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Namaste Theory: A Quantitative Grounded Theory on Religion and Spirituality in Mental Health Treatment

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Abstract: A growing body of research is beginning to identify characteristics that influence or are related to helping professionals' integration of clients' religion and spirituality (RS) in mental health treatment. This article presents Namaste Theory, a new theory for understanding the role of mental health practitioners' RS in clinical practice. Using Glaser's (2008) formal quantitative grounded theory approach, this article describes an emerging theme in the author's line of work—particularly that practitioners' intrinsic religiosity is significantly related to their consideration of clients' RS—and explores the findings of related, interdisciplinary studies. The Hindu term, *Namaste*, meaning, “the sacred in me recognizes the sacred in you”, provided a framework to explain the emerging theme. Specifically, Namaste Theory introduces the concept that as helping professionals infuse their own RS beliefs/practices into their daily lives, deepening their intrinsic religiosity and awareness of what they deem sacred, they tend to consider and integrate clients' RS beliefs/practices, and what clients consider sacred as well. In order words, as the helping professional recognizes the sacred within him or herself, s/he appears to be more open to recognizing the sacred within his/her client. Future directions for research, as well as practice and education implications, are discussed.

Keywords: mental health; religion; spirituality; Namaste; grounded theory; therapy; counseling; clinical social work

Over the past few decades, religion and spirituality (RS) have reemerged in helping professions' literature in the United States (US). Not only do a majority of Americans consider RS important in their lives ([Pew Research Center 2015](#)), but clients are often expressing a preference for their RS to be included in mental health treatment ([Harris et al. 2016](#)). Though numerous definitions exist for RS, spirituality can be defined as “the search for the sacred”, whereas religion is “the search for significance that occurs within the context of established institutions that are designed to facilitate spirituality” ([Pargament et al. 2013](#), pp. 14–15). Further, sacred may include positive or negative elements of life, with particular attention to the divine ([Pargament et al. 2013](#)).

Regarding religion, one noteworthy distinction is Allport and Ross's two poles of religiosity, including intrinsic and extrinsic, such that, “the extrinsically motivated person uses his religion, whereas the intrinsically motivated lives his religion” ([Allport and Ross 1967](#), p. 434). For those who lean towards being extrinsically religious, religion exists to support the individual's needs (e.g., social support, some form of security, status, or self-justification). On the other hand, those who are more intrinsically religious tend to be motivated by their religion, desiring to fully embrace, internalize, and live out their beliefs ([Allport and Ross 1967](#)).

Oftentimes, US practitioners find themselves ill prepared to address this area of clients' lives due to a glaring lack of training ([Oxhandler and Pargament 2014](#); [Oxhandler et al. 2015](#)). Given that RS were removed from many professions' curriculum between the 1920s and early 1980s due a variety of reasons ([Canda and Furman 2010](#); [Koenig 2012](#)), and many professions continue to report receiving

little content on RS in the classroom, US practitioners have had to identify other ways of attending to this area of clients' lives in mental health treatment. Recognizing the critical role many helping professionals have in clients' mental health treatment, the self-reported importance of RS in Americans' lives (Pew Research Center 2015), and clients' use of RS to positively or negatively cope with mental and behavioral health struggles (Pargament 1997, 2007), it is imperative helping professions better understand the complex mechanisms that influence the assessment and integration of clients' RS into treatment.

Thus, the purpose of the current study was to generate a theory, grounded in previous studies, to explain the role of practitioners' RS on their attitudes and behaviors related to integrating clients' RS in mental health treatment.

1. Design

Though grounded theory (GT) is often understood within the context of utilizing qualitative data, many have discussed the use of quantitative data and findings to build theory. For example, Strauss and Corbin (2000) have indicated, "grounded theorists can utilize quantitative data or combine qualitative and quantitative techniques of analysis" (p. 274). Further, Johnson et al. (2010) argue that GT truly has the ability to be grounded in both quantitative and qualitative methods and data.

