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Spiritual and Religious Competencies in Psychology

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Abstract

Religion and spirituality (R/S) are important aspects of human diversity that should be explicitly addressed in the field of psychology. The field has already included R/S in its definitions of multiculturalism, but while multicultural training is routinely included in doctoral level psychology coursework and internship programs, it rarely includes specific training in R/S diversity. Polls of the American public indicate that religion and spirituality are important in most people's lives, and hundreds of studies demonstrate empirical links between R/S and psychological health and well-being. In clinical practice, there is evidence that clients would prefer to have their R/S addressed in psychotherapy. However, R/S issues are typically neither discussed in psychotherapy nor included in assessment or treatment planning. In research, religion and spirituality are often assessed with a single item on religious affiliation. Psychologists receive little or no training in R/S issues, in part because no agreed upon set of spiritual competencies or training guidelines exist. This article summarizes the rationale for including religious and spiritual competencies in psychology training and practice, reviews research establishing a set of religious and spiritual competencies (attitudes, knowledge, and skills) that we propose all psychologists should demonstrate, and provides practical recommendations for inquiring about religion and spirituality.

Keywords: competencies, spirituality, religion, training

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Public Significance Statement: This article reviews links between mental health and religion/spirituality and recommends specific ways that psychologists and other mental health professionals can ethically and effectively address religious/spiritual diversity in the practice of psychology.

Spiritual and Religious Competencies in Psychology

Spiritual and religious background, beliefs, and practices (SRBBPs) are an important aspect of most people's psychological functioning, and a robust body of evidence indicates that SRBBPs play a role in psychological well-being. Religion and spirituality (R/S) are also meaningful aspects of cultural diversity, and like other forms of multicultural diversity, when not addressed can result in inadequate or insensitive care and increase barriers to care. Attending to the spiritual and religious aspects of people's lives in the practice of psychology is a form of both clinical and cultural competence.

Religion and Spirituality are Important Forms of Multicultural Diversity

There are substantial differences in worldviews, meaning systems, orienting principles, and ways of being between people from different religious and spiritual traditions. There is also considerable diversity *within* religions (e.g., multiple highly varied forms of Buddhism and Protestantism) and even within denominations (e.g., conservative vs. liberal Presbyterians). Spiritual and religious beliefs and practices can be quite diverse across the lifespan, with spiritual and religious developmental stages affecting people's perceptions and behaviors differently throughout the seasons of their lives (Walsh, 2011). Similar to individual differences in race,

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ethnicity, gender, age, or sexual orientation, SRBBPs can carry with them psychological strengths and resources, can be associated with discrimination, historical oppression and intergenerational trauma, and can be relevant to psychological problems. Recent religiously motivated shootings and domestic and international terrorism are extreme examples of how mental illness and aberrant forms of R/S can intersect in tragic ways.

Cultural competence has been defined as a set of skills and practices that lead to appropriate services that respect clients' ethno-cultural beliefs, values, attitudes, and conventions (Bhui, Warfa, Edonya, McKenzie, & Bhugra, 2007). Interest in cultural competence arose as research uncovered large inequities in access and quality of mental healthcare based on race and ethnicity, with minorities seeking care less and receiving sub-par care (Sibrava et al., 2019). Training in multicultural competency introduced a set of practices that could help reduce these disparities by making health services psychology more responsive to ethno-cultural differences, less biased, and thus more attractive, helpful, and engaging for more marginalized populations. Multicultural competencies have also impacted research in fields such as social and cognitive psychology by making demographic assessment broader and more accurate, requiring efforts in representative sampling, and encouraging caution in generalizing results from homogeneous samples. However, most of the training in multicultural competency focuses on ethnic and racial diversity. Counseling and clinical training programs pay inadequate attention to religious and spiritual aspects of diversity in multicultural training (Shafranske, 2016).

Spiritual and religious competence, similar to other forms of multicultural competence, includes basic attitudes, knowledge and skills - such as becoming aware of our own religious, spiritual, or non-religious/non-spiritual views and how they might influence or bias our work as psychologists, inquiring about RS in clinical and research settings, being able to effectively inquire about a client's or research participant's spiritual and religious background, beliefs, and practices, incorporating SRBBPs into overall assessment and treatment planning when indicated, or being willing to refer and collaborate with clergy if needed. Competence here refers to basic attitudes, knowledge and skills we propose all psychologists should possess, rather than advanced expertise.

Both Religion and Spirituality?

