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Competencies for Psychologists in the Domains of Religion and Spirituality

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Religion and spirituality are important aspects of human diversity that should receive adequate attention in cultural competence training for psychologists. Furthermore, spiritual and religious beliefs and practices are relevant to psychological and emotional well-being, and clinicians who are trained to sensitively address these domains in their clinical practice should be more effective. Our research team previously published a set of 16 religious and spiritual competencies based on a combination of focus group and survey research with the intent that they could be used to guide training. In the present study, we conducted a survey to determine whether these competencies would be acceptable to a broader population of practicing clinicians. Results indicate a large degree of support for the proposed competencies. Between 73.0 and 94.1% of respondents agreed that psychologists should receive training and demonstrate competence in each of the 16 areas. The majority (52.2%–80.7%) indicated that they had received little or no training, and between 29.7% and 58.6% had received no training at all, in these competencies. We conclude with recommendations for integrating these religious and spiritual competencies more fully into clinical training and practice.

Keywords: competencies, religion, skills, spiritual, spirituality

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Religion and spirituality are important parts of the lives of most people in the United States. Gallup polls between 1992 and 2012 (Gallup, 2015) reveal that over the last two decades 79% to 88% of Americans have said that religion is "very important" or "fairly important" in their lives. A full 92% believe in God, and nearly 70% report being either "very religious" or

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"moderately religious" (Gallup, 2011, 2015). A recent Pew Research Center (Lugo, 2012) survey found that even among those who report no specific religious affiliation, more than half self-identify as a religious or spiritual person. More than a third of those who are unaffiliated (37%) self-identify as "spiritual, but not religious," and about 15% to 30% of individuals in the general population report being in this category (Lugo, 2012; Marler & Hadaway, 2002; Moore, 2003).

Religion and Spirituality and Psychological Health

Research has shown that for many people, spiritual and religious beliefs and practices (SRBPs; Saunders, Miller, & Bright, 2010) are intertwined with psychological and emotional well-being. Spirituality and religion substantially color the way people understand themselves and the world around them, including their values, morals, and behaviors, their stance or orientation toward other people, their feelings of happiness and safety, their capacities for forgiveness and gratitude, their level of social support and engagement, and how they interpret the meaning of events and situations, including their approach to illness and death in themselves and others (Emmons & Paloutzian, 2003; Norenzayan, Dar-Nimrod, Hansen, & Proulx, 2009; Park, 2013; Schultz, Tallman, & Altmaier, 2010; Tay, Li, Myers, & Diener, 2014; Vallurupalli et al., 2012).

Many SRBPs are positively related to psychological health (George, Ellison, & Larson, 2002; Green & Elliott, 2010; Koenig, King, & Carson, 2012; Pargament, Mahoney, Exline, Jones, & Shafranske, 2013; Miller & Kelley, 2005; Miller & Thoresen, 2003; Oman & Thoresen, 2005; Park & Paloutzian, 2013; Plante & Sherman, 2001; Seybold & Hill, 2001; Wong, Rew, & Slaikeu, 2006). SRBPs play a significant role in psychological functioning and development (Hathaway, Scott, & Garver, 2004), including areas such as identity (Fukuyama & Sevig, 2002; Magaldi-Dopman & Park-Taylor, 2010), worldview (Arredondo et al., 1996; Leong, Wagner, & Tata, 1995), avoidance of risky scenarios (McNamara, Burns, Johnson, & McCorkle, 2010), the ability to cope with difficulties (Arredondo et al., 1996), and stress management (Ano & Vasconcelles, 2005; Cornah, 2006; Ironson, Stuetzle, & Fletcher, 2006; Pargament, 1997; Pargament, Ano, & Wachholtz, 2005; Pargament, Koenig, Tarakeshwar, & Hahn, 2004).

In one Gallup poll, individuals in the U.S. with no self-reported religious identity yielded the lowest Well-Being Index composite score compared with those reporting a religious affiliation (Newport, Witters, & Agrawal, 2012). The poll controlled for demographic characteristics (e.g., region of the country, socioeconomic status, etc.) and produced the composite score based on responses from six subindex categories: Life Evaluation, Work Environment, Emotional Health, Basic Access, Physical Health, and Healthy Behaviors. Within these subindexes, those reporting no religious affiliation (which included individuals identifying as Atheistic/Agnostic) yielded the lowest average scores on the Emotional Health and Healthy Behaviors indexes when compared with the average scores of each of the other religious groups.

SRBPs have also been linked to psychological and emotional difficulties (Exline, 2013; Exline & Bright, 2011; Exline, Grubbs, & Homolka, in press; Exline, Prince-Paul, Root, & Peereboom, 2013; Exline, Yali, & Lobel, 1999; Lukoff, Lu, & Yang, 2011; Pargament, 1997; Pargament, Murray-Swank, Magyar, & Ano, 2005; Powell, Shahabi, & Thoresen, 2003; Rosenfeld, 2010; Zinnbauer, 2013). For example, characteristics such as scrupulosity and hyper-religiosity have been associated with obsessive–compulsive and psychotic disorders (Brewerton, 1994; Greenberg, Witztum, & Pisante, 1987). Furthermore, some people misuse spiritual or religious practices to avoid dealing with important psychological or relationship problems (Cashwell, Bentley, & Yarborough, 2007; Cortright, 1997; Welwood, 2000). In short, the evidence is clear that religion and spirituality are important dimensions of psychological functioning that deserve to be explicitly addressed.

Religion and Spirituality as Aspects of Cultural Diversity

Not only are SRBPs strongly related to psychological and emotional health, many psychologists pursuing the development of spiritual competencies have recognized SRBPs as im-

portant aspects of muliticultural competency (Lukoff & Lu, 1999; McMinn, Hathaway, Woods, & Snow, 2009; Richards & Bergin, 2000). Spiritual and religious beliefs and practices qualify as aspects of human diversity equivalent in importance to race, ethnicity, gender, or sexual orientation. Based on the ethical codes that have guided our field for over a decade, psychologists should receive training in competencies related to religion and spirituality just as the field of psychology now requires for other forms of cultural competence.

