despite the importance that was placed on spirituality by the participants of the study no generalizable trend related to spirituality and goal attainment or spirituality and symptom reduction of adolescents in crisis residence was evident. Some adolescents who identified spirituality as being important in their lives may have demonstrated higher therapeutic goal attainment and symptom change while others may have demonstrated lower therapeutic goal attainment and symptom change. Additionally, some adolescents who did not identify spirituality as being important in their lives may have demonstrated higher therapeutic goal attainment and symptom change while others may have demonstrated lower therapeutic goal attainment and symptom change.

The results of this study do not indicate that spirituality is important or unimportant to symptom change or therapeutic goal attainment in general. Rather, in the confounds of this study, adolescents in crisis residence demonstrated the same results for goal attainment and symptom change regardless of the importance they placed on spirituality in their lives. The role of spirituality appears to be a unique construct, which may still have an effect on client outcomes. However, that depends on the degree to which the individual client may feel that spirituality is important.

This finding is similar to the original Wheel of Wellness model in which spirituality was defined as the center of wellness that provided the core or foundation for all other areas of wellness (Myers, Sweeney, & Witmer, 2000). Initially, spirituality was seen as a central component of wellness. Later, however, Myers and Sweeney (2005) proposed the Indivisible

Self model of wellness in which spirituality was not the center of, or central component of wellness. Rather, a more holistic view of wellness was adopted in which all components of the model interacted with each other and were equally important for functioning of the individual (Myers & Sweeney, 2005). The extent to which spirituality contributed to wellness depended on the level of importance that each individual placed on spirituality. Spirituality is a construct that is unique to each individual, so individual concerns and beliefs regarding spirituality must be explored with each client to determine the role it plays in overall wellness. Similarly, the results of this study indicated that spirituality may not be the most important factor in stabilization of adolescents in crisis treatment. Spirituality may be explored with individual adolescents to determine the extent to which spirituality influences the many components of their life and may affect treatment outcome.

Comparison of Results to Previous Studies

Some contradictory findings were reported from previous studies. Religion and spirituality were described as protective factors that inhibit negative outcomes or increase resilience in adolescents (Bullock, Nadeau, & Renaud, 2012; Crawford, Wright, & Masten., 2006; Koenig, McCullough, & Larson, 2001; Van Dyke & Elias, 2007; Werner, 1984). Religion and spirituality in adolescents were also, however, linked to negative outcomes. The protective factor of religiosity was negated when negative peer-influence was present and possible negative effects of religion or spirituality included poor psychological functioning, avoidant coping, escape or denial (Ano & Vasconcelles, 2005; Brenda & Corwyn, 1997; Callaghan & Irwin, 2003; Chadwick & Top, 1993; Grier & Gudiel, 2011; Mason & Windle, 2002; Ano & Vasconcelles, 2005). Similarly, the results of this study indicated that the implications of spirituality for adolescent treatment varied depending on the individual. Some adolescents who

reported that spirituality was important met treatment goals and demonstrated a decrease in symptomology while others did not. These findings are consistent with the literature in that there is not one general trend regarding adolescent spirituality that can be reported in all scenarios.

The results of this study also differed from those of several previous studies related to adolescents in treatment facilities. A positive relationship between spirituality and depression was reported for adolescent psychiatric outpatients (Dew, et al., 2008), a positive relationship between spirituality and therapeutic engagement was reported among adolescent in residential drug treatment (Hawke, Hennen, & Gallilone, 2005), and a positive relationship was found between involvement in spiritual mentoring of adolescents during residential treatment and improvement in psychological functioning and adjustment (Taylor, 2005). The sample of adolescents in this study, however, received treatment in a different setting than in previous studies. Adolescents in crisis care may be a unique population of adolescents in which spirituality does not influence the outcome of their treatment.

Adults in an acute psychiatric inpatient setting participated in a spirituality and cognitive behavioral therapy group and 90% of them reported that they believed spirituality was important and relevant to their treatment (Rosmarin, Aurbach, Bidga-Peyton, Bjorgvinsson, & Levenduscky, 2011). The results of this study indicated that there may be a difference between adults and adolescents in residential crisis care settings. Spirituality was not included in the treatment of adolescents in this study, but the results demonstrate that spiritual beliefs of the individual did not impact goal attainment or symptom change. Spirituality may not be as helpful for adolescents in this treatment setting as it is for adults. There may be several explanations for this difference.

