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Psychology Doctoral Students' Perspectives on Addressing Spirituality and Religion With Clients: Associations With Personal Preferences and Training

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Abstract

Students (n = 543) in doctoral clinical and counseling psychology programs were surveyed about training experiences with regard to addressing the spiritual and religious beliefs and practices (SRBP) of their patients. About one fourth of the respondents indicated they had received no training related to patients' SRBP. Another

half had only read material on their own or discussed such issues with a supervisor. Nonetheless, respondents almost universally endorsed the idea that patients should be asked about spirituality and religiousness. Participants also rated the appropriateness of spiritual and religious queries that might be asked of patients. As expected, queries about the relevance of SRBP were rated as the most appropriate, whereas queries that implied a disrespectful or challenging tone were rated as the least appropriate. Participants' personal SRBP and training that was specific to patients' SRBP were weakly but significantly associated with appropriateness ratings. The results suggest that students are formulating ideas about how to ask patients about their spiritual and religious issues despite potentially inadequate formal instruction.

Keywords

training, spirituality, religion, multicultural competence

Introduction

There are many reasons why psychologists should address patients' spiritual and religious beliefs and practices (SRBP). Religion is important in the majority of people's lives (Gallup Organization, 2009), and many patients desire that their SRBP be acknowledged or perhaps even incorporated into their medical and psychological health care (Martinez, Smith, & Barlow, 2007). Research suggests an association between spiritual and religious (S–R) variables and better psychological health, including increased hope and lower levels of depression, anxiety, substance abuse, and suicide (Koenig, 2009). Evaluating patients' SRBP offers insight into their worldview, values, and social networks (Pargament, 2007) and the manner in which patients express distress and disability (Hathaway, Scott, & Garver, 2004).

SRBP are an integral part of one's cultural identity, and it has been argued that multicultural competence within mental health services must include awareness and respect of S–R issues (e.g., American Psychological Association [APA], 2010; Crook-Lyon et al., 2012; Lukoff & Lu, 1999). Moreover, surveys have found that the majority of practicing psychologists recognize that SRBP issues are important to mental health and relevant to psychological care (Delaney, Miller, & Bisonó, 2007; Hathaway et al., 2004). However, research also suggests that psychologists do not regularly address S–R issues with their patients. Hathaway and colleagues found that only one third of practitioners asked patients' about S–R issues most of the time, and Frazier and Hansen (2009) found that, on average, psychologists reported discussing S–R issues with less than one third of their patients.

Psychologists assert various reasons for not addressing patients' SRBP. Some attribute external barriers, such as lack of time (Koenig, 2009). Another possible reason is lack of training. Crook-Lyon et al. (2012) found that in a random selection of APA-affiliated psychologists, 76% of respondents believed that their graduate programs inadequately addressed training related to S–R issues of patients. Brawer, Handal, Fabricatore, Roberts, and Wajda-Johnston (2002) and Russell and Yarhouse (2006) both surveyed directors of APA-accredited clinical programs and APA-accredited internship programs, respectively. Both surveys found that few programs systematically incorporated training and education in regard to S–R issues (e.g., 13% of programs offered courses specifically focused on religion, and S–R issues were most likely addressed only during supervision after the patient introduced them). Schafer, Handal, Brawer, and Ubinger (2011) conducted a follow-up survey of APA-accredited clinical programs and found an increase in coverage of S–R topics related to coursework, supervision, and research but no increase in systematic coverage.

Research into professional psychologists' attitudes and practices regarding the S–R aspects of their patients' lives has been limited, and even less research has been conducted evaluating the experiences of graduate students. Accordingly, we conducted a survey of graduate students in pursuit of three aims. First, we sought to assess graduate students' training experiences with regard to the S–R issues of patients as well as graduate student characteristics that are associated with such training. Other research (e.g., Jackson, 1999) has revealed an association between personal characteristics and training experiences, therefore it was hypothesized that students with relatively more personal adherence to SRBP would be more likely to report such training. The

second aim was to evaluate graduate students' attitudes about specific S–R queries that were categorized, a priori, as either generally appropriate or generally inappropriate. It was hypothesized that students' ratings would generally correspond to the a priori categorization regarding appropriateness. Finally, we evaluated the association between ratings of queries and both students' personal SRBP and training with regard to S–R issues of patients. Consistent with prior findings (Reynolds & Rivera, 2012), it was hypothesized that the queries would be rated as more appropriate by respondents who reported relatively frequent engagement in religious behaviors and relatively higher ratings of religious and spiritual well-being, as well as by respondents who had received training with regard to S–R issues of patients.

Method

Procedures

Marquette University's institutional review board approved the study. A list of APA-accredited programs in clinical psychology and counseling psychology located in the United States was compiled (APA, 2008b, 2008c). Training directors were identified and contacted through e-mail in January 2009. They were asked to forward the e-mail to current doctoral students. It is not possible to ascertain how many complied with the request. Potential participants were informed that their participation was voluntary, their responses would be anonymous, and they could discontinue participation at any time without penalty. They were also informed that they could enter a drawing to win one of eight gift certificates on completion of the survey (less than half asked to be placed into the drawing). Students consented by completing the survey by following a link to SurveyMonkey.