For instance, according to the APA Ethics Code (American Psychological Association, 2003) psychologists should consider religious diversity as they do other forms of diversity such as race, ethnicity, gender, and sexual orientation:

> Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status and consider these factors when working with members of such groups. (p. 1063)

Furthermore, the APA Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists (American Psychological Association, 2003) identify religion and spirituality as important aspects of multiculturalism that should be included in cultural competency training, defining culture as "the embodiment of a worldview through learned and transmitted beliefs, values, and practices, including religious and spiritual traditions" (p. 8). In 2007, APA adopted a comprehensive "Resolution on Religious, Religion-Based and/or Religion-Derived Prejudice," condemning prejudice and discrimination against individuals or groups based on their SRBPs and resolving to include information on religious/spiritual prejudice and discrimination in multicultural and diversity training material and activities (American Psychological Association, 2007a).

Finally, the APA Commission on Accreditation's (CoA) Guidelines and Principles for Accreditation of Programs in Professional Psychology (American Psychological Association, 2013) stipulate in Domain A.5 that cultural and individual diversity includes religion, and require that each APA-accredited doctoral, internship and postdoctoral programs (for those nonreligiously affiliated and thus not under the auspices of Footnote 4) adhere to the following definition of diversity: "personal and demographic characteristics . . . [include], but are not limited to, age, disability, ethnicity, gender, gender identity, language, national origin, race, religion, culture, sexual orientation, and social economic status" (p. 6).

Avoidance of Religion and Spirituality in Clinical Practice

A survey of more than 300 clinical psychologists on a mailing list of randomly selected APA members who had a doctorate in clinical psychology and were practicing clinicians found that these psychologists discuss religion and spirituality with only 30% of their clients, and fewer than half address clients' SRBPs in any way during assessment or treatment planning (Hathaway et al., 2004).

Why is this the case? It does not appear to be because of lack of interest. Psychotherapists indicate an openness to engage the topic of religious and spiritual issues with clients (Brown, Elkonin, & Naicker, 2013; Knox, Catlin, Casper, & Schlosser, 2005) and a survey of college counselors revealed that more than 70% were open to in-session discussions of religious and spiritual issues (Weinstein, Parker, & Archer, 2002). Moreover, clients report that they would like to discuss religious and spiritual matters in psychotherapy (Goedde, 2000; Post & Wade, 2009). Most clients want to be asked about their SRBPs (Blanton, 2005; Diallo, 2012; Knox et al., 2005; Oxhandler & Pargament, 2014; Post & Wade, 2009). For example, in a survey of clients ($N = 74$) from nine different counseling centers, Rose, Westefeld, and Ansely (2001) found that 55% of clients wanted to discuss religious/spiritual concerns with their psychotherapist and 63% thought it was appropriate to do so.

Avoidance of religion and spirituality in clinical practice may instead be attributable to the fact that most psychologists receive little education or training in how to ethically and effectively attend to religious and spiritual domains in clinical practice, or guidance about the extent to and methods by which they should incorporate this dimension into their work (Brawer, Handal, Fabricatore, Roberts, & Wajda-Johnston, 2002; Hage, Hopson, Siegel, Pay-

ton, & DeFanti, 2006; Schafer, Handal, Brawer, & Ubinger, 2011; Schulte, Skinner, & Claiborn, 2002). Attention to spirituality and religion as components of multicultural diversity is inadequate, with most of the focus in training on ethnic and racial diversity (Frazier & Hansen, 2009). For example, Nagai (2008) found that clinicians' self-ratings were much higher for ethnic/racial cultural competence compared to their ratings of spiritual competence.

Just over a decade ago, only 13% of APA accredited clinical psychology programs included any formal coursework in religion/spirituality (Brawer et al., 2002), and 90% of psychologists reported that SRBPs were not discussed in their academic training (Miller & Thoresen, 2003). Since that time, spirituality and religion are being addressed more often in supervision and coursework, but still only a quarter of psychology training programs provide even one course in religion and spirituality (Schafer et al., 2011). In contrast, 84% to 90% of medical schools offer courses or formal content on spirituality and health (Koenig, Hooten, Lindsay-Calkins, & Meador, 2010).

One important reason for this paucity of training may be a historical bias against religion and spirituality in the field of psychology (Emmons & Paloutzian, 2003). There seems to be a variety of reasons for this bias, including the fact that psychologists as a group are much less religious than their clients (Shafranske & Cummings, 2013). For example, 66% of psychologists believe in God compared to more than 90% of the general population, and only 35% of psychologists report that their approach to life is based on their religion compared with 72% of the public (Delaney, Miller, & Bisonó, 2007).

Lack of training in religious and spiritual diversity may have significant consequences for clinical practice, especially because there is evidence that psychologists may hold explicit and implicit negative biases based on perceived client religiosity—for example, assessing religious clients as having worse prognoses (O'Connor & Vandenberg, 2005; Ruff, 2008). O'Connor and Vandenberg (2005) found that when 110 mental health professionals were asked to assess vignettes of patients 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 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, contrary to *DSM–IV* guidelines" (p. 616).

Another factor contributing to the widespread lack of training in religious and spiritual competencies may be a lack of commonly agreed upon guidelines for addressing SRBPs in clinical practice. As a result, many doctoral programs and predoctoral internships rely on informal and unsystematic sources of learning to address the topic of religious and spiritual diversity (Vogel, 2013), in contrast to following guidelines for competencies in gender, sexual orientation, aging, and multicultural issues that are already in place or in development (American Psychological Association, 2003, 2007b, 2012, 2009).

