Brigham Young University
BYU ScholarsArchive

Theses and Dissertations

2020-07-27

An In-Depth Exploration of Clinical Patterns Within Spiritually Integrated Therapy

Russell Neilend Jackson
Brigham Young University

Follow this and additional works at: https://scholarsarchive.byu.edu/etd

Part of the Counseling Commons

BYU ScholarsArchive Citation

Jackson, Russell Neilend, "An In-Depth Exploration of Clinical Patterns Within Spiritually Integrated Therapy" (2020). *Theses and Dissertations*. 8605.
https://scholarsarchive.byu.edu/etd/8605

This Dissertation is brought to you for free and open access by BYU ScholarsArchive. It has been accepted for inclusion in Theses and Dissertations by an authorized administrator of BYU ScholarsArchive. For more information, please contact scholarsarchive@byu.edu, ellen_amatangelo@byu.edu.

An In-Depth Exploration of Clinical Patterns Within Spiritually Integrated Therapy

Russell Neilend Jackson

A dissertation submitted to the faculty of
Brigham Young University
in partial fulfillment of the requirements for the degree of

Doctor of Philosophy

Lane Fischer, Chair
Aaron Jackson
Kristina Hansen
Vaughn Worthen

Department of Counseling Psychology and Special Education

Brigham Young University

Copyright © 2020 Russell Neilend Jackson

All Rights Reserved

ABSTRACT

An In-Depth Exploration of Clinical Patterns Within Spiritually Integrated Therapy

Russell Neilend Jackson
Department of Counseling Psychology and Special Education, BYU
Doctor of Philosophy

The last 3 decades have seen a dramatic increase in the creation and effective use of spiritually integrated therapy (SIT) for a wide variety of client populations and clinical issues. The outcome research on SIT has increased and improved dramatically, yet process research on SIT has lagged somewhat. While valuable, prior process-oriented studies on SIT have used retrospective survey methods and asked about generalized usage rates of predetermined spiritual interventions. Rather than relying on retrospective reports of SIT with clients, there is great value and likely greater accuracy in examining session-by-session usage of SIT with clients and identifying correlational patterns between clinical issues and spiritual interventions. The current study used a descriptive, practice-based evidence approach and analyzed session-by-session process data from a private practice explicitly marketed as offering SIT. After every therapy session, eight therapists at this site completed an in-depth process measure, the Clinically Adaptive Therapist Session Checklist, and reported which clinical issues they discussed and which spiritual interventions they used in session. Findings revealed that therapists discussed self-esteem, anxiety, depression, and religious/spiritual concerns in over half of their sessions. Therapists also endorsed affirming clients' divine worth, encouraged trusting God, encouraged clients to listen to their heart, and encouraged accepting God's love in over half of their sessions. The strongest positive correlations between spiritual interventions and clinical issues were between challenging shame and challenging fear, and emotional orientation (r = 0.664 and 0.648, respectively). The clinical patterns found in this analysis illustrate one way of incorporating spirituality into clinical work. This study highlights the importance of routine outcome/process monitoring systems to help illuminate the process of SIT and contribute to deliberate practice efforts in the field. This study also stimulated discussion on the distinction between SIT and being a spiritually centered therapist.

Keywords: spiritually integrated therapy, practice-based evidence, process-oriented research, routine outcome monitoring

ACKNOWLEDGMENTS

Credit for the completion of this project goes to many people, each of whom have made this project possible. First, to my indescribably patient wife, Meg. Your character is godlier than anyone I have ever met. I cannot think how this would have been possible without you next to me. You make me see more in myself than I ever could.

To my five lovely, rambunctious children, Liam, Logan, Mason, Isla, and Maddox. Your innocence, compassion, and entertaining craziness has lifted and carried me through in ways that you will hopefully understand as you have children of your own. This has all been for you. In many ways, the experience of being a husband and father has been my own 12-year spiritual therapy.

To my chair, advisor, carpool mate, and friend, Dr. Lane Fischer. I tearfully reflect on how much you have done for my family for the past five years. To the rest of my committee, Drs. Aaron Jackson, Kristina Hansen, and Vaughn Worthen. I am grateful for all I have learned from you as committee members, supervisors, professors, and trusted friends.

To God. Your angels have lived up to your promise. I have felt and seen their hands bear me up. While I do not understand everything that made all this possible, I believe that your grace was a key force.

Finally, to the individually and collectively vital people who have been there to help, lift, and encourage me, and lovingly kick me forward when I did not think I had anything else to give. There is not space here to name each of you. However, I hope you know who you are and can feel or see my deepest and heartfelt appreciation. Seriously, thank you.

TABLE OF CONTENTS

TITLE PAGE i

ABSTRACT ii

ACKNOWLEDGMENTS iii

TABLE OF CONTENTS iv

LIST OF TABLES vii

LIST OF FIGURES viii

DESCRIPTION OF DISSERTATION STRUCTURE AND CONTENT ix

Introduction 1

Interface Between Religion/Spirituality and Psychology 1

Research on SIT 3

Operational Considerations 3

Outcome Research on SIT 8

Process Research on SIT 9

Research Design on SIT 11

Purpose of the Current Study 14

Method 15

Practice-Based Evidence Approach 15

Methodology—Topographic Analysis 15

Participants 16

Data Collection and Measure 18

Data Analysis 20

Hypotheses 21

Results 21
Most and Least Frequently Used Spiritual Interventions 21
Most and Least Frequently Discussed Clinical Topics 22
Topographical Analysis 23
Discussion 26
Specific Findings 26
What is Spiritually Integrated Therapy? 30
CA-TSC as a Process Illumination and Deliberate Practice Tool 33
Implications for Practitioners 35
Limitations 36
Future Directions 38
Conclusion 41
References 42
Tables 55
Figures 60
APPENDIX A: Review of the Literature 64
Interface Between Religion/Spirituality and Psychology 64
Current Use of the Terms *Religion* and *Spirituality* 64
Religion/Spirituality in the United States 65
Period of Separation 66
Period of Acceptance and Integration 67
Religion and Spirituality in Psychotherapy 68
Operational Considerations 69

Research on SIT 73

Outcome Research 73

Process Research on SIT 75

Research Design 79

References 83

APPENDIX B: Consent and Approval Letter from Canyon Counseling Center 94

APPENDIX C: Bracketing 95

DISSERTATION REFERENCES 98

LIST OF TABLES

Table 1 *Total Frequency of Spiritual Interventions Utilized* 55

Table 2 *Total Frequency of Clinical Issues Discussed* 57

LIST OF FIGURES

Figure 1. *Example Correlation Matrix*..........60

Figure 2. *Complete Topographical Analysis Chart*..........61

DESCRIPTION OF DISSERTATION STRUCTURE AND CONTENT

This dissertation, *An In-Depth Exploration of Patterns Within Spiritually Integrated Therapy*, has been written in a journal-ready format. This format is a combination of traditional dissertation requirements and requirements of journal publications. The journal to which this work is to be submitted has not yet been decided.

The preliminary pages of this document are in line with university submission requirements. The main body of the document is in line with academic journal submission requirements (e.g., length, style). This journal-ready format contains three reference lists. The first includes the references used in the journal-ready portion of the document. The second includes the references used in the review of literature. The third includes all references cited outside of the article and the review of literature.

The review of literature is included herein as Appendix A. A signed letter of consent from the study site is included at Appendix B. A statement on bracketing in research is included as Appendix C.

Introduction

Spiritually integrated therapies (SITs) have becoming more accepted and widespread in clinical practice as psychology has become more attuned to the role of religion and spirituality in many peoples' lives. This increased attunement has come partially from a greater appreciation for a multicultural understanding of therapy clients. During the past three decades, SIT has been used to treat a variety of client populations, presenting with a variety of clinical concerns (Jackson et al., 2019).

Interface Between Religion/Spirituality and Psychology

Previous research has indicated that there is no mutually agreed upon definition of either religion or spirituality (Scott, 1997; Zinnbauer et al., 1997). This lack of agreement has been noted as problematic by several researchers (e.g., Pargament, Exline, et al., 2013; Zinnbauer et al., 1997). With respect to ongoing debate about this definitional issue, the current study adhered to definitions provided by Pargament, Exline, et al. (2013). These authors defined spirituality as a "search for the sacred," and religion as the "search for significance that occurs within the context of established institutions . . . designed to facilitate spirituality" (p. 15). They claimed that religion is often directed toward the sacred and that religion may also serve other purposes for some individuals (e.g., social interaction) which are not in pursuit of the sacred. They concluded that while religion does not necessarily implicate the sacred, and vice versa, religion and spirituality are indistinguishable when religion is directed at the sacred. This conditional overlap was of interest in the current study, such that in SIT, the spiritual or sacred—not simply the social, psychological, or physical—is used to facilitate healing. Hence, the following terms were used during the current study to connote this focus: "spirituality," or "religion/spirituality (R/S)."

Recent reports have suggested that most American adults identify as having some religious/spiritual beliefs. In the 2014 U.S. Religious Landscape Survey, over 75% of adults reported a “fairly certain” or “absolutely certain” belief in God, and that religion was at least somewhat important in their lives (Pew Research Center, 2015). Further, between 50% and 59% of adults said they have felt a sense of spiritual peace and well-being and a deep sense of wonder about the universe at least once a week. Sperry (2012) emphasized R/S’s significant influence in many peoples’ lives, and Gallup (1999) found that religious/spiritual beliefs were often more important than other aspects of identity.

The current understanding of the significance of R/S’s role in peoples’ lives has countered what the field of psychology seemed to think previously. Through most of the 20th century, there was an apparent schism between psychology and R/S (Richards & Bergin, 2005) as prominent, outspoken opponents of religion such as Sigmund Freud, Albert Ellis, and others claimed R/S had no place in behavioral science. They viewed religion as unhelpful and irrational, and believed in many cases that it contributed to the development and maintenance of mental health difficulties (Ellis, 1980; Strachey, 1961). This attitude was challenged in the latter part of the 20th century by authors who argued that integrating spirituality into behavioral science could lead to a more comprehensive understanding of the universe and human behavior (Bergin, 1980; Campbell, 1975; Jones, 1994).

Researchers have since found a generally positive association between R/S and physical and psychological health (e.g., Koenig et al., 2012; Levin, 2010; Sanders, Allen, et al., 2015). Pargament, Exline, et al. (2013) posited that R/S can often provide meaning and significance to help people cope with adversity. Richards and Bergin (2014) suggested that R/S can positively impact therapy outcomes. Many therapy clients have reported a desire to integrate their beliefs

into therapy (e.g., Post & Wade, 2009; Stanley et al., 2011), and many therapists have cited the importance of being sensitive to clients' R/S (e.g., Furman et al., 2004; Post & Wade, 2009).

Consequently, therapists and researchers have described and implemented what is known by many as spiritually integrated therapy (SIT; Pargament, 2007; Pargament, Mahoney, et al., 2013). SIT refers to a general approach which is "sensitive to the spiritual dimension" (Pargament, Mahoney, et al., 2013, p. 227).

Research on SIT

Operational Considerations

The extant literature illustrates that the field has not yet established a universally agreed upon name for SIT. This may be related to the definitional issues regarding R/S. To date, there have been many different labels for therapy approaches that have included explicitly religious/spiritual components: faith-adapted (Anderson et al., 2015), faith-supportive (Scott, 2003), mind-body-spirit therapy (Targ & Levine, 2002), pastoral (Houck & Moss, 1977), religious-cultural (Razali et al., 2002), spiritual (Tadwalker et al., 2014), spiritual or religion-accommodative (Worthington et al., 2013), spiritually informed (Nohr, 2000), spiritually modified (Hodge, 2006), spiritually oriented (Sperry & Shafranske, 2005), spiritually sensitive (Bowland et al., 2013), and theistic spiritual (Richards & Bergin, 2005) psychotherapy, among others. Others have referred to a therapy approach using the name of an identified religious/spiritual tradition, such as Taoist cognitive (Zhang et al., 2002), Islamically integrated (Al-Karam, 2018), and Christian (Sutton et al., 2018) psychotherapy.

Some studies in the literature have referred not to an overall spiritual approach to therapy or counseling, but rather to specific therapeutic interventions designed to encourage people toward spirituality. For example, some of these interventions have been referred to as religious

based (Stewart et al., 2006), religiously tailored (Wade et al., 2007), spiritually based (Sheridan, 2009), spiritually-derived (Sheridan, 2004), and spiritually integrated (Harris et al., 2011),

Similarly, researchers have designed, executed, and studied many approaches that have integrated explicit religious/spiritual principles or perspectives. In some cases, researchers have evaluated traditional therapy approaches that have been modified to include religious/spiritual language, references, homework, etc. For example, Nohr (2000) experimentally tested the differences between a workshop-style standard cognitive-behavioral treatment (CBT) and spiritually informed CBT (SCBT). The participants, students at a religiously affiliated university, were measured on several outcome variables, including general and spiritual well-being and psychological distress. The SCBT group "was guided by a cognitive-behaviorally-based manual compiled by [the author] and was identical to the CBT condition, except that several suggestions and illustrations to incorporate spirituality were offered" (p. 165). Razali et al. (2002) conducted an experimental study examining the effect of a religiously modified cognitive therapy for Malay patients diagnosed with generalized anxiety disorder, half of whom identified as Muslim. The treatment condition was labeled as religious-cultural psychotherapy (RCBT). As opposed to the control group, which received standard cognitive therapy, the RCBT group was run "similar to the cognitive model of Beck and colleagues" (Razali et al., 2002, p. 132). The researchers explained that faulty and distorted automatic thoughts, cognitive schemata, and psychoeducation and coping mechanisms related to anxiety were reframed and addressed from a Muslim perspective to help patients.

Other researchers have studied SIT which has focused on the religious/spiritual components, rather than a standard treatment with a religious/spiritual appendage. For example, Oman et al. (2007) examined the differential effects of passage meditation (PM)—participants

practiced sitting and meditating on a specific passage of religious text or a quote from a spiritual figure—and mindfulness-based stress reduction—participants focused on being aware of the present moment and meditating specifically on their breath. The PM intervention was described as an explicitly spiritually based practice and was not adapted from a cognitive-behavioral, interpersonal, rational-emotive, or other traditional psychotherapy approach.

Still others have investigated the effectiveness of spiritual practices per se and discussed the importance of exploring the health and wellness of individuals who engage these practices. Schiff and Moore (2006) published a pilot study on the effectiveness of sweat lodge ceremonies, a sacred practice for many North American Aboriginal groups. Tripathi and Bano (2014) explored the benefits of yogic practices, an exercise that originated in ancient India and is viewed by many as a holistic (including spiritual) health aid. Vasiliauskas and McMinn (2013) conducted a study that examined the effects of personal prayer for individuals who were working on interpersonal forgiveness.

In each of these aforementioned examples, the labels associated with therapy approaches in general or interventions in specific have suggested that the primary focus was the therapeutic approach itself—the therapeutic orientation, the specific intervention being employed, the unique combination of interventions in a model of therapy—and less so on the spirituality of the individuals who participated in the therapeutic interaction.

In another arena, some researchers and theorists have argued less for labeling a therapy approach or intervention as spiritual, and more for considering the perspective, input, and intention of the individuals engaged in a therapeutic exchange. For example, Gleave (2012) argued against the creation and promotion of an all-encompassing "gospel-centered therapy" (p. 1). Speaking to an audience of members of The Church of Jesus Christ of Latter-day Saints,

Gleave posited that labeling a therapy approach as spiritual per se would fundamentally undermine an important Latter-day Saint principle. He worried that such labels would overshadow and dismiss the notion that physical and spiritual progress are unique, nuanced, contextual, and cannot be gained by adhering to a prescribed, preset list of interventions. This argument was congruent with Stiles' (2013) position that

> the pervasiveness of human responsiveness implies that clients in the same experimental condition . . . each receives a different individually tailored treatment. Such variability impairs any study's conclusions because the treatment names, such as *psychoanalysis* or *cognitive—behavioral therapy* (CBT) or *treatment as usual*, have no stable meaning. Named treatments vary not just from study to study, but from therapist to therapist, from client to client, from session to session, and from minute to minute. (Stiles, 2013, p. 34)

Rather than focusing on labeling a treatment as spiritual, Gleave (2012) argued for the development of gospel-centered therapists—or spiritually centered therapists, for the purposes of the current study. Gleave asserted that an intervention or therapy approach is not inherently spiritual, but that the people engaged in a therapeutic interaction can be spiritually centered. He stated:

> I suggest it is the more prudent course to become very well grounded in both [spirituality] and our professions and then to use our best informed judgment and our agency to create a relationship and a synergistic interaction with our clients that they can use in their own way—expressing their own judgment and agency to meet the unique challenges and circumstances of their own lives. I argue that this is a far nobler endeavor than giving clients "correct" answers to specific questions. (Gleave, 2012, p. 8)

In a similar yet distinct vein, some researchers have asserted that spiritual components exist in phenomena which may not be universally perceived as spiritual. For instance, Fischer (2019) discussed the spiritual ramifications of guilt and shame with a group of counselors and therapists who were members of the Church of Jesus Christ of Latter-day Saints. He argued that guilt may be a healthy part of a spiritually inherited internal bearing system referred to by Latter-day Saints as the Light of Christ. From this perspective, Fischer asserted, guilt serves as a negative affective signal which is felt to "disconfirm the appropriateness of behavior" and "lead to correction or repair in the relationship with God and others." On the other hand, Fischer asserted that shame "is a corruption of the Light of Christ that is painful, yet does not lead to correction or repair." On the surface, there may be room for lively debate on the spiritual roots of guilt and shame, yet Fischer's claim has provided evidence that some researchers and practitioners maintain spiritual explanations and definitions of these concepts. Other examples of these implicitly spiritual interventions have been studied, such as therapists encouraging "listening to the heart" and encouraging forgiveness (Sanders, Richards, et al., 2015, p. 184). Fischer's (2019) argument suggested that whether a therapeutic intervention is spiritual may depend at least partially on the perspective of the practitioner. Thus, spiritually centered therapists, according to their spiritual perspective of a clinical situation, may have used an intervention they read as spiritual, regardless of whether the intervention fits within a preset model of SIT. Extrapolating from this past literature, we may assume that the client's perspective may have an important role in discerning whether a given intervention, approach, or moment is spiritually centered or integrated.

Outcome Research on SIT

Hundreds of empirical studies from the last several decades have suggested that SIT, in all its operational varieties, can be used to effectively treat a wide variety of clinical issues (Jackson et al., 2019). Some examples have included eating disorders (Tonkin, 2005), depression (Azhar & Varma, 1995), anxiety (Azhar et al., 1994), and post-traumatic stress disorder and abuse recovery (Allen & Wozniak, 2011), among others. These approaches have been effective with many different populations, including clients of varying religious and spiritual traditions, sexual orientations, ages, and ethnic and national backgrounds (Jackson et al., 2019). Further, 11 reviews and meta-analyses on SIT research have concluded that SIT may be at least as effective as traditional psychotherapy approaches, if not more so (e.g., Anderson et al., 2015; Cornish & Wade, 2010; Hook et al., 2010; Jackson et al., 2019; Worthington et al., 1996). These reviews and meta-analyses have corroborated the idea that sensitivity to and clinically indicated utilization of spirituality can produce positive change in therapy (Miller, 1999).

These positive findings have not suggested, however, that SIT has been wholly more effective than traditional therapy approaches. As Wampold (2001, 2019) has concluded, "despite numerous clinical trials comparing psychotherapies intended to be therapeutic . . . it appears that all of the approaches are about equally effective" (2019, p. 123). Perhaps, as Wampold (2019) has suggested, the success of SIT depends primarily on (a) the clinical indication of such an approach and (b) the strength of the therapeutic alliance. This conclusion has led to research questions of not just the science, but the art of therapy. As is related to the current study, the SIT literature base may benefit from a deeper study of what specifically constitutes SIT.

Process Research on SIT

Process research on SIT potentially holds the answers to questions about the art of therapy. In addition to asking whether SIT can be clinically or statistically effective, it is equally important to address what effective SIT looks like in routine practice.

To date, approximately 40 published studies have explicitly examined SIT processes. Jackson et al. (2019), in a comprehensive review of SIT literature, concluded that the process research conducted on SIT can be organized into four primary categories: (a) rates of SIT generally; (b) usage rates of specific spiritual interventions; (c) usage rates of spiritual interventions among religious/spiritual practitioners; and (d) usage rates of spiritual interventions among non-religious/non-spiritual practitioners. The extant process-oriented studies have suggested a wide variety of usage rates, depending on several factors including the specific healthcare setting in which a practitioner works, the personal religious/spiritual identity of the practitioner, and the spiritual interventions being investigated in a given study. From these studies on SIT process, many practitioners have endorsed the usefulness of SIT and utilize it in their work, especially when working with R/S clients.

