

# Psychology of Religion and Spirituality

## **Spiritual and Religious Competencies for Psychologists**

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# Spiritual and Religious Competencies for Psychologists

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It is clear from polls of the general public that religion and spirituality are important in most people's lives. In addition, the spiritual and religious landscape is becoming increasingly diverse, with nearly a fifth of people unaffiliated with a religion, and increasing numbers of people identifying themselves as spiritual, but not religious. Religion and spirituality have been empirically linked to a number of psychological health and well-being outcomes, and there is evidence that clients would prefer to have their spirituality and religion addressed in psychotherapy. However, most often, religious and spiritual issues are not discussed in psychotherapy, nor are they included in assessment or treatment planning. The field of psychology has already included religion and spirituality in most definitions of multiculturalism and requires training in multicultural competence, but most psychotherapists receive little or no training in religious and spiritual issues, in part because no agreed-on set of spiritual competencies or training guidelines exist. In response to this need, we have developed a proposed set of spiritual and religious competencies for psychologists based on (1) a comprehensive literature review, (2) a focus group with scholars and clinicians, and (3) an online survey of 184 scholars and clinicians experienced in the integration of spiritual and religious beliefs and practices and psychology. Survey participants offered suggestions on wording for each item, and a subset of 105 licensed psychotherapists proficient in the intersection of spirituality/religion and psychology rated clarity and relative importance of each item as a 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 demonstrate in the domain of spiritual and religious beliefs and practices.

*Keywords:* competencies, skills, spiritual, spirituality, religion, religious

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The United States is a religious and spiritual nation. Gallup Polls from 1992 to 2012 indicate that 55–59% of Americans say that

religion is “very important” in their lives and another 24 – 29% say that religion is “fairly important in their lives” (Gallup, 2012a, p.1). Forty percent of Americans report being “very religious and another 29% consider themselves “moderately religious” (Gallup, 2012b, p. 1). Further, 92% of Americans believe in God (Gallup, 2011, p. 1).

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When dealing with a serious problem, two thirds of Americans prefer a psychotherapist with spiritual values (Lehmann, 1993) and one who integrates these values into psychotherapy (Gallup & Bezilla, 1994). University counseling center clients have indicated that they would prefer to have religion/spirituality discussed during counseling (Rose, Westefeld, & Ansley, 2001). Therapists report being open to discussing spiritual and religious issues and clients want to discuss these matters in psychotherapy (Post & Wade, 2009). However, psychologists report discussing spirituality and religion with only 30% of their clients, and less than half address clients' spiritual or religious beliefs and practices (SRBP) (acknowledgments to Saunders, Miller, & Bright, 2010 for this

term) during assessment or treatment planning (Hathaway, Scott, & Garver, 2004).

Most psychologists do not receive formal training in the intersection of psychology and spirituality, nor on the variety of world religions (Hage, 2006). As most psychologists have received little education or training in how to attend to the religious and spiritual domains in clinical practice ethically and effectively (Brawer, Handal, Fabricatore, Roberts, & Wajda-Johnston, 2002; Hage, Hopson, Siegel, Payton, & DeFanti, 2006; Schafer, Handal, Brawer, & Ubinger, 2011; Schulte, Skinner, & Calibom, 2002), the extent to and methods by which they should incorporate this dimension into their work has been unclear.

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 SRBP were not discussed in their academic training (Miller & Thoresen, 2003). Though incorporation of spirituality and religion into supervision and coursework in APA-accredited graduate training programs has increased since that time, still only a quarter of psychology training programs provide even one course in religion/spirituality (Schafer et al., 2011). A recent study of 292 APA-accredited psychology training program faculty and students indicated that doctoral programs and predoctoral internships were relying on informal and unsystematic sources of learning to provide training in religious and spiritual diversity (Vogel, 2013). In contrast, 84–90% of medical schools offer courses or formal content on spirituality and health (Koenig, Hooten, Lindsay-Calkins, & Meador, 2010).

Psychologists are lagging behind other health care fields in establishing basic spiritual and religious competencies. For example, more than a decade ago the American Psychiatric Association (Campbell, Stuck, & Frinks, 2012) began to require training in spiritual competencies during residency, and religious and spiritual competencies for psychiatrists have been partially established (Josephson, Peteet, & Tasman, 2010; Verhagen & Cox, 2010). For more than a decade, the American Association of Medical Colleges (1999) has recommended that training programs:

incorporate awareness of spirituality, and cultural beliefs and practices, into the care of patients in a variety of clinical contexts . . . [and] recognize that their own spirituality, and cultural beliefs and practices, might affect the ways they relate to, and provide care to, patients (p. 25).

The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), which provides health care accreditation to more than 19,000 health care organizations in the United States, requires a spiritual assessment as a standard element of patient care (JCAHO, 2008). Similar movements to establish spiritual and religious competencies have been active for nurses (McSherry, Gretton, Draper, & Watson, 2008; Pesut, 2008; van Leeuwen, Tiesinga, Middel, Post, & Jochemsen, 2008), social workers (Hodge, 2007), and professional counselors (Council for Accreditation of Counseling & Related Educational Programs, 2009; Miller, 1999; Robertson, 2010; Young, Cashwell, Wiggins-Frame, & Belaire, 2002).

In contrast, the field of psychology has yet to establish a research-based consensus set of spiritual and religious competencies, standards for training in them, or a method for assessing them (Hathaway, 2008). A majority of psychologists (76%) believe that

SRBP are currently inadequately addressed in training (Crook-Lyon, O'Grady, Smith, Jensen, Golightly & Potkar, 2012). However, because no formal set of spiritual and religious competencies for the field of clinical psychology has been established, guidelines for what should be included in this training are lacking.

### Not Just Religious, but Spiritual

There is a need not only for religious competencies, but also for *spiritual* competencies. Although the words have historically often been used interchangeably, spirituality and religion are increasingly being viewed as distinct yet overlapping constructs (Kapusinski & Masters, 2010; Piedmont, Ciarrochi, Dy-Liacco, & Williams, 2009; Schlehofer, Omoto, & Adelman, 2008; Zinnbauer et al., 1997). Though the term *spirituality* is notably missing from the APA Ethical Principles for Psychologists and Code of Conduct (2010), in 2011 the APA Division 36 Psychology of Religion was renamed the Society for the Psychology of Religion and Spirituality, and their journal is titled the *Psychology of Religion and Spirituality* (Piedmont, 2009).