While the words have historically often been used interchangeably, spirituality and religion are increasingly being viewed as distinct yet partially overlapping constructs. Religion most often refers to an organized belief system, guided by shared values, practices and understandings of the divine, and involvement in a religious community. Spirituality can be defined more broadly as an individual's internal sense of connection to something beyond oneself, which could be perceived as a higher power or God, and/or a more general sense of the sacred, consciousness, or interconnectedness to all of nature and life (Mahoney & Shafranske, 2013).

Religion and spirituality play a central role in the lives of most people in the United States. Gallup polls between 1992 and 2016 show that despite a decline over the last two

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decades, 72% of Americans still report that religion is "very important" or "fairly important" in their lives (Brenan, 2018), 89% believe in God, and half of US citizens regularly participate in an organized religious community (Gallup, 2016). However, while 70.8% of people identify as Christian and 5.9% come from other faiths, a recent Pew Forum survey found that 27% of people self-identify as "spiritual, but not religious," a 5% jump since 2012 (Lipka & Gecewicz, 2017).

Since the 1960s, interest in Asian spiritual practices such as yoga, meditation, qigong, and tai chi has increased in the USA, as has participation in sweat lodges, drumming circles, ritualized and therapeutic use of entheogens, plant medicines, or psychedelics, and modern versions of traditional religious and spiritual, or eclectic spiritually-oriented, practices and groups. There is a growing evidence base for the beneficial effects of many of these practices on mental health (for example, Griffiths et al., 2019; Saeed, Cunningham & Bloch, 2019), and they can cause intense or disruptive psychological states as well (Lindahl, Fisher, Cooper, Rosen & Britton, 2017; Richert & DeCloedt, 2018).

Though the term "spirituality" does not appear in the APA Ethical Principles for Psychologists and Code of Conduct (2017), APA's Division 36 Psychology of Religion was renamed the Society for the Psychology of Religion and Spirituality in 2011, and their APA publication launched in 2009 is entitled the *Psychology of Religion and Spirituality*. APA's 2017 "Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality" also identifies both religion and spirituality as aspects of multiculturalism. While once it may

have been enough to include only religion as a form of diversity, now it is important to include spirituality as well.

Religion and Spirituality Are Clinically Relevant

Studies indicate that greater involvement in R/S practices and communities is linked to better psychological health. R/S has been linked to an increased sense of meaning, purpose, resilience, satisfaction and happiness (Abu-Raiya & Pargament, 2015; Pargament & Mahoney, 2009). A recent nationwide survey of 989 mental health care clients showed that 64.9% agreed that engaging in SRBBPs "improves my mental health," and 64% viewed their R/S as relevant to their mental health (Oxhandler, Pargament, Pearce, Vieten, & Wong, in press).

Four R/S areas that appear to be particularly related to psychological functioning are reviewed below: 1) participation in organized R/S, 2) religious and spiritual coping 3) engagement in personal R/S, and 4) R/S problems.

Participation in Organized Religion and Spirituality

SRBBPs are associated with 1) lower rates of mental, medical and substance abuse problems; 2) better recovery from mental disorders, substance abuse, illnesses, and surgery, and 3) less depression and anxiety, both in the USA and in other countries, among both adolescents and adults (Oman, 2018). While these effects likely occur in part through the same pathways theorized to link R/S to physical health such as enhanced social networks and marital stability (Oman and Syme, 2018), the literature suggests that there is an independent contribution of organized SRBBPs to psychological well-being through elevating mood, lessening distress,

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enhancing well-being, improving processes of coping with stress, cultivating salutary virtues and character strengths, and encouraging the pursuit of more adaptive life goals (Greenfield, Vaillant & Marks, 2009).

In a meta-analysis that selected studies that 1) employed repeated measurements of service attendance and health to help rule out the possibility of reverse causation where the associations between religious participation and health occur only because those who are healthy are able to attend religious services, 2) used a large sample size, and 3) controlled for numerous potential confounding variables, and used contemporary causal modeling, RS attendance was associated with 30% reduction in the incidence of depression (Li, Okereke, & VanderWeele, 2016). While correlational results must be interpreted with caution, since people with depression and suicide ideation may well attend services less than those who are not, R/S attendance has been associated with lower levels of suicidal ideation, suicide attempts, and completed suicides, after adjusting for demographics and previous suicide attempts (Lawrence, Oquendo, & Stanley, 2016), as well as being associated with a five-fold reduction in the likelihood of suicide (VanderWeele, Li, Tsai, & Kawachi, 2016). In a clinical sample of patients at risk of violence to self, Price and Callahan (2017) found that religious attendance (RA) “exerted a significant direct effect” (p. 103) on suicide ideation (SI), with increased attendance associated with decreased SI, independent of substance abuse or social support, concluding that “RA appears to serve as a protective variable against SI, independent of clients’ social support” (p. 110).

