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Novel Online Training Program Improves Spiritual Competencies in Mental Health Care

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We designed the online Spiritual Competency Training in Mental Health (SCT-MH) program to train providers across mental health fields in basic religious and spiritual (RS) competencies. The goal was to help address the professional training gap in RS aspects of multicultural diversity and integration. We hypothesized that providers completing the program would demonstrate an increase in attitudes, knowledge, and skills relevant to RS issues in mental health care. The SCT-MH program, offered online through the edX platform, consists of 8 hr of multimedia content. Participants (N = 169) across a broad range of mental health disciplines completed a pre- and posttraining survey, which evaluated their spiritual competency using measures assessing their attitudes, knowledge, and skills in the intersection of RS and mental health. We also collected qualitative data to evaluate participants' levels of satisfaction with the content and format of the program. Participants showed significantly increased spiritual competency in all measures of attitudes, knowledge, and skills following their participation in the course. Participants reported high satisfaction with both the content and the online format of the training program, and a decrease in perceived barriers to integrating RS in practice. These results demonstrate that a brief, novel online training program can help address the current gap between the clinical need and professional requirements for spiritual competency and the general lack of graduate training in this area of multiculturalism. Suggestions for how this program and others like it can be integrated into graduate education and impact clinical care are discussed.

Keywords: spirituality, religion, mental health, competency, training

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Mental health consumers are a diverse group. As such, practitioners must be well versed in providing effective and ethical care to people with a broad range of backgrounds, issues, diagnoses, preferences, belief systems, and behaviors. Religion and spirituality (RS) is an area of diversity in which mental health practitioners must demonstrate competence. Indeed, the professional associations of most mental health providers require graduate and postgraduate training in multicultural competence, with religion and spirituality included in their definitions of multiculturalism (American Psychological Association [APA], 2015; Commission on Accreditation for Marriage and Family Therapy Education, 2016; Council for Accreditation of Counseling and Related Educational Programs, 2015; Council on Social Work Education, 2015). Despite these professional requirements, practitioners in most mental health disciplines do not generally receive training in effectively working with religious and spiritual issues that can arise in treatment, nor integrating an RS approach into treatment (Oxhandler, Parrish, Torres, & Achenbaum, 2015; Schafer, Handal, Brawer, & Ubinger, 2011; Vogel, McMinn, Peterson, & Gathercoal, 2013). Complicating matters is the fact that, to date, there is no agreed upon set of spiritual competencies, training guidelines, or methods of evaluating such competency acquisition for mental health providers (Hodge, 2016; Oxhandler & Pargament, 2018; Vieten et al., 2016).

To address the gap between the demonstrated need for spiritual competency in mental health care and the general lack of training in graduate programs, we developed the online Spiritual Competency Training in Mental Health (SCT-MH) program. This novel program is designed to train providers across all mental health fields in basic spiritual and religious competencies. Before describing this program, first we define what we mean by spiritual competency, why it is important in mental health care, and emerging findings from medicine that suggest training can increase spiritual competency.

Spiritual Competency

Spiritual competency has been defined as "a form of cultural competence that deals with spirituality and religion, specifically clients' individually constructed spiritual worldviews" (Hodge, 2016, p. 2). Hodge (2004), who the first to propose the notion of spiritual competency, based this concept on multicultural counseling competencies (Sue, Arredondo, & McDavis, 1992). Because then, others have expanded the definition of spiritual competency to a dynamic set of attitudes, knowledge, and skills regarding different religious and spiritual traditions that is developed over time (Furness & Gilligan, 2010). Vieten and colleagues (2013, 2016) furthered this work by identifying and verifying 16 basic spiritual competencies—three attitudes, seven knowledge items, and six skills—through a comprehensive literature review, a series of working groups, and surveys with experts and clinicians. The SCT-MH program is based on these 16 spiritual competencies, and its goal is to equip practitioners with these basic competencies.

The Need for Spiritually Integrated Mental Health Care

In addition to the professional guidelines and accreditation standards described in the preceding text, there are other strong rationales for the integration of religion and spirituality into mental health assessment and treatment. Religion and spirituality (RS) are associated with health and well-being and many individuals rely on their spirituality to cope with life stressors (Koenig, King, & Carson, 2012; Pargament, 2007). Spiritual beliefs and practices can be a resource in therapy and can foster positive psychological states and behaviors such as hope, meaning, peace, forgiveness, and social support. In contrast, certain forms of RS, such as RS struggles, are associated with an increased risk of mental and physical health problems and a poorer prognosis for psychotherapy (Abu-Raiya, Pargament, Krause, & Ironson, 2015; Exline, 2013; Pargament, 2007). Therapists need to be aware of and skillful in dealing with both strengths and struggles related to RS in the context of treatment. In addition, many clients want their therapists to bring up RS issues and desire spiritually sensitive care (Bannister, Park, Taylor, & Bauerle, 2015; Leitz & Hodge, 2013; Oxhandler, Ellor, & Stanford, 2018; Post, Wade, & Cornish, 2014; Rose, Westefeld, & Ansley, 2001; Stanley et al., 2011). Thus, the existing educational deficit in spiritual competency may have negative consequences for men-

tal health care. First, there may be an underidentification and underuse of potentially valuable RS resources that could facilitate effective treatment. Second, inattention to RS struggles can interfere with the achievement of health and well-being among clients. Third, mental health providers and clients may develop a less effective therapeutic working alliance as a result of RS bias, insensitivity, or lack of knowledge. Finally, ethical and professional mandates for competent and effective care may not be adequately met.

Advances in Training in Medicine

The field of mental health lags behind that of medicine in terms of teaching trainees how to assess and address RS in patient care. For example, 84% to 90% of medical schools offer courses or formal content on spirituality and health (Koenig, Hooten, Lindsay-Calkins, & Meador, 2010). In contrast, only 25% of psychology (Schafer et al., 2011) and 30% of social work (Moffatt & Oxhandler, 2018) training programs provide even one course in RS. Other mental health professions, such as marriage and family therapists and counselors, have reported receiving little training in this area, despite a desire for more education (Carlson, Kirkpatrick, Hecker, & Killmer, 2002; Oxhandler & Parrish, 2016). Across mental health fields, psychiatry has devoted the most attention to training in spiritual competency (Oxhandler & Pargament, 2018), with many requiring completion of an RS curriculum over the course of their residency (Awaad, Ali, Salvador, & Bandstra, 2015). However, few of these courses have formally evaluated changes in participants' competence.

Although not focused on mental health care, recent data from a training program among students in health-related fields suggest such education can lead to changes in spiritual competencies. Osório and colleagues (2017) randomized 49 students (first or second year medical, nursing, physiotherapy, and psychology students) to either a theoretical-practical interprofessional course in spirituality and health or to a wait-list control group. The intervention consisted of 14 hr of theoretical classes and discussion and 10 hr of practical activities, including conducting spiritual histories with patients and receiving feedback on their performance. The students' spirituality and health knowledge, attitudes, and skills (through use of a simulated patient) were then assessed. They found that students in the intervention group achieved higher scores on knowledge tests, reported feeling more comfortable and prepared to discuss (RS) beliefs with patients, were more likely to see the importance of hospital chaplains, and were more likely to state that spirituality is important in clinical care. Compared with the control group, these students were also more skillful at obtaining a patient's spiritual history. Although this program was offered in-person rather than online and was geared toward mainly medical rather than mental, health care professional students, it does suggest that spiritual competency can be increased through an educational program. Other in-person training programs for psychiatry residents (6 mandatory hours) have also demonstrated an increase in spiritual competency scores and comfort addressing spiritual issues from pre- to posttraining (Awaad et al., 2015; Grabovac, Clark, & McKenna, 2008); however, the sample sizes were small (i.e., 19 and 30, respectively).