Many psychologists have endeavored to establish a set of "spiritual competencies" (Aten & Hernandez, 2004; Brownell, 2014; Delaney, Forcehimes, Campbell, & Smith, 2009; Gonsiorek, Richards, Pargament, & McMinn, 2009; Hathaway & Ripley, 2009; Lopez, Brooks, Phillips, & Hathaway, 2005; Lukoff, Lu, & Turner, 1995; McMinn, Aikins, & Lish, 2003; Nagai, 2008; Pisano, Thomas, & Hathaway, 2005; Abu Raiya & Pargament, 2010; Richards, 2009; Richards & Bergin, 2005, 2014; Saunders, Miller, & Bright, 2010; Sperry, 2012; Vieten et al., 2013). In addition to the term competence, authors have used various terms such as "spiritually sensitive" (Sperry, 2012), "spiritually conscious" (Saunders et al., 2010) and for higher levels of proficiency, "spiritually integrated" (Pargament, 2007) and "spiritually-oriented" (Sperry & Shafranske, 2005). These recommendations have overlapped, yet are distinct from one another in their emphases and approaches.

Perhaps the most comprehensive work toward establishing agreed upon guidelines have been the set of preliminary practice guidelines for working with religious and spiritual issues proposed by Hathaway and Ripley (2009). This set of guidelines is described as "common best practice recommendations from exemplar clinicians who special-

ize in addressing religious and spiritual issues in practice" (p. 33), and includes sections addressing assessment, intervention, and multicultural diversity. In addition, Sperry (2012) developed a list of core competencies for conducting "spiritually sensitive psychotherapy" (p. 231), including such items as "Responds to client communications about R/S [religion/spirituality] with acceptance and sensitivity" and "Sets goals with the client that are consistent with the client's R/S perspectives" (p. 231). While serving as useful guidelines, to our knowledge, previous proposed competencies have not been empirically validated, nor has their acceptability to the larger field has been assessed. Thus, no standardized training models or criteria yet exist (McMinn, Snow, & Orton, 2012).

To address this gap, in previous work our research team developed a set of empirically based spiritual and religious competencies for mental health professionals (Vieten et al., 2013). We developed these through a comprehensive literature review and a focus group with scholars and clinicians who were experts in the intersection of spirituality and psychology. We then conducted an online survey of 184 scholars and clinicians experienced in the integration of SRBPs and psychology. Survey participants offered suggestions on wording for each item, and a subset of 105 licensed psychotherapists who self-reported being "very proficient" in the intersection of spirituality/religion and psychology rated the clarity and relative importance of each provisional basic spiritual and religious competency. The result is a set of 16 basic spiritual and religious competencies (attitudes, knowledge, and skills) that we propose all licensed psychologists should receive training in, and be able to demonstrate in their clinical practice (Vieten et al., 2013).

This provisional set of competencies, and most sets of competencies by other scholars, relied on experts in the intersection of religion/spirituality and psychotherapy. The next step in this line of research was to investigate how a more general sample of psychologists (not necessarily with expertise, interest, or sympathy toward this domain) would respond to these competencies. Would they find them acceptable as training guidelines? Had they received training in these arenas? How would they rate their own competency in them? And which competencies did they see as most (and least) important to integrate into training and clinical practice?

Method

Participants

Of the total respondents who completed the survey (n = 272), 82% held an MA, PsyD, or PhD and were licensed to practice psychotherapy (n = 222). We utilized this subset of participants in analyzing results (excluding those who were lower than master's level, and who were not licensed clinicians. Data from the full set of participants is available from the authors). This subset of respondents (see Table 1) had a mean age of 55.1 (SD = 13.6), were 50% female, and were 87.8% White/Caucasian. Participants averaged 23.3 (SD = 13.2) years of clinical practice. There was a generally normal distribution of self-reported expertise in the intersection of spirituality/religiosity and psychology, with almost 40% of participants reporting they felt "competent," and approximately equal proportions reporting greater and lesser expertise. In terms of spiritual or religious affiliation, 41% of the sample reported being "spiritual but not religious," 37% identified as both "both spiritual and religious," 18% were "neither spiritual nor religious," and nearly 3% "religious but not spiritual."

Procedures

Approval was obtained by the Institute of Noetic Sciences Institutional Review Board. Participants were recruited at the 2013 American Psychological Association Convention through distribution of recruitment materials in the exhibit hall, from an online psychologist directory (the American Board of Professional Psychology [ABPP]), and from psychology-related list-servs. To reduce bias of respondents based on interest in the topic, the subject of religion and spiritual competence was intentionally masked in recruitment materials by presenting the survey as "a confidential online survey about how to address specific domains of diversity in the clinical practice of psychology." Participants were entered into a drawing to win a free iPad Mini once they completed the survey,

