A CALL TO SPIRITUAL HUMILITY: AN EXPLORATION OF SPIRITUALITY, THE US HEALTHCARE SYSTEM AND BEHAVIORAL HEALTH PROVIDERS

by

Taylor P Young

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Director of Dissertation: Damon Rappleyea, Ph.D.

Major Department: Human Development and Family Science

ABSTRACT

Though spirituality has become a more prominent feature in holistic healthcare it is still overlooked in US healthcare systems and behavioral health providers (BHP). The impact of spiritual inclusion in healthcare has been demonstrated to have a beneficial impact on medical and psychological treatment. Researchers and healthcare practitioners must continue to explore how to acknowledge spirituality and access their associated benefits for the patients they work with. The purpose of these studies is to shed light on how BHPs and their training can play a pivotal role in acknowledging spirituality within holistic healthcare in the US healthcare system. The 5 chapters in this dissertation, include a/an: (a) Introduction to spirituality and its benefits within the US healthcare system through Peek's 3 world view, (b) systematic review of spirituality training interventions for BHPs, (c) methodology chapter describing the original study, (d) original research study that reports the results from a mixed methods survey exploring BHP past spirituality training and how it influences BHP spiritual integration scores, and (e) conclusion chapter.

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Taylor P. Young

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Director of Dissertation: Damon Rappleyea, PhD, LMFT

Dissertation Committee Members:

Jake Jensen, PhD, LMFT

Natalia Sira, PhD

Heather Quagliana, PhD

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PREFACE

“There is nothing in this world, I venture to say, that would so effectively help one to survive even the worst conditions as the knowledge that there is meaning in one's life” (Frankl, 2006, p 109). The desire to research spirituality stemmed from my interactions with Viktor Frankl’s take on the concept and his view on logos (i.e., “the search for meaning”). In his model Frankl created a healing process that connects to my existential nature and points towards a deeper sense of health that few venture towards. I decided to partake in that venture and aim to increase awareness of what meaning and purpose can bring to Biopsychosocial-spiritual (BPSS) health and the US healthcare system. During my marriage and family therapy (MFT) master’s program I was employed at a mental health hospital. Through this experience I interacted with numerous individuals that were repeat patients for multiple psychological struggles. Even though their medications would help there was still something missing that kept them from realizing their full potential in attaining a healthy and full life. In my conversations with these patients, I saw that a significant part of what was missing was spirituality and its connection to meaning, purpose and hope. I saw a connection to a diverse aspect of spirituality that can aid a diverse range of clients/patients in their search of their BPSS health. This then blossomed into an exploration of spirituality throughout my PhD in Medical Family Therapy. I realized that the mission of a MedFT aligned with my desire to fully acknowledge my clients/patients BPSS health and wanted to add to the acknowledgment of spirituality specifically. This venture connected with my own spiritual journey and with my desire to see something more in my own care as a therapist, MFT, MedFT and as a human helping other humans.

Role of the Researcher

Throughout my time as a doctoral student, I realized that diversity and humility are important parts of ethical and equitable care and this applies to spiritual care as well. These aspects should always be at the forefront of my research and my care as a responsible healthcare provider in the US healthcare system. To do this successfully I need to be daily reminded of my own biases as a therapist who values spirituality within their care. The following are some of those biases/belief's that I need to be aware of, especially in lieu of my focus for my dissertation. These include my own social locations (i.e., white, cis gender, heterosexual, man, educated, middle class, English speaking, Christian, and American citizen) and my views on team-based care (integrated care and the incorporation of behavioral health as equitable and ethical). It is important for me to acknowledge that these beliefs and biases could influence my research on spirituality and with other behavioral health providers within the US healthcare system. The ongoing need for reflexivity and self-reflection is central as I navigate this venture of research. I also must acknowledge the expansive nature of spirituality and how difficult it is to research. It is my privilege and honor to stand on the shoulders of those who have prioritized spirituality in their research and paved the way for this dissertation.

My Why

For the past thirty years I have personally gone through a journey that has been difficult, enlightening, and purposeful. In this journey I have concluded that my own spiritual search for meaning and purpose is just as important as my clients/patients. It is through this search that I have encountered those who are also on a journey. Through these encounters I discovered aspects of spirituality that were foreign to my own personal experiences. Individuals who were

looking for purpose and meaning through their own cultures, beliefs and experiences impacted my journey in a profound way. These encounters looked like, discussions with my patients as a certified nursing assistant, talks with my friends who possessed different social locations and interventions with my clients as a therapist. I was able to discuss aspects such as end of life concerns, purpose talks, and different belief's than that my own. Even though, many with my background would see these encounters as a threat to their belief's I saw them as enriching, grounding and exciting. In fact, in these diverse encounters, I found a truth in my own beliefs that I have never seen before. This is my why for this dissertation because my own search for purpose and meaning did so much and I know that my clients/patients search can do the same.

Even though this topic has been at the forefront of my mind for quite some time, the event that solidified this as my dissertation topic was my experience with my late friend Lorenzo who was a part of the LGBTQIA+ community and struggled with cancer. In what would become my last discussion with Lorenzo he stated, "I do not know what to believe or where to find my own purpose". His struggle with spirituality and finding purpose emerged from the marginalization he experienced in his identified social location from community members and his family. Lorenzo passed due to cancer a week later and I promised myself that I would work as hard as a I can to aid people in their spiritual search and avoid the "I do not know" statements that occasionally emerge in our lives. In this promise I see uncertainty in our spiritual searching as a life-giving aspect for purpose and meaning because in the search is possibility, discovery, and freedom. I aim to be the person who walks alongside those in the search and provide a friendly hand in a curious and humble manner.

Conclusion

This dissertation explores the acknowledgment of spirituality in context of the US healthcare system and how BHPs can play their part. The aim of this dissertation is to heighten awareness of the benefits of acknowledging spirituality and truly providing holistic healthcare that addresses the diverse spiritual needs of our clients/patients. It aims to pave the way for BPSS health to be fully addressed and create a more equitable healthcare system.

CHAPTER 1: THE CURRENT STATE OF SPIRITUALITY: A FOUR WORLD VIEW

Spirituality is a concept that is often misunderstood in the US healthcare system (Balboni et al., 2022; de Brito Sena et al., 2021; & Koenig, 2008). This is due to its ever-expanding nature and its lack of operationalization within research (Koenig, 2008; & Koenig, 2012). However, Koenig (2008) argues for an operational version of spirituality within clinical care. He labels this the modern clinical version of spirituality. According to this version spirituality is an umbrella term that encompasses other terms such as religion, hope, connection, meaning, secularism, etc. This is contrary to historical spirituality which is synonymous with religion. Also, according to this modern version, spirituality is a universal part of humanity and of every person's healthcare. Meaning that spirituality can be an important part of life for all individuals, even those who are not religious, and use labels such as secular, pagan, or atheist. This change in definition creates a more inclusive view of the term but it also puts more stress on healthcare providers to keep up with the ever-changing theoretical and clinical understanding of spirituality.

The connection between the universal nature of spirituality and health has been highlighted within the literature for some time (Oman, 2018; Wright et al., 1996). It has also been and still is an important part of holistic healthcare frameworks like biopsychosocial-spiritual (BPSS) health (Engel, 1977 & Wright et al., 1996). However, despite this acknowledgment providers' comfort with the ever-changing term and incorporating it into healthcare is low and at some points ignored (Kusnanto et al., 2018; & Mendenhall et al., 2021). Even providers whose training is more conducive to cultural inclusivity (Kondili et al., 2022) such as Behavioral Health Providers (BHP) ignore spirituality in their treatment plans, interventions, conceptualization, and care (Errington, 2017; & Ferrell et al., 2020). There are a plethora of reasons for this but the most significant is provider comfort when addressing

spirituality (Gillilan et al., 2017; Lloreda-Garcia, 2017; Mendenhall et al. 2021; Rosmarin et al., 2021; & Tehranineshat et al., 2019). This creates the dilemma of Spirituality being missed within the BPSS health and within the larger US healthcare system and in turn creates dilemmas such as increased discrimination, decreased access to care, increased unmet needs, worsened mental health, and much more (Azhar et al., 2022; Dein et al., 2012; Kalánková et al., 2021; Martin et al., 2010; & Michlig et al., 2022). Due to this lack of comfort from BHPs the most logical place for a solution is within the training of BHPs; from their academic training, and continuing education units (CEU) to clinical training. However, to create a clear connection between BHP training and successful acknowledgment of spirituality it is important to review the presence of spirituality in all aspects of the US healthcare system.

Spirituality in the US Healthcare System.

Peek's (2008) three World View, which also includes a fourth hidden world (training), provides a helpful framework for understanding the landscape of spirituality within the US contemporary healthcare system. According to Peek (2008), the Three World View includes the clinical, operational, financial, and a hidden world of training/educational worlds. While all four worlds are individually important, together they make up what is necessary for a healthcare system to be successful. The clinical world focuses on direct patient care and the relationship between providers and their patients/clients. It also considers the quality of this relationship and the care provided. The operational world includes organizational policies, protocols, and workflow, while including tools like electronic health records (EHR) and patient communication. The communications include referrals, prescriptions, and the tools that aid in the process. The operational world also includes the personnel and staff that make up a healthcare system, which

is not limited to providers (Mendenhall et al, 2021). The financial world comprises payments, reimbursements, and billing systems; it interacts with insurance, third-party payers, and the overall allocation of funds necessary for the healthcare system to operate effectively. Lastly, the training/educational world includes enhancing clinical skills, professional and academic training programs or initiatives, and continuing education for providers within healthcare systems. Each world aids in the optimal functioning of the entire healthcare system. It is important to provide an up-to-date status of spirituality within all four worlds. This will increase insight into incorporating spirituality and its health benefits within the US healthcare system and will highlight the most appropriate world to begin. This introduction will provide that status and argue that the training/educational world is the most logical starting point for the improvement of spiritual care which will in turn affect the other three worlds.

Clinical

Historically spirituality has found its clinical home within, palliative care, hospice, and nursing, and is newly found in other team-based care models like integrated care (de Diego-cordero et al., 2021; Ferrell et al., 2020). Also, spirituality has become more present within clinical care due to world events like the COVID-19 pandemic.

Within palliative and hospice care there is a natural progression towards spiritual concepts within conversations of chronic illness and end-of-life. Patients usually wrestle with questions of meaning and purpose (Taylor, 2021); why is this happening to me, how does this affect my family, relationships, and overall life, what is the point of going on with this prognosis, is this a punishment? To address these questions and other spiritual issues palliative- care and hospice utilize care teams to provide holistic treatment to their patients (Wallerstedt et al, 2018) These

teams usually include nurses, chaplains, and physicians. They also include a Behavioral Health Provider (BHP) like a social worker. Through the collaboration of these providers, it is the aim to address a patient's whole BPSS health. However, even though spirituality is a natural part of palliative and hospice care providers still struggle with feeling comfortable in addressing it and often ignore it (Taylor, 2021).

Within nursing, there is a consensus that patients and families need holistic/spiritual care (Bahramnezhad & Asgari, 2020). Along with palliative and hospice care, nursing has led the way in incorporating spirituality into care but provider voices of uncomfortably in fully acknowledging it within a patient's health are still prevalent. Hawthorne and Gordon (2019) state the following as reasons for these feelings of discomfort; “fear of imposing their beliefs on others, fear of personal spiritual vulnerability, and limited education in the area of spirituality including spiritual assessment” (p. 148). However, due to care guidelines (JHACO, 2022) nurses are expected to at the very least address spiritual concerns within their care by way of assessments and appropriate referrals. This is due to the research displacing how patients utilize spiritual resources to cope with the broad spectrum of healthcare experiences (Hall et al, 2019). There are also numerous correlations between spirituality and better health outcomes (Balboni et al, 2022), and this is strengthened by over 100 systematic reviews on spirituality and health outcomes in the past 25 years (Oman, 2018). Recent world events have also highlighted the importance of spirituality within healthcare, like the COVID-19 Pandemic.

Along with other pandemics, COVID-19 creates uncertainty, fear, and disease containment issues, which in turn increases spiritual issues/questions in patients, their families, and healthcare workers (Bahramnezhad & Asgari, 2020). As a threat to everyday health and

wellness, COVID-19 created a vacuum of unanswered questions for patients, similar to palliative care patients. These questions and needs were mostly overlooked because of the strain that the epidemic had on the healthcare industry (Ferrell et al, 2020). One common spiritual need that may have been overlooked is the lack of peaceful death options for hospital patients (Bahramnezhad & Asgari, 2020) and the effect that this has on patients' families. This issue came about because of the high risk of transmission, and patients' families could not say goodbye or perform spiritual rituals pivotal to their grieving process.

Spirituality is often unacknowledged and uncared for in other types of tertiary and secondary care, outside of hospice and palliative care (Balboni et al, 2023), and the same can be said for primary care and mental health services (Isaac et al, 2016; & Rosmarin et al, 2021). This starkly contrasts patients' desire for spirituality to be incorporated into their care. For example, the American Medical Association (AMA) found in one study that 41% of patients desire a deeper conversation about spirituality in relation to their healthcare (AMA, 2016). In another study, 66% percent of patients stated that the act of physicians asking about spirituality would increase their trust in them (Ehman et al, 1999). Within the mental health field, about 80% of patients/clients turn to spirituality to cope with their illness, and half desire to talk about spirituality within psychotherapy sessions (Rosmarin et al, 2021). Because of this, it is important to create, improve upon, and implement models of care that aid in addressing spirituality.

Financial

A probable connection between spirituality, BHPs and the financial world is the benefit of utilizing systems-trained BHPs (Crane & Christenson, 2014). Systemic BHPs like Marriage and Family Therapists (MFT), Medical Family Therapists, and Licensed Clinical Social Workers

(LCSW) tend to practice through a systemic lens (Mendenhall, 2021). Through a systemic lens, healthcare is provided holistically alongside a biomedical provider; this has been shown to reduce the rates of healthcare services utilized (Crane, 2008). This reduction addresses the issue of "high utilizers," who are patients/clients that utilize services such as emergency rooms and other hospital-based services (Shemesh et al, 2022). Systemic providers are more likely to include spirituality in their clinical work and address BPSS health with patients, but these providers may not have the adequate training to know how to appropriately do so.

Outside of BHPs, there are other providers who interact with spirituality in healthcare such as spiritual specialists who bring financial benefits to the healthcare system. Spiritual specialists such as chaplains have been shown to save the healthcare system money by providing spiritual support to not just patients but also to staff and clinicians (Hall & Powell, 2021). Factors such as burnout and compassion fatigue have been shown to increase medical errors (Patel et al, 2018) which in turn creates more financial burden on the system. Spiritual specialists are primed to provide support to providers by exploring spiritual concepts such as the meaning and purpose of their care (Hall & Powell, 2021; & Koenig 2012). This service can also positively impact the working culture of a healthcare system and can improve staff morale, and retention turnover rates (Hall & Powell, 2021). The downside to this benefit is the increase of what could be labeled as shadow work for spiritual specialists. Shadow work is an unforeseen increase in workload that goes beyond a worker's expected load. Even though staff support is included in most spiritual specialist's job descriptions the workload and what is required to significantly decrease medical errors can be ambiguous. However, this should not dissuade systems from parsing out this financial benefit and utilizing spiritual specialists in an appropriate manner.

Utilizing spiritual specialists within healthcare also increases patient satisfaction (Hall & Powell, 2021). Patient satisfaction has long been the factor that predicts the success of healthcare facilities and impacts the rate of reimbursements from insurance (Manzoor et al, 2019). When spiritual issues are adequately addressed during a healthcare visit a patient's experience is shown to be positively affected (Hall & Powell, 2021), which has a positive relationship with the financial world. Those who receive inadequate spiritual care are shown to have higher care costs and higher utilization of services. For example, Morrison et al. (2008) report a monetary savings of $1696 per patient discharged from the hospital who is receiving spiritual care through palliative services and Hall & Powell (2021) highlight these savings as pivotal to the financial world of a healthcare system. Spiritual specialists have the capability to address spirituality and, in the end, reduce the financial burden on healthcare systems.

The issue then becomes the ambiguity of spirituality within the billing of healthcare systems (Hall & Powell, 2021). Due to the separation of church and state spiritual care is not typically reimbursable through a billable healthcare code (Warnock, 2008). There have been recommendations for creating billable codes for spiritual specialists, but these are not financially acknowledged by federal funds (CMS, 2023). This is where the connection between spiritual specialists and systemic BHPs is pivotal. Even though BHPs are not able to bill at the same rates as biomedical providers (Mendenhall et al, 2021), they still possess billable codes acknowledged by most states and specifically by federal funds. Systemic BHPs can provide much-needed spiritual acknowledgment within their billable patient/client visits and provide continuous support by collaborating with spiritual specialists. This could be an answer to the shadow work

dilemma of spiritual specialists and create a stronger connection between systemic BHPs, spirituality, and the financial world.

Operational

Within the operational world, spirituality is mostly relegated to spiritual specialists or team-based care (Baxter et al., 2018). However, team-based care is usually limited to specialty areas like palliative care and care models like integrated care (CFHA, 2022). There are numerous challenges with implementing team-based care models and even when implemented successfully spirituality is seldom addressed (Bamber & Marshall, 2023; & Mendenhall et al, 2022). This has created a system that is dependent on intentional referrals done by the provider or requested by the patient. Operationally this creates a system that is fragmented and unable to adequately address a patient's whole spirituality and their whole BPSS health. There are numerous causes for this, but the majority are the historic separation of church and state, a lack of validation within spiritual tools and assessments, and a lack of spirituality-focused training for providers outside of spiritual specialists (Hall & Powell, 2021; Kestenbaum et al, 2021; & Mendenhall et al, 2022). Because of these other operational areas lack a presence of spirituality. For example, a lack of standardized spiritual tools and assessments and acknowledgment correlates with a lack of note templates within a healthcare facility's EHR (Kestenbaum et al., 2021). There are usually places within a provider's note to address the biological, psychological, and social but outside of spiritual specialists' notes, the spiritual aspects of a patient's care are absent.

An additional aspect of spirituality within a healthcare system is spiritual specialists aiding in the fight against burnout and compassion fatigue for providers (Tata et al., 2021). They also can aid in the management of a positive work culture. Mendenhall et al. (2022) point out

that this is a significant part of the operational world due to the influence it has on staff sick days, work performance, productivity, and turnover rates. It is shown that these are reduced when spirituality is acknowledged within a provider's life and their patients' health. Because of these benefits and others, it is important to build up spirituality and its acknowledgment within the operational world. By doing this, providers and the healthcare system can build on the current system of referral-based care and fully acknowledge spirituality within BPSS health. As mentioned before in the other worlds an avenue that can be taken in enhancing spiritual care is to incorporate BHPs. Within the operational world, this would look like the collaboration between BHP's, biomedical providers, and spiritual specialists. However, the dilemma of adequate training to increase spiritual acknowledgment continues to be ever-present.

Training

The pressing question is then; out of Peek's four worlds which one would be the most advantageous to create a solution and increase the acknowledgment of spirituality within the US healthcare system? Based on how the four worlds interact, literature and clinical judgment it is the opinion of the authors that the most advantageous starting point is the training world and more specifically training BHPs. Training BHPs can increase their understanding of the concept of spirituality and their own comfort in acknowledging spirituality within their holistic care. It would be a moot point to create or enhance current spiritual assessments and tools (clinical), billable codes (financial), and EHR systems (operational) if healthcare providers do not feel comfortable enough to interact with them. BHPs also have a point of contact with the patient and other providers that can aid in pulling together the healthcare system to fully address BPSS

health (CFHA, 2022). This is why training BHPs on spirituality will create ripple effects that will enhance the presence of spirituality in the three other worlds.

The issue then becomes the current state of the spirituality training world. According to the literature most spirituality training for BHPs is limited to faculty interest and there are few evidence-based trainings (CACREP, 2015; Richards et al, 2023; & Williams-Reade et al, 2019). Also, spirituality training is often limited to diversity classes which focus predominantly on major world religions and not on spirituality (Mendenhall et al., 2021). This can be an issue because of numerous leaders in spiritual care acknowledging the modern version of spirituality and its ever-changing and expanding nature (Hill & Pargament, 2003; Koenig, 2008; & Reinert & Koenig, 2013) Because of this there is a lack of clarity on the current state of spirituality training for BHPs. This is why there is a need for further exploration of the BHP spirituality training world, its strengths, and its weaknesses. Through this exploration, a clear direction in spirituality training and a connection for spiritual care with the other three worlds can be made.

Purpose/Design

This dissertation walks through the BHP spirituality training world and its connection to the US healthcare system. More specifically, Chapter 1 serves as an overview of the current state of spirituality within the entire US healthcare system through Peeks (2008) four world view. This chapter creates a clear connection between the common issue of lack of acknowledgment of spirituality within healthcare and a possible solution to this within BHP spirituality training.

To continue past this overview in Chapter 1 and create a clear picture of the status of spirituality training for BHPs Chapter 2 delivers a systematic review that focuses on all spirituality training/educational interventions. This review outlines the presence of these

interventions and their characteristics; demographics, profession of BHP learners, setting, number of participants, type of intervention, educational content, method of instruction, timeframe of training, instructors, curriculum, and validated measures used. It was concluded that there is a lack of consensus on validated measures and on limited evidence-based curricula utilized for spirituality training. However, even amongst these issues, a thematic analysis of the content reveals themes that align with the modern clinical version of spirituality (Koenig, 2008). Those themes are Multiculturalism, Professional Development, Clinical Skills, and Biopsychosocial-Spiritual health. The authors utilized these themes to create a flexible framework/clinical posture for the direction of spirituality training, Spiritual Humility. Spiritual Humility can be utilized to guide future curricula and validated measures. It can also change and expand alongside the ever-changing and expanding concept of Spirituality.

To further expand our understanding of BHP spirituality training Chapter 3 outlines the methodology utilized in a mixed methods approach. It provides a description of the quantitative survey being utilized along with the qualitative questions included in this survey. The survey also utilizes a modified version of the validated measure; The Religious/Spiritually Integrated Practice Assessment Scale (RSIPAS V.2). The aim is to assess the level of spiritual integration through the modified RSIPAS V.2 for BHPs and what factors affect this level (i.e., training, experience, demographics, religious affiliation, et.). Through this research this dissertation will help to fill a gap in spirituality training for BHP and in turn increase appropriate and universal acknowledgment of spirituality within the US healthcare system.

Conclusion

This dissertation explores the current state of spirituality training and aims to generally answer questions such as *what is the status of spirituality BHP training? why do they not aid in increasing provider comfort with the term?* and *can BHPs help fill the gap in spiritual acknowledgment within healthcare?* This dissertation also aims to bring attention to the lack of acknowledgment of spirituality within the US healthcare system, the importance of spirituality within holistic healthcare, its universality to all patients/clients and how BHP training plays a part.

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CHAPTER 2: EVERYWHERE BUT NOWHERE: A SYSTEMATIC REVIEW ON SPIRITUAL TRAINING INTERVENTIONS FOR BEHAVORIAL HEALTH PROVIDERS

Introduction

Within the United States (US) healthcare system, spirituality is generally defined as the beliefs, practices, and experiences that create ultimate meaning and purpose (Balboni et al, 2022; de Brito Sena et al., 2021). Spirituality also includes aspects such as secularism, connection, wellbeing and hope and modern definitions include religion as a subpart (Hill & Pargament, 2003; Koenig et al., 2012; Rosmarin & Koenig, 2020). These definitions encompass some dimensions of spirituality but fail to provide a conceptual direction for providers to follow when addressing it within their care. The main reason for this nonexistent direction is due to spirituality lacking a full conceptual breadth, meaning that the concept changes depending on the context of the individual or system and is ever-expanding (Koenig, 2008).