Description of the SCT-MH Program

To close this training gap across mental health disciplines, we developed the SCT-MH program, an online, 8-hr training program delivered across eight modules. We chose this length of time because it was both feasible (which is similar to the length of time in the previously evaluated psychiatry residency training programs) and sufficient to cover the basic competency content in this area. The goal of the program is to equip providers with greater confidence and competence in dealing with RS issues in their clinical work, and the program was offered online to increase its reach, accessibility, and convenience. There was no charge for participating in the program, and participants were eligible to receive continuing education (CE) or continuing medical education (CME) credits upon completion.

As described in Pearce, Pargament, Oxhandler, Vieten, and Wong (2019), the program is characterized by four core features. First, the course is aimed at fostering basic rather than advanced RS competencies and is geared toward the majority of mental health professionals who do not intend to specialize in spiritually integrated care. Second, it is multidisciplinary,

focusing on core RS competencies that underlie effective mental health care across all mental health disciplines (i.e., social work, psychology, psychiatry, marriage and family therapy, professional counseling) and therapeutic orientations (e.g., cognitive-behavioral therapy [CBT], psychodynamic). Third, it is grounded in state-of-the-art science and practice and builds upon advances in knowledge gleaned from scientific studies of RS and mental health. Finally, SCT-MH is based upon sound pedagogical principles and makes use of adult-learning instructional methods, particularly within an asynchronous (prerecorded and self-paced), online platform (e.g., engaging activities, multimodal presentations, self-testing).

The curriculum was developed by the course directors (Michelle Pearce and Ken Pargament) by drawing upon educational materials on spiritually integrated psychotherapy and spiritual competencies that have been disseminated over the last 15 years (e.g., Doehring, 2015; Griffith, 2010; Pargament, 2007; Pearce, 2016; Richards & Bergin, 2005; Vieten & Scammell, 2015). Experts in the field, five study consultants from different mental health fields, and two coinvestigators (Holly Oxhandler and Cassandra Vieten) also provided input and feedback on the course content. Our instructional design team helped to present the content online in a creative fashion to enhance learning and retention. Using adult learning principles (Taylor & Parsons, 2011), we ensured that participants had opportunities to actively engage with the material (e.g., self-reflection questions with text boxes for responses, self-knowledge checks), used short videos, and provided numerous examples and activities to show how the material can be applied in clinical contexts. See Table 1 for a description of the content in each module. For a detailed description of the program, see Pearce et al. (2019).

Study Aims

Our main research questions were whether this program is a feasible, helpful, and effective way to share knowledge and increase competencies in spirituality and mental health care among mental health professionals. We assessed prepost changes among program participants with respect to their basic RS competencies (attitudes, knowledge, and skills) in mental health care. We also assessed whether perceived barriers to practice decreased as a result of participating in the training. Finally, we evaluated participants' levels of program satisfaction and gathered their concrete suggestions for ways to improve the training program. Our hypotheses were as follows:

> *Hypothesis 1:* Spiritual competency scores will increase from pre- to posttraining. Specifically, we hypothesize that scores on individual measures of attitudes, knowledge, and skills will increase from pre- to posttraining. We also hypothesize that perceived barriers to training will decrease from pre- to posttraining.
>
> *Hypothesis 2:* The online training program is a feasible, helpful, and relevant way to deliver training on spiritual competencies in mental health care, as demonstrated by recruitment and retention rates and participant feedback.

As far as we can determine, this is the first study that is designed to empirically test the viability and effectiveness of an online spiritual competency training program and does so for a large and diverse group of mental health professionals.

Method

Study Design

This study used a quasi-experimental one-group pretest-posttest design to evaluate an online educational program offered through edX and the University of Maryland, Baltimore from November 2018 to May 2019. We used quantitative and qualitative methods to assess program feasibility and acceptability, as well as the effects of the program on mental health professionals' self-reported RS competency. The institution's review board granted the study exempt status. The study was registered with Open Science Framework prior to data collection.

Participants

Practicing licensed mental health professionals from the fields of psychology, psychiatry, marriage and family therapy, clinical social work, and professional counseling were invited to participate in the training program; our inclu-

Table 1
Description of SCT-MH Training Program Modules

Training program module	Description	Spiritual competencies addressed in module
Module 1: Introduction and Orientation	What is spiritually integrated mental health care? Why integrate spirituality into therapy? What does it take to do spiritually integrated therapy?	3. Being aware of your own beliefs: Attitude 10. Being aware of legal and ethical issues: Knowledge 15. Staying up to date: Skill
Module 2: Understanding Spirituality	Defining spirituality and religion: Similarities and differences Religious and spiritual diversity Spiritual development across the lifespan and the forces that influence this process	5. Understanding RS as different but overlapping: Knowledge 7. Recognizing RS development over lifespan: Knowledge 8. Learn about diverse beliefs and practices: Knowledge
Module 3: Guiding Principles for Spiritually Integrated Mental Health Care	Inappropriate therapist orientations to spirituality in mental health Effective therapist orientation to spiritually competent care The therapists' own spiritual orientation and spiritual biases	1. Demonstrating empathy, respect, and appreciation: Attitude 2. Appreciating RS diversity: Attitude 3. Being aware of your own beliefs: Attitude
Module 4: Distinguishing between Helpful and Harmful Types of Spirituality	Life-affirming, helpful forms of spirituality Life-limiting, unhelpful forms of spirituality Distinguishing between spiritual experiences and psychopathology?	6. Difference between spirituality and psychopathology: Knowledge 8. Learn about clients' RS resources: Knowledge 9. Recognize harmful RS involvement: Knowledge
Module 5: Assessing Spirituality in Mental Health Care	Setting the stage for spiritual assessment Initial, implicit, and explicit spiritual assessment	11. Working with RS diversity: Skill 12. Conducting RS assessment: Skill
Module 6: Assessing and Mobilizing Spiritual Resources	Guidelines for integrating spiritual resources into therapy Cultivating and mobilizing spiritual resources	8. Learn about clients' RS resources: Knowledge 13. Helping clients identify/access RS resources: Skill
Module 7: Assessing and Addressing Spiritual Problems	What not to do when encountering spiritual problems How to address spiritual problems in therapy Addressing spiritual problems	9. Recognize harmful RS involvement: Knowledge 14. Helping clients identify and deal with RS problems: Skill 16. Acknowledging limits: Skill
Module 8: Putting it All Together, Challenges, and Future Directions	Ethical challenges of spiritually integrated therapy Synthesize and apply knowledge from all eight modules to a hypothetical clinical case planning decision making Summing up the program	10. Develop awareness of legal and ethical issues: Knowledge 15. Staying up to date: Skill 16. Acknowledging limits: Skill

Note. SCT-MH = Spiritual Competency Training in Mental Health; RS = religious and spiritual.

sion criteria are listed below. We aimed to recruit 200 licensed providers with the expectation that half would complete the program (i.e., 50% attrition rate), resulting in a final sample of 100 providers. We used G*Power to determine the number of program completers required for an 80% power to detect medium effect sizes.