This preliminary work has established SIT's clinical utility. However, most of these studies have relied on retrospective reports of practitioners to gather general usage rates of SIT approaches or specific interventions. Researchers have often asked practitioners if they have ever used a specific intervention or requested responses in Likert-style statements about general spiritual intervention frequency. For example, Kvarfordt and Sheridan (2007) analyzed survey responses from 283 practitioners who worked with children or adolescents on usage rates of 28 religious/spiritual interventions. Respondents reported usage rates on a 4-item Likert-type scale of "never" to "often used." This kind of data has been useful in understanding practitioners'

frequency and types of SIT used in working with clients. What these studies have not been able to determine is whether those self-reported recollections are accurate. We have also not gained much insight into the nuanced practice of using SIT with clients. The SIT process literature has historically lacked in-depth, session-by-session information regarding the nuance of how SIT has been conducted or what specific processes may have contributed to positive client change. This has limited the field's understanding of what it can mean to conduct SIT and how SIT may change depending any number of factors such as the client presenting concern.

The extant literature has included a few examples of exploring the routine practice of SIT. One example was from Sanders, Richards, et al. (2015), who explored the processes and outcomes of SIT in a sample of 304 clients and their therapists at a private, religiously affiliated university. They used routine, session-by-session process/outcome measures to collect their data. They found that SIT, as practiced at this university, was effective in reducing client symptoms across several domains of functioning. Their process findings showed that practitioners discussed religious/spiritual concerns in 33% of their sessions overall, and that the most frequently endorsed spiritual interventions were (a) therapist silent prayer (53% of sessions), (b) teaching spiritual concepts (42% of sessions), and (c) encouraging clients to "listen to the heart" (27% of sessions).

Lea et al. (2015) conducted an in-depth process and outcome study of SIT. They used an intensive, mixed-method, single-*N* design, and examined the process and outcome of therapy for a religious female client who presented with eating disorder concerns comorbid with major depression, anxiety, and a personality disorder. At the end of each therapy session with this client, the therapist completed an in-depth, routine process measure completed to highlight, among other things, the specific spiritual interventions used by the therapist in each session (e.g.,

therapist praying silently, encouraging client to accept God's love). At each session, the client also completed a routine outcome measure that assessed distress in several areas. Overall, the client showed significant improvement in all areas of functioning on the outcome measure. Finally, the researchers used open-ended interviews with the client and her therapist to provide rich descriptive data about treatment. These data provided insight that an important part of the client's recovery was attributable to the therapist's "integration of spirituality" in the therapeutic process (p. 198).

Jackson et al. (2016) conducted a study on the process of SIT as practiced at Brigham Young University—Idaho, a religiously-affiliated university. They found that clinicians tended to endorse spiritual interventions most frequently in sessions where religious/spiritual concerns were brought up by the client, compared to other clinical issues. Finally, Wheatley et al. (2017) conducted a replication study of Jackson et al. (2016) and found roughly comparable results. Currently, it is important that the field move beyond retrospective reports of SIT usage. Rather, we could move toward session-by-session data that help examine the effectiveness of SIT and the nuance of how SIT is used in the context of various mental health issues and the timing of SIT.

Research Design on SIT

One primary reason for the lack of in-depth, descriptive process studies has been the field's traditional reliance on top-down research designs (Castonguay et al., 2013; Chambless et al., 1998) where "science is transmitted . . . via researchers informing therapists about the issues that have been studied and the lessons that can be derived from the findings" (Castonguay et al., 2013, p. 86). In these designs, researchers have preemptively investigated theory, created measures, crafted manualized therapy protocols, hypothesized outcomes and significant change

processes, and analyzed data according to the theoretically based hypotheses upon which a study was based. Randomized controlled trials (RCTs) have typically been called the gold standard of top-down approaches (DeAngelis, 2005). RCTs have provided invaluable information about the efficacy and causal effects of various therapeutic interventions. They have also been used to create and disseminate manualized treatment protocols to practitioners so they can effectively treat clinical issues. Yet, RCT designs have imposed limits on client and therapist characteristics, therapy process variables, diagnostic comorbidity, and so on (Barkham et al., 2010). These restrictions have provided RCT results with internal validity, or reasonable assurance that theorized mechanisms of change accounted for change in client outcome. But they have also often created artificial, "pure" environments which have been difficult to generalize to real-world therapy settings where any number of variables cannot be controlled (Sanders, Richards, et al., 2015).

Related to process research on SITs, if an RCT has shown SIT to be efficacious, researchers have advertised and disseminated their manualized protocol to practitioners to inform their practice. Despite some recognized benefits of a top-down prescriptive approach, practitioners have struggled to generalize the findings of an RCT to everyday therapy settings (Castonguay et al., 2013) or view a manualized protocol as detrimental to therapy (Millet, 2016). Many, therefore, have not utilized these prescribed approaches. This disconnect between top-down treatment protocols and everyday therapy has contributed to the field's scant information on how effective SITs are routinely conducted.

In response to this research-practice dilemma, the American Psychological Association (APA) Presidential Task Force on Evidence-Based Practice (2006) concluded that "[evidence-based practice in psychology] requires an appreciation of the value of multiple sources of

scientific evidence" (p. 280). While recognizing the value of top-town research approaches, the task force encouraged practitioners and researchers to adopt multiple research designs to study any given therapeutic approach or intervention, including qualitative research, process-outcome studies, RCTs, and effectiveness research ("real-world" therapy practice studies).

Practice-based evidence (PBE; Barkham et al., 2010) is a research framework that has provided an alternative way to conduct therapy outcome and process research—in everyday clinical settings. Whereas top-down approaches have created and executed therapy protocols and tested for efficacy, PBE is a bottom-up approach that has been used to observe, examine, and evaluate therapy in routine practice. It has aimed to study, understand, and disseminate effective practice evidence by analyzing the work of practitioners in routine practice settings. This has involved establishing data on client outcomes and studying how therapists conduct therapy via routinely administered process measures. Practice-based evidence has been seen as a promising avenue "to make outcome research more relevant to clinical practice" (Sanders, Richards, et al., 2015, p. 181). In addition, "knowledge derived from practice-based evidence should not be antagonistic to those who conduct RCTs, but rather the top-down and bottom-up evidence will converge to create an amalgam that is richer and more useful than evidence from any one method" (Barkham et al., 2010, p. xix).

Bottom-up, PBE studies have not avoided their own limitations, however. One limitation in most PBE SIT process studies has been the tendency to still use a partially top-down approach. For example, many researchers have created and sent surveys to practitioners asking about usage rates of spiritual interventions. These surveys are generated as predetermined lists of interventions by the researchers themselves, who have then asked participants to respond to the interventions on the list, without allowing for custom items to be added to the list by participants

(e.g., Richards & Potts, 1995). These designs, while intent on gaining insight from practitioners on their routine practice, has potentially limited the amount of information researchers have been able to gather. For example, practitioners may have regularly conducted spiritual interventions in their work on which they were unable to report, given that it was not included in the prescribed list. Some studies have begun to address this limitation through the creation of new routine monitoring systems, such as the Bridges Assessment System (BAS; Sanders & McBride, 2018). The BAS, an online, checklist-based, adaptive outcome and process measurement tool which comes with a preset list of interventions to endorse, was designed to allow practitioners to easily add items to the list if needed to more accurately capture their approach in a therapy session.

The current study recognized that in-depth, session-by-session PBE research from a more completely bottom-up approach could help close the research-practice divide in SIT. This study also assumed that studies from this perspective could potentially provide much needed understanding of what it means to conduct SIT in routine practice from practitioners' points of view.

Purpose of the Current Study

In line with the 2006 APA Presidential Task Force report, the current study recognized the clinical utility of practice-based methods in understanding the routine practice of SIT. However, with the limited in-depth information on SIT process, one primarily important question has emerged from the literature: What does SIT look like in everyday therapy settings? Operationalizing this broad question, the current study examined three questions: (1) What spiritual interventions are most and least frequently used in SIT? (2) What are the most and least frequently discussed clinical issues in SIT? (3) Do practitioners display patterns of using certain spiritual interventions in the presence of certain presenting issues? These questions were

answered in the context of a small private practice which is expressly advertised as a SIT practice (Canyon Counseling Center, 2019).

Method

Practice-Based Evidence Approach

The current study utilized a PBE approach to address the research questions. According to Castonguay et al. (2013), "practice-based evidence encompasses a broader, looser—less focused—collection of activities, but takes its starting point as what practitioners do in everyday routine practice" (p. 98). While the implementation of PBE is inherently more flexible than traditional evidence-based practice research, Castonguay et al. asserted that "the central component is the adoption and implementation of a measurement and monitoring system as part of routine practice" (p. 98). The current study gathered its data from the process portion of the BAS, which therapists at a small private practice completed at the end of each therapy session.

Methodology—Topographic Analysis

The current study was an amalgam of qualitative and quantitative methods. The raw data consisted of numbers which showed how often therapists used spiritual interventions and discussed clinical topics in therapy sessions. While the data were numerical, the exploratory research questions and my philosophical affinity as the primary researcher did not lend themselves easily to either a traditional quantitative or qualitative approach in terms of analyzing the data.

The descriptive term for the methodological approach used in this study was called a "topographic analysis." The study intended to describe the correlational patterns between topics discussed in therapy and the spiritual interventions these practitioners used in session. I created and explored a correlation matrix that showed all correlations between clinical topics and

spiritual interventions, and color-coded correlations according to strength and direction. The result was a correlational "topographical map." The descriptive analysis aimed to identify patterns of spiritual intervention use and clinical issue discussion, and note whether there were topics and interventions, or groups of each, which stood out as having noticeably stronger correlations with each other. This was analogous to how one would read a topographical map for any noticeable heights or dips in terrain (United States Geological Survey, n.d.). This study's exploration thus illuminated patterns and themes of how these self-advertised SIT practitioners conduct SIT and offered something of a detailed bird's eye view of SIT in a way that has not been done before. The analysis was neither a traditional quantitative nor qualitative approach. During the creation and coding of the matrix and identifying patterns within it, I hid variable names to avoid any undue bias in the patterns I noticed. Avoiding such bias was typical of a more qualitative approach. Like a quantitative study, the data were numerical and initially analyzed to produce Pearson correlations. However, the analysis was not inferential and was intentionally limited to a descriptive evaluation. This deliberate limit allowed me to focus attention to the *what* of a PBE study that has traditionally been absent in the PBE literature on SIT.

Participants

The participants in this study were all eight licensed practitioners who worked at Canyon Counseling Center (CCC), a small private practice in Orem, Utah, between 2013 and 2017. Most importantly to the current study, this site was selected because of their "common belief is that God helps people in their healing," and they "seek growth and progression with each client by applying psychological principles that are grounded in spiritual values" (Canyon Counseling Center, 2019). This is in line with a spiritually integrated approach (Pargament, Mahoney, et al.,

2013). The practitioners at CCC provided their consent to participate, and IRB approval was granted to conduct this study.

Some evidence of clinical effectiveness has been gathered and reported in previous research. Jackson et al. (2017a) studied client outcome data at CCC during the same period that the process data for the current study were being collected. They used the BAS to collect these data. The outcome portion of the BAS is a 25-item client survey which tracks outcomes in five areas of functioning—therapy expectations, relationship distress, psychological distress, physical health distress, and spiritual distress. Jackson et al. analyzed data from 400 unique clients who attended a total of 1,565 therapy sessions between early 2013 and mid-2017. They used hierarchical linear modeling to detect whether clients were reporting significant changes in distress across treatment at CCC. Their findings suggested that the SIT conducted at CCC was effective overall, and that client improvement followed a nonlinear pattern ($t = -2.362$, $p = 0.019$). Further, they found that clients reported significantly lower distress across treatment in all five areas of functioning measured on the BAS.

It should be noted that the clients who attend therapy at CCC self-select to receive services from CCC. Due to CCC's self-endorsed SIT practice, and the predominantly religious population that CCC serves, a higher than average number of clients may have historically sought SIT services specifically. In fact, approximately 90% of CCC clients have stated that (a) R/S is important in their lives, (b) they wish to discuss religious or spiritual concerns in therapy if relevant, and (c) they would consider trying religious or spiritual suggestions from their therapist if it appeared that it could be helpful (Jackson et al., 2017b). This information was pertinent to the current study, as one considers how frequently the therapists at CCC may have

utilized spiritual interventions in their work, perhaps compared to another practice serving a generally less religious client population.

This study was conducted in a naturalistic setting and made no additional time requirements of the therapists. Therapists were not financially compensated for their participation in the study.

Data Collection and Measure

The data for this study were obtained from routinely collected therapy session data from the therapists at CCC after receiving written and verbal consent to use the data. I, as the primary researcher, organized and analyzed the data in this study.

The Clinically Adaptive Therapist Session Checklist (CA-TSC; Richards et al., 2014), one of two components of the BAS, was used to collect data for this study. The CA-TSC is the process portion of the BAS which "enables therapists to document what clinical issues they explored and what interventions they used" in each session (Richards et al., 2015, p. 176). The CA-TSC was created by Richards et al. (2014) to generate a process measure that could serve as a useful, convenient, and feasible tool for practitioners to document what happened in each session. The CA-TSC is a check-box style online survey. Practitioners complete information about the following topics: (a) theoretical orientation/framework used; (b) specific clinical interventions utilized; (c) clinical topics discussed; (d) therapist intentions during the session; (e) mood, mental status, response, and progression of the client; and (f) interaction style between therapist and client (Richards & Rose, 2018). In addition, and of interest in the current study, the CA-TSC allows therapists to indicate whether they used a SIT approach, and any applicable spiritual interventions they utilized. The CA-TSC is adaptable, allowing therapists to add items that may not be included in the standard checkbox list. For example, an emotion-focused

therapist may frequently recommend a certain book to her clients and may add "bibliotherapy" or the name of the book as a unique intervention she uses. This has given the CA-TSC the capacity to identify highly detailed and specific information about the process of therapy, including spiritual interventions. Even though the CA-TSC provides detailed information about a given session, it only requires one to two minutes to complete (Richards et al., 2015). Finally, the CA-TSC was designed to be completed at the end of each session and serves as a HIPPA-secure note-keeping system. The practitioners at CCC have been using the CA-TSC since at least early 2013, and all therapists at the CCC complete the CA-TSC as part of their routine practice.

Studies have yet to be conducted to validate the CA-TSC. To date, only one study has provided some evidence of its reliability. Jackson et al. (2018) gathered quantitative data from the CA-TSC at a private practice and conducted qualitative interviews with the practitioners to explore the process of SIT for treating perfectionism. The quantitative findings from the CA-TSC suggested that the most frequently endorsed spiritual interventions in SIT for perfectionism were affirming client's divine worth, encouraging listening to the heart, and encouraging accepting God's love. The other most frequently endorsed interventions were communicating unconditional positive regard, focusing on creating a warm and supportive environment in session, empathic affirmation, and challenging cognitive distortions. The themes gathered from the qualitative interviews with these therapists illustrated a similar process. Combined, these results demonstrated that therapists' daily documentation of their therapy process was remarkably congruent with how they described their experience of and process in therapy when working with perfectionistic clients. Although it was not the intention of the study to argue the CA-TSC's credibility, Jackson et al.'s (2018) findings provided some preliminary evidence that the CA-TSC is a reliable measure for documenting the process of therapy. Further, since the CA-

TSC is completed routinely, after every therapy session, the documentation helps the CA-TSC provide more accurate information on therapy process, instead of relying on past recollections.

In addition to this preliminary evidence, anecdotal evidence has also been informally noted by the creators of the CA-TSC. To date, the CA-TSC has been used in multiple university counseling centers, an inpatient eating disorder treatment center, and private practice settings. The creators of the CA-TSC have stated that these setting have used the CA-TSC for both clinical and research purposes. Further, many therapists who have used the CA-TSC have responded positively regarding its clinical utility and efficiency.

Data Analysis

The primary goal of this study was to gain an in-depth understanding clinical patterns within SIT. Data analysis was done through IBM SPSS Statistics 25.0. After the CA-TSC data from the CCC had been compiled, the pertinent information was synthesized and analyzed. The pertinent information for this study were the spiritual interventions endorsed by the therapists and the clinical issues discussed in session. A total of 33 unique spiritual interventions and 49 unique clinical issues were found across all documented sessions and correlational analysis was run. The resulting correlation matrix, which showed all combinations of spiritual interventions and clinical issues, contained 1,617 correlation coefficients.

The next task was to organize the matrix in a way that provided the clearest sense of any patterns, or “topography,” in the data. Each row in the matrix corresponded with one of the 49 clinical topics and each column represented one of the 33 spiritual interventions used. The variables were then organized according to frequency. The most frequently endorsed clinical topics and spiritual interventions were set in the top and left section of the matrix, respectively.

The topics and interventions were set in descending order of frequency as the matrix flowed down and to the right.

I then color-coded the matrix to create the topography and make it more easily readable. The strongest negative correlation found was -0.210, and the strongest positive correlation was 0.664. The total number of sessions for which the CA-TSC was completed was 6,549. The color-coding system was thus arranged: correlations from -0.210 and -0.100 were coded purple; from -0.099 and -0.033 were coded blue; from -0.320 and 0.320 were coded green; from 0.033 and 0.199 were coded yellow; from 0.200 and 0.399 were coded orange; and from 0.400 and 0.664 were coded red. The result was a rainbow-like array that thus created the topography of the matrix. As seen in Figure 1, an example of this type of matrix has been provided for the reader to gain a clearer picture of the design prior to seeing the full matrix:

Hypotheses

Given the inherently exploratory nature of PBE research designs (Barkham et al., 2010), no specific hypotheses were proposed for the current study.

Results

Data were collected from February 20, 2013, to October 18, 2017. During that time, the eight therapists at CCC conducted a total of 6,549 therapy sessions with 543 unique clients. The CA-TSC was completed for every session. The number of sessions per client ranged from one to 74, with an average of 12.

Most and Least Frequently Used Spiritual Interventions

Of the 6,549 sessions, the therapists at CCC endorsed utilizing the following spiritual interventions in more than 10% of sessions: “affirmed client’s divine worth” (74.0%); “affirmed trusting God” (64.0%); “encouraged listening to the heart” (62.7%); “encouraged acceptance of

God's love" (58.9%); "discussed forgiveness" (24.0%); "challenge shame" (22.2.%); "challenge fear" (20.6%); "encouraged personal prayer" (20.0%); "as therapist, engaged in silent prayer" (14.6%); and "used spiritual assessment" (11.0%).

The therapists at CCC also endorsed utilizing the following spiritual interventions in between 2% and 10% of sessions: "discussed hope" (8.1%); "discussed the spiritual dimension of problems and solutions" (7.7.%); "listened to spiritual issues" (6.6%); "discussed compassion" (4.2%); "referred to religious community" (4.0%); "used spiritual confrontation" (3.3%); "identified pathways to God or the sacred" (2.7%); "engaged in spiritual self-disclosure" (2.5%); "encouraged charitable service" (2.2%); "explored religious questions and doubts" (2.2%); "used religious bibliotherapy" (2.1%); and "affirmed client confession/repentance" (2.0%).

Finally, the therapists at CCC endorsed utilizing the following spiritual interventions in less than 2% of sessions: "helped in discerning God's will" (1.8%); "explored questions about ultimate meaning" (1.5%); "encouraged reconciling beliefs in God with pain and suffering" (1.4%); "encouraged spiritual meditation" (1.3%); "identify blessings/gratitude" (1.2%); "engaged in spiritual relaxation or imagery" (0.6%); "discussed gratitude" (0.50%); "clarified thoughts about evil" (0.4%); "encouraged spiritual journal writing" (0.2%); "discussed humility" (0.1%); and "discussed self-control" (0.0%). Table 1 contains a complete list of these frequencies.

Most and Least Frequently Discussed Clinical Topics

The following clinical topics were discussed in more than 10% of the sessions at CCC: "self-esteem/identity" (74.7%); "emotions (protection—panic, anxiety)" (67.6%); "emotions (reintegration—grief, depression)" (63.3%); "religion/spirituality" (51.3%); "relationships (family of origin)" (48.3%); "relationships (marriage/partner/dating)" (48.2%); "relationships

(friends/acquaintances)" (32.7%); "emotions (rejection—disgust, dislike)" (29.4%); "problem management/coping" (29.2%); "emotions (affiliation—love, liking)" (28.9%); "employment" (24.6%); "perfectionism" (22.5%); "emotions (self-affirmation—joy, serenity)" (18.2%); "career/life planning" (17.8%); "sexuality" (15.8%); "moral/ethical concerns" (15.8%); "abuse (emotional)" (15.7%); "emotions (orientation—surprise, confusion)" (14.7%); "emotions (destruction—rage, anger)" (14.0%); "relationships (other)" (12.0%); and "child rearing/parenting" (11.9%).

The therapists at CCC endorsed discussing the following clinical topics in between 2% and 10% of sessions: "physical health" (9.9%); "addictions" (9.6%); "living conditions/housing" (8.8%); "eating/body image" (7.9%); "relationships (co-workers, supervisors)" (7.4%); "academics" (6.9%); "boundaries" (6.2%); "abuse (physical)" (4.4%); "loneliness" (3.8%); "abuse (sexual)" (3.8%); "sleep disturbance" (3.7%); "therapy progress" (3.2%); "therapeutic relationships" (2.8%); "relationships (family)" (2.3%); "divorce" (2.1%); and "financial concerns" (2.1%).