Spirituality's ever-expanding definition and deficiency of clear direction in the US healthcare system has kept its care at arm's length for providers. In fact, most healthcare providers fail to at least acknowledge it within their patient's/clients' healthcare journey. In contrast to this lack of acknowledgment are major healthcare models/frameworks that include spirituality. For example, Engel (1977) presents the Biopsychosocial (BPS) model as an alternative to the biomedical model. This was due to the limitations of the biomedical model regarding holistic health and its tendency to fragment health into individual parts of a whole (Doherty et al., 2014). The BPS framework fights against this fragmentation and creates avenues for patient's whole health to be adequately addressed (Mendenhall et al., 2018). Later it became the Biopsychosocial-Spiritual (BPSS) model (Engel, 1977 & Wright et al., 1996). Wright et al

(1996) discusses the interplay of patient's beliefs with healing, medicine and their overall healthcare journey. They provide a starting point for healthcare providers when considering how to interact with a patient, their full BPSS health. Since its conception the BPSS has provided an overall framework that allows and encourages inclusive and equitable whole health care. In summation it champions the message; everyone's whole health, including spirituality, deserves to be addressed.

However, despite the groundwork done by the BPSS framework, a patient's whole health continues to be fragmented and aspects such as spirituality continue to be left out and unacknowledged (Kusnanto et al., 2018; & Mendenhall et al., 2021). There is a plethora of reasons for this, but the most significant is provider comfortability in acknowledging spirituality (Delbridge et al, 2014; Errington, 2017; Mendenhall et al, 2021; & Saad et al, 2017). This lack of comfort is commonly connected to the training that these providers receive on spirituality (Jones et al, 2021). Because of this it is the aim of this systematic review to explore the question; who is being trained on the concept of spirituality and how are they being trained? More specifically, due to their role within healthcare and the lack of exploration in their spirituality training. This review will explore the training of behavioral health providers (BHP). To accomplish this the authors will present an up-to-date summation of religion, spirituality; their relationship with each other and with BPSS health. Lastly it will provide a comprehensive exploration of spirituality trainings, what they are teaching, what they are not teaching and the general direction of current spirituality training for BHPs.

Theoretical Underpinnings

As mentioned before the difficult aspect of exploring spirituality is its expansive definition and its lack of operational boundaries. This makes it difficult to measure within research (Koenig, 2008). Because of this it is important to establish an expansive and non-restrictive theoretical framework that will dissuade the authors from being anchored to one definition or view of the concept spiritually. Existential theory can aid in this as it correlates with the human experience and the freedom of choice in finding meaning and purpose (Kaufmann, 1956). Much of the human experience with spirituality relates to freedom and how an individual finds meaning and purpose in their lives (Kaufmann, 1956; Yalom, 1980; & Frankl, 2006). Existential theory provides a succinct conceptual framework from which to understand the human connection to spirituality (e.g., personal understanding of the human existence, freedom of choice, meaning of life, values, and defining purpose in life) (Kaufmann, 1956). The theory provides a solid foundation by which this systematic review and the relevant findings will be grounded. Existential theorists believe that individuals can find meaning, purpose and other spiritual concepts through a plethora of sources that include but is not limited to themselves, higher power, external objects/persons, spirituality, and religion. Individuals can search for truth with an open mind to avoid placing preconceptions, labels or categories on oneself and others. Existential theory is self-defining, expansive and conceptually universal to humanity. The same can be said about the concept of spirituality and more specifically spirituality within clinical care (Koenig, 2008). This is also why it is important to establish a clinical version of spirituality to better understand its elusive and contextual dynamic and how it is universal to all.

No One Left Behind

Koenig (2008) presents a modern clinical version of spirituality while exploring the pros and cons of spirituality within research. Koenig (2012) reinforces his clinical version by describing spirituality as "once based on religion, spirituality is increasingly viewed as a broader concept that each individual defines for themselves" (p. 91). Within this modern clinical version it is posited that spirituality is a universal part of general human existence and encompasses all identities including ones such as secularism (a term used for those who are not religious). This is useful because a clinician's responsibility is to use inclusive language/terms to provide equitable care for diverse populations. By using this clinical version and definition, the authors come alongside Koenig in stating that spirituality is a universal part of the human experience, and more so spirituality is a universal part of everyone's BPSS health. This framework expands spirituality and allows a freedom from borders or restrictions while simultaneously accounting for individual aspects/identities that are connected or are an inherent part of spirituality (e.g., religion, secularism, meaning, purpose, connection, peace, culture, social location etc.) (Koenig, 2012). Lastly it aids in the authors mission of leaving no one behind in BPSS healthcare.

With the underpinnings of existentialism, and Koenig's clinical version of spirituality the authors propose the, "No one left behind" framework. This framework will aid this systematic review in openly exploring the current state of BHP spirituality training. It is also the authors aim to ascertain future directions of curriculum, and education to better connect training to clinical practice.

Literature Review

Spirituality and Religion

When exploring spirituality and its place in healthcare and in BHP training it is important to highlight the concept of religion. Overall, there is a consensus on the operational definition of religion within healthcare (Koenig et al, 2012; Hill & Pargament, 2003; Oman, 2018; & Pargament et al, 2013). Religion is straight forward and is usually defined as the beliefs, practices, and rituals related to the divine/sacred (Koenig et al, 2012) and historically religion and spirituality has been seen as one in the same (Koenig, 2008; & Oman, 2018). Additionally, this inseparable view of religion and spirituality is evident in past research and literature (Ferngren, 2014). However, modern healthcare providers and researchers have begun to differentiate spirituality from religion (Balboni et al., 2022; Currier et al., 2019; Delbridge et al., 2014; Ebenau et al., 2019). In this modern view, religion is positioned as being an important subpart within the larger concept of spirituality.

It is also important to highlight the relationship between religion and BPS health outcomes and how these connect to spirituality. The operational definition of religion commonly correlates to better physical (Cotton et al., 2006; & Ferngren, 2014), psychological (Richards et al., 2023; & Rosmarin & Koenig, 2020), and social (Oman, 2018) health outcomes which makes it applicable across BPS health (Delbridge et al, 2014; Mendenhall et al., 2021). More specifically Religion is linked to improved recovery rates, fewer symptoms of depression, lower rates of suicide, lower rates of substance use, and improved social relationships (Richards et al., 2023; & Rosmarin & Koenig, 2020). Literature connecting religion to BPS health has been present within healthcare throughout history and has increased exponentially since the year 2000

(Koenig, 2012a). In fact, since 2000 there have been over 100 systematic reviews on religion and the individual parts of BPS health (Oman, 2018). Under the modern view of religion, the connection to beneficial health outcomes now falls within the concept of spirituality. However, even though religion is a more straight forward and operational subpart of spirituality, it shares the common struggle of a lack of acknowledgment by most healthcare providers and BHPs (Abdulla et al., 2019).

In summation, religion is a subpart of spirituality, the second S of the BPS(S) framework. In addition, regardless of the connection to better health outcomes religion joins other subparts of spirituality (i.e., secularism, meaning, purpose, connection, wellbeing, hope, etc.) in going unacknowledged.

Spirituality and BHPs

There have been numerous attempts to capture and operationalize spirituality for research and clinical purposes (Clark & Emerson, 2020; de Brito Sena et al., 2021; Reinert & Koenig, 2013; Steinhauser et al., 2017). While all share similar aspects there are unique differences and variability. However, despite this, there is still correlations between acknowledging spirituality and better health outcomes for BPSS health (Clark & Emerson, 2020; Delbridge et al., 2014; Richards et al., 2023; Wilson et al., 2018). Accordingly, medical, and behavioral health professions acknowledge the importance of spirituality within their standards of care (AAMFT, 2018; CACREP, 2015; JCAHO, 2021). This is due to spirituality connecting to a plethora of cultures, social locations, and identities and their BPSS health (Anders et al., 2021; Fair, 2021; Salami et al., 2022; & Sprik & Gentile, 2020). This is overly evident for BHPs who deal with spirituality in both medical settings (Balboni, 2013; Oman, 2018; & Richards et al, 2023) and in

traditional behavioral health therapy (Rosmarin & Koenig, 2020) which creates a clear connection between BHPs and acknowledging spirituality within healthcare.

This connection between BHPs and spirituality is present in their current training through aspects such as multiculturalism and cultural humility (Anders et al., 2021; Kondili et al., 2022; Mendenhall et al., 2021; & Wilson et al., 2018). Because of this BHPs are primed to acknowledge spirituality within all forms of healthcare and for all individuals. Multiculturalism has been a dominant guide in BHP training to assess their readiness to interact with diverse patients/clients and their diverse backgrounds and identities (Kondil et al., 2022) and spirituality is often included in this diversity. Most programs discuss parts of spirituality (i.e., mainly religion and cultural belief's) through the lens of cultural humility, which is the understanding that all identities are complex, and this understanding is never fully realized but should continuously evolve throughout one's life (Hook et al., 2017; & Tervalon & Murray-Garcia, 1998).

This continuous growth aims to create a sensitivity and acknowledgment of all aspects of culture and should include spirituality. Despite this aim BHP training lacks a clear direction in connecting spirituality to care. Within BHP training the concept is touched on minimally by way of faculty interest or diversity classes. (CACREP, 2015; Richards et al, 2023; & Williams-Reade et al, 2019). Also, within BHP training, spirituality is often limited to one of its subparts (i.e., religion) by way of a singular focus on major world religions (Mendenhall et al, 2021). This inadequate state of spirituality training lacks a clear direction but displays a clear reason for why BHPs continue to feel uncomfortable when addressing spirituality (Errington, 2017: & Williams-

Reade et al, 2019). This inadequate state of training creates a dilemma that the authors label as the “Missing S.”

The Missing S

The “Missing S” is when BHPs fail to acknowledge spirituality within their assessments, plans, and treatments for their patients/clients BPSS health (Ferrell et al., 2020; & Mendenhall et al 2021). Additionally, it is when BHPs do not address their uncomfortable feelings and avoid the concept of spirituality all together (Gillilan et al., 2017; Lloreda-Garcia, 2017; Rosmarin et al., 2021; Tehranineshat et al., 2019). In doing this they maintain a hesitancy in their care and fail to connect spirituality to its evident BPS health outcomes (Kwok & Kwok Lai Yuk Ching, 2022; & Saad et al., 2018). This dilemma can be detrimental to healthcare due to its effects of increased discrimination, decreased access to care, increased unmet needs, worsened mental health, and much more (Azhar et al., 2022; Dein et al., 2012; Kalánková et al., 2021; Martin et al., 2010; & Michlig et al., 2022). These effects stem from inadequate training and cause an increase in BHPs discriminatory reactions and a lack of respect for spirituality and its subparts (Brown, 2010; Fadiman, 2012; Moghaddam et al., 2013). Because of this BHPs fail in their responsibility to mitigate the “Missing S” dilemma within their BPSS care and within healthcare.

A lack of general direction in spirituality training for BHPs creates a need for clarity and this clarity will hopefully address the "Missing S” dilemma. A clear direction in BHP training will allow BHPs to acknowledge the “Missing S,” work through their discomfort or misunderstanding of the concept and care for BPSS health in its entirety. To provide insight into this clarity and direction a comprehensive review of the current state of spirituality training for BHPs was done. There have been multiple reviews of spirituality training for other health care

professionals (Jones et al, 2021; Paal et al, 2015; & Rykkje et al, 2021) and while these reviews are helpful, they provide little insight into BHPs training.

Aim and Research Questions

The aim of this systematic review is to provide clarity and direction for spirituality training by exploring spiritual educational interventions for BHPs; their implementation, and to answer the following questions:

1) How are spirituality and spiritual care incorporated into all types of educational interventions for BHPs?

2) Do these interventions account for the modern clinical version of spirituality and its universal application to humanity?

3) Do these trainings differentiate spirituality (i.e., religion, secularism, meaning, purpose, connection, wellbeing, and hope), from religion (i.e., beliefs, practices, traditions and rituals related to the sacred.)

Methods

Search Strategy

A systematic search was conducted in November 2022 to identify studies that detailed spiritual care training with BHPs. The authors utilized the following databases in the search: PubMed, CINAHL, and PsycINFO. These three databases were chosen to explore spirituality educational interventions across healthcare fields and environments in relation to BHPs. PubMed is a major journal for biomedical literature and focuses on medicine in general (NIH, 2023). CINAHL explores literature predominantly within nursing literature but also includes allied health literature (EBSCO, 2023). Nurses are also one of the major healthcare fields to explore

spirituality within their individual and team-based care (Balboni et al, 2022; & Oman, 2018). PsychINFO is the leading journal for the American Psychological Association (APA) and BHPs (APA, 2023) It explores most of the literature on behavioral health and social sciences research and interventions (APA, 2023). These databases provide a comprehensive overview of spirituality training for BHPs across the healthcare environments and fields. Cochrane Library and PROSPERO were also searched for ongoing systematic review protocols and published reviews about spirituality and training for BHPs. After testing and validating our search in PubMed the authors translated the search strategy for use in CINAHL and PsycINFO. Three researchers independently conducted the initial screening of titles and abstracts of articles identified through the search. The full-text articles were also reviewed by three researchers for inclusion.

Inclusion/Exclusion Criteria

The inclusion/exclusion criteria were defined using the PICOS (see Table 1) approach which defines population, intervention, comparisons, and outcomes relevant to the review (Cook & West, 2012). We considered all primary studies, regardless of design, as eligible for inclusion if they examined spirituality within training, education, or curriculum for BHPs from the year 2000 to 2022.

Data extraction

A two-step data extraction process was applied to synthesize the data for the final discussion. Firstly, available data was systematically identified and documented. Extracted data was collected in the COVIDENCE systematic review online screening tool. Through

COVIDENCE each article was assessed thoroughly to extract the information in a threefold manner.

1. The characteristics of the articles: demographics, profession of learners, setting, number of participants, if the setting was secular or faith based, if the article differentiates spirituality from religion (see Table 2).
2. The characteristics of the educational intervention: type of intervention, educational content, method of instruction, timeframe of training, instructors, and curriculum (see Table 3).
3. Validated measures: measures, purpose, subscales, and results (see Table 4). Even though measures are a part of the exclusion when comparing the interventions, it is still important to ascertain the presence or lack thereof for future directions and research.

To ascertain a current general direction of BHP spirituality curriculum the content of these interventions were subjected to a thematic synthesis (Thomas & Harden, 2008). This was done to parse out analytical themes from curriculum being taught. The data was analyzed separately by three independent researchers, who defined descriptive themes from just the extracted data and then defined analytical themes in relation to the data and researdch questions. The themes emerging from the extracted data were discussed by the group to avoid bias towards a certain outcome. The group of three consisted of the lead author, a prior abstract and full text screener, and a researcher not priorly involved in the project. The purpose of this team was to avoid bias and create themes true to the data and results of this review. Only the lead author was aware of the research questions, with the other two being informed of them after the first step of the thematic synthesis.

Results

From 9295 preliminary hits, 53 full text articles were assessed for eligibility and 37 were selected for the final review. A Prisma diagram was developed to provide readers with a stepwise process of the search parameters (see Figure. 1).

Setting

Out of the 37 articles there are 19 educational interventions done in academic settings, 17 in clinical settings, and one in a professional conference. Additionally, 23 of these settings are secular and 14 are faith based.

Profession

The interventions include the following BHP professions; social work (*n* = 19), counseling (*n* = 10), clinical psychology (*n* = 7), psychiatry (*n* = 6), marriage and family therapy (*n* = 3), counselor education (*n* = 1), and school counseling (*n* = 1). There are 23 interventions that include only one BHP and 14 that include more than one BHP. Of the interventions that include more than one BHP, 13 are labeled as interprofessional and one is a mix of BHP master's level students. Interprofessional training happens when two or more professions are taught to work together in creating a collaborative treatment plan surrounding common goals (Green & Johnson, 2015).

Intervention Type

There are four different types of educational interventions:

1. Frameworks/models (*n* = 5).
2. Standards (*n* = 2).
3. Direct patient care (*n* = 19).

4. Academic (*n* = 11).

The first is based on interventions that propose frameworks/models surrounding spirituality training. These interventions focus on a specific theory or model that guides the general direction of their training. An example of this is the Discrimination Model which Polanski, 2023 uses to break down supervision of BHPs surrounding spiritual concepts to its simplest form. The second type, proposed standards, are guidelines for specific BHP training. These provide a formal direction of skills and competencies for BHPs regarding spirituality within their care. The third type is direct patient care which is training that is clinically applied to the patient/client during the program and does not include a structured course. Psychiatry residency programs are considered underneath this type since residency is not an academic portion of their training and focuses on patient care within clinical settings (Award et al., 2015; Campbell et al., 2012; Grabovac et al, 2008; Kozak et al., 2010; McCarthy & Peteet, 2003; & McGovern et al., 2017). The last theme alludes to when BHPs receive an educational intervention within the academic portion of their training, and this occurs by way of an instructor and within a specific academic course. This includes classes such as a practicum class, or field work class which is still a structure course residing in the academic portion of a BHPs training while they are actively providing care to patients/clients.

Differentiates Spirituality from Religion

The “No One Left Behind” framework allows for the definition of spirituality to be self-defining, but also points out that spirituality is not just limited to religion but encompasses aspects such as secularism, meaning, purpose, connection, wellbeing, hope, and social locations/identities. Therefore, the authors propose that to differentiate spirituality from religion

the articles must; define spirituality, separate the term from religion, and discuss the relationship between them. It is believed that doing this will add value to an educational intervention surrounding the topic of spirituality (Koenig et al., 2012). There are 19 interventions that report a written definition of spirituality and 18 who do not report a written definition (see Table 3). Four of the 18 interventions that do not report a written definition of spirituality, in text, still differentiate spirituality from religion within their discussion (See Table 2, Bowser et al., 2022; Kozak et al., 2010; Thiel et al., 2020; & Zollfrank et al., 2015). In summation there are 17 interventions that adequality differentiate spirituality from religion according to the framework, four* that partially do, and 16 that do not.

Themes

The findings of the thematic synthesis have been organized into 4 overarching themes:

1. Professional development.
2. Clinical skills.
3. Multiculturalism.
4. BPSS.

Professional Development

A wide range of content and educational interventions were utilized to help providers develop professionally while integrating spirituality into their care. To better align with professional development, it is important to first highlight the proposed standards amongst the interventions (Bohecker et al., 2017; & Hagedorn & Gutierrez, 2009). Standards provide BHP professionals and academic programs avenues to assess BHPs on, their spiritual care, spiritual integration ability, ethical considerations, and growth in attuning to spiritual issues. For example,

the standards proposed by the Association for Spiritual, Ethical and Religious Values in Counseling (ASERVIC), measure aspects of care like the "ability to identify limitations of one's own understanding of a clients religious or spiritual expression and the ability to make appropriate referrals and provide resources" (Hagedon & Gutierrez, 2009; see Table 3, Standards). The proposed ninth Council for Accreditation of Counseling and Related Educational Programs (CACREP) standard highlights referral skills that providers should possess when interacting with chaplains and spiritual leaders (Bohecker, 2017). They also provide considerations on how to assess for spiritual integration skills within BHP training. Even more important are aspects of development such as transference/countertransference and boundaries and this came up in educational interventions for psychiatrists (Grabovac et al., 2008; & McCarthy & Peteet, 2003;).

Lastly are the ethical obligations of including spirituality into care and the ethical guidelines that surround spiritual care. Educational interventions like the program curriculum for psychiatrists enacted by McGovern et al., (2017) emphasize that holistic care has an ethical obligation to include spiritual care. There are also interventions that focus on ethical spiritual care practices and when to refer to a spiritual specialist (i.e., chaplains). This provides guidelines on scope of practice regarding spiritual concepts. The importance of addressing ethical guidelines in spirituality is overtly present in 14 of the interventions (Award et al., 2015; Bandini et al., 2019; Blaclock & Holden, 2018; Bohecker et al., 2017; Hagedorn & Gutierrez, 2009; Kozak, 2010; McGovern et al., 2017; Pate & Hall, 2005; Puchalski et al., 2020; Rawlings et al., 2019; Roberson et al., 2020; Robinson et al., 2016; Thiel et al., 2020; Zollfrank et al., 2015).

Self of The Provider

Self of the provider is another aspect of professional development in BHP training and more specifically in spirituality training. A BHP brings with them a multitude of values, morals, relationships, competence, education, social locations, and trainings that impact care (Sude & Baima, 2020). Self of the provider work can be important in making ethically sound and unbiased decisions when integrating spirituality into care. All 37 educational interventions within this review acknowledge that an awareness of one's own spirituality is important in its training and care. Some do this by allowing time for providers to attempt spiritual interventions on themselves (n = 6). Some include telling of personal spiritual stories (Sloan-Power et al., 2013), completing a spiritual life map that directly highlights spiritual experiences (Buser et al., 2013), meditation exercises (Birkenmaier et al., 2005), painting exercises and drama therapy activities (Meyer, 2012), screening tools (i.e., Faith and belief, Importance, Community, Address in Care (FICA), and Spiritual belief system, Personal spirituality, Integration in spiritual community, Ritualized practices, Implications for medical practice (SPIRIT)) (Piotrowski, 2013) and the creation of a spiritual genogram (Bowser et al., 2022).

Other articles encourage growing in this awareness of spirituality for oneself and one's clients. They develop this awareness by way of small group discussions, creating personal definitions of spirituality and religion, and self-exploration. For example, Polanski (2003) proposes a supervision model that encourages counselors to explore their own personalization skills when it comes to acknowledging spirituality in care. They did this by utilizing the discrimination model which reduces supervision to its simplest form and allows for an increase in self-awareness. Still other interventions use process-oriented discussions to explore concepts

like, psychiatrists' fears and reservations about discussing spirituality with their patients (Awaad et al., 2015), how to develop a relational spirituality (Callahan & Benner, 2018) and how to be a compassionate presence and the role of a BHPs personal spirituality (Puchalski et al., 2020).

Clinical Skills

According to this review a major component of clinical skills is the ability to have general skills in spiritual care. Four of the interventions label these skills as being a Spiritual Generalist (Bandini et al., 2019; Robinson et al., 2016; Szilagyi et al., 2021; & Theil et al., 2020), and deal with direct care of a patient within a clinical setting (i.e., primary care, hospital unit, etc.). According to Szilagyi et al., (2021) a Spiritual Generalist "addresses patients' spiritual distress and strengths to collaborate with spiritual care specialists" (p. 3). They provide a direct list of basic spiritual care skills that they believe each provider should possess. Even though the term of "Spiritual Generalist" is limited to four interventions, the skills required are present within all 37 of the interventions. Those skills include assessment and acknowledgment (n = 15), chaplain referrals (n = 11), and recognizing spiritual distress within client's lives (n = 5). Most of these interventions attempt to educate BHPs on recognizing spiritual distress when clients present in medical or therapeutic settings.

Multiculturalism

Multiculturalism is commonly defined as "the quality or condition of a society in which different ethnic and cultural groups have equal status and access to power but each maintains its own identity, characteristics, and more" (APA, 2023). Within this review and the 37 interventions there is an emphasis on making BHPs aware of the multicultural aspects of spirituality. This theme is present within 18 of the educational interventions and spans through

all four types of interventions (frameworks/models, standards, direct patient care, and academic). These interventions include education on different religions, cultures, spiritual/faith traditions, worldviews, and perspectives. This is done to increase the cultural humility of BHPs, so they can provide equitable care. Cole (2020) teaches this concept of multiculturalism through the ecological framework, which is an emphasis on the *person:environment* relationship. This allows social workers to view their clients within the context of their personal and community environments. There is also Fowler's theory of faith development which is used in a proposed counseling supervision model (Ogden & Sias, 2011). Through this theory, students acknowledge that faith or spirituality is globally universal and is a significant part of general humanity.