Pargament (2007) has defined spirituality as “. . . the journey people take to discover and realize their essential selves and higher order aspirations” (p. 58), or a “search for the sacred” (Pargament, 2007, p. 52), whereas religion has been defined as “the search for significance that occurs within the context of established institutions that are designed to facilitate spirituality” (Pargament, Mahoney, Exline, Jones, & Shafranske, 2013, p. 15). Hill et al. (2000) define spirituality as thoughts, feelings, and behaviors related to concern about, a search for, or a striving for understanding and relatedness to the transcendent. Spirituality has also been defined as an individual's internal orientation toward a transcendent reality that binds all things into a unitive harmony (Dy-Liacco, Piedmont, Murray-Swank, Rodgerson, & Sherman, 2009). Kapuscinski and Masters (2010) found that “communion with the sacred, or a search for the sacred” (p. 194) was included in 67% of studies that provided a definition of spirituality. The word sacred most commonly referred to God or to the transcendent, and the authors propose that this focus is what differentiates spirituality from other psychological constructs such as meaning, purpose, or wisdom.

The landscape of SRBP in the United States is rapidly shifting. Although a majority of Americans (74%) consider themselves Christian, a growing number identify themselves as religiously unaffiliated (16.1% reported by Pew Forum, 2008; and 17.8% reported by Gallup, 2012a). Fuller (2001) estimated that almost 40% of Americans were not affiliated with any church or religion, and approximately 20% identified themselves spiritual but not religious. In 2003, a Gallup Poll showed that as many as 33% of Americans identified as spiritual but not religious (Gallup, 2003). Based on age distribution analysis, that report predicted a continued decline in the number of Protestants and an increase in religiously unaffiliated individuals. That prediction has been fulfilled. Today, 72% of millennials (18–29 year olds) describe themselves as spiritual but not religious (Phillips, 2010). Clearly, a competent psychologist must be familiar not only with religious aspects of client experiences, but also the less easily defined spiritual aspects of them. Psychologists must also be aware that many people do not engage in any religious or spiritual practice whatsoever. Spiritual and religious competencies must include

attention to and respect for *lack* of religious or spiritual involvement in clients as well.

### Spiritual and Religious Competence as a Form of Multicultural Competence

Three basic activities of multicultural competence are as follows: (1) to engage in the process of becoming aware of one's own assumptions about human behavior, values, biases, preconceived notions, personal limitations, and so forth; (2) to attempt to understand the worldview of culturally different clients without judgment; (3) to implement relevant, and sensitive intervention strategies with culturally different clients (Arredondo et al., 1996; Sue, 1998). These capacities clearly extend to cultural differences involving religion and spirituality.

But, one might ask, why should training in multicultural competence explicitly include spiritual and religious competencies? The mere fact that many people are spiritual and/or religious does not necessarily indicate that psychologists should attend to this dimension of individual difference. Prevalence alone is insufficient justification. For example, if a large percentage of the population took an interest in stock car racing, it is unlikely that competencies in this area would be required for practicing psychology.

First, most psychologists already recognize religion and spirituality as important aspects of human diversity (Crook-Lyon et al., 2012; McMinn, Hathaway, Woods, & Snow, 2009). The APA Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists (American Psychological Association, 2002) explicitly define culture as "the embodiment of a worldview through learned and transmitted beliefs, values, and practices, including religious and spiritual traditions" (p. 8). APA's Guidelines and Principles for Accreditation of Programs in Professional Psychology (American Psychological Association, 2009a) stipulate that cultural and individual diversity includes religion, and requires that each APA-accredited program "has and implements a thoughtful and coherent plan to provide students with relevant knowledge and experiences about the role of cultural and individual diversity" (p. 10) and that all interns "demonstrate an intermediate to advanced level of professional psychological skills, abilities, proficiencies, competencies, and knowledge in the areas of . . . issues of cultural and individual diversity" (p. 15).

Yet the majority of work in fostering multicultural competency focuses on ethnic and racial diversity, whereas attention to spiritual and religious aspects of diversity is inadequate (Frazier & Hansen, 2009). For example, Nagai (2008) found that among clinicians working with Asian and Asian American clients, self-ratings of spiritual competence were significantly lower than those for ethnic/racial cultural competence. Specific competencies exist or are in development for gender (American Psychological Association, 2007a), sexual orientation (American Psychological Association, 2012), aging (American Psychological Association, 2009b), and multicultural issues (American Psychological Association, 2002). Similar specific competencies for spiritual and religious diversity are needed.

Second, SRBP are important in the psychological functioning of most adolescents and adults (Hathaway et al., 2004), contributing to their identity development (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), and ability to cope with difficulties (Arredondo et al., 1996). SRBP provide meaning and support in times of stress (Oman & Thoresen, 2005; Park, 2005) and positive religious coping has been shown to contribute to successful stress management (Ano & Vasconcelles, 2005; Cornah, 2006; Ironson, Stuetzle, & Fletcher, 2006; Pargament, 1997; Pargament, Ano, & Wachholtz, 2005; Pargament, Koenig, Tarakeshwar, & Hahn, 2004). More than 80% of severely mentally ill patients report using religion to cope (Rogers, Poey, Reger, Tepper, & Coleman, 2002; Tepper, Rogers, Coleman, & Malony, 2001), and spirituality has long been recognized as a core component of recovery from substance use disorders (Delaney, Forchimes, Campbell, & Smith, 2009). Spirituality has also been linked to an increased sense of meaning, purpose, resilience, satisfaction, and happiness (Fredrickson, 2002; Fry, 2000; Pargament, 2007; Pargament, Exline et al. 2013).

A robust body of empirical evidence has demonstrated beneficial relationships between various dimensions of SRBP and psychological health (George, Ellison, & Larson, 2002; Green & Elliott, 2010; Koenig, King, & Carson, 2012; Miller & Kelley, 2005; Miller & Thoresen, 2003; Oman & Thoresen, 2005; Plante & Sherman, 2001; Seybold & Hill, 2001; Wong, Rew, & Slaikeu, 2006). In addition, interventions that have roots in spiritual traditions have been increasingly used for treatment of depression and anxiety, as well as for enhancing psychological well-being. For example, mindfulness-based psychotherapies have demonstrated effectiveness for improving anxiety and mood symptoms (Hofmann, Sawyer, Witt, & Oh, 2010; Toneatto & Nguyen, 2007). Dialectical Behavior Therapy and adaptations of it have shown promise and efficacy for treating borderline, substance abusing, eating disordered, incarcerated, and depressed populations (Robins & Chapman, 2004). Acceptance and Commitment Therapy has demonstrated robust effect sizes compared to control groups across a number of outcomes (Powers, Zum Vörde Sive Vörding, & Emmelkamp, 2009). Various forms of spiritually informed cognitive-behavioral therapies have demonstrated success, in particular with clients to whom religion is important (Waller, Trepka, Collerton, & Hawkins, 2010).