Table 1
Demographics

Item	(*N* = 222) %	Mean (*SD*)
Age		55.1 (13.6)
Gender		
Female	50.0%	
Male	49.1%	
Other	0.9%	
Race/Ethnicity (check all that apply)		
White/Caucasian	87.8%	
Asian/Pacific Islander	4.1%	
Hispanic/Latino/Spanish Descent	3.6%	
Black/African	3.2%	
Other	2.7%	
American Indian/Alaskan Native	2.3%	
Highest graduate degree		
PhD	75.2%	
PsyD	18.0%	
MA/MS	5.0%	
Other	1.8%	
License		
Psychologist	91.0%	
MFT	3.2%	
LCSW	1.4%	
LPC/Licensed Professional Counselor	1.4%	
Ordained Clergy/Pastoral Counselor	1.4%	
Other	4.5%	
Years in clinical practice		23.3 (13.2)
How many client-hours do you spend providing psychotherapy or counseling each week?		
More than 40	3.6%	
21–40	13.5%	
21–30	9.0%	
11–20	24.8%	
Fewer than 10	48.2%	
To what extent do you consider yourself competent or proficient in integrating spirituality and/or religion in the practice of psychology?		
Very proficient	13.5%	
Proficient	19.8%	
Competent	39.6%	
Minimally competent	22.5%	
Not competent	3.6%	
Do you consider yourself:		
Spiritual but not religious	41.0%	
Both religious and spiritual	37.4%	
Neither spiritual nor religious	18.0%	
Religious but not spiritual	2.7%	
Do you identify with any of the following? (Check all that apply)		
Christianity (Protestant/ Non-Catholic)	27.9%	
Christianity (Catholic)	20.3%	
Buddhism	21.6%	
Judaism	20.3%	
Agnosticism	16.7%	
Atheism	11.7%	
Other	12.6%	
Pagan or Earth-Based Religion (e.g. Shamanism)	8.6%	

(*table continues*)

Table 1 (*continued*)

Item	(*N* = 222) %	Mean (*SD*)
Native American Spirituality	5.9%	
Hinduism	3.6%	
Islam	.9%	
How much did religion or spirituality influence your upbringing (in other words, how much was religion or spirituality a part of your family life while growing up)?		
Very much	22.1%	
Quite a bit	22.5%	
A fair amount	17.1%	
Somewhat	18.9%	
A little	13.1%	
Not at all	5.9%	

Note. Percentages for each category in the tables may not add up to 100% of the sample because respondents may have skipped a question. Respondents who skipped more than five questions total were not included in the sample.

if they chose to provide contact information. Data were collected via an online survey hosted on Survey Monkey, with no collection of IP addresses.

Measures

Participants were asked to complete four ratings for each of the 16 proposed competencies. For each competency, respondents were asked the following: 1. "Do you believe that psychologists should receive training in, and demonstrate competence in, this area?" (yes or no); 2. to were asked to select a response to the sentence stem "In my training program I: (a) did not receive any explicit training in this domain, (b) received a little bit of explicit training in this domain, (c) received some explicit training in this domain, (d) received comprehensive formal training in this domain, or (e) received too much training in this domain. Respondents were then asked to rate the extent to which they believe they demonstrate each competency, by selecting a response to the stem "In my practice of psychology, I . . ." followed by the content of each proposed competency, such as, ". . . demonstrate empathy, respect, and appreciation for clients from diverse spiritual, religious or secular backgrounds and affiliations" (*completely*, *mostly*, *somewhat*, *a little*, or *not at all*).

Finally, participants were asked to rate the relative importance of each competency for the practice of psychology (*very important*, *somewhat important*, *a little bit important*, or *not important*), and to provide demographic information. The survey began by providing respondents with working definitions of terms as follows:

> Religion is defined as an organization that is guided by shared beliefs and practices, whose members adhere to a particular understanding of the divine and participate in religious rituals. Spirituality is defined more broadly as an individual's internal sense of connection to something "more," something beyond oneself, which could be perceived as a higher power or God, but could also be a more general sense of the sacred, consciousness, or interconnectedness to all life. Some people's spirituality is deeply informed by participation in organized religions, while others describe themselves as "spiritual but not religious." Still others do not have any spiritual or religious involvement in their background, but this lack of spiritual or religious involvement may influence their worldview and behavior as well. Many of the items in this survey refer to one's "spiritual or religious background" so please be aware that this also includes a lack of spiritual or religious involvement in one's background.

Attitudes and beliefs refer to psychologists' implicit and explicit perspectives and biases people hold about spirituality and religion as it relates to the practice of psychology. Knowledge refers to information, facts, concepts, and awareness of research literature about spirituality and religion as it relates to the practice of psychology. Skills refer to psychologists' use of their knowledge of spirituality and religion in their clinical work with clients.

The entire survey is available from the corresponding author or in the online supplemental materials.

Results

In response to the question "Do you believe that psychologists should receive training in, and demonstrate competence in, this area?" across all items, an average of 85.8% (SD = 6.3%) of respondents answered "yes" (range = 73.0% to 94.1%). Ratings for acceptability of each individual competency are provided in Table 2. The item with the least agreement (26.6% of respondents answering "no") was psychologists staying abreast of the research literature in the intersection of religion/spirituality and psychology, and assessing their own competence in an ongoing manner. In addition, nearly a quarter of respondents (23.0%) did not think psychologists should be trained to, or be required to demonstrate the ability to, help clients explore and access their spiritual and/or religious strengths and resources. The item with the most agreement (94.1% of respondents answering "yes") was psychologists' understanding that clients may have experiences that are consistent with their spirituality or religion, yet may be difficult to differentiate from psychopathological symptoms.

Means and standard deviations were calculated for importance ratings (see Table 2). Importance ratings were coded as follows: *very important* = 4; *somewhat important* = 3; *a little bit important* = 2; *not important* = 1. The three items that received the highest importance ratings were: (a) Psychologists demonstrate empathy, respect, and appreciation for clients from diverse spiritual, religious or secular backgrounds and affiliations; (b) Psychologists are able to conduct empathic and effective psychotherapy with clients from diverse spiritual and/or religious backgrounds, affiliations, and levels of involvement; and (c) Psychologists are aware of how their own spiritual and/or religious background and beliefs may influence their clinical practice, and their attitudes, perceptions, and assumptions about the nature of psychological processes.

The three items receiving the lowest importance ratings were: (a) Psychologists can describe how spirituality and religion can be viewed as overlapping, yet distinct, constructs; (b) Psychologists help clients explore and access their spiritual and/or religious strengths and resources; and (c) Psychologists stay abreast of research and professional developments regarding spirituality and religion specifically related to clinical practice, and engage in ongoing assessment of their own spiritual and religious competency.