Perhaps spirituality is an abstract construct that requires higher levels of cognitive and moral development to make it a useful construct in the treatment of adolescent clients. Allport (1950) described adolescence as a period of doubt concerning a belief in a higher power. This is due in part to the fact that adolescence is a time when individuals are only beginning to understand abstract concepts, draw conclusions at a high-level, think in terms of goodness and evil, and analyze interrelationships - all of which are characteristics that are necessary for developing a religious identity (Piaget, 1950; Gollnick, 2005).

Additionally, adolescents do not have a firm grasp of their own identities or posses autonomous judgment to form and uphold a personal perspective of faith (Fowler, 1981). During the Synthetic-Conventional stage of faith (the most common during adolescence), an individual "has an 'ideology,' a more or less consistent clustering of values and beliefs, but he or she has not objectified it for examination and in a sense in unaware of having it" (Fowler, 1981, p.173).

Furthermore, adolescents have an "orientation toward authority, fixed rules, and the maintenance of the social order" (Kohlberg & Hersh, 1977, p.55). From a moral perspective, adolescents are preoccupied with respecting authority and maintaining the predetermined social order (Rest, et al., 1969). Rather than make decisions concerning spiritual matters for themselves, adolescents may align their beliefs with those of individuals whom they respect or believe to be in a position of authority. This makes spirituality a construct that is not meaningful or important to the individual on a personal level and therefore would not be useful in treatment.

Implications for Counseling

The results of this study are meaningful for counselors and counselor educators. One important implication for counselors is that spirituality may not be an essential component to crisis stabilization of adolescents. Counselors who may utilize spiritual principles as the primary

tool for stabilization of adolescents may want to rethink their treatment protocols. While spirituality was not found to hinder treatment in any way, there was no evidence that a focus on spirituality will improve treatment outcomes.

Additionally, counselors should be aware that spirituality is a uniquely personal construct that each individual views differently. Exploring the importance placed on spirituality and the extent to which spiritual principles guide an individual's life is no less important based on the results of this study. To someone who places much importance on spiritual matters, addressing spirituality in treatment may be beneficial to attaining goals and reducing symptoms. However, an individual who places no importance on spirituality can still achieve the same treatment outcomes in crisis residence. The issue of spirituality is not one that should be forced onto adolescents in crisis residence since there is no empirical evidence that spirituality aids in the stabilization process.

Counselor educators can use this information to further the understanding that students have of adolescents in crisis care. Students should know that the most important consideration for treatment of this population is stabilization of the adolescent. Any variable that may aid in stabilization is of utmost importance. The results of this study highlight the need for a broader understanding of adolescents in crisis care. Discussion of this topic with students and of variables that aid in the stabilization process will be important to prepare future counselors for working with this particular population.

Limitations of the Study

Since adolescence is a time of increased questioning or conversion of religious beliefs (Gollnick, 2005; Spika, Hood, Hunsberger, & Gorsuch, 2003; Paloutzian, 1996), participants of this study may have reported that spirituality was important, but may or may not infuse spiritual

beliefs into their daily lives because they are still unsure of what they actually believe. According to the faith development model, adolescents are most likely to experience the developmental tasks associated with stage 3 of the model: synthetic-conventional faith (Fowler, 1981). Adolescents in this stage focus on the expectations and judgments of those they hold in high regard and do not have a firm grasp of their own identities or posses autonomous judgment to form and uphold a personal perspective of faith (Fowler, 1981). Kohlberg and Hersh (1977) also reported that conformity is important to adolescents and decisions they make are based upon meeting the expectations of those they hold in high regard. This means that adolescents may internalize the expectations and evaluations of others concerning their spirituality to such a degree that they conform to those expectations rather than make their own decisions about their spiritual beliefs.