In an effort to lay the foundation for quantitative grounded theory (QGT) with his text, Glaser (2008) described formal QGT as one option that allows scholars to generate theory by comparing the results across multiple surveys for conceptual generation, which is the "product of doing formal GT" (p. 60). Glaser (2008) posits that formal QGT compares various groups' or subgroups' responses regarding a particular item or topic across surveys in order to detect patterns and for conceptual generation. Further, Glaser (2008) suggests that such comparisons also include qualitative studies on related subgroups when available. These comparisons are not solely to identify similarities or differences, but rather, for conceptual generation.

Therefore, the current study utilizes a two-part approach for conceptual generation and the early development of a theory. First, the author describes and explores the results of her own three-pronged study of a national sample of clinical social workers' integration of clients' RS in practice and the pattern that emerged from the analyses. Second, the author turned to the broader literature to further support the theory that was emerging regarding helping professionals' integration of clients' RS in practice.

2. Initial Development of Theory

The initial seed for this theory emerged after conducting a three-pronged study of a national survey of licensed clinical social workers (LCSWs) to better understand their views and behaviors surrounding the integration of clients' RS into treatment (Oxhandler et al. 2015; Oxhandler and Giardina 2017; Oxhandler and Parrish 2016). The author began identifying practitioners' intrinsic religiosity (IR) as an important characteristic among those integrating clients' RS in practice. Simultaneously, she began to recognize variations of RS (e.g., personal RS, frequency of RS service attendance, and RS affiliation) as reportedly important factors in other studies of practitioners' views and behaviors regarding integrating clients' RS. Before describing this role of IR across studies, it is important to reflect upon what IR is and how it has been measured, particularly in the author's studies described below.

As mentioned above, IR involves one's desire to deeply live out, internalize, embrace, and be motivated by their beliefs (Allport and Ross 1967). In 1997, the Duke University Religion Index was developed as a brief, five-item alternative to Hoge (1972) IR scale, measuring two elements of extrinsic religiosity (ER; organized and non-organized religious activity) and a three-item subscale to measure IR (Koenig et al. 1997; Koenig and Büssing 2010). The DUREL IR items were taken from Hoge (1972) IR scale to measure the degree to which the respondent experiences the presence of the Divine, their religious beliefs influence their approach to life, and their religion is infused into their life. Though there are a number of ways in which IR can be measured (Liu and Koenig 2013), the DUREL

was used in the studies below due to its ability to measure IR and ER, as well as its brevity within a large, cross-sectional survey that contained a 40-item scale, over 20 background items, and two open-ended items.

2.1. Part 1: Intrinsic Religiosity among a National Sample of Licensed Clinical Social Workers

Study 1. The first study tested the reliability and various levels of validity of the newly developed Religious/Spiritually Integrated Practice Assessment Scale (RSIPAS) with a national sample of 470 LCSWs (Oxhandler and Parrish 2016). The RSIPAS was developed specifically to measure practitioners' attitudes, self-efficacy, perceived feasibility, and behaviors related to integrating clients' RS in practice, with an overarching construct of practitioners' overall orientation toward integrating clients' RS into practice. As described in the article, the confirmatory factor analysis resulted in four first-order factors, as well as a second-order factor. Criterion validity was tested by comparing the subscale scores and overall RSIPAS score with various background variables, including prior course or continuing education on RS in practice, knowledge of empirically-supported interventions on RS, and the DUREL (Koenig and Büssing 2010). Of any background items to test criterion validity, IR emerged as having the strongest significant relationship with all four subscales ($r = 0.31\text{--}0.43$, $p < 0.01$) and the overall scale ($r = 0.46$, $p < 0.01$).

Study 2. The second study explored the responses of this administration of the RSIPAS, and included a regression analysis to identify practitioner characteristics that predict their views, behaviors, and overall orientation toward integrating clients' RS (Oxhandler et al. 2015). Interestingly, there were no significant relationships between practitioners' RSIPAS score and their age, race, region in the US, gender, age of clients served, years in practice, or degree of burnout. The only significant variables, which ended up accounting for 37% of the variance, included their score on the DUREL IR scale ($\beta = 0.44$, $p < 0.001$) having the most influence on the model, with prior training (course or continuing education) ($\beta = 0.32$, $p < 0.001$) as the other influential variable.