Procedure

We recruited our sample of practicing mental health professionals by sending out announcements to national mental health associations, newsletters, list-servs, social media sites, mental health care agencies, and individuals in our

collective networks. Those who expressed interest in participating in a free spiritual competency online training program were provided additional information and a link to a short screening questionnaire. Participants who were licensed mental health professionals, had less than 6 hr of previous training in RS and mental health, and had access to a computer to complete the training program were eligible. People who completed any graduate or postgraduate courses on RS in clinical practice were excluded. Individuals who were eligible completed a pretraining battery of questionnaires before enrolling in the online spiritual competency training housed on the edX platform, and they had access to the online training program material for 4 weeks. Free CE or CME credits were offered as an incentive for completing the program. Participants were sent several e-mail reminders throughout the program prompting completion. When participants finished the program, they were asked to complete a posttraining assessment in order to receive a certificate of completion to be used for CE credits, if applicable. All data were collected through Qualtrics (Provo, UT), a HIPAA-compliant online survey service. Data were downloaded directly into statistical software, with identifiers separated from data.

The Training Program

The SCT-MH consisted of about 8 hours of training through eight online modules. As in a traditional learning environment, the edX platform includes course content, readings, activities, and assessments in one online location, hosted at the University of Maryland, Baltimore, which can be accessed at anytime from anywhere with an Internet connection. The content of the modules corresponded to the 16 basic RS competencies generated through the research of Vieten and colleagues (2013) and refined through this project. Key topics include common stereotypes about RS; the diversity of RS forms and expressions; why it is important to address RS in treatment; the importance of the therapist's own RS attitudes, beliefs, and practices; how to assess RS; how to help clients access RS resources; and how to respond to RS problems that arise in treatment (see Table 1).

SCT-MH is a self-paced training program, such that participants were able to complete the modules when they preferred over a period of 4 weeks postenrollment. The training was designed such that participants needed to complete the modules in consecutive order without skipping ahead, as each module builds on the last. It was also designed such that participants had to complete at least 70% of the activities (e.g., self-reflection questions, knowledge check questions) in each module before the next module would unlock. This controlled advancement method helped to ensure a minimal level of engagement with the content across all participants. The program was purposefully created to ensure that those who had never taken an online course would not find the online format a barrier, and technical support was available to participants.

Measures

Demographic and religious/spiritual data. Participants reported their age, gender, race/ethnicity, education, practice license held, clinical practice information (e.g., years in practice, setting), previous training in RS and mental health, religious preference, self-identification as a religious or spiritual person, frequency of religious service attendance, and frequency of private religious activities.

Spiritual competency. We assessed spiritual competencies using three methods: The Religious/Spiritually Integrated Practice Assessment Scale (RSIPAS, Oxhandler & Parrish, 2016; Spiritual Competency Questionnaire [SCQ]; RS Knowledge Questionnaire).

RSIPAS. This five-point Likert-type measure was used to assess self-reported competencies in one attitude domain (attitudes about RS integrated clinical practice [12 items], range = 12–60), two skills domains (self-efficacy with RS integrated clinical practice [13 items], range = 13–65; current engagement in RS integrated practice behaviors [nine items], range = 9–45), and one feasibility domain (feasibility to engage in RS integrated clinical practice to assess potential barriers to spiritually integrated practice [six items], range = 6–30). Sample items include the following: "It is essential to assess clients' religious/spiritual beliefs in practice" (attitude); "I am comfortable discussing my clients' religious/spiritual struggles" (self-efficacy); "I use empirically supported interventions that specifically outline

how to integrate my clients' religion/spirituality into treatment" (current engagement); and "I have enough time to assess my clients' religious/spiritual background" (feasibility). Each subscale score was computed separately rather than as a single overall score. We used these measures at pre- and posttraining. A validation study demonstrated excellent convergent and divergent validity for the four subscales, as well as internal reliability, with subscale alpha coefficients ranging from .84 to .91 for the four subscales and .95 for the total scale (Oxhandler & Parrish, 2016). The subscales in the current study showed good overall reliability (standardized Cronbach's $\alpha = .82$ for attitudes, .84 for current engagement, .77 for feasibility, .90 for self-efficacy).

Spiritual Competency Questionnaire. We developed 16 items to assess the 16 spiritual competencies based on Vieten et al. (2016). This scale was designed to measure attitudes (three items, range = 3–21), skills (seven items, range = 6–42), and subjective knowledge (six items, range = 7–49). We used this measure at pre- and posttraining. Sample items include, "I pay attention to how my own spiritual and/or religious background may influence my clinical practice" and "I inquire about clients' religion and/or spirituality as a standard part of my assessment process" (1 = *not at all true of me* to 7 = *completely true of me*). The scale is available upon request. The larger sample from the pretraining data ($n = 252$) was used to conduct a confirmatory factor analysis (CFA) using three factors. Results indicated an acceptable fit. Although the chi-square was significant ($\chi^2 = 24$, $p < .001$), other fit measures were acceptable, with a root mean square error of approximation of .07 (95% CI [.06, .09]), a CFI of .92, and an SRMR of .05. All hypothesized factor loadings were significant (range = .47 to .85). Interfactor correlations were not excessively high (attitude with skill .57; attitude with knowledge .69; knowledge with skill .78) supporting the use of three subscales. Reliability was assessed by Cronbach's alpha yielding .84 for the Knowledge subscale, .66 for Attitude subscale, .85 for Skills subscale, and .90 for total scale. (The CFA is available in the online supplementary material).

RS Knowledge Questionnaire. We developed a new objective measure to assess RS knowledge, as no measure of clinician's actual knowledge of facts (as opposed to self-assessment of competence) in RS domains existed, particularly as it pertained to spiritually integrated clinical practice. In other words, unlike the items for self-assessed clinical competency, these items are objective measures of content knowledge. The 23 items (score range = 0–23) were based on the content of the curriculum, reflecting the knowledge competencies we sought to develop. Two parallel forms were created, so that different but similar difficulty and content area questions could be asked before and after the training. Once the items were created, an expert panel in the field of RS and mental health reviewed the items for accuracy and clarity. We then modified the items based on this expert feedback. Next, we pilot tested the items on a small sample of mental health trainees to ensure equivalency of the items and two forms, refined the items, and pilot tested again. Pilot testing confirmed equivalency of the two forms in difficulty level, as indicated by average and range percent correct. Alternate forms of the RS Knowledge Questionnaire were randomized across respondents, with half receiving Form A ($\alpha = .52$) in the pretraining assessment and Form B ($\alpha = .56$) in the posttraining assessment and half receiving Form B pretraining and Form A posttraining. Items are available from the Michelle J. Pearce on request.

Process assessment data. We gathered quantitative and qualitative evaluative feedback regarding participants' satisfaction with the learning experience, helpfulness, relevance of the material, and ease of navigating the curriculum presentation and the online platform. We also asked about their intention to use the material in their clinical practice, whether they would recommend the program to others, and other topics they would like to see included in this training. Data from these content and process assessments will be used to make changes to the curriculum content, organization, length, and presentation; and to inform development of future research, continuing education courses for practicing professionals, and training curricula for students in mental health professional training programs. We also gathered data about recruitment, enrollment, and retention to inform future strategies for research in this arena.