Third, although the majority of clinicians regard religion as beneficial (82%) rather than harmful (7%) to mental health (Delaney, Miller, & Bisono, 2007), the relationship between SRBP and well-being is not consistently positive (Powell, Shahabi, & Thoresen, 2003; Rosenfeld, 2010). There is evidence that some spiritual and religious practices and beliefs can impair psychological well-being (Exline & Rose, 2005; Exline, Yali, & Lobel, 1999; Pargament, 1997; Pargament, Murray-Swank, Magyar, & Ano, 2005). For example, scrupulosity and hyper-religiosity are characteristics of some obsessive-compulsive and psychotic disorders (Brewerton, 1994; Greenberg, Witztum, & Pisante, 1987). The term *spiritual bypassing* has been used to describe an unhealthy misuse of religion or spiritual practices or terminology to avoid dealing with important psychological, relationship, or global functioning problems (Cashwell, Bentley, & Yarborough, 2007; Cortright, 1997; Welwood, 2000). Also, religious and spiritual struggles in and of themselves may require informed interventions (Exline, 2013; Lukoff, Lu, & Turner, 1992; Lukoff, Lu, & Yang, 2011). Both positive and dysfunctional forms of religious and



spiritual involvement are important for psychologists to recognize and address (Zinnbauer, 2013).

Finally, there is evidence that psychologists hold explicit and implicit negative biases based on perceived client religiosity, for example, appraising religious clients as more mentally ill or having a poorer prognosis (O'Connor & Vandenberg, 2005; Ruff, 2008). Perceptions of psychologist bias or prejudice against religion and spirituality may prevent utilization of services by clients who find these domains important, as well as limiting referrals from clergy or spiritual directors who fear the spiritual or religious domain might be ignored, misunderstood or pathologized in psychotherapy (Richards & Bergin, 2000; Worthington & Sandage, 2002). Active investigation of potential biases combined with training in how to appropriately address spiritual and religious issues in clinical practice should advance the field and improve the quality of clinical practice.

### Barriers to Establishing Spiritual and Religious Competencies

A number of barriers have prevented or delayed spiritual and religious competencies from being established in the field of psychology. First, as a group, psychologists are considerably less religious than the clients with whom they work (Bergin & Jensen, 1990; Delaney et al., 2007; Shafranske, 1996, 2000; Shafranske & Cummings, 2013), and have been described as antagonistic to religion and spirituality (Hill, 2000; Plante, 2008). For example, whereas 95% of the general population believes in God, only 66% of psychologists do, and whereas 75% of the public agree that their approach to life is based on their religion, only 35% percent of psychologists surveyed agree with this statement (Delaney et al., 2007). Because spirituality and religion are less important to psychologists overall than their clients, they may have been neglected as important aspects of multicultural competency.

Second, an emphasis on establishing psychology as a scientific discipline may have led to a reluctance to acknowledge the relevance of spirituality and religion in psychological functioning (Coon, 1992; Miller & Thoresen, 2003; Plante, 2008), resulting in what Saunders, Miller, and Bright (2010) have called "spiritually avoidant care" (p. 355). Particularly among academic psychologists who chafe at psychology being considered a "soft" science, there may be hesitation to acknowledge or investigate domains of human existence that could potentially be viewed as metaphysical or supernatural.

A third barrier to establishing spiritual and religious competencies has been uncertainty about their role in training or practice (Carlson, Kirkpatrick, Hecker, & Killmer, 2002; Hathaway et al., 2004; Mrdjenovich, Dake, Price, Jordan, & Brockmyer, 2012). A consensus set of spiritual and religious competencies should provide clearer guidelines.

### Current Status of Spiritual and Religious Competency in Psychology

At its most rudimentary level, spiritual and religious competence in psychology entails avoiding prejudice based on SRBP. The American Psychological Association adopted a comprehensive *Resolution on Religious, Religion-Based and/or Religion-Derived Prejudice* in 2007, condemning prejudice and discrimina-

tion against individuals or groups based on their SRBP and resolving (among other things) to include information on religious/spiritual prejudice and discrimination in multicultural and diversity training material and activities (American Psychological Association, 2007b).

Beyond this, there have been primarily theoretical advances regarding spiritual and religious competence in psychology practice. Saunders, Miller, and Bright (2010) recommend that psychologists engage in "spiritually conscious care" (p. 355), which neither avoids spiritual and religious issues nor engages in spiritual directiveness, but instead assesses the importance of SRBP to clients, the influence of SRBP on the presenting problem, and the potential of SRBP to be tapped as a psychotherapeutic resource for clients.

In paper presentations at the American Psychological Association Convention, Lopez, Brooks, Phillips, and Hathaway (2005) proposed a set of seven preliminary religious/spiritual multicultural practice and diversity guidelines, including such items as "psychologists make reasonable efforts to become familiar with the varieties of spirituality and religion present in their client population" (p. 1) and "psychologists are encouraged to gain competence in working with clients of diverse religious/spiritual backgrounds through continuing education, consultation, and supervision" (p. 1). Likewise, Pisano, Thomas, and Hathaway (2005) proposed a set of eight preliminary religious/spiritual assessment guidelines, such as "psychologists are encouraged to routinely incorporate brief screening questions to assess for the presence of clinically salient religious/spiritual client concerns" (p. 1) and "psychologists are cautious to avoid interpreting client reports of attitudes or behaviors that are normative for a client's religious community as indicative of pathology" (p. 1).

A thoughtful set of recommendations for working with Muslim clients that seems applicable to clients of any religious or spiritual tradition was proposed by Raiya and Pargament (2010), including (1) directly asking about the place of religion in clients' lives, (2) asking what Islam means in their clients' lives and educating themselves about basic Islamic beliefs and practices, (3) helping clients draw upon Islamic religious coping methods, (4) assessing for religious struggles and referring to a clergy member if appropriate, and (5) participating in education of the Islamic public about psychology. Delaney et al. (2009) have also offered a set of open-ended questions that can be used for inquiry with substance abuse treatment patients (which could be applicable to other patient populations), as well as guidelines for deciding when to draw upon a client's existing spiritual resources.

Richards (2009) suggested that psychotherapists might self-assess their level of spiritual competence by asking themselves if they have the ability to (1) create a spiritually safe and affirming therapeutic environment for their clients, (2) have the ability to conduct an effective religious and spiritual assessment of their clients, (3) use or encourage religious and spiritual interventions, if indicated, to help clients access the resources of their faith and spirituality during treatment and recovery, and (4) effectively consult and collaborate with, and when needed, refer to clergy and other pastoral professionals. Similarly, Pargament (2007) articulated four essential qualities of therapists who want to practice spiritually integrated psychotherapy, including the following: (1) knowledge about religion and spirituality and how to integrate them into treatment; (2) openness and tolerance of diverse forms of

religious and spiritual expression; (3) self-awareness of the psychotherapist's own spiritual attitudes and values; (4) authenticity and genuineness in relating to clients about religious and spiritual issues. To assess spiritual and religious competency, Nagai (2008) modified a number of multicultural competency measures to develop the Culture and Spirituality Self Assessment (CSSA) for a study of clinicians working with Asian American populations.