Study 3. Finally, the author explored the practitioners' responses to the two open-ended items in the survey. The first asked, "What (if anything) has helped or supported you to assess and/or integrate your clients' religious/spiritual beliefs in your clinical practice?" ($n = 319$). The second item asked, "What (if anything) has hindered or prevented you from assessing and/or integrating your clients' religious/spiritual beliefs in your clinical practice?" ($n = 279$). A total of 329 LCSWs responded to either item (Oxhandler and Giardina 2017). Though the respondents had no priming questions regarding what helps or hinders such integration, it was interesting to see that nearly half of the respondents (43.9%) freely indicated in their open-ended response that their personal religiosity (including their RS journey, RS belief system, RS practices, and RS curiosity) helped them to consider their clients' RS in practice.

2.2. Part 2: Exploring the Role of Practitioners' RS in the Broader Literature

The second part of this design was to compare the role of practitioners' RS in the broader literature and other studies conducted by the author to further support this conceptual generation and theory development. Though the aforementioned findings between IR and integrating clients' RS were limited to LCSWs in the US, their findings are not limited to social workers. In fact, Oxhandler (2016) revalidation of the RSIPAS with five helping professions in Texas (LCSWs, licensed professional counselors, marriage and family therapists, advanced practice nurses, and psychologists) also reported the DUREL IR scale had strong, significant relationships with all four subscales ($r = 0.29\text{--}0.45$, $p < 0.01$) and had the strongest relationship with the overall scale ($r = 0.45$, $p < 0.01$) across criterion variables with this diverse sample. Additionally, the qualitative responses to what helps and hinders such integration across these diverse professions were similar to the findings in study 3, above (Oxhandler et al. n.d.). Similarly, within marriage and family therapy, McNeil et al. (2012) surveyed 135 graduate students and also found a positive relationship between Allport and Ross's IR ($r = 0.31$, $p < 0.001$) and ER ($r = 0.19$, $p < 0.05$) scores with whether they considered incorporating RS in therapy to be important.

Other elements of RS and the integration of clients' RS. Though IR initially emerged in this pattern recognition, certainly not all researchers assess for respondents' IR in their surveys and may measure other, tangentially-related elements of practitioners' RS. Interestingly, it is clear that the depth and frequency of the practitioners' RS beliefs and practices appears to have a strong relationship with their attitudes and engagement of clients' RS in practice. Generally, these other RS elements indicated within the literature include personal RS, frequency of RS practices or service attendance, and RS affiliation.

Personal RS. A number of studies across helping professions have shown personal RS has directly or indirectly influenced the consideration of RS in practice. Stewart et al. (2006) identified a model that indicated social workers' personal RS was directly related to utilized RS-related interventions, which impacted their perceived appropriateness and attitudes toward RS in practice. Specifically, spirituality was "conceptualized as a general connection with some transcendent force or being and the importance of that connection in daily life" (p. 75) and measured based on the Multidimensional Measurement of Religiousness/Spirituality (Fetzer Institute and National Institute of Aging Working Group 1999). The results suggested spirituality had the largest effect size ($\beta = 0.42, p < 0.001$) related to the practitioners' integration of RS. Also in social work, Mattison et al. (2000) found that the more important the social worker viewed religion to be important in his/her life, the more appropriate they viewed various RS practices to be in their social work practice. Similarly, Shafranske and Maloney (1990) found psychologists with an "ends orientation", by which religion provides answers to existential questions, had the highest degree of competence in knowledge and skills in addressing RS issues with clients [$F(2, 398) = 8.39, p < 0.001$].