Finally, the following topics were discussed in less than 2% of sessions: "self-injury" (1.4%); "legal concerns" (1.4%); "neglect" (1.3%); "negative habits" (1.1%); "suicide" (1.1%); "alcohol/drug use" (0.7%); "medications" (0.5%); "death/grieving" (0.3%); "emotions (exploration—anticipation, curiosity)" (0.2%); "violence" (0.0%); "cultural diversity" (0.0%); and "discrimination" (0.0%). Table 2 contains a complete list of these frequencies.

Topographical Analysis

The matrix created for this study contained correlations that were examined for patterns. Highlights of the matrix will be described here, and readers are encouraged to examine the

matrix for further details of this study's findings. The complete correlation matrix has been included as Figure 2.

Most of the strongest correlations in the matrix were found in the top-left quadrant. This quadrant contained nearly all the correlations which were coded red, orange, and purple (strongest positive and negative). The correlations between the four most frequent spiritual interventions and the four most frequent clinical issues (4x4 square of correlations in top-left) were all coded either red or orange, with the exception of one ("encouraged acceptance of God's love" x "emotions (protection—panic, anxiety)"). The lower and right quadrants of the matrix contained most of the weakest correlations. For example, "discussed humility" X "violence" (r = 0.000).

Of the significant correlations, 18 were coded red, and ranged from 0.400 to 0.664. They included the following: "challenge shame" X "emotions (orientation—surprise, confusion)" (r = 0.664); "challenge fear" X "emotions (orientation—surprise, confusion)" (r = 0.648); "challenge shame" X "emotions (rejection—disgust, dislike)" (r = 0.606); "challenge fear" X "emotions (rejection—disgust, dislike)" (r = 0.587); "challenge shame" X "emotions (affiliation—love, liking)" (r = 0.531); "challenge fear" X "emotions (affiliation—love, liking)" (r = 0.504); "discussed hope" X "emotions (orientation—surprise, confusion)" (r = 0.500); "challenge fear" X "boundaries" (r = 0.477); "challenge shame" X "emotions (self-affirmation—joy serenity)" (r = 0.475); "challenge fear" X "emotions (self-affirmation—joy, serenity)" (r = 0.473); "discussed the spiritual dimensions of problems and solutions" X "emotions (orientation—surprise, confusion)" (r = 0.473); "challenge shame" X "boundaries" (r = 0.473); "listened to spiritual issues" X "emotions (orientation—surprise, confusion) (r = 0.463); "encouraged charitable service" X "loneliness" (r = 0.444); "affirmed client's divine worth" X "self-esteem/identity" (r

= 0.441); “affirmed trusting God” X “religion/spirituality” (*r* = 0.421); “challenge shame” X “problem management/coping” (*r* = 0.420); and “challenge fear” X “problem management/coping” (*r* = 0.414). Notably, 15 of the 18 strongest positive correlations were connected to the spiritual interventions “challenge shame” and “challenge fear,” and the clinical topic “emotions: orientation (surprise, confusion).”

There were also 30 purple-coded correlations and ranged from -0.210 to -0.102. The details of all these correlations were too lengthy to include here. However, the strongest negative correlation was “as therapist, engaged in silent prayer” X “relationships (marriage/partner/dating)” (*r* = -0.210). It should be noted that 22 of the purple-coded correlations were connected to the spiritual interventions “challenge shame,” “challenge fear,” “encouraged personal prayer,” and “as therapist, engaged in silent prayer.” Further, 10 of those 22 were connected to “as therapist, engaged in silent prayer.”

The clinical topic “religion/spirituality” contained one red-coded correlation, with “affirmed trusting God” (*r* = 0.421). It held eight orange-coded correlations, which were with: “affirmed client’s divine worth” (*r* = 0.325), “ encouraged listening to the heart” (*r*=0.289), “encouraged acceptance of God’s love” (*r* = 0.286), “challenge shame” (*r* = 0.393), “challenge fear” (*r* = 0.395), “discussed hope” (*r* = 0.242), “discussed the spiritual dimension of problems and solutions” (*r* = 0.233), and “listened to spiritual issues” (*r* = 0.222). The topic of “religion/spirituality” also contained 16 yellow coded correlations, six green coded correlations, and two blue-coded correlations.

One spiritual intervention contained an interestingly opposite set of correlations: “as therapist, engaged in silent prayer.” The correlations connected to this variable included five that were coded orange. The topics with these correlations with silent therapist prayer were

"moral/ethical concerns" (*r* = 0.369), "sexuality (*r* = 0.357), "addictions" (*r* = 0.311), "loneliness" (*r* = 0.282), and "relationships (family) (*r* = 0.217). However, endorsing a silent therapist prayer was also negatively correlated with 10 clinical topics, including the following: "self-esteem/identity" (*r* = -0.135), "emotions (protection—panic, anxiety)" (*r* = -0.176), "emotions (reintegration—grief, depression)" (*r* = -0.156), "relationships (marriage/partner/dating)" (*r*= -0.210), "career/life planning" (*r* = -0.161), "emotions (orientation—surprise, confusion)" (*r* = -0.120), "child rearing/parenting" (*r* = -0.141), "physical health" (*r* = -0.134), "relationships (co-workers/supervisors)" (*r* = -0.117), and "boundaries" (*r* = -0.106).

Discussion

At its outset, the current study aimed to focus solely on clinical patterns within SIT. This study has provided a unique perspective on SIT patterns regarding various treatment topics. The findings demonstrate that in-depth, session-by-session information can be gathered on SIT usage, and that this information can be analyzed and illustrated in previously untested ways. This study also demonstrates that using the CA-TSC provides a tool to collect and examine this session-by-session.

Specific Findings

The therapists at CCC endorsed discussing "self-esteem/identity," emotions (protection—panic, anxiety)," "emotions (reintegration—grief, depression)," and "religion/spirituality" in at least half of their sessions. It was not surprising that issues of anxiety and depression were dominant issues. This finding is consistent with national statistics that suggest anxiety and depression are the most frequently diagnosed and co-occurring mental health issues in the United States (National Institute of Mental Health, 2018). The finding that self-esteem and identity

issues were frequently discussed suggests that a significant portion of therapists' work at CCC involved helping clients bolster their sense of self and become more secure in who they are. Additionally, that R/S was discussed in over half of the total sessions was expected, given that CCC's self-description endorses SIT practice. It may be that many clients choose to receive therapy services at CCC assuming their beliefs would be honored and attended to, if clinically relevant to their presenting concerns.

The therapists at CCC endorsed "affirmed client's divine worth," "affirmed trusting God," "encouraged listening to the heart," and "encouraged acceptance of God's love" in at least half of their sessions. By themselves, the frequent use of these spiritual interventions suggests that the therapists at CCC regularly integrate their clients' spiritual resources in their work. When juxtaposed with the most frequently endorsed clinical issues, this finding suggests that the CCC therapists regularly help their clients work through issues of self-esteem, anxiety, depression, and R/S by helping them utilize positive religious/spiritual coping strategies (e.g., accepting one's divine worth and God's love). The therapists at CCC may likely assume that a client's theistic beliefs would be influenced by introducing concepts consistent with those beliefs and values. This idea is strengthened by the matrix, which showed strong positive correlations between each of the four most frequently endorsed spiritual interventions and clinical issues. This finding further suggests that the therapists at CCC align with Richards and Bergin's (2005) position that SIT may be very helpful in the treatment of religious/spiritual clients, when indicated.

This study found that the strongest positive correlations were between "challenging shame" and "emotions (orientation–surprise, confusion)," and "challenging fear" and the same clinical issue. This finding suggests at least two things. First, it suggests that the pairing of

addressing shame, fear, and emotionally disorienting experiences is not merely coincidental in the work at CCC. It is possible that clients at CCC, when facing situations that leave them feeling confused, surprised, or otherwise at a loss of how to proceed, are met with feelings of shame and fear. In response, the therapists appear to regularly use confrontation regarding the shame and fear to help reduce client distress. These interventions and issue were only endorsed in an average of 19% of sessions, yet their intersection contained the two strongest correlations in the data, with coefficients of approximately 0.650. The significance of these correlations is highlighted by suggesting a contrasting hypothetical situation. Consider a spiritual intervention, “X,” and a clinical issue, “Y,” which are addressed in 100% of sessions. The resulting correlation coefficient would be 1.00, perfectly strong and positive. Nevertheless, this correlation would be strong by default, regardless of any actual relationship between X and Y. Thus, with “challenging shame,” “challenging fear,” and “emotions (orientation—surprise, confusion)” being strongly correlated yet somewhat infrequently endorsed, the correlations are potentially even more meaningful and worth deeper exploration.

A second noteworthy implication of this finding is that the therapists and/or clients at CCC perceive something spiritual about challenging shame and fear. This idea is supported by Fischer (2019). The findings of the current study do not suggest specific reasons for this perception. Nonetheless, it is important to note that for them and at least some others, this intervention is interpreted from a religious/spiritual perspective.

The correlations between “religion/spirituality” and the spiritual interventions was of interest in this study, given the study focused on SIT. Religious/spiritual concerns were endorsed in slightly more than half of the sessions at CCC. It was somewhat surprising that the correlations between “religion/spirituality” were not higher across the spiritual interventions.

This finding contradicts Jackson et al.'s (2016) finding that six of the seven most frequently used spiritual interventions in their study were endorsed most often in sessions where religious/spiritual concerns were discussed. The fact that "religion/spirituality" displayed weaker—albeit generally moderate-strong positive—correlations than other clinical issues in the current study is interesting. It suggests that perhaps the therapists at CCC use spiritual interventions more frequently in general or across a broader range of clinical issues, compared to the therapists in Jackson et al.'s study. This preliminary reasoning may give some additional credibility to the practitioners at CCC in that they offer SIT to treat a wide range of issues. Additionally, this finding might also begin to highlight one of the differences between a therapist conducting SIT and a therapist being spiritually integrative or spiritually centered (Gleave, 2012).

The study revealed an interesting pattern of correlations with one intervention, which contained several moderately strong positive correlations as well as one-third of the strongest negative correlations: "as therapist, engaged in silent prayer." The strongest positive correlations with therapists endorsing a silent prayer on their part (moral and ethical concerns, sexuality, addictions, loneliness, and family relationships) are worth exploring. Most clients at CCC identify as members of The Church of Jesus Christ of Latter-day Saints (Wheatley et al., 2017). Within this religious group, issues of morality/ethics, sexuality, addiction, and family relationships are highly sensitive and significant issues (Richards & Bergin, 2014). One possible explanation for this correlational pattern is that, when faced with highly sensitive clinical issues, given their client population, the effective SIT clinicians at CCC may find it beneficial to petition their own source of attunement to help these clients most effectively.

Of interest, then, is the finding that therapist silent prayer was connected to 10 of the strongest negative correlations. It is possible, given the strong positive correlations with certain, sensitive clinical issues, that the therapists at CCC feel more confident in relying more heavily on their experience with and clinical knowledge of these issues (e.g., anxiety, depression, self-esteem) to treat these clients. It is also possible that some of the other negatively correlated clinical issues are perceived by both client and therapist as more strictly secular concerns (e.g., physical health, relationships with co-workers, career/life planning) and not related to R/S. Given the tenuous nature of this speculation, however, this finding is one of several potential springboards for future studies.

What is Spiritually Integrated Therapy?

This study highlights an interesting question: What constitutes a spiritual intervention or a spiritually integrated therapy?" Is it the client's spirituality that defines it, the therapist's, or both? Is the explicit presence of religious/spiritual distress and discussion in session a primary, ancillary, or optional consideration? Is SIT a matter of using explicitly religious/spiritual interventions, or more about the context that sets up a clinical indication for these interventions? These questions are reminiscent of past debate on definitional issues of religion/spirituality, in that religion/spirituality can be hard to universally define (e.g., Pargament, Exline, et al., 2013; Scott, 1997). If definitions of religion/spirituality have not been agreed upon, it may be that therapy named using these terms could be difficult to universally agree on, as well as difficult to coherently operationalize and study in replicable ways. However, examining the current study's findings may help illuminate how some practitioners view these questions and answer them in their own work.

The therapists at CCC endorsed using spiritual interventions that may be more commonly understood as religious/spiritual, such as "affirmed trusting God" and "encouraged personal prayer." Use of these interventions would initially qualify these therapist's practice of SIT by many research standards, including prior SIT process-oriented survey studies (e.g., Kvarfordt & Sheridan, 2007; Richards & Potts, 1995).

At the same time, this study suggests that the therapists at CCC may perceive spirituality beyond explicit mention of R/S. For example, they reported high usage rates of several interventions which may not initially appear to be spiritual, such as "encouraged listening to the heart" and "challenge shame." These interventions were expressly affirmed by the therapists at CCC as spiritual interventions. This affirmation indicates that these therapists perceived their work in these areas as being connected to spirituality. While an exploration of the therapists' precise beliefs on this matter were beyond the scope of this study, these findings may be an indication that spirituality is more deeply ingrained in the CCC therapists' work than what can be seen externally. Explicitly, however, the therapists' endorsement of these interventions as spiritual is not without corroboration. "Encouraged listening to the heart" may be an intervention aimed at helping clients tap into their perceived source of "truth" to help them find answers to their problems. Phrased in this way, encouraging a client to listen to their heart can be interpreted as spiritual and broadly applicable to clients from representing a wide variety of cultures, backgrounds, and belief systems. In addition, Gleave (2012) argued for this type of clinical scenario when he argued for the development of a synergistic relationship with a client that would help them "[express] their own judgment and agency to meet the unique challenges . . . of their lives" (p. 8). "Challenging shame" may also be a spiritual intervention, inasmuch therapists perceive a spiritual component to the origin and process of overcoming shame (Fischer, 2019). It

should also be noted that any of these interventions may not be viewed this way by other practitioners. In other words, one therapist's spiritual intervention may not be another's.

This study also found that many spiritual interventions were utilized outside the context of religious/spiritual-related concerns. This suggests that SIT is not simply therapy where a client brings up a religious/spiritual issue and a therapist responds with an expressly religious/spiritual intervention. This is line with Pargament, Mahoney, et al. (2013), who argued that an explicit focus on religious/spiritual concerns or reducing religious/spiritual distress is not necessary for a therapy approach to be considered spiritually integrated.

This study suggests that the therapists at CCC may work as spiritually centered therapists rather than those who adhere to a prescribed spiritually integrated therapy model. Referring to CCC's own statement, therapists at this site endorse their (a) application of professional psychological principles grounded in spiritual values, (b) belief in the spiritual nature of the healing process, and (c) commitment to meet each client with a tailored experience for growth and progression (Canyon Counseling Center, 2019). This statement is akin to Gleave's (2012) position that becoming a spiritually centered therapist is about (a) studying and becoming experts in our profession, (b) learning how to be "perfumed lightly" by spiritual sources in their work (Kimball, 1967), and (c) being "eager to get [our] hands dirty in the service of supporting the ongoing growth of real people, one hour at a time" (Gleave, 2012, p. 8). At the same time, the therapy work at CCC appears consistent with Pargament, Mahoney, et al.'s (2013) definition of SIT. It seems possible that while therapists conducting SIT do not necessarily need to be spiritually centered therapists themselves (Richards & Bergin, 2005), there may be a natural pairing between operating as a spiritually centered therapist and conducting therapy which is "sensitive to the spiritual dimension" (Pargament, Mahoney, et al., 2013, p. 227). Further, I

would argue that sensitivity to the spiritual dimension is not as much a matter of using religious/spiritual language or an intervention, but of attempting to be attuned to spirituality as it is exists or is perceived in the therapy room. This, perhaps, is congruent with emotion-focused therapists not simply reciting emotion vocabulary, but working to become attuned to emotions as they exist or are perceived in the therapy room.

Interestingly, this position is reminiscent of the definitional difficulties related to the constructs of R/S. In the same way that some individuals may not exclusively use religion as a means toward the spiritual (the sacred), it does not appear that a therapist conducting SIT, using religious/spiritual based interventions, must perceive themselves as spiritually centered. It also appears that, as religion and spirituality may be indistinguishable from one another when religion is directed toward the sacred (Pargament, Exline, et al., 2013), a spiritually centered therapist may naturally conduct therapy that would be referred to by many as SIT. In this sense, I would echo Gleave (2012) and assert that a spiritually centered therapist may simply work on “being” with their clients, with their base of psychological knowledge, and with their own (and their client’s) spiritual, existential, or transcendental beliefs, and then co-constructing a healing experience. Ultimately, these findings highlight the need to examine, from both a therapist and client perspective, the contextual factors that constitute a SIT approach, session, or moment, or a spiritually centered therapist.

CA-TSC as a Process Illumination and Deliberate Practice Tool

The study supports the clinical and research usefulness of the CA-TSC. As seen, the CA-TSC can provide deep, rich information regarding clinical patterns within SIT, and therapy more generally. The CA-TSC, as a session-by-session tool, can provide data on therapeutic interventions that most process measures cannot. While the current study demonstrated the

power of the CA-TSC to illuminate therapy process, there are yet many unexplored facets of the CA-TSC (e.g., therapist intentions). Further, the current study is a good demonstration of the adaptability of the CA-TSC. This survey allows therapists to add their own custom items rather than restricting them to a preset list of interventions, clinical topics, intentions, and so on. Indeed, even in the current study, the therapists at CCC added several unique spiritual interventions and clinical issues to tailor the CA-TSC to their unique clinical needs.

This study suggests that the CA-TSC can be used as a useful tool to enhance deliberate practice. As defined by Ericsson et al. (1993), “deliberate practice includes activities that have been specially designed to improve the current level of performance” by allowing for “repeated experiences in which [an] individual can attend to the critical aspects of the situation and incrementally improve her or his performance in response to knowledge of results, feedback, or both from a teacher” (p. 368). Indeed, clinician efforts to deliberately improve themselves in their craft, such in-depth, real-time feedback on their therapy process is invaluable. Rather than relying on retrospective memory alone to recall specific therapy sessions with specific clients, clinicians could use the CA-TSC to document the data immediately after a session. Then therapists could review it to intentionally evaluate and alter their performance, either to better meet client needs or to further refine their own style and theory of effective therapy. The idea that deliberate practice could be enhanced by using the CA-TSC is supported by Sanders, Richards, et al. (2015) and Lea at al. (2015). Both of these studies found that the CA-TSC, and the BAS system overall, was helpful in illuminating the process and outcome of therapy overall (Sanders, Richards, et al., 2015) and of therapy with specific clients (Lea et al., 2015).

Implications for Practitioners

Findings from this study have several implications for practitioners. First, the study provides some robust and detailed information into how one group of experienced practitioners conducts SIT. Accordingly, the current results should be of value to practitioners interested in beginning to provide SIT and becoming more sensitive clinicians to the religious/spiritual dimension of their clients' concerns. Along with several previous SIT process studies (e.g., Sanders, Richards, et al., 2015) this study serves as a helpful base from which to understand how some practitioners may practice SIT in the presence of certain clinical issues. There may be clinicians who work primarily with conservative Christian clients or clients who are members of The Church of Jesus Christ of Latter-day Saints. Those clinicians may find this study particularly useful as they engage with similar groups of clients. Regardless, most American adults identify as religious/spiritual (Pew Research Center, 2015) and working with religious/spiritual clients is inevitable for nearly all practitioners. In line with the APA (2017) professional code of ethics, it behooves practitioners to become competent in working with religious/spiritual clients and working effectively within this area of diversity. Reading the results of this and other process-oriented SIT studies is one way for practitioners to develop this area of multicultural competency.

Examining one's own religious/spiritual, transcendent, or existential perspective or beliefs about SIT also seems important for practitioners. It is reasonable from the study to assume that the therapists at CCC perceive themselves as conducting SIT whether religious/spiritual concerns are brought up explicitly by the client, and that spiritual interventions may encompass interventions that may not universally be seen as spiritual. Thus, practitioners

generally may benefit from examining their own perspective on this topic and knowing for themselves whether what they do is spiritually integrative.

This study also provides evidence for the clinical utility of the CA-TSC in specific, and perhaps other routine outcome/process monitoring systems in general. For practitioners who are interested in an efficient way of documenting process and outcomes of their own work, the CA-TSC and the larger BAS comprise a rather unique system for doing so. The CA-TSC can automatically store a variety of data about each therapy session. This information can, in turn, be readily translated into not only a topographic table like the one contained in this study, but into a wide variety of other helpful tables and charts about other aspects of the CA-TSC. Further, when practitioners use this or some other routine outcome/process monitoring system, deliberate practice efforts would become more feasible.

Limitations

Because of the exploratory, correlational nature of this study, causal attributions cannot be made about whether a spiritual intervention led to a certain outcome, or whether each discussion of a clinical issue caused therapists to use a certain spiritual intervention. The study assessed the correlation between interventions and issues. Thus, discerning patterns of interventions related to certain clinical issues was the design of this study. A related limitation is that information on therapist intentions when utilizing certain spiritual interventions was not examined. This limitation is natural, as the study intended only to provide a descriptive topographical analysis of SIT, as opposed to inferential analysis. Information on therapist intentions may have served at least a dual purpose: (a) to further illuminate the process of SIT as practiced at CCC; and (b) to help tie together the *whys* of SIT and provide a tentative rationale for the use of spiritual interventions in specific situations.