Participants

A total of 581 students currently enrolled in clinical or counseling psychology doctoral programs completed the questionnaire. Participants that responded to less than 80% of the survey (n = 38) were excluded from analyses. The 543 respondents included 343 (63.2%) students in clinical psychology doctoral programs, 176 (32.4%) in clinical psychology doctor of psychology programs, and 24 (4.4%) in counseling psychology doctoral programs. Regarding their program's training model, 341 (62.8%) indicated scientist–practitioner, 143 (26.3%) indicated practitioner–scholar or practitioner, 34 (6.3%) indicated clinical scientist, and 25 (4.6%) indicated that they were uncertain of their program's training model. The sample included 122 (22.5%) first-year students, 92 (16.9%) second-year students, 97 (17.9%) third-year students, 167 (30.8%) fourth- or fifth-year students, and 65 (12.0%) in their sixth year or beyond. Approximately half of the sample (n = 267, 49.2%) had less than 2 years of treatment experience.

The sample consisted of 419 females (77.2%) and 124 males (22.8%). Participants' mean age was 28.93 years old (SD = 6.99, range = 21–66). Half of the participants (n = 273, 50.3%) were single and never married; 246 (45.3%) were either married or living with a romantic partner; and 24 (4.4%) were separated, divorced, or widowed. Most indicated that they were Caucasian (n = 453, 83.5%); of the remainder, 19 (3.5%) indicated that they were African American, 19 (3.5%) were either Asian or Pacific Islander, 9 (1.7%) were Hispanic or Latino, 8 (1.5%) were Middle Eastern, 1 (0.2%) was Native American, 4 (0.7%) endorsed "other" (including Indo-Trinidadian, Portuguese Goan, and Caribbean American), and 29 (5.4%) indicated that they were multiracial. In 2008, 77.5% of all 23,511 students enrolled in doctoral clinical, counseling, and school psychology programs were female (APA, 2008a), which is comparable to our sample. However, our sample was underrepresented with regard to race and ethnicity, as approximately 68.5% of all doctoral students were Caucasian.

Materials

Participants completed an online survey that assessed demographic information (i.e., gender, race and ethnicity, age, and relationship status), personal SRBP, general training and treatment experience, and training

experiences specific to S–R issues of patients. Participants also rated the appropriateness of S–R-related queries that might potentially be asked of patients.

Personal SRBP of participants

Participants responded to two items, on a scale with ranges 1 (*not at all*), 2 (*somewhat*), and 3 (*very*), to indicate the extent to which they considered themselves to be religious (religiousness) and to be spiritual (spirituality).

The Religious Participation scale was created by averaging responses to four questions, adapted from Levin (2003), addressing the frequency of both public (e.g., frequency of attendance at religious services) and private (e.g., frequency of prayer) religious practices. There were eight options, ranging from 1 (*never*) to 8 (*several times a day*). The internal consistency (Cronbach's α coefficient) of the four items was 0.79.

Participants completed the Brief RCOPE (Pargament, Feuille, & Burdzy, 2011), which is a 14-item scale that assesses how frequently respondents used religious forms of coping "in an effort to cope with negative events in my life." The items of the measure create two subscales, Negative Religious Coping (e.g., concern about God's punishment) and Positive Religious Coping (e.g., using religion when worried). Respondents endorse each item using one of four responses, ranging from 1 (*not at all*) to 4 (*a great deal*). Empirical studies have reported good internal consistency of the subscales and have likewise established their construct, predictive, and incremental validities (Pargament et al., 2011) as well as its test–retest reliability (Giaquinto, Cipolla, Giachetti, & Onorati, 2011). In this study, the internal consistency for both the Negative Religious Coping and the Positive Religious Coping subscales was adequate (α = .76 and .94, respectively).

Participants also completed the 20-item Spiritual Well-Being Scale (Ellison, 1983), which has two subscales. The Religious Well-Being (RWB) subscale assesses the respondent's relationship with God (e.g., believing God cares). The Existential Well-Being (EWB) subscale addresses attitude toward the world and life in general (e.g., feeling happy in life). Possible responses range from 1 (*strongly disagree*) to 6 (*strongly agree*). Prior research supports the test–retest reliability and internal consistency of the scales as well as their face and construct validity (Bufford et al., 1991). In this study, the internal consistency for both the RWB and EWB were very high (α = .99 and .91).

Training experience

Participants were asked to indicate, "In your program, how much training regarding religious and spiritual issues of patients have you received so far?" Responses included (a) no training whatsoever; (b) discussed issues with supervisor(s) to some extent; (c) discussed issues with supervisor(s) to a great extent; (d) had one course on religious and spiritual issues; (e) had several courses on religious and spiritual issues; (f) attended a seminar or seminars on religious and spiritual issues; and (g) read a book or books on religious and spiritual issues. Responses were not mutually exclusive, with the exception of "no training whatsoever."

Opinion regarding asking patients about SRBP

Respondents were asked to indicate their opinion regarding whether a mental health professional should ask about religious and spiritual beliefs in the course of conducting evaluations and interventions. The five response options were that a mental health professional should never, almost never, sometimes, almost always, or always ask.