Still other interventions create specific educational milestones; ethnic, racial, and cultural considerations (Lennon-Dearing, 2012), diverse spiritual and religious perspectives (Bohecker et al., 2017), cultural context of spiritual beliefs (Hagedorn & Gutierrez, 2009), spiritual worldviews (Campbell et al., 2012), global care (Ferrell et al., 2022), major world traditions/religions (Kozak et al., 2010; McGovern et al., 2017; & McMinn et al., 2014) and secular worldviews (Robinson et al., 2016 Thiel et al., 2020). These interventions aim to educate BHPs on the specific dynamics of spiritual multiculturalism, and they also emphasize the need for BHPs to grow in their understanding that spirituality is a universal part of BPS health, even for those who identify as secular. In an interprofessional workshop they require social workers to define concepts like spirituality, culture, cultural humility, and cultural competence (Rawlings et al., 2019). In another interprofessional workshop on spiritual generalists' social workers, and clinical psychologists are taught to develop respect for all spiritual traditions (religious or secular) when assessing for spiritual distress (Robinson et al., 2016). Thiel et al. (2020)

emphasizes diverse "spiritual talk" that spans multiple identities and social locations (i.e., secularism, religion, culture, etc.) within their interprofessional workshops. In an academic class for social workers, they aim to increase spiritual sensitivity of course material by examining spirituality within human behavior and examining cultural competence within oneself (Callahan & Benner, 2018).

BPSS

Only two articles make a direct reference to BPSS in their spirituality training (Birkenmaier et al., 2005; & Campbell et al., 2012). In a direct patient care intervention, a psychiatry residency program requires second-year residents to spend four hours developing their own BPSS evaluation (Campbell et al., 2012). The second intervention is a framework/model, and it is a one-time training for social workers where they discuss BPSS health and how it fits into clinical work (Birkenmaier et al., 2005). Outside of these two interventions, other direct patient care interventions connect spirituality to overall health or mental health (n = 3). Also, the proposed ninth CACREP standard puts forth an emphasis to learn about the impacts of spirituality on health issues and other dynamics of health that one would label BPSS in nature (i.e., medical issues, trauma, addiction, sexuality, etc.) (Bohecker et al., 2017). Altogether six interventions make a direct connection of spirituality to other aspects of health (BPS).

Discussion

This systematic review of spirituality training for BHPs reveals numerous educational interventions (i.e., classes, workshops, program curriculum, supervision models, one-time training, etc.). However, only two interventions use a curriculum that is evidence-based

(Puchalski et al., 2020; & Szilagyi et al., 2021), the Interprofessional Spiritual Care Education Curriculum (ISPEC). The settings of these studies are a palliative care unit (Szilagyi et al., 2021) and the Veterans Administration (Puchalski et al., 2020). Additionally, following the common dilemma in spirituality research, ISPEC's success is based on its collaborative content but not on its validated measures. In the absence of these measures, the ISPEC training does follow-up evaluations at three, six, and twelve-months post-training. These evaluations focus on how ISPEC is implemented into an organization but a universal measure that displays the successful implementation and growth of spiritual generalist skills is needed.

The other 35 also lack consistent validated measures. This is mostly because their implementation, content, and instruction are limited to; faculty/administrational interest and diversity classes. Only three used validated measures to solidify intervention outcomes (Boheck et al., 2017; Crabtree et al., 2020; & Sloan-Power, 2013) (see Table 4). Additionally, not one of these measures is repeated in other spirituality training, and all three studies chose separate measures due to different study foci (i.e., integration of spirituality into practice, level of personal humility, personal efficacy, anxiety levels, etc.). The measures are usually program specific and do not enhance the training of spirituality universally. Since spirituality has yet to be operationalized across clinical disciplines and research, a lack of consensus on useful validated measures and a lack of consensus on using evidence-based training is to be expected. However, there is a need for a clear direction when it comes to spirituality training for BHPs. According to the content of the educational interventions, this direction should include aspects like professional development, clinical skills, multiculturalism, and BPSS health. It should also

include a general understanding of the modern concept of spirituality and that it is universal to all patients and clients.

A Clinical Starting Point: Spiritual Generalist

Even though these interventions lack validated measures their content is still consistent with important aspects of the modern view of spirituality. Take for example the ISPEC, which can be an evidence-based tool used to teach clinical skills. The ISPEC is an international curriculum that trains clinical providers on how to become Spiritual Generalists when addressing spiritual needs within healthcare settings (GWish, 2023). This curriculum is backed by over two decades of research and focuses on addressing the whole health of a patient/client in healthcare settings (GWish, 2023). The ISPEC is a good starting point for overall spirituality training for BHPs when it comes to general clinical skills. However, according to this review, the ISPEC has not been applied to academic settings of BHP training. This could be due to its natural appeal to medical providers or the format of the course being more conducive to on-the-job clinical training, but this should not stop BHP programs from utilizing the ISPEC.

The role of a Spiritual Generalist is to have basic skills in acknowledging spirituality within their patient's/client's lives and BPSS health. An emphasis should be made on the word acknowledge, because it should not be the sole responsibility of a BHP to fully address and treat spiritual issues. It is also the responsibility of a BHP to grow in the skills of a Spiritual Generalist and know how to clinically interact with spiritual issues. Training that starts with the clinical skills of a Spiritual Generalist can create a pathway to correcting the “Missing S” dilemma. This can be done by creating a distinction between providers who have the competency to clinically acknowledge spirituality and those who do not. Again, these skills focus on welcoming

spirituality into a patient's/client's BPSS health but do not require a BHP to be an expert on spiritual issues.

Through a Spiritual Generalist view a BHP can acknowledge the "Missing S," develop basic skills for utilizing spiritual assessments/interventions and be informed on how to make appropriate referrals and who to collaborate with when acknowledging spiritual issues. A simple starting point for both clinical and academic BHP training programs should be the act of implementing Spiritual Generalist training. They then can measure the success of this content and aid in the creation of universally validated measures for spiritual clinical skills required by BHPs. This measure should center around and be informed by the list of Spiritual Generalist Skills which are universal to all 37 of these interventions. A current scale that could apply to general clinical skills is the first subscale of the Religious/Spiritually Integrated Practice Assessment Scale (RSIPAS). The RSIPAS is a 40-item scale that originally measures the integration of religion/spirituality into the practice and training of social workers (Oxhandler & Parrish, 2016). The first subscale of the RSIPAS focuses on the self-efficacy of a provider in their clinical skills surrounding spirituality. With already high reliability (a=.95) amongst social workers (Oxhandler & Parrish, 2016) and other BHP professions (Oxhandler, 2019) the RSIPAS could be a starting point for a universal validated measurement. With the implementation of items encompassing all the skills of a Spiritual Generalist, the first subscale could become an adequate measure for overall clinical skills.

A Proposed Framework: Spiritual Humility

Clinical skills can be a concrete starting point for spirituality training and its validated measures, but there are other parts of spirituality training that still need to be incorporated (i.e.,

multiculturalism, spiritual health, self-of-the-provider-work, and professional development). These themes are important aspects of spirituality training according to this review and according to major proponents in the field (Koenig et al, 2012; Hill & Pargament, 2003; Oman, 2018; Pargament et al, 2013; & Richards et al., 2023). Multiculturalism is an important aspect of BHP spirituality training and should be attuned to by educators and administration. A BHP will find themselves taking care of patients representing a plethora of different cultures, social locations, and identities and this plethora results in a diverse presentation of spirituality. From the therapy room to the exam room BHPs will encounter all kinds of spiritual presentations from their clients. A common example is sacred healing which BHPs sometimes find unsettling in medical and traditional therapy settings (Brown, 2010; Fadiman, 2012; Moghaddam et al., 2013). It is important for BHPs to learn about spirituality through multiculturalism to be able to give care to all kinds of individuals and avoid discrimination. Then there is the concept of spiritual health which is an addition that the authors made based on the "no one left behind" framework. This concept works through the BPSS model and aims to educate BHPs on the modern version of spirituality (Koenig, 2008), in that it is patient-defined and ever-changing. This version of spirituality is also universal to all individuals.

To make sure that there is adequate growth in clinical skills, multicultural care, and understanding of spiritual health it is also important to incorporate self of the provider work. Self-of-the-provider work aids a BHP in developing their own spiritual awareness. This awareness is about a BHPs own spirituality and how their bias affects their interaction with client's/patient's spirituality. A BHP must learn how to grow in their spiritual awareness to avoid discrimination and provide ethical care that leaves no one behind. This work can also aid

in encountering and respecting a belief system or spiritual practice that might be different than the BHPs personal belief (Azhar et al., 2022). Self-of-the-provider-work is a significant part of the broader theme, of professional development. This aspect of professional development allows BHPs to realize that they provide care from their own biased perspective. If their training is lacking, then that perspective can become rigid, and stale and biases can become a stumbling block towards equitable care. Lastly, there is the part of professional development that centers around ethical actions. After a BHP solidifies the clinical skill/practice of making referrals they must be aware of the ethical guidelines, surrounding it. Meaning they need to be aware of their own scope of practice/skills and when a spiritual specialist is needed to avoid coercion. Professional development will also aid BHPs in ascertaining whether they are falling prey to the "Missing S" dilemma. In seeking out peer consultation and accountability a BHP can assess their own integration of spirituality in their care and whether they fully address a patient's BPSS health.

As one can conclude, spirituality training is far more than just a set of clinical skills. It is a concept that is multifaceted and multidirectional, and its training should be the same. The issue is that most spirituality trainings, whether clinical or academic, lack a universal framework or model to base their training on. The interventions in this review all utilize a plethora of frameworks but lack a cohesive and united direction. With a direction and an agreed-upon framework, spirituality training can take steps toward creating validated measures that apply to all BHPs. It is because of this that the authors propose the framework of Spiritual Humility (See Figure 2) a concept that combines spiritual health with the themes (professional development, clinical skills, and multiculturalism, BPSS) of this review. Spiritual Humility can be used as a

general direction for all BHP training through the clinical and academic world. The important aspect to emphasize is that Spiritual Humility is a framework or model on which educational interventions can be based on. It is not a curriculum or an educational intervention in and of itself. The concept can also describe the overall posture that a BHP can take when interacting with spirituality. This posture is informed by aspects of cultural humility (Hook et al., 2017; & Tervalon & Murray-Garcia, 1998), where, like cultural humility, spiritual competence can never be achieved but Spiritual Humility can be ever-present and ever-growing. Behavioral health providers should be able to understand that spirituality is complex, abstract, ever expansive, and universal. They should also acknowledge that this understanding is never fully realized but should continuously evolve throughout their career.

Spiritual Humility and BPSS

Spiritual Humility also serves to inform the BPSS health framework and further address the dilemma of the "Missing S." It can aid BHPs in acknowledging spirituality within their care and create a natural shift from BPS to a full acknowledgment of BPSS. However, due to the limited nature of the BPSS theme within this review (n = 6), a more overt direction should be taken to include BPSS training within all types of educational interventions. A BHP field that does this is medical family therapy (Hodgson et al., 2014a). Medical Family Therapists (MedFTs) include the BPSS framework in their program curriculum and have created a continuum to measure skills and knowledge (Hodgson et al., 2014) and they apply this continuum to the individual aspects of BPSS health, like spirituality (Wilson et al., 2018). MedFTs also pioneered the creation of BPSS assessment tools like the BPSS interview, which includes questions that correlate with the individual parts of BPSS health (i.e., Biological,

Psychological, Social, Spiritual) (Hodgson et al., 2007). However, despite this profession's focus on BPSS, major leaders in the field still acknowledge the underdevelopment of the "Missing S" (Mendenhall et al., 2021). The authors propose the Spiritual Humility concept to aid in the development of spirituality within the BPSS framework.

Spiritual Humility and How it Fits

When considering where to implement Spiritual Humility it should be a seamless fit into BHP academic training programs due to these programs' acknowledgment of concepts like cultural humility and diversity (CACREP, 2015; Grauf-Grounds et al., 2020; Kondili et al., 2022; & NASW, 2015). Also, some would argue that the concept belongs underneath a diverse class or a class including cultural humility. However, the issue is that spirituality or at least a limited version of spirituality (i.e., mainly religion) has been present within diversity classes for quite some time and BHPs still lack the comfort to adequately acknowledge it (Mendenhall et al., 2021). This is why the concept of Spiritual Humility is not an individual class or intervention but rather a framework or a clinical posture that can be pervasive throughout a BHPs training and career. It can aid an academic program in expanding its view on spirituality to encompass its other subparts and not be limited to major religions. For example, a BHP program could create spiritual care competencies from the individual tenants of Spiritual Humility and use them to better diversify and inform case presentations. Still, another academic avenue to utilize spiritual humility is in role plays, where the masquerading client uses the framework to enhance their spiritual presentation.

Clinically Spiritual Humility can still act as a framework for on-the-job training but also as a posture taken by BHPs. Ideally, it would be beneficial to train BHPs on this posture

beginning in their academic programs, but the task of training spirituality presents itself throughout BHP growth. As mentioned before Spiritual Humility aims to be moldable to all levels of BHP careers. Spiritual Humility can aid a clinic or program in creating or adopting an educational intervention to include all important aspects of care. For example, if a clinic decides to begin the ISPEC course they could use the Spiritual Humility framework to fill in the gaps since the ISPEC is mainly focused on clinical skills. Lastly, with the implementation of Spiritual Humility, there is a future need for the creation of valid measures to increase its validity and reliability. Even though measures surrounding clinical skills have been suggested it would be beneficial to create a measure that encompasses all aspects of Spiritual Humility. A good start for this would be to utilize and modify not just the first subscale but the whole 40-item RSIPAS measure. The whole RSIPAS measure addresses a provider's self-efficacy, attitudes, behaviors, perceived feasibility, and integration of religion and spirituality within clinical practice (Oxhandler & Parrish, 2016). This measure would need to be modified to incorporate the modern version of spirituality and some of its items would need to be changed to reflect this. Overall, the authors intend Spiritual Humility to be a flexible framework that can ebb and flow with the expanding term of spirituality and with the ever-growing needs of training.

Limitations

This systematic review has the following limitations to report. Firstly, spirituality is a concept that is expansive, self-defining, and potentially has no restrictions, which makes it difficult to capture with empirical measures and operationalize. This also makes it difficult when selecting search terms and some relevant papers could have been missed. The absence of a quality assessment tool is another limitation that the authors acknowledge. However, this is due

to the concept of spirituality being difficult to operationalize, and the lack of validated measures for spiritual educational interventions. This review focuses on quantity to create a better picture of the overall presence and development of spiritual educational interventions for BHPs. Thirdly, the review considers original papers within the US and in English only, excluding publications in other languages and countries. This could limit the cultural scope of spirituality to a Westernized version. A more comprehensive search globally could strengthen the multiculturalism theme. Lastly, this review did not consider book chapters which are a big portion of academic educational interventions. Because of this, the authors could be missing important aspects of spiritual care that are not directly integrated into published educational interventions.

Conclusion

This systematic review complements previous literature on spirituality and its modern clinical version. It identifies and summarizes published educational interventions that train BHPs on aspects of spirituality and spiritual care. The reviewed literature highlights important themes of spirituality training; professional development, clinical skills, multiculturalism, and BPSS health. These themes create a general training direction (Spiritual Humility) to aid BHPs in acknowledging spirituality and its universal nature. Incorporating Spiritual Humility within all types of educational training interventions will increase a BHPs understanding of spirituality and aid in their overall, assessment and treatment of BPSS health. Spiritual Humility can also aid BHPs to take a posture of growth and acceptance rather than one of rigidity and inclusivity. This is because Spiritual Humility, like cultural humility, is a skill that continuously evolves and is never fully realized. This means that BHPs should aim to be spiritually humble throughout their whole career and should aim to grow this posture every day. The findings of this review indicate

that to overcome the "Missing S" dilemma in BPSS health spiritual educational interventions should provide the time and space necessary to integrate Spiritual Humility.

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Figure 1.

Prisma Search Strategy

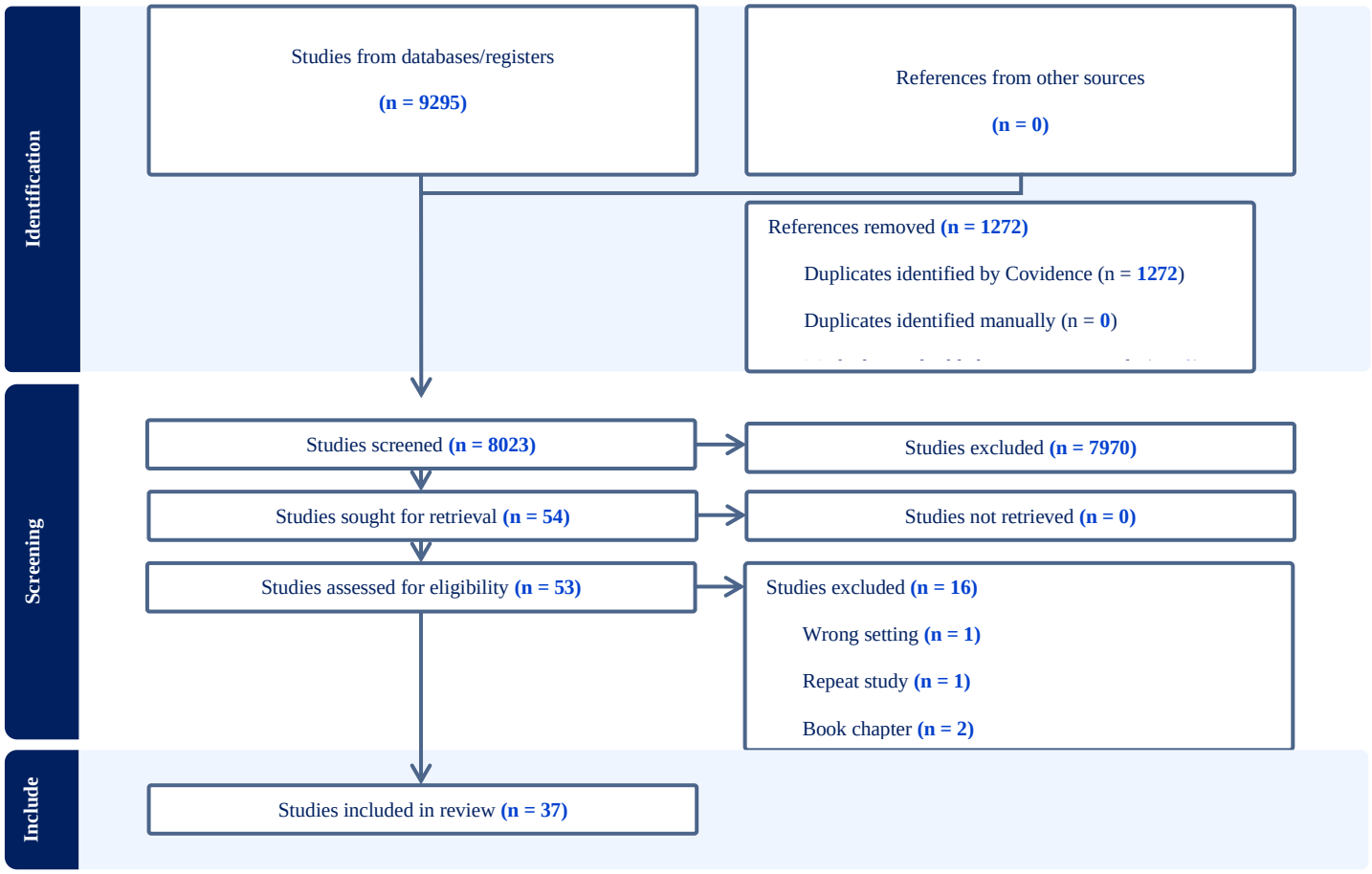

Figure 2.

Spiritual Humility (The Missing S)

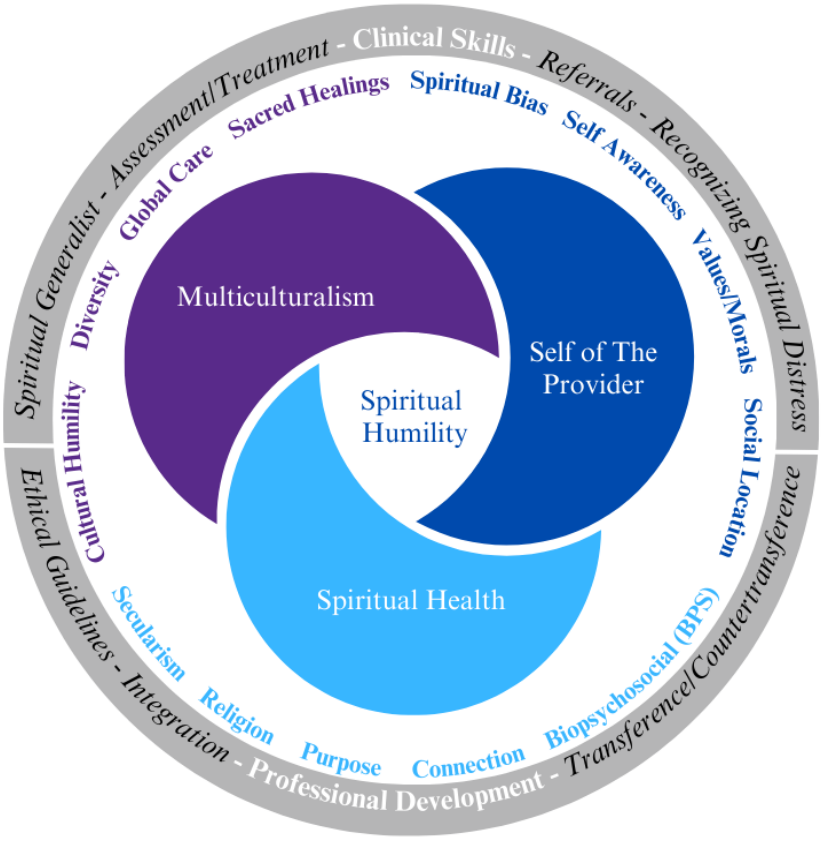

Table 1.

PICO Exclusion and Inclusion Criteria

	Inclusion Criteria	Exclusion Criteria
Population	● **Behavioral health providers/personnel, including psychiatry.** ● **Any clinical, academic, or therapeutic setting.** ● English Language	• Clergy and seminary training. • Any providers that are not behavioral health.
Intervention	● All forms of **education, curriculum** and **training** interventions for **behavioral health providers** and students on **spirituality, its definition and conceptual breadth** ● Proposed educational interventions or curriculum. ● Within US borders. ● Years 2000-2022	● Articles in languages other than English ● Programs outside of the US ● Conference abstracts/Ph.D. theses/commentaries ● Book or book Chapters ● Systematic Reviews
Comparison	● Between spirituality **training programs** ● Between academic and clinical settings.	● Validated measures
Outcomes	● This systematic review is not looking for specific outcomes from the interventions. It is only looking for the presence of educational interventions and their implementation. ● However, the authors will still report the use of **validated** measures and their outcomes.	● The authors will exclude any self-made or modified measures.

