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Broaching the Topics of Religion and Spirituality in Therapy: Considering the Influence of Therapist Competence and Organizational Competence

Papa N. Adams

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LOYOLA UNIVERSITY CHICAGO

BROACHING THE TOPICS OF RELIGION AND SPIRITUALITY IN THERAPY:
CONSIDERING THE INFLUENCE OF
THERAPIST COMPETENCE AND ORGANIZATIONAL COMPETENCE

A DISSERTATION SUBMITTED TO
THE FACULTY OF THE GRADUATE SCHOOL
IN CANDIDACY FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

PROGRAM IN COUNSELING PSYCHOLOGY

BY

PAPA N. ADAMS

CHICAGO, IL

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I've been to your future and it all works out.

—Paa Kwesi Adams

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ABSTRACT

Many individuals have identified religion and/or spirituality (R/S) as integral in the construction of their worldview and important in mental health. Research has demonstrated that clinicians hold positive attitudes towards integrating R/S into therapy yet reported low levels of actually integrating R/S into therapy sessions. This study examined therapist behavior in regard to broaching discussions about R/S in psychotherapy sessions. This study proposed that clinician broaching behavior would be correlated with the clinician's R/S competence. Furthermore, the relationship between broaching and clinician's competence would be moderated by the R/S competence of the clinician's environment (defined as the organizational/institutional R/S competence). Complete data from 147 clinicians (77 mental health professionals and 70 graduate student trainees) was analyzed. Through the use of hierarchical multiple regression it was found that clinician R/S broaching behavior is positively and significantly correlated with clinician R/S competence. This study also found that organizational R/S competence is positively and significantly correlated with clinician R/S broaching behavior. The proposed moderation model involving organizational R/S competence as a moderating variable was not significant. Additionally, post-hoc analyses, limitations, future directions, and clinical/training implications are discussed.

CHAPTER ONE

INTRODUCTION

There exists a longstanding relationship between psychology and religion/spirituality. Psychologists, in trying to understand and make sense of the scope of human emotion, thought and behavior have considered the influence of religion and spirituality (Freud, 2012; James, 1961; Jung, 1959). The relationship between psychology and religion/spirituality is complex. Some, such as Sigmund Freud, considered religion and spirituality to be constructs that fueled denial and in turn blocked insight and self-knowledge (Moodley & Barnes, 2015). Alternatively, William James (1961) differentiated between institutional religion and personal religion and was interested in considering the practical application of one's religion practice on well-being (James, 1961). More recently, Fontana (2003) wrote, "Religion has been one of the major formative influences upon human thought and behavior throughout the centuries." This statement is supported by data demonstrating that the majority of Americans have identified religion and/or spirituality as integral in the construction of their worldview and important in coping with daily stressors (PEW Research Center, 2018; Gallup, 2015; Graham et al., 2001; Belavich, 1995). Additionally, in considering the influence of religion/spirituality on human emotion, thought and behavior it is necessary to consider those who identify as atheist, agnostic, apostate or none. The choice to identify with or without a religious/spiritual affiliation may carry an emotional or mental weight. Considering that religion/spirituality is thought to be involved in the thoughts, emotions, behaviors and identity formation of individuals, it would be worthwhile for therapists

and mental health practitioners to discuss topics of religion/spirituality with clients. This study aims to understand factors that influence whether therapists are able to discuss religion and spirituality with their clients in therapy.

In spite of the number of Americans who have religious and/or spiritual beliefs, who have renounced their beliefs or identify as agnostic, mental health professionals report significant levels of reluctance in discussing religion and spirituality with therapy clients (Drew & Banks, 2019). Questions involving the integration of religion and spirituality into counseling may arise for clinicians, such as: is the topic necessary for assessment and treatment; is it my role to broach these subjects; will I harm the client or commit a microaggression; is it better to wait for the client to broach the topic; what if the client asks me to disclose my relationship with religion or spirituality (Brown et al., 2013; Oxhandler & Giardina, 2017)? These considerations present valid and often not discussed challenges in navigating the integration of religion and spirituality into therapy.

Research has shown that therapists feel ill-prepared to address matters of religion and spirituality in clinical practice (Dailey, 2012; Robertson, 2010). A study by Oxhandler and Parrish (2016), found that therapists feel and think that discussing religion/spirituality with clients is important, but they do not actually have discussions with clients on the topic. Oxhandler and Parrish (2016) demonstrated that clinicians held positive attitudes towards integrating religion and spirituality into counseling yet reported low levels of both perceived feasibility and engagement in actual behaviors to integrate religion and spirituality into therapy sessions. Understanding this discrepancy between therapist thought and behavior around discussing religion/spirituality with clients will require a more in-depth examination of therapist behavior in-session. Of particular interest for this study is considering the extent to which

therapist behavior is associated with individual and organizational factors. At the individual level, I am interested in understanding how the therapists feeling of competence in the area of religion/spirituality is associated with their ability to discuss religion/spirituality with clients. Furthermore, I am interested in whether the institution the clinician works for plays a role in this process. This study will examine if the institution's (academic/professional/training) level of competence in the area of religion/spirituality is associated with the relationship between therapist competence and discussing religion/spirituality with therapy clients.