Rating the appropriateness of specific queries

Respondents were presented with a list of 23 questions and statements. Respondents rated each according to the appropriateness of "questions that a mental health professional might ask or statements that a mental health professional might make" during an initial meeting with a patient. Possible responses ranged from 1 (*very inappropriate*) to 4 (*very appropriate*). Subscale scores were calculated as the mean of the items.

The queries were based on Pargament (2007), who recommended that mental health professionals always evaluate the salience of S–R to all patients. If salient, subsequent evaluation should include whether a patient has a specific S–R affiliation, any association between S–R issues and presenting problems, and whether the patient's SRBP might be a resource for coping with problems. On the basis of this work, 16 of the 23 items were categorized into four subscales, each comprising four items, labeled Salience/Relevance, Affiliation/Community, Cause/Part of Problems, and Support to Solve Problems. These items were deemed, a priori, to be generally appropriate. A fifth subscale, labeled Disrespectful/Challenging, comprised seven items intended to be perceived as challenging or even disrespectful toward a patient's SRBP. These were deemed a priori to be inappropriate.

We finalized the item content of the survey through two pilot studies. First, we administered 40 possible items to a sample of 94 undergraduate students drawn from a general psychology subject pool to verify that they were readable and understandable. Second, the items were administered through online survey to 108 therapy clients (89 female and 19 male clients, predominately Caucasian [90%], with mean age of 30.7 years) recruited from outpatient clinics. These patients indicated to what extent they would want a mental health professional to direct these queries to them by endorsing one of four options from *definitely* or *probably would not want* through *probably* or *definitely would want*. The items rated as being most desirable were retained for the four subscales corresponding to Pargament's (2007) recommendations, and the seven items rated as least desirable were retained for Disrespectful/Challenging subscale. Patients' responses are shown in Table 1 (combining *probably* and *definitely*).

Table 1. Ratings of Items and Subscales

	Patient ratings	Graduate student ratings	
Subscales–items	Probably or definitely would want (%)	Appropriate or very appropriate (%)	*M* (*SD*)
Salience–relevance			3.26 (0.53)
1. Tell me about your religious or spiritual beliefs.	79	94	3.45 (0.67)
2. How important is your religion or spirituality to you?	81	94	3.36 (0.64)
3. Tell me about your religious or spiritual practices.	78	91	3.30 (0.69)
4. How strong would you say your religious or spiritual beliefs are?	73	80	2.94 (0.74)
Affiliation–community			3.08 (0.53)
1. Tell me about your religious or spiritual community.	73	92	3.23 (0.66)
2. Do you feel connected to your religious or spiritual community?	77	92	3.17 (0.62)
3. Does your family agree with your religious or spiritual beliefs?	83	87	3.05 (0.64)
4. Are you satisfied with your religious or spiritual community?	75	76	2.89 (0.70)
Cause–part of problems			2.83 (0.57)

1. Does your religion or spirituality ever cause distress in your life?	71	84	3.01 (0.66)
2. Have you ever had problems that related to your religion or spirituality?	75	80	2.93 (0.70)
3. Do you feel bad if you do things that conflict with your religious or			
spiritual beliefs?	68	70	2.76 (0.77)
4. Does your family pressure you into performing religious and spiritual			
practices that you don't want to?	69	63	2.64 (0.74)
Support to solve problems			3.10 (0.58)
1. Does your religion or spirituality influence other aspects of your life?	81	91	3.18 (0.65)
2. Does your religious or spiritual community offer you support when you			
are having a problem?	80	90	3.16 (0.65)
3. Does your religion or spirituality ever reduce distress in your life?	79	89	3.10 (0.64)
4. Do your religious or spiritual beliefs influence your mental health?	80	76	2.95 (0.79)
Disrespectful–challenging			2.08 (0.60)
1. Do you fear that your god or higher being will punish you?	47	43	2.31 (0.80)
2. Do you think that you are being punished by your god or higher being?	49	42	2.29 (0.79)
3. Do you wonder if your beliefs are wrong?	42	32	2.13 (0.82)
4. What would your life be like if you changed to a different religion or to			
different spiritual beliefs?	40	34	2.17 (0.79)
5. Do you think that your life would be better if you were a member of a			
religious or spiritual community?	48	30	2.12 (0.78)
6. Should your religion or spirituality be more important to you than it is?	42	21	1.94 (0.76)
7. Why aren't you religious or spiritual?	34	16	1.66 (0.78)

Note. Rating scale: 1 (very inappropriate), 2 (inappropriate), 3 (appropriate), 4 (very appropriate).

Results

Participant Training

Training specific to SRBP of patients

Participants indicated the amount of training received in regard to the S–R issues of patients. About one fourth of the participants (*n* = 146, 26.9%) indicated that they had "no training whatsoever." The most common training experience reported was discussion with supervisors to some or to a great extent (*n* = 329, 60.6%). Of respondents who endorsed any training, 46.9% reported this only. Relatively few participants indicated they have taken either a single course (*n* = 54, 9.9%) or several courses (*n* = 68, 12.5%) on the topic. More common was for participants to have had attended a seminar or more than one seminar (*n* = 93, 17.1%) or to have read a book or several books on the topic (*n* = 138, 25.4%).