Table 2

Characteristics of Spiritual Training Intervention

Study ID	*Reported Demographics*	*Profession of Learners*	*Setting*	*Total Number of Participants*	*Secular or Faith-Based Institution*	*Differentiates Spirituality and Religion*
Award, 2015	Not Reported	Psychiatry	Clinical	20	Secular	No
Bandini, 2019	-Age -Experience -Ethnicity -Gender	Interprofessional -Social Work	Clinical	68	Faith-Based	No
Birkenmaier, 2005	Not Reported	Social Work	Academia	8	Faith-Based	Yes
Blalock, 2018	N/A	Counseling	Academia	N/A	Secular	Yes
Bohecker, 2017	N/A	Counseling	Academia	N/A	Faith-Based	Yes
Bowser, 2022	-Age -Sex -Religious Affiliation -Ethnicity	-Counseling -Marriage and Family Therapy -School Counseling	Academia	15	Faith-Based	Yes*
Buser, 2013	-Age -Sex -Ethnicity -Religious Affiliation	Counseling	Academia	39	Secular	Yes
Callahan, 2018	Not Reported	Social Work	Academia	37	Secular	Yes
Campbell, 2012	Not reported	Psychiatry	Clinical	80	Secular	Yes
Cole, 2020	N/A	Social Work	Academia	N/A	Faith-Based	No
Crabtree, 2021	-Race -Education -Prior spirituality and religion training -Gender -Sexual orientation -Religious Affiliation	Interprofessional -Social Work -Clinical Psychology -Counseling -Marriage and Family Therapy	Clinical	48	Faith-Based	Yes
Ellman, 2012	Gender	Interprofessional -Social Work	Clinical	309	Faith-Based	No
Ferrell, 2022	-Gender -Race -Ethnicity	Interprofessional -Social Work	Clinical	126	Secular	No
Grabovac, 2008	Not reported	Psychiatry	Clinical	30	Secular	Yes
Hagedorn, 2009	N/A	Counseling	Academia	N/A	Secular	No
Kozak, 2010	Not Reported	Psychiatry	Clinical	Not Reported	Secular	Yes*

Lennon-Dearing, 2012	Not reported	Interprofessional -Social Work	Academia	53	Secular	No
McCarthy, 2003	Not Reported	Psychiatry	Clinical	Not reported	Faith-Based	No
McGovern, 2017	-Age -Gender -Nationality -Religious affiliation	Psychiatry	Clinical	12	Secular	Yes
McMinn 2014	Not reported	Clinical Psychology	Academia	N/A	Faith-Based	No
Meyer 2012	Not reported	Counseling	Academia	8	Secular	Yes
O'Connor, 2004	-Gender -Age	Counseling	Academia	25	Faith-Based	No
Ogden, 2011	N/A	Substance Abuse Counseling	Academia	N/A	Secular	Yes
Pate, 2005	Not Reported	Counselor Education	Academia	21	Secular	No
Piotrowski, 2013	Not Reported	Interprofessional -Social Worker	Clinical	374	Secular	No
Polanski, 2003	N/A	Counseling	Academia	N/A	Secular	Yes
Puchalski, 2020	Gender	Interprofessional -Social Worker -Clinical Psychology	Clinical	38	Secular	No
Rawlings, 2019	-Gender -Race -Ethnicity	Interprofessional -Social Work	Academia	251	Faith-Based	No
Roberson, 2021	N/A	Social Work	Academia	N/A	Faith-Based	Yes
Robinson, 2016	-Age -Years of experience -Ethnicity -Gender	Interprofessional -Social Work -Clinical Psychology	Clinical	115	Secular	Yes
Rosenberg 2019	Not reported	Interprofessional -Social work	Professional Conference	142	Secular	No
Rupert, 2019	Not Reported	Interprofessional -Psychology -Social Work -Psychiatry	Clinical	Not Reported	Secular	Yes
Sloan-Power, 2013	-Age -Gender -Race -Ethnicity -Religious affiliation	Social Work	Academia	165	Secular	No
Szilagyi, 2022	-Age -Gender -Ethnicity -Race -Religious affiliation	Interprofessional -Social Work -Clinical Psychology	Clinical	21	Faith-Based	Yes
Thiel, 2020	-Age -Gender -Years of experience -Ethnicity	Interprofessional -Social Work -Clinical Psychology	Clinical	211	Secular	Yes*

Williams-Reade, 2019	-Age -Gender -Religious affiliation -Ethnicity	Marriage and Family Therapy	Academia	17	Faith-Based	Yes
Zollfrank, 2015	-Age -Gender -Education -Religious affiliation -Years of experience -Patients per week	Interprofessional -Social Work -Clinical Psychology	Clinical	55	Secular	Yes*

Note. Differentiates in text but did not provide an official written out definition of spirituality.

Table 3.

Spiritual Training Interventions

Study ID	*Intervention*	*Content*	*Method of Instruction*	*Timeframe*	*Instructors*	*Curriculum*	*Definition of Spirituality*
Frameworks/Models							
Cole, 2020	Program Curriculum	Lectures on: - The history of social work and the creation of a timeline - The ecological model, society, and spirituality/religion. -Diverse religions and faith traditions -Spirituality and religion as sources of strength and coping -Students can also practice self-awareness about religion and spirituality and their own lives	Lecture style within an Introduction to Social Work Course. -Small Group discussion The authors also propose this framework be taught in later courses in the program but in way of lecture. Classes surrounding: -Practice -Research -Policy	Not Reported	Faculty	The curriculum is based on the ecological framework.	Not Reported
Birkenmaier, 2005	One-Time Training	-Meditation exercises, background music -Exercises to grow empathy (i.e., envision life at 80 years old) -Creating a personal definition of spirituality based on water metaphors, automobiles, or weather. -Self-exploration of aging, religion, and spirituality -Discussions on BPSS health -Discussing spiritual assessments and interventions	-Experiential activities -Small Group discussion -Specific questions posed surrounding the student's thoughts on religion and spirituality personally and generally -Assigned Readings -Final project to incorporate spirituality into a well-known social work assessment tool.	3, 4-hour sessions	Authors/Faculty	Reflections on Spirituality and Aging (ROSA)	“They used The National Interfaith Coalition on Aging (NICA) definition: ‘‘the affirmation of life through relationships with self and community in an environment that nurtures and celebrates wholeness’’ along with other definitions based on wholeness and connection to meaning making.”
Lennon-Dearing, 2012	Workshop	Instruction on a spiritual assessment model. This 7X7 holistic assessment model involves 1) medical health, 2) psychological health, 3) psycho-social health, 4) family systems, 5) ethnic, racial, and cultural, 6) social issues, and 7) the spiritual dimension	-Collaborative learning model -Didactic presentations -Experiential activities -Group Discussions -Personal Reflection	1 day	Interprofessional faculty	7X7 Spiritual assessment Model	"Spirituality is the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred."

			-Adult learning theory				
Ogden, 2011	Supervision Model*	-Fowler's theory of faith development ("Endorsed the idea of faith as a human universal. that is, to a greater or lesser degree, faith is a part of the human experience.") -Kohlberg's theory of moral development. ("Moral development is characterized by an increasing sense of differentiation, the ability to view situations from another 's frame of reference, and increased integration of one's own views and ideas.") -Multidimensional -General education on spirituality and religion	Supervision	N/A	Supervisors	The Integrative Spiritual Development Model (ISDM)	"Spirituality is a comprehensive construct that consists of practice, belief, and individual experience."
Polanski, 2003	Supervision Model*	3 focus areas -Intervention (Spiritual assessments, questions, techniques) -Conceptualization skills (Acknowledging that spiritual experiences affect a person's behavior and how to integrate spiritual information) -Personalization skills. (Spiritual awareness for oneself and clients)	Supervision	N/A	Faculty	Discrimination Model (Reduces supervision to its simplest components)	"A subjective, personal experience of the transcendental nature of the universe."
Standards							
Bohecker, 2017	Standards*	Standards/competencies on spirituality and religion: SPIRITUALITY AND RELIGION a. history and development of counseling from spiritual and religious perspectives b. contemporary spirituality, spiritual identities, faith-based cultures, and world religions c. models of faith, spiritual, and religious development across the life span d. theories and models of spiritual and religious supervision, collaboration, and consultation e. principles of spiritual wellness, healthy spiritual and faith-based functioning, and the	Proposed Standards	N/A	A culturally diverse expert panel of counselor educators with a minimum of 3 years of experience as an educator reviewed the proposed competencies. 11 reviewers 4 -School Counseling 4 - Clinical Mental health counseling 1 - Qualitative Research 1 - Marriage and Family Therapy	Proposed Standards - The Expert-Reviewed Ninth CACREP Core Curriculum Area of Spirituality and Religion	"This spiritual tendency moves the individual toward knowledge, love, meaning, peace, hope, transcendence, connectedness, compassion, wellness, and wholeness. Spirituality includes one's capacity for creativity, growth, and the development of a value system. Spirituality encompasses a variety of phenomena, including experiences, beliefs, and practices. Spirituality is approached from a variety of perspectives, including psychospiritual, religious, and transpersonal. While spirituality is usually expressed through culture, it both precedes and transcends culture."

		impact of spiritual or religious identity of origin f. principles and models of clinical assessment, case conceptualization, and diagnosis and treatment planning, if applicable, from diverse spiritual and religious perspectives g. competencies for addressing spiritual and religious issues in counseling. h. societal trends and treatment issues related to working with diverse spiritual and religious systems i. strategies for counseling, interviewing, and assessing individuals, couples, and families from diverse spiritual and religious perspectives. j. methods of identifying spiritual and religious values and beliefs of the client to implement appropriate treatment, planning, and intervention strategies. k. the impact of spiritual and religious beliefs on the grief and loss process, rituals, behaviors, aging, intergenerational influences, crisis and trauma, addictions, human sexuality (gender identity, sexual functioning, sexual orientation), couple and family functioning, infidelity, violence, abuse, and health issues l. ethical and culturally relevant strategies for referrals and consultation with spiritual leaders			7 from a faith-based institution		

Hagedorn, 2009	Standards*	Spiritual competencies created by the Association for Spiritual, Ethical and Religious Values in Counseling (ASERVIC). There are 9 competencies all together: 1) Ability to explain the difference between religion and spirituality. 2) Ability to describe religious and spiritual beliefs and practices in a cultural context. 3) Engage in self exploration of religious and spiritual belief to increase spiritual sensitivity, understanding and acceptance of diversity. 4) Ability to describe one's own religious and or spiritual belief system and explain models of development across the lifespan. 5) Ability to demonstrate sensitivity and acceptance of a variety of religious or spiritual expressions from clients. 6) Ability to identify limitations of one's own understanding a clients religious or spiritual expression. Ability to make appropriate referrals and provide resources. 7) Ability to assess relevance of religious and or spiritual domains in clients' issues. 8) Ability to be sensitive and receptive of religious and or spiritual themes in counseling. 9) Ability to use clients religious and or spiritual beliefs in relation to the clients' goals.	The method of instruction was based on the different competencies. They include: -Small group -Journaling -Discussions -Lecture -Creating a spiritual genogram -Process questions -guided meditation -Reflection papers -Student prepared presentations -Art -Role-plays	N/A	Experts that are a part of ASERVIC	Proposed collaborative curriculum	Not reported
Direct Patient Care							
Award, 2015	Residency Training	Discussions about: Session 1 -Learning about spirituality/religion in their medical training -Taking a spiritual history (assessment) -Fears or reservations about discussing spirituality/religion with their patients Session 2 -Learning more about taking a spiritual history - History of the relationship between religion, science, and psychoanalytic theory	-Brief didactics -Process-oriented discussions -Clinical case discussions	Semester long	Faculty and Chaplains	Koenig H: Spirituality in Patient care why, how, when and what. West Conshohocken, Templeton Press, 2013	Not reported

		Sessions 3 & 4 -Explore patient encounters with religious/spiritual themes -Discussions based on experiences not role-play Session 5 -A panel of chaplains was invited to attend - Chaplain referrals -Promoted interdisciplinary collaboration Session 6 -Reflection on the student's experience during the course.					
Bandini, 2019	Workshop	-Describing the foundations of becoming a spiritual generalist -Familiarizing oneself with spiritual screenings -Recognizing and addressing spiritual distress -Collaborating and identifying resources with chaplaincy services at the sites	-Powerpoint presentations -Brief videos -Live simulations (with actors) -Resources	1 Day-long	Authors	A modified version of a one-day training program used for pediatric interprofessional providers - Robinson MR, Thiel MM, Shirkey K, et al.: Efficacy of training interprofessional spiritual care generalists. J PalliatMed 2016;19:814–82-	Not Reported
Campbell, 2012	Residency Training	PGY1 Cultural/spiritual worldviews, issues specific to Southeast/South Carolina, socioeconomic factors affecting our patients, interviewing skills using a spiritual and cultural history, and clinical vignettes PGY2 4 hours of developing the BPSS evaluation Residents served as teachers for another 4 hires on a self-chosen topic on spirituality. PGY3 Seminars on hospice, death, and dying. Other topics covered were pain and addiction recovery PGY4 An elective where faculty and residents planned a spiritual/cultural project.	-360 Evaluations -Didactics -Seminars -Case Conferences -Interdisciplinary Workshop	5 years	Faculty/Students	The formulation of the curriculum, learning objectives, and assessment tools were derived from feedback from focus groups of residents and fellows. Integration of the FICA spiritual assessment tool and workshops with pastoral counselors Modified the competencies surrounding spirituality training for the residency programs.	“One’s connection to realities larger than oneself,”
Crabtree, 2021	One-Time Training	Cultivate skills and capacity to be sensitive and aware of spiritual, existential, religious, and theological (SERT) topics. The experiential and relational exercise is supposed to promote personal reflection, discussion, and self-awareness.	-SERT discussion groups	Once a week for 75 minutes for 9 months	Clinical Staff	Rupert, D., Moon, S. H., & Sandage, S. J. (2018). Clinical training groups for spirituality and religion in psychotherapy. Journal of Spirituality in Mental Health. doi:10.1080/19349637.2018.1465879	"The ways in which people relate to the sacred, with the sacred being whatever a person reveres or considers of ultimate importance."

Ellman, 2012	Workshop	A fabricated clinical case exploration of a 68-year-old African American woman with end-stage metastatic breast cancer. Focus -Addressing the patient's spiritual needs -Recognizing spiritual distress/challenges -Family involvement and or conflict -Goals of care -Symptom management -Exploration of one's own spiritual or cultural life and bias's	-Online interactive multimedia case modules -Discussion questions -Live small group simulation workshops	30 minutes online 90 minutes in person	Interprofessional faculty	Case exploration	Not reported
Ferrell, 2022	Workshop	Based off the National Consensus Project (NCP) guidelines for quality care in the spiritual domain -Domain 5 - Spiritual, Religious, and Existential Aspects of Care -Guideline 5.1 - Global -Guideline 5.2 - Screening and Assessment -Guideline 5.3 - Treatment -Guideline 5.4 - Ongoing Care Clinical implications Essential Palliative Cares skills needed Also promotes communication principles and teaching strategies -Empathic Communication in Assessing Spiritual Concerns -Listening -Communication Coaching -Family Communication	Goal directed method teaching to promote communication education -Role-plays -Case studies - Communication/conversation guides -Didactic lectures -Small group activities	3 days	Interprofessional Team	The Interprofessional Communication Curriculum (ICC)	Not Reported
Grabovac, 2008	Residency Training	Session 1 Definitions of religion and spirituality and the historical relationship between these areas and psychiatry Session 2 Reviewed scientific evidence to associate spirituality, religion, and mental health Session 3 Clinical assessment Session 4 Case based discussion of spirituality related phenomenology Session 5 Transference and countertransference during assessment Session 6 Case based discussion with panel of faculty.	-Didactic instruction -Case based discussions	6 weeks	Interprofessional	Larson D, Lu F, Swyers J: A Model Curriculum for Psychiatry Residency Training Programs: Religion and Spirituality in Clinical Practice. Rockville, Md, National Institute for Healthcare Res, 1997	"An individual phenomenon, identification with personal transcendence, and meaningfulness. The construct definitions were compared with spirituality, defined broadly to include aspects of oneself that may or may not include a personal relationship with God."

Kozak, 2010	Residency Training	-General background on religious/spiritual beliefs of different world traditions -The role of R/S in treatment -The taking of a R/S history -Collaboration with chaplains -Increasing self-awareness -R/S issues in patients' lives -Visiting places where R/S are relevant to culture.	-Didactic sessions -Rotation experiences -Presentations -Case conferences -Field experiences	4 years	Faculty	Religion/Spirituality and Culture in Psychiatry	Not reported
McCarthy, 2003	Residency Training	-Taking a religious/spiritual history -Meditation and prayers link to relaxation and less stress -History of psychiatry and religion -Exploration of spirituality within patients' lives -Transference, countertransference, boundaries, consent, and ethical concerns for spiritual/religious treatment -The topic of 3 sessions were chosen by the residents based on an annotated bibliography (common choses were cults, major religions, and chaplaincy)	-Interactive presentations -Guest speakers -Group Discussion -Readings -Meditation -Case presentations	12 sessions	Invited MD providers	Mental Health, Religion and Culture	Not Reported
McGovern, 2017	Residency Training	-Exploration of world views, mental health and humans suffering -Ethical standards -Body-mind-spirit connection -Operational definitions of spirituality for patients and families -Cultural dimensions -Spirituality in clinical encounters and its connection to long-term mental illness, recovery from addiction and end of life. -Introduction to pastoral care and hospice care -Chaplain referrals -Spiritual history taking -ACGME competencies.	-Didactics -Seminars -Case conferences -Grand Rounds -Spirituality dinners	3 years	Faculty	Handbook of Spirituality and Worldview in Clinical Practice by Allan M. Josephson and John R. Peteet and Encountering the Sacred in Psychotherapy by James L. Griffith and MelissaE. Griffith.	"The aspect of humanity that refers to the way individuals seek and express meaning and purpose, and the way they experience their connectedness to the moment, to self, to other, to nature and to the significant or sacred"
Piotrowski, 2013	One-Time Training	-Spiritual Screening tools Faith and belief, Importance, Community, Address in Care (FICA) Spiritual belief system, Personal spirituality, Integration in spiritual community, Ritualized practices, Implications for medical practice (SPIRIT)	-Powerpoint training	Not Reported	Clinical Staff	FICA and SPIRIT screening tools	Not Reported
Puchalski, 2020	Workshop	-Introduction to Spirituality and Health Care Model -Spiritual Assessment -Developing a Treatment Plan -Professional Development: Ethical Issues and Dilemmas, Compassionate Presence, and the Role of Clinician's Spirituality. -Chaplain referrals	-Didactic presentations -Discussions -Labs -Skills Building	1.5 days	Clinical staff	Interprofessional Spiritual Care Education Curriculum (ISPEC)	"A dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, and transcendence, and experience relationship to self, family, others, community, society, nature, and the significant or sacred. Spirituality is expressed through beliefs, values, traditions, and practices.'

Rawlings, 2019	One-time training	-Defines religion, faith and spirituality, culture, cultural humility and cultural competence -Integration with Screening, Brief Intervention, and Referral to Treatment (SBIRT) -Connection of faith and spirituality to SUD -Assessment Tools -Spirituality and behavior change -Chaplain referrals -Ethical practice guidelines	Online training	4 hours	Faculty	The Faith & Spirituality Integrated SBIRT	Not Reported
Robinson, 2016	Workshop	-Spiritual generalist skills (15 skills) -Inclusive definition of spirituality -Faith and Belief, Importance, Community, Address (FICA) screening tool -Developing respect for all spiritual traditions. -Demographics of spirituality in the US -Current research -Spiritual distress -Ethics for spiritual care -Boundaries -How to respond to spiritual requests (Prayer, or personal information from staff.) -Information on Chaplains, referral system, difference between chaplains and community spiritual leaders	-Didactic presentations -Slideshow of pictures -Educational videos -Case Simulation (with actors)	1 Day	Clinical staff	Program to Enhance Relational and Communication Skills (PERCS): creating a safe learning environment; emphasizing the moral and relational dimensions of healthcare; suspending healthcare hierarchy; valuing reflection and self-awareness; and honoring multiple interprofessional perspectives	"Spirituality is experienced in the context of a person's relationship with something that is greater than oneself that is perceived as ultimately trustworthy and a source of ultimate meaning or value. Spirituality can be a source of in-spiration and hope, comfort, and courage. Foci of spirituality often include such things as nature, one's family, mindfulness of the present moment, empirical research, artistic expression, or the vocation to which one is devoting one's life."
Rosenberg 2019	Workshop	-Workshops aimed at identifying guiding principles for navigating either race/ethnicity, financial resources, religion/spirituality, and family for pediatric palliative care. -Multicultural	- Clinical case presentation -Discussion	1 Day	Authors	Proposed Curriculum - ''Pediatric Palliative Care in a Multicultural Context''	Not reported
Rupert, 2019	Group Training	-The positions and responses of group members to Spiritual, Existential, Religious, and Theological (SERT) factors arising in clinical and professional practice	-Relational approach -Group discussions -Small group training	Continuous	Licensed Clinical Staff	SERT Goals: Cultivate facilitating attitudes and capacities. Increase knowledge and perspective on SERT. Develop better SERT interventions. Increase support and accountability.	"The ways in which people relate to the sacred."
Szilagyi, 2022	Asynchronous Workshop	Training to be a spiritual care generalist Topics: -Spiritual distress -Compassionate presence -Communication about spiritual issues and spiritual assessment -Whole person assessment and treatment planning -Ethics and professional development	-Online modules -Group discussion	Weekend or six weekly sessions	Clinical staff	Interprofessional Spiritual Care Education Curriculum (ISPEC)	"Dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, and transcendence, and experience relationship to self, family, others, community, society, nature, and the significant or sacred."