In response to the query regarding training received (see Table 3), an average of less than 1.0% of respondents responded that they received "too much training in this domain" (x = 0.70%, SD = 0.20%, range = 0.50% to 0.90%). An average of nearly 10% responded that they received "comprehensive formal training in this domain," x = 9.48%, SD = 2.9%, range = 6.3% to 15.8%). Nearly 20% responded they received "some explicit training in this domain" (x = 19.8%, SD = 5.7%, range = 11.3% to 29.7%). An average of 24.9% (SD = 2.4%, range = 21.6% to 28.4%) responded that "I received a little bit of training in this domain," and an average of 44.5% (SD = 8.7%, range = 29.7% to 58.6%) responded that they "did not receive any explicit training in this domain." On average, nearly 70% of participants reported having received "a little bit" or "no explicit training" in these competencies (x = 69.4%, SD = 8.3%, range = 52.2% to 80.7%).

Despite this general lack of training, across all 16 domains (see Table 3) nearly 30% of respondents reported that in their own practice they demonstrated each competency "completely"(x = 29.7%, SD = 14.4%, range = 10.4% to 59.5%). Another nearly 40% (x = 37.7%, SD = 8.9%, range = 21.6% to 57.7%) reported that they "mostly" demonstrated each competency. Nearly 20% (x = 18.4%, SD = 8.9%, range = 2.3% to 29.7%) reported that they demonstrated each competency "somewhat." Almost 10% (x = 9.6%, SD = 7.3%, range = 0.5% to 23.9%) reported that they demonstrated each competency "a little," and an average of 4.2% (SD = 4.3%, range = 0.0% to 15.8%) reported that they demonstrated each competency "not at all."

Discussion

Results of this survey study demonstrate a very large degree of support for the proposed competencies. More than 70% to 90% of respondents agreed that psychologists should receive training in and demonstrate competence in each of the 16 domains. This overwhelming majority of positive responses may reflect psychologists' increasing recognition of spirituality

Table 2
Acceptability and Importance of Competencies

Acceptability: Do you believe that psychologists should receive training in, and demonstrate competence in, this area?

Relative importance: You may believe that some of these competencies are essential, whereas others are less important. Please rate the relative importance of each of these competencies for the practice of psychology. (1 = *not important* to 4 = *very important*)

Competency	(*N* = 222) Agreement		(*N* = 222) Importance
	Yes	No	Mean (*SD*)
Attitudes and beliefs			
1. Psychologists demonstrate empathy, respect, and appreciation for clients from diverse spiritual, religious or secular backgrounds and affiliations.	91.9%	8.1%	3.9 (.4)
2. Psychologists view spirituality and religion as important aspects of human diversity, along with factors such as race, ethnicity, sexual orientation, socioeconomic status, disability, gender, and age.	90.5%	9.5%	3.7 (.7)
3. Psychologists are aware of how their own spiritual and/or religious background and beliefs may influence their clinical practice, and their attitudes, perceptions, and assumptions about the nature of psychological processes.	88.7%	10.4%	3.8 (.6)
Knowledge			
4. Psychologists know that many diverse forms of spirituality and/or religion exist, and explore spiritual and/or religious beliefs, communities, and practices that are important to their clients.	82.4%	17.1%	3.3 (.9)
5. Psychologists can describe how spirituality and religion can be viewed as overlapping, yet distinct, constructs.	79.3%	19.8%	3.0 (.9)
6. Psychologists understand that clients may have experiences that are consistent with their spirituality or religion, yet may be difficult to differentiate from psychopathological symptoms.	94.1%	5.4%	3.6 (.7)
7. Psychologists recognize that spiritual and/or religious beliefs, practices and experiences develop and change over the lifespan.	84.2%	15.3%	3.3 (.8)
8. Psychologists are aware of internal and external spiritual and/or religious resources and practices that research indicates may support psychological wellbeing, and recovery from psychological disorders.	86.0%	13.5%	3.3 (.8)
9. Psychologists can identify spiritual and religious experiences, practices and beliefs that may have the potential to negatively impact psychological health.	90.1%	9.0%	3.5 (.7)
10. Psychologists can identify legal and ethical issues related to spirituality and/or religion that may surface when working with clients.	89.6%	9.0%	3.4 (.8)
Skills			
11. Psychologists are able to conduct empathic and effective psychotherapy with clients from diverse spiritual and/or religious backgrounds, affiliations, and levels of involvement.	94.1%	5.9%	3.8 (.6)
12. Psychologists inquire about spiritual and/or religious background, experience, practices, attitudes and beliefs as a standard part of understanding a client's history.	86.9%	12.2%	3.3 (.9)
13. Psychologists help clients explore and access their spiritual and/or religious strengths and resources.	76.1%	23.0%	2.9 (1.0)
14. Psychologists can identify and address spiritual and/or religious problems in clinical practice, and make referrals when necessary.	79.3%	18.9%	3.2 (1.0)
15. Psychologists stay abreast of research and professional developments regarding spirituality and religion specifically related to clinical practice, and engage in ongoing assessment of their own spiritual and religious competency.	73.0%	26.6%	2.9 (1.0)
16. Psychologists recognize the limits of their qualifications and competence in the spiritual and/or religious domains, including their responses to clients spirituality and/or religion that may interfere with clinical practice, so that they (a) seek consultation from and collaborate with other qualified clinicians or spiritual/religious sources (e.g. priests, pastors, rabbis, imam, spiritual teachers, etc), (b) seek further training and education, and/or (c) refer appropriate clients to more qualified individuals and resources.	86.9%	12.6%	3.5 (.8)

Note. Percentages for each category in the tables may not add up to 100% of the sample because respondents may have skipped a question. Respondents who skipped more than five questions total were not included in the sample.