Training experiences with regard to the S–R of patients were twice recategorized. First, we created two groups to compare participants with no training whatsoever (*n* = 146, 26.9%) to participants with at least some training (*n* = 397, 73.1%). Any training experience was more common for more advanced respondents: 54.9% of first-year respondents had no training, compared with 32.6% of second year, 16.5% of third year, 13.2% of fourth and fifth year, and 16.9% of sixth year and beyond respondents, $\chi^2(4, N = 543) = 75.47$, $p < .001$.

Second, we created four groups according to their level of training in regard to S–R issues of patients. In addition to a no training group, those with some training were categorized into three subgroups: 221 (40.7% of total sample) participants who discussed S–R issues with a clinical supervisor to some extent and/or read a book or books, 91 (16.8%) participants who attended a seminar or seminars and/or had one course, and 85 (15.7%) participants who discussed S–R issues with a clinical supervisor to a great extent and/or had taken several courses. Level of training experience was also associated with year in the program. More advanced respondents reported greater levels of training, $\chi^2(12, N = 543) = 85.92$, $p < .001$.

Participants' personal SRBP and training specific to S-R issues of patients

The correlations among the measures of participants' personal SRBP are shown in Table 2. The subscales tended to be robustly correlated.

Table 2. Correlations Between Measures of Graduate Students' Personal Spiritual and Religious Beliefs and Practices and Subscales

Graduate students' characteristics	1	2	3	4	5	6	7	8	9	10	11	12
1. Religious participation	—	.66**	.71**	.76**	.21**	.74**	.11*					
2. Religiousness		—	.52**	.69**	.18**	.70**	.05					
3. Spirituality			—	.61**	.12**	.64**	.15**					
4. Positive religious coping				—	.37**	.83**	.07					
5. Negative religious coping					—	.24**	.27**					
6. Religious well-being						—	.15**					
7. Existential well-being							—					
Subscales												
8. Salience/Relevance	.04	.06	.08	.15**	.04	.07	.09*	.77/.63	.75**	.59**	.67**	.43**
9. Affiliation/Community	.05	.02	.04	.12**	.04	.03	.07		.82/.72	.69**	.75**	.50**
10. Cause/Part of Problem	.07	.07	.07	.12**	.07	.06	.01			.79/.59	.76**	.67**
11. Support to Solve Problems	.05	.06	.07	.12**	.05	.05	.08				.86/.76	.49**
12. Disrespectful/Challenging	.14**	.10*	.10*	.17**	.06	.12**	.04					.88/.77

Note. For the subscales, Cronbach's alpha and Guttman's split-half reliabilities are displayed in the diagonal.

* p < .01.
** p <.001.

The average response to the measures of personal SRBP are shown in Table 3. For example, the average response to the Religious Participation scale indicated engaging in the activities, on average, between once a month and several times per month. We conducted *t* tests to compare the personal SRBP of respondents who had no training in regard to S–R issues of patients to the personal SRBP of those who had some training. Results indicated that the groups did not differ across the seven variables (*t* scores ranged from 0.04–2.05). The personal SRBP of respondents was also compared across the four training categories through one-way analyses of variance (ANOVAs). Table 3 displays the results (alpha was adjusted to .007 through Bonferroni statistical correction). Four of the seven participant SRBP variables were significantly associated with training, although the effect sizes were small. Tukey's honestly significant difference (HSD) post hoc analyses indicated that participants who had the most SRBP training endorsed higher levels of religious participation, spirituality, positive religious coping, and religious well-being.

Table 3. Relationship Between Participants' Personal Spiritual and Religious Beliefs and Practices (SRBP) and Training Specific to SRBP Issues

		Training specific to SRBP issues					
	All respondents	No training	Some supervision discussion and/or books	Seminars and/or one course	Great deal of supervision discussion and/or several courses		
Measure	*M* (*SD*)	*M* (*SD*)	*M* (*SD*)	*M* (*SD*)	*M* (*SD*)	F(3, 539)	η^2
Religious Participation	3.25 (1.69)	3.00 $(1.59)_a$	2.86 $(1.55)_a$	3.38 $(1.60)_b$	4.59 $(1.68)_c$	24.95*	.12
Spirituality	1.67 (0.72)	2.10 $(0.66)_a$	2.03 $(0.72)_a$	2.19 $(0.68)_a$	2.52 $(0.61)_b$	10.62*	.06
Religiousness	2.15 (0.70)	1.70 (0.72)	1.57 $(0.67)_a$	1.65 (0.71)	1.87 $(0.81)_b$	3.65	
Positive Religious Coping	2.07 (0.92)	2.06 $(0.92)_a$	1.89 $(0.88)_a$	2.08 $(0.87)_a$	2.56 $(0.91)_b$	11.47*	.06
Negative Religious Coping	1.29 (0.38)	1.29 (0.36)	1.28 (0.39)	1.30 (0.44)	1.33 (0.36)	0.43	
Religious Well-Being	3.49 (1.76)	3.40 $(1.75)_a$	3.15 $(1.74)_a$	3.63 (1.70)	4.35 $(1.57)_b$	10.52*	.06
Existential Well-Being	4.78 (0.75)	4.73 (0.88)	4.78 (0.71)	4.78 (0.65)	4.89 (0.71)	0.83	

Note. Subscripts denote significant mean differences (Tukey's honestly significant difference, p < .01).
* p < .007.