Thiel, 2020	Workshop	-Spiritual generalist skills -Screening for spiritual needs of patients (FICA) -Identifying Spiritual talk in all languages (I.e., religious or secular) -Ethical guidelines -Vocabulary to respond to spiritual concerns -How to spot spiritual distress -Chaplain referrals	-Didactic Simulation -Case Simulations (with actors)	1 Day	Clinical staff	Interprofessional spiritual generalist training with an emphasis on individual learning and clinical practice.	Not Reported
Zollfrank, 2015	One-Time Training	Educational -Awareness in diverse spiritual and religious paths -Spiritual assessment -Spiritual care skills Clinical -Enhancing application of spiritual competencies -Assuming the role of spiritual care provider -Chaplain referrals	-Didactic presentations -Case presentations -Process groups -Leading interfaith services -Written assignments -Supervision	5 months 100 hours educational 300 hours clinical	Nationally Certified Instructor (Chaplain)	Clinical Pastoral Education for Healthcare Providers (CPE-HP)	Not Reported
Academic							
Blalock, 2018	Class	Increasing awareness of Potentially spiritually transformative experiences (pSTEs,) how to avoid ethical and clinical pitfalls when patients disclose pSTEs, and how to garner resources when dealing with pSTEs.	-Face-to-face -Assigned Readings -Online training programs -Experiential activities -Role-play exercises	3-4 hours	Not Reported	Proposed curriculum with a multicultural emphasis on pSTEs.	"The universal human capacity to experience self-transcendence and awareness of sacred immanence, with resulting increases in greater self–other compassion and love"
Bowser, 2022	One-Time Training	Activity 1 - Discussion promoting awareness of spirituality and religion. Students had to develop their own definitions of spirituality and religion Activity 2 - Discussions on two case studies that increased self-awareness of spiritual issues Activity 3 - Explored and discussed spiritual development through the creation of a spiritual genogram Activity 4 - Students developed several questions to address spirituality and religion in their assessments. Activity 5 - Students developed a case conceptualization of a case study that focused on the diagnosis and treatment of spiritual and religious issues	-5 Problem-Solving Activities -Discussions -Questions -Case studies -Genograms.	2.5 hours	Licensed Professional Counselor (LPC)	Guidelines for constructivist education: Shaw, B., Bayne, H., & Lorelle, S. (2012). A constructivist perspective for integrating spirituality into counselor training. Counselor Education and Supervision, 51(4), 270–280. doi:10.1002/ j.1556-6978.2012.00020.x Activities based on The Association for Spiritual, Ethical, and Religious Values in Counseling(ASERVIC) competencies and six sub scales of the SCS-R-II	Not Reported (students created their own)

Buser, 2013	One-Time Training	The spiritual Lifemap is a creative intervention that brings to light the story of clients' spiritual experiences and their backgrounds using symbols and words. This is done by starting out with a blank piece of paper. In this paper, the client sketches spiritually significant life events and issues. The instructor trained the students in the spiritual life map intervention and led them through creating their own.	-Lectures -Experiential role-plays with colleagues -Reflection papers on the experience.	30-minutes	Authors/Faculty	Spiritual Lifemap	"Existential relationship with God (or perceived Transcendence) that fosters a sense of meaning, purpose, and mission in life."
Callahan, 2018	Class	-The critical examination of the impact of religion and spirituality on human behavior -How spirituality influences the students worldview and professional use of self -How helping professionals can support the provision of spiritual care. It is also centered around cultural competence; spiritual competence; and spiritual sensitivity.	Asynchronous online class -Reflection papers -Readings (books and articles) -Online discussion boards -Informational powerpoints -Workbooks	Semester	Faculty	Spirituality and Healthcare Based their curriculum off textbook: Koenig, H. G. (2005). Spirituality in patient care: Why, how, when, and what. WestConshohocken, PA: Templeton Press Foundation	"Spirituality is an important but more ambiguous dimension of diversity; what defines spirituality is relative to each person, although the experience of spirituality has been considered universal"
McMinn 2014	Program Curriculum*	-Diversity Competencies -Major world religions -Spiritual formation -Fundamental doctrines of Christian belief -Religious and spiritual issues in psychological assessment and intervention. - Student and supervisor spiritual awareness	- Training model based on knowledge, skills, and attitudes framework -Coursework -Seminars -Religion and spirituality diversity class -Supervision -Clinical training	N/A	Faculty/ Students	- Acquired training through the two courses: Religious and Spiritual Diversity and Integrative Approaches to Psychotherapy - The Addressing Model (Hays, P. A. (2008). Addressing cultural complexities in practice: Assessment, diagnosis, and therapy (2nd ed.). Washington, DC: American Psychological Association.doi:10.1037/11650-000)	Not Reported
Meyer 2012	Classroom Intervention	- Religious painting exercise to promote personal growth, demonstrate counseling techniques, and teach students how to apply drama therapy activities to counseling.	- Experiential activity - small group discussion - enactments - online discussion board	1 class	faculty	The activity followed the multicultural competencies of awareness, knowledge, and skills	"Spirituality was defined at the Summit on Spirituality (1995) as something unique for all individuals that moves individuals toward such things as meaning, love, hope, peace, knowledge, connectedness, compassion, and wellness."
Pate, 2005	Asynchronous Class	-Relationship between counseling and spirituality -Religious journey of a local author -Role of spirituality and religion in the lives of clients -Pastoral counselor perspectives -S/R's connection to health	-Virtual -Discussion boards -Seminars -Readings -Essays -Presentations -Role Plays	Semester	Faculty	Counseling and Spirituality -Created this class to address CACREP standards	Not Reported

O'Connor, 2004	Class	-Ritual introductions (i.e., symbols that have S/R significance) -Individual definitions of S/R -Models of S/R development -Varieties of religious systems and spiritual beliefs -Assessment and intervention strategies -The intersection of Religion, Spirituality, Ethnicity and Culture. -Ethical considerations -Meditation at the beginning of each session -Spiritual autobiography -12 Step	-Discussions -Presentations -Readings -Community panel of therapists -Weekly Support groups -Reflection papers -Journaling	10 sessions (2.5 hours each)	Faculty	Frame, M. W. (2003). Integrating religion and spirituality into counseling: A comprehensive approach. Pacific Grove, CA: Brooks/Cole Thomson Learning.	Not Reported
Roberson, 2021	Program Curriculum*	Spirituality and faith integration through courses: -Human Rights and Social Justice/Ethics -Diversity -Practice -Field Education -Faith Integration	Not Reported	N/A	Faculty	-Worldview Continuum -Holistic competence -Competence -Ethical integration of faith and spirituality.	"Spirituality refers to a human being's subjective relationship (cognitive, emotional, and intuitive) to what is unknowable about existence, and how a person integrates that relationship into a perspective about the universe, the world, others, self, moral values, and one's sense of meaning"
Sloan-Power, 2013	Classroom intervention	-A telling of participants spiritual story or lack of spiritual story.	Modified reflecting team	2.5 hours	Faculty	Reflection-in Action (RIA) Narrative-Deconstructive Work	Not Reported
Williams-Reade, 2019	Class	-Introduction to spirituality and integrating it into practice -Completing and discussing a spiritual assessment on oneself -Exploring how to integrate spirituality into therapy and professional life	-Discussion -Readings -Case Presentations -Student led discussions	Semester	Faculty	Proposed Curriculum for MFT practicum course	"While the definition of spirituality is personal to each individual, in this article we consider spirituality an umbrella term that refers to a dimension of life that provides meaning-making, purpose, and perspective to people who identify as religious, spiritual, both, or neither."

Note. * Proposed Educational Interventions

Table 4.

Validated Measures & Outcomes

Study ID	*Validated Scales/Measures*	*Purpose*	*Subscales*	*Results*
Bohecker, 2017 Standards	-Spiritual Competency Scale-Revised-II (SCS-R-II) -Counselor Activity Self-Efficacy Scale (CASES) -Spiritual Well-Being Scale (SWBS)	-SCS-R-II - Measures a counselor's mastery of the Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC) spiritual and religious competencies -CASES - Measures a counselor's self-efficacy -SWBS - Assesses the spiritual well-being of an individual	-SCS-R-II (1) Culture and Worldview (2) Counselor Self-Awareness (3) Human and Spiritual Development (4) Communication (5) Assessment (6) Diagnosis and Treatment CASES (1) Exploration (2) Insight (3) Action (4) Session Management (5) Client Distress (6) Relationship Conflict SWBS (1) Existential Well-Being (2) Religious Well-Being	There was an overall significant increase in the SCS-R-II Scale from pre- to post-test ($t(14) = 3.82, p = .002, d = 1.02$) and a significant increase in three of the SCS-RII's sub-scales: Assessment ($t(14) = 3.72, p < .006, d = .87$), Counselor Self Awareness ($t(14) = 2.86, p = .01, d = .76$) Communication ($t(14) = 2.56, p = .02, d = .68$). The SWBS was moderately correlated with the total SCS-R-II score ($r = .60$, $p = .019$).
Crabtree, 2021 SERT training	-Religious/spiritually integrated practice assessment scale (RSIPAS) -Differentiation of Self Inventory-Revised-Short Form (DSI-SF) -General Humility Scale (GHS)	RSIPAS - Assesses the self-efficacy, attitudes, behaviors, and perceived feasibility of practitioners to integrate religious and spiritual beliefs of their clients/patients. DSI-SF - Assesses participants ability to balance individuality and togetherness with others, and to think rationally in emotionally charged situations. GHS-Assesses humility of participants.	RSIPAS 1) Self-Efficacy 2)Attitudes	The authors looked at clinician traits (e.g., humility and self-differentiation) and how these influence spiritual and religious self-efficacy and attitudes. The authors found that humility was directly associated with and has a stronger correlation with spiritual and religious attitudes whereas differentiation of self strongly correlated with self-efficacy.
Sloan-Power, 2013 Classroom intervention	The Adult Manifest Anxiety Scale (AMASA) Generalized Self-Efficacy Scale (GSES) Emotional Assessment Scale (EAS)	The authors focused on the GSES to measure efficacy and the AMASA and EAS to measure anxiety.	N/A	The in-class intervention was found to decrease student anxiety and increase self-efficacy regarding spirituality and religion topics. They also found a negative correlation with EAS anxiety and generalized self-efficacy, where decreasing anxiety predicts increasing self-efficacy ($r = -.237$, ($p > .01$).

CHAPTER 3: METHOD

Filling the Gap

Even though spirituality has become more prevalent in holistic or biopsychosocial-spiritual (BPSS) health it is still glossed over by most healthcare providers and more specifically behavioral health providers (BHP). This creates a dilemma within BPSS health where spirituality is not acknowledged, and the framework is limited to the BPS parts. This is because BHPs fail to acknowledge spirituality within their assessments, plans, and treatments for their patients/clients' BPSS health (Ferrell et al., 2020; & Mendenhall et al 2021). Additionally, BHPs continue to voice a lack of comfort in acknowledging spirituality and do not have adequate trainings to address this (Gillilan et al., 2017; Lloreda-Garcia, 2017; Rosmarin et al., 2021; Tehranineshat et al., 2019). A lack of adequate training maintains the hesitancy that BHPs have in acknowledging spirituality and rounding out their assessment of their patient's/clients' BPSS health. Assessing BPSS health without the last S is detrimental to healthcare due to its effects of increased discrimination, decreased access to care, increased unmet needs, worsening mental health, and much more (Azhar et al., 2022; Dein et al., 2012; Kalánková et al., 2021; Martin et al., 2010; & Michlig et al., 2022).

Adequate spirituality training for BHPs would allow for an acknowledgment of spirituality and a route to fill the gap within BPSS health. Because of this, it is important to assess BHP's spirituality training and how it affects levels of spiritual integration across both the healthcare system and BHP academic programs. Spiritual integration is when healthcare providers acknowledge spirituality within their holistic care of patients/clients and can interact with spirituality in an efficacious manner (Sinha & Kumar, 2014). It is also important to point out that healthcare refers to any care that addresses any part of or the whole of BPSS health. This

means that BHPs who conduct their care within a private practice model and who are not necessarily within a hospital or medical setting are still considered a part of the healthcare system.

Theoretical Foundation

Koenig (2008) presents a modern clinical version of spirituality, explores the pros and cons of spirituality within research, and reinforces the clinical version by describing spirituality as "once based on religion, spirituality is increasingly viewed as a broader concept that each individual defines for themselves" (Koenig et al, 2012; p. 91). Within this modern clinical version, it is posited that spirituality is a universal part of general human existence and encompasses all identities including ones such as secularism (a term used for those who are not religious). This is useful because a behavioral health provider's responsibility is to use inclusive language/terms to provide equitable care for diverse populations. By using this clinical version and definition, this study aimed to explore the spirituality training of BHPs through a framework that encourages inclusion and diversity. This framework expands spirituality and allows freedom from borders or restrictions while simultaneously accounting for individual aspects/identities that are connected or are an inherent part of spirituality (e.g., religion, secularism, meaning, purpose, connection, peace, culture, social location, etc.) (Koenig, 2012). It also posits spirituality as a universal part of the human experience and of every human's Biopsychosocial-Spiritual (BPSS) health which enforces the mission of leaving no one behind in BPSS healthcare.

Biopsychosocial-Spiritual BPSS

Engel (1977) presents the Biopsychosocial (BPS) model as an alternative to the biomedical model. This was due to the limitations of the biomedical model regarding holistic health and its tendency to fragment health into individual parts of a whole (Doherty et al.,

2014). The BPS framework fights against this fragmentation and creates avenues for patients' whole health to be adequately addressed (Mendenhall et al., 2018). Later it became the Biopsychosocial-Spiritual (BPSS) model (Engel, 1977 & Wright et al., 1996). Wright et al (1996) discuss the interplay of patients' beliefs in healing, medicine, and their overall healthcare journey. They provide a starting point for healthcare providers when considering how to interact with a patient and their full BPSS health. Since its conception, the BPSS has provided an overall framework that allows and encourages inclusive and equitable whole health care. In summation it champions the message; everyone's whole health, including spirituality, deserves to be addressed.

Research Questions and Hypotheses

This study aims to help fill that gap by exploring the relationship between BHPs, their demographics and experience, their current state of spirituality training, and the level of spiritual integration within their care. In lieu of that aim the authors propose the exploration of the following research questions:

RQ1: What is the effect of BHPs demographics, clinical experience, and spiritual care experience on their level of spiritual integration?

RQ2: What is the effect of spirituality training or lack thereof on BHPs level of spiritual integration?

RQ3: Which BHP profession is more apt to have higher levels of spiritual integration?

RQ4: What is the difference in the level of spiritual integration between BHP students and BHPs who have completed their academic training and are clinically active?

The authors also propose the following hypotheses based on current literature and the state of spirituality training:

H1: There will be a positive effect of experience (clinical and spiritual) on BHP levels of spiritual integration.

H2: There will be a positive effect of spirituality training and its characteristics on BHP levels of spiritual integration.

H3: The professions that will have the highest scores on the validated spiritual integration measure will be those that have systemic thinking built into their training programs. Out of the five proposed professions for this study (i.e., social work, marriage and family therapy, professional counseling, psychology, and psychiatry) social workers and marriage and family therapists have the highest levels of systemic training so in turn might score higher on spiritual integration.

H4: BHP professionals will have higher spiritual integration scores than BHP students.

Methodology

The methodology for this study was a mixed methods methodology informed by the combination of quantitative and qualitative data using a survey consisting of demographic information, open and closed-ended questions, and validated assessment measures. This methodology was chosen to reflect not only the quantitative measures of the constructs (i.e., spirituality, training, and spiritual integration) but also to clarify behavioral health providers' (BHPs) understanding and definition of spirituality and their training experiences that inform the data collected by the validated measures.

Design

This study utilized a convergent design to collect and analyze both quantitative and qualitative data at the same time. A convergent approach brings together quantitative and qualitative results to either compare or combine them (Creswell & Plano-Clark, 2018). Through this approach, quantitative and qualitative data can be either equal or unequal in size (Creswell & Plano-Clark,

2018). Both the quantitative and qualitative data were collected through survey research and the qualitative data was a smaller portion of the survey than the quantitative data. Additionally, a convergent design is ideal for this collection due to both the quantitative data (i.e., integration, demographics, spiritual affiliation, BHP role/profession/experience, and experience in spiritual care and training**)** and qualitative data (i.e., BHPs definition of spirituality, their opinions/experiences of spirituality training, their definition of BPSS health) creating a better understanding of the current state of spirituality training and how it affects BHPs acknowledgment of it within BPSS health. This study aims to measure the spiritual integration levels of BHPs in their care and hopes to make clear the rate of BHPs that acknowledge spirituality within BPSS care and if training (type, setting, and duration of) or lack thereof plays a part. It also aims to explore the difference in spiritual integration levels between BHPs currently in their academic training programs to BHPs who have completed their academic program and are clinically active. Additionally, this study compared spiritual integration levels among different BHP professions (i.e., social work, marriage and family therapy, psychology, and psychiatry).

Participant Recruitment

Upon approval from the Institutional Review Board (IRB), participants were recruited using purposeful sampling via email sent through BHP-related listservs (e.g., American Association for Marriage and Family Therapy, National Association of Social Workers, American Psychological Association, American Psychiatric Association), and through local connections to health care systems and academic programs within the state of North Carolina and Colorado. Each email included a flyer with a brief description of the purpose of the study, inclusion criteria, incentive information, and a quick response (QR) code linked to the survey of

the study via (Research Electronic Data Capture) REDCap. Gift cards were used as incentives to help recruit willing participants for this study. The incentive was a $10 gift card.

Sample

Sampling included a questionnaire including demographic information, open and closed questions, and a validated assessment measure. The final sample size was 157 behavioral health providers for the qualitative analysis and 143 for the both the qualitative and quantitative analysis. This is due to only 143 participants fully completing the quantitative measure. The inclusion criteria for this study included: (a) adults at least 18 years or older; (b) current BHPs in the United States (including psychiatrists); (c) BHPs who are currently students in academic training programs; and (d) BHPs who have finished their academic training and are clinically active.

Measures

Informed consent

The informed consent procedure was built into the survey utilized through REDCap (Harris et al., 2009). Participants were able to review the consent which entailed the purpose of the study, limits of confidentiality, and data management procedures before any data was collected. The participants were also reminded that participation is completely voluntary and were provided with resources for mental health and spiritual health.

Modified Religious/Spiritually Integrated Practice Assessment Scale V.2

The Religious/Spiritually Integrated Practice Assessment Scale (RSIPAS V.2) is a 40-item scale that originally measures the integration of religion/spirituality into the practice and

training of social workers (Oxhandler & Parrish, 2016) but was reevaluated on five (psychologists, clinical social workers, marriage and family therapists, professional counselors, and advanced practice nurses) BHP professions (Oxhandler, 2019). The RSIPAS V.2 measures four components of religious/spiritually integrated practice (a) self-efficacy (SE), (b) attitudes toward integration (AtI), (c) feasibility of integration (FoI), and (d) rate of integration (RoI). Questions were answered based on frequency; participants respond on a five-point Likert-type scale ranging from one, "Strongly agree" to five "Strongly disagree" for the first three measures (e.g., SE, AtI, and FoI), and from one, "Never" to five "Very Often" for the fourth measure; (RoI). The 40-item scale assessed for religious/spiritual integration through, SE; thirteen questions, AtI; 12 questions, FoI; six questions and RoE; nine questions. The RSIPAS V.2 overall had an internal consistency of a = .95 and a = .91 for SE, a = .71 for AtI, a = .88 for FoI and a = .87 for RoI. and standard error for SE is 7.47, AtI is 6.47, FoI is 4.54 and RoI is 6.74 (Oxhandler, 2019). The scale is on a range of 1–5 possible points per question with a total possible score of 200 and the questions within that require reverse scoring prior to summing each subscale include FoI3, and FoI4 (Oxhandler & Parrish, 2016). There are possible subscale scores of 65 for SE, 60 for AtI, 30 for FoI, and 45 for RoE (Oxhandler & Parrish, 2016).

Even though the RSIPAS V.2 is a strong measure its view of the relationship between religion and spirituality is contrary to the view of this study. The RSIPAS V.2 provides psychoeducation within the introduction of the measure that states:

> In addition, while religion and spirituality have two distinct definitions (as shown above), the two terms share many common elements and are often used interchangeably to describe an important area in many people's lives. For the purpose of this scale, please

> consider the terms religion and spirituality as interchangeable as you respond to the items (Oxhandler, 2019; p. 1).

This is contrary to this study's foundational view of spirituality based on Koenig's (2008 & 2012) modern version. Within modernity spirituality is considered an umbrella term for religion, meaning that religion is a subpart of the broader concept of spirituality. It joins other subparts such as paganism, secularism, meaning, purpose, connection, wellbeing, hope, etc. Koenig displays spirituality in this way to highlight the message that spirituality is universal to all humans and is not restricted by the practice of religion or a connection to a higher power. This is not to say that religion should not be assessed within BPSS health, but rather when assessing spirituality religion is only one possible part of the whole picture. Because of this discrepancy, RSIPAS V.2 was modified to reflect the modernity of spirituality which enforces it as an umbrella term. The modified scale includes a different rendition of psychoeducation provided before the scale:

> The next set of questions is a modified version of the Religious/Spiritually Integrated Practice Assessment Scale. This scale was modified to consider the modern version of spirituality that is inclusive to all of humanity.
>
> Definitions to be aware of for this survey:
>
> 1. Religion is "a system of beliefs and practices observed by a community, supported by rituals that acknowledge, worship, communicate with, or approach the Sacred, the Divine, God (in Western cultures), or Ultimate Truth, Reality, or nirvana (in Eastern cultures)," relies on scriptures, teachings, and offers a moral code of conduct (Koenig, 2008, p.11).

2. Spirituality is "more difficult to define since today there are no commonly agreed on characteristics of spirituality, and the traditional definition of spirituality has been changing. Once based on religion, spirituality is increasingly viewed as a broader concept that each individual defines for themselves." This definition is considered the modern version of spirituality and displays it as an umbrella concept that encompasses other concepts. Within this modern version Spirituality includes concepts such as religion, secularism, meaning, purpose, connection, well-being, and hope and is ever-expanding to include more. (Koenig, 2012 p. 91).

In addition, while religion and spirituality are often used interchangeably it is important to acknowledge the modern version of spirituality and re-evaluate our use of both terms. This is important because Spirituality has grown past and encompassed religion and can be seen as an inclusive term for all of humanity. Through this modern version, spirituality is a universal part of life for all humans, even those who identify as secular, pagan, etc. This means that instead of spirituality and religion being interchangeable, spirituality is an umbrella term that can either include or exclude religion. For the purpose of this survey, please consider the term spirituality as an ever-changing concept that is dependent on who is defining it. Also please consider spirituality as an umbrella term that can either include or exclude religion as you respond to the items.

It also replaces the combination term religion/spirituality (RS) with the umbrella term spirituality in each of the questions. Lastly, question number three in the SE subscale was deleted due to its limitation to religion and its inability to be inclusive of all parts of spirituality. The question is stated as

> I know what to do if my client brings up thoughts of being possessed by Satan or the Devil (Oxhandler, 2019; p. 2)

The authors want to iterate that this question can be an important part of assessing religion within spirituality, but it is not needed within this study due to its heavy religious focus and the fact that it is not applicable to all religions nor to the other subparts of spirituality.

In conclusion, the Modified RSIPAS V.2, except for these changes, will be scored the same and will be a total of 39 questions with twelve questions for SE, twelve questions for AtI, six questions for FoI, and nine questions for RoE.

Demographics and Spiritual Affiliation

To best capture a diverse representative sample of BHPs the researchers developed demographic questions that gather age, gender identity, preferred pronouns, sexual orientation, race, ethnicity, and relationship status. It also includes three questions centered around spiritual affiliation. Inclusive options were given for spiritual affiliation and the survey also provides a space for the participants to write their s own explanation or definition of their spirituality. This is to allow the participants the flexibility to explain spirituality in a way that honors the modern version (Koenig, 2008), where spirituality is often self-defined and universal to all.

The survey also included five questions about the BHPs official role (i.e., student, pre-licensed/intern, or licensed professional), BHP profession, years of experience (clinically or academically), and clinical work setting.

Spiritual Care Experience and Past Spirituality Training

Lastly, the survey included twelve questions asking the participants about their spiritual care experience and past spirituality training. The questions asked BHPs the number of times that they have encountered spiritual issues and if they have had prior training on spirituality. If they answered yes to prior training, they were then asked to choose its setting, type of training, and the instructor. There were also options for the participants to describe in their own words the setting, type of training or instructor if the answers do not represent the training they received.

Procedures

Data were collected and managed using REDCap tools (Harris et al., 2009) licensed by East Carolina University. REDCap has been recognized as a secure, web-based software platform designed to support data capture for research studies, providing (a) an intuitive interface for validated data capture; (b) audit trails for tracking data manipulation and export procedures; (c) automated export procedures for seamless data downloads to common statistical packages; and (d) procedures for data integration and interoperability with external sources (Harris et al., 2009).

Quantitative Data Analysis

Frequencies, correlations, and *t*-tests were run to assess for significant differences in spiritual integration levels between BHP professions and between current BHP students and BHPs who have finished their academic training and are clinically active. Logistic and multiple regressions were used to determine which variables predict a BHPs overall score on the Modified RSIPAS V.2. The main predictor variables explored were (a) BHP experience (professional and

in spiritual care), (b) the presence or lack thereof of spiritual training, and (c) spiritual affiliation (Howell, 2013).