Religious and Spiritual Coping

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For many people, SRBBPs serve as strengths that help them cope with stressful life circumstances. Increased attendance at religious and/or spiritual services and contact with clergy and/or spiritual leaders are frequently used as coping mechanisms during difficult times (Gall & Guirguis-Younger, 2013). In a recent survey of 2050 individuals receiving mental health services and their family members, 80% agreed or strongly agreed that spirituality was important to their mental health (Yamada, Lukoff, Lim, & Mancuso, 2019). Studies have found that among diverse populations including African American/Black and First Nations/Native American populations, engaging in present-day religious and spiritual rituals and practices derived from indigenous traditions are associated with increases in psychological well-being and resilience to historical trauma and oppression (Boyd-Franklin, 2010; Harper & Pargament, 2015; Limb & Hodge, 2008).

Pargament has suggested that the use R/S to cope can be divided into two broad classes: “Positive” R/S coping and “Negative” R/S coping (Pargament, Feuille, & Burdzy, 2011). Examples of Negative R/S coping include feeling alienated from God or one’s religious/spiritual community or beliefs of being punished by God, which have been associated with higher levels of PTSD symptomatology after trauma, higher frequency and intensity of suicidal ideation, depression, and anxiety in clients with psychotic disorders, and poorer mental health outcomes in general (Gall & Guirguis-Younger, 2013).

Positive R/S coping strategies are characterized by “a secure relationship with a transcendent force, a sense of spiritual connectedness with others, and a benevolent world view”

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(Pargament, Feuille, & Burdzy, 2011, p. 51) - such as feeling or perceiving that one is part of God's plan or drawing strength from one's connection to a spiritual source. Positive R/S coping has been linked to better psychological and physical health biomarkers and outcomes, as well as successful stress management in several populations (Gall & Guirguis-Younger, 2013). Research on R/S coping has consistently demonstrated its value for supporting wellness and recovery among individuals receiving mental health services (Oxhandler, Narendorf, & Moffatt, 2018),

Personal Religious and Spiritual Practices

Many clients also engage in private SRBBPs that appear to promote a positive sense of self and hope, increasing quality of life, reducing symptoms and lowering risk of suicide (Mohr, 2013). Mental health care recipients report a high level of participation in private R/S activities that they perceive as helpful to their mental health including: prayer (73%), meditation (47%), spending time in nature (41%), and reading sacred texts or spiritual self-help books (36%) (Yamada et al., 2019).

Some studies have found that these private activities may be even more helpful to clients than organized forms of R/S practice. For example, Cruz, et al. (2009) found that reductions in depression and hopelessness scores among older adults being treated for depression were more related to their "private" religious involvement (prayer and meditation) than their "public" involvement (attendance at church). In a longitudinal study, self-reported importance of religious and spiritual beliefs served as a protective factor in warding off depression among children with depressed parents, whereas religious attendance was unrelated to outcomes (Miller et al., 2012).

Robinson et al. (2011) found that in people with a history of alcohol use disorders, “6-month increases in private spiritual or religious practices and forgiveness of self were the strongest predictors of improved drinking outcomes” (p. 660). Similarly, in a nationally representative cross-sectional sample of U.S. adults (N = 39,809), among those who self-reported having had "a problem with alcohol or drugs but no longer do. Overall, spirituality but not religion, appears to play a role in aiding recovery" (Kelly & Eddie, 2020, p. 116).

Religious and Spiritual Struggles/Problems

R/S struggles, defined as “conflicting intrapersonal, interpersonal, religious, and spiritual beliefs causing significant distress, negative affect, and anger at God and/or religious institutions” (Abu-Raiya & Pargament, 2015, p. 246), have been linked with depression, paranoid ideation, somatization, anxiety, posttraumatic stress disorder (PTSD), paranoid ideation, suicidal ideation, social isolation, and lower life satisfaction, as well as immune system declines, slower rehabilitation from disease, and declines in emotional and physical health, and mortality (Exline, 2013). College students frequently seek help from university counseling centers due to distress from religious or spiritual concerns (Wortmann, Park, & Edmondson, 2012).

Rejection of variations in sexual orientation and gender identity by some religious institutions predict mental health problems (Sowe, Taylor & Brown, 2017). The prevalence of abuse by clergy which has increasingly come to light, can also contribute to increased lifetime

incidence of psychological problems and "loss of faith in God and the Church" (McGraw, Ebadi, Dalenberg, Wu, Naish, & Nunez, 2019, p. 242).