This study will use the theory of planned behavior as a framework for conceptualizing the variables selected. Theory of planned behavior states that an individual's behavior is predicted by their intention to behave. Intention to behave is shaped by a combination of three factors: perceived behavioral control, subjective norm, and attitude. A more expansive definition of each variable will be provided in Chapter 2; however, brief definitions will be provided below. Perceived behavioral control refers to the perceived ease or difficulty of performing the specific behavior (such as having the skills and/or abilities). Subjective norm refers to social pressure to perform or not to perform the specific behavior. Attitude refers to the extent to which a person holds a favorable or unfavorable view of the behavior.

The main study variables selected for this study are reflective of the components of theory of planned behavior. Clinician's R/S competence is a substitute for perceived behavioral control, organizational R/S competence is a proxy for subjective norm, and broaching R/S is the individual's planned behavior. Though not a main study variable, clinician's R/S affiliation maps onto the theory of planned behavior construct of attitude. The following sections will present descriptions of each study variable.

Clinician's Religious/Spiritual Competence Influences Integration

In the following section I focus on the clinician's religious and/or spiritual competence as a predictor variable of broaching behavior. The term spiritual competence, as it pertains to counseling, originated in 1995 when the Association for Spiritual, Ethical and Religious Values in Counseling (ASERVIC) developed a list of competencies to assist counselors in understanding how to address matters of religion and/or spirituality with clients. According to Hathaway et al. (2004) only 30% of a sample of psychologists discussed religion and spirituality with clients. In 2013, Vieten et al. observing the importance of religion and spirituality in human diversity, proposed religious and spiritual competencies for psychologists. They defined religious and spiritual competence as the set of attitudes, knowledge, and skills in the domains of spirituality and religion that facilitates effective and ethical practice of psychology, regardless of whether or not they conduct spiritually oriented psychotherapy or consider themselves spiritual or religious. Attitudes refer to the implicit and explicit perspectives and/or biases people hold about spirituality and religion as they relate to the practice of psychology. Knowledge refers to information, facts, concepts, and awareness of research literature psychologists should possess about spirituality and religion as it relates to the practice of psychology. Skills refer to psychologists' ability to effectively utilize their knowledge of spirituality and religion in their clinical work with clients. As stated previously, clinicians hold positive attitudes towards religion and/or spirituality (Walker et al., 2004; Oxhandler & Parrish, 2018), yet report low levels of proficiency or difficulty in effectively utilizing their skills in clinical work (Richards et al., 2009; Oxhandler & Parrish, 2018).

Further understanding of religious and spiritual competence and its impact on clinical work required the creation of a valid, accurate measure. The development and validation of the

Spiritual Competence Scale (SCS) (Robertson, 2010; Dailey et al., 2015; Lu et al. , 2018) demonstrates an effort to provide researchers with a functional measure. The SCS conceptualizes religious and spiritual competence of the counselor as comprised of six factors: Assessment; Counselor Self-Awareness; Diagnosis and Treatment; Human and Spiritual Development; Culture and Worldview; Communication. The ability to quantify religious and spiritual competence opens the door for a novel understanding of its role in clinician efficacy.

Religious and spiritual competence is a subset of multicultural competency. Clinician's multicultural competence has been identified as an important component in psychotherapy. Tao et al. (2015) linked clinician's perceived multicultural competence with increased efficacy in psychotherapy processes (i.e. working alliance, general counseling competence, client satisfaction, and session impact) and treatment outcome (i.e. psychological symptoms or client estimate of improvement) (Tao et al., 2015). Tao et al. (2015) found moderate to large effect sizes for the associations between clinician's perceived multicultural competence and session impact ($r = 0.58$), working alliance ($r = 0.61$), general competence ($r = 0.62$) and client satisfaction ($r = 0.72$). Additionally, the authors' study also found moderate effect size for the relationship of clinician's perceived multicultural competence and treatment outcomes ($r = 0.29$). Religious and spiritual competences, being a subset of multicultural competencies, may have the potential of being an equally important aspect of the psychotherapy process and treatment. I hypothesize a moderate, positive relationship between clinician religious and spiritual competence and clinician broaching behavior. While spiritual competency has been identified as a meaningful factor in the process of integrating religion/spirituality into clinical practice (Dailey 2012; Robertson, 2010), further research is needed to determine how competence relates to the therapist's actual broaching behavior.