Participants' General Opinion About Asking About SRBP

The responses to the question whether a mental health professional should ask patients about their SRBP were as follows: "should always ask" (21.9%), "should almost always ask" (31.5%), "should sometimes ask" (42.5%), "should almost never ask" (2.9%), and "should never ask" (n = 6, 1.1%). Those with some training regarding S–R issues of patients compared with those with none were more likely to say that patients should be asked, $\chi^2(4, N = 543) = 35.66$, $p < .001$. Similar results were found when comparing the four training levels: 70.5% of those with the most training said that a clinician should always or almost always ask a patient about SRBP, compared with 35.6% of those with no training, $\chi^2(12, N = 543) = 55.99$, $p < .001$.

Item Subscale Analyses

Table 1 shows the percentage of respondents who indicated that a particular query was appropriate or very appropriate. There was good congruence between participant ratings of the appropriateness and the patient ratings of whether they would want a mental health professional to pose each query (Spearman's ρ = .84, p < .001). Also shown are the means and standard deviations for both individual queries and the subscales. Cronbach's alpha and Guttman's split-half reliability coefficients of the subscales as well as the correlations among them are shown in Table 2. All correlations were positive and statistically significant.

One-way repeated-measures ANOVA uncovered a statistically significant difference between participants' ratings of the appropriateness of the five subscales, $F(4, 537) = 553.87$, Wilks's $\lambda = .20$, $p < .001$, partial $\eta^2 = .81$. Bonferroni pairwise comparisons revealed significant differences between subscale ratings (all ps < .001). The Salience/Relevance subscale had a higher appropriateness rating than all other subscales. The Affiliation/Community and Support to Solve Problems subscales were not different in terms of appropriateness ratings, but both obtained higher appropriateness ratings than the Cause/Part of Problems and the Disrespectful/Challenging subscales. The Disrespectful/Challenging subscale obtained lower appropriateness rating than all of the other subscales.

Participant Characteristics and Appropriateness of S-R Queries Subscale Ratings

Participant demographics

Analyses were conducted to compare participants' demographic characteristics and subscale scores. Differences related to race–ethnicity were not examined because of the imbalance between Caucasian and all other participants.

Age was not significantly related to any subscale score (correlational coefficients ranged from −0.01 to −0.06). Male participants obtained significantly higher (i.e., more appropriate) mean scores than female participants on the Cause/Part of Problems subscale: male participants, $M = 2.98$, $SD = 0.62$; female participants, $M = 2.78$, $SD = 0.54$; $t(541) = 3.43$, $p < .01$, $\eta^2 = .02$; and on the Disrespectful/Challenging subscale, male participants, $M = 2.28$, $SD = 0.70$; female participants, $M = 2.03$, $SD = 0.55$; $t(170.06) = 3.73$, $p < .001$, $\eta^2 = .03$. Respondents who were married or living with a romantic partner ($M = 3.34$, $SD = 0.50$) obtained significantly higher scores on the Salience/Relevance subscale than those who were single, separated, divorced, or widowed ($M = 3.20$, $SD = 0.54$), $t(541) = -3.08$, $p < .01$, $\eta^2 = .02$. Although the effect sizes were small, gender and relationship status were treated as covariates in subsequent analyses.

Participants' personal SRBP

Table 2 shows the correlations between participants' SRBP and their endorsement of the appropriateness of S–R queries subscales. Positive Religious Coping was significantly correlated with ratings of appropriateness of all subscales. All but two measures of participants' SRBP were associated with the Disrespectful/Challenging subscale.

Participants' training specific to WR of patients

One-way between-groups multivariate analysis of covariance (MANCOVA) was conducted to compare level of training in the S–R issues of patients and appropriateness ratings of the five appropriateness of S–R queries subscales. There was a statistically significant difference between the four groups on the combined dependent variables, $F(15, 1466.26) = 2.05$, $p = .01$, Wilks's $\lambda = .94$, partial $\eta^2 = .02$. Considered separately, scores on the Salience/Relevance, $F(3, 535) = 5.57$, $p = .001$, partial $\eta^2 = .03$, and the Affiliation/Community, $F(3, 535) = 3.18$, $p = .02$, partial $\eta^2 = .02$, subscales were significantly different. Bonferroni pairwise comparisons revealed that participants with no training gave lower ratings of appropriateness than the other three groups with at least

some training on both the Salience/Relevance subscale (*M* = 3.12 vs. means ranging from 3.31–3.34; *p*s < .02) and the Affiliation/Community subscale (*M* = 2.97 vs. means ranging from 3.12–3.14; *p*s < .05).

Regression analyses

Post hoc, we evaluated the relative contribution of training in the S–R issues of patients and personal SRBP on respondents' ratings of the appropriateness of the queries. Using stepwise regression analyses, we first entered the demographic characteristics (gender and marital status) found to be associated with the ratings. Training and personal SRBP were entered at Step 2. Regarding personal SRBP, only Positive Religious Coping was used, as it was the most strongly correlated with all of the appropriateness ratings. The dichotomous categorization of training (no training in S–R issues of patients vs. at least some training) was dummy coded. The final equations are summarized in Table 4. Positive coping was a significant contributor to all of the regression equations, and training contributed to three of the equations.