In a transdisciplinary meta-analysis, Walker et al. (2004) explored the relationship between therapists' (psychologists, marriage and family therapists, and social workers) personal RS and willingness to discuss RS issues in counseling. Among the four studies identified, an overall average r of 0.39 ($p < 0.01$) emerged, indicating a significant relationship between the two variables. Similarly, in social work, Sheridan (2009) literature review found four out of five studies had personal RS (measured as either religious affiliation, participation in communal RS services, or personal RS practices) as a significant predictor of higher RS intervention use. More recently, Cummings et al. (2014) conducted a systematic review regarding the relationship between practitioners' RS and therapy attitudes and behaviors, and found seven of eight identified articles indicated a positive, significant relationship between the two. Further, five out of six studies found a positive association between therapists' RS and self-rated competence with integrating clients' RS, and eight out of 10 studies found therapists' RS predicted the use of RS interventions in treatment. Finally, the authors included studies that described the relationships between therapists' RS and the therapeutic relationship, as well as the effects of therapists' RS on treatment outcomes (Cummings et al. 2014).

More recently, Blair (2015) conducted a qualitative study to explore the influence of nine therapists' spirituality on their practice. He found that there is a "reflective, dynamic, and developmental process to integrate spiritual and therapeutic identities" (p. 164), and that therapists' spirituality not only influenced their work, but they often strive to find harmony between their spirituality and profession.

Frequency of RS practices/service attendance. The frequency of RS service attendance or RS practices is arguably one of the strongest methods for measuring degree of RS, as it reduces tautological issues that often accompany many spirituality measurements (King 2011). Thus, the frequency of RS practices and service attendance has often been used in studies that explore the consideration of clients' RS in treatment as a way to measure practitioners' RS.

Among social workers in New York, the frequency of spiritual participation had a significant, positive correlation with their attitudes toward RS in practice ($r = 0.47, p < 0.001$) (Heyman et al. 2006). Further, within two regression analyses, the frequency of spiritual participation was the largest predictor. In the first, spiritual participation ($\beta = 0.50, p < 0.001$) was the only predictor compared with age, gender, and race. In the second analysis, spiritual participation ($\beta = 0.46, p < 0.001$) was the largest predictor compared with age, gender, race, years of social work experience ($\beta = 0.20, p < 0.05$),

or whether they had taken a course in spirituality ($\beta = 0.18, p < 0.01$). Similarly, in a mid-Atlantic state, 204 clinical social workers' participation in communal RS services ($\beta = 0.17, p = 0.02$) emerged as one of the four significant predictors of using spiritually derived interventions in practice (Sheridan 2004). Among 299 gerontological social workers, Murdock (2005) found that private spiritual activities were significantly related with the use of RS interventions in practice. In one survey of clinical social workers working with youth across the US, Kvarfordt and Sheridan (2009) found the frequency of engaging in personal RS practices among the top predictors of their use of spiritually derived interventions in practice ($\beta = 0.14, p < 0.01$). Interestingly, a follow-up path analysis suggested the frequency of personal RS practices was the initial starting point for each path to the use of spiritually derived interventions, with personal practices having the strongest impact on general attitudes toward the role of RS in practice ($\beta = 0.56, p < 0.001$).

Religious affiliation. Practitioners' religious affiliation has somewhat mixed results in the literature. Utilizing the same sample described above in studies 1–3, Oxhandler and Ellor (2017) compared Christian responses with those who did not self-identify as Christian, given: (1) a majority of social workers self-identify as being affiliated with a Christian denomination (Furman et al. 2011; Sheridan et al. 1992), and (2) Sherwood (1999) description of how a Christian worldview and ethical code may affect how a social work practitioner views and engages with clients. However, only five items (one attitude, three self-efficacy, and one behavior item) across the 40-item RSIPAS indicated a significant difference, with Christians having higher responses. Further, there was no difference between the two groups regarding their overall orientation toward integrating clients' RS.

Still, other studies have found religious affiliation to influence whether practitioners integrate clients' RS. For example, to assess discriminant validity for the Spiritually Derived Intervention Checklist, Canda and Furman (2010) compared Christians' and Atheists/Agnostics' responses. Similarly, as outlined in Cummings et al. (2014) review, having an RS affiliation has been positively related to RS intervention use (Shafranske and Maloney 1990), more self-disclosure of RS beliefs (Payman 2000), and therapists' view of appropriateness of discussing RS (Beatty et al. 2007).