Table 3
Amount of Training and Self-Rated Competence

	Training received (N = 222)									
	Amount of training: "In my training program (formal coursework or internship)":					Self-rated competence: "I demonstrate this competency in my clinical practice":				
Competency	I received too much training in this domain	I received comprehensive formal training in this domain	I received some explicit training in this domain	I received a little bit of explicit training in this domain	I did not receive any explicit training in this domain	Completely	Mostly	Somewhat	A little	Not at all
1. Psychologists demonstrate empathy, respect, and appreciation for clients from diverse spiritual, religious or secular backgrounds and affiliations.	.9%	8.6%	22.1%	25.2%	43.2%	59.5%	37.8%	2.3%	.5%	0%
2. Psychologists view spirituality and religion as important aspects of human diversity, along with factors such as race, ethnicity, sexual orientation, socioeconomic status, disability, gender, and age.	.9%	10.4%	25.7%	22.5%	40.1%	59.0%	32.9%	6.8%	.5%	.9%
3. Psychologists are aware of how their own spiritual and/or religious background and beliefs may influence their clinical practice, and their attitudes, perceptions, and assumptions about the nature of psychological processes.	.5%	11.3%	20.3%	28.4%	38.7%	34.7%	57.7%	5.4%	1.8%	.5%

(*table continues*)

Table 3 (*continued*)

	Training received (N = 222)									
	Amount of training: "In my training program (formal coursework or internship)":					Self-rated competence: "I demonstrate this competency in my clinical practice":				
Competency	I received too much training in this domain	I received comprehensive formal training in this domain	I received some explicit training in this domain	I received a little bit of explicit training in this domain	I did not receive any explicit training in this domain	Completely	Mostly	Somewhat	A little	Not at all
4. Psychologists know that many diverse forms of spirituality and/or religion exist, and explore spiritual and/or religious beliefs, communities, and practices that are important to their clients.	.5%	7.7%	21.2%	26.1%	43.7%	31.1%	37.4%	23.4%	5.9%	2.3%
5. Psychologists can describe how spirituality and religion can be viewed as overlapping, yet distinct, constructs.	.9%	7.7%	11.3%	23.0%	55.9%	35.1%	34.7%	17.1%	8.6%	3.2%
6. Psychologists understand that clients may have experiences that are consistent with their spirituality or religion, yet may be difficult to differentiate from psychopathological symptoms.	.5%	11.7%	27.9%	28.4%	30.6%	32.0%	40.5%	20.7%	5.4%	.9%

Table 3 (*continued*)

	Training received (N = 222)									
	Amount of training: "In my training program (formal coursework or internship)":					Self-rated competence: "I demonstrate this competency in my clinical practice":				
Competency	I received too much training in this domain	I received comprehensive formal training in this domain	I received some explicit training in this domain	I received a little bit of explicit training in this domain	I did not receive any explicit training in this domain	Completely	Mostly	Somewhat	A little	Not at all
7. Psychologists recognize that spiritual and/or religious beliefs, practices and experiences develop and change over the lifespan.	.5%	8.1%	15.8%	22.5%	52.3%	39.6%	41.0%	10.4%	8.1%	.5%
8. Psychologists are aware of internal and external spiritual and/or religious resources and practices that research indicates may support psychological wellbeing, and recovery from psychological disorders	.5%	8.6%	23.0%	26.1%	41.4%	21.2%	41.4%	24.3%	10.8%	1.4%
9. Psychologists can identify spiritual and religious experiences, practices and beliefs that may have the potential to negatively impact psychological health.	.5%	6.8%	18.0%	25.2%	49.1%	14.4%	40.5%	28.4%	10.8%	5.0%

(*table continues*)

Table 3 (*continued*)

	Training received (N = 222)									
	Amount of training: "In my training program (formal coursework or internship)":					Self-rated competence: "I demonstrate this competency in my clinical practice":				
Competency	I received too much training in this domain	I received comprehensive formal training in this domain	I received some explicit training in this domain	I received a little bit of explicit training in this domain	I did not receive any explicit training in this domain	Completely	Mostly	Somewhat	A little	Not at all
10. Psychologists can identify legal and ethical issues related to spirituality and/or religion that may surface when working with clients.	.9%	8.1%	14.9%	23.0%	52.7%	14.9%	33.3%	29.7%	14.4%	7.2%
11. Psychologists are able to conduct empathic and effective psychotherapy with clients from diverse spiritual and/or religious backgrounds, affiliations, and levels of involvement.	.9%	15.8%	29.7%	22.5%	29.7%	30.6%	53.6%	11.7%	2.7%	1.4%
12. Psychologists inquire about spiritual and/or religious background, experience, practices, attitudes and beliefs as a standard part of understanding a client's history.	.5%	15.8%	26.6%	25.7%	31.1%	32.4%	34.2%	21.6%	8.1%	3.6%

Table 3 (*continued*)

	Training received (N = 222)									
	Amount of training: "In my training program (formal coursework or internship)":					Self-rated competence: "I demonstrate this competency in my clinical practice":				
Competency	I received too much training in this domain	I received comprehensive formal training in this domain	I received some explicit training in this domain	I received a little bit of explicit training in this domain	I did not receive any explicit training in this domain	Completely	Mostly	Somewhat	A little	Not at all
13. Psychologists help clients explore and access their spiritual and/or religious strengths and resources.	.9%	6.3%	20.7%	21.6%	50.0%	17.1%	27.9%	27.9%	17.6%	8.6%
14. Psychologists can identify and address spiritual and/or religious problems in clinical practice, and make referrals when necessary.	.5%	7.2%	13.1%	27.9%	51.4%	18.0%	28.8%	19.4%	23.9%	9.0%
15. Psychologists stay abreast of research and professional developments regarding spirituality and religion specifically related to clinical practice, and engage in ongoing assessment of their own spiritual and religious competency.	.9%	6.8%	11.3%	22.1%	58.6%	10.4%	21.6%	28.8%	23.4%	15.8%