Table 4. Summary of Regression Analyses

	Predictor variables	Predictor variables	Predictor variables	Predictor variables		
Dependent variable	Relationship status	Gender	Training	Positive religious coping	F	Adj. R^2
		Standardized coefficient (β)	Standardized coefficient (β)			
Salience/Relevance	.14**	.03	.17***	.15***	9.95***	.07
Affiliation/Community	.10*	.02	.13**	.12**	5.62***	.04
Cause/Part of Problems	.07	.14**	.06	.12**	6.12***	.04
Support to Solve Problems	.10*	.01	.08*	.12**	4.35**	.03
Disrespectful/Challenging	02	-.18**	.03	.15***	8.55***	.06

Note. Gender: 0 = male, 1 = female. Relationship status: 0 = single/divorced/separated/widowed, 1 = married or living with romantic partner. Training: 0 = no training, 1 = some training.
* p < .05.
** p < .01.
*** p < .001.

Discussion

This study examined the associations between clinical and counseling psychology graduate students' characteristics, their personal SRBP, and their training experiences specific to the S–R issues of patients, as well as the association between these factors and their opinion regarding the appropriateness of S–R-related queries that they might direct at patients.

Almost all respondents endorsed the idea that patients should be asked about S–R issues at least sometimes. These results are consistent with surveys that find that practicing psychologists recognize the importance of spirituality and religion to the mental health and care of their patients (e.g., Delaney et al., 2007). Almost three of four respondents reported at least some training in regard to S–R issues of patients. Training was related to year in the program, as more advanced students were most likely to report training. However, just over 30% of respondents indicated that they had received training that was part of a course or seminar. As reported by others (Brawer et al., 2002; Schafer et al., 2011), it appears that most students are not receiving systematic (i.e., curriculum based) training to enhance competency in S–R issues but rather that it is most often accomplished through discussions with supervisors.

It is interesting that the percentage of students indicating some training in regard to S–R issues of patients did not significantly differ among students in their third year and beyond. This finding could be interpreted in several ways. This could be a cohort effect, where training is becoming more commonplace in recent years. Another possible explanation is that if students do not receive training within the first 3 years, they develop the perception that S–R issues are not relevant. More specifically, because the vast majority of respondents endorsed the idea that patients should be asked about S–R issues at least sometimes, it might be that students develop over time the perception that these issues are not relevant within their training program.

The results suggest that respondents' personal interest in S–R issues was related to whether they received training in the S–R issues of patients. Higher religious well-being, higher self-rated spirituality, and greater endorsement of positive religious coping were related to training, but the effect sizes were relatively small. Training in the S–R issues of patients was more robustly related to level of participation in religious events. We speculate that these findings may be related to a self-selection phenomenon. For example, more religiously oriented students might be more likely to attend faith-affiliated programs, which in turn are probably more likely to offer training in S–R issues of patients. We consider this problematic. Personal preferences should not be a determinant of whether students are trained to competence in a culturally relevant issue (APA, 2010). It would be more appropriate that all students receive mandated training in understanding the S–R issues with which patients might present.

Students' Opinions Regarding Asking Patients About Spirituality and Religion

Respondents rated the appropriateness of various queries that they might address to patients. The queries were categorized into subscales that corresponded to Pargament's (2007) recommendations that all patients be asked about the salience of S–R issues. Those who indicated salience should then be asked about any S–R affiliations, whether S–R issues are related to the problem, and whether S–R-related resources might be helpful in addressing the problem. These queries were categorized a priori as generally appropriate. We also presented respondents with queries that were intended to be perceived as disrespectful and challenging, and these queries were categorized a priori as generally inappropriate. As predicted, respondents rated queries about the potential relevance of spirituality and religion as almost always appropriate, whereas disrespectful and challenging queries received the lowest ratings of appropriateness.

The results nonetheless suggest the need for explicit training about addressing S–R issues with patients. First, most respondents, including over 90% of those with no training in this regard, said that patients should at least sometimes be asked about S–R issues. However, knowing how to ask seems to be related to training. That is, participants with at least some training in the S–R issues of patients were more likely than those with no training to endorse the appropriateness of queries related to salience and affiliation. Second, the results suggest that respondents believed it more appropriate to ask patients whether their spirituality and religion might be a potential resource than whether S–R issues might be part of the problem. For some patients S–R issues might be problematic, such as problems with compulsive praying or religious delusions (e.g., Huppert, Siev, & Kushner, 2007). Asking patients about potential problems is important, and these results suggest students might benefit from training that emphasizes this.

Third, training might be important to help students recognize that language matters greatly. All of the potential queries in our survey used the possessive pronoun "your," such as "your religion or spirituality." It would be better to start queries without implying that the patient actually has such beliefs or practices (cf. Saunders, Miller, & Bright, 2010). Likewise, the finding that many respondents rated appropriate the query, "Do you wonder if your beliefs are wrong?" might cause some concern. Training about the use of language when asking about sensitive issues such as SRBP, as well as the potential need to clarify misunderstanding, might be beneficial.