Recognizing that most spiritual competency training occurs (though inconsistently) during internship (Brawer et al., 2002; Russell & Yarhouse, 2006), Aten and Hernandez (2004) identified eight domains within which to increase supervisee SRBP competency, including the following: (a) spiritual and religious intervention skills; (b) spiritual and religious assessment approaches and techniques; (c) supervisee awareness of how they influence the assessment process; (d) cultural sensitivity to spiritual and religious differences; (e) supervisee awareness of the approach of her or his theoretical orientation toward spirituality and religion; (f) case conceptualization that includes spiritual or religious themes; (g) development of treatment goals and plans that fit with a client's spiritual or religious beliefs, values, and practices; and (h) familiarity with ethical guidelines that relate to spiritual or religious clients and issues.

To our knowledge, none of these proposed guidelines have been empirically validated, formally vetted by members of the field, or incorporated into policy. To address the lack of consensus in the field about how spirituality and religion should be addressed in the practice of psychology, we engaged in a series of activities to establish a proposed set of empirically based spiritual and religious competencies.

## Method

### Working Definitions

Kaslow (2004) defines competence as "an individual's capability and demonstrated ability to understand and do certain tasks in an appropriate and effective manner consistent with the expectations for a person qualified by education and training in a particular profession or specialty thereof" (p. 774). As a subset of multicultural competencies, *spiritual and religious competencies* are defined as a set of attitudes, knowledge, and skills in the domains of spirituality and religion that every psychologist should have to effectively and ethically practice psychology, regardless of whether or not they conduct spiritually oriented psychotherapy or consider themselves spiritual or religious. *Attitudes* refers to the implicit and explicit perspectives and/or biases people hold about spirituality and religion as they relate to the practice of psychology. *Knowledge* refers to information, facts, concepts, and awareness of research literature psychologists should possess about spirituality and religion as it relates to the practice of psychology. *Skills* refer to psychologists' ability to effectively utilize their knowledge of spirituality and religion in their clinical work with clients.

### Participants

Participants were 184 psychologists and mental health professionals recruited through a variety of listservs and recommendations by colleagues, 105 of whom were designated as experts in the

intersection of spirituality/religion and psychology. Experts were defined by being licensed clinicians, masters-level or above, who self-rated themselves as proficient or very proficient in the intersection of religion/spirituality and psychotherapy. This number of participants has been suggested as appropriate for initial scale development (Hinkin, 1998). Demographics of the sample are provided in Table 1.

### Design

Kapuscinski and Masters (2010) recommend both deductive and inductive methods when creating scales relevant to religion and spirituality, because of the wide variety of definitions of terms. Phase I of the project involved a thorough literature review by the authors that informed a set of 24 provisional competencies (deductive). Phase II was a half-day focus group in March 2010 with 15 experts (including psychologists, scholars, and a physician skilled in attending to spiritual and religious issues in clinical practice) who discussed the content and wording of the provisional items (inductive), revising them in a consensus process. Expert focus groups are a useful strategy for gaining information that cannot be easily garnered from literature reviews and surveys/questionnaires, because information can emerge from interactions through chaining and cascading of ideas in the dialogic process (Lindlof & Taylor, 2002). In this case, focus groups were used to review and refine a set of provisional competencies, identify awkward language or redundancies, and suggest important competencies that had not been addressed. Phase III was a 2011 online survey of psychologists and psychotherapists to further assess the content and importance of these refined competencies. Phase IV, in 2012, included qualitative and quantitative analysis of responses and revision of items in a series of consensus building meetings, resulting in a finalized proposed set of spiritual and religious competencies (see Table 2).

### Procedures

Consent was obtained from all participants, and the study was approved by the Institutional Review Board at the Institute of Noetic Sciences. After participants consented to participate, they responded to an online survey.

### Measures

The online survey began with an overview of the purpose of the project and provided working definitions of terms. Each of 24 provisional competencies was presented one at a time. First respondents were asked to rate "Is this aspect of competency described clearly?" by endorsing one of the following: "not described very clearly," "moderately clear, but could be improved," or "described very clearly." They were then asked to respond to the open-ended question "Do you have any suggestions for changing the content or wording of this aspect of competency?" Then, respondents were asked to assess "In terms of your own practice of psychology, please rate the extent to which you possess this competency," by selecting "not at all," "a little," "somewhat," "mostly," or "completely." Then respondents were asked to rate the relative importance of each item as compared with others in the same category (e.g., attitudes and