The CA-TSC relies on therapist self-report. The nature of self-report measures is that they inherently risk inaccuracy or bias in reporting. As well, for the current study, the self-report required the assumption that the CA-TSC was parsed out sufficiently to capture the essence and nuance of what the therapists at CCC did in each therapy session. This is an unavoidable artifact of using self-report data. Ironically, this limitation highlights one of the CA-TSC's strengths. Richards et al. (2014) designed the CA-TSC to be adaptable, by allowing therapists to add interventions, clinical issues, etc., to their checklist that are not listed in the prepackaged survey. The inherent adaptability of the CA-TSC is a strength yet may also make results difficult to replicate in other settings where those unique adjustments to not apply. Like other self-report measures, the CA-TSC is subject to the limitations of both what it can measure and how it does not allow for further clarification and deeper probing.

Another limitation is that different therapists may conduct the same spiritual intervention in different ways. This makes it difficult to precisely nail down what happened in each session without an accompanying audio or video recording. This limitation is reminiscent of Stiles' (2013) argument about the inherently unstable venture of labeling therapy approaches. Extrapolating to specific interventions used in the current study, different therapists, in different sessions, with different clients, recorded the use of the "same" intervention. The inherent difficulty in this is that the "same" intervention may not have been identical across contexts. For example, consider the CA-TSC intervention, "used spiritual assessment." For one therapist, a spiritual assessment may be a semi-structured event that only appears early in therapy as part of a structured intake session. However, another therapist may view spiritual assessment as an unstructured exploration of a client's worldview that occurs equally across treatment. Both

therapists may check the same box. Yet, what this means, how it is applied, and when it is endorsed may be quite different.

Other limitations of this study may be best conceptualized as unique contextual details rather than limitations. The clients seen at CCC were predominantly White, conservative Christian individuals, approximately 90% of whom expressed a desire to integrate their spirituality into treatment. Similarly, the therapists in this study shared some of the same identities as many of their clients (e.g., White, Christian), and explicitly marketed themselves as spiritually integrative therapists. This context may provide a unique perspective on SIT, as many studies survey clinician and client populations who are differentially religious/spiritual than the current sample. While this provides a unique perspective that will enrich the SIT process research, it may not accurately generalize to SIT at other sites, as conducted by other therapists, or with other client populations.

Future Directions

To continue addressing the lack of in-depth SIT process research in the literature, future studies may focus on several things. First, the CA-TSC is a uniquely complex and clinically useful process measure. It contains many facets that were not only outside the scope of this study but have also not been explored in other studies. Future studies may benefit from exploring that complexity and utilizing the many different and useful features of the CA-TSC (e.g., therapist intentions). Analyzing this information could help bridge some of the tentativeness of the current study when illustrating the connection between spiritual interventions and clinical issues. Additionally, whether the CA-TSC and larger BAS are used in future studies, the field would likely benefit from the development and use of session-by-session outcome/process measures.

Qualitative, single-N, and other focused studies could help illuminate not just patterns within SIT but also its process. These studies could speak to a variety of aspects of SIT (e.g., experience overall, use of specific spiritual interventions in response to client presenting concerns, change moments). As well, Wampold (2019) concluded that successful therapy depends partially on the clinical indication of a certain approach. Accordingly, the SIT evidence base may benefit from adding studies which focus on understanding when SIT might be contraindicated.

Future studies on experiences with SIT may also offer some research-based relief to the definitional issues that have persisted in the SIT literature. While a single definition may not become universally agreed upon across cultures, contexts, etc., such research may help to identify how certain groups of individuals conceptualize and perceive and experience SIT. Related to this, this research may offer insight data regarding whether therapists and clients consider SIT as an intervention-driven phenomenon or a contextual product of the client and a spiritually centered therapist working together. In conducting this focused research, it may be best practice to explore the experiences of both clients and therapists. Such dual-sided research would adhere to Palinkas et al.'s (2015) admonition that

> selecting participants on the basis of whether they were a practitioner (or) consumer. may fail to identify those with the greatest experience or most knowledgeable or most able to communicate what they know and/or have experienced, thus limiting the depth of understanding. (p. 7)

Future in-depth SIT process studies would also benefit from sampling clients and clinicians from other backgrounds (religious/spiritual, racial, ethnic, gender, age, theoretical orientation, etc.). Further, should these future studies also utilize the CA-TSC, the results of

these studies could be more directly compared with the results of the current study. Future studies could also be conducted at therapy sites where certain clinical issues may be discussed more frequently. For example, violence and discrimination were not frequently endorsed clinical issues at CCC. While there could be several reasons for this, examining how SIT changes when these issues are more frequently endorsed would enrich the SIT process literature altogether.

In line with theory of process research (e.g., Barkham et al., 2010), it is also important to conduct studies that can examine the relationship between therapy process and client outcome. The CA-TSC is the process-based portion of the overall BAS. The outcome-based portion is called the Clinically Adaptive Multidimensional Outcome Survey (CAMOS; Sanders et al., 2017). Using the BAS, or another routine outcome/process monitoring system, researchers and therapists could analyze in-depth, session-by-session process and outcome data. Bottom-up, PBE studies that incorporate outcome assessment would enrich the SIT process literature. Such studies could provide information on: (a) the effectiveness of certain patterns of spiritual intervention use; (b) the connection between client amenability to SIT and SIT outcomes; (c) whether and how therapist intentions moderate/mediate the effectiveness of certain spiritual interventions; and (d) the potential differences in delivery of SIT based on theoretical orientation or other therapist and client variables.

Finally, deliberate practice may be enhanced by utilizing routine outcome/process monitoring systems in routine clinical work, such as the BAS. These systems could provide both immediate and long-term feedback for clinicians interested in further developing their skills and effectiveness. Future studies may address the clinical and research utility of using these systems to aid deliberate practice efforts. These future studies may also help researchers and therapists

evaluate service delivery as therapists use routine outcome/process monitoring systems to critically examine their practice, process, and client outcomes.

Conclusion

To date, minimal literature has attended to the “what” of SIT compared to its efficacy or effectiveness. The current study sought to help address that gap in the research and provided rich, session-by-session data about clinical patterns within SIT. By using an in-depth process measure, the CA-TSC, this study created a topography of the SIT practices at one therapy clinic. For process research to catch up to the invaluable outcome data already available, future research should seek to use clinical tools which can provide in-depth, session-by-session information to evaluate SIT clinical practices. This will help build the empirical evidence base for spiritually integrated treatments. Finally, the findings from in-depth outcome/process studies using a variety of philosophical perspectives and methodological approaches, will help mental health professionals understand more deeply the what, how, and why of both spiritually integrated therapy and spiritually centered therapists.

References

Al-Karam, C. Y. (2018). Islamically integrated psychotherapy: Uniting faith and professional practice. Templeton Press.

Allen, K. N., & Wozniak, D. F. (2011). The language of healing: Women's voices in healing and recovery from domestic violence. *Social Work in Mental Health, 9*(1), 37–55. https://doi.org/10.1080/15332985.2010.494540

American Psychological Association. (2017). *Ethical principles of psychologists and code of conduct*. https://www.apa.org/ethics/code/

Anderson, N., Heywood-Everett, S., Siddiqi, N., Wright, J., Meredith, J., & McMillan, D. (2015). Faith-adapted psychological therapies for depression and anxiety: Systematic review and meta-analysis. *Journal of Affective Disorders, 176*, 183–196. https://doi.org/10.1016/j.jad.2015.01.019

American Psychological Association Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist, 61*(4), 271–285. https://doi.org/10.1037/0003-066X.61.4.271

Azhar, M. Z., & Varma, S. L. (1995). Religious psychotherapy in depressive patients. *Psychotherapy and Psychosomatics, 63*(3–4), 165–173. https://doi.org/10.1159/000288954

Azhar, M. Z., Varma, S. L., & Dharap, A. S. (1994). Religious psychotherapy in anxiety disorder patients. *Acta Psychiatrica Scandinavica, 90*(1), 1–3. https://doi.org/10.1111/j.1600-0447.1994.tb01545.x

Barkham, M., Hardy, G. E., & Mellor-Clark, J. (Eds.). (2010). *Developing and delivering practice-based evidence: A guide for the psychological therapies*. Wiley-Blackwell. https://doi.org/10.1002/9780470687994

Bergin, A. E. (1980). Psychotherapy and religious values. *Journal of Consulting and Clinical Psychology, 48*(1), 75–105. https://doi.org/10.1037/0022-006X.48.1.95

Bowland, S. E., Foster, K., & Vosler, A. N. R. (2013). Culturally competent and spiritually sensitive therapy with lesbian and gay Christians. *Social Work, 58*(4), 321-332. https://doi.org/10.1093/sw/swt037

Campbell, D. T. (1975). On the conflicts between biological and social evolution and between psychology and moral tradition. *American Psychologist, 30*(12), 1103–1126. https://doi.org/10.1037/0003-066X.30.12.1103

Canyon Counseling Center. (2019). *Canyon Counseling*. https://canyoncousnelingctr.com/

Castonguay, L., Barkham, M., Lutz, W., & McAleavey, A. (2013). Practice-oriented research: Approaches and applications. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (6th ed., pp. 85–133). Wiley.

Chambless, D. L., Baker, M. J., Baucom, D. H., Beutler, L. E., Calhoun, K. S., Crits-Christoph, P., Daiuto, A., DeRubeis, R., Detweiler, J., Haaga, D. A. F., Johnson, S. B., McCurry, S., Mueser, K. T., Pope, K. S., Sanderson, W. C., Shoham, V., Stickle, T., Williams, D. A., & Woody, S. R. (1998). Update on empirically validated therapies, II. *Clinical Psychologist, 51*(1), 3–16.

Cornish, M. A., & Wade, N. G. (2010). Spirituality and religion in group counseling: A literature review with practice guidelines. *Professional Psychology: Research and Practice, 41*(5), 398–404. https://doi.org/10.1037/a0020179

DeAngelis, T. (2005). Shaping evidence-based practice. *Monitor on Psychology, 36*(3), 26–28. https://www.apa.org/monitor/mar05/shaping

Ellis, A. (1980). *Case against religion: A psychotherapists view and the case against religiosity*. American Atheist Press.

Ericsson, K. A., Krampe, R. T., & Tesch-Römer, C. (1993). The role of deliberate practice in the acquisition of expert performance. *Psychological Review, 100*(3), 363–406. https://doi.org/10.1037/0033-295X.100.3.363

Fischer, L. (2019, October 3–4). *Shame matrix: Assessing and helping recovery using the shame matrix* [Conference session]. 2019 Association of Mormon Counselors and Psychotherapists Convention, Salt Lake City, UT, United States.

Furman, L. D., Benson, P. W., Grimwood, C., & Canda, E. (2004). Religion and spirituality in social work education and direct practice at the Millennium: A survey of UK social workers. *British Journal of Social Work, 34*(6), 767–792. https://doi.org/10.1093/bjsw/bch101

Gallup, G., Jr. (1999, April 2). *Easter draws Americans back to church*. Gallup. https://www.gallup.com/poll/3958/Easter-Draws-Americans-Back-Church.aspx

Gleave, R. (2012). Gospel-centered “therapist” or gospel-centered “therapy”: Is there a difference and does it matter? *Issues in Religion and Psychotherapy, 34*(1), Article 3. https://scholarsarchive.byu.edu/irp/vol34/iss1/3

Harris, J. I., Erbes, C. R., Engdahl, B. E., Thuras, P., Murray-Swank, N., Grace, D., Ogden, H., Olson, R. H. A., Winskowski, A. M., Bacon, R., Malec, C., Campion, K., & Te, T. (2011). The effectiveness of a trauma-focused spiritually integrated intervention for

veterans exposed to trauma. *Journal of Clinical Psychology, 67*(4), 425–438. https://doi.org/10.1002/jclp.20777

Hodge, D. R. (2006). Spiritually modified cognitive therapy: A review of the literature. *Social Work, 51*(2), 157–166. www.jstor.org/stable/23721280

Hook, J. N., Worthington, E. L., Jr., Davis, D. E., Jennings, D. J., II, Gartner, A. L., & Hook, J. P. (2010). Empirically supported religious and spiritual therapies. *Journal of Clinical Psychology*, *66*(1), 46–72. https://doi.org/10.1002/jclp.20626

Houck, J. B., & Moss, D. M. (1977). Pastoral psychotherapy: The fee-for-service model, and professional identity. *Journal of Religion and Health, 16*(3), 172–182. https://doi.org/10.1007/BF01533318

Jackson, R. N., McBride, J. A., & Richards, P. S. (2018, October 3–5). *"Be ye therefore perfect": Theoretical and practical tools for spiritually integrated treatments for perfectionism* [Conference session]. 2018 Association for Mormon Counselors and Psychotherapists Convention, Salt Lake City, UT, United States.

Jackson, R. N., Richards, P. S., & Sanders, P. W. (2016, August 4–7). Processes of spiritually oriented psychotherapy: A practice-based investigation. In P. S. Richards & J. N. Nelson (Chairs), *Spiritually orientation psychotherapy: Processes, outcomes, and research challenges* [Symposium]. American Psychological Association 124th Annual Convention, Washington, DC, United States.

Jackson, R. N., Richards, P. S., Wheatley, A., Crowton, S. A., & Rees, M. (2019). *Religion and spirituality in psychotherapy: A 20-year review and research prospectus* [Manuscript in preparation]. Department of Counseling Psychology and Special Education, Brigham Young University.

Jackson, R. N., Sanders, P. W., & Richards, P. S. (2017a, August 3–6). A practice-based investigation of the outcomes of spiritually integrated therapy. In P. S. Richards (Chair) *Enhancing practice-based evidence for spiritually integrated psychotherapies* [Symposium]. American Psychological Association 125th Annual Convention, Washington, DC, United States.

Jackson, R. N., Sanders, P. W., & Richards, P. S. (2017b). *Clinical outcomes of spiritually integrated therapy* [Unpublished raw data on clinical outcomes of clients receiving spiritually integrated therapy]. Brigham Young University.

Jones, S. L. (1994). A constructive relationship for religion with the science and profession of psychology: Perhaps the boldest model yet. *American Psychologist, 49*(3), 184–199. https://doi.org/10.1037/0003-066X.49.3.184

Kimball, S. W. (1967, September 12). *Education for eternity* [Conference session]. 1967 Brigham Young University Annual Faculty Conference, Provo, UT, United States. https://speeches.byu.edu/talks/spencer-w-kimball/education-eternity/

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

Kvarfordt, C. L., & Sheridan, M. J. (2007). The role of religion and spirituality in working with children and adolescents: Results of a national survey. *Journal of Religion & Spirituality in Social Work, 26*(3), 1–23. https://doi.org/10.1300/J377v26n03_01

Lea, T., Richards, P. S., Sanders, P. W., McBride, J. A., & Allen., G. E. K. (2015). Spiritual pathways to healing and recovery: An intensive single-N study of an eating disorder patient. *Spirituality in Clinical Practice, 2*(3), 191–201. https://doi.org/10.1037/scp0000085

Levin, J. (2010). Religion and mental health: Theory and research. *International Journal of Applied Psychoanalytic Studies, 7*(2), 102–115. https://doi.org/10.1002/aps.240

Miller, W. (Ed.). (1999). *Integrating spirituality into treatment: Resources for practitioners*. American Psychological Association. https://doi.org/10.1037/10327-000

Millet, A. (2016). *A phenomenological study of the therapist's experience when using a manualized approach to parent-child psychotherapy* (Publication No. 10196053) [Doctoral dissertation, Saint Louis University]. ProQuest Dissertations and Theses Global.

National Institute of Mental Health. (2018, January). *Mental health information*. https://www.nimh.nih.gov/health/index.shtml

Nohr, R. W. (2000). *Outcome effects of receiving a spiritually-informed vs. a standard cognitive-behavioral stress-management workshop* (Publication No. 9977718) [Doctoral dissertation, Marquette University]. ProQuest Dissertations and Theses Global.

Oman, D., Shapiro, S. L., Thoresen, C. E., Flinders, T., Driskill, J. D., & Plante, T. G. (2007). Learning from spiritual models and meditation: A randomized evaluation of a college course. *Pastoral Psychology*, *55*(4), 473–493. https://doi.org/10.1007/s11089-006-0062-x

Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration and Policy in Mental Health and Mental Health Services Research, 42*(5), 533–544. https://doi.org/10.1007/s10488-013-0528-y

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

Pargament, K. I., Exline, J. J., & Jones, J. W. (Eds.). (2013). *APA handbook of psychology, religion, and spirituality (Vol. 1): Context, theory, and research*. American Psychological Association.

Pargament, K. I., Mahoney, A., & Shafranske, E. P. (Eds.). (2013). *APA handbook of psychology, religion, and spirituality (Vol. 2): An applied psychology of religion and spirituality*. American Psychological Association.

Pew Research Center (2015). *America's changing religious landscape: Christians decline sharply as share of population; unaffiliated and other faiths continue to grow*. https://www.pewforum.org/files/2015/11/201.11.03_RLS_II_full_report.pdf

Post, B. C., & Wade, N. G. (2009). Religion and spirituality in psychotherapy: A practice-friendly review of research. *Journal of Clinical Psychology, 65*(2), 131–146. https://doi.org/10.1002/jclp.20563

Razali, S. M., Aminah, K., & Khan, U. A. (2002). Religious-cultural psychotherapy in the management of anxiety patients. *Transcultural Psychology, 39*(1), 130–136. https://doi.org/10.1177/136346150203900106

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

Richards, P. S., & Bergin, A. E. (Eds.). (2014). *Handbook of psychotherapy and religious diversity* (2nd ed.). American Psychological Association. https://doi.org/10.1037/14371-000

Richards, P. S., & Potts., R. W. (1995). Using spiritual interventions in psychotherapy: Practices, successes, failures, and ethical concerns of Mormon psychotherapists. *Professional*

Psychology: Research and Practice, 26(2), 163–170. https://doi.org/10.1037/0735-7028.26.2.163

Richards, P. S.., & Rose, A. (2018, September 27–29). Therapist Session Checklist: A routine process monitoring measure. In M. Barkham & P. S. Richards (Chairs), *The Therapist Session Checklist: Bringing psychotherapy process research to routine outcome monitoring* [Symposium]. North American chapter of the Society for Psychotherapy Research 2018 Conference, Salt Lake City, UT, United States.

Richards, P. S., Sanders, P. W., Lea, T., McBride, J. A., & Allen, G. E. K. (2015). Bringing spiritually oriented psychotherapies into the health care mainstream: A call for worldwide collaboration. *Spirituality in Clinical Practice, 2*(3), 169–179. https://doi.org/10.1037/scp0000082

Richards, P. S., Sanders, P. W., McBride, J. A., & Lea, T. (2014, August 7–10). *Bridging the research-practice gap with a clinically adaptive Internet-based outcome system* [Paper presentation]. American Psychological Association 122nd Annual Convention, Washington, DC, United States.

Sanders, P. W., Allen, G. E. K., Fischer, L., Richards, P. S., Morgan, D. T., & Potts, R. W. (2015). Intrinsic religiousness and spirituality as predictors of mental health and positive psychological functioning in Latter-Day Saint adolescents and young adults. *Journal of Religion and Health, 54*(3), 871–877. https://doi.org/10.1007/s10943-015-0043-4

Sanders, P. W., & McBride, J. A. (2018, September 27–29). Bridges Assessment System. In M. Barkham & P. S. Richards (Chairs), *The Therapist Session Checklist: Bringing psychotherapy process research to routine outcome monitoring* [Symposium]. North

American chapter of the Society for Psychotherapy Research 2018 Conference, Salt Lake City, UT, United States.

Sanders, P. W., Richards, P. S., & McBride, J. A. (2017). Development of the clinically adaptive multidimensional outcome survey. *Psychotherapy Research, 28*(6), 925–939. https://doi.org/10.1080/10503307.2016.1277039

Sanders, P. W., Richards, P. S., McBride, J. A., Lea, T., Hardman, R. K., & Barnes, D. V. (2015). Processes and outcomes of theistic spiritually oriented psychotherapy: A practice-based evidence investigation. *Spirituality in Clinical Practice, 2*(3), 180–190. https://doi.org/10.1037/scp0000083

Schiff, J. W., & Moore, K. (2006). The impact of the sweat lodge ceremony on dimensions of well-being. *American Indian and Alaska Native Mental Health Research, 13*(3), 48–69. https://doi.org/10.5820/aian.1303.2006.48

Scott, A. B. (1997). *Categorizing definitions of religion and spirituality in the psychological literature: A content analysis method* [Unpublished manuscript]. Department of Psychology, Bowling Green State University.