Statistical Analysis

To test Hypothesis 1, a multivariate repeated-measures analysis of variance (ANOVA) was used to test whether posttraining measures of attitudes, knowledge, and skills were higher than pretraining measures among those who completed the program. Individual one-way ANOVAs then assessed each measure separately. Using a paired *t* test, we assessed whether perceived barriers to integration (e.g., time it takes to integrate RS) decreased after participation in the program.

To test Hypothesis 2, descriptive statistics were used to summarize evaluative feedback provided by program participants. Open-ended responses were examined to generate useful ideas for programmatic changes and to determine areas of strength and opportunities for improvement. These data were used to highlight quantitative findings that emerged through statistical analyses.

To address the possibility of missing data, respondents were eliminated from any analysis in which they had not answered the relevant questions. All analyses were conducted using IBM Corp, (2011), with statistical significance set as a *p* value of less than .05.

Results

We examined the data for homogeneity and normality. One participant was eliminated as a result of erroneous completion of the posttraining survey prior to the pretraining survey. We used forced response in Qualtrics, so there were no missing data on the surveys.

Study Population

Exceeding our expectations, we recruited 318 eligible individuals and concluded with a sample of 169 program completers. Specifically, 630 individuals completed the eligibility screen; 318 were eligible; 252 completed the pretraining assessment; 244 enrolled in the edX program; and 169 completed all eight modules and the posttraining assessment. We had a 67% completion rate (calculated as those who completed both the pre- and postassessment). Figure 1 provides the flowchart showing recruitment and program completion of participants. *T* tests and chi-square analyses revealed no significant differences between those who completed the program and those who did not by gender, race/ethnicity, education level, age, or religious factors.

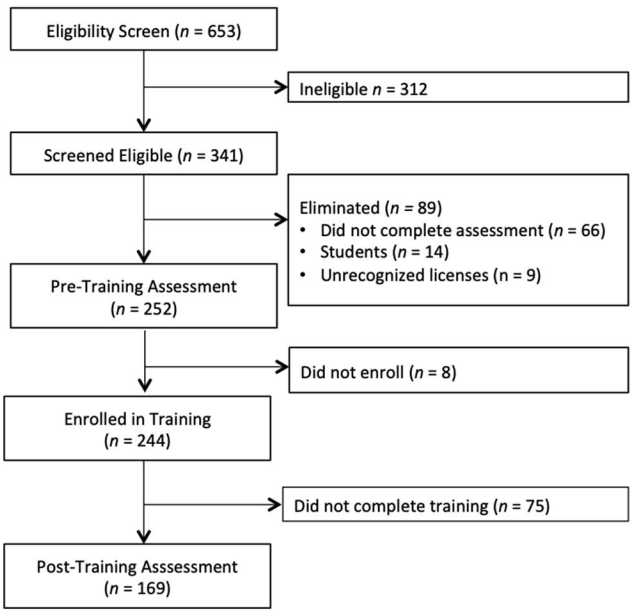

Figure 1. Recruitment and program completion flowchart.

Participants ranged from 23 to 76 years old ($M = 43.9$, $SD = 12.2$) and 83% were female (see Table 2). Sixty-nine percent were Caucasian, 16% were African American/Black, 8% were Asian/Pacific Islander, 4% were Hispanic or Latinx, 0.6% were American Indian/Alaskan Native, and 3% categorized themselves as other. The majority of the sample were psychologists (36%), followed by social workers (34%), professional counselors (12%), other license or certification (10%), master's level counselors (7%), psychiatrists (4%), psychiatric mental health nurses (2%), marriage family therapists (1%), and an advanced practice nurse (1%). (Note that some individuals reported more than one degree.) For the highest degree obtained, 54% held a master's degree, 40% held a PhD, 4% held an MD, and 2% stated "other (e.g., EdS)." The average number of years in clinical practice was 11.9 ($SD = 10$). Very few had any prior training in RS issues: 11% indicated some training and 89% indicated no training.

Most of the sample identified as Christian (51%), followed by other (18%), none (12%), Buddhist (7%), Jewish (2%), Muslim (1%), and Native American (1%). Most considered themselves not or slightly religious (56%) versus moderately or very religious (44%). In contrast, most considered themselves to be moderately or very spiritual (83%) versus not or slightly spiritual (17%; see Table 2).

Hypothesis 1 proposed that spiritual competencies, as measured by attitudes, knowledge, and skills, would increase from pre- to posttraining. We expected scores that measured perceived ability to execute a skill would increase more than scores for actual use of a skill, given the short duration of the program. Pre- and posttraining results are listed in Table 3.

Multivariate repeated-measures analyses for each domain; attitudes, $F(2, 167) = 44.84$, $p < .001$, knowledge, $F(2, 167) = 119.95$, $p < .001$, and skills, $F(3, 166) = 130.61$, $p < .001$, revealed significant increases from pre to post completion (see Table 3). Follow-up univariate tests showed significant positive changes on all individual competency measures (see Table 4). Specifically, participants scored significantly higher on the attitude competencies on both the RSIPAS (pre $M = 50.49$, post $M = 53.97$) and on the SC Questionnaire (pre $M = 18.75$, post $M = 19.23$). The attitudes that showed the greatest amount of change were "I pay attention

Table 2
Sociodemographic Characteristics of Sample (N = 169)

Characteristic	*n*	%	*M* (*SD*), Range
Age			43.85 (12.19), 23–76
Gender			
Female	140	82.8	
Male	29	17.2	
Race			
White or Caucasian	116	68.6	
African American/Black	27	16.0	
Asian/Pacific Islander	13	7.7	
Hispanic or Latino(a)	7	4.1	
Other	5	3.0	
American Indian/Alaskan Native	1	.6	
Discipline*			
Psychologist (licensed clinical psychologist)	60	35.5	
Social worker (LMSW/LCSW/LISW)	58	34.3	
Professional counselor (LPC)	20	11.8	
Other license or certification	17	10.1	
Master's level counselor	12	7.1	
Psychiatrist (MD)	7	4.1	
Chemical dependency counselor (CAADAC)	5	3.0	
Psychiatric mental health nurse (PMH-RN)	4	2.4	
Marriage family therapist (licensed MFT)	2	1.2	
Advanced practice nurse (APN)	1	.6	
Degree			
Master's degree	92	54.4	
Doctorate	67	39.6	
MD	7	4.1	
Other	3	1.8	
Region			
Pacific United States	28	16.6	
Frontier United States	8	4.7	
Midwest/Northeast United States	92	54.4	
South United States	31	18.3	
International	10	5.9	
Years in clinical practice			11.88 (9.98), 1 month to 42 years
Employment setting			
Secular	135	79.9	
Faith-based	34	20.1	
Religious preference			
Christian	86	50.8	
Other	30	17.8	
None	21	12.4	

(*table continues*)

Table 2 (*continued*)

Characteristic	*n*	%	*M* (*SD*), Range
Buddhist	19	11.2	
Inter-nondenominational	6	3.6	
Don't know	6	3.6	
Jewish	4	2.4	
Muslim/Islam	2	1.2	
Native American	2	1.2	
Religiosity			
Not religious	61	36.1	
Slightly religious	34	20.1	
Moderately religious	48	28.4	
Very religious	26	15.4	
Spirituality			
Not spiritual	7	4.1	
Slightly spiritual	22	13.0	
Moderately spiritual	67	39.6	
Very spiritual	73	43.2	
Religious attendance			
Never	26	15.4	
Once a year or less	33	19.5	
A few times a year	36	21.3	
A few times a month	20	11.8	
Once a week	42	24.9	
More than once a week	12	7.1	
Private religious activities			
Rarely or never	30	17.8	
A few times a month	24	14.2	
Once a week	12	7.1	
Two or more times a week	36	21.3	
Daily	50	29.6	
More than once a day	17	10.1	
Importance of religion			3.53 (1.24), 1–5
Prior training in RS			
Yes	19	11.2	
No	150	88.8	

Note. RS = Religion/spirituality.

to how my own spiritual and/or religious background may influence my clinical practice," "Practitioners who take time to understand their clients' religious/spiritual beliefs show greater concern for client well-being than practitioners who do not take time to understand their clients' religious/spiritual beliefs," and "There is a religious/spiritual dimension to the work I do."