2.3. Summary

The initial development of this theory had two-parts, based in Glaser (2008) formal QGT methods. The first part was to explore the authors' previous studies of LCSWs, which formed the initial seed of this theory. The second part included examining the literature and comparing others' results regarding the relationship between practitioners' RS and the integration of clients' RS. Though RS has not been measured in the same way across studies, and neither have practitioners' views and behaviors related to integrating clients' RS, it is clear a conceptual pattern has largely emerged across studies related to practitioners' RS and their views and behaviors related to integrating clients' RS.

3. Namaste

One term that helped organize and make sense of what was happening within the data was *Namaste*. Nambiar describes *Namaste* as a combination of two Sanskrit words: *Namah* (to bow or bend) and *te* (to you), with the two influences behind this word being "Matter and Spirit" (Nambiar 1979, p. 5). He explains the secret of *Namaste* is the "blending of matter with spirit or the mortal body with the immortal soul, as demonstrated by the folded hands" (Nambiar 1979, p. 18), and that the "gesture is an expression of humility: 'I recognise God in you' . . . a feeling that almost becomes an instinct." (Nambiar 1979, p. 7). Similarly, Chatterjee describes a related term, *Namaskar*, as an ancient Hindu word used to describe a posture of greeting the sacred in others by "touching of the forehead with folded hands as the thumbs touch the forehead several times as if one is respecting the other by touching the point of the third eye or between the eyebrows" (Chatterjee 1996, p. 47).

In America's culture today, *Namaste* is used as a term to greet others and is often said at the conclusion of yoga classes, with the usual translation being 'the sacred in me honors the sacred in you'. Others have written about *Namaste* as "the God in me greets the God in you" (Cessna 2011, p. 43) or "to

honor the spirit within” (Duffin 2012, p. 14) or “I bow to you” (Cotton 2011, p. 108). Namaste has been integrated into a program for caring for older adults, entitled Namaste Care (Duffin 2012; Simard 2007), and even conceptualized as an approach to grading (Cotton 2011). Further, Namaste Care has been extended to older adults’ mental health, noting that not only does it focus on gentle, loving, respectful touch, but also that “it is in this reciprocal process that the mental health aspect is made clear. Implicit in that reciprocity is the notion that mental health is at least a two-way process: caring for someone else’s mental health implies a simultaneous caring for one’s own.” (Nicholls et al. 2013, p. 572).

Namaste Theory and Helping Professionals

Thus, recognizing the role IR or some deeply personal religiosity appears to have on the integration of clients’ RS within the aforementioned studies, this idea of *Namaste* then began to bring order or attempt to explain this phenomenon. Specifically, as practitioners experience, are engaged in, become aware of, and infuse their own RS beliefs and practices into their daily lives—deepening their IR and becoming more attune to the sacred within—they tend to hold more positive views and engage in clients’ RS beliefs and practices as well. In other words, as helping professionals recognize the sacred within themselves, they appear to be more open to recognizing the sacred within their client.

This idea is not specific to one denomination or RS affiliation, but appears to transcend across RS affiliations, again focusing on the degree to which one’s awareness of the sacred in his/her life is infused into the everyday, including their clinical practice. Nambiar expands upon this idea of *Namaste* extending beyond denominations or affiliations:

Namaste in its true spirit helps our ego to surrender to the goal of our faith. With folded hands and with mind attuned to the feeling of the oneness of humanity, we slowly and steadily attain complete identification with God. In this manner, *Namaste* helps us to break all the barriers in us and to become humble. This in turn makes us work as an instrument of God in the spiritual or social fields of our activities . . . When this knowledge grows in faith, it becomes wisdom and this is the goal of the simple *Namaste* greeting and therefore it is equally applicable to everybody alike, irrespective of caste, creed, colour, or nationality. (Nambiar 1979, pp. 20–21)

Utilizing this perspective, regardless of RS affiliation, it is truly the recognition of the sacred within that allows and empowers us to recognize the sacred within others. The term sacred has been defined as “a person, an object, a principle, or a concept that transcends the self. Though the Sacred may be found within the self, it has perceived value independent of the self. Perceptions of the Sacred invoke feelings of respect, reverence, devotion and may, ideally, serve an integrative function in human personality” (Hill et al. 2000, p. 64). Understanding sacred in this capacity, not limited to the confines of RS traditions or language, then allows the concept of *Namaste* to extend beyond religion, or even spirituality, to also include what those who consider themselves Atheists or Agnostics hold to be sacred.