Table 1  
*Demographics of the Online Survey Sample and Subset of Experts*

| Item  | All ( <i>n</i> = 184) |                    | Expert ( <i>n</i> = 105) |                    |
|---|-----------------------|--------------------|--------------------------|--------------------|
|   | %                     | Mean ( <i>SD</i> ) | %                        | Mean ( <i>SD</i> ) |
| Age   |                       | 54.32 (12.42)      |                          | 56.66 (10.14)      |
| Gender  |                       |                    |                          |                    |
| Male  | 50.0%                 |                    | 55.2%                    |                    |
| Female  | 48.9%                 |                    | 43.8%                    |                    |
| Other/Decline   | 1.1%                  |                    | 1.0%                     |                    |
| Race/Ethnicity  |                       |                    |                          |                    |
| White/Caucasian   | 90.8%                 |                    | 90.5%                    |                    |
| Black/African American  | 1.6%                  |                    | 2.9%                     |                    |
| American Indian/Alaskan Native  | 1.6%                  |                    | 1.0%                     |                    |
| Hispanic/Latino/Spanish descent   | 4.9%                  |                    | 4.8%                     |                    |
| Asian/Pacific Islander  | 1.1%                  |                    | 1.0%                     |                    |
| Other   | 4.3%                  |                    | 4.8%                     |                    |
| Highest degree  |                       |                    |                          |                    |
| BA/BS   | 6.5%                  |                    | 0%                       |                    |
| MA/MS   | 34.8%                 |                    | 36.2%                    |                    |
| MD  | 2.2%                  |                    | 3.8%                     |                    |
| PhD   | 48.9%                 |                    | 53.3%                    |                    |
| PsyD  | 7.6%                  |                    | 6.7%                     |                    |
| License   |                       |                    |                          |                    |
| CADAC/Licensed chemical dependency counselor  | 0.5%                  |                    | 0%                       |                    |
| LCSW  | 1.6%                  |                    | 2.9%                     |                    |
| LPC   | 15.8%                 |                    | 22.9%                    |                    |
| MD  | 1.6%                  |                    | 2.9%                     |                    |
| MFT   | 12.0%                 |                    | 17.1%                    |                    |
| Ordained clergy/Pastoral counselor  | 4.9%                  |                    | 5.7%                     |                    |
| Psychologist  | 35.9%                 |                    | 48.6%                    |                    |
| None/No answer  | 27.7%                 |                    | 0%                       |                    |
| % of clinicians   | 72.2%                 |                    | 100%                     |                    |
| Years in clinical practice  |                       | 16.92 (11.73)      |                          | 19.33 (11.29)      |
| For how many years have you integrated a spiritual/religious perspective into your work in the field of psychology? |                       | 17.68 (10.51)      |                          | 19.41 (10.26)      |
| Self-rated proficiency in the integration of spirituality and psychology  |                       |                    |                          |                    |
| Not competent   | 1.1%                  |                    | 0%                       |                    |
| Minimally competent   | 5.5%                  |                    | 0%                       |                    |
| Competent   | 16.6%                 |                    | 0%                       |                    |
| Proficient  | 37.0%                 |                    | 45.7%                    |                    |
| Very proficient   | 39.8%                 |                    | 54.3%                    |                    |
| Do you consider yourself (check all that apply)   |                       |                    |                          |                    |
| Neither spiritual nor religious   | 1.0%                  |                    | 0%                       |                    |
| Both religious and spiritual  | 49.5%                 |                    | 53.3%                    |                    |
| Spiritual but not religious   | 49.5%                 |                    | 46.7%                    |                    |
| Agnostic  | 5.4%                  |                    | 4.8%                     |                    |
| Atheist   | 4.9%                  |                    | 3.8%                     |                    |
| Buddhist  | 39.1%                 |                    | 36.2%                    |                    |
| Christian (Catholic)  | 25.5%                 |                    | 22.9%                    |                    |
| Christian (Protestant)  | 44.0%                 |                    | 49.5%                    |                    |
| Hindu   | 12%                   |                    | 11.4%                    |                    |
| Muslim  | 4.9%                  |                    | 3.8%                     |                    |
| Judaism   | 9.2%                  |                    | 10.5%                    |                    |
| Other   | 23.3%                 |                    | 22.9%                    |                    |
| How much did religion or spirituality influence your upbringing?  |                       |                    |                          |                    |
| Not at all  | 6%                    |                    | 4.8%                     |                    |
| A little  | 15.8%                 |                    | 16.2%                    |                    |
| Somewhat  | 13.0%                 |                    | 12.4%                    |                    |
| A Fair amount   | 11.4%                 |                    | 13.3%                    |                    |
| Quite a bit   | 23.9%                 |                    | 22.9%                    |                    |
| Very much   | 29.3%                 |                    | 30.5%                    |                    |

Table 2

*Proposed Spiritual and Religious Competencies for Psychologists*

## Attitudes

- 1) Psychologists demonstrate empathy, respect, and appreciation for clients from diverse spiritual, religious, or secular backgrounds and affiliations.
- 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.
- 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.

## 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.
- 5) Psychologists can describe how spirituality and religion can be viewed as overlapping, yet distinct, constructs.
- 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.
- 7) Psychologists recognize that spiritual and/or religious beliefs, practices, and experiences develop and change over the lifespan.
- 8) Psychologists are aware of internal and external spiritual and/or religious resources and practices that research indicates may support psychological well-being, and recovery from psychological disorders.
- 9) Psychologists can identify spiritual and religious experiences, practices, and beliefs that may have the potential to negatively impact psychological health.
- 10) Psychologists can identify legal and ethical issues related to spirituality and/or religion that may surface when working with clients.

## 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.
- 12) Psychologists inquire about spiritual and/or religious background, experience, practices, attitudes and beliefs as a standard part of understanding a client's history.
- 13) Psychologists help clients explore and access their spiritual and/or religious strengths and resources.
- 14) Psychologists can identify and address spiritual and/or religious problems in clinical practice, and make referrals when necessary.
- 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 competence.
- 16) Psychologists recognize the limits of their qualifications and competence in the spiritual and/or religious domains, including any 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.

beliefs, knowledge, and skills) by responding to the following: "You may believe that some of these competencies are essential, while others are less important. Please rate the relative importance of each of these competencies for the practice of psychology," using the scale "not important," "a little bit important," "somewhat important," or "very important." Finally, participants were asked to respond to demographic and professional history items, and offer any final comments.

## Results

Both quantitative ratings and qualitative feedback informed the revision of provisional items. Means and standard deviations were calculated (by C.V.) for clarity, self-assessment, and importance ratings. Thematic analyses were completed (by I.A.) on open-ended responses to suggestions for content or wording revisions, in which similar responses were grouped into categories. Categories with higher frequencies were considered for inclusion into finalized items. Item revision took place during a series of consensus-building meetings among all authors, three in-person and two via conference call.

First, clarity scores (rated on a scale of 1–3) were examined. When mean clarity scores were below 2.5, the item was flagged for potential revision. The results of the thematic analysis for each flagged item were reviewed to inform their revision. Through this process, some items were revised, and some were combined with others. Next, relative importance scores (rated on a scale of 1–4) were examined. When importance was lower than 3.0, the item was flagged for potential deletion. If it was

determined that wording revisions or combining items addressed the concern, the item was retained in a new form. If importance received a rating less than 3, and wording revisions were not required, the item was deleted. Examples of deleted items are "Psychologists discern how religious oppression, discrimination, or stereotyping may have affected them personally," and "Psychologists acknowledge how holding membership in a mainstream religious tradition may have afforded privilege; in other words, a degree of comfort or benefit from participation in a mainstream religious or spiritual community". The 24 provisional competencies, means and SDs for clarity, self-assessment, and importance ratings, and list of revisions, deletions, and combinations of items can be found in the online supplement to this article, and raw qualitative data and the survey instrument are available upon request.

This process resulted in the following 16 proposed spiritual and religious competencies for psychologists, three in the area of Attitudes, seven in the area of Knowledge, and six in the area of Skills (see Table 2). Brief descriptions of each item are presented below.

### Attitudes

**1) Psychologists demonstrate empathy, respect, and appreciation for clients from diverse spiritual, religious, or secular backgrounds and affiliations.** In the ethical practice of psychology, practitioners are required to demonstrate empathy, respect, and appreciation for clients from all backgrounds, and this includes religious, spiritual, and for that matter, secular



backgrounds. Some psychologists may be aware that they have difficulties fully empathizing with, respecting, or appreciating clients with religious and/or spiritual orientations different from their own, and may address this challenge through personal and professional development or by making appropriate referrals. Perhaps more salient is the possibility that lack of training in spiritual and religious diversity may impair treatment in ways that psychologists are *not* aware of. The purpose of this competency, in addition to encouraging empathy, respect, and appreciation, is to encourage exploration of biases that may exist below the level of conscious awareness.