Similarly, participants reported a significant increase in their knowledge of RS in mental health from pre- ($M = 33.65$) to posttraining ($M = 40.59$) on both the self-reported Knowledge subscale on the SC Questionnaire, and on the objective RS Knowledge Questionnaire (pre $M = 0.45$; post $M = 0.55$). The knowledge items that demonstrated the most change were "I can name at least five spiritual and/or religious resources and practices that may support psychological well-being," "I can name specific ethical issues related to spirituality and/or religion that may surface when working with clients," and "I can articulate ways in which clients' religion and/or spirituality can develop and change over the lifespan."

Finally, there was a significant increase from pre ($M = 24.07$) to posttraining ($M = 29.70$) in participants' reported skills related to RS in mental health, as measured by the Skills subscale on the SC Questionnaire. There was also an increase in their scores on the RSIPAS Efficacy subscale (i.e., perceived skills; pre $M = 45.27$, post $M = 53.36$) and on the RSIPAS Behaviors subscale (i.e., actual use of the skills; pre $M = 28.60$, post $M = 32.39$). As expected the impact on perceived self-efficacy (M difference = 8.09, $t = 16.18$) was slightly stronger than it was for behaviors (M difference = 3.79, $t = 8.92$). The skills that showed the greatest reported change over the course of the program were as follows: "I use empirically supported interventions that specifically outline how to integrate my clients' religion/spirituality into treatment," "I use specific spiritually integrative skills to conduct psychotherapy with clients from diverse spiritual and/or religious backgrounds," and "I know what to do if my client brings up thoughts of being possessed by Satan or the Devil."

As a post hoc analysis, we tested whether the religious and spiritual demographic variables of participants predicted change in RS competency scores. We found that baseline demographic variables generally failed to predict unique variance in hierarchical regression models on posttraining knowledge, skills, and attitudes. Thus, the program's effectiveness does not appear to be dependent on participants' level of religiousness or spirituality.

Regarding feasibility/barriers to addressing RS in practice, there was a significant decrease

Table 3
Multivariate Analyses for Change in Attitudes, Knowledge, and Skills at Posttraining (N = 169)

Competency	*F*	*df*	*p*	Hotelling's trace
Attitudes	44.84	2, 167	<.001	.54
Knowledge	119.95	2, 167	<.001	1.44
Skills	130.61	3, 166	<.001	1.60

Table 4
Univariate Follow-Up Analyses for Change in Attitude, Knowledge, and Skills Scores at Posttraining (N = 169)

Competency measure	*t*	*p*	*df*	*M* difference (post–pre)	Pre (*SD*)	Post (*SD*)	Possible range
				Attitude			
RSIPAS Attitude	9.28	<.001	168	3.49	50.49 (5.16)	53.97 (5.07)	12–60
SC Attitude	3.07	.003	168	.49	18.75 (2.34)	19.23 (1.75)	3–21
				Knowledge			
SC Knowledge	14.06	<.001	168	6.93	33.65 (6.81)	40.59 (5.13)	7–49
Knowledge Questionnaire	8.33	<.001	168	.10	.45 (.12)	.55 (.13)	0–1
				Skills			
RSIPAS Skills	8.92	<.001	168	3.79	28.60 (5.65)	32.39 (6.14)	9–45
RSIPAS Self-efficacy	16.18	<.001	168	8.09	45.27 (7.09)	53.36 (6.13)	13–65
SC Skills	11.28	<.001	168	5.63	24.07 (6.84)	29.70 (6.85)	6–42

Note. *M* = mean; *SD* = standard deviation; SC= spiritual competency; RSIPAS = Religious/Spiritually Integrated Practice Assessment Scale.

in perceived barriers to addressing RS in practice after completing the program (note that higher scores mean a lower perceived barrier): baseline ($M = 20.95$, $SD = 3.67$) to follow up ($M = 23.33$, $SD = 3.59$), $t(168) = 9.50$, $p < .001$. Specifically, we observed a decrease in all six of the barriers assessed—time to assess clients' RS background, time to identify potential RS strengths and struggles, primary practice setting does not support integration of RS, time to think about using a RS integrated approach, time to integrate RS if clients communicate a preference for this, and adequate training to integrate RS. The barrier that showed the greatest change was feeling adequately trained to integrate RS into treatment.

Hypothesis 2

On average, participants took 9 hours ($SD = 6$) to complete the training. Participants' ratings of the training program were favorable across the board. The majority of participants were extremely (39%) or very satisfied (50%) with the program, and 95% would recommend it to a colleague (5% said "maybe"). Nine out of 10 stated the program was extremely (37%) or very helpful (53%) in preparing them to engage in spiritually integrated therapy. A majority reported the training was extremely (32%) or very relevant (50%) to their clinical work. Only 2% said it was "not very relevant." Most felt it was the right amount of material (83%) and the right length (69%), whereas 18% felt it was "moderately too long" and 11% felt it was "moderately too short." Overall, 63% ranked the quality of the material as "excellent," 35% as "good," and 2% as "fair." Most of the participants envisioned using spiritually integrated therapy in their clinical practice "very often" (27%), "often" (44%), and "some of the time" (25%).

Qualitative questions assessed what participants liked about the program, suggested changes, what they learned, how their clinical practice would change as a result of the training, and feedback about the online format of the program. Some of the themes in response to the question, "What did you like about this training program?", included the following: participants reported enjoying that the program was self-paced, well-organized, kept their attention with a variety of learning formats and training modalities, practical and applicable, relevant, evidence-based, and comprehensive without feeling overwhelming. The training also facilitated personal reflection, discovery, and changes to the way they practiced therapy.

The following extracts are some sample quotes from the participants:

> I feel like this training has definitely increased my comfort level in integrating spirituality and religion more often with the clients that I see. In addition, it has increased my therapeutic confidence in knowing where to go when this presents as a piece of a client's identity and/or a piece of the presenting concern.

> This training program fills a gap in training that I view as essential to ethical, competent practice. Most of my patients are religious, yet my training program and subsequent CE opportunities do not directly discuss how to assess or incorporate the patient's belief system into therapy.
>
> This was very informative. It helped me see that spirituality and religion could be integrated without it being seen as "conversion" or trying to put your viewpoints on others. But rather, using where they are already coming from as a source of healing and understanding.