"Religious or Spiritual Problem" (Code V62.89) (Lukoff, Lu, & Turner, 1992) is categorized as a condition that is a focus of clinical attention in the DSM-5 (American Psychiatric Association, 2013), as well as the ICD-10 (Code Z65.8, *ICD-10-CM*, 2019). In a study that systematically identified the most commonly reported types of religious or spiritual problems in articles indexed in PubMed (Lukoff, Provenzano, Lu, & Turner, 1999), loss or questioning of faith was the most frequently reported type of religious or spiritual problem. Other high frequency R/S problems included changes in religious or spiritual membership, dysfunctional practices and beliefs, unhealthy involvement in new religious movements and cults, religious struggles during life-threatening and/or terminal illnesses, and certain forms of mystical, near-death, possession, and spiritual practice-related experiences.

A powerful example of the potential impact of loss of faith comes from a longitudinal study conducted by Pargament, Koenig, and Tarakeshwar (2001) finding that elderly patients who felt alienated from God, felt they were being punished, or felt abandoned by their church community were at 19-28% increased risk of dying within the next two years, and negative religious coping was associated with declines in mental and physical health, compared with those who had no such religious doubts. In addition, religious and spiritual struggles partially mediate the relationship between stressful life events and psychological adjustment – in other words, "in the wake of stressful events, many people find that their most deeply held values and beliefs are

shaken and this is part of what leads to psychological distress (Pomerleau, Pargament, Krause, Ironson & Hill, 2019).

A recent survey found that the number of Americans engaged in yoga has grown by over 50% from 20.4 million in 2012 to over 36 million as of 2016 (Ipsos Public Affairs, 2016), while the National Center for Health Statistics reports that the use of meditation increased more than threefold from 4.1% in 2012 to 14.2% in 2017 (Clarke, Barnes, Black, Stussman, & Nahin, 2018). While the preponderance of evidence indicates that such mind-body practices are benign or beneficial, there are documented adverse effects (some of which are culturally normative aspects of these practices) (Hofman, 2013; Hwang, 2007 & Lindahl et al., 2017). There are numerous published accounts of individuals in the midst of intense R/S experiences induced by such practices who have been hospitalized and medicated when less restrictive and more therapeutic interventions could have been utilized by spiritually-competent clinicians (Lukoff, 2007).

Client Views on Attending to Spirituality and Religion

Most clients report that they would like to be asked about and discuss their SRBBPs in psychotherapy (Oxhandler, Ellor, & Standford, 2018; Harris, Nienow, Choi, Engdahl, Nguyen, & Thuras, 2015). In a study of 3141 hospital patients, those with whom clinicians had discussions of SRBBPs were more likely to rate their care at the highest level on four different measures of patient satisfaction (Williams, Meltzer, Arora, Chung, & Curlin, 2011). Yet psychologists report discussing R/S issues in therapy with only 30% of their clients, and less than

half include R/S in assessment (Hathaway, Scott & Garver, 2004). While it is likely that fewer than 30% of clients will present with religious or spiritual issues, we are suggesting that psychologists routinely inquire about SRBBPs since like other areas of diversity, SRBBPs may intersect with the presenting problem.

In addition, even clients for whom SRBBPs are important and psychologically relevant may not bring them up at all if not asked. Like sexual orientation, SES, or disability, R/S is often an invisible form of diversity, and without inquiry by the psychologist, may not be surfaced by the client. In fact, research shows that many clients do not raise or discuss their R/S beliefs and concerns in therapy, even when their R/S beliefs may interact with behavioral and relational problems (Hodge, 2013). As with other forms of diversity, some people avoid seeking psychological treatment altogether because they fear that their SRBBPs will be judged, minimized, or ignored (Ayvaci, 2016), or will be weakened by non-religious psychotherapy (Mayers, Leavey, Vallianatou, & Barker, 2007).

Establishing Spiritual and Religious Competencies

Most psychologists already view religion and spirituality as important aspects of human diversity and indicate an openness to engage the topic of religious and spiritual issues with clients (Shafranske & Cummings, 2013). Why then, are R/S issues inadequately addressed in psychology education, practice, and research?

Lack of Training. Seventy-five percent of psychology training programs do not provide any courses in religion/spirituality (Schafer, Handal, Brawer, & Ubinger, 2011). In a study of

543 doctoral clinical and counseling psychology students, almost all endorsed the idea that clients should be asked about spirituality and religiousness, but a quarter of the respondents indicated they had received no training related to clients' SRBBPs (Saunders, Petrik, & Miller, 2014). In another study of 532 doctoral students, interns, faculty, and training directors in APA-accredited programs, R/S issues were rated as one of the areas (along with disability and age) given the least attention in diversity training. Among counseling psychology training directors, 82% reported that R/S is less frequently addressed within the curriculum than other areas of diversity (Schulte, Skinner, & Claiborn, 2002), and 68% of all APA accredited internship training directors reported that they "never foresee religious/spiritual training being offered in their program" (Russell & Yarhouse, 2006, p. 434).