Scott, S. (2003). *Faith supportive group therapy and symptom reduction in Christian breast cancer patients* (Publication No. 3075442) [Doctoral dissertation, Regent University]. ProQuest Dissertations and Theses Global.

Sheridan, M. (2004). Predicting the use of spiritually-derived interventions in social work practice: A survey of practitioners. *Journal of Religion & Spirituality in Social Work: Social Thought, 23*(4), 5–25. https://doi.org/10.1300/J377v23n04_02

Sheridan, M. (2009). Ethical issues in the use of spiritually based interventions in social work practice: What are we doing and why. *Journal of Religion & Spirituality in Social Work, 28*(1–2), 99–126. https://doi.org/10.1080/15426430802643687

Sperry, L. (2012). *Spirituality in clinical practice: Theory and practice of spiritually oriented psychotherapy*. Taylor & Francis Group.

Sperry, L., & Shafranske, E. P. (Eds.). (2005). *Spiritually oriented psychotherapy*. American Psychological Association. https://doi.org/10.1037/10886-000

Stanley, M. A., Bush, A. L., Camp, M. E., Jameson, J. P., Phillips, L. L., Barber, C. R., Zeno, D., Lomax, J. W., & Cully, J. A. (2011). Older adults' preferences for religion/spirituality in treatment for anxiety and depression. *Aging & Mental Health, 15*(3), 334–343. https://doi.org/10.1080/13607863.2010.519326

Stewart, C., Koeske, G., & Koeske, R. (2006). Personal religiosity and spirituality associated with social work practitioners' use of religious based intervention practices. *Journal of Religion & Spirituality in Social Work: Social Thought, 25*(1), 69–85. https://doi.org/10.1300/J377v25n01_05

Stiles, W. B. (2013). The variables problem and progress in psychotherapy research. *Psychotherapy, 50*(1), 33–41. https://doi.org/10.1037/a0030569

Strachey, J. (1961). *The standard edition of the complete psychological works of Sigmund Freud, volume XXI (1927–1931): The future of an illusion, civilization and its discontents, and other Works*. Hogarth Press.

Sutton, G. W., Kelly, H. L., Griffin, B. J., Worthington, E. L., Jr., & Dinwiddie, C. (2018). Satisfaction with Christian psychotherapy and well-being: Contributions of hope,

personality, and spirituality. *Spirituality in Clinical Practice, 5*(1), 8–24. https://doi.org/10.1037/scp0000145

Tadwalker, R., Udeoji, D. U., Weiner, R. J., Avestruz, F. L., LaChance, D., Phan, A., Nguyen, D., Bharadwaj, P., & Schwarz, E. R. (2014). The beneficial role of spiritual counseling in heart failure patients. *Journal of Religion and Health, 53*(5), 1575–1585. https://doi.org/10.1007/s10943-014-9853-z

Targ, E. F., & Levine, E. G. (2002). The efficacy of a mind-body-spirit group for women with breast cancer: A randomized controlled trial. *General Hospital Psychiatry, 24*(4), 238–248. https://doi.org/10.1016/S0163-8343(02)00191-3

Tonkin, K. M. (2005). *Obesity, bulimia, and binge-eating disorder: The use of a cognitive behavioral and spiritual intervention* (Publication No. 3201378) [Doctoral dissertation, Bowling Green State University]. ProQuest Dissertations and Theses Global.

Tripathi, R. C., & Bano, S. (2014). Yogic practices: A healing therapy to relieve stress of middle age people. *Journal of Psychosocial Research, 9*(2), 319–328.

United States Geological Survey. (n.d.). *Topographic Maps*. https://www.usgs.gov/core-science-systems/national-geospatial-program/topographic-maps

Vasiliauskas, S. L., & McMinn, M. M. (2013). The effects of a prayer intervention on the process of forgiveness. *Psychology of Religion and Spirituality, 5*(1), 23–32. https://doi.org/10.1037/a0029324

Wade, N. G., Worthington Jr., E. L., & Vogel, D. L. (2007). Effectiveness of religiously tailored interventions in Christian therapy. *Psychotherapy Research, 17*(1), 91–105. https://doi.org/10.1080/10503300500497388

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings.* Lawrence Erlbaum Associates.

Wampold, B. E. (2019). *The basics of psychotherapy: An introduction to theory and practice* (2nd ed.). American Psychological Association.

Wheatley, A. M., Jackson, R. N., & Richards, P. S. (2017, August). Processes of spiritually integrated therapy: A practice-based evidence analysis. In P. S. Richards (Chair) *Enhancing practice-based evidence for spiritually integrated psychotherapies* [Symposium]. American Psychological Association 125th Annual Convention, Washington, DC, United States.

Worthington, E. L., Jr., Kurusu, T. A., McCullough, M. E., & Sandage, S. J. (1996). Empirical research on religion and psychotherapeutic processes and outcomes: A 10-year review and research prospectus. *Psychological Bulletin, 119*(3), 448–487. https://doi.org/10.1037/0033-2909.119.3.448

Worthington, E. L., Jr., Hook, J. N., Davis, D. E., Gartner, A. L., & Jennings, D. J., II. (2013). Conducting empirical research on religiously accommodative interventions. In K. I. Pargament, A. Mahoney, & E. P. Shafranske (Eds.), *Handbook of psychology, religion, and spirituality (Vol. 2): An applied psychology of religion and spirituality*. American Psychological Association. https://doi.org/10.1037/14046-034

Zhang, Y., Young, D., Lee, S., Zhang, H., Xiao, Z., Hao, W., Feng, Y., Zhou, H., & Chang, D. F. (2002). Chinese Taoist cognitive psychotherapy in the treatment of generalized anxiety disorder in contemporary China. *Transcultural Psychiatry, 39*(1), 115–129. https://doi.org/10.1177%2F136346150203900105

Zinnbauer, B. J., Pargament, K. I., Cole, B., Rye, M. S., Butter, E. M., Belavich, T. G., Hipp, K. M., Scott, A. B., & Kadar, J. L. (1997). Religion and spirituality: Unfuzzying the fuzzy. *Journal for the Scientific Study of Religion, 36*(4), 549-564. https://doi.org/10.2307/1387689

Tables

Table 1

Total Frequency of Spiritual Interventions Utilized

Spiritual Intervention	Frequency	% of Sessions
Affirmed client's divine worth	4849	74.0%
Affirmed trusting God	4191	64.0%
Encouraged listening to the heart	4108	62.7%
Encouraged acceptance of God's love	3859	58.9%
Discussed forgiveness	1572	24.0%
Challenge shame	1453	22.2%
Challenge fear	1352	20.6%
Encouraged personal prayer	1309	20.0%
As therapist engaged in silent prayer	957	14.6%
Used spiritual assessment	720	11.0%
Discussed hope	533	8.1%
Discussed the spiritual dimensions of problems and solutions	505	7.7%
Listened to spiritual issues	435	6.6%
Discussed compassion	278	4.2%
Referred to religious community	263	4.0%
Used spiritual confrontation	214	3.3%
Identified pathways to God or the sacred	176	2.7%
Engaged in spiritual self-disclosure	161	2.5%

Encouraged charitable service	143	2.2%
Explored religious questions and doubts	141	2.2%
Used religious bibliotherapy	140	2.1%
Affirmed client confession/repentance	134	2.0%
Helped in discerning Gods will	121	1.8%
Explored questions about ultimate meaning	95	1.5%
Encouraged reconciling beliefs in God with pain and suffering	91	1.4%
Encouraged spiritual meditation	86	1.3%
Identify Blessings/Gratitude	76	1.2%
Engaged in spiritual relaxation or imagery	41	0.6%
Discussed gratitude	31	0.5%
Clarified thoughts about evil	26	0.4%
Encouraged spiritual journal writing	12	0.2%
Discussed humility	5	0.1%
Discussed self-control	1	0.0%

Table 2

Total Frequency of Clinical Issues Discussed

Clinical Issue	Frequency	% of Sessions
Self-esteem/identity	4891	74.7%
Emotions: Protection (panic, anxiety)	4424	67.6%
Emotions: Reintegration (grief, depression)	4148	63.3%
Religion/spirituality	3362	51.3%
Relationships: Family of origin	3164	48.3%
Relationships: Marriage/partner/dating	3158	48.2%
Relationships: Friends/acquaintances	2143	32.7%
Emotions: Rejection (disgust, dislike)	1926	29.4%
Problem management/coping	1914	29.2%
Emotions: Affiliation (love, liking)	1890	28.9%
Employment	1613	24.6%
Perfectionism	1474	22.5%
Emotions: Self-affirmation (joy, serenity)	1191	18.2%
Career/life planning	1167	17.8%
Sexuality	1037	15.8%
Moral/ethical concerns	1034	15.8%
Abuse: Emotional	1027	15.7%
Emotions: Orientation (surprise, confusion)	962	14.7%
Emotions: Destruction (rage, anger)	920	14.0%

Relationships: Other	789	12.0%
Child rearing/parenting	779	11.9%
Physical Health	649	9.9%
Addictions	627	9.6%
Living conditions/housing	578	8.8%
Eating/body image	517	7.9%
Relationships: Co-workers/supervisor	487	7.4%
Academics	451	6.9%
Boundaries	405	6.2%
Abuse: Physical	289	4.4%
Loneliness	251	3.8%
Abuse: Sexual	251	3.8%
Sleep disturbance	244	3.7%
Therapy progress	210	3.2%
Therapeutic relationship	182	2.8%
Relationships: Family	150	2.3%
Divorce	140	2.1%
Financial concerns	137	2.1%
Self-injury	94	1.4%
Legal concerns	92	1.4%
Neglect	84	1.3%
Negative habits	75	1.1%
Suicide	74	1.1%

Alcohol/drug use	49	0.7%
Medications	35	0.5%
Death/grieving	22	0.3%
Emotions: Exploration (anticipation, curiosity)	16	0.2%
Violence	2	0.0%
Cultural diversity	1	0.0%
Discrimination	1	0.0%

Figures

Figure 1

Example Correlation Matrix

	Intervention A	Intervention B	Intervention C	Intervention D	Intervention E
Topic 1	0.500	0.421	0.310	0.090	-0.200
Topic 2	0.495	0.678	0.270	0.000	0.032
Topic 3	0.664	0.530	0.219	-0.026	0.039
Topic 4	0.199	0.200	0.398	0.106	-0.033
Topic 5	0.045	-0.179	0.009	-0.018	-0.210

Figure 2

Complete Topographical Analysis Chart

	Affirmed client's divine worth	Affirmed trusting God	Encouraged listening to the heart	Encouraged acceptance of God's love	Discussed forgiveness	Challenge Shame	Challenge Fear	Encouraged personal prayer	As therapist engaged in silent prayer	Used spiritual assessment	Discussed hope
Self-Esteem/ Identity	0.441	0.301	0.306	0.347	0.031	0.276	0.266	0.026	-0.135	-0.094	0.151
Emotions (panic/anxiety)	0.293	0.223	0.259	0.172	-0.028	0.332	0.331	-0.058	-0.176	0.068	0.197
Emotions (grief/depression)	0.325	0.247	0.246	0.258	0.020	0.360	0.346	-0.021	-0.156	0.064	0.210
Religion/ Spirituality	0.325	0.421	0.289	0.286	0.144	0.393	0.395	0.089	0.065	-0.020	0.242
Relationships (family of origin)	0.198	0.122	0.084	0.184	-0.079	0.318	0.311	-0.078	-0.091	0.045	0.151
Relationships (romantic)	0.256	0.253	0.290	0.187	-0.043	0.356	0.337	-0.116	-0.210	0.054	0.241
Relationships (social)	0.191	0.126	0.087	0.175	-0.022	0.336	0.329	0.073	0.004	-0.035	0.245
Emotions (disgust/dislike)	0.284	0.264	0.171	0.303	0.002	0.606	0.587	-0.026	-0.022	-0.087	0.391
Problem management/coping	0.165	0.223	0.134	0.199	-0.026	0.420	0.414	-0.009	-0.018	-0.095	0.232
Emotions (love/liking)	0.246	0.274	0.193	0.274	0.016	0.531	0.504	0.004	-0.019	-0.130	0.253
Employment	0.084	0.100	0.046	-0.009	-0.015	0.152	0.137	-0.071	-0.055	-0.096	0.106
Perfectionism	0.103	0.068	0.180	0.096	0.146	-0.154	-0.140	0.210	0.131	0.034	-0.067
Emotions (joy/serenity)	0.189	0.250	0.237	0.258	0.087	0.475	0.473	0.056	0.094	-0.106	0.275
Career/life planning	0.016	0.032	-0.019	-0.052	-0.107	0.072	0.051	-0.004	-0.161	0.072	0.034
Sexuality	0.038	0.069	0.058	0.076	0.304	-0.125	-0.128	0.244	0.357	-0.063	-0.079
Moral/ethical concerns	0.019	0.093	0.062	0.079	0.286	-0.113	-0.110	0.246	0.369	-0.087	-0.058
Abuse (emotional)	0.167	-0.021	0.004	0.169	-0.085	-0.021	-0.011	-0.015	-0.044	0.024	-0.045
Emotions (surprise/confusion)	0.169	0.203	0.190	0.190	-0.035	0.664	0.648	-0.067	-0.120	-0.038	0.500
Emotions (rage/anger)	0.101	0.047	0.012	0.110	-0.028	0.229	0.218	-0.036	0.012	-0.037	0.158
Relationships (other)	0.101	0.116	0.086	0.092	0.000	0.269	0.282	-0.041	-0.065	-0.084	0.149
Child rearing/parenting	0.100	0.158	0.110	0.058	-0.028	0.148	0.142	-0.114	-0.141	-0.070	0.073
Physical Health	0.070	0.069	0.044	0.057	-0.097	0.250	0.246	-0.042	-0.134	-0.004	0.101
Addictions	0.007	0.058	0.048	0.052	0.230	-0.115	-0.119	0.224	0.311	0.050	-0.093
Living conditions/ housing	-0.040	0.003	-0.038	0.010	-0.043	0.081	0.078	-0.053	0.015	-0.044	0.018
Eating/Body Image	0.013	0.013	0.008	0.031	-0.054	0.149	0.154	-0.051	-0.047	-0.076	0.064
Relationships (professional)	0.119	0.131	0.115	0.146	-0.038	0.339	0.317	-0.099	-0.117	-0.040	0.260
Academics	-0.022	-0.060	0.006	-0.103	-0.054	0.036	0.028	-0.026	-0.095	0.055	-0.017
Boundaries	0.132	0.148	0.160	0.127	-0.015	0.473	0.477	-0.087	-0.106	-0.064	0.362
Abuse (physical)	0.068	0.040	0.010	0.040	-0.056	-0.007	-0.003	0.030	-0.003	0.048	-0.037
Loneliness	-0.043	0.002	0.007	0.018	0.143	-0.107	-0.102	0.147	0.282	-0.070	-0.059
Abuse (sexual)	0.078	0.040	0.011	0.058	-0.030	0.037	0.036	-0.042	-0.029	0.026	0.016
Sleep disturbance	0.032	0.022	-0.007	0.025	-0.028	0.153	0.155	-0.072	-0.029	-0.015	0.086
Therapy progress	-0.088	-0.040	-0.066	-0.021	0.076	-0.097	-0.093	0.059	0.187	-0.058	-0.054
Therapy Relationship	-0.046	-0.013	-0.060	0.001	0.096	-0.090	-0.086	0.090	0.185	-0.059	-0.050
Relationships (family)	-0.033	0.002	0.006	0.018	0.091	-0.082	-0.078	0.082	0.217	-0.054	-0.046
Divorce	0.088	0.100	0.103	0.111	-0.009	0.274	0.285	-0.069	-0.061	-0.035	0.180
Financial Concerns	0.065	0.059	0.027	0.053	-0.065	0.228	0.221	-0.068	-0.060	-0.017	0.035
Self-injury	0.042	0.005	-0.077	0.064	-0.053	0.013	0.011	-0.003	0.012	0.081	0.006
Legal Concerns	0.032	0.052	0.028	0.013	-0.064	0.027	0.026	-0.053	-0.049	-0.013	-0.017
Neglect	0.058	0.040	0.040	0.054	-0.042	0.213	0.217	-0.057	-0.047	-0.018	0.001
Negative Habits	0.038	0.054	0.038	0.052	0.007	0.195	0.168	-0.029	-0.045	0.008	0.278
Suicide	0.017	-0.004	0.032	0.010	-0.016	0.110	0.106	-0.043	-0.028	0.027	0.047
Alcohol/Drug use	-0.013	-0.005	-0.014	-0.003	-0.049	0.069	0.065	-0.004	-0.036	-0.014	0.020
Medications	-0.004	-0.002	-0.004	0.002	-0.022	0.132	0.128	-0.031	-0.030	0.021	0.116
Death/ Grieving	0.034	0.038	0.023	0.043	-0.002	0.109	0.114	-0.029	-0.024	-0.012	0.021
Emotions (anticipating/curious)	0.029	-0.008	-0.007	0.041	-0.013	-0.026	-0.025	0.037	-0.020	0.022	-0.015
Violence	-0.030	-0.023	-0.023	-0.021	-0.010	-0.009	-0.009	-0.009	-0.007	0.022	-0.005
Cultural Diversity	-0.021	-0.016	-0.016	-0.015	-0.007	-0.007	-0.006	-0.006	-0.005	-0.004	-0.004
Discrimination	-0.021	-0.016	-0.016	-0.015	-0.007	-0.007	-0.006	-0.006	-0.005	-0.004	-0.004