In response to the question, "What did you not like about this training program?", participants noted "nothing" or "N/A" most often, as well as frustration with a technical issue answering one of the drag-and-drop multiple choice knowledge check questions. Many also requested a printable PDF summary of each module's content for future use. Some participants felt the program was too short and they would have liked more depth, whereas others felt it was too long, with too much information. Some wanted more videos and case examples and less text. A few felt the facilitators were not animated and engaging enough in their didactic videos. Others requested covering more advanced topics in RS (e.g., LGBTQ+ issues, history of major religions, children and adolescents), the addition of interactive discussions and virtual reality role plays, and a follow-up program.

When asked, "What were your primary takeaways from this program?", participants had a lot to say. The majority reported that they would be changing their clinical practice by using more RS assessment and integrated practices. Understanding the benefits for integrating RS was listed as one of the top reasons for this change in behavior. They appreciated being given assessment questions and language to use, as well as a variety of "tools for their toolbox." A number stated that they appreciated learning that RS could be both life-affirming and a positive resource as well as life-limiting and a source of distress/struggle. Participants reported they were more likely to contact clergy for consultation and had a greater awareness of their own biases.

Similarly, participants were asked, "How do you see yourself utilizing the tools covered in this training in your practice?" Most respondents stated that they would begin (or had already begun) implementing routine assessment of RS with their clients. Participants reported that they would use the training across a broad range of contexts—in their clinical work with clients, in supervision and consultation sessions, in the training of graduate students and interns, in training employees, and in their discussions with colleagues. Many also said they would be seeking out additional training, building their RS network, and accessing the resources and references provided in the program.

When asked if they would prefer online or in-person training, 63% preferred online, 12% said in-person, and 25% said equal preference. When asked if the online format was easy to use, 97% said yes, and 3% said no. Those who preferred the online format indicated that they liked its flexibility, feasibility, and accessibility and used language such as: straightforward, convenient, intuitive, easy to access, navigate, and use, work at my own pace, and fit different learning style needs. Many said they wouldn't have attended the training if it had been in person due to time and financial constraints. A few said they liked being introduced to the topic online and would like in-person follow-up training. Some participants also mentioned that they enjoyed being able to go back to review material again. Those who preferred in-person training said they missed having interaction with others and opportunities for hands-on practice and follow-up questions.

Discussion

Previous research has underscored the need for training in RS competencies in mental health care (Oxhandler et al., 2015; Schafer et al., 2011; Vogel et al., 2013; Vieten et al., 2013). This study was the first to target and evaluate the achievement of spiritual competencies—consisting of attitudes, knowledge, and skills—across mental health disciplines using an online format. Complementing the results of the few previous studies on RS competency training programs, the present findings provided empirical evidence for the viability and effectiveness of a training program for a large and diverse group of mental health professionals.

As we hypothesized, participants who completed the online SCT-MH program reported a significant increase in their spiritual competence in mental health practice. Specifically, the results revealed that participants' attitudes,

knowledge, and skills each increased, likely as a result of completing the training program. These results were consistent across all seven measures used to assess RS competence.

We wondered whether this training program would attract a sample of providers that were religious and spiritual as well as highly favorable toward including RS in treatment. As such, we were unsure whether we would find a change in attitudes after completing the program given the possibility of a ceiling effect for attitude scores before training. However, consistent with national surveys of mental health providers, our sample was less likely to consider themselves religious and more likely to consider themselves spiritual. A ceiling effect did not emerge for attitudes at the pretraining assessment and, as reported, attitudes did become significantly more positive at posttraining. In addition, the program's effectiveness did not appear to be dependent on participants' baseline level of religiousness or spirituality, as demographic variables measuring various aspects of participants' RS did not predict changes in competency scores.

We also wondered whether we would see a change in the actual use of the RS skills in clinical practice, as participants had only four weeks to complete the program. The results revealed that individuals' scores for both the self-efficacy (perceived ability to use the skills) and the behavior items (actual use of skills) increased by the posttraining assessment. These changes were also reflected in the qualitative feedback, as many participants described how they were already using the information and skills in their work with clients.

We were also encouraged to see a reduction in the perceived barriers to integrating RS into practice as a result of the training. The largest reduction was in the perceived barrier of not being adequately trained in the integration of RS into clinical practice. This suggests that a short training program is sufficient for practitioners to feel equipped to integrate RS issues in their clinical work. In addition, after the training, participants reported feeling that they had more time to assess and address RS issues with their clients. This suggests that their perception of how much time it takes to integrate RS was reduced and that they now felt addressing these issues was possible in session. Thus, the training program appeared to help practitioners to feel that addressing RS issues was easier and less time consuming than they had previously perceived.

The qualitative feedback provided helpful information about the program's content and format. Most participants preferred the online format of the program and stated that they would not have completed the program if it had been in-person. They cited time, inconvenience, and finances as the major barriers to in-person training. Those that did prefer in-person training missed the interaction with peers and the ability to practice skills and ask questions. The program was deemed easy and straightforward to use, access, and navigate. Participants enjoyed working at their own pace and the variety of learning materials and methods. Many reported insight into their own RS biases and a greater awareness of the lack of training in this area in their graduate programs. Much of the feedback about areas for improvement had to do with the length and depth of the program (with some participants wanting more and others wanting less), as well as providing more information, case examples, discussions with peers, and advanced topics.

Many participants had already made changes to the way they practice therapy, and many others had clear plans to do so. The main change was including regular and explicit assessment of RS issues into their clinical practice. Others plan to use RS integrated strategies, particularly religious CBT, and indicated intentions to reach out to clergy as needed. Many stated they felt more confident and comfortable asking RS questions and including RS strategies in treatment, which was the major goal of this training program. It was also interesting to hear that participants planned to use this material in ways that went beyond psychotherapy with their clients. Many reported that they would be using the information to train their graduate students, interns, supervisees, consultees, employees, and staff, as well as in dialogue with their colleagues.

We will use the qualitative content and process data to refine the curriculum content, organization, length, and presentation of the SCT-MH program, as well as to inform the development of future research, continuing education courses for practicing professionals, and training curricula for students and trainees in mental health professional training programs.

At the time of this publication, the SCT-MH program is available to the public on edX as a professional education course for a small fee. Those who complete the program are eligible for six continuing education credits sponsored by the APA. Interested readers can find the course on the edX platform by searching for "Spiritual Competency Training for Mental Health Providers."

Limitations

Several limitations of this study should be noted. First, the sample is self-selected, which may mean these practitioners were more open to RS in mental health care to begin with and thus more likely to experience (or report experiencing) a change in competency scores. However, as mentioned, the sample was less likely to identify as religious and more likely to identify as spiritual. Thus, their own personal religiosity was likely not a driving factor for acquiring training in this area.

Second, the majority of the participants were female and Caucasian and were trained as a psychologist or social worker. As noted by the Substance Abuse and Mental Health Services Administration (2012), the largest proportion of mental health care providers include clinical social workers (over 193,000), followed by counselors (over 144,000), and then psychologists (over 95,000). Although our sample may have fewer counselors, social workers and psychologists represented the majority of providers in this study, though we recognize our results may not generalize to the broader population of mental health providers. Further, we recognize those who do not identify as female and Caucasian may have a different experience with the training.

Third, we did not have a control group. Although we believe that is unlikely that participants' RS competence would have collectively increased over time without the intervention, we cannot rule out the possibility of history or maturation effects here unrelated to the effects of SCT-MH. Clearly, more sophisticated evaluative designs are needed to provide stronger support for the effectiveness of this program.

Fourth, we did not have a follow-up assessment, given the limited time provided for this grant-funded study. As such, we are unable to determine whether these changes were temporary or long-lasting. Future longitudinal research is needed to assess the stability of these changes over a longer period.