In fact, while peer debriefing the findings with colleagues, one point of discussion was the potential for this theory to extend beyond practitioners deeply recognizing their RS and in turn, considering clients’ RS. For example, practitioners who are deeply aware of and invested in understanding the intersectionality of other various, diverse elements of their identity and/or culture (e.g., race, ethnicity, sexual orientation, sexual identity, gender, age, ability/disability, politics, community, socioeconomic status, geography, career, education, interests, etc.) may be more likely to consider the role these various elements play in others’ lives, such as their clients (Elizabeth Goatley, personal communication, 22 May 2017; Danielle Parrish, personal communication, 29 March 2017). Phrased in another way, the more practitioners are reflective and aware of their own intersectionality, including how a variety of unique elements of diversity influences them as individuals, and the more practitioners take the time to deeply understand who they are, it may then be that those practitioners

are more likely to recognize such intersectionality in clients' lives. However, this extends beyond the current study and may be worth exploring in future studies.

Though this concept certainly mirrors elements of the use of self as a skill discussed in helping professions, use of self is a largely ambiguous term. Indeed, [Dewane \(2006\)](#) has attempted to hone in an explanation of this skill to include our use of personality, belief system (though RS is not explicitly mentioned in this example but can be inferred), relational dynamics, anxiety, and self-disclosure. What the use of self as a skill fails to address however, is this process in Namaste Theory which states, "the sacred in me sees and honors the sacred in you." The helping professionals who have taken the time and energy to deeply discover their RS beliefs/practices, have infused RS in their whole approach to life, find RS to influence their daily life, report experiencing the Divine and have higher DUREL IR scores, and freely describe their personal RS as being what helps them to integrate clients' RS, appear to be more likely to recognize this element in clients' lives.

4. Discussion

Given the growing body of research that has explored the role of the practitioners' RS—particularly IR—and its relationship with integrating clients' RS, Namaste Theory provides one option for organizing these results into a conceptualized explanation. Specifically, as practitioners reflect on and recognize the sacred within themselves (in this case, their own RS beliefs/practices, infused into their daily lives), they appear to recognize this within their clients.

Though practitioners' RS, as well as their views and behaviors related to integrating clients' RS, have been previously measured in a variety of ways, future studies of this theory may want to utilize more intentional measurement strategies. With regards to practitioners' RS, the DUREL is a brief, validated instrument to measure not only IR, but also ER ([Koenig and Büssing 2010](#)). As Pargament reminds us, "much of religious experience remains private, subjective, and highly symbolic" ([Pargament 1997](#), p. 11), so careful consideration of measurement strategies is important. Measuring practitioners' IR and ER can help to alleviate the potentially positive bias of some RS instruments and reduce the risk of tautological issues ([King 2011](#)). To assess helping professionals' integration of clients' RS in practice, the RSIPAS is the only reliable and valid instrument that not only has excellent reliability and established all forms of validity, but is valid across five helping professions. Further, the RSIPAS is able to measure practitioners' attitudes, self-efficacy, perceived feasibility, behaviors, and their overall orientation toward integrating clients' RS in practice ([Oxhandler 2016](#); [Oxhandler and Parrish 2016](#)). Additionally, future studies may utilize qualitative methods to deeply investigate the three DUREL IR subscale questions, particularly as they relate to working with clients. Similarly, researchers may be interested in having practitioners frequently journal about their IR and clinical practice to better understand how their RS is infused into professional practice ([Moffatt and Oxhandler forthcoming](#)).