Qualitative Analysis

The authors utilized content analysis to explore the text answers provided by BHPs in response to the open-ended questions within the survey. Content analysis is often used in social sciences, communication studies, and other fields to gain insights into the patterns, trends, themes, correlations, and meanings present within the collected data (Weber, 1990). It provides a structured way to analyze data such as various forms of communication, text, audio, video, or images (Neuendorf, 2017). Content analysis is also a valuable tool for studying, understanding, and ascertaining connections between quantitative and qualitative data in a mixed methods design (Schreier, 2017). According to Krippendorff (2019), "content analysis is a research technique for making replicable and valid inferences from text to the context of their use" (p. 18). In using this approach, the authors aimed to ascertain common trends, themes, or characteristics within the answers that are applicable to the research questions, the quantitative data, and the hypotheses. It was the aim of the authors to utilize content analysis to develop a coding scheme based on the research objectives/questions when analyzing the content of the open-ended questions. Through this coding scheme, the authors were able to quantify and bring to light specific aspects of the content such as the frequency of certain words, themes, sentiments, or other relevant attributes.

Conclusion

The aim of this study was to assess a BHPs level of spiritual integration and discover what predicts these levels (i.e., experience, spiritual affiliation, past training, etc.) using a mixed methods design. The quantitative data focused on the presence of certain BHP demographics in

relation to the score of the Modified RSIPAS V.2 while the qualitative data focused on a BHPs opinion of spirituality, holistic health, what belongs in spirituality training, and what setting it should be given in. It was the intention of this study to provide an expansive exploration of spirituality training for BHPs and how it affects their spiritual integration.

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CHAPTER 4: MOVING AWAY FROM THE R/S PHENOMENON: AN EXPLORATION OF SPIRITUALITY AND BEHAVIORAL HEALTH PROVIDER TRAINING

Introduction

Since the year 2000 there have been over 100 systematic reviews that connect aspects of spirituality to better overall health (Oman, 2018). Along with overall health benefits spirituality has been shown to aid the healthcare system in financial savings (Hall & Powell, 2021), clinical health outcomes (Balboni et al, 2023; Clark & Emerson, 2020; Delbridge et al., 2014; Richards et al., 2023; Wilson et al., 2018), and provider work culture (Tata et al., 2021). Accordingly, medical and behavioral health professions acknowledge the importance of spirituality within their standards of care (AAMFT, 2018; CACREP, 2015; JCAHO, 2021). This is due to spirituality connecting to a myriad of cultures, social locations, identities, and patients' whole health (Anders et al., 2021; Fair, 2021; Salami et al., 2022; & Sprik & Gentile, 2020).

Behavioral health providers (BHP) are at the forefront of this acknowledgment due to dealing with spirituality in both medical settings (Balboni, 2013; Oman, 2018; & Richards et al, 2023) and in traditional behavioral health therapy (Rosmarin & Koenig, 2020). However, Spirituality's ever-expanding definition and deficiency of clear direction in the US healthcare system has kept its care at arm's length for BHPs (Errington, 2017; & Ferrell et al., 2020). Many BHPs fail to acknowledge spirituality within their assessments, plans and treatments (Ferrell et al., 2020; & Mendenhall et al 2021).

In fact, most healthcare providers fail to acknowledge it within their patient's/clients' healthcare journey (Kusnanto et al., 2018; & Mendenhall et al., 2021). In contrast to this lack of acknowledgment are major healthcare models/frameworks that include spirituality like Biopsychosocial-Spiritual (BPSS) health (Engel, 1977 & Wright et al., 1996). The BPSS

framework fights against healthcare fragmentation and creates avenues for patient's whole health to be adequately addressed (Doherty et al, 2014; & Mendenhall et al., 2018). Since its conception BPSS health encourages inclusive and equitable whole health care. In summation it champions the message; everyone's whole health, including spirituality, deserves to be addressed.

This dichotomy of spirituality's clear benefits to healthcare but lack of acknowledgment creates a dilemma within the message of BPSS health where spirituality is ignored, and its benefits are left at the door. The question then becomes, "why this is happening?" For BHPs, specifically, there appears to be a lack of comfort in acknowledging spirituality and of not having adequate trainings to address it appropriately and ethically within their clients BPSS health. (Gillilan et al., 2017; Lloreda-Garcia, 2017; Rosmarin et al., 2021; Tehranineshat et al., 2019). Most of the training is haphazard and limited to faculty interest and diversity classes that only focus on the major world religions (CACREP, 2015; Richards et al, 2023; & Williams-Reade et al, 2019). This lack of adequate training could be the primary source of hesitation for BHPs in acknowledging spirituality and rounding out their assessment of their patient's/clients' BPSS health. Assessing BPSS health without spirituality is detrimental to healthcare due to increased discrimination, decreased access to care, increased unmet needs, worsening mental health, and much more (Azhar et al., 2022; Dein et al., 2012; Kalánková et al., 2021; Martin et al., 2010; & Michlig et al., 2022).

This discomfort is likely due to confusion about spirituality's definition and the tendency of spirituality being lumped in with religion in what the authors label as the "R/S phenomenon" (Koenig, 2021, Oxhandler, 2019, Jeserich et al 2023). The R/S phenomenon views spirituality and religion as interchangeable and one in the same, which limits spirituality in its scope and diversity (Koenig, 2012). Training BHPs can increase their understanding of the diverse concept

of spirituality and their own comfort in acknowledging spirituality within their clients/patients BPSS health. This is why an in-depth analysis of BHPs comfort with integrating spirituality into their care, and past spirituality training, is necessary.

By completing this analysis, we aimed to measure the spiritual integration of Behavioral Health Providers (BHPs) and the impact previous training may have had. Additionally, we wanted to know if there were measurable differences in spiritual integration levels between BHP students and professionals and different BHP professions. This article provides a/an (a) introduction to the methodology and analyses used; (b) explanation of results for both quantitative and qualitative data using descriptive statistics, frequencies, regressions, ANOVA, and content analysis; (c) discussion of core contributions to the literature through the analysis of the data; and (d) implications for BHP spirituality training; recommendations, successes as well as strategies for future research that provide further insight into to how BHPs can be adequately trained to address spirituality appropriately.

Theoretical Foundation

Koenig (2008) in presenting a modern clinical version of spirituality, explores the advantages and disadvantages of spirituality research, and reinforces the modern clinical version by describing spirituality as "once based on religion, spirituality is increasingly viewed as a broader concept that each individual defines for themselves" (Koenig et al, 2012; p. 91). Within this version, Koenig suggests that spirituality is a universal part of general human existence and encompasses all identities spiritual, religious or those that are not religiously affiliated. This modern clinical version allows for a client/patient centered version of spirituality but in turn creates a dilemma of BHPs receiving inadequate training on how to address the expansive subject with their clients/patients. By using this clinical version and definition, we aimed to

explore the spirituality training of BHPs through a framework that aligns with the full vision of BPSS health and encourages inclusion and diversity. Koenig's (2008 & 2012) framework allows freedom from borders or restrictions while simultaneously accounting for individual aspects/identities that are connected or are an inherent part of spirituality (e.g., religion, secularism, meaning, purpose, connection, peace, culture, social location, etc.).

Methods

The current study utilized a convergent design to collect and analyze both quantitative and qualitative data simultaneously. A convergent approach brings together quantitative and qualitative results to either compare or combine them (Creswell & Plano-Clark, 2018). Additionally, a convergent design is ideal for this study due to both the quantitative and qualitative data creating a better understanding of the current state of spirituality training and how it affects BHPs spiritual integration scores. We pose the following research questions for the study:

RQ1: What is the effect of BHPs demographics, clinical experience, and spiritual care experience on their level of spiritual integration?

RQ2: What is the effect of spirituality training or lack thereof on BHPs level of spiritual integration?

RQ3: Which BHP profession is more apt to have higher levels of spiritual integration?

RQ4: What is the difference in the level of spiritual integration between BHP students and BHPs who have completed their academic training and are clinically active?

We also propose the following hypotheses based on current literature and the state of spirituality training:

H1: There will be a positive effect of experience (clinical and spiritual) on BHP levels of spiritual integration.

H2: There will be a positive effect of spirituality training and its characteristics on BHP levels of spiritual integration.

H3: The professions that will have the highest scores on the validated spiritual integration measure will be those that have systemic thinking built into their training programs. Out of the five proposed professions for this study (i.e., social work, marriage and family therapy, professional counseling, psychology, and psychiatry) social workers and marriage and family therapists have the highest levels of systemic training so in turn might score higher on spiritual integration.

H4: BHP professionals will have higher spiritual integration scores than BHP students.

Design

Data collection was conducted by way of an online survey disseminated to current BHP students and BHP professionals. Both quantitative and qualitative data were

collected through this survey and the qualitative data was in the form of two open ended questions at the end. Purposeful sampling was utilized via email sent through BHP-related listservs (e.g., American Association for Marriage and Family Therapy, National Association of Social Workers, American Psychological Association, American Psychiatric Association), and through local connections to health care systems and academic programs within the state of North Carolina and Colorado. Each email included a flyer with a brief description of the purpose of the study, inclusion criteria, incentive information, and a quick response (QR) code linked to the survey of the study via a secure online survey platform REDCap (Research Electronic Data Capture). $10 gift cards were used as incentives to help recruit willing participants for this study. All research procedures were approved by the Institutional Review Board of an Eastern Coast University (UMCIRB #; See Appendix A).

The inclusion criteria for this study included: (a) adults at least 18 years or older; (b) current BHPs in the United States (including psychiatrists); (c) BHPs who are currently students in academic training programs; and (d) BHPs who have finished their academic training and are clinically active.

Data Analysis

Descriptive statistics were used to summarize and describe the sample. Multiple regressions were used to determine which set of variables were significant predictors of BHP scores on the MRSIPAS V.2. The main predictor variables explored were (a) BHP experience (professional and in spiritual care), (b) the presence or lack thereof of spiritual training, (c) training characteristics and (c) demographics (Howell, 2013). For the significant categorical variables an analysis of variance (ANOVA) were used to determine mean differences of groups within the variables. Another variable that was used is the framework of Spiritual Humility (Young, 2023) which was created in a prior study. It is a framework that the author proposed for the future direction of BHP spiritual training.

A content analysis was used to explore the text answers provided by BHPs in response to two open-ended questions at the end of the survey. Content analysis is often used in social sciences, communication studies, and other fields to gain insights into the patterns, trends, themes, correlations, and meanings present within the collected data (Weber, 1990). It provides a structured way to analyze data such as various forms of communication, text, audio, video, or images (Neuendorf, 2017). Content analysis is also a valuable tool for studying, understanding, and ascertaining connections between quantitative and qualitative data in a mixed methods design (Schreier, 2017). According to Krippendorff (2019), “content analysis is a research technique for making replicable and valid inferences from text to the context of their use” (p.

18). In using this approach, the authors aimed to ascertain common trends, themes, or characteristics within the answers that are applicable to BHPs thoughts on what should be included in spirituality training and who should be teaching/providing the training. For this study the answers of the two open ended questions were analyzed separately by three independent researchers, who defined descriptive themes from just the extracted data and then defined sub themes in relation to the data. The themes emerging from the extracted data were discussed by the group to avoid bias towards a certain outcome. The group of three consisted of the lead author, and two individuals who were not previously involved in the data collection. The purpose of this team was to avoid bias and create themes true to the data and results of this study. Through this coding scheme, the authors were able to quantify and bring to light further implications for the future of spirituality training for BHPs

Measures

Modified Religious/Spiritually Integrated Practice Assessment Scale V.2

The Religious/Spiritually Integrated Practice Assessment Scale (RSIPAS V.2) is a 40-item scale that originally measures the integration of religion/spirituality into the practice and training of social workers (Oxhandler & Parrish, 2016) but was reevaluated on five (psychologists, clinical social workers, marriage and family therapists, professional counselors, and advanced practice nurses) BHP professions (Oxhandler, 2019). The RSIPAS V.2 measures four components of religious/spiritually integrated practice (a) self-efficacy (SE), (b) attitudes toward integration (AtI), (c) feasibility of integration (FoI), and (d) rate of integration (RoI). Questions were answered based on frequency; participants respond on a five-point Likert-type scale ranging from one, “Strongly agree” to five “Strongly disagree” for the first three measures (e.g., SE, AtI, and FoI), and from one, “Never” to five “Very Often” for the fourth measure;

(RoI). The 40-item scale assessed for religious/spiritual integration through, SE; thirteen questions, AtI; 12 questions, FoI; six questions and RoE; nine questions. The RSIPAS V.2 overall had an internal consistency of *a* = .95 and *a* = .91 for SE, *a* = .71 for AtI, *a* = .88 for FoI and *a* = .87 for RoI.(Oxhandler, 2019). The scale is on a range of 1–5 possible points per question with a total possible score of 200 and the questions within that require reverse scoring prior to summing each subscale include FoI3, and FoI4 (Oxhandler & Parrish, 2016). There were possible subscale scores of 65 for SE, 60 for AtI, 30 for FoI, and 45 for RoE (Oxhandler & Parrish, 2016).

This study utilized a modified RSIPAS V.2 (MRSIPAS V.2). In this version the authors changed/modified the introductory psychoeducation surrounding spirituality and religion. The authors also changed how each question utilized the word spirituality and religion within its text. There was also a question left out due to its focus on aspects of spirituality that were solely linked to religion or religious ideas. These changes were made to reflect Koenig's (2008 & 2012) modern clinical version of spirituality. Within this version spirituality is considered an umbrella term for religion, meaning that religion is a subpart of the broader concept of spirituality. This allows for spirituality to be expansive and diverse and avoids the using religion and spirituality synonymously as the R/S phenomenon does and in turn the original RSIPAS V.2 does as well. For the full MRSIPAS V.2 please reference appendix B. The MRSIPAS V.2 overall had an internal consistency of *a* = .9. For the sub scale there was an internal consistency of *a* = .89 for SE, *a* = .77 for AtI, *a* = .77 for FoI and *a* = .79 for RoI.

Results.

Descriptives

Sample

The current study analyzed data from a sample total of 161 behavioral health providers. 146 BHPs provided qualitative answers that were used in the content analysis and only 143 completed the full spiritual integration measure and were able to be quantitatively analyzed. The sample of BHPs consisted mostly of Marriage and Family Therapists (n = 65), females (n = 115), non-Hispanic white (n = 117) and with a mean age of 37.30. The majority were BHP professionals (n = 98) and were representative of 27 states within America. For an expanded view of the demographics please reference **Table 1**.

Quantitative

Study Variables

The analysis centered around the spiritual integration score of BHPs. The mean score was 144.21 and the mean scores for the sub scales were; (a) Self-Efficacy (SE) (*M* = 46.66), (b) Attitudes Toward Spiritual Integration (AtI) (*M* = 46.42), (c) Feasibility of Integration (FoI) (*M* = 22.3), and Rate of Integration (RoI) (*M* = 28.82). With max scores of SE (60), AtI (60), FoI (30) and RoI (45). Scores were significantly different between groups for presence of training, and professionals and students (**Table 5**). With those who received training and professionals having higher spiritual integration scores. There were also significantly different scores between groups for the number of instructors, number of training types, effectiveness of training and number of Spiritual Humility components. (**Table 4**). Those who received training through multiple different types, from multiple different instructors and including multiple components

of Spiritual Humility had significantly higher scores. Lastly those who perceived the training as very effective had higher scores than those who perceived past training as not effective or somewhat effective.

Predicting Spiritual Integration

To test the effect of spirituality training on spiritual integration scores, a multiple regression was conducted (**Table 2**). The individual predictors were spiritual training characteristics (number of settings, types, instructors), number of spiritual humility components, and perceived effectiveness of training. Spiritual integration served as the dependent variable. Overall, the results showed the utility of the predictive model was significant, F (5,81) = 11.954, $R2$ = .417, p< .001. All the predictors explain a large amount of the variance between the variables (42%). The results showed that the number of different instructors was a significant predictor of spiritual integration scores (β=.37, t= 2.756, p = .007). It also shows that the perceived effectiveness of spirituality training was a significant predictor of spiritual integration score (β=.-.402, t= -4.412, p < .001) in that those who perceived their training as very effective had a significantly better score than those who perceived it as somewhat effective. The answers were coded (1-Very Effective, 2-Somewhat effective and 3-Not effective) which explains the negative correlation with integration score. The results also showed that number of settings, number of types and number of spiritual humility components (β=-.53, t= -.556 p= .58; β=-.011, t= -.081 p= .94; and β=-.16, t=1.742 p= .08) were not significant predictors of spiritual integration scores.

To test the effect of demographics, experience, and the presence of training on spiritual integration scores a multiple regression was conducted (**Table 3).** The individual predictors were

demographics, number of spiritual discussions with clients/patients (monthly), years of experience, number of job settings and the presence of past training. Spiritual integration scores served as the dependent variable. Overall, the results showed the utility of the predictive model was significant, F (12, 82) = 3.608, R^2 = .346, p < .001. All the predictors explain a large amount of the variance between the variables (35%). The results showed that the number of monthly spiritual discussions with clients was a significant positive predictor of spiritual integration scores (β=.28, t= 2.35, p = .02). It also shows that the presence of spirituality training is a significant predictor of spiritual integration scores (β=.35, t= 3.58, p < .001).

Qualitative

Through initial coding of qualitative answers to the two questions, there were three themes: (a) Spiritual Integration; (b) Cultural humility; and (c) Information for the first question and an overall theme of diverse perspective for the second question. A description of each theme was developed from participant answers (**Table 6**).

Spiritual Integration

Spiritual integration represents BHPs desire for spirituality training to include case examples, interventions, assessments, resources, referrals, ethics, skill development, and evidence-based practice, and assessing positives VS negatives of spiritual beliefs (n = 64). The question asked directly about BHPs opinions on what should be included in competency-based spirituality training (**Table 6**). BHPs expressed a want for more clarity on when to engage in spiritual discussions in a productive and beneficial manner and assessing the harm/benefit of these discussions. They also wanted to know when to utilize certain assessments, evidence-based interventions and referrals.

Cultural Humility

Cultural humility represents BHPs desire for spirituality training to explore self of the therapist work, spirituality of clients and BHPs, and diverse cultures & social locations (n = 54). BHPs expressed a want for more insight into how the differences of spiritualities plays a part in the care process and how BHPs can be humbler and more open to the process. They also report desires for training on sensitivity towards others spiritualities and how it interplays with their own. Some expressed desires to break possible tension that could be created through having a different spirituality than patients.

Information

Information represents BHPs desire for training to include topics such as spirituality VS religion, holistic care, ethics, different types of spiritualities, culture, history of spirituality, spiritual health and wellness, frameworks, and scope of practice (n = 59). BHPs expressed a desire to learn more about different types of spiritualities to create a higher awareness of their client's culture and background that could aid in care. They also want more information on models of care that include spirituality and how they fit into care with patients that don't necessarily have an obvious form of spirituality. Lastly, they expressed a desire to have more knowledge on the difference between spirituality and religion and how it fits into their scope of practice.

Diverse Perspectives

Diverse perspectives represent BHPs desire to have more than one type of instructors for trainings in spirituality. Most of the BHPs expressed a need for training in multiple types and from multiple instructors (n = 118) with the second most common being the singular answer of

academic programs (n = 33). This shows that BHPs desire diversity in who teaches spirituality and in where the training takes place.

Discussion

The aim for holistic health to be just that, holistic, includes the struggle of addressing spirituality affectively with our clients/patients. This aligns with the mission of BPSS health which fights against the fragmentation of holistic health and creates avenues for patient's whole health to be adequately addressed (Mendenhall et al., 2018). However, aspects of provider care like hesitancy to acknowledge and lack of comfort with the topic have stood in the way of that mission being fully enacted (Delbridge et al, 2014; Errington, 2017; Mendenhall et al, 2021; & Saad et al, 2017). Due to these issues, this study is important to the future of holistic healthcare, spirituality as defined by Koenig's (2008 & 2012) modern clinical version and BPSS health. It is also important for the future care that BHPs will provide to their clients/patients if in fact they are aiming for holistic care, to avoid fragmentation and fully enact BPSS healthcare.

The Shift

The results and themes from this study infer above average levels of spiritual integration despite the inadequate attempts at spirituality training within the United States (Young, 2023). With an average mean score of 144.21 out of 195 (**Table 1**), the scores were higher than the authors expectations but there is still room for improvement. There was also an overwhelming agreement on two points; that spirituality is different than religion (138 agreed) and it belongs in holistic healthcare (141 agreed) (**Table 1**). This shift could be a result of the self-scoring aspect of the MRSIPAS V.2 and further exploration on the enactment of spiritual integration with the other half of the healthcare relationship, the clients/patients perceptions, and needs, is needed. It is important to ascertain if clients/patients experience this above average acknowledgment and

see it being done effectively and in tune with their care. This is especially important because the clients/patients are asking for more acknowledgment of spirituality within care with 41-83% of patients desiring a deeper conversation about spirituality in relation to their healthcare (AMA, 2016 & McCord et al, 2004) and with over 75% seeing spirituality as overall important in their lives (Heric, 2024). Also 80% of patients/clients turn to spirituality to cope with Mental health issues (Rosmarin et al, 2021). This is due to the expansive and client/patient-defining nature that spirituality is presumed to possess (Koenig, 2012).

Even though education on this version of spirituality was given in the beginning of the survey the current state of spirituality training leans towards teaching spirituality under the guise of the R/S definition and is limited in scope an application (Jones et al, 2021; Young, 2023). Even the RSIPAS V.2 which was used as recently as 2019 (Oxhandler, 2019) states, "For the purpose of this scale, please consider the terms religion and spirituality as interchangeable as you respond to the items" (Oxhandler, 2019, p. 1 of the scale). Additionally, Koenig still views research through the R/S guise and does not adequately separate them in his analysis and discussions (Koenig, 2021; & Moreira-Almeida et al, 2014). This lumping of R with S (R/S) limits our spiritual care and does not allow its full diversity to be acted on. When we lump spirituality in with religion we go against the modern version and spirituality is often overshadowed by the looming presence of religion. In doing this we look away from those patients/clients who find purpose, meaning, connection and hope in spiritualities that are not religious at all.

The More You Do the More you Become

Through multiple regressions it was shown that monthly spiritual discussions with clients was significant and had a positive relationship with spiritual integration scores (**Table 3**) and

through t-tests we saw that professionals had significantly higher scores than students (**Table 5**). These two support the authors first and fourth hypothesis that experience in spiritual care positively effects spiritual integration scores and that professionals would have higher scores than students. However, the more direct measurement of general experience in years was not a significant predictor. Additionally, the third hypothesis; that systemically trained BHPs will have higher scores, was also negated. This could be due to the survey's participants being 60% from systemic BHPs (i.e., marriage and family therapists, & social workers) and the depreciation that this could have on the average mean scores. But it could also beg the question; do spiritual integration scores depend more on a certain type of experience in practice and training rather than being limited to systemic or holistic training?

A certain type of experience brings to the forefront the comfortability of BHPs with spiritual integration which was thought to be low (Kusnanto et al., 2018; & Mendenhall et al., 2021) however, the results from this study are mixed on this claim due to the mean score of the SE subscale (46.6) indicating that BHPs feel somewhat comfortable with spiritual integration, conflicting with the mean score of the RoI subscale (28.82) representing a relatively low rate of spiritual integration. This indicates a somewhat above average level of comfort despite low levels of actual clinical experiences in conducting BPSS assessments, integrating client's spirituality into practice, helping clients consider spiritual support systems and how it connects to meaning and purpose (e.g., according to the RoI subscale in the MRSIPAS V.2.). Also, those who have more monthly spiritual discussions with their clients have higher scores, but the mean of those monthly discussions was 9.76 (**Table 3**). When compared to the percentage of patient desires for spiritual conversations mentioned before, this average alongside the RoI sub scale can confirm that spirituality is still limited in its acknowledgment (Kondili et al., 2022; Kusnanto et

al., 2018; & Mendenhall et al., 2021). However, where is this above average comfort level coming from if not from spiritual integration experiences in training or with clients? Since the interaction with clients is below average and training is limited where is the source of these BHPs comfort with spirituality? These BHPs could have a false sense of comfort due to spirituality being self-defining, in the sense that most BHPs self-define their spiritual approach with their clients in the absence of spiritual training or spiritual competencies.