Most doctoral programs and internships rely on informal and unsystematic sources of learning to provide training in religious and spiritual diversity (Vogel, McMinn, Peterson, & Gathercoal, 2013). A review of studies on R/S training found that, "In most cases, training was implemented infrequently." (Jafari, 2016, p. 264). Most psychologists (76%) believe that R/S is currently inadequately addressed in training (Crook-Lyon, O'Grady, Smith, Jensen, Golightly, & Potkar, 2012), and as noted earlier, 52 – 81% report receiving little to no training in R/S/ competencies (Vieten et al. 2016).

Less Religious. Another factor that may have inhibited incorporating spiritual and religious competencies in psychology is that as a group, psychologists are considerably less religious than the clients with whom they work (Shafranske & Cummings, 2013). While 48% of

psychologists describe religion as unimportant in their lives, only 15% of the general public felt the same (Delaney et al. 2007). Eighty-nine percent of the general population believes in God, whereas 50% of psychology professors do, making them among the least religious of the top 20 academic fields (Gross & Simmons, 2009). Research psychologists in particular are similar to scientists from other disciplines in being less likely to endorse a religious denomination, believe in God, or regularly attend religious services (Pew Research Center, 2009). However, compared to other mental health service professionals, "not identifying with a religious group tended to be most common among...psychologists (9.7%)" (Oxhandler, Polson, Moffatt and Achenbaum, 2017, p. 9). While spiritual and religious competencies do not require being religious or spiritual, any more than cultural competencies require identifying with any one particular cultural group, it is possible that because SRBBPs are less important to psychologists than to their clients, they may have been neglected as important aspects of multicultural competency.

Biases. Cultural, educational, and sociodemographic differences from the populations psychologists typically study and/or serve may also contribute to the gap between the importance psychologists place on SRBBPs and the importance their clients place on them. There is empirical evidence that psychologists hold explicit and implicit negative biases based on perceived client religiosity. For example, O'Connor and Vandenberg (2005) found that when 110 mental health professionals were asked to assess vignettes of clients with the same symptoms but different religious affiliations, those who were described as being part of a mainstream Christian religion were rated as less pathological than those who were identified as Mormon, and both

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were rated less pathological than those described as being affiliated with the Nation of Islam. Ultimately, the "mental health professionals made differential assessments of pathology for vignettes of individuals who held legitimate beliefs of an established religion" (p. 616).

Work to Establish Competencies

In 2007 the American Psychological Association adopted a comprehensive Resolution on Religious, Religion-Based and/or Religion-Derived Prejudice, resolving that information on religious prejudice and discrimination should be included in multicultural and diversity training material and activities. APA's Standards of Accreditation (American Psychological Association, 2019) also include religion in the definition of cultural and individual differences and diversity (Standard II.B.2.a), and identify competence in individual and cultural diversity as a "required profession-wide competency" (Standard II.A.2.c) that all APA accredited programs must provide opportunities for their interns to achieve and demonstrate.

Unlike psychiatry and medicine, which has established spiritual and religious competencies (Moreira-Almeida, Sharma, van Rensburg, Verhagen, & Cook, 2016), requires coursework in spirituality and health (Koenig, Hooten, Lindsay-Calkins, & Meador, 2010), and has required training in R/S competencies during residency training since 2008 (Campbell, Stuck, & Frinks, 2012), the field of psychology has not yet established competencies for training in spiritual and religious diversity.

The concept of spiritual competency was originally proposed by Hodge (2004), drawing on a seminal article on multicultural counseling competencies by Sue, Arredondo, and McDavis

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(1992). Others have also called for increased attention to spiritual competency in clinical care (Richards, Scott and Bergin, 2000). In addition to the term competence, authors have used terms such as “spiritually sensitive” (Sperry, 2012), “spiritually conscious” (Saunders, Miller, & Bright, 2010) “spiritually integrated” (Pargament, 2012) and “spiritually-oriented” (Shafranske & Sperry, 2005). Hathaway and Ripley (2009) proposed a set of “common best practice recommendations from exemplar clinicians who specialize in addressing religious and spiritual issues in practice” (p. 33). Plante (2014) suggested 4 steps to increasing spiritual and religious competency, including (a) being aware of biases, (b) considering religion like any other type of diversity, (c) taking advantage of available resources, and (d) consulting colleagues, including clerics. Most competencies proposed thus far, have relied on literature review, theory and clinical expertise in the intersection of R/S and psychotherapy.