(*table continues*)

Table 3 (*continued*)

	Training received (N = 222)									
	Amount of training: "In my training program (formal coursework or internship)":					Self-rated competence: "I demonstrate this competency in my clinical practice":				
Competency	I received too much training in this domain	I received comprehensive formal training in this domain	I received some explicit training in this domain	I received a little bit of explicit training in this domain	I did not receive any explicit training in this domain	Completely	Mostly	Somewhat	A little	Not at all
16. Psychologists recognize the limits of their qualifications and competence in the spiritual and/or religious domains, including their responses to clients spirituality and/or religion that may interfere with clinical practice, so that they (a) seek consultation from and collaborate with other qualified clinicians or spiritual/religious sources (e.g. priests, pastors, rabbis, imam, spiritual teachers, etc), (b) seek further training and education, and/or (c) refer appropriate clients to more qualified individuals and resources.	.9%	10.8%	15.8%	28.4%	43.2%	25.7%	39.6%	17.1%	10.4%	6.3%

and religion as important aspects of human diversity, as well as their importance in people's psychological lives.

The high level of support may also reflect that most of these competencies have been structured at a realistic level of expertise to be acceptable as basic training guidelines for the general population of psychologists. To date, addressing spirituality and religion in psychotherapy has been considered a specialty or niche requiring specific training. This set of knowledge, attitudes, and skills was intentionally designed to include basic competencies for all psychologists, rather than guidelines for gaining proficiency in spiritually oriented psychotherapy. They were also carefully constructed to be appropriate for psychologists who do or do not have any religious or spiritual beliefs or practices. In other words, being competent in these domains requires no religious or spiritual beliefs or practices on the part of psychologists.

Between half and 80% of respondents confirmed that they had received little or no training in these competencies. More than a quarter to more than half reported receiving *no training at all* in each of the competencies. This confirms the paucity of training in spiritual and religious competencies reported by other researchers, and highlights the need for guidelines to help psychology programs effectively incorporate training. Without adequate training in how to address religious and spiritual issues sensitively in psychotherapy, it would be difficult for psychotherapists to be effective in these arenas, possibly leading to unintentionally inadequate responses, or what Saunders, Miller and Bright (2010) have called spiritually avoidant care.

Notably, although most psychologists in this survey admitted they have received little or no training in religious and spiritual competences, most claimed that they regard themselves as fully or mostly competent in these attitudes, behaviors, and knowledge domains. Almost two thirds claimed to be "completely" or "mostly" competent across all of the surveyed domains. In two of the four domains judged to be most important to include in training (items 1 and 2; Table 2), nearly 60% of participants claimed to already be "completely" competent.

This may indicate that these competencies are in fact part of a psychologist's baseline clinical and multicultural skill set. Alternatively, this could reflect biased self-reporting. The influence of socially desirable self-reporting has been observed in other multicultural competency assessments (Constantine, 2000; Constantine & Ladany, 2000; Worthington, Mobley, Franks, & Tan, 2000). Clinicians may perceive that they possess competence in these domains merely as a function of their own faith, lack thereof, or general life experience. Gonsiorek et al. (2009) asked, "On what basis do psychologists conclude that they possess adequate competence with spiritual and religious issues? . . . The assumption that personal religious faith (or equally held agnosticism or atheism) is adequate is an error" (p. 386). Pargament (2007) agrees that, "religious and spiritual experience, reflection, devotion, or formal training do not establish competence in the area of spiritually integrated psychotherapy" (p. 391, commentary in Gonsiorek). Gonsiorek et al. (2009) suggest instead that,

> sufficient competence in spiritual and religious issues in psychology should resemble competence in other areas of expertise: a sufficiently broad and detailed combination of course work, supervised experience, continuing education, professional reading, consultation, and other standard training vehicles that together are satisfactory to licensing boards and ethics committees. (p. 386)

Further research is needed to determine how these self-reported high levels of competence may indeed have been developed through continuing education trainings, increased media coverage of religion, or personal spiritual practices. To evaluate the reliability and validity of self-reported spiritual competency, it will be important to establish standardized measures to assess therapist self-reported religious and spiritual competence in comparison to client perceptions.

The three competencies rated as having the greatest relative importance for the practice of psychology were (a) showing empathy, respect, and appreciation for clients from diverse spiritual, religious, or secular backgrounds and affiliations; (b) ability to conduct empathic and effective psychotherapy with clients from diverse spiritual and religious backgrounds; and (c) cultivating an awareness of how clinicians' own spiritual and/or religious background and beliefs may influence their clinical practice, and their attitudes, perceptions, and assumptions about the nature of psychological processes. When it is not practical to include all 16 com-

petencies in training programs, we agree with respondents that these three are the most essential to include.

The attitudes dimension is perhaps the most important of the three (attitudes, knowledge and skills). In the more mature arena of racial and ethnic cultural competency (Sue, Arredondo, & McDavis, 1992) the attitudes dimension is recognized as crucial because it provides the foundation on which other dimensions of cultural competence rest. "Shortcomings in skill sets and knowledge of other cultural worldviews are likely to be overlooked if the appropriate attitudes exist, but the converse is less likely to occur" (Hodge, 2007, p. 289). Similarly, Brownell (2014) maintains that:

> It is not necessary nor is it even possible, to know everything about all the diverse religious and spiritual streams flowing among the communities of faith in this world. What is necessary is that one begin to see spiritual and religious life as an important consideration, right up there alongside cognition, affect, and development. (p. 2)

In our study, there were competencies that were considered less important, based on less agreement with their inclusion into training and lower ratings of importance. One of these was the expectation that psychologists would stay up-to-date with research and professional developments in the intersection of religion and spirituality, and engage in ongoing self-assessment of competence. Just over 25% of respondents disagreed that this should be included as a basic competency, which may reflect that this may be unrealistic or burdensome for clinicians who are not specializing in this arena.