These results do provide a connection between adequate spirituality training and BHPs having diverse experiences within training and with clients/patients. There is a sense of "the more you do the more you become," that should be taken into consideration when enacting spirituality training for BHPs. How do we capture these experiences that aid BHPs in their actual comfort levels and make sure that in "the doing" BHPs are increasing their rate of spiritual acknowledgment with appropriate assessments and interventions that are client/patient centered, client/patient defining and based in curiosity and humility. This is important due to the results confirming the authors second hypothesis that training would be a significant positive predictor of spiritual integration scores (**Table 3**). Those who received training had a significantly higher average score of +9.9 (**Table 5**). This points to the fact that spirituality training is important for BHPs and in turn improvements of that training should be undertaken (Gillilan et al., 2017; Lloreda-Garcia, 2017; Rosmarin et al., 2021; Tehranineshat et al., 2019; & Young, 2023).

Who, What, When, Where, Why and How

The overall aim of this study was to explore the state of spirituality training and ascertain if the training is as inadequate as the literature states (Gillilan et al., 2017; Lloreda-Garcia, 2017; Rosmarin et al., 2021; Tehranineshat et al., 2019). This still appears to be the case with 56 (39.2%) BHPs in this study reporting that they have had no prior spirituality training. Also, the

results of most instances of training being within academic programs (*n* = 74) in the form of a class (*n* = 68) and from academic professors (*n* = 71*)* (**Table 1**) might confirm the claim that training is limited to faculty interest and diversity classes (CACREP, 2015; Richards et al, 2023; & Williams-Reade et al, 2019). However, a more direct question of the structure of these classes and what the instructors were teaching would have been beneficial in confirming this common trend found in the literature. The overall question then settles on what the future state of BHP spirituality training should look like. Can we create a new "Who, What, When, Where, Why and How," of BHP spirituality training? The shift of opinion seen from BHPs in this study and the conflicting R/S paradigm of current research could create this new direction for the future of spirituality training of BHPs. How do we create a new direction of spirituality training that is effective for BHPs and for their clients/patients?

Based on the qualitative questions in this survey opinions of BHPs show a strong connection to the modern clinical version of spirituality (Koenig, 2012) just from their views on the relationship between spirituality with religion and holistic health and their desire for more training on certain aspects of spirituality. The overall themes of the first question; Spiritual Integration, Cultural Humility, and Information (**Table 6**) display that BHPs in this study have expressed a desire for a new system of training that can shift away from the R/S phenomenon and move towards the modern version of spirituality. Within this want is a chance for more diversity in spirituality training that would be in line with BHPs training system's current view on culture and mirror the term of cultural humility in the term spiritual humility (Young, 2023). Through new types of training BHPs can learn of the diversity of spirituality and increase their understanding of a self-defining theoretical lens for a clients/patients holistic BPSS health. There can be a new understanding of spirituality within healthcare that is not overshadowed by

religious beliefs, higher powers, etc. This is not to say that religion is not an important part of spirituality but that it is not the only part and that with a humble posture spirituality can be acknowledged as a pivotal aspect of everyone's healthcare. Considering this the authors propose the framework of spiritual humility to guide new attempts of spirituality training and spiritual competencies. Based on recent reviews (Young, 2023) it was found that there are only two proposed spiritual competencies for BHPs (Bohecker et al, 2017; & Hagedorn & Gutierrez, 2009). Spiritual Humility can aid to expand these competencies and move from proposed to be enacted. Within Spiritual Humility are major themes such as multiculturalism, self of the provider, spiritual health, ethics, and holistic or BPS healthcare. This aligns with the results that show significantly higher spiritual integration scores for BHP training that included more Spiritual Humility components and more exploration of the generalizability of this framework is needed.

There are probably thoughts about the utility of the term Spiritual Humility since it could be seen as a natural subcategory of cultural humility. In fact, most programs discuss parts of spirituality (i.e., mainly religion) through the lens of cultural humility, which is the understanding that all identities are complex, and this understanding is never fully realized but should continuously evolve throughout one's life (Hook et al., 2017; & Tervalon & Murray-Garcia, 1998). This would be a good fit if not for the fact that training under this framework has limited spirituality to the major world religions and haphazard faculty interest (CACREP, 2015; Richards et al, 2023; & Williams-Reade et al, 2019). That is why there is a need in academic training programs, BHP supervision, CEUs, on-the-job training, etc. to focus intentionally on spirituality and all its diversity and aid BHPs in fully caring for clients/patients BPSS health. To

do anything less ignores the diversity of spirituality and ignores the benefits of acknowledging it in healthcare.

As far as who and where this training takes place the authors propose divers experiences to allow BHPs to come into contact with as many client/patient defining spiritualities as possible. Diverse experiences can aid with creating real comfort levels interacting with spirituality in a diverse manner and can connect spirituality to its positive health outcomes (Kwok & Kwok Lai Yuk Ching, 2022; & Saad et al., 2018). This diversity can also help with fix the issues of unacknowledged spirituality in increased discrimination, decreased access to care, increased unmet needs, worsened mental health, and much more (Azhar et al., 2022; Dein et al., 2012; Kalánková et al., 2021; Martin et al., 2010; & Michlig et al., 2022). This diversity should look like different types of instructors due to integration being significantly impacted by the diversity of instructors (**Table 4**). There was also a significant score difference between those who received training through different types (i.e., classroom, supervision, CEUs, conferences, workshops, etc.). This points to the fact that the more diversity in instructors' and types, could aid BHPs in their comfort with and acknowledging spirituality. This also aligns with the qualitative theme for the second question, Diverse Perspectives.

Lastly it is important to find different ways that "the doing" of spiritual integration can be incorporated into training programs and types. This could look like more case examples and role plays which include different aspects of spiritual care and BPSS health. Instead of a case example limited to depression and anxiety there should be case examples where clients/patients explore the purpose/meaning of their struggles. Or a case example where instead of throwing coping skills (religious or not) at feelings of hopelessness a BHP can explore these feelings of hopelessness and aid the patient in truly exploring what gives them hope in their struggle.

Creating a new "Who, What, When, Where, Why and How," of spirituality training can aid BHPs in acknowledging spirituality with their clients/patients and in turn helping the healthcare system reap the benefits of acknowledging spirituality.

Recommendations

The data and discussion from this study shows that changes in spirituality training need to be implemented. Those changes should include diversity in BHP training, meaning more diverse instructors, types, and settings. The theoretical frameworks and understanding of spirituality could be enacted in academic training programs but how this happens needs to change. Spirituality within a diversity class does not address the necessary understanding of spirituality for BHPs. The change should look like specific classes (or portions of classes), supervision focuses, and educational experiences that highlight the modern version of spirituality, and Spiritual Humility through diverse perspectives and lens. The key to these new implementations is diversity. Instead of lecturing about these concepts there should be more patient panels, guest speakers and exposure to the client/patient-defining concept of spirituality.

This looks like more role plays, case examples and collaborative exercises with other types of providers (MDs, case workers, nurses, etc.). Through this addition a BHP can enact the "More you do, the more you become" aspect of learning. With this there is also the important addition of learning theoretical frameworks of spirituality like the modern clinical version (Koenig, 2012), that will enhance BHPs understanding of the concept and keep the "R/S phenomenon" from being the dominating theoretical understanding of spirituality. Alongside the modern clinical version, training should also utilize the Spiritual Humility framework (Young, 2023), to aid in exploring spirituality's importance to the patients' health and diversity. There should also be a change in training where spirituality is addressed as its own component of

diversity training instead of falling underneath cultural humility or major world religions. This is because spirituality is still ignored when addressed in this manner in BHP training. This aligns with the qualitative themes where BHPs desire to learn more about the theoretical aspects of spirituality, its relationship to clients/patients healthcare and how to be humble in its acknowledgment.

Limitations

Although the current study provides important contributions to the literature, there are limitations to this study. One limitation pointed out prior is the fact that the MRSIPAS V.2 is a self-report measure done by BHPs. Even though the self-report data is important to BHPs comfort with spiritual integration it leaves out the other half of the relationship, the clients/patients perception of how affective a BHPs acknowledgment of spirituality is. It is important to have additional studies that explore the clients/patients side to create a full picture of that state of spiritualty within the US healthcare system and in holistic/BPSS healthcare. Additionally, due to the sampling strategy of the study (i.e., snowball sampling; using emails and flyers dispersed to BHPs and BHP training programs) the greater generalization related to more diversity of BHP professions, clinical settings, health specialties, training programs, social locations, and other factors is not fully realized. In the exploration of spirituality, a diverse representation of different social locations, cultures, races, ethnicities, cities, and states is needed. While the identities focused on for this study add to the body of literature and are representative of the field a study with more diversity across the board would align better with the mission of exploring spirituality and its relation to diversity within healthcare. The growing trend for spirituality to be innate in our humanity and healthcare necessitates that it is explored within all

parts of humanity for our clients/patients health and for ourselves as BHPs providing holistic/BPSS healthcare.

Conclusion

With increased need for a diverse outlook on spirituality from BHPs in the coming years, it is essential that training programs and initiatives become more aligned with the modern clinical version of spirituality, Spirituality Humility and avoid the R/S phenomenon. Diversifying our view of spirituality and championing the patient defining aspect to take center stage will improve holistic healthcare and better align with the true mission of BPSS health. It will also aid the healthcare system to reap the benefits of acknowledging spirituality in a more direct fashion. This study has made clear the aspects of training that need more exploration and those that could possibly aid in creating a better spirituality training system for BHPs. It also contributes to the body of literature to meet the spiritual needs of our clients/patients nationwide and better support those individuals whose spirituality is often ignored and unacknowledged. The authors would also like to emphasize that spirituality should be acknowledged in the same sense that culture is with patients/clients. This means that spirituality is an important part of a clients/patients healthcare and BHPs should be prepared to interact with it if it comes up. They should also be prepared to assess for spiritual struggle and bring it up with clients as BHPs do with cultural aspects in a humble and empathic manner more directly.

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Table 1.
Descriptive statistics of spiritual integration of BHPs (N = 143)

Demographic Variables	Number, Percent (%)
Age (*n* = 143)	*M* = 37.30 (SD = 12.11)
Gender (*n* = 143)	
Female	(115, 80.4%)
Male	(22, 15.4%)
Nonbinary	(4, 2.8%)
Transgender Male	(2, 1.4%)
Race (*n* = 143)	
Non-Hispanic White	(117, 81.8%)
African American/Black	(14, 9.8%)
Asian/Pacific Islander	(9, 6.3%)
American Indian/Alaska Native	(3, 2.1%)
Sexual Orientation (*n* = 143)	
Straight	(114, 79.7%)
Bisexual	(12, 8.4%)
Pansexual	(6, 4.2%)
Queer	(6, 4.2%)
Lesbian	(4, 2.8%)
Gay	(1, 0.7%)
BHP Profession (*n* = 143)	
Marriage and Family Therapist	(65, 54.5%)
Psychologist	(35, 24.5%)
Social Worker	(20, 14%)
Licensed Professional Counselor	(20, 14%)
Certified Clinical Mental Health Counselor	(3, 2.1%)
BHP Status (*n* = 143)	
Professionals	(98, 68.5%)
Students	(45, 31.5%)
Spiritual Affiliation (*n* =143)	
I consider myself spiritual but not religious	(28, 19.6%)
Other Christian groups	(38, 26.6%)
Protestant	(30, 21%)
Agnostic	(11, 7.7%)
Catholic	(11, 7.7%)
Share your spiritual affiliation in your own words	(8, 5.6%)
Atheist	(6, 4.2%)
I do not consider myself spiritual or religious	(6, 4.2%)
Judaism	(3, 2.1%)
Buddhist	(2, 1.4%)
How many spiritual gatherings/meetings do you attend WEEKLY? (*n* = 142)	*M* = .78 (SD = .97)

How many times do you partake in private spiritual activities, such as prayer, meditation, purpose/meaning work, or sacred scripture study within one WEEK? (*n* = 143)	*M* = 5.27 (SD = 5.86)
In your estimation how often do you discuss spiritual issues/topics with your clients/patients on a MONTHLY basis? Please provide a numerical value. (*n* = 143)	*M* = 9.76 (SD = 12.61) (monthly conversations)
If you answered pre-licensed professional or licensed professional how many years of post-degree experience do you have? (*n* = 98)	*M* = 9.47 (SD = 8.56) (years)
If you answered STUDENT how many years of your academic program have you completed? (*n* = 45)	*M* = 1.93 (SD = 1.3) (years)
In your opinion, is there a difference between spirituality and religion? (*n* = 143) Yes No	 (138, 96.5%) (4, 2.8%)
In your opinion does spirituality belong in holistic healthcare (*n* = 143) Yes No	 (141, 98.6%) (2, 1.4%)
Have you ever received training on how to address spirituality with your clients? (*n* = 143) Yes No	 (87, 60.8%) (56, 39.2%)
Type of Training (Select all That Apply)	Academic Class (*n* = 68) Academic Supervision (*n* = 53) Peer Consultation (*n* = 31) CEU (*n* = 26) Workshop (*n* = 25) Clinical Supervision (*n* = 20) Conference (*n* = 19) On-the-Job-Training (*n* =16) Other (*n* = 5)
Instructor of Training (Select All That Apply)	Professor (*n* = 71) Academic Supervisor (*n* = 44) Professional Organization (*n* = 22) Clinical Supervisor (*n* = 21) Clergy/Spiritual Leader (*n* = 20) Other (*n* = 9)
Setting of Training (Select All That Apply)	Academic Program (*n* = 74) Clinical/Professional Setting (*n* = 34) Other (*n* = 8)
Average Spiritual Integration Score	*M* = 144.21 (SD = 16.64)
**Self-Efficacy (Max score = 60)*	*M* = 46.66 (SD = 7.15)
**Attitudes Toward Integration (Max Score = 60)*	*M* = 46.42 (SD = 4.85)

**Feasibility of Integration (Max Score = 30)*	*M* = 22.3 (SD = 3.82)
**Rate of Integration (Max Score = 45)*	*M* = 28.82 (SD = 5.61)

a. * = Sub Score

Table 2.
Training Characteristics

	Model 1		
Variable	*B*	*SE B*	*β*
# of settings	-1.70	3.22	-.053
# of types	-.107	1.321	-.011
# of instructors	5.68	2.06	**.37
# of Spiritual Humility Components	2.11	1.207	.16
R^2		.43	
F for change in R^2		11.49	

a. Dependent Variable: Spiritual Integration Score (0-195)
*p < .05. **p < .01.

Table 3.

Demographics, Experience, and Training

	Model 2		
Variable	*B*	*SE B*	*β*
Age (In Years):	.35	3.22	.24
Race	-2.50	1.32	-.14
Gender	.32	2.06	.01
Sexual orientation	-.31	1.21	-.02
Spiritual Affiliation	-.46	2.43	-.10
Student vs Professional	-.99	7.77	-.01
Relationship Status	-.82	2.45	-.03
Experience (In Years)	.13	.26	.07
# of spiritual conversations with clients (Monthly	.28	.12	*.25
BHP Profession	-1.08	1.18	-.09
Training (Yes/No)	10.87	3.21	**.33
R^2		.32	
F for change in R^2		3.99	

a. Dependent Variable: Spiritual Integration Score (0-195)
*p < .05. **p < .01.

Table 4.

Training characteristics & BHP professions

Measure	N	M	SD	F	P
# of training instructors**				(4, 138) 8.83	<.001
1	28	139.93	13.28		
2	30	146.43	14.80		
3	19	157.47	16.66		
4-5	10	158.20	11.25		
# of training type**					
1	16	139.31	14.58		
2	22	139.45	14.72		
3	20	155.75	13.23		
4	12	154.08	12.30		
5-8	17	154.35	15.83		
Perceived effectiveness**				(2, 84) 20.45	<.001
VERY EFFECTIVE	37	154.89	12.93		
SOMEWHAT EFFECTIVE	46	145.78	13.86		
NOT EFFECTIVE	4	112.00	4.08		
Spiritual Humility**				(4, 138) 7.19	<.001
2-3	21	136.80	15.42		
4	17	146.58	15.64		
5	25	149.28	14.42		
6	24	156.08	14.47		

a. **p<.001

Table 5.

Score Differences

	N	M	SD	t(141)	P	Cohen's D
Spirituality Training				-3.632	<.001	-.623
Yes	87	148.1	15.95			
No	56	138.2	15.99			
Professionals VS Students				2.66	=.009	.468
Professional	98	146.61	16.62			
Student	45	138.98	15.61			
Systemic VS Others				.135	=.893	.023
Systemic	85	144.36	16.82			
Others	58	143.98	16.52			

Table 6.

Themes and subthemes related to BHPs opinions on spirituality training

Themes	*n* size (*n* = 146)	Thematic Examples	Quotes
Q1: What should be included in competency-based spirituality training? (n=144)			
Spiritual Integration	*n = 64*	Case examples, interventions, assessments, resources, referrals, ethics, skill development, and evidence-based practice, assessing positives VS negatives	"A course on clinical implications and how to navigate these conversations," "Questions that should be asked to gauge client's spirituality," "More focus on empirical-based interventions," "Specific interventions. Ways for navigating sensitive conversations with clients," "Definitely empirically supported interventions that can support us in integrating spirituality (all encompassing) into practice," "Ways in which spiritual practices can be beneficial in healing and change, ways in which people can develop spiritual beliefs that are constraining, how to navigate both the empowering and constraining aspects of a person's spirituality."
Cultural Humility	*n = 54*	Self of the therapist, spirituality of clients & BHPs, and diverse cultures & social locations	"How to be curious about patient's spirituality and how to integrate questioning about spirituality into each session as appropriate," "The role of spirituality in a person's life," "Cultural humility. Explore the client's perceptions of spirituality as that is the perception that matters, not that of an "expert" who writes about it." "Understanding how to effectively work with individuals from a different religious background." "Being sensitive to cultural differences." "Awareness of various religions and spiritual journeys. Practice holding space and working with people with different beliefs than the providers - increase comfort and competence. Defining one's own spiritual beliefs, exploring how to use those to enhance our work, keep us grounded, and protect from compassion fatigue."

			"Educating yourself to understand a wide range of spiritual and religious practices. An openness to learn from clients and other practitioners whose views differ from your own," "How to approach the subject sensitively, how to not allow your opinion to phase a clients perhaps differing opinion."
Information	*n = 59*	Spirituality VS religion, holistic care, different types of spiritualities, culture, history of spirituality, ethics, spiritual health & wellness, frameworks, and scope of practice	"Diversity and understanding of language and meaning as it relates to spirituality," "I think it would be important to include information about various ways people engage in spirituality as it can look different for everyone." "Information about the importance of spirituality and how to integrate spirituality into work with clients." "Techniques or models that aid clinicians in integrating spirituality/religion with other theories/approaches to therapy," "Ethics; consequences of avoiding this topic; how to separate religious hurt from religion (I don't practice religion but there are fantastic things about religion and really hurtful things about religion, so it's so important that I call out the shame and the hurt in therapy that is related to why their coming in, without disparaging their whole belief system, this is a complex skill we're not taught a lot about but it comes up so often in therapy for me.)" "The different models that are considered spirituality focused." "Basic fundamentals of a diverse range of religions and spiritual practices so clinicians can utilize the understanding of those practices in session (for example having an AA client who has an altar where she speaks to her ancestors)." "Guidance for how to learn about other religions and how to find resources for them." "Education on the difference between spirituality and religion," "Overview of major religions, and their view of mental health/wellness. Eastern religious philosophies should be included as well- with

		the caveat that their constituent biopsychosocial models be included (Chinese medicine, Ayurveda, etc.),”

Q2: Who should teach competency-based spirituality training? (n = 144)		
Diverse Perspectives	*n = 118*	Academic classes, CEUs, clinical/on the job training, BHPs with training and expertise, supervision, and clergy/spiritual leaders

CHAPTER 5: A CALL TO SPIRITUAL HUMILITY: AN EXPLORATION OF SPIRITUALITY, THE HEALTHCARE SYSTEM AND BEHAVIORAL HEALTH PROVIDERS; CONCLUSION

This chapter summarizes the contributions to research of this dissertation and translates the findings into practical recommendations. It includes a (a) review of previous chapters one through four, (b) discussion of how this dissertation is theoretically grounded in and contributes to the field of Medical Family Therapy, (c) review of the contributions to research specifically surrounding diversity, and holistic/Biopsychosocial (BPSS) health regarding spirituality and (d) justifying a new direction for BHP spirituality training that incorporates the framework of Spiritual Humility.

Dissertation Review

This dissertation opened with a chapter reviewing the current state of spirituality through Peeks (2008) three world view with the addition of the hidden world of training. This article is under review for publishment in the Journal for the Study of Spirituality (Young et al., 2024). This article provides a review of the state of spirituality in the US healthcare system. It points out the benefits of acknowledging spirituality in the four worlds of healthcare (i.e., clinical, operational, financial, and training). This chapter provides an up-to-date state of spirituality and recommendations centered around the world of training. It is the opinions of the authors that implementing improvements in behavioral health providers (BHP) spirituality training will create ripple effects and increase appropriate acknowledgment of spirituality in the other 3 worlds of the US healthcare system.

While Chapter 1, begins the discussion of BHP training being the place to start for better acknowledgment overall, Chapter 2 continues this discussion with a look at the status of BHP

spirituality training. This article provides a glimpse into the current spirituality educational interventions that are provided to BHPs within the US. It spanned all training in and outside of academic programs for BHPs who were both students and clinically active. Attention is given to this issue through a systematic review of the literature to answer the question, "Who is being trained on the concept of spirituality and how are they being trained?" There were 4 overall types of educational interventions: (a) frameworks, (b) standards, (c) direct patient care and (d) academic. It was found that the state of spirituality training for BHPs is limited to one evidence based educational intervention (Puchalski et al., 2020; & Szilagyi et al., 2021) in the Interprofessional Spiritual Care Education Curriculum (ISPEC). It was also found that most of the educational interventions, including the ISPEC, lacked consistent validated measures to help the reliability, validity, and generalizability of the interventions. However, even though the educational interventions were not as rigorous the content of the training was still valuable for the future of spirituality training. Because of this the authors did a thematic analysis of the content of the curriculum and created an educational framework titled Spiritual Humility. This framework includes the themes: (a) professional development with a subtheme of (a^1) self of the provider, (b) clinical skills, (c) multiculturalism, and (d) BPSS health. This framework is made to be ever changing and ever expanding and hopes to mirror the ever-expanding nature of spirituality.

Chapters 1 and 2 contributed to the design and methodology of an original research study outlined in Chapter 3. The methodology includes a mixed methods approach to research exploring spiritual integrations scores of BHPs and how prior training effects these scores. The study included a quantitative survey for BHPs, students and professionals in the United States. The survey comprised of demographics, questions about prior training (i.e., its setting, type, and

instructors) and two open ended questions. The two open ended questions asked about BHPs opinions on what should be included in competency-based spirituality training and who should provide the instruction.