	Discussed R/S dimension of issues	Listened to spiritual issues	Discussed compassion	Referred to religious community	Used spiritual confrontation	Identified pathways to God/sacred	Engaged in spiritual self-disclosure	Encouraged charitable service	Explored R/S questions or doubts	Used religious bibliotherapy	Affirmed client confession/ repentance
Self-Esteem/ Identity	0.139	0.127	0.119	0.006	0.079	0.092	0.020	-0.021	0.082	0.011	0.040
Emotions (panic/anxiety)	0.192	0.172	0.146	-0.136	0.080	0.113	0.036	-0.113	0.094	0.096	0.006
Emotions (grief/depression)	0.194	0.176	0.155	-0.061	0.083	0.121	0.021	-0.125	0.100	0.049	0.041
Religion/ Spirituality	0.233	0.222	0.164	0.109	0.081	0.150	-0.057	0.047	0.134	0.015	-0.008
Relationships (family of origin)	0.151	0.135	0.145	-0.051	-0.051	0.102	0.026	-0.096	0.048	-0.016	-0.075
Relationships (romantic)	0.246	0.233	0.156	-0.025	0.055	0.157	0.048	-0.040	0.124	0.037	0.018
Relationships (social)	0.222	0.192	0.192	0.065	-0.093	0.184	-0.073	0.021	0.148	-0.078	0.039
Emotions (disgust/dislike)	0.369	0.351	0.295	-0.004	-0.066	0.187	-0.068	-0.057	0.181	-0.081	0.042
Problem management/coping	0.216	0.190	0.163	-0.022	-0.118	0.126	-0.078	-0.048	0.106	-0.065	0.099
Emotions (love/liking)	0.272	0.228	0.183	0.065	-0.117	0.169	-0.064	-0.054	0.119	-0.080	0.060
Employment	0.096	0.091	0.041	-0.007	-0.057	0.100	0.037	-0.032	0.052	-0.060	-0.073
Perfectionism	-0.074	-0.078	-0.030	0.031	0.037	-0.013	0.011	0.090	-0.030	0.123	0.041
Emotions (joy/serenity)	0.270	0.264	0.170	0.101	-0.082	0.171	-0.075	-0.022	0.151	-0.061	0.033
Career/life planning	0.039	0.039	0.003	-0.069	0.000	0.068	-0.022	-0.070	0.030	-0.047	-0.067
Sexuality	-0.067	-0.049	-0.037	0.175	0.029	-0.018	-0.069	0.144	-0.018	-0.032	0.055
Moral/ethical concerns	-0.058	-0.047	-0.039	0.259	-0.016	0.008	-0.034	0.219	-0.012	0.011	0.038
Abuse (emotional)	-0.060	-0.044	-0.039	-0.056	-0.001	-0.033	0.070	-0.050	-0.018	0.093	0.077
Emotions (surprise/confusion)	0.473	0.463	0.368	-0.041	-0.076	0.243	-0.030	-0.047	0.298	-0.058	-0.014
Emotions (rage/anger)	0.117	0.150	0.120	-0.049	0.002	0.093	0.029	-0.045	0.088	-0.054	-0.021
Relationships (other)	0.150	0.152	0.136	-0.045	-0.039	0.020	-0.028	-0.055	0.081	-0.035	-0.053
Child rearing/parenting	0.078	0.072	0.016	-0.056	0.012	-0.006	0.067	-0.055	0.036	-0.028	-0.020
Physical Health	0.103	0.088	0.052	-0.031	0.005	0.040	-0.033	-0.050	0.088	-0.035	-0.044
Addictions	-0.082	-0.070	-0.063	0.253	0.042	-0.044	-0.052	0.101	-0.048	0.006	-0.021
Living conditions/ housing	0.025	-0.001	0.036	-0.014	-0.057	0.008	-0.046	-0.032	-0.020	-0.046	-0.041
Eating/Body Image	0.072	0.058	0.042	-0.031	-0.032	0.053	-0.025	-0.044	0.027	-0.024	0.010
Relationships (professional)	0.265	0.238	0.108	-0.037	-0.036	0.133	-0.004	-0.042	0.098	-0.034	0.017
Academics	0.001	-0.014	0.015	-0.019	-0.043	0.014	-0.031	-0.008	0.001	0.006	0.029
Boundaries	0.325	0.296	0.273	-0.014	-0.047	0.122	-0.028	-0.038	0.124	-0.029	-0.001
Abuse (physical)	-0.034	-0.027	-0.030	-0.025	0.032	-0.017	0.110	-0.032	-0.011	0.045	-0.031
Loneliness	-0.058	-0.053	-0.042	0.291	-0.037	-0.033	-0.032	0.444	-0.030	-0.030	-0.029
Abuse (sexual)	0.011	0.004	0.001	0.004	-0.023	-0.023	0.004	0.063	-0.024	0.047	-0.018
Sleep disturbance	0.091	0.080	0.063	-0.028	-0.036	0.057	-0.031	-0.029	0.015	-0.029	0.029
Therapy progress	-0.053	-0.049	-0.038	0.038	-0.033	-0.030	-0.012	-0.027	-0.027	-0.027	-0.026
Therapy Relationship	-0.049	-0.045	-0.036	-0.030	-0.015	-0.028	-0.027	0.032	-0.025	-0.025	-0.018
Relationships (family)	-0.044	-0.041	-0.032	0.213	-0.028	-0.025	-0.024	0.236	-0.023	-0.023	-0.022
Divorce	0.135	0.126	0.084	-0.009	-0.027	0.021	-0.023	-0.022	0.124	-0.022	-0.014
Financial Concerns	0.038	0.008	0.038	-0.014	-0.027	-0.004	-0.023	-0.022	-0.007	-0.022	-0.021
Self-injury	0.008	-0.006	0.032	0.028	0.108	0.012	-0.019	-0.018	0.000	-0.018	-0.017
Legal Concerns	-0.020	-0.006	0.001	0.002	-0.022	0.020	-0.019	-0.018	-0.009	-0.018	0.001
Neglect	0.003	-0.003	0.010	0.039	-0.021	-0.002	-0.018	-0.017	0.011	-0.017	-0.016
Negative Habits	0.308	0.277	0.291	0.022	-0.020	0.310	-0.017	-0.016	0.162	-0.006	0.136
Suicide	0.034	0.018	0.063	0.052	-0.020	0.018	-0.017	-0.016	-0.016	-0.006	-0.015
Alcohol/Drug use	0.055	0.062	0.034	0.036	-0.016	0.117	-0.014	-0.013	-0.013	-0.013	-0.013
Medications	0.097	0.098	0.047	-0.015	-0.013	0.078	0.002	-0.011	0.076	-0.011	0.004
Death/ Grieving	0.023	0.027	-0.012	0.109	-0.011	-0.010	-0.009	-0.009	0.028	-0.009	-0.008
Emotions (anticipating/curious)	-0.014	-0.013	-0.010	-0.010	-0.009	-0.008	-0.008	-0.007	-0.007	-0.007	0.058
Violence	-0.005	-0.005	-0.004	-0.004	-0.003	-0.003	-0.003	-0.003	-0.003	-0.003	-0.003
Cultural Diversity	-0.004	-0.003	-0.003	-0.003	-0.002	-0.002	-0.002	-0.002	-0.002	-0.002	-0.002
Discrimination	-0.004	-0.003	-0.003	-0.003	-0.002	-0.002	-0.002	-0.002	-0.002	-0.002	-0.002

	Helped in discerning God's will	Explored questions about meaning	Reconcile belief in God with pain	Encouraged spiritual meditation	Identify blessings/ gratitude	Spiritual relaxation or imagery	Discussed gratitude	Clarified thoughts about evil	Encouraged spiritual journal writing	Discussed humility	Discussed self-control
Self-Esteem/ Identity	0.059	0.065	0.069	0.058	0.060	0.042	0.040	0.037	0.025	0.016	0.007
Emotions (panic/anxiety)	0.090	0.084	0.077	-0.009	0.075	0.055	0.048	0.044	0.007	0.019	0.009
Emotions (grief/depression)	0.093	0.087	0.090	0.015	0.077	0.056	0.052	0.048	0.033	0.021	0.009
Religion/ Spirituality	0.131	0.105	0.100	-0.041	0.086	0.073	0.045	0.061	0.006	0.027	0.012
Relationships (family of origin)	0.062	0.051	0.050	0.015	0.098	0.039	-0.009	0.036	-0.006	0.006	-0.012
Relationships (romantic)	0.135	0.103	0.102	0.047	0.109	0.074	0.058	-0.017	0.009	0.029	0.013
Relationships (social)	0.127	0.130	0.087	0.028	0.067	-0.010	0.099	0.054	-0.007	0.028	0.018
Emotions (disgust/dislike)	0.190	0.163	0.184	-0.057	0.149	0.102	0.102	0.098	0.019	0.043	0.019
Problem management/coping	0.144	0.093	0.145	-0.059	0.053	0.021	0.044	0.013	0.051	0.031	0.019
Emotions (love/liking)	0.133	0.112	0.057	0.039	0.154	0.009	0.103	0.040	0.028	0.031	-0.008
Employment	0.064	0.034	0.084	-0.035	0.044	0.004	0.007	0.003	-0.024	0.010	-0.007
Perfectionism	-0.003	0.011	-0.023	0.018	0.017	-0.034	-0.027	-0.028	0.003	-0.015	0.023
Emotions (joy/serenity)	0.153	0.161	0.089	-0.047	0.134	0.023	0.129	0.065	-0.002	0.030	0.026
Career/life planning	0.013	0.020	0.016	0.062	0.061	0.004	0.003	-0.017	-0.020	0.002	-0.006
Sexuality	-0.004	-0.032	-0.051	-0.050	-0.035	-0.013	0.031	-0.007	-0.019	0.003	0.028
Moral/ethical concerns	0.000	-0.025	-0.037	-0.028	-0.039	-0.008	0.049	-0.001	-0.019	0.018	0.029
Abuse (emotional)	-0.044	-0.010	0.017	0.124	-0.047	-0.034	-0.030	0.040	-0.018	-0.012	-0.005
Emotions (surprise/confusion)	0.235	0.195	0.242	-0.048	-0.013	0.027	0.047	0.070	0.012	0.051	0.030
Emotions (rage/anger)	0.023	0.102	0.132	0.038	0.055	0.074	-0.028	-0.026	-0.017	0.021	-0.005
Relationships (other)	0.047	0.045	0.100	-0.043	-0.040	0.048	-0.026	0.096	-0.016	0.024	-0.005
Child rearing/parenting	0.016	0.058	0.073	.053	0.004	-0.029	-0.025	0.022	-0.016	-0.010	-0.005
Physical Health	0.046	0.020	0.122	0.007	-0.007	0.013	-0.023	-0.013	-0.014	-0.009	-0.004
Addictions	-0.045	-0.039	-0.030	-0.038	-0.006	0.106	-0.022	-0.021	-0.014	-0.009	-0.004
Living conditions/ housing	0.001	-0.011	0.009	-0.036	0.001	0.009	0.018	0.049	-0.013	-0.009	-0.004
Eating/Body Image	0.027	0.054	0.043	-0.034	0.148	0.013	0.021	0.009	0.027	-0.008	-0.004
Relationships (professional)	0.117	0.126	0.130	-0.033	0.192	-0.008	0.082	0.010	0.029	0.034	-0.004
Academics	0.016	0.007	-0.022	-0.031	-0.029	0.047	0.025	-0.017	0.002	0.014	-0.003
Boundaries	0.177	0.117	0.148	-0.030	0.002	0.012	0.056	0.145	-0.011	0.062	-0.003
Abuse (physical)	-0.029	-0.026	0.006	0.217	-0.023	-0.017	-0.015	-0.014	-0.009	-0.006	-0.003
Loneliness	-0.027	-0.024	-0.024	-0.023	-0.022	-0.016	-0.014	-0.013	-0.009	-0.006	-0.002
Abuse (sexual)	0.026	-0.011	0.044	-0.023	-0.014	0.004	-0.014	-0.013	-0.009	0.023	-0.002
Sleep disturbance	0.093	0.037	0.073	0.006	-0.006	0.015	-0.014	-0.012	-0.008	0.024	0.063
Therapy progress	-0.025	-0.022	-0.022	-0.021	-0.020	-0.014	-0.013	-0.011	-0.008	-0.005	-0.002
Therapy Relationship	-0.023	-0.021	-0.020	0.160	-0.018	-0.013	-0.012	-0.011	-0.007	-0.005	-0.002
Relationships (family)	-0.021	-0.019	-0.018	-0.018	-0.017	-0.012	-0.011	-0.010	-0.007	-0.004	-0.002
Divorce	0.019	0.070	0.127	-0.017	-0.016	-0.012	-0.010	-0.009	-0.006	-0.004	-0.002
Financial Concerns	-0.020	0.000	-0.017	-0.017	-0.006	0.002	-0.010	-0.009	-0.006	-0.004	-0.002
Self-injury	-0.007	0.018	0.008	-0.014	-0.013	0.267	-0.008	-0.008	-0.005	-0.003	-0.001
Legal Concerns	-0.016	-0.004	-0.003	-0.014	-0.013	-0.009	-0.008	-0.008	-0.005	-0.003	-0.001
Neglect	0.005	0.009	0.010	-0.013	-0.012	-0.009	-0.008	0.014	-0.005	-0.003	-0.001
Negative Habits	0.092	0.179	0.024	0.076	0.270	0.010	0.118	0.062	-0.005	-0.003	0.115
Suicide	0.007	0.023	0.012	-0.012	-0.012	-0.008	-0.007	-0.007	-0.005	-0.003	-0.001
Alcohol/Drug use	-0.012	-0.011	-0.010	-0.010	0.173	-0.007	-0.006	-0.005	-0.004	-0.002	-0.001
Medications	0.052	0.114	0.009	-0.008	0.031	-0.006	0.025	-0.005	-0.003	-0.002	-0.001
Death/ Grieving	0.031	-0.007	-0.007	-0.007	-0.006	-0.005	-0.004	-0.004	-0.002	-0.002	-0.001
Emotions (anticipating/curious)	-0.007	-0.006	-0.006	0.049	-0.005	-0.004	-0.003	-0.003	0.143	-0.001	-0.001
Violence	-0.002	-0.002	-0.002	-0.002	-0.002	-0.001	-0.001	-0.001	-0.001	0.000	0.000
Cultural Diversity	-0.002	-0.001	-0.001	-0.001	-0.001	-0.001	-0.001	-0.001	-0.001	0.000	0.000
Discrimination	-0.002	-0.001	-0.001	-0.001	-0.001	-0.001	-0.001	-0.001	-0.001	0.000	0.000

Note. For concision, some variable names were modified. Red cells show $0.400 \leq r \leq 0.664$; orange cells show $0.200 \leq r \leq 0.399$; yellow cells show $0.033 \leq r \leq 0.199$; green cells show $-0.032 \leq r \leq 0.032$; blue cells show $-0.099 \leq r \leq -0.033$; purple cells show $-0.210 \leq r \leq -0.100$.

APPENDIX A

Review of the Literature

Within the last three decades, the field of psychology has become more amenable to sensitivity and utilization of clients' spirituality in therapy. Consequently, spiritually integrated therapy approaches have become more accepted and widespread in practice and the number of clinical issues being effectively treated by such approaches has expanded greatly. Such issues include depression, anxiety, eating disorders, abuse and trauma, grief, substance abuse, and obsessive-compulsive disorders, among others (see Jackson et al., 2019, for a recent review). The efficacy and effectiveness of spiritually integrated treatments has been demonstrated through hundreds of empirical studies.

Interface Between Religion/Spirituality and Psychology

Current Use of the Terms *Religion* and *Spirituality*

To discuss religion and spirituality in a coherent way for the current discussion, it is necessary to explain how these terms will be used. As previous research indicates, there is no mutually agreed upon definition of either religion or spirituality (Scott, 1997; Zinnbauer et al., 1997). As this lack of agreement has been noted as problematic by several researchers (Pargament, Exline, et al., 2013; Zinnbauer et al., 1997), this paper will adhere to definitions provided by Pargament, Exline, et al. (2013).

Spirituality was defined by Pargament, Exline, et al. (2013) as a "search for the sacred," which in many cases is attached to a specific religious tradition, but not always. Per their discussion, spirituality relates to God, another higher power, or another aspect of an individual's life he/she connects to the divine or transcendent. This concept is similar, but not identical, to *religion*, which is the "search for significance that occurs within the context of established

institutions that are designed to facilitate spirituality" (Pargament, Exline, et al., 2013, p. 15). In other words, religion is an organized system intending to foster spiritual development.

In line with other definitional positions (e.g., Sperry, 2012), Pargament, Exline, et al.'s (2013) definitions of religion and spirituality are intertwined yet different in most cases. They noted that religion's search for significance may entail the sacred or transcendent, but may also be directed at social, psychological, or physical goals or significance. The current argument follows Pargament, Exline, et al.'s position that when religion is directed at the sacred, religion and spirituality are indistinguishable. During the current study, the sacred – as opposed to only the social, psychological, or physical – will be investigated as a mechanism to facilitate healing. Per Pargament, Exline, et al.'s suggestion, it follows that either word would suffice. Thus, to be more consistent when referring to these ideas, the term "spirituality," or the combined term "religion/spirituality (R/S)" will be used hereafter. The former denotes the emphasis on the sacred, and the latter represents the interchangeability of these terms when the sacred is emphasized.

Religion/Spirituality in the United States

While the percentage of American adults claiming to be religious appears to have dropped modestly in recent years, most adults in the United States nonetheless self-report that they are religious/spiritual (Pew Research Center, 2015). The results of the 2014 U.S. Religious Landscape Survey revealed that, of a nationally representative sample, 83% of adults reported having a fairly certain or absolutely certain belief in God, and 77% reported that religion is at least somewhat important in their lives. 71% of these respondents said they pray at least weekly. Additionally, 59% stated that they frequently (at least once a week) feel a sense of spiritual peace and well-being, while 50% feel a deep sense of wonder about the universe at least once a week.

These reports indicate that most American adults are religious/spiritual (Pew Research Center, 2015).

Not only are most American adults religious/spiritual, but this mindset seems to significantly influence their lives (Sperry, 2012). Gallup (1999) concluded that religious commitment is a more impactful aspect of people's lives regarding how they behave and think than many other personal characteristics, including education, age, and political perspectives. Given the importance of R/S for some individuals, the interface between R/S and mental health is a long-running and highly investigated line of research. There was, however, a period of distinct separation between R/S and psychology before they were successively integrated (Richards & Bergin, 2005).

Period of Separation

For most of the 20th century, the fields of psychology and spirituality intentionally existed separately (Richards & Bergin, 2005). During this period, there were many influential and prominent figures in psychology who were outspoken opponents of religion per se, such as Sigmund Freud and Albert Ellis, who argued that religion was an illusion, symptomatic of a disturbed and irrational mind. For example, Freud referred to religion as "the universal obsessional neurosis of humanity" (Strachey, 1961, p. 43). Similarly, earlier in his career, Ellis (1980) contended that religion carries with it many negative side effects for religious individuals, including obsessive-compulsive problems, lack of self-acceptance, and inhibited mental flexibility. Others raised their voices in support of a naturalistic perspective within the behavioral sciences, asserting that the behavioral sciences were best understood through a naturalistic lens, and that religion had no positive role in explaining human behavior (Richards & Bergin, 2005).

Period of Acceptance and Integration

Beginning in the latter part of the 20th century, researchers and authors such as Bergin (1980), Campbell (1975), and Jones (1994) began to challenge the reigning naturalistic assumptions within psychology. They posited that including a spiritual perspective in the behavioral sciences could yield many positive benefits, as such inclusion could offer a more complete understanding of the complexities of the universe and of human nature and behavior. Additionally, researchers began to find a generally positive association between religion and mental health (e.g., Levin, 2010).

Currently, R/S is seen by many individuals and researchers as an important healing and coping resource (Pargament, 1997; Richards & Bergin, 2014). For example, many religious individuals use their faith and beliefs during times of struggle to help them cope. Pargament (1997) indicated that “coping is a search for significance in times of stress” (p. 90). He later explained that religion often provides people with a sense of meaning and significance; religiously/spiritually minded people look to their faith as a resource to help them cope with and overcome adversity (Pargament, Exline, et al., 2013). In line with this theory, research has shown that religiousness, especially when it is intrinsically motivated, is generally associated with fewer depressive symptoms (e.g., Helms et al., 2015; Mosqueiro et al., 2015), increased mental and spiritual well-being (e.g., Sanders, Allen, et al., 2015), increased longevity (e.g., Koenig et al., 2012), and many other benefits (e.g., Koenig et al., 2012; Richards & Bergin, 2005; Sanders, Allen, et al., 2015).

Despite these generally positive findings, unhealthy religious perspectives may contribute to an individual’s mental health struggles (Richards & Bergin, 2014). These unhealthy religious perspectives may reflect an individual correctly living an actual tenet of their religion, or may be

a result of an extreme or unhealthy interpretation of what otherwise might be an adaptive or healthy aspect of one's faith tradition (MacKenna, 2007). Nevertheless, it is well documented that many people have used their faith as a source of healing in their lives (Pargament, 1997).

Religion and Spirituality in Psychotherapy

Because most research has found a positive relationship between religion and mental health, and since the initial proposals calling for the integration of spirituality into psychology, there has been an increased recognition that R/S may be able to play an important and therapeutic role in psychotherapy (Richards & Bergin, 2014). The idea of utilizing R/S as a healing resource has become increasingly popular in psychotherapy work (Richards & Bergin, 2005; 2014). Recent studies show that many clients want to be able to integrate their R/S beliefs into their therapy work (e.g., Post & Wade, 2009; Stanley et al., 2011). Many therapists report that being sensitive and accommodating to their clients' religious or spiritual perspectives in therapy is important and potentially beneficial (e.g., Furman et al., 2004; Post & Wade, 2009). Consequently, therapists and researchers have created, described, and implemented what has come to be known by some as spiritually integrated therapy (Pargament, 2007; Pargament, Mahoney, et al., 2013).

Spiritually integrated therapy (SIT) is a general term referring to a therapy approach which is "sensitive to the spiritual dimension" (Pargament, Mahoney, et al., 2013, p. 227). SITs are viewed as those which consider the potential healing role that a client's religious or spiritual resources have for him or her in the therapeutic process. These approaches have grown increasingly popular in the past two to 3 decades, and there is a growing body of empirical and theoretical research supporting their use (Jackson et al., 2019).

Operational Considerations

The extant literature illustrates that the field has not yet established a universally agreed upon name for SIT. This may be related to the definitional issues regarding R/S. To date, there have been many different labels for therapy approaches that have included explicitly religious/spiritual components: faith-adapted (Anderson et al., 2015), faith-supportive (Scott, 2003), mind-body-spirit therapy (Targ & Levine, 2002), pastoral (Houck & Moss, 1977), religious-cultural (Razali et al., 2002), spiritual (Tadwalker et al., 2014), spiritual or religion-accommodative (Worthington et al., 2013), spiritually informed (Nohr, 2000), spiritually modified (Hodge, 2006), spiritually oriented (Sperry & Shafranske, 2005), spiritually sensitive (Bowland et al., 2013), and theistic spiritual (Richards & Bergin, 2005) psychotherapy, among others. Others have referred to a therapy approach using the name of an identified religious/spiritual tradition, such as Taoist cognitive (Zhang et al., 2002), Islamically integrated (Al-Karam, 2018), and Christian (Sutton et al., 2018) psychotherapy.

Some studies in the literature have referred not to an overall spiritual approach to therapy or counseling, but rather to specific therapeutic interventions designed to encourage people toward spirituality. For example, some of these interventions have been referred to as religious based (Stewart et al., 2006), religiously tailored (Wade et al., 2007), spiritually based (Sheridan, 2009), spiritually-derived (Sheridan, 2004), and spiritually integrated (Harris et al., 2011),

Similarly, researchers have designed, executed, and studied many approaches that have integrated explicit religious/spiritual principles or perspectives. In some cases, researchers have evaluated traditional therapy approaches that have been modified to include religious/spiritual language, references, homework, etc. For example, Nohr (2000) experimentally tested the differences between a workshop-style standard cognitive-behavioral treatment (CBT) and

spiritually informed CBT (SCBT). The participants, students at a religiously affiliated university, were measured on several outcome variables, including general and spiritual well-being and psychological distress. The SCBT group "was guided by a cognitive-behaviorally-based manual compiled by [the author] and was identical to the CBT condition, except that several suggestions and illustrations to incorporate spirituality were offered" (p. 165). Razali et al. (2002) conducted an experimental study examining the effect of a religiously modified cognitive therapy for Malay patients diagnosed with generalized anxiety disorder, half of whom identified as Muslim. The treatment condition was labeled as religious-cultural psychotherapy (RCBT). As opposed to the control group, which received standard cognitive therapy, the RCBT group was run "similar to the cognitive model of Beck and colleagues" (Razali et al., 2002, p. 132). The researchers explained that faulty and distorted automatic thoughts, cognitive schemata, and psychoeducation and coping mechanisms related to anxiety were reframed and addressed from a Muslim perspective to help patients.