Vieten et al. (2013, 2016) developed a set of empirically based R/S core competencies for psychologists including attitudes, knowledge and skills in the domains of religion and spirituality. In two studies, mental health professionals rated a provisional set of competencies on clarity and relative importance, resulting in a set of 16 competencies (three in the area of Attitudes, seven in the area of Knowledge, and six in the area of Skills (see Supplemental Materials: Table 1). Between 73.0 and 94.1% (depending on which of the 16 areas of competency) of respondents agreed that psychologists should receive training and demonstrate competence in these areas and 52.2% - 80.7% of respondents reported receiving “little” or “no” training in these competencies, with 29.7% - 58.6% reporting “no” training at all (Vieten et al.,

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2016). Work continues to refine these competencies and translate them into curricula and assessments.

Assessment of Spiritual and Religious Competency

Basic spiritual and religious competence does not imply specialization or advanced expertise, and does not require any form of religious or spiritual belief on the part of psychologists. An agnostic or atheist psychologist can recognize that SRBBPs shape multiple aspects of many of their clients' or participants' lives, can respect their SRBBPs as often helpful and sometimes disruptive influences in their lives, and learn to inquire about and address them at a general practice level - making referrals when issues arise that are outside of their scope of practice.

To determine whether someone is sufficiently competent requires clear measurable benchmarks as well as self- and supervisor/objective assessment. Competencies include a specific measurable set of knowledge base and skills, as opposed to a general familiarity with the topic. Assessment of competence has become a standard of practice in the training of psychologists, and guiding principles for the assessment of competence have been developed by the American Psychological Association's Task Force on Assessment of Competence in Professional Psychology (Kaslow et al., 2007). Despite reporting little or no training, 75% of psychologists report being "mostly" or "completely" competent in R/S (Vieten et al., 2016). However, personal religion or spirituality does not confer competence.

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Guiding principles have been articulated by the Assessment of Competency Benchmarks Work Group (American Psychological Association, 2006), which presented behavioral benchmarks for 3 levels of competency: Readiness for Practicum, Readiness for Internship, and Readiness for Entry to Practice. These correspond to levels of competence expected of program graduates for both core knowledge base and skills, categorized as exposure, experience, and expertise. While Vieten and Scammell (2009) have provided initial assessment items for each competency, an example of benchmarks for competency 12 (being able to conduct a spiritual assessment) in line with these guidelines are:

Readiness for Practicum: “exposure”: can articulate clinical research and APA ethical guidelines that support taking a spiritual assessment

Readiness for Internship: “experience”: has tried asking clients questions to conduct a spiritual assessment

Readiness for Entry to Practice: “expertise”: able to conduct an ethical, evidence-informed spiritual assessment

Inquiring About SRBBPs

Assessing a client’s R/S history is one of the most important skills that can quickly establish to the client that the clinician is aware of spiritual and religious diversity, that the topic of religion and spirituality is welcome in the clinical setting, that the therapist is willing to discuss these matters and cares about this aspect of their client’s life. Studies have shown that those who received a spiritual assessment at intake responded positively and attended more of

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their subsequent mental health care appointments than clients in a randomly assigned group who did not receive a spiritual assessment (Huguelet, Brandt, & Mohr, 2016). In simulated clinical interviews, Terepka & Hatfield (2020) reported that, "individuals asked about their religiosity during the interview experienced the interviewer as more empathetic, warm, understanding, experienced, trustworthy, and friendly. Participants reported being more willing to disclose personal information to the interviewer in the future when queried about their religiosity during initial interviews" (p.3). These findings support the value of conducting a spiritual assessment for strengthening the therapeutic alliance. In addition, where researchers in psychology have typically relied on assessing R/S with a single item asking about religious affiliation/denomination, with "none" or "other" as alternate choices, these items might inform expanding demographic RS assessment when feasible.

One of us (DL) developed a clinical interview which covers these areas called the SSOPP[1] (pronounced "ES-sop")—an acronym for:

[1] The second author (DL) started conducting spiritual assessments in the late 1980's when, as a psychologist at the San Francisco VA Medical Center, I started leading a dual diagnosis group. To address issues patients were raising about difficulties connecting to a higher power that were interfering with their participation in a 12-step program. I sought out instruments to systematically collect information from patients about their R/S backgrounds, beliefs and practice. In 1988, psychology did not have much to offer in this area. I was able to obtain a copy of a Spiritual Needs Assessment form from St. Elizabeth's Hospital in Washington, DC which historically has had an active pastoral counseling program, and there was also a model spiritual assessment published in the nursing literature (Stoll, 1979). Later, when conducting "Spirituality 101" trainings for the California Department of Mental Health, Kaiser Permanente, and other agencies, I incorporated questions aligned with the strengths-based recovery approach advocated by SAMHSA (Jones-Smith, 2014), and also added questions to assess R/S problems or struggles that could be sources of distress or barriers to accessing R/S resources or support.