Determinants of Appropriateness Ratings

Regression analyses indicated that both personal SRBP and training were related to attitudes toward S–R queries directed at patients, although the effect sizes were small. Positive religious coping was associated with appropriateness ratings of all the subscales, whereas training (dichotomously coded as *none* or *some*) was related to three of the subscales. These findings underscore the need to emphasize awareness that one's own attitudes and biases have the potential to influence professional behavior (Daniel, Roysircar, Abeles, & Boyd, 2004).

Study Limitations

Features of the study limit the interpretation and external validity of the results. These include limitations usually associated with convenience samples and correlational methodology based on survey data. Another limitation of these results concerns self-selection of participants, which likely happened at two levels. Training directors were asked to forward the invitation e-mail to students in their program, but we cannot determine to what extent they complied with the request. It also cannot be determined which or what percentage of students completed the survey. It seems likely that self-selection at both points would be related to characteristics that might influence the results. Training directors and students who are most interested in S–R issues in mental health may have been most likely to respond and may also have been more likely to affirm the appropriateness of S–R-related queries. We attempted to mitigate self-selection by the use of an incentive to complete the survey, but we cannot ascertain the effects of our attempt.

The survey was developed for the study. This was necessary, as a study like this has never before been conducted. The subscales were based on the recommendations of one of the leading researchers in the area of spirituality and mental health, and they had sufficient internal consistency in this study. Nonetheless, the validity of these items and of the methodology in general (i.e., asking students to rate the appropriateness of specific queries) is open to question.

The study methodology compels caution in drawing conclusions. For example, we asked students to indicate whether they had taken coursework with regard to religious and spiritual issues of patients. The survey did not allow participants to make a distinction between enrollment in a course that integrated S–R issues into a larger topic, such as a multicultural psychology course, and enrollment in a course exclusively devoted to S–R issues of patients. Similarly, respondents could not indicate whether the course was required or elective. Students who elect to take a course about S–R issues likely have a greater inherent interest in the issue as compared to students who are required to address S–R issues in their coursework. More research is needed to determine the variety of S–R-related coursework offered in programs and the impact of such coursework.

Contextual issues are also important to consider. Context alters the possible meaning and thus the potential appropriateness of the various queries. For example, it would be appropriate to ask a patient about "your religion" if the patient has previously indicated that religion is an important aspect of her life, whereas it would be inappropriate to use the phrase to begin the focus on the topic (e.g., "How important is your religion to you?"). Future research evaluating contextual issues more extensively would be helpful.

This study also did not obtain information about the influence of faith at the educational institution, and future research into this should at least gather information if a respondent is attending a faith-affiliated or faith-based program. Future research in this domain may also benefit from using clinical vignettes, rather than isolated queries, to determine the appropriateness of statements regarding clients' SRBP. Qualitative investigations into students' perspectives on their training may reveal rich and new perspectives on this topic.

Finally, we note that many of the effect sizes were small. Caution must be taken in drawing conclusions from the study until future studies either support or refute them.

Implications and Future Directions

Principle E of the APA Ethics Code asserts that clinical psychologists should be "aware of and respect cultural and individual differences, including those based on … religion" (APA, 2010, p. 4). Consistent with this, these results and other studies (e.g., Brawer et al., 2002; Crook-Lyon et al., 2012) suggest that both students and practicing professionals recognize that S–R issues should be formally incorporated into clinical psychology training. More studies are needed to determine the most appropriate training to be used. Establishing a definition of competence with regard to S–R issues of patients (Kaslow, 2004), followed by models and methods for integrating S–R issues into coursework, training, and perhaps research (e.g., Aten & Hernandez, 2004), would be a good first step. Development of methods to evaluate this competency is also needed. A starting point might be the various questionnaires and interviews that are currently available for evaluating a person's spiritual and religious beliefs and practices (such as the Brief RCOPE or the Spiritual Well-Being Scale, both used in this study).

Components of S–R training should emphasize the ethical principles of integrity and respect (cf. Plante, 2007). Practicing with integrity means recognizing one's competence and not misrepresenting one's expertise. Respect means avoiding trivialization of another's SRBP. For example, respect entails recognizing the potentially immense variability of beliefs, attitudes, and behaviors that occur within faith systems. We have advocated training students to engage in "spiritually conscious care" (Saunders et al., 2010). In the absence of proper training, students might continue to feel compelled to seek such information on their own or, perhaps worse, to use their personal experiences as a guide.

References

American Psychological Association. (2008a). *Accredited programs in clinical psychology*. Retrieved from http://0-www.apa.org.libus.csd.mu.edu/Ed./accreditation/programs/clinical.aspx

American Psychological Association. (2008b). *Accredited programs in counseling psychology*. Retrieved from www.apa.org/Ed./accreditation/programs/accred-counseling.aspx

American Psychological Association. (2008c). *Commission on accreditation 2008 annual report online summary data: Doctoral programs*. Washington, DC. Retrieved from www.apa.org/Ed./accreditation/about/research/2008-doctoral-summary.pdf

American Psychological Association. (2010). *Ethical principles of psychologists and code of conduct*. Washington, DC: Author. Retrieved from www.apa.org/ethics/code/principles.pdf

Aten, J., & Hernandez, H. (2004). Addressing religion in clinical supervision: A model. *Psychotherapy: Theory, Research, Practice, Training*, *41*, 152–160. doi:10.1037/0033-3204.41.2.152

Brawer, P. A., Handal, P. J., Fabricatore, A. N., Roberts, R., & Wajda-Johnston, V. A. (2002). Training and education in religion/spirituality within APA-accredited clinical psychology programs. *Professional Psychology: Research and Practice*, *33*, 203–206. doi:10.1037/0735-7028.33.2.203

Bufford, R. K., Paloutzian, R. F., & Ellison, C. A. (1991). Norms for the spiritual well-being scale. *Journal of Psychology and Theology*, *19*, 56–70.