Finally, Chapter 4 presents original research contributing to literature on BHP spirituality training through a mixed methods study that analyzed both quantitative and qualitative data. The measure that was utilized was the Modified Religious/Spiritually Integrated Practice Assessment Scale (MRSIPAS V.2). This study included 161 participants all together but only 143 participants quantitative data could be analyzed due to 18 participants leaving significant questions blank in the MRSIPAS V.2. The quantitative data was analyzed using descriptive statistics, frequencies, multiple regressions, ANOVAs and t-tests. The average spiritual integration score was 144.21 and presence of training, perceived effectiveness of that training, number of instructors for the trainings, and monthly spiritual conversations with clients were the significant multiple regression predictors of BHP integration scores. Also, significant differences were found in BHP scores between; students and professionals, those who received training and those who did not, number of different types of trainings, number of different instructors, and those who perceived the training as very effective and somewhat effective. Through a content analysis of the qualitative data (n = 146) four themes were found that represent the desires of BHPs in future spirituality trainings (a) spiritual integration, (c) cultural humility, (d) information (e) diverse perspectives. These themes were organized and presented through the lens of the modern version of spirituality (Koenig, 2008 & 2012) with recommendations for the future of BHP spirituality training, and further research that can aid in the improvement of acknowledgment of spirituality by BHPs in their care for their clients within the US healthcare system.

Contributions to Medical Family Therapy

Medical Family Therapy aims to enact the philosophy and purpose of MFT as a field to better utilize a BPSS systemic framework through a sociocultural lens. MedFTs work to incorporate larger systems to better inform their enactment of BPSS care within primary medical care and other medical settings (McDaniel et al., 2013 & von Bertalanffy, 1968). They do this through the integrated care model and in collaboration with entire healthcare teams (medical doctors, nurses, case workers, social workers, front desk staff, medical assistants, etc.) (Doherty et al., 2014). Their goal as behavioral health providers within healthcare systems is to provide holistic care in its entirety through the BPSS framework. This dissertation is theoretically informed by BPSS health, the splits within healthcare (Doherty et al., 2014) and other spirituality frameworks including the modern clinical version of spirituality (Koenig, 2008 & 2012).

A way that BPSS health is fully enacted is by looking beyond the natural fragmentations that happen in healthcare (Doherty et al., 2014); the body and mind, the individual and family, and the family and larger systems. It is the job of a MedFT to mend these fragments and bring equitable BPSS healthcare to their clients/patients in healthcare systems. This dissertation points out an additional split that happens within BPSS health and the broader healthcare system and that is the Biopsychosocial/Spiritual (BPS/S) fragmentation. Even though spirituality is highlighted in our frameworks and textbooks which include a continuum to measure BPSS skills and knowledge (Hodgson et al., 2014) and they apply this continuum to the individual aspects of BPSS health, like spirituality (Wilson et al., 2018), it still suffers under the BPS/S split where acknowledging spirituality within our clients/patients healthcare is an afterthought. This dissertation brings attention to this fragmentation under the “Missing S” phenomenon (See Chapter 2) where spirituality is often missing from our BPSS care.

More specifically this dissertation brings to the forefront the importance of and benefits from the acknowledgment of spirituality with the healthcare system (Chapter 1), a need for new and improved spirituality training for MedFTs and BHPs in general due to the haphazard state of current training (Chapter 2), and frameworks, specific training characteristics, and BHPs experiences that will help in creating new and improved spirituality training (Chapter 2 & Chapter 4).

This dissertation advocates for MedFTs and BHPs in general to take on the mission of BPSS healthcare in its entirety and fix the "Missing S" issue by improving their training and fully acknowledging spirituality within the BPSS framework.

Contributions to Spirituality Research

This dissertation in its entirety contributes to the world of training for BHPs on spirituality. In reviewing articles for this dissertation, it became clear that the state of empirically based spirituality training is haphazard at best and more exploration was needed to improve the current state of spirituality BHP training and create pathways to improvements. The original research in Chapter 4 explored who is being trained, how they are being trained and what can improve BHPs spiritual integration scores. In this exploration variables came to light that can significantly impact the effectiveness of future spirituality training (i.e., diversity in instructors, exposure to more spiritual conversations with clients, the presence of training, and perceived effectiveness of the training). Spirituality training needs to change and Chapter 4 gives a general direction to start that change. Outside of training there are two other aspects of spirituality research that this dissertation adds to and that is spirituality as a matter of clients/patients health and as a matter of diversity.

A Matter of Health

Spirituality has long been an optional aspect of clients/patients health and because of this it is often ignored. Chapter 1 explains why to ignore spirituality is to also ignore the systemic benefits that healthcare systems can reap in its acknowledgment. This dissertation brings to the forefront a mission of acknowledging spirituality as an important part of holistic/BPSS healthcare. With the framework of modern spirituality this dissertation seeks to raise awareness on issues like the BPS/S split (Missing S), spirituality being ignored or being limited to religion, spirituality training being haphazard and BHPs being uncomfortable with and not fully understanding the ever-expanding and patient defining concept of spirituality (Chapter 2). It is important to address these issues in the pursuit of realizing the full mission of BPSS health, fully acknowledging spirituality within healthcare, and reaping its benefits.

A Matter of Diversity

This dissertation also brings awareness to the thought that spirituality is an innate part of every human's life and healthcare and that to ignore it is to take a step back in acknowledging the diversity of our clients/patients. Many who read this will have the thought, well I am not spiritual due to spirituality being lumped with religion in the R/S phenomenon, but this dissertation highlights the difference between R/S and spirituality (Chapter 4). Spirituality includes religion but also includes aspects such as purpose, meaning, connection and hope. These aspects do not have to be connected to a religion or higher power and in that claim is the argument of the universality of spirituality. Those who are not religious or believe in a higher power still strive to find a purpose and meaning to their lives that brings hope. This is why this dissertation advocates for a better understanding of the modern clinical version of spirituality and bring to light that each client/patient defines their own spirituality. This journey is not unlike the

concept of culture for clients, in that BHPs have become more aware of how to incorporate a clients/patients culture into their healthcare journey in a humble and curious manner. This dissertation asks why spirituality should be any different? Spirituality is about exploring the diversity of our clients and highlighting inclusion to those who do not fit the R/S mold. Through the concept of Spiritual Humility (Chapter 2), this dissertation adds seeks to provided answers that will improve BHPs outlook on spirituality and truly acknowledge our clients/patients diversity entirely.

Lastly, it needs to be stated that this dissertation does not advocate for forced BHP interventions/assessments that ignore the clients/patients self-defining spirituality but rather a curious and humble approach that acknowledges spirituality as a part of the journey (i.e., Spiritual Humility). It advocates that spirituality is an innate part of humanity and healthcare in the form of looking for meaning, purpose, hope and connection.

Recommendations

Through the analysis of the mixed methods study (Chapter 4) it was shown that BHPs have an average score of 144.21 and even though this was higher than expected there is still room for improvement. Also 39.2% (56 participants) reported not having any spirituality training and training had a significant impact on spiritual integration scores. This data shows that changes in spirituality training need to be implemented. Those changes should include diversity in BHP training, meaning more diverse instructors, types, and settings. Spirituality cannot be limited to a classroom lecture but should be experienced through role plays, case examples and collaborative exercise with other types of providers (MDs, case workers, nurses, etc.). Through this addition a BHP can enact the "More you do, the more you become" (Chapter 4) aspect of learning. With this there is also the important addition of learning theoretical frameworks of spirituality like the

modern clinical version (Koenig, 2012), that will enhance BHPs understanding of the concept and to keep the R/S phenomenon from being the dominating theoretical understanding of spirituality. Alongside the modern clinical version, training should also utilize the Spiritual Humility framework (Chapter 2) to aid in exploring spiritualities importance to the patients' health and diversity. There should also be a change in training where spirituality is addressed as its own component of diversity training instead of falling underneath cultural humility or major world religions. This is because spirituality is still ignored when addressed in this manner in training. This aligns with the qualitative data (Chapter 4) where BHPs desire to learn more about the theoretical aspects of spirituality, and its relationship to clients/patients healthcare.

Future Research

In addition to the need for BHP spirituality training to change there is also a need to explore those implementations of changes through validated measures grounded in measuring educational outcomes. There is a need for measures to be based in competencies in spiritual education for BHPs. However, competencies are also an area of research that needs to be expanded to solidify competencies for education on spirituality for BHPs. This could be explored by applying the framework of Spirituality Humility as a proposed version for competencies. One validated measure could be the MRSIPAS V.2 but to increase its validity more research is needed. Alongside this is the need to explore the other half of the relationship in acknowledging spirituality, the clients/patients. An updated exploration of clients/patients wants for spiritual acknowledgment and how BHPs are doing is needed to add to the current literature of the wants and needs of clients/patients in healthcare (Chapter 1).

Conclusion

The focus of this dissertation is the increase of the acknowledgment of spirituality within the healthcare system by way of BHPs training. With the state of spirituality training being minimal and limited future changes to that training are an important aspect for holistic BPSS health and diversity. The original research of this dissertation brings light to those potential changes and adds to the literature of spirituality within healthcare.

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APPENDIX A: IRB APPROVAL

EAST CAROLINA UNIVERSITY
University & Medical Center Institutional Review Board
Willis Building · Mail Stop 682
600 Moye Boulevard · Greenville, NC 27834
Office **252-744-2914** · Fax **252-744-2284** · **rede.ecu.edu/umcirb/**

Notification of Exempt Certification

From: Social/Behavioral IRB
To: Taylor Young
CC: Damon Rappleyea
Date: 11/15/2023
Re: UMCIRB 23-001959
Spirituality and Spiritual Integration Scores Among Behavioral Health Providers

I am pleased to inform you that your research submission has been certified as exempt on 11/15/2023. This study is eligible for Exempt Certification under category # 2 AB.

It is your responsibility to ensure that this research is conducted in the manner reported in your application and/or protocol, as well as being consistent with the ethical principles of the Belmont Report and your profession.

This research study does not require any additional interaction with the UMCIRB unless there are proposed changes to this study. Any change, prior to implementing that change, must be submitted to the UMCIRB for review and approval. The UMCIRB will determine if the change impacts the eligibility of the research for exempt status. If more substantive review is required, you will be notified within five business days.

Document	Description
Consent(0.01)	Consent Forms
Email Template(0.01)	Recruitment Documents/Scripts
Flyer(0.01)	Recruitment Documents/Scripts
Proposal(0.01)	Study Protocol or Grant Application
Survey(0.01)	Surveys and Questionnaires

For research studies where a waiver or alteration of HIPAA Authorization has been approved, the IRB states that each of the waiver criteria in 45 CFR 164.512(i)(1)(i)(A) and (2)(i) through (v) have been met. Additionally, the elements of PHI to be collected as described in items 1 and 2 of the Application for Waiver of Authorization have been determined to be the minimal necessary for the specified research.

The Chairperson (or designee) does not have a potential for conflict of interest on this study.

APPENDIX B: RESEARCH FLYER

APPENDIX C: SURVEY

Spiritual Integration and Behavioral Health Providers

Please complete the survey below. Thank you!

Thank you for your participation in this study. I am so grateful for your interest in this study and your contribution is much appreciated. The purpose of this study is to get a better understanding of behavioral health providers integration of spirituality into their care of patients/clients. Please remember that this study has been approved by the institutional review board at East Carolina University, and that the information you share is confidential and will be deidentified (e.g., excluding any identifying information such as names of people or places). Any information given for this study will be used to further research that will bolster spirituality training for behavioral health providers and increase the acknowledgment of spirituality within holistic healthcare. If you have further questions on confidentiality of the project that were not addressed in the informed consent, please reach out to the primary investigator, Taylor Young (youngtay21@students.ecu.edu).

Dear Participant,
I am a Licensed Marriage and Family Therapist and a Ph.D. student at East Carolina University in the Human Development and Family Science Department. I am asking you to take part in a research study entitled, "Spirituality: To Address or Not to Address".
The purpose of this research is to explore spirituality within the context of the broader healthcare system, the state of spirituality training for Behavioral Health Providers (BHPs), and how comfortable BHPs are in addressing spirituality with their clients.

By doing this research, I hope to learn:
-BHPs' level of spiritual integration into their clinical work with clients/patients
-The effect of current spirituality training and BHP experience on their spiritual integration -The effects and differences in spirituality training between academic and clinical settings and between BHP professions

You are being invited to take part in this research because you are a Behavioral Health Provider (BHP) that is either:
1) Currently in your academic portion of your BHP training
OR
2) You have graduated from your academic program and are actively treating or caring for clients/patients
OR
3) You are a current student and also clinically active (i.e., PhD students)

If you agree to take part in this survey, you will be asked questions that relate to your thoughts and perceptions of spirituality, your training on the concept, and your comfort in addressing it with clients/patients.

This research is overseen by the University and Medical Center Institutional Review Board (UMCIRB) at ECU. Therefore, some of the UMCIRB members or the UMCIRB staff may

need to review your research data. The information that you provide in the survey will be kept confidential, and unassociated with your name or likeness. Identifiable information will be removed from the dataset and all research reports to ensure confidentiality.

Please call Taylor Young at 330-353-9275 for any research-related questions. If you have questions about your rights when taking part in this research, call the University and Medical Center Institutional Review Board (UMCIRB) at 252-744-2914 (days, 8:00 a.m.-5:00 p.m.). If you would like to report a complaint or concern about this research study, call the Director of Human Research Protections, at 252-744-2914.

Your participation is entirely voluntary and if completed you will receive a $10 Amazon GIFT CARD for your time. You should receive this card within 1-2 months after completion of the survey. This survey should take about 15 minutes to complete. You will be asked for an email to send this gift card at the end of the survey.

Thank you for taking the time to participate in this research.

Age (In Years):

Gender:
Female
Male
Nonbinary
Trans Male
Trans Female

Preferred Pronouns:
he/him
she/her
they/them
she/they
he/they

Sexual Orientation:
Gay
Lesbian
Bisexual
Pansexual
Queer
Asexual
Questioning
Straight

Race:
African American/Black
Asian/Pacific Islander
American Indian/Alaska
Native
White

Ethnicity, Hispanic/Latinx:
Yes
No

Relationship Status:
Single (never married)
Married, or in a domestic partnership
Widowed
Divorced
Separated

How would you label your spiritual affiliation?
Catholic
Protestant
Other Christian groups
Buddhist
Islam
Judaism
Sikh
Atheist
Agnostic
I consider myself spiritual but not religious
I do not consider myself spiritual or religious
Please see the next question if your spiritual preference is not listed

Share your spiritual affiliation in your own words if it was not listed in the prior question:

_____

_____

How many spiritual gatherings/meetings do you attend WEEKLY?

_____

_____

How many times do you partake in private spiritual activities, such as prayer, meditation, purpose/meaning work, or sacred scripture study within one WEEK?

In your opinion is there a difference between Spirituality and Religion?
Yes
No

In your opinion does spirituality belong in holistic healthcare?
Yes
No

This section will ask you about your current role as a Behavioral Health Provider and your clinical working experience.

What is your current role as a behavioral health provider? Select all that apply.
Student
Pre-licensed Professional or Intern (Still accruing post-degree clinical hours)
Licensed Professional

If you answered STUDENT please select the degree you are currently obtaining.
Masters
PhD
Psychiatric Residency
Psychiatric Nurse Practitioner Degree

If you answered STUDENT how many years of your academic program have you completed?

_____
_____

If you answered Pre-Licensed Professional or Licensed Professional how many years of post-degree experience do you have?

_____
_____

What profession of Behavioral Health Provider are you?
Social Worker
Marriage and Family Therapist
Licensed Professional Counselor
Certified Clinical Mental Health Counselor
Psychiatrist
Psychiatric Nurse Practitioner
Psychologist

What is your current clinical/job setting? Select all that apply
Student
Inpatient Setting

Out-Patient Setting
School-Based Setting
Private Practice Setting
Academic Healthcare Setting

In your estimation how often do you discuss spiritual issues/topics with your clients/patients on a MONTHLY basis? Please provide a numerical value representing the number of conversations NOT a percentage.

Have you ever received training on how to address spirituality with your clients?
Yes
No

If yes, in what setting did this training take place? (Select all that apply)
Academic degree program
Clinical/Professional setting
Other

If you answered other please describe the setting of the training.

In what way did you receive training on spirituality? (Select all that apply)
Academic Class
Supervision (During Academic Degree Program)
Supervision (Post Academic Degree Program) Workshop
Conference
Continuing Education Unit (CEU)
Peer consultation
On-the-job training
Other

If you answered other please describe the type of training

Who taught or facilitated this training for you? (Select all that apply)
Professor
Supervisor (During Academic Degree Program) Supervisor (Post Academic Degree Program)
Professional Organization
Clergy or Spiritual Leader

Other

If you answered other please describe who taught or facilitated your spirituality training:

_____

_____

This section will ask about your experience with spirituality and any prior training on spirituality training that you might have gone through.

While receiving spirituality training did you learn about the following concepts in relation to spirituality? (Select all that apply)
Multiculturalism/Diversity
Self of the provider work
Spiritual health
Ethics of spiritual care
Holistic care
Cultural Humility

In your opinion, how effective was this spirituality training on your understanding of spiritual care and how to address it with your clients?
Very Effective
Somewhat Effective
Not Effective

The next set of questions is a modified version of the Religious/Spiritually Integrated Practice Assessment Scale. This scale was modified to take into account the modern version of spirituality that is inclusive to all of humanity. Before you proceed, kindly take a moment to read the following message.

Definitions to be aware of for this survey:
1. Religion is "a system of beliefs and practices observed by a community, supported by rituals that acknowledge, worship, communicate with, or approach the Sacred, the Divine, God (in Western cultures), or Ultimate Truth, Reality, or nirvana (in Eastern cultures)," relies on scriptures, teachings, and offers a moral code of conduct (Koenig, 2008, p.11).
2. Spirituality is "more difficult to define since today there are no commonly agreed on characteristics of spirituality, and the traditional definition of spirituality has been changing. Once based on religion, spirituality is increasingly viewed as a broader concept that each individual defines for themselves." This definition is considered the modern version of spirituality and displays it as an umbrella concept that encompasses other concepts. Within this modern version Spirituality includes concepts such as religion, secularism, meaning, purpose, connection, well-being, and hope and is ever-expanding to include more. (Koenig, 2012 p. 91).

In addition, while religion and spirituality are often used interchangeably it is important to acknowledge the modern version of spirituality and re-evaluate our use of both terms. This is important because Spirituality has grown past and encompassed religion and can be seen as an inclusive term for all of humanity. Through this modern version spirituality is a universal part of life for all humans, even those who identify as secular, pagan, etc. This means that instead of spirituality and religion being interchangeable, spirituality is an umbrella term that can either include or exclude religion. For the purpose of this survey, please consider the term spirituality as an ever-changing concept that is dependent on who is defining it. Also please consider spirituality an umbrella term that can either include or exclude religion as you respond to the items. In addition, please interpret the term "client" to include patients and "treatment" to include care, depending on the term that is most appropriate for your profession.

Section I. Self-Efficacy with Spiritually Integrated Practice
Please indicate the response to the right that best fits how much you agree or disagree with the statements regarding religious/spiritually integrated practice. The choices include:
Strongly Disagree
Disagree
Neutral
Agree
Strongly Agree

I know how to skillfully gather a history from my clients about their spiritual beliefs and practices.
I am able to recognize when my clients are experiencing religious/spiritual struggles. (e.g. tension or conflict with his/her Higher Power, spiritual community, spiritual beliefs, etc.)

I consider the unique needs of diverse clients with different spiritual backgrounds in my practice.

I am able to recognize when my clients utilize positive spiritual coping strategies. (e.g. trying to find a spiritual lesson in the presenting issue, meaning, purpose, hope, etc.)

I am able to ensure my clients have access to spiritual resources if they see this as an important aspect of their healing process. (e.g. spiritual reading materials, spiritual counseling, contact information to local spiritual leaders, or a meditation room/place of worship/place of spiritual significance).

I feel as though I have the skills to discuss my clients' spiritual strengths.

I feel confident in my ability to integrate my clients' spiritual beliefs into their treatment.

I know when it is beneficial to refer my client to spiritual counseling that aligns with their belief systems (i.e., guru, pastor, spiritual guide/teacher, mystic, priest, shaman, rabbi, etc).

I feel as though I have the skills to discuss my clients' spiritual struggles.

I am able to recognize when my clients utilize negative spiritual coping strategies. (e.g. viewing the presenting issue as divine punishment or connecting it with their ultimate meaning/purpose, etc.)

I know what to do when my client defines or interacts with spirituality in a way that I am unfamiliar with.

I am comfortable discussing my clients' spiritual struggles.

Section II. Attitudes About Spiritually Integrated Practice
Please indicate the response to the right that best fits how much you agree or disagree with the statements regarding spiritually integrated practice. The choices include:
Strongly Disagree
Disagree
Neutral
Agree
Strongly Agree

It is essential to assess clients' spirituality in practice.

Integrating clients' spiritual needs during treatment helps improve client outcomes.

Practitioners who take time to understand their clients' spirituality show greater concern for client well-being than practitioners who do not take time to understand their client's spirituality.

Integrating clients' spirituality in treatment helps clients meet their goals.

I am open to learning about my clients' spirituality that may differ from mine.

Attending to clients' spiritual needs is consistent with the principles of meeting the client where they are at.

Sensitivity to clients' spirituality will improve one's practice.

I am open to referring my clients to qualified spiritual leaders for counseling.

Attending to clients' spirituality is consistent with my profession's code of ethics.

Empirically-supported spiritually integrated treatments are relevant to my practice.
There is a spiritual dimension to the work I do.

I refuse to work within my clients' spirituality if it differs from my own.

Section III. Feasibility for You to Engage in Spiritually Integrated Practice
Please indicate the response to the right that best fits how much you agree or disagree with the statements regarding spiritually integrated practice. The choices include:
Strongly Disagree
Disagree
Neutral
Agree
Strongly Agree

I have enough time to assess my clients' spiritual background.

I have enough time to identify potential strengths or struggles related to my clients' spirituality.

My primary practice setting does not support the integration of spirituality into practice.

I don't have enough time to think about incorporating a spiritually integrated approach to practice.

Given the many issues that must be addressed in treatment, I still find time to integrate my clients' spirituality if they communicate a preference for this.

I have been adequately trained to integrate my clients' spirituality into treatment.

Section IV. How Often Do You Currently Engage in Spiritually Integrated Practice?
For this section, please indicate the response that best fits the frequency with which you currently engage in spiritually integrated practice. The choices include:
Never
Rarely
Some of the Time
Often
Very Often

I seek out consultation on how to address clients' spiritual issues in treatment.

I read about ways to integrate clients' spirituality to guide my practice decisions.

I read about research evidence on spirituality and its relationship to health to guide my practice decisions.

I involve clients in deciding whether their spirituality should be integrated into their treatment.

I use empirically supported interventions that specifically outline how to integrate my clients' spirituality into treatment.

I conduct a full biopsychosocial-spiritual (BPSS) assessment with each of my clients.

I link clients with spiritual resources when it may potentially help them (e.g. spiritual reading materials, contact information to local spiritual leaders, or a meditation room/place of gathering).

I help clients consider ways their spiritual support systems may be helpful.

I help clients consider the meaning and purpose of their current life situations.

The following two questions ask for your opinion on competency-based spirituality training.

As a behavioral health provider, what should be included in competency-based spirituality training for behavioral health providers?

Who should provide competency-based spirituality training for behavioral health providers (e.g., academic programs, clinical training programs, on-the-job training, CEUs, etc.)? Please explain why.

APPENDIX D. INCENTIVE

Incentive

Please complete the survey below.

Thank you!

To receive your $10 Amazon Gift Card you must fill in the information below. Remember that all this information will be kept confidential and will be de-identified. This information is to help the research team parse out bots and provide the most accurate survey data. Again thank you so much for your participation.

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1) Do you consent to research staff emailing you to send your $10 Amazon gift card?
   ◯ Yes
   ◯ No

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2) Please provide the State that you practice in and/or are a student in
   _____

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3) Email
   _____