We were also unable to assess the exact level of participant engagement with the content of the program. For example, edX was only able to provide aggregate information on which videos were viewed, but not individual level data, nor the amount of time each video was viewed. Thus, we cannot determine the degree to which participants reviewed the content in each module. That said, we did put parameters around engagement, such that each participant had to complete 70% of the activities in the module in order to see the content of the next module. We set this at 70% instead of 100% to reduce frustration and confusion from human and technological error, which could have led to an increased dropout rate. Notably, even without ensuring that all content was accessed, we saw a significant increase in all competency scores.

Another limitation was the relatively low reliability coefficients ($\sim$.50) for the two versions of the RS Knowledge Questionnaire created for the purposes of this study. Given the items tap into different domains of knowledge (e.g., general facts about RS, facts related to RS practice issue, facts related to RS research), it is not surprising that the alphas were lower on this scale than they were for our other measures. Further research is needed on the development and refinement of a scale to assess knowledge competency in RS issues in mental health. Despite the low alphas, demonstrating change of RS knowledge using an objective measure, in addition to the self-report knowledge measure, is an important contribution and helps to strengthen the findings.

A final limitation is the degree to which the changes in competency translated into long-term changes in clinical practice, beyond those participants reported making to their clinical practice in both their open-ended feedback and in their self-reported use of skills, and in client outcomes. The ultimate goal of competency training is to improve client care and outcomes. This was the first step in a program of research designed to develop and test spiritual competency in mental health providers. A longer and more comprehensive study is the next step to assess long-term changes in provider behavior and client outcomes.

Despite these limitations, the study has some notable strengths. Of the few studies conducted on spiritual competency training to date, this study had the largest sample size ($n = 169$) and included practicing professionals across mental health disciplines. This broader sample provides a better snapshot of spiritual competency attitudes, knowledge and skills in the mental health field at large. Our study also evaluated the competencies by their separate domains (i.e., attitudes, knowledge, and skills) rather than these being combined. This more granular assessment allowed us to reveal specific potential strengths and deficiencies in the program. Finally, to our knowledge, this was the first online spiritual competency training program. The online format allows for greater reach and convenience. It remains a viable program that can be continuously accessed and used by providers, even now that this initial evaluation is complete. Revisions will be made based on participants' feedback.

Implications and Future Directions

The SCT-MH program is brief, basic, accessible, evidence-based, and designed to reach members of diverse mental health professionals. As such, this online program should continue to be of interest to a large potential audience. That said, when it comes to providing training and developing competencies, we recognize that one size does not fit all. Learners have different needs and preferences with respect to how the material is presented (e.g., online, in-person, or hybrid), when it is presented, and what is presented (e.g., basic vs. advanced competency). We propose that bridging the training gap will be best accomplished through offering providers and trainees a menu of training options. These options could range from brief and basic, to comprehensive and intensive. The positive changes in competency scores and very positive feedback about the online SCT-MH program suggests it can and should be one of these training options. Other training options might include longer (>6–8 hr) online programs addressing advanced competencies in RS and mental health, in-person day-long workshops that include experiential small-group training formats (for continuing education credit), a semester-long graduate course, and internship and residency curriculum and practicum experiences. RS competency training could also be added as a module in existing courses in multicultural competence.

Medicine and psychiatry are farther ahead in RS graduate training than other mental health fields (Oxhandler & Pargament, 2018). One of the major reasons for this are the seed grants that were provided by the John Templeton Foundation to medical schools a little over a decade ago (Koenig et al., 2010). Faculty at the various medical schools then developed and implemented RS training into their curriculum. A similar initiative in other mental health fields may produce similar results. Evaluation of the various training options would provide important information on the effectiveness of each strategy for developing spiritual competency. Our hope is that successful efforts to foster wider adoption of training in RS competencies would assist in the addition of specific RS competencies among mental health professional boards. The synergy between the two—successful training efforts and professional boards' specific training requirements—would likely create greater momentum for change in the field.

We also envision a centralized repository of resources for practitioners. A website that contained information about various RS issues, belief systems, and access to clergy members of various faith traditions, as well as experts in the mental health field who are available for consultation and/or supervision, would provide real-time knowledge and assistance for practitioners and their clients.

Conclusion

In summary, the online SCT-MH program helps to bridge the gap between the current lack of graduate and professional training in RS issues and the needs and realities of clinical practice. This brief online program housed on edX provides training to providers across all mental health fields in basic RS competencies. Participants who completed the program reported a significant positive change in their attitudes, knowledge, and skills in assessing and addressing RS issues in clinical practice. The online format was easy to use, met the needs of learners, and was the preferred delivery method. Perceived barriers to integrating RS into practice also decreased as a result of participating in this training program. Future research and dis-

semination efforts are needed to continue to meet the needs for greater multicultural training in RS and mental health and the integration of an RS client-centered approach to psychotherapy.

References

Abu-Raiya, H., Pargament, K. I., Krause, N., & Ironson, G. (2015). Robust links between religious/spiritual struggles, psychological distress, and well-being in a national sample of American adults. *American Journal of Orthopsychiatry, 85,* 565–575. http://dx.doi.org/10.1037/ort0000084

American Psychological Association. (2015). *Commission on accreditation: Implementing regulations related to the standards of accreditation*. Retrieved from http://www.apa.org/ed/accreditation/section-c-soa.pdf

Awaad, R., Ali, S., Salvador, M., & Bandstra, B. (2015). A process-oriented approach to teaching religion and spirituality in psychiatry residency training. *Academic Psychiatry, 39,* 654–660. http://dx.doi.org/10.1007/s40596-014-0256-y

Bannister, S. H., Park, H. S., Taylor, S., & Bauerle, E. N.. (2015). Clients' expectations and preferences for marital Christian counseling: A chronological literature review and contemporary evaluation. *Social Work & Christianity, 42,* 63–95.

Carlson, T. D., Kirkpatrick, D., Hecker, L., & Killmer, M. (2002). Religion, spirituality, and marriage and family therapy: A study of family therapists' beliefs about the appropriateness of addressing religious and spiritual issues in therapy. *The American Journal of Family Therapy, 30,* 157–171. http://dx.doi.org/10.1080/01926180275357386 7

Commission on Accreditation for Marriage and Family Therapy Education. (2016). *Accreditation standards: Graduate & post-graduate marriage and family therapy training programs*. Retrieved from https://www.coamfte.org/Documents/COAMFTE/Version%2012/COAMFTE_Accreditation_Standards_Version_12.pdf

Council for Accreditation of Counseling and Related Educational Programs. (2015). *2016 CACREP standards*. Retrieved from http://www.cacrep.org/wp-content/uploads/2018/05/2016-Standards-with-Glossary-5.3.2018.pdf

Council on Social Work Education. (2015). *Educational policy and accreditation standards for baccalaureate and master's social work programs*. Retrieved from http://www.cswe.org

Doehring, C. (2015). *The practice of pastoral care*. Louisville, KY: Westminster John Knox Press.

Exline, J. J. (2013). Religious and spiritual struggles. In K. I. Pargament, J. J. Exline, & J. W. Jones (Eds.), *APA handbook of psychology, religion, and spirituality: Context, theory and research* (pp. 459–475). Washington, DC: American Psychological Association.