Crook-Lyon, R. E., O'Grady, K. A., Smith, T. B., Jensen, D. R., Golightly, T., & Potkar, K. A. (2012). Addressing religious and spiritual diversity in graduate training and multicultural education for professional psychologists. ***Psychology of Religion and Spirituality***, *4*, 169–181. doi:10.1037/a0026403

Daniel, J. H., Roysircar, G., Abeles, N., & Boyd, C. (2004). Individual and cultural diversity competency: Focus on the therapist. *Journal of Clinical Psychology*, *60*, 755–770. doi:10.1002/jclp.20014

Delaney, H. D., Miller, W. R., & Bisonó, A. M. (2007). Religiosity and spirituality among psychologists: A survey of clinician members of the American Psychological Association. *Professional Psychology: Research and Practice*, *38*, 538–546. doi:10.1037/0735-7028.38.5.538

Ellison, C. A. (1983). Spiritual well-being: Conceptualization and measurement. *Journal of Psychology and Theology*, *11*, 330–340.

Frazier, R. E., & Hansen, N. D. (2009). Religious/spiritual psychotherapy behaviors: Do we do what we believe to be important?*Professional Psychology: Research and Practice*, *40*, 81–87. doi:10.1037/a0011671

Gallup Organization. (2009). *Religion*. Retrieved from www.gallup.com/poll/1690/Religion.aspx

Giaquinto, S., Cipolla, F., Giachetti, I., & Onorati, D. (2011). Italian validation of the Brief Rcope scale for religious coping. *Journal of Medicine and the Person*, *9*, 70–75. doi:10.1007/s12682-011-0087-5

Hathaway, W. L., Scott, S. Y., & Garver, S. A. (2004). Assessing religious/spiritual functioning: A neglected domain in clinical practice?*Professional Psychology: Research and Practice*, *35*, 97–104. doi:10.1037/0735-7028.35.1.97

Huppert, J. D., Siev, J., & Kushner, E. S. (2007). When religion and obsessive-compulsive disorder collide: Treating scrupulosity in ultra-orthodox Jews. *Journal of Clinical Psychology*, *63*, 925–941. doi:10.1002/jclp.20404

Jackson, L. C. (1999). Ethnocultural resistance to multicultural training: Students and faculty. *Cultural Diversity and Ethnic Minority Psychology*, *5*, 27–36. doi:10.1037/1099-9809.5.1.27

Kaslow, N. J. (2004). Competencies in professional psychology. *American Psychologist*, *59*, 774–781. doi:10.1037/0003-066X.59.8.774

Koenig, H. G. (2009). Research on religion, spirituality, and mental health: A review. Canadian Journal of Psychiatry. *Revue canadienne de psychiatrie*, *54*, 283–291.

Levin, J. (2003). Private religious practices. In *Multidimensional Measurement of Religiousness/Spirituality for Use in Health Research* (pp. 39–42). Kalamazoo, MI: Fetzer Institute. Retrieved from www.fetzer.org/images/stories/pdf/MultidimensionalBooklet.pdf

Lukoff, D., & Lu, F. G. (1999). Cultural competence includes religious and spiritual issues in clinical practice. *Psychiatric Annals*, *29*, 469–472.

Martinez, J. S., Smith, T. B., & Barlow, S. H. (2007). Spiritual interventions in psychotherapy: Evaluations by highly religious clients. *Journal of Clinical Psychology*, *63*, 943–960. doi:10.1002/jclp.20399

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

Pargament, K., Feuille, M., & Burdzy, D. (2011). The Brief RCOPE: Current psychometric status of a short measure of religious coping. *Religions*, *2*, 51–76. doi:10.3390/rel2010051

Plante, T. G. (2007). Integrating spirituality and psychotherapy: Ethical issues and principles to consider. *Journal of Clinical Psychology*, *63*, 891–902. doi:10.1002/jclp.20383

Reynolds, A. L., & Rivera, L. M. (2012). The relationship between personal characteristics, multicultural attitudes, and self-reported multicultural competence of graduate students. *Training and Education in Professional Psychology*, *6*, 167–173. doi:10.1037/a0029774

Russell, S. R., & Yarhouse, M. A. (2006). Training in religious/spirituality within APA-accredited psychology predoctoral internships. *Professional Psychology: Research and Practice*, *37*, 430–436. doi:10.1037/0735-7028.37.4.430

Saunders, S. M., Miller, M. L., & Bright, M. M. (2010). Spiritually conscious psychological care. *Professional Psychology: Research and Practice*, *41*, 355–362. doi:10.1037/a0020953

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. doi:10.1007/s10943-009-9272-8