**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.** While previous versions of the APA Ethical Principles for Psychologists and Code of Conduct (American Psychological Association, 1992) did not address religion or spirituality as aspects of cultural diversity, the current version (American Psychological Association, 2010) asserts that psychologists have an ethical responsibility to consider religious issues as an aspect of multicultural diversity along with gender, race and others (Principle E). The working Group Competencies Conference: Future Directions in Education and Credentialing in Professional Psychology (Kaslow, 2004) agreed that attending to individual and cultural diversity (including religious and spiritual diversity) is a core crosscutting competency required across patient populations, as opposed to a specialized competency needed only in certain niche practices. Shafranske and Sperry (2005) have pointed out that “the development of diversity competence involves attention to all aspects of culture and individual difference, including religious and spiritual factors, which contribute to a client’s worldview” (p. 13). This competency encourages psychologists to recognize that attending to spiritual and religious diversity is an essential aspect of multicultural competence.

**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.** It may not be clear to psychologists how their spiritual, religious, or secular beliefs influence their practice. Gonsiorek, Richards, Pargament, and McMinn (2009) offer examples:

Nonreligious psychologists who perceive client faith as indicative of rigidity, low intelligence, or poor coping; nonreligious psychologists who perceive spiritual and religious concerns as of little consequence, thereby disparaging an important aspect of clients’ worldview; religious psychologists who view nonreligious clients as immoral, defective, or untrustworthy; religious psychologists who view clients from a tradition other than their own as misguided; and other variations. What these share is that psychotherapists’ personal views on spirituality and religion serve as a basis for negative evaluation of clients’ views on spirituality and religion (p. 386).

A psychologist’s SRBP can also influence assumptions about a wide variety of issues that may surface in clinical work, including marriage, sexual orientation, abortion, suicidality, free will, and personal responsibility. This competency encourages psychologists to actively explore how their own spiritual or religious background may influence a broad range of clinical issues from

diagnosis and assessment, to the language they use with clients, to their attitudes toward clients and clients’ issues, to the content and tone of their clinical interventions.

## 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.** As Eck (2001) of the Harvard Pluralism Project noted, the United States has become the most religiously diverse nation in the world. In recent years, Muslims, Hindus, and Buddhists, and adherents of many other religions, have arrived here from every part of the globe, radically altering the religious landscape of the United States. Vasquez (2007) has noted the following:

The more psychologists understand about those with whom they work, including understanding their worldview and perspective, the more likely they are to promote a therapeutic alliance. This implies learning as much as possible about the various values, norms, and expectations of various ethnic and racial group members with whom one works. The challenge in learning about cultural groups is to avoid stereotyping; rather, the knowledge is to be used to assess the degree of application of various cultural values, behaviors, and expectations (p. 882).

This applies equally to religion and spirituality. Several resources exist to foster greater literacy in the various forms of religion and spirituality one might encounter in clinical practice (Hood, Hill, & Spilka, 2009; Nelson, 2009; Paloutzian & Park, 2005; Pargament, Exline, Jones, Mahoney, & Shafranske, 2013; Richards & Bergin, 2000). It is also important to note that there is significant diversity *within* religious and spiritual traditions, and that simply being a member of a tradition does not necessarily confer competence. This competency is designed to support psychologists’ curiosity about the rich variety of spiritual and religious perspectives, and to use this knowledge to enhance their effectiveness.

**5) Psychologists can describe how spirituality and religion can be viewed as overlapping, yet distinct, constructs.** As discussed earlier, religion and spirituality are distinct constructs. For some, a Venn diagram of religion and spirituality might be represented by two completely aligned circles, whereas for others the two might be connected only peripherally, if at all. Our review of the literature led us to the following proposed definitions: *Religion* refers to affiliation with an organization that is guided by shared beliefs and practices, whose members adhere to a particular understanding of the divine and participate in sacred rituals. *Spirituality* refers to an individual’s internal sense of connection to, or search for, the sacred. Here it is important to note that the term *sacred* is used inclusively, as Pargament et al. (2013) have noted:

To refer not only to concepts of God and higher powers, but also to other aspects of life that are perceived to be manifestations of the divine or imbued with divine-like qualities, such as transcendence, immanence, boundlessness, and ultimacy (Pargament & Mahoney, 2005). Beliefs, practices, experiences, relationships, motivations, art, nature, war—virtually any part of life, positive or negative, can be endowed with sacred status (Mahoney, Pargament, & Hernandez, 2013).

For some, spirituality is a broad term that includes but is not limited to religion, whereas religion may encompass spirituality for others. Some people's spirituality is informed by participation in organized religion, whereas others describe themselves as spiritual but not religious. This competence encourages psychologists to understand that spirituality can transcend religious involvement, and to pay equal attention to each domain in the practice of psychology.

**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.** Historically, psychological theory and diagnostic classification systems have tended to either ignore or pathologize intense religious and spiritual experiences. The mystical experience has been described as symptomatic of ego regression, borderline psychosis, psychotic episode and temporal lobe dysfunction (Lukoff et al., 1992). Freud (1929) reduced the "oceanic experience" of mystics to a regressive return to "limitless narcissism" (p. 5) and religious engagement as "patently infantile" (p. 7). There are numerous published accounts of individuals in the midst of intense religious and spiritual experiences who report that their experiences were pathologized or ignored, or some who have been hospitalized and medicated when less restrictive and more therapeutic interventions could have been used (Lukoff, 2007).

Although some religious or spiritual problems can reflect mental health problems, a variety of religious and spiritual experiences may be beneficial. For example, Maslow (1970) described the mystical experience as an aspect of everyday psychological functioning: "It is very likely, indeed almost certain, that these older reports [of mystical experiences], phrased in terms of supernatural revelation, were, in fact, perfectly natural, human peak experiences of the kind that can easily be examined today" (p. 20). One study showed that those reporting mystical experiences scored lower on psychopathology scales and higher on measures of psychological well-being than control subjects (Wulff, 2000). This competency encourages psychologists to differentiate intense religious and spiritual experiences from psychopathology.

**7) Psychologists recognize that spiritual and/or religious beliefs, practices and experiences develop and change over the life span.** It is important for psychologists to know that SRBP are not static attributes, but can vary across an individual's life span (McCullough & Boker, 2007; McCullough, Enders, Brion, & Jain, 2005). Forty-four percent of people report having changed their religious affiliation, moved from religious nonaffiliation to specific affiliation, or moved from specific affiliation to nonaffiliation in their lifetimes (Pew Forum, 2008). As with other aspects of cultural diversity, it is inaccurate to make assumptions about religious or spiritual affiliation based on a client's upbringing, or even on the basis of initial assessment. Psychologists are encouraged by this competency to be attentive to their clients' spiritual and religious development.