Screening for R/S Relevance

Strengths R/S

Organized R/S

Personal R/S

Problems with R/S

The SSOPP (Lukoff, 2016) is modeled after the FICA (Puchalski and Romer, 2000), a brief 3-5 minute intake spiritual history that is taught at many medical schools The questions presented below have been field tested and taught to mental health professionals for the past 30 years including at county mental health clinics and at APA conferences

As reviewed earlier, four areas of R/S functioning are clinically pertinent to assess: 1) R/S Strengths (including positive R/S coping), 2) involvement in Organized R/S, 3) engagement in Personal R/S, and 4) R/S Problems (including negative R/S coping). A clinical interview which covers these areas is called the SSOPP (pronounced "ES-sop")—an acronym for: **S**creening for R/S Relevance**, S**trengths R/S, **O**rganized R/S**, P**ersonal R/S, and **P**roblems with R/S (Lukoff, 2014). A table of the interview questions can be found in the Supplemental Materials, Table 2.

Screening for Importance of R/S

Because clients "may be reticent to disclose R/S-related aspects of their struggles in a presumably secular setting" (Captari et al., 2018, p. 1938), we suggest using proactive screening questions to determine if clients view themselves as religious or spiritual, and how they describe

their R/S life. Note that the first screening question does not ask directly about R/S: 1) *Do you have any beliefs or practices that help you cope with difficulties or stress?* Clients may spontaneously mention religion or spirituality, but if they don't, you can ask a more direct question: 2) *For some people, religion or spirituality are a source of strength and comfort in dealing with life's challenges. Are they for you?* If the answer is no, ask: 3) *What are your sources of hope and strength when you face life's challenges?* Among clients who self-identify as atheist, agnostic, secular, or just uninterested in R/S, the clinician may discontinue the interview.

Organized R/S

The three questions in this area address not only congregational forms of worship, but also meditation groups, yoga classes, or spiritual study groups. They include: 1) *Do you belong to a religious or spiritual community such as a church, temple, mosque or other place of worship or spiritual study/practice?;* 2) *Is there another community or group of people you really love and engage with on a regular basis, such as at a yoga studio, dojo, choir, or bible study group?;* and if yes, 3) *How does it support you and your mental health?* If no, *Are you interested in finding a R/S community?* These questions are not designed to suggest that all clients should engage in organized R/S. They are designed to identify one of many potential resources that might be harnessed to improve a client's functioning.

R/S Strengths/Positive R/S Coping

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The questions in this area are designed to elicit SRBBPs that support the client's well-being, recovery, and mental health. They include: 1) *How do your spiritual and religious beliefs and practices support your well-being and mental health?;* and 2) *Are there certain spiritual and religious beliefs and practices that you find particularly helpful in dealing with difficulties?*

Personal R/S

The questions in this section can help elicit and support personal practices or settings clients may draw upon in their therapy and treatment planning. They include: 1) *Do you have any personal or private religious or spiritual beliefs or practices that you do on your own and find helpful such as prayer, meditation, reading scripture, listening to music, walking in nature, gardening?;* and 2) *Do you have a special place in your home to engage in spiritual or religious practices, such as a place designated for prayer or contemplation, or an altar to honor your beliefs?* Again, these questions are not prescriptive, but are intended to gain information that can assist with treatment planning, and demonstrate that these conversations are welcome in the therapy room.

R/S Problems

The questions in this section are designed to reveal R/S struggles, which as reviewed earlier, can directly affect a client's mood and functioning. They include: 1) *Have your psychological difficulties changed your relationship to God /higher power, or your spiritual or religious beliefs and practices?;* 2) *What aspects of your religious or spiritual community and their beliefs are helpful and not so helpful to you?,* and 3) *Do you have any spiritual needs in*

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your life that are not being met? Note that clients' ability to engage in and draw strength from their SRBBPs, particularly if they have in the past, can be impaired by psychological disorders, just as there can be adverse impacts on occupational or social adjustment (Hathaway, 2013).