Furness, S., & Gilligan, P. (2010). *Religion, belief, and social work: Making a difference*. Bristol, UK: Policy Press.

Grabovac, A., Clark, N., & McKenna, M. (2008). Pilot study and evaluation of postgraduate course on "the interface between spirituality, religion and psychiatry." *Academic Psychiatry, 32,* 332–337. http://dx.doi.org/10.1176/appi.ap.32.4.332

Griffith, J. L. (2010). *Religion that heals, religion that harms: A guide for clinical practice*. New York, NY: Guilford Press.

Hodge, D. (2004). Spirituality and people with mental illness: Developing spiritual competency in assessment and intervention. *Families in Society, 85,* 36–44. http://dx.doi.org/10.1606/1044-3894.257

Hodge, D. (2016). Spiritual competence: What is it, why is it necessary, and how to develop it. *Journal of Ethnic & Cultural Diversity in Social Work, 27,* 124–139. http://dx.doi.org/10.1080/15313204.2016.1228093

IBM Corp. (2011). *IBM SPSS statistics for windows* (Version 20). Armonk, NY: Author.

Koenig, H. G., Hooten, E. G., Lindsay-Calkins, E., & Meador, K. G. (2010). Spirituality in medical school curricula: Findings from a national survey. *International Journal of Psychiatry in Medicine, 40,* 391–398. http://dx.doi.org/10.2190/PM.40.4.c

Koenig, H. G., King, D. E., & Carson, V. B. (2012). *Handbook of religion and health* (2nd ed.). New York, NY: Oxford University Press.

Leitz, C. A., & Hodge, D. R. (2013). Incorporating spirituality into substance abuse counseling: Examining the perspectives of service recipients and providers. *Journal of Social Service Research, 39,* 498–510. http://dx.doi.org/10.1080/01488376.2012.676023

Moffatt, K. M., & Oxhandler, H. K. (2018). Religion and spirituality in master of social work education: Past, present, and future considerations. *Journal of Social Work Education, 54,* 543–553. http://dx.doi.org/10.1080/10437797.2018.1434443

Osório, I. H. S., Gonçalves, L. M., Pozzobon, P. M., Gaspar Júnior, J. J., Miranda, F. M., Lucchetti, A. L. G., & Lucchetti, G. (2017). Effect of an educational intervention in "spirituality and health" on knowledge, attitudes, and skills of students in health-related areas: A controlled randomized trial. *Medical Teacher, 39,* 1057–1064. http://dx.doi.org/10.1080/0142159X.2017.1337878

Oxhandler, H. K., Ellor, J. W., & Stanford, M. S. (2018). Client preferences for integrating religion/spirituality in mental health treatment: Scale development and client responses. *Social Work, 63,* 337–346. http://dx.doi.org/10.1093/sw/swy041

Oxhandler, H. K., & Pargament, K. I. (2018). Measuring religious and spiritual competence across helping professions: Previous efforts and future directions. *Spirituality in Clinical Practice, 5,* 120–132. http://dx.doi.org/10.1037/scp0000149

Oxhandler, H. K., & Parrish, D. E. (2016). The development and validation of the Religious/Spiritually Integrated Practice Assessment Scale. *Research on Social Work Practice, 26,* 295–307. http://dx.doi.org/10.1177/1049731514550207

Oxhandler, H. K., Parrish, D. E., Torres, L. R., & Achenbaum, W. A. (2015). The integration of clients' religion/spirituality in social work practice: A national survey. *Social Work, 60,* 228–237. http://dx.doi.org/10.1093/sw/swv018

Pargament, K. I. (2007). *Spiritually integrated psychotherapy: Understanding and addressing the sacred*. New York, NY: Guilford Press.

Pearce, M. (2016). *Cognitive behavioral therapy for Christians with depression: A practical tool-based primer*. West Conshohocken, PA: Templeton Press.

Pearce, M. J., Pargament, K. I., Oxhandler, H., Vieten, C., & Wong, S. (2019). A novel training program for mental health providers in spiritual competencies. *Spirituality in Clinical Practice*. Advance online publication. http://dx.doi.org/10.1037/scp0000195

Post, B. C., Wade, N. G., & Cornish, M. A. (2014). Religion and spirituality in group counseling: Beliefs and preferences of university counseling center clients. *Group Dynamics, 18,* 53–68. http://dx.doi.org/10.1037/a0034759

Richards, P. S., & Bergin, A. E. (2005). *A spiritual strategy for counseling and psychotherapy* (2nd ed.). Washington, DC: American Psychological Association. http://dx.doi.org/10.1037/11214-000

Rose, E. M., Westefeld, J. S., & Ansley, T. N. (2001). Spiritual issues in counseling: Clients' beliefs and preferences. *Journal of Counseling Psychology, 48,* 61–71. http://dx.doi.org/10.1037/0022-0167.48.1.61

Schafer, R. M., Handal, P. J., Brawer, P. A., & Ubinger, M. (2011). Training and education in religion/spirituality within APA-accredited clinical psychology programs: 8 years later. *Journal of Religion and Health, 50,* 232–239. http://dx.doi.org/10.1007/s10943-009-9272-8

Stanley, M. A., Bush, A. L., Camp, M. E., Jameson, J. P., Phillips, L. L., Barber, C. R., . . . Cully, J. A. (2011). Older adults' preferences for religion/spirituality in treatment for anxiety and depression. *Aging & Mental Health, 15,* 334–343. http://dx.doi.org/10.1080/13607863.2010.519326

Substance Abuse and Mental Health Services Administration. (2012). *Behavioral health, United States, 2012*. Retrieved from https://www.store.samhsa.gov/product/Behavioral-Health-United-States-2012/SMA13-4797

Sue, E. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Multicultural Counseling and Development, 20,* 64–88. http://dx.doi.org/10.1002/j.2161-1912.1992.tb00563.x

Taylor, L., & Parsons, J. (2011). Improving Student Engagement. *Current Issues in Education (Tempe, AZ), 14,* 1–33. Retrieved from https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=4&ved=0ahUKEwjRnszLibAhXvzVkKHVILBVcQFghLMAM&url=https%3A%2F%2Fcie.asu.edu%2Fojs%2Findex.php%2Fcieatasu%2Farticle%2Fdownload%2F745%2F162%2F0&usg=AOvVaw1KNl_akXp0Rn2LRxW3O0Bu

Vieten, C., & Scammell, S. (2015). *Spiritual and religious competencies in clinical practice: Guidelines for psychotherapists and mental health professionals*. Oakland, CA: New Harbinger Publications.

Vieten, C., Scammell, S., Pierce, A., Pilato, R., Ammondson, I., Pargament, K. I., & Lukoff, D. (2016). Competencies for psychologists in the domains of religion and spirituality. *Spirituality in Clinical Practice, 3,* 92–114. http://dx.doi.org/10.1037/scp0000078

Vieten, C., Scammell, S., Pilato, R., Ammondson, I., Pargament, K. I., & Lukoff, D. (2013). Spiritual and religious competencies for psychologists. *Psychology of Religion and Spirituality, 5,* 129–144. http://dx.doi.org/10.1037/a0032699

Vogel, M. J., McMinn, M. R., Peterson, M. A., & Gathercoal, K. A. (2013). Examining religion and spirituality as diversity training: A multidimensional look at training in the American Psychological Association. *Professional Psychology: Research and Practice, 44,* 158–167. http://dx.doi.org/10.1037/a0032472

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