**8) Psychologists are aware of internal and external spiritual and/or religious resources and practices that research indicates may support psychological well-being, and recovery from psychological disorders.** As reviewed earlier, a large body of research indicates that religious and spiritual beliefs and practices are associated with a number of aspects of psychological well-being. Also, numerous clinical interventions that incorporate religious and spiritual elements have demonstrated efficacy. Just as clinicians routinely assist their clients in accessing secular re-

sources to aid psychological growth or recovery, psychologists can also use clients' spiritual or religious resources, both internal and external (such as social support). This competency is designed to encourage psychologists to investigate religious and spiritual resources that may support the therapeutic process and may have historically been overlooked.

**9) Psychologists can identify spiritual and religious experiences, practices and beliefs that may have the potential to negatively impact psychological health.** Just as many religious and spiritual resources are correlated with psychological health, some spiritual and religious beliefs and practices can be harmful. Psychologists who are unfamiliar with this body of literature can err by assuming religious or spiritual involvement is always benign, or by overestimating the potential harm of certain SRBP. This competency requires that psychologists recognize the range and intensity of common religious and spiritual problems (Lukoff et al., 2011), especially because there can be conflicts that impair other domains of functioning (Hathaway, 2003), signal psychological crises (Pargament et al., 2003), and interfere with clients' ability to access SRBP as resources (Hays, 2008).

**10) Psychologists can identify legal and ethical issues related to spirituality and/or religion that may surface when working with clients.** Legal and ethical issues specific to SRBP may arise in clinical practice (, e.g., beliefs about medical interventions for children, or practices protected by religious freedom that would otherwise be illegal). Lack of training in how to address such issues may partially underlie some clinicians' reluctance to attend to such material (Brawer et al., 2002; Russell & Yarhouse, 2006). Psychologists are encouraged by this aspect of competency to become aware of and able to discuss legal and ethical issues pertaining to SRBP (Plante, 2008; Yarhouse & Johnson, in press).

## 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.** In addition to approaching clients from all religious, spiritual, and secular backgrounds with an attitude of respect and appreciation (see #1), this competency requires that psychologists develop specific skills for providing empathic and effective treatment with regard to religious and spiritual diversity. In a training context, this might involve role playing therapeutic encounters with clients with different religious beliefs, delivery of interventions that attend to aspects of SRBP that are important to clients, practicing effective responses to client requests to explore SRBP in sessions, methods of sensitive inquiry regarding SRBP, and ongoing reflection on one's own biases that may impact the therapeutic relationship.

**12) Psychologists inquire about spiritual and/or religious background, experience, practices, attitudes and beliefs as a standard part of understanding a client's history.** Although psychologists routinely ask clients about their family, social, educational, and professional backgrounds, their spiritual and religious background are often not explicitly addressed. This competency suggests that psychologists include this essential information in their history taking. A number of methods for such assessment exist (Hodge, 2006; Pargament, 2011; Plante, 2009; Puchalski et

al., 2009; Richards & Bergin, 2005), and should be included in both training and routine clinical practice.

**13) Psychologists help clients explore and access their spiritual and/or religious strengths and resources.** Once psychologists understand that clients can draw upon inner and outer spiritual and religious resources to support their psychotherapeutic process (see #8), they can develop skills to sensitively help clients explore what these resources are and how to access them. This is a delicate process. Rather than spiritual direction, which lies outside most psychologists' scope of practice, this involves assisting clients in identifying for themselves how spiritual and/or religious beliefs, practices, and communities may support their psychological well-being (see Shafranske & Sperry, 2005 for a discussion of the distinction). This competency recognizes that psychologists should receive training in facilitating this exploration.

**14) Psychologists can identify and address spiritual and/or religious problems in clinical practice, and make referrals when necessary.** *Religious and Spiritual Problems* is now a V-Code in the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision (*DSM-IV-TR*; American Psychiatric Association, 2000), but only 6.2% of psychologists report having ever used this code, except in the military, where 75% of psychologists have used this diagnosis (Hathaway et al., 2004). Nearly one third of the college students seeking help from university counseling centers report experiencing some distress from religious or spiritual problems (Johnson & Hayes, 2003). Religious and spiritual problems may include a loss or questioning of faith; frequent changes in religious or spiritual membership, dysfunctional practices and beliefs (including conversion); unhealthy involvement in new religious movements and cults; religious struggles during life-threatening and/or terminal illnesses; and certain forms of mystical, near-death, psychic, possession, or spiritual practice-related experiences (Lukoff et al., 1992). There is increasing agreement that psychologists should receive training in recognizing religious and spiritual problems, and assessing their salience as problems that require intervention or as indicators of other issues (Zinnbauer, 2013). In addition, psychotherapists should be able to recognize *spiritual bypassing*, in which religious or spiritual concepts or beliefs are used to rationalize or avoid psychological problems (Cashwell, Bentley, & Yarborough, 2007; Cortright, 1997; Welwood, 2000). A comprehensive volume suggests a research agenda for *DSM-V* to better address issues of religion and spirituality in diagnosis, strongly suggesting that clinicians should be aware of these issues, demonstrate competency in addressing them, and receive relevant training and/or continuing education (Petee, Lu, & Narrow, 2010). Psychologists should also demonstrate competence in recognizing and working with religious and spiritual problems when they arise, collaborating with clergy and spiritual directors to address these issues, and making referrals when necessary.

**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 competence.** This competency encourages psychologists to include spirituality and religion in their ongoing review of literature, and to pay attention to significant findings in these domains as they would in any other domain important to psychological functioning. Psychologists should recognize that development of spiritual and religious com-

petence is not a fixed end point, but rather an ongoing process of professional development.

**16) Psychologists recognize the limits of their qualifications and competence in the spiritual and/or religious domains, including any 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.** Even among highly competent psychologists, there will be domains of spiritual and religious issues that arise in clinical practice that will require consultation, additional training, or referral. There is a need for greater coordination between psychologists and clergy, to address the religious and/or spiritual needs of clients while honoring appropriate boundaries between clinical mental health practice and spiritual direction (Milstein, Yali, & Manierre, 2010). Richards and Worthington (2010) offered a list of times when consultation or referral might be indicated:

- (a) You are struggling to understand or feel confused by the religious beliefs or thought world of a religious client;
- (b) You are wondering whether a religious client's religious beliefs are healthy and normative or unhealthy and idiosyncratic;
- (c) You believe a client's religious beliefs may be keeping him or her emotionally stuck;
- (d) A client expresses feelings of guilt that seem to originate in violations of his or her religious beliefs and values;
- (e) A client expresses a desire to reconnect with previously held religious beliefs and community;
- (f) A client raises questions about God, or a higher power, or other sources of hope;
- (g) A client expresses a desire to participate in or experience a religious ritual, or inquires about spiritual—religious resources;
- (h) A religious client is severely depressed and socially isolated;
- (i) A religious client is suffering from serious illness, loss, or grief (pp. 390–391).