While various practitioner characteristics did not have a significant relationship with their views or behaviors related to integrating clients' RS in many studies above ([Oxhandler et al. 2015](#)), it is worth exploring other mechanisms that support RS integration. For example, in [Oxhandler and Giardina \(2017\)](#), though 44% of practitioners freely mentioned that their personal RS helped them to assess and integrate clients' RS, 56% did not include this. In fact, two other themes emerged in this sample, and in many cases, respondents mentioned more than one of these themes in their response. Indeed, a majority mentioned having an RS-sensitive practice (67%) helped them consider clients' RS, with utilizing a person-centered approach as the most common practice, and 25% mentioned educational experience. Thus, it is worth better understanding what exactly having an RS sensitive practice means to practitioners in order to clarify what influences the process of RS integration. For example, for practitioners who do not view themselves as religious or spiritual, perhaps claiming to be open to understanding clients' RS is how they define having an RS-sensitive practice. Still, one might argue that practitioners who claim to offer an RS-sensitive practice have done reflective work on their own RS beliefs, whatever they may be, to the point they feel comfortable exploring what clients believe.

On the other hand, there may be other characteristics that help and/or hinder integrating clients' RS, which cannot be captured in a quantitative survey or brief, open-ended response. For example, though age of the practitioner, age of client served, region of the country, gender, years of practice, and degree of burnout were not significantly related to integrating clients' RS (Oxhandler et al. 2015), that does not mean these characteristics are not relevant for some practitioners when it comes to considering clients' RS. Other characteristics that could potentially impact RS integration include: (1) practitioners' views of God/Higher Power as benevolent, critical, distant, or authoritative (Froese and Bader 2010); (2) their previous experience with RS organizations; (3) whether or not they work in a secular or religiously-affiliated setting; (4) the types of presenting clinical issues in their practice; (5) the amount of time allowed with each client; or (6) the clients' views of RS. Some of these barriers are mentioned by practitioners in Oxhandler and Giardina (2017), but would require more exploration.

Regardless, identifying that practitioners' IR and other RS elements can and do influence whether and the degree to which practitioners integrate clients' RS has a number of practical and educational implications. Given that RS emerges across multiple helping professions' ethical codes, primarily focused on not discriminating but also on the integration of clients' RS (American Psychological Association 2010; American Association for Marriage and Family Therapy 2012; American Counseling Association 2014; American Nurses Association 2015; National Association of Social Workers 2008), helping professions must carefully attend to this area in training programs and during post-graduate supervision. Additionally, it is important that practitioners be well trained to effectively and ethically assess for and integrate clients' RS while setting appropriate boundaries related to their own RS beliefs and practices. As Canda (2008) noted, practitioners' beliefs "may intentionally or unintentionally be a direct or indirect party to . . . harmful practices" (p. 32). Though growing evidence suggests ethically assessing and integrating clients' RS yields positive health and mental health outcomes (Koenig et al. 2001, 2012), previous research and this theory clearly indicates the practitioners' RS (particularly their IR) cannot be ignored.

Although the early development of Namaste Theory offers an initial option to help organize the results regarding practitioners' IR and their integration of clients' RS into a conceptual explanation, future research is necessary to obtain practitioners' views regarding this theory and to ground it in qualitative data. Glaser (2008) recommendations for formal QGT served as an appropriate foundation for examining and generating this concept, with the ability to relax typically strict guidelines often found in quantitative studies in order for the theory to emerge. Certainly, studies may exist or be conducted in the future that refute this theory. During this review of studies exploring the integration of clients' RS, only one study (Larsen 2011) was identified that found practitioners' RS—measured by Hodge (2003) Intrinsic Spirituality Scale—was not significantly related to their use of RS interventions in practice; though, other studies may exist. However, the evidence was overwhelming supportive of the emergence of Namaste Theory and the author hopes it provides a meaningful framework for practice and education across helping professions. The author also hopes that those who test Namaste Theory will share their results regarding its viability, as it must be continually tested in order to remain grounded in data.

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