Adolescents who scored high on spirituality measures in this study may have answered the assessments with what they thought was socially desirable based on the judgments of those around them. They may not have developed their own faith identity at this point in their life, meaning that even though they scored high on the spiritual measures utilized in this particular study, spirituality may not be important in their lives to the degree that they reported it to be or vice versa.

Adolescents who participated in this study received treatment from multiple clinicians. No evidence was presented to determine the theoretical approach that each of these counselors utilized. Because each participant did not receive identical treatment at the hospital, results of this study may be skewed. Treatment strategies by individual counselors may have influenced the scores for treatment outcome measures.

Treatment outcome measures for this study did not address spiritual concerns. Utilizing outcome measures that accounted for spirituality in the results would have provided additional information about the relationship of spirituality to treatment outcome.

Spirituality measures for the study were completed by participants while outcome measures for the study were completed by clinicians. Individual participants may have reported different outcome scores than clinicians did. Clinician bias could be possible in regards to outcome measures and response bias could be possible if adolescents were not completely honest when completing spirituality measures.

Suggestions for Future Research

Although they viewed spirituality as being important, participants in this study may not have utilized spiritual beliefs to help get through the crisis they were experiencing. The extent to which each adolescent felt that spirituality was important does not explain the degree to which spiritual principles guide the individual's life, decisions, coping mechanisms, or thought processes. Qualitative research could be utilized to gather more information related to the interplay of spirituality and treatment outcome for individual adolescents in crisis care.

As Allport (1950) suggested, the sentiment of religion is a personal one that leads to special significance in each individual's life. Further exploration of individual perceptions of spirituality for adolescents is needed. Spirituality appears to be a construct that is unique to each individual, so qualitative studies that take into account the spiritual perceptions of each individual would greatly add to the understanding of the role that spirituality plays in the lives of adolescents.

This study could be replicated with a larger sample or in a different area of the country to compare results with those of the sample utilized for this study. All of the participants in this

study received crisis care from the same hospital. Investigation of results across geographical areas or treatment centers would be interesting. Also, exploring the results of infusing spirituality into treatment strategies with this population of adolescents would be useful. For example, would including a spirituality group in the treatment of adolescents in crisis residence improve or hinder treatment outcomes?

Additional studies that take into account the diagnosis of the individual in treatment would add to the knowledge base greatly. Does the diagnosis of the adolescent have a relationship with his or her views of spirituality? Does the relationship between spirituality and outcome of treatment change depending upon the diagnosis of the adolescent? Do adolescents with certain diagnosis depend on spirituality to assist with coping more than others?

The study of adolescents in crisis care is an area to which more research should be devoted. Constructs that affect treatment have not been studied to a large degree in the literature. Furthermore, an understanding of individuals who receive crisis care is needed. A qualitative interview with adolescents in treatment regarding what they feel is the most helpful component of treatment would yield new insight for crisis care. Additionally, study of the long term implications of care is needed. How often do adolescents return to a crisis care facility after being treated? What is the length of time between visits? What variables influence the long term success of adolescents who have been treated? Are adolescents who receive treatment for a crisis more likely to experience other mental health problems throughout their lifespan? Looking at each of these relationships with adolescents who score high on spirituality measures would also be valuable. These are all questions worthy of consideration that would bring more knowledge to the table for counselors who treat this population of adolescents.

Conclusion

Great strides have been made in the counseling profession to explore and understand the value of incorporating spirituality into client care. While most spirituality studies focused on adult populations, there is a growing trend in the exploration of spirituality and treatment for adolescent clients. One particular population that very little research was devoted to is adolescents in crisis residence. This study attempted to fill a gap in the literature related to spirituality and adolescent crisis through answering the research question, what is the relationship between spirituality and treatment outcome of adolescents in crisis residence? Results of this study were not statistically significant, meaning that no relationship between the variables under investigation was evident. However, the results are still meaningful for counselors and counselor educators. Clinicians should not focus primarily on spirituality when attempting to stabilize adolescents in crisis residence. This is a construct that more research should be devoted to, however. Understanding the personal implications of spirituality for individual adolescents in crisis care and in general is an area in need of further exploration. Additionally, understanding the value of incorporating spirituality into treatment of adolescents in crisis residence is an area that has not been explored and would be meaningful.

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