Rather than simply avoiding the domain of religion and spirituality, ethics indicate that psychologists should consult or refer when an issue lies beyond their scope of expertise.

## Discussion

Pargament (2009) noted that “dealing with religious and spiritual issues in psychotherapy is inherently messy” (p. 391). Our hope is that the spiritual and religious competencies we have proposed may make this less so. *Our goal is not to require that psychologists employ religious or spiritual interventions, nor to encourage them to personally adopt any form of spiritual or religious beliefs and practices.* Determining how and when to actively include religious or spiritual interventions into psychotherapy for those clients who request it requires proficiency, rather than basic competence. In fact, when religious or spiritual interventions are requested by clients and are appropriate, psychologists should integrate them into psychotherapy *only* when they have the training and clinical competence to do so, have knowledge of the relevant literature, and are aware of ethical issues that may arise in terms of boundaries and multiple relationships, informed consent, etc.

Instead, the purpose of creating spiritual and/or religious competencies is threefold. First, we hope these competencies will help clinicians avoid biased, inadequate, or inappropriate practice when



they encounter spiritual or religious issues. Second, these competencies are meant to 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. Third, the proposed set of competencies is intended to provide baseline standards for content that can be integrated throughout clinical training and supervision, which programs may choose to modify or elaborate according to their training models (Hage, 2006). We imagine that these proposed competencies will result in some discussion in the field, and we welcome dialogue that is rooted in both theory and empirical data.

Although most agree on the importance of multicultural competencies, there have been some critiques of their utility (Patterson, 2004; Weinrach & Thomas, 2002; see Arredondo & Toporek, 2004; Sue, 2003 for responses;). The main critique has been that scant empirical evidence exists to support the necessity for multicultural competencies and that focusing the field on differences rather than similarities may inadvertently cause additional discrimination. It is possible that similar critiques will be directed against establishing religious and spiritual competencies. It may also be argued that clinical practice that involves religious and spiritual issues may be best considered a niche or specialty practice rather than a general competence, and that imposing spiritual and religious competencies for either generalists or specialists could exert undue influence over those who identify with specific religious orientations, or have other specialties (Hathaway et al., 2004). In addition, requiring such competencies may inconvenience or even offend practitioners who do not engage the religious or spiritual domain in their own lives, find it distasteful or harmful, or view such a requirement as a violation of the boundary between science and religion, or between church and state in government-funded settings.

Our response to these critiques is described in the case we have built in the background section, but can be summarized as (1) it is clear from polls of the general public cited earlier that religion and spirituality are important in most people's lives, (2) there is evidence that clients would prefer to have their spirituality and religion addressed rather than ignored in psychotherapy, (3) religion and spirituality have been empirically linked to a number of psychological health and well-being outcomes, as well as some psychological problems, (4) the field has already included religion and spirituality in most definitions of multiculturalism and requires training in multicultural competence, and (5) most psychotherapists receive little or no training in religious and spiritual issues. Our proposed set of competencies are intended to be reasonable guidelines that mandate no particular worldview, are equally applicable to religiously oriented and atheist/agnostic psychotherapists, and advocate a patient-centered approach emphasizing appreciation, respect, knowledge of the literature, and skills for appropriately inquiring into the role of spirituality and religion in clients' psychological well-being.

Another concern is that introducing spiritual and religious issues as competencies may risk the psychologization of these issues, or reduction of spiritual issues to psychological constructs (Cortright, 1997; Sperry, 2010). As in any domain of psychotherapy, knowledge and technique are no substitute for a psychotherapist's personal qualities that foster the therapeutic relationship (Patterson, 2004). These qualities must be nurtured throughout training and learning experiences that include experiential components. For

example, an understanding of how a client's religious beliefs may affect her feelings regarding an abortion is important. But what can potentially help the client is the psychotherapist's capacity to inquire into and respect these beliefs, develop rapport and empathize with the client's suffering, and be aware of his or her own biases.

We intentionally included a broad range of religious and spiritual orientations in our sample of survey respondents, but a limitation of this study is that the demographics and religious affiliations of the survey participants are not representative of the nation as a whole (Pew Forum, 2008), nor of the general population of psychotherapists which in 1990 was nearly 80% Christian and only 1% affiliated with Eastern traditions (Bergin & Jensen, 1990). This may limit the generalizability of our findings to the larger population of psychologists.

### Future Directions

We suggest that the next steps for this work would be to vet these proposed competencies among a broad selection of stakeholders, with a view toward eventual adoption into practice and training guidelines. Before they can be adopted as standards in the field, psychologists who are not experts in or particularly in favor of the integration of spirituality and psychology must be consulted. We are presently conducting a large scale survey of a representative sample of psychologists to assess the broad-based acceptability of these competencies, as well as exploring how prevalent training needs are, and how they might be assessed. Subsequently, methods for operationalizing these competencies and developing valid and reliable assessments for measuring the success of training programs in cultivating them should be developed. These could be informed by similar efforts to operationalize and assess multicultural competencies (see Arredondo et al., 1996; Hays, 2008).

### Conclusion

Research has made it increasingly clear that effective psychotherapy must encompass the spiritual and/or religious dimensions. Shafranske (2010) has asked the salient question:

Given the lack of attention given to the religious and spiritual dimension in most psychology training, how prepared are clinicians to be mindful of the potential impacts their religious and spiritual commitments have on their professional practice, to appropriately and ethically integrate spirituality in psychological treatment, or respond to emergent transcendent experiences? (p. 125)

Until now, there have been no empirically derived set of competencies among practicing psychologists that we are aware of that address the significant impact of clients' SRBP on both psychopathology and psychological health. Few graduate psychology programs have required coursework focusing on how spiritual or religious attitudes and practices support psychological health. Though major professional health care organizations (e.g., JCAHO and ACGME for psychiatric residency programs) have incorporated basic competency standards, most clinical psychology programs have no such required content. This can result in inadequate assessment, misdiagnosis, less effective treatment, and unnecessary suffering. Emulating the movements that brought attention to the role of gender in psychotherapy, and the establishment of



cultural competencies for psychotherapists, we have proposed a set of basic competencies (attitudes and beliefs, knowledge and skills) that all licensed psychologists should possess in the domain of spiritual and religious beliefs and practices.

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