Other researchers have studied SIT which has focused on the religious/spiritual components, rather than a standard treatment with a religious/spiritual appendage. For example, Oman et al. (2007) examined the differential effects of passage meditation (PM)—participants practiced sitting and meditating on a specific passage of religious text or a quote from a spiritual figure—and mindfulness based stress reduction—participants focused on being aware of the present moment and meditating specifically on their breath. The PM intervention was described as an explicitly spiritually based practice and was not adapted from a cognitive-behavioral, interpersonal, rational-emotive, or other traditional psychotherapy approach.

Still others have investigated the effectiveness of spiritual practices per se and discussed the importance of exploring the health and wellness of individuals who engage these practices.

Schiff and Moore (2006) published a pilot study on the effectiveness of sweat lodge ceremonies, a sacred practice for many North American Aboriginal groups. Tripathi and Bano (2014) explored the benefits of yogic practices, an exercise that originated in ancient India and is viewed by many as a holistic (including spiritual) health aid. Vasiliauskas and McMinn (2013) conducted a study that examined the effects of personal prayer for individuals who were working on interpersonal forgiveness.

In each of these aforementioned examples, the labels associated with therapy approaches in general or interventions in specific have suggested that the primary focus was the therapeutic approach itself—the therapeutic orientation, the specific intervention being employed, the unique combination of interventions in a model of therapy—and less so on the spirituality of the individuals who participated in the therapeutic interaction.

In another arena, some researchers and theorists have argued less for labeling a therapy approach or intervention as spiritual, and more for considering the perspective, input, and intention of the individuals engaged in a therapeutic exchange. For example, Gleave (2012) argued against the creation and promotion of an all-encompassing “gospel-centered therapy” (p. 1). Speaking to an audience of members of The Church of Jesus Christ of Latter-day Saints, Gleave posited that labeling a therapy approach as spiritual per se would fundamentally undermine an important Latter-day Saint principle. He worried that such labels would overshadow and dismiss the notion that physical and spiritual progress are unique, nuanced, contextual, and cannot be gained by adhering to a prescribed, preset list of interventions. This argument was congruent with Stiles’ (2013) position that

> the pervasiveness of human responsiveness implies that clients in the same experimental condition . . . each receives a different individually tailored treatment. Such variability

> impairs any study's conclusions because the treatment names, such as *psychoanalysis* or *cognitive—behavioral therapy* (CBT) or *treatment as usual*, have no stable meaning. Named treatments vary not just from study to study, but from therapist to therapist, from client to client, from session to session, and from minute to minute. (Stiles, 2013, p. 34)

Rather than focusing on labeling a treatment as spiritual, Gleave (2012) argued for the development of gospel-centered therapists—or spiritually centered therapists, for the purposes of the current study. Gleave asserted that an intervention or therapy approach is not inherently spiritual, but that the people engaged in a therapeutic interaction can be spiritually centered. He stated:

> I suggest it is the more prudent course to become very well grounded in both [spirituality] and our professions and then to use our best informed judgment and our agency to create a relationship and a synergistic interaction with our clients that they can use in their own way—expressing their own judgment and agency to meet the unique challenges and circumstances of their own lives. I argue that this is a far nobler endeavor than giving clients "correct" answers to specific questions. (Gleave, 2012, p. 8)

In a similar yet distinct vein, some researchers have asserted that spiritual components exist in phenomena which may not be universally perceived as spiritual. For instance, Fischer (2019) discussed the spiritual ramifications of guilt and shame with a group of counselors and therapists who were members of The Church of Jesus Christ of Latter-day Saints. He argued that guilt may be a healthy part of a spiritually inherited internal bearing system referred to by Latter-day Saints as the Light of Christ. From this perspective, Fischer asserted, guilt serves as a negative affective signal which is felt to both disconfirm the appropriateness of one's actions and lead to repair in one's relationships with God and others. Conversely, Fischer asserted, shame is

a corruption of the Light of Christ which is painful but does not lead an individual to correction in these relationships. On the surface, there may be room for lively debate on the spiritual roots of guilt and shame, yet Fischer's claim has provided evidence that some researchers and practitioners maintain spiritual explanations and definitions of these concepts. Other examples of these implicitly spiritual interventions have been studied, such as therapists encouraging "listening to the heart" and encouraging forgiveness (Sanders, Richards, et al., 2015, p. 184). Fischer (2019) suggested that whether a therapeutic intervention is spiritual may depend at least partially on the perspective of the practitioner. Thus, spiritually centered therapists, according to their spiritual perspective of a clinical situation, may have used an intervention they read as spiritual, regardless of whether the intervention fits within a preset model of SIT. Extrapolating from this past literature, we may assume that the client's perspective may have an important role in discerning whether a given intervention, approach, or moment is spiritually centered or integrated.

Research on SIT

Outcome Research

Substantial empirical evidence from the last several decades demonstrates that SIT has been used effectively with a wide variety clinical issues (Jackson et al., 2019). Some clinical issues where these approaches have been effective include eating disorders (e.g., Lea et al., 2015; Tonkin, 2005), depression (e.g., Azhar & Varma, 1995; Chan et al., 2014), anxiety (e.g., Azhar et al., 1994), and PTSD and abuse recovery (e.g., Allen & Wozniak, 2011; Bormann et al., 2013). These approaches have been effective with many different populations as well, including clients of different religious and spiritual traditions, sexual orientations, ages, and ethnic and national backgrounds (Jackson et al., 2019).

Several reviews and meta-analyses have been conducted on SIT, which have concluded that in many instances, SIT appears to be at least as effective as traditional psychotherapy approaches (e.g., Anderson et al., 2015; Worthington et al., 1996). Jackson et al. (2019) found that, of 127 published studies comparing SIT to secular therapy outcomes, 46 found no significant difference between the two. However, 77 studies found that SITs significantly outperformed a secular therapy or no treatment control group. Only four of these studies showed a secular therapy approach outperforming SIT. The differences in these findings likely depend on many different factors, including clinical issue, client population, practitioner views on R/S and SIT, and others. Deeper investigation into the circumstances under which SIT produces similar, superior, or worse outcomes than a traditional therapy may be indicated at this point. However, it is of primary importance for the current project to identify that review and meta-analytic findings suggest that sensitivity to and clinically indicated utilization of spirituality can produce positive change in therapy (Miller, 1999).

Despite decades-long argument of which therapy approaches are “better” than others, compelling evidence suggests that no single theoretical or intervention-based approach guarantees especially successful therapy outcomes. Wampold (2019) has reiterated an earlier and robust conclusion that “despite numerous clinical trials comparing psychotherapies intended to be therapeutic . . . it appears that all of the approaches are about equally effective” (p. 123). The findings of the numerous review and meta-analytic findings on SIT should not, therefore, be interpreted to say that SIT is inherently more effective than secular or traditional therapy approaches. Perhaps the success of SIT depends primarily on (a) the clinical indication of such an approach and (b) the strength of the therapeutic alliance (Wampold, 2019). More nuanced research questions which explore client amenability to spiritual intervention use in a given

session rather than in therapy overall, clinician attunement to clients' needs regarding spiritual integration in a given moment, and clinician skill in integrating religious/spiritual interventions in those moments, could be conducted to further explore the idea of what therapy approaches will effectively help which clients. Questions such as these would allow researchers and clinicians to explore not just the science, but the art of therapy.

Process Research on SIT

While the efficacy and effectiveness of SIT has been increasingly demonstrated, there is a notable lack of in-depth, process-oriented research on SIT. Some researchers have explored the use of spiritual interventions in clinical settings (e.g., Murdock, 2005; Sanders, Richards, et al., 2015). Studies such as these have helped lay important groundwork for understanding what practitioners mean when reporting that they conduct SIT with their clients. Sanders, Richards, et al. (2015) explored the processes and outcomes of SIT in a sample of 304 clients and their therapists at a private, religiously affiliated university. They found that SIT, as practiced at this university by practitioners experienced in SIT, was effective in reducing client symptoms in psychological, relationship, work/school, physical health, and spiritual distress, and concerns about therapy progress. After analyzing routinely collected process data, they found that practitioners discussed religious/spiritual concerns in 33% of their sessions overall, and that the most frequently endorsed spiritual interventions were (a) therapist silent prayer (53% of sessions), (b) teaching spiritual concepts (42% of sessions), and (c) encouraging clients to "listen to the heart" (27% of sessions).

Approximately 40 other published studies have explicitly examined SIT processes. According to a comprehensive review of literature on SIT (Jackson et al., 2019), much of the process research conducted on SIT can be simplified into four primary categories: (a) rates of

SIT generally; (b) usage rates of specific spiritual interventions; (c) rates of spiritual intervention use among religious/spiritual practitioners; and (d) rates of spiritual interventions use among non-religious/spiritual practitioners. The body of published work in this area has demonstrated a wide variety of usage rates, which appears to depend somewhat on several factors including the specific healthcare field in which a practitioner works, the personal religious/spiritual identity of the practitioner, the spiritual interventions being investigated in a given study, and the setting of the practice (e.g., a hospital vs. an identified religious counseling practice). Jackson et al. found that 17 spiritual interventions were reportedly used by at least half of the respondents across 46 samples. From the limited number of studies explicitly investigating the process of SIT, many practitioners seem to not only endorse the usefulness of SIT approaches, but also utilize them frequently in their work, especially when working with R/S clients.

This preliminary work has been vital in helping establish SIT's clinical utility, yet several questions still exist about the process of SIT which have not been adequately addressed in the extant literature. For example, almost all of the published process-oriented research studies have been limited to retrospective studies inquiring about general usage rates of SIT approaches or specific interventions; researchers have typically asked practitioners if they have *ever* used a specific intervention, or request responses in Likert-style statements about general spiritual intervention frequency. For example, Kvarfordt and Sheridan (2007) analyzed survey responses from 283 practitioners who worked with children or adolescents on usage rates of 28 religious/spiritual interventions. Respondents reported usage rates on a 4-item Likert-type scale of "never" to "often used." The resulting data from this study were highly useful in understanding practitioners' SIT work with children and adolescents. Yet the nature of nearly all these studies has required practitioners to recall general usage rates of spiritual interventions.

Again, while these studies are important, the body of SIT process literature lacks in-depth session-by-session information into the nuance of how SIT is conducted. In other words, the field has very little information on what it can mean to conduct SIT, the intentions of doing so, and how SIT may change depending on the client and clinical issue present in session.

In 2015, Pfeifer and Strunk conducted a selected review of the research on cognitive therapy (CT) for depression. Their primary conclusion regarding the state of CT process research was stated as the following:

> After several decades of research on CT for depression, the efficacy of the treatments has been well established. However, there remains much that we do not know about the processes by which it achieves its effects, and how these processes may vary across different patients. The promise of process research is its potential to address these questions. (Pfeifer & Strunk, 2015, p. 414)

Pfeifer and Strunk's (2015) argument aptly extrapolates to the current state of SIT process research as well. The field simply does not have much information on the specific processes whereby effective SIT occurs. Taking it one step further, I, the current author, would argue that gaining a deeper understanding what effective psychotherapy *is* ought to be considered equally if not more important as understanding whether it is clinically or statistically *useful*. What it looks like in real-world practice, why it is practiced a certain way, and how it changes depending on presenting concerns or other nuanced aspects of a given session.

Despite the dearth of this specific type of research, the extant literature has included a few examples of exploring the routine practice of SIT. One example was from Sanders, Richards, et al. (2015), who explored the processes and outcomes of SIT in a sample of 304 clients and their therapists at a private, religiously affiliated university. They used routine,

session-by-session process/outcome measures to collect their data. They found that SIT, as practiced at this university, was effective in reducing client symptoms across several domains of functioning. Their process findings showed that practitioners discussed religious/spiritual concerns in 33% of their sessions overall, and that the most frequently endorsed spiritual interventions were (a) therapist silent prayer (53% of sessions), (b) teaching spiritual concepts (42% of sessions), and (c) encouraging clients to "listen to the heart" (27% of sessions).

Lea et al. (2015) conducted an in-depth process and outcome study of SIT. They used an intensive, mixed-method, single-*N* design, and examined the process and outcome of therapy for a religious female client who presented with eating disorder concerns comorbid with major depression, anxiety, and a personality disorder. At the end of each therapy session with this client, the therapist completed an in-depth, routine process measure completed to highlight, among other things, the specific spiritual interventions used by the therapist in each session (e.g., therapist praying silently, encouraging client to accept God's love). At each session, the client also completed a routine outcome measure that assessed distress in several areas. Overall, the client showed significant improvement in all areas of functioning on the outcome measure. Finally, the researchers used open-ended interviews with the client and her therapist to provide rich descriptive data about treatment. These data provided insight that an important part of the client's recovery was attributable to the therapist's "integration of spirituality" in the therapeutic process (p. 198).

Jackson et al. (2016) conducted a study on the process of SIT as practiced at Brigham Young University—Idaho, a religiously-affiliated university. They found that clinicians tended to endorse spiritual interventions most frequently in sessions where religious/spiritual concerns were brought up by the client, compared to other clinical issues. Finally, Wheatley et al. (2017)

conducted a replication study of Jackson et al. (2016) and found roughly comparable results. Currently, it is important that the field move beyond retrospective reports of SIT usage. Rather, we could move toward session-by-session data that help examine the effectiveness of SIT and the nuance of how SIT is used in the context of various mental health issues and the timing of SIT.

Research Design

Traditionally, randomized controlled trials (RCTs) have been a golden standard of establishing an evidence base for psychotherapy practice, and SIT research is no exception. RCT research is the field's best tool for establishing causal relationships between therapeutic interventions and client outcome. RCTs can provide invaluable information to practitioners and researchers about the efficacy of different therapy approaches. Yet, as Barkham et al. (2010) and others have shown, RCTs necessarily impose restrictions on client and therapist characteristics, therapy process variables, diagnostic comorbidity, and so on. This is done to increase a study's internal validity, or the amount of assurance that researchers have that their theorized mechanisms of change account for change in client outcome. These restrictions increase the internal validity of the studies but often create an artificial, "pure" environment. Consequently, it can be difficult to generalize RCTs to real-world therapy settings in which any number of variables cannot be feasibly controlled (Sanders, Richards, et al., 2015). Thus, what RCTs provide to the field in internally valid evidence, it often lacks in externally valid and clinically relevant findings for day-to-day therapy settings.

Related to process research on SITs, if an RCT has shown SIT to be efficacious, researchers have advertised and disseminated their manualized protocol to practitioners to inform their practice. Despite some recognized benefits of a top-down prescriptive approach,

practitioners have struggled to generalize the findings of an RCT to everyday therapy settings (Castonguay et al., 2013) or view a manualized protocol as detrimental to therapy (Millet, 2016). Many, therefore, have not utilized these prescribed approaches. This disconnect between top-down treatment protocols and everyday therapy has contributed to the field's scant information on how effective SITs are routinely conducted.

In 2006, the American Psychological Association (APA) Presidential Task Force on Evidence-Based Practice concluded that "[evidence-based practice in psychology] requires an appreciation of the value of multiple sources of scientific evidence" (p. 280). The task force encouraged practitioners and researchers to adopt multiple research designs to study any given therapeutic approach or intervention, including qualitative research, process-outcome studies, RCTs, and effectiveness research ("real-world" therapy practice studies). The task force highlighted the need to utilize approaches which come from both an efficacy (top-down, experimental) and effectiveness (bottom-up, "real-world") philosophy.

Practice-based evidence (PBE; Barkham et al., 2010) is a research framework that provides one way to conduct therapy effectiveness research. PBE consciously moves away from relying on researchers to carefully construct and sharply implement therapy protocols as in traditional evidence-based practice methods. Conversely, PBE aims to study, understand, and disseminate effective practice evidence by analyzing the work of effective practitioners "in the field." This involves establishing a therapist's effectiveness based on client outcome measures, and then studying how they conduct therapy via routine process measures. PBE is a promising avenue "to make outcome research more relevant to clinical practice" (Sanders, Richards, et al., 2015, p. 181). In addition, "knowledge derived from practice-based evidence should not be antagonistic to those who conduct RCTs, but rather the top-down and bottom-up evidence will

converge to create an amalgam that is richer and more useful than evidence from any one method" (Barkham et al., 2010, p. xix).

Bottom-up, PBE studies have not avoided their own limitations, however. One limitation in most PBE SIT process studies has been the tendency to still use a partially top-down approach. For example, many researchers have created and sent surveys to practitioners asking about usage rates of spiritual interventions. These surveys are generated as predetermined lists of interventions by the researchers themselves, who have then asked participants to respond to the interventions on the list, without allowing for custom items to be added to the list by participants (e.g., Richards & Potts, 1995). These designs, while intent on gaining insight from practitioners on their routine practice, has potentially limited the amount of information researchers have been able to gather. For example, practitioners may have regularly conducted spiritual interventions in their work on which they were unable to report, given that it was not included in the prescribed list. Some studies have begun to address this limitation through the creation of new routine monitoring systems, such as the Bridges Assessment System (BAS; Sanders & McBride, 2018). The BAS, an online, checklist-based, adaptive outcome and process measurement tool which comes with a preset list of interventions to endorse, was designed to allow practitioners to easily add items to the list if needed to more accurately capture their approach in a therapy session.

The current study recognized that in-depth, session-by-session PBE research from a more completely bottom-up approach could help close the research-practice divide in SIT. This study also assumed that studies from this perspective could potentially provide much needed understanding of what it means to conduct SIT in routine practice from practitioners' points of view.

Despite PBE's own limitations, in-depth, session-by-session PBE studies could provide much needed understanding of what it means to conduct SIT in routine practice. Such studies could work together with top-down approaches to create a more solid evidence base and a more clinically relevant store of resources for SIT practitioners. With such limited information on in-depth SIT process, one important question emerges from the literature: What does SIT look like in everyday therapy settings? Accordingly, the current study aimed to answer this question.

References

Al-Karam, C. Y. (2018). *Islamically integrated psychotherapy: Uniting faith and professional practice*. Templeton Press.

Allen, K. N., & Wozniak, D. F. (2011). The language of healing: Women's voices in healing and recovery from domestic violence. *Social Work in Mental Health, 9*(1), 37–55. https://doi.org/10.1080/15332985.2010.494540

Anderson, N., Heywood-Everett, S., Siddiqi, N., Wright, J., Meredith, J., & McMillan, D. (2015). Faith-adapted psychological therapies for depression and anxiety: Systematic review and meta-analysis. *Journal of Affective Disorders, 176*, 183–196. https://doi.org/10.1016/j.jad.2015.01.019

American Psychological Association Presidential Task Force on Evidence-Based Practice (2006). Evidence-based practice in psychology. *American Psychologist, 61*(4), 271–285. https://doi.org/10.1037/0003-066X.61.4.271

Azhar, M. Z., & Varma, S. L. (1995). Religious psychotherapy in depressive patients. *Psychotherapy and Psychosomatics, 63*(3–4), 165–173. https://doi.org/10.1159/000288954

Azhar, M. Z., Varma, S. L., Dharap, A. S. (1994). Religious psychotherapy in anxiety disorder patients. *Acta Psychiatrica Scandinavica, 90*(1), 1–3. https://doi.org/10.1111/j.1600-0447.1994.tb01545.x

Barkham, M., Hardy, G. E., & Mellor-Clark, J. (Eds.). (2010). *Developing and delivering practice-based evidence: A guide for the psychological therapies*. Wiley-Blackwell. https://doi.org/10.1002/9780470687994

Bergin, A. E. (1980). Psychotherapy and religious values. *Journal of Consulting and Clinical Psychology, 48*(1), 75–105. https://doi.org/10.1037/0022-006X.48.1.95

Bormann, J. E., Thorp, S. R., Wetherell, J. L., Golshan, S., & Lang, A. J. (2013). Meditation-based mantram intervention for veterans with posttraumatic stress disorder: A randomized trial. *Psychological Trauma: Theory, Research, Practice, and Policy, 5*(3), 259–267. https://doi.org/10.1037/a0027522

Campbell, D. T. (1975). On the conflicts between biological and social evolution and between psychology and moral tradition. *American Psychologist, 30*(12), 1103–1126. https://doi.org/10.1037/0003-066X.30.12.1103

Castonguay, L., Barkham, M., Lutz, W., & McAleavey, A. (2013). Practice-oriented research: Approaches and applications. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (6th ed., pp. 85–133). John Wiley.