More than 20% of respondents disagreed that helping clients explore and access their spiritual or religious strengths and resources should be included in training. This is a bit more troubling given that the literature indicates religion and spirituality play a strong role in many people's psychological well-being. It is understandable that some psychologists may feel this skill would entail too active or prescriptive a stance, or lie outside of their scope of practice. But ideally, with training, psychologists would be willing to help clients access *any* strengths or resources that may aid in their mental and emotional health, including those that are religious or spiritual.

These findings should be interpreted with a few limitations in mind. First, all data were collected via online survey and are subject to self-report and recall biases that survey research entails. Generalizability of the results to the overall population of practicing clinical psychologists may be limited. The sample was not randomly selected, but instead were volunteers. Although the specific topic of religious and spiritual competencies was intentionally masked in recruitment materials and subjects were incentivized by being entered into a drawing for a free iPad, it is possible that those who held no interest in, or antagonism toward, this topic did not complete the survey once they read the consent form. Further, the sample included an older segment of psychologists (mean age = 55.1, SD = 13.6), whose responses may not accurately represent the current level of training being offered.

Overall, the results of this survey support the conclusion that these 16 domains of spiritual and religious competency are important, relevant, and acceptable to the vast majority of psychologists. We recommend they be routinely included in multicultural competency training in psychology programs, as well as practicum and internship sites. Training in these competencies should (a) help clinicians avoid biased, inadequate, or inappropriate treatment when encountering spiritual or religious issues, (b) enable clinicians to identify and address spiritual or religious problems and to harness clients' inner and outer spiritual and religious resources, thus improving treatment outcomes, and (c) provide baseline standards for content that can be integrated throughout clinical training and supervision, which programs could modify or elaborate according to their training models (Hage, 2006). We agree with the premise that:

> General multicultural training is not sufficient to address this area: Working sensitively and effectively with religious and spiritually oriented clients often requires more than just general multicultural attitudes and skills. It can require specialized knowledge and training about the religious beliefs and practices of religious traditions and communities, about the spiritual issues and needs of human beings, and about religious and spiritual assessment and intervention techniques. (Richards & Bergin, 2005, p. 12)

These competencies should support the development of a systematic approach to training that can be adopted and incorporated into graduate curriculum, clinical training, and continuing education to help clinicians attain the skills, knowl-

edge, and attitudes necessary to function as a spiritually competent psychologist. In psychology training programs, we recommend either specialized coursework on these competencies, or explicit integration of these issues into more generic courses on assessment and treatment. Site reviewers could use these competencies to evaluate clinical training and internship programs. In addition, items informed by these competencies could be included in professional licensing exams, and form the basis for continuing education courses for practicing psychologists.

It will also be important to develop methods to evaluate the effectiveness of various training methods in fostering these competencies. As Brownell (2014) notes,

> The assessment and development of spiritual competency requires an organized approach to the development of such competency . . . so that their students and trainees emerge from their studies knowledgeable and capable in regard to the role of spirituality and religion in life. (p. 8)

Psychologists teaching graduate students or supervising intern and practicum students might ask where to start the process of ensuring spiritual and religious competence among their students and supervisees. To start, being able to conduct a spiritual assessment has emerged as a foundational skill that appears in most of the proposed spiritual competency guidelines discussed in this article. In addition, the Joint Commission on Accreditation of Healthcare Organizations (2005), the leading health care organization accreditation agency, mandates that health care practitioners conduct an initial brief spiritual assessment with clients in hospitals and in behavioral health organizations. At minimum, the brief assessment should include an exploration of three areas: (a) denomination or faith tradition, (b) significant spiritual beliefs, and (c) important spiritual practices. The assessment needs to be documented in patients' charts (Joint Commission on Accreditation of Healthcare Organizations, 2005).

Lucchetti, Bassi, and Lucchetti (2013) recently reviewed 25 spiritual history instruments and one that received a high rating based on their standards was the FICA assessment (an acronym standing for Faith or belief, Importance of spirituality, individual's spiritual Community, and interventions to Address spiritual needs). This assessment was developed by a physician working in end-of-life care (Puchalski & Romer, 2000) and is taught at most medical schools and in many trainings including for public mental health staff. For training mental health professionals, one of us (D.L.) developed a similar brief four-question assessment interview focused on the spiritual needs of mental health clients (Lukoff, 2014). SOPP is an acronym used to remind clinicians to routinely assess (a) religious and spiritual Strengths, (b) involvement in Organized religion/spirituality, (c) Personal religion/spirituality, and (d) Problems with religion/spirituality.

Sperry (2012) considers the recent interest in development of spiritual competencies to be an "indication of a paradigm shift" (p. 223). There seems to be a growing consensus that "all psychologists are ethically obligated to incorporate religion and spirituality into their practices, at least to the extent that they can 'ensure the competence of their services' with religious and spiritual clients" (Richards, commentary in Gonsiorek p. 389). Brownell (2014) makes a strong argument that:

> Psychotherapists who believe that religion is the cause of suffering, religious people are weak-minded, and that there is no reason to make religious or spiritual concerns integral to the process of psychotherapy would be unethical and incompetent to work with clients who strongly believe in God or those who adhere diligently to a spiritual discipline. (p. 12)

Our hope is that this research, in addition to the work of other scholars in this arena, has provided empirical support for progress toward guidelines for working with religious and spiritual diversity being formally adopted by the American Psychological Association, such as those existing for working with girls and women (American Psychological Association, 2007b) and lesbian, gay, and bisexual clients (American Psychological Association, 2012).

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