Cautionary Note: Practicing Within the Scope of Competency

As stated earlier, religious and spiritual competency does not suggest that psychologists, whether researchers or mental health providers, should 1) engage in religious or spiritual interventions, 2) weigh religion or spirituality more heavily than other forms of diversity, or 3) subscribe to any religious or spiritual worldview themselves. Psychologists should integrate R/S interventions into psychotherapy only when they have adequate training and clinical competence to do so and are aware of ethical issues that may arise. This is in line with the APA Ethical Code Standard 2.01a on working within one's scope of competency and is also addressed in proposed competency #16 in the Supplemental Materials Table 1. Even among highly competent psychologists, spiritual and religious issues may arise in clinical practice that require consultation, additional training, collaboration, or referral. At times, coordination between psychologists and clergy can be useful to address the R/S needs of clients (Milstein, Manierre, & Yali, 2010). Richards and Worthington (2010) offer a list of 9 situations in which consultation or referral might be indicated, such as struggling to understand or feeling confused by the religious beliefs or thought world of a religious client, or a client expresses a desire to reconnect with previously held religious beliefs and community.

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In addition to consulting with clergy on religious and spiritual issues that may be outside the psychologist's scope of expertise or practice, another role that psychologists can play is supporting ministers, priests, rabbis, imams and other R/S authorities who are often on the front line in dealing with mental health issues. Clergy are frequently the 'first responders" to crisis and life cycle events, and can often benefit from consulting with a psychologist trained in spiritual and religious competencies (Wang, Berglund, & Kessler, 2003). There are also times when psychologists are involved with a client in dual roles – serving as both a spiritual guide/clergy member and as a psychologist. This is not unethical but like other dual roles, but requires clear boundaries, and should be handled with caution and discernment (Plante, 2007).

Conclusion

It would not be unusual for a client to undergo a course of treatment with a psychologist without being asked about their spiritual or religious background, beliefs or practices. This puts psychologists at risk for unintentional failures in empathy, respect, appreciation, and therapeutic alliance building – and not just in highly religious clients. The impact of leaving the religious and spiritual aspects of people's lives unaddressed in assessment and treatment is not dissimilar from disregarding their gender, age, culture, race or other aspects of diversity.

Specific practice guidelines exist in psychology for multiple other forms of gender, age, sexual orientation, and multicultural diversity (https://www.apa.org/practice/guidelines/). Given the importance of SRBBPs to most clients, their relevance to psychological well-being, their role in access to care, and their involvement in mental health related behaviors, it is important to

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establish similar guidelines for adequately addressing religion and spirituality, and their intersectionality with other forms of diversity. An APA Division 36 task force has been established to advance this aim.

While integrating these competencies into psychology should be tailored to fit each setting, suggestions include 1) adding religion and spirituality to multicultural competency training alongside racial, ethnic, gender, sexual orientation, age, and other forms of diversity; 2) including specific curricula on R/S diversity to meet requirements for cross-cultural coursework; 3) addressing the role of SRBBPs in psychology in textbooks; 4) including more comprehensive ways of measuring R/S factors in research; 5) including SRBBP assessment in courses teaching clinical skills; 6) including religious/spiritual content in clinical vignette training; 7) providing didactic training in graduate and post-graduate contexts; 8) training supervisors to ask trainees if and how they inquired about R/S; 9) including items related to R/S competency in self- and supervisor assessments; 10) and offering CE credit for online training in R/S competency. For example, a recent online course on the EdX platform entitled Spiritual Competency Training in Mental Health (SCTMH) incorporating these and other spiritual and religious knowledge, attitudes, and skills has proven effective for increasing clinicians self-reported competency and decreasing perceived barriers to integrating spirituality and religion in clinical practice (Pearce, Pargament, Oxhandler, Vieten, & Wong, 2019a, 2019b).

Our recommendation is that a formal set of clinical practice guidelines for attending to spiritual and religious diversity be developed and adopted by the Association, and that explicit

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training in spiritual and religious competencies be included in pre- and post-doctoral training for psychologists. In addition to addressing this important aspect of diversity, attention to the spiritual and religious domains of people's lives should result in greater client satisfaction, better outcomes, and a more complete approach to clinical care.

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[1] The second author (DL) started conducting spiritual assessments in the late 1980's when, as a psychologist at the San Francisco VA Medical Center, I started leading a dual diagnosis group. To address issues patients were raising about difficulties connecting to a higher power that were interfering with their participation in a 12-step program. I sought out instruments to systematically collect information from patients about their R/S backgrounds, beliefs and practice. In 1988, psychology did not have much to offer in this area. I was able to obtain a copy of a Spiritual Needs Assessment form from St. Elizabeth's Hospital in Washington, DC which historically has had an active pastoral counseling program, and there was also a model spiritual assessment published in the nursing literature (Stoll, 1979). Later, when conducting "Spirituality 101" trainings for the California Department of Mental Health, Kaiser Permanente, and other agencies, I incorporated questions aligned with the strengths-based recovery approach advocated by SAMHSA (Jones-Smith, 2014), and also added questions to assess R/S problems or struggles that could be sources of distress or barriers to accessing R/S resources or support.