Chan, C. H. Y., Chan, T. H. Y., & Chan, C. L. W. (2014). Translating Daoist concepts into integrative social work practice: An empowerment program for persons with depressive symptoms. *Journal of Religion & Spirituality in Social Work: Social Thought, 33*(1), 61–72. https://doi.org/10.1080/15426432.2014.873662

Ellis, A. (1980). *Case against religion: A psychotherapists view and the case against religiosity*. American Atheist Press.

Fischer, L. (2019, October 3–4). *Shame matrix: Assessing and helping recovery using the shame matrix* [Conference session]. 2019 Association of Mormon Counselors and Psychotherapists Convention, Salt Lake City, UT, United States.

Furman, L. D., Benson, P. W., Grimwood, C., & Canda, E. (2004). Religion and spirituality in social work education and direct practice at the Millennium: A survey of UK social

workers. *British Journal of Social Work, 34*(6), 767–792. https://doi.org/10.1093/bjsw/bch101

Gallup, G., Jr. (1999, April 2). *Easter draws Americans back to church*. Gallup. https://www.gallup.com/poll/3958/Easter-Draws-Americans-Back-Church.aspx

Gleave, R. (2012). Gospel-centered "therapist" or gospel-centered "therapy": Is there a difference and does it matter? *Issues in Religion and Psychotherapy, 34*(1), Article 3. https://scholarsarchive.byu.edu/irp/vol34/iss1/3

Harris, J. I., Erbes, C. R., Engdahl, B. E., Thuras, P., Murray-Swank, N., Grace, D., Ogden, H., Olson, R. H. A., Winskowski, A. M., Bacon, R., Malec, C., Campion, K., & Te, T. (2011). The effectiveness of a trauma-focused spiritually integrated intervention for veterans exposed to trauma. *Journal of Clinical Psychology, 67*(4), 425–438. https://doi.org/10.1002/jclp.20777

Helms, S. W., Gallagher, M., Calhoun, C. D., Choukas-Bradley, S., Dawson, G. C., & Prinstein, M. J. (2015). Intrinsic religiosity buffers the longitudinal effects of peer victimization on adolescent depressive symptoms. *Journal of Clinical Child and Adolescent Psychology, 44*(3), 471–479. https://doi.org/10.1080/15374416.2013.865195

Hodge, D. R. (2006). Spiritually modified cognitive therapy: A review of the literature. *Social Work, 51*(2), 157–166. www.jstor.org/stable/23721280

Houck, J. B., & Moss, D. M. (1977). Pastoral psychotherapy: The fee-for-service model, and professional identity. *Journal of Religion and Health, 16*(3), 172–182. https://doi.org/10.1007/BF01533318

Jackson, R. N., Richards, P. S., & Sanders, P. W. (2016, August 4–7). Processes of spiritually oriented psychotherapy: A practice-based investigation. In P. S. Richards & J. N. Nelson

(Chairs), *Spiritually orientation psychotherapy: Processes, outcomes, and research challenges* [Symposium]. American Psychological Association 124th Annual Convention, Washington, DC, United States.

Jackson, R. N., Richards, P. S., Wheatley, A., Crowton, S. A., & Rees, M. (2019). *Religion and spirituality in psychotherapy: A 20-year review and research prospectus* [Manuscript in preparation]. Department of Counseling Psychology and Special Education, Brigham Young University.

Jones, S. L. (1994). A constructive relationship for religion with the science and profession of psychology: Perhaps the boldest model yet. *American Psychologist, 49*(3), 184–199. https://doi.org/10.1037/0003-066X.49.3.184

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

Kvarfordt, C. L., & Sheridan, M. J. (2007). The role of religion and spirituality in working with children and adolescents: Results of a national survey. *Journal of Religion & Spirituality in Social Work, 26*(3), 1–23. https://doi.org/10.1300/J377v26n03_01

Lea, T., Richards, P. S., Sanders, P. W., McBride, J. A., & Allen., G. E. K. (2015). Spiritual pathways to healing and recovery: An intensive single-*N* study of an eating disorder patient. *Spirituality in Clinical Practice, 2*(3), 191–201. https://doi.org/10.1037/scp0000085

Levin, J. (2010). Religion and mental health: Theory and research. *International Journal of Applied Psychoanalytic Studies, 7*(2), 102–115. https://doi.org/10.1002/aps.240

MacKenna, C. (2007). The dream of perfection. *British Journal of Psychotherapy, 23*(2), 247–266. https://doi.org/10.1111/j.1752-0118.2007.00021.x

Miller, W. (Ed.). (1999). *Integrating spirituality into treatment: Resources for practitioners*. American Psychological Association. https://doi.org/10.1037/10327-000

Millet, A. (2016). *A phenomenological study of the therapist's experience when using a manualized approach to parent-child psychotherapy* (Publication No. 10196053) [Doctoral dissertation, Saint Louis University]. ProQuest Dissertations and Theses Global.

Mosqueiro, B. P., da Rocha, N. S., & de Almeida Fleck, M. P. (2015). Intrinsic religiosity, resilience, quality of life, and suicide risk in depressed inpatients. *Journal of Affective Disorders, 179*, 128–133. https://doi.org/10.1016/j.jad.2015.03.022

Murdock, V. (2005). Guided by ethics: Religion and spirituality in gerontological social work practice. *Journal of Gerontological Social Work, 45*(1–2), 131–154. https://doi.org/10.1300/J083v45n01_08

Nohr, R. W. (2000). *Outcome effects of receiving a spiritually-informed vs. a standard cognitive-behavioral stress-management workshop* (Publication No. 9977718) [Doctoral dissertation, Marquette University]. ProQuest Dissertations and Theses Global.

Oman, D., Shapiro, S. L., Thoresen, C. E., Flinders, T., Driskill, J. D., & Plante, T. G. (2007). Learning from spiritual models and meditation: A randomized evaluation of a college course. *Pastoral Psychology*, *55*(4), 473–493. https://doi.org/10.1007/s11089-006-0062-x

Pargament, K. I. (1997). *The psychology of religion and coping: Theory, research, and practice*. Guilford Press.

Pargament, K. I., Exline, J. J., & Jones, J. W. (Eds.). (2013). *APA handbook of psychology, religion, and spirituality (Vol. 1): Context, theory, and research*. American Psychological Association.

Pargament, K. I., Mahoney, A., & Shafranske, E. P. (Eds.). (2013). *APA handbook of psychology, religion, and spirituality (Vol. 2): An applied psychology of religion and spirituality*. American Psychological Association.

Pew Research Center (2015). *America's changing religious landscape: Christians decline sharply as share of population; unaffiliated and other faiths continue to grow*. https://www.pewforum.org/files/2015/11/201.11.03_RLS_II_full_report.pdf

Pfeifer, B. J., & Strunk, D. R. (2015). A primer on psychotherapy process research: A review of cognitive therapy of depression. *Australian Psychologist, 50*(6), 411–415. https://doi.org/10.1111/ap.12147

Post, B. C., & Wade, N. G. (2009). Religion and spirituality in psychotherapy: A practice-friendly review of research. *Journal of Clinical Psychology, 65*(2), 131–146. https://doi.org/10.1002/jclp.20563

Razali, S. M., Aminah, K., & Khan, U. A. (2002). Religious-cultural psychotherapy in the management of anxiety patients. *Transcultural Psychology, 39*(1), 130–136. https://doi.org/10.1177/136346150203900106

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

Richards, P. S., & Bergin, A. E. (Eds.). (2014). *Handbook of psychotherapy and religious diversity* (2nd ed.). American Psychological Association. https://doi.org/10.1037/14371-000

Richards, P. S., & Potts., R. W. (1995). Using spiritual interventions in psychotherapy: Practices, successes, failures, and ethical concerns of Mormon psychotherapists. *Professional*

Psychology: Research and Practice, 26(2), 163–170. https://doi.org/10.1037/0735-7028.26.2.163

Sanders, P. W., Allen, G. E. K., Fischer, L., Richards, P. S., Morgan, D. T., & Potts, R. W. (2015). Intrinsic religiousness and spirituality as predictors of mental health and positive psychological functioning in Latter-Day Saint adolescents and young adults. *Journal of Religion and Health, 54*(3), 871–877. https://doi.org/10.1007/s10943-015-0043-4

Sanders, P. W., & McBride, J. A. (2018, September 27–29). Bridges Assessment System. In M. Barkham & P. S. Richards (Chairs), *The Therapist Session Checklist: Bringing psychotherapy process research to routine outcome monitoring* [Symposium]. North American chapter of the Society for Psychotherapy Research 2018 Conference, Salt Lake City, UT, United States.

Sanders, P. W., Richards, P. S., McBride, J. A., Lea, T., Hardman, R. K., & Barnes, D. V. (2015). Processes and outcomes of theistic spiritually oriented psychotherapy: A practice-based evidence investigation. *Spirituality in Clinical Practice, 2*(3), 180–190. https://doi.org/10.1037/scp0000083

Schiff, J. W., & Moore, K. (2006). The impact of the sweat lodge ceremony on dimensions of well-being. *American Indian and Alaska Native Mental Health Research, 13*(3), 48–69. https://doi.org/10.5820/aian.1303.2006.48

Scott, A. B. (1997). *Categorizing definitions of religion and spirituality in the psychological literature: A content analysis method* [Unpublished manuscript]. Department of Psychology, Bowling Green State University.

Scott, S. (2003). *Faith supportive group therapy and symptom reduction in Christian breast cancer patients* (Publication No. 3075442) [Doctoral dissertation, Regent University] ProQuest Dissertations and Theses Global.

Sheridan, M. (2004). Predicting the use of spiritually-derived interventions in social work practice: A survey of practitioners. *Journal of Religion & Spirituality in Social Work: Social Thought, 23*(4), 5–25. https://doi.org/10.1300/J377v23n04_02

Sheridan, M. (2009). Ethical issues in the use of spiritually based interventions in social work practice: What are we doing and why. *Journal of Religion & Spirituality in Social Work, 28*(1–2), 99–126. https://doi.org/10.1080/15426430802643687

Sperry, L. (2012). *Spirituality in clinical practice: Theory and practice of spiritually oriented psychotherapy*. Taylor & Francis.

Sperry, L., & Shafranske, E. P. (Eds.). (2005). *Spiritually oriented psychotherapy*. American Psychological Association. https://doi.org/10.1037/10886-000

Stanley, M. A., Bush, A. L., Camp, M. E., Jameson, J. P., Phillips, L. L., Barber, C. R., Zeno, D., Lomax, J. W., & Cully, J. A. (2011). Older adults' preferences for religion/spirituality in treatment for anxiety and depression. *Aging & Mental Health, 15*(3), 334–343. https://doi.org/10.1080/13607863.2010.519326

Stewart, C., Koeske, G., & Koeske, R. (2006). Personal religiosity and spirituality associated with social work practitioners' use of religious based intervention practices. *Journal of Religion & Spirituality in Social Work: Social Thought, 25*(1), 69–85. https://doi.org/10.1300/J377v25n01_05

Stiles, W. B. (2013). The variables problem and progress in psychotherapy research. *Psychotherapy, 50*(1), 33–41. https://doi.org/10.1037/a0030569

Strachey, J. (1961). *The standard edition of the complete psychological works of Sigmund Freud, volume XXI (1927–1931): The future of an illusion, civilization and its discontents, and other Works*. Hogarth Press.

Sutton, G. W., Kelly, H. L., Griffin, B. J., Worthington, E. L., Jr., & Dinwiddie, C. (2018). Satisfaction with Christian psychotherapy and well-being: Contributions of hope, personality, and spirituality. *Spirituality in Clinical Practice, 5*(1), 8–24. https://doi.org/10.1037/scp0000145

Tadwalker, R., Udeoji, D. U., Weiner, R. J., Avestruz, F. L., LaChance, D., Phan, A., Nguyen, D., Bharadwaj, P., & Schwarz, E. R. (2014). The beneficial role of spiritual counseling in heart failure patients. *Journal of Religion and Health, 53*(5), 1575–1585. https://doi.org/10.1007/s10943-014-9853-z

Targ, E. F., & Levine, E. G. (2002). The efficacy of a mind-body-spirit group for women with breast cancer: A randomized controlled trial. *General Hospital Psychiatry, 24*(4), 238–248. https://doi.org/10.1016/S0163-8343(02)00191-3

Tonkin, K. M. (2005). *Obesity, bulimia, and binge-eating disorder: The use of a cognitive behavioral and spiritual intervention* (Publication No. 3201378) [Doctoral dissertation, Bowling Green State University). ProQuest Dissertations and Theses Global.

Tripathi, R. C., & Bano, S. (2014). Yogic practices: A healing therapy to relieve stress of middle age people. *Journal of Psychosocial Research, 9*(2), 319–328.

Vasiliauskas, S. L., & McMinn, M. M. (2013). The effects of a prayer intervention on the process of forgiveness. *Psychology of Religion and Spirituality, 5*(1), 23–32. https://doi.org/10.1037/a0029324

Wade, N. G., Worthington Jr., E. L., & Vogel, D. L. (2007). Effectiveness of religiously tailored interventions in Christian therapy. *Psychotherapy Research, 17*(1), 91–105. https://doi.org/10.1080/10503300500497388

Wampold, B. E. (2019). *The basics of psychotherapy: An introduction to theory and practice* (2nd ed.). American Psychological Association.

Wheatley, A. M., Jackson, R. N., & Richards, P. S. (2017, August). Processes of spiritually integrated therapy: A practice-based evidence analysis. In P. S. Richards (Chair) *Enhancing practice-based evidence for spiritually integrated psychotherapies* [Symposium]. American Psychological Association 125th Annual Convention, Washington, DC, United States.

Worthington, E. L., Jr., Hook, J. N., Davis, D. E., Gartner, A. L., & Jennings, D. J., II. (2013). Conducting empirical research on religiously accommodative interventions. In K. I. Pargament, A. Mahoney, & E. P. Shafranske (Eds.), *Handbook of psychology, religion, and spirituality (Vol. 2): An applied psychology of religion and spirituality*. American Psychological Association. https://doi.org/10.1037/14046-034

Worthington, E. L., Jr., Kurusu, T. A., McCullough, M. E., & Sandage, S. J. (1996). Empirical research on religion and psychotherapeutic processes and outcomes: A 10-year review and research prospectus. *Psychological Bulletin, 119*(3), 448–487. https://doi.org/10.1037/0033-2909.119.3.448

Zhang, Y., Young, D., Lee, S., Zhang, H., Xiao, Z., Hao, W., Feng, Y., Zhou, H., & Chang, D. F. (2002). Chinese Taoist cognitive psychotherapy in the treatment of generalized anxiety disorder in contemporary China. *Transcultural Psychiatry, 39*(1), 115–129. https://doi.org/10.1177%2F136346150203900105

Zinnbauer, B. J., Pargament, K. I., Cole, B., Rye, M. S., Butter, E. M., Belavich, T. G., Hipp, K. M., Scott, A. B., & Kadar, J. L. (1997). Religion and spirituality: Unfuzzying the fuzzy. *Journal for the Scientific Study of Religion, 36*(4), 549–564. https://doi.org/10.2307/1387689

APPENDIX B

Consent and Approval Letter from Canyon Counseling Center

Canyon Counseling Center

Courtyard at Jamestown

3651 North 100 East, Suite 100 ~ Provo, UT 84604 ~ (801)356-0014

Scott D. Owen, Ph.D. _ Shawn C. Edgington, Ph.D. _ Alan B. Hansen, Ph.D.

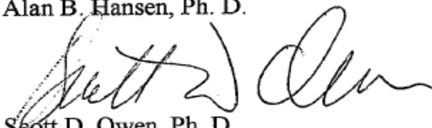
Dear IRB,

We, Canyon Counseling Center, are willing to have Russell N. Jackson collect data for his dissertation at our facility. We understand the demands that will be placed on our clients and we are willing to accommodate those demands.

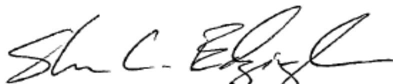
If you have any further questions, feel free to contact us at (801) 356-0014.

Sincerely,

Alan B. Hansen, Ph. D.



Scott D. Owen, Ph. D.



Shawn C. Edgington, Ph. D.

Partners at Canyon Counseling Center
3651 North 100 East, Suite 100
Provo, UT 84604

APPENDIX C

Bracketing

To constrain any inherent bias I may have had toward the data or findings of this study, I, as the researcher in this study, admit the inevitability of my own perceptions and bias to impact my interpretation of the data. In line with Beech's (1999) admonition, it will benefit this study, my own legitimacy as a transparent researcher, and readers of this study, to explicate the process of bracketing so that "others can observe and understand the rules of the game [so] the researcher can legitimately use the word [bracketing]" (p. 44). Gearing (2004) and Tufford and Newman (2010) explained that the concept of bracketing has become increasingly and problematically ambiguous and enigmatic. Gearing (2004) illustrates that this is mostly a consequence of bracketing's continuous evolution and disconnect from its philosophical origins. Consequently, research often "inappropriately and erroneously" reduces "bracketing to a formless technique, value stance, or black-box term in studies" (p. 1432).

The preconceptions researchers have at the outset of any project are not inherently problematic. The danger, however, is in researchers remaining unchecked in their own biases and entering an inquiry assuming their view of the world is objective reality. This would result in an, inhibited ability to accept and understand the experience and reality of those with whom they interact. Researchers' preconceptions are to be openly acknowledged, during all parts of the research process, from project conceptualization to the write-up (Tufford & Newman, 2010). This does not deny a researcher's own thoughts and feelings. Rather, it insures against interpretations and conclusions that reflect the researcher's own preconceptions and escape the lived experiences of those involved in the research itself (e.g., participants). Bracketing, or recognizing one's own bias and accepting others' experiences as givens in their own right,

should take place to "mitigate the potential deleterious effects of unacknowledged preconceptions related to the research and thereby to increase the rigor of the project" (Tufford & Newman, 2010, p. 81).

It therefore behooves me, the researcher in this study, to bracket my own preconceptions of SIT. I, the primary researcher in this study, am a doctoral candidate in Brigham Young University's Counseling Psychology Ph.D. program. I am a lifelong member of The Church of Jesus Christ of Latter-day Saints. Further, I consider myself a deeply spiritual person. I am interested in researching SIT for personal and professional reasons. While in my own therapy years ago, I coincidentally met with a spiritually integrative therapist, who frequently included spirituality in his work with me. This included quoting scriptures, discussing inherent self-worth, challenging my negativistic image of God, and reflecting on how my spiritual values seemed to affect my psychological and spiritual concerns. This process was remarkably therapeutic for me. I learned to trust my therapist and the therapeutic process, find healing and healthy boundaries in relationships, successfully challenge unhealthy psychological paradigms born out of earlier life experiences, reinterpret spiritual beliefs and expectations in healthy ways that permitted me to believe in a benevolent God, and become more functional in academic and professional pursuits.

Because of that experience, I believe in the healing potential of an individual's own R/S. As a therapist, I have worked primarily with highly religious/spiritual clients at a religiously affiliated university and a private practice in the same community. My clients frequently endorse R/S as significant aspects of their identity, and are generally interested in finding spiritual applications to life's problems, understanding how their spiritual resources can help them successfully work through their presenting clinical issues, exploring or challenging predominant cultural/religious beliefs, and (infrequently) in understanding how their beliefs may differ from

my own and the implications of working with someone who may have a different worldview. When clinically indicated, I find ways to integrate my clients' spiritual resources into therapy.

As well, I view myself as a spiritually centered psychotherapist (Gleave, 2012). I approach my work with the assumption that I can be an expert in psychological theory and actively solicit inspiration from temporal and spiritual sources to know how to best help my clients heal and live fuller, healthier lives. As a professional therapist, I have learned to trust that intuitive resource, referred to in my religious community as the Spirit of God and emanating from God, ancestors, and other spiritual sources. As I have done so, it has helped me be more sensitive to the specific needs of my clients, whether that sensitivity leads to the use of explicitly religious or spiritual interventions in session or not.

Thus, I have personal and professional investment in researching SIT process. I believe that SIT effected positive changes in my life. I recognize that this may have colored my perception and discussion of the data, the attention I paid to certain aspects of the data, and how I framed this research at the outset. While this is inherently true for any research, my efforts to bracket my perspective hopefully brought awareness to my own biases and preconceptions, and created an atmosphere of sensitivity to the data per se. This, I hope, allowed for a richer and more accurate perspective of the clinical patterns within SIT.

DISSERTATION REFERENCES

Beech, I. (1999). Bracketing in phenomenological research. *Nurse Researcher, 6*(3), 35-51. https://doi.org/10.7748/nr1999.04.6.3.35.c6086

Gearing, R. E. (2004). Bracketing in research: A typology. *Qualitative Health Research, 14*(10), 1429-1452. https://doi.org/10.1177/1049732304270394

Gleave, R. (2012). Gospel-centered “therapist” or gospel-centered “therapy”: Is there a difference and does it matter? *Issues in Religion and Psychotherapy, 34*(1), Article 3. https://scholarsarchive.byu.edu/irp/vol34/iss1/3

Tufford, L., & Newman, P. (2010). Bracketing in qualitative research. *Qualitative Social Work, 11*(1), 80-96. https://doi.org/10.1177/1473325010368316