Understanding Integration through the Broaching Framework

Previous research has explored clinicians' integration of religion/spirituality into clinical practice primarily as a dichotomous variable. It tends to explore clinicians' ability to integrate religion/spirituality as falling into one of two categories, either "yes to integrating" or "no to integrating." Recent research into the multicultural behavior and attitudes of clinicians has yielded a more nuanced understanding of clinicians' approach to topics related to multiculturalism. An article by Day-Vines et al. (2007) introduced the concept of broaching. Broaching is one manner of assessing how clinicians discuss a topic with clients.

Broaching the topics of religion and/or spirituality during the psychotherapy process can include an assortment of discussions or issues. One issue is how an individual client may identify their religion and/or spirituality. Streib and Klein (2013) outline a variety of religious and/or spiritual identities that individuals may use, including: religious but not spiritual; more religious than spiritual; spiritual but not religious; more spiritual than religious; religious and spiritual; atheist; agnostic; apostate (a dis-identification and eventual disaffiliation from a religious tradition). Furthermore, Streib and Klein (2013) caution against the tendency to lump together atheism, agnosticism, and apostasy as being "unaffiliated" or having no faith or practice. They state that in cultures where understandings and conceptualizations of God or a Higher Power vary and change, people may need to consider that there are as many varieties of atheism and agnosticism, as there are varieties of belief in God.

Additionally, clients may present with religious and/or spiritual struggles. Zinnbauer (2013) encourages psychologists to recognize this as important and to address both positive and dysfunctional forms of religious and spiritual involvement in therapy. An openness and ability to discuss religious and/or spiritual identities, to understand the varieties of identities and

experiences and assist clients in connecting religion and/or spirituality to their mental health represents religious and spiritual competence.

Having the ability, as a clinician, to effectively assess for these experiences, determine their relevance for the client's presenting problem, and understand the possibility for their incorporation into the treatment process is vitally important. We cannot assume that knowing whether a client is religious and/or spiritual to be enough. If necessary, an exploration of the client's relationship history with religion and/or spirituality may yield clinically helpful information. Therefore, understanding the factors relevant to increased clinician broaching behavior is meaningful.

According to Day-Vines, et al. (2013), the term broaching reflects the counselor's efforts to initiate or respond to racial, ethnic, and cultural stimuli that arise during treatment, translate the client's sociocultural and sociopolitical realities into meaningful counseling practice, and subsequently promote client empowerment, coping, problem solving, resilience, and more effective functioning.

The concept of broaching was developed in part to combat the notion of "color blind" counseling (Day-Vines et al., 2007). According to Neville et al. (2006), being "color blind" is defined as being free of bias but is harmful in that it rejects the notion that issues of race, ethnicity and culture matter and have significant meaning for the way clients experience the world. We theorize that, similarly to issues of race and ethnicity, clients may need an emotionally safe space to discuss issues of religion/spirituality as they pertain to their mental and emotional well-being.

Broaching refers to counselor behaviors and attitudes, as they exist along a continuum (Day-Vines et al., 2007). According to Day-Vines et al. (2007) there is a continuum of broaching

behavior. Clinicians can assume four particular orientations toward broaching or introducing issues of race, ethnicity, and culture with their clients. The orientations are avoidant; continuing/incongruent; integrated/congruent; and infusing. Avoidant counselors tend to adopt an attitude that views issues of race, ethnicity and culture as not important or necessary for counseling treatment. Behaviorally, avoidant counselors may avoid or shut down honest conversations about race, ethnicity and culture. Continuing/incongruent counselors are described as being “mechanical” in their approach to discussing issues of race, ethnicity and culture. They recognize the necessity for broaching, but feel unskilled, awkward and having challenges identifying helpful responses when discussing the topic.

In contrast, integrated/congruent counselors are able to honestly discuss issues of race, ethnicity and culture. They are able to broach the topic as well as respond to client comments during counseling sessions. Integrated/congruent counselors are skilled in making responses that permit the client to consider culture-specific interpretations of their presenting problems and issues in counseling. Infusing counselors are well developed in their understanding of how the client is influenced by the intersection of culture, politics and society. These counselors are able to infuse advocacy, social justice, and systemic interventions that improve the lives of clients on a much broader scale. The current study will utilize the “Integrated/congruent” subscale of the BABS to assess therapist’s broaching behavior. The aim of this study will be to assess the relationship between clinician’s religious/spiritual competence and broaching behavior (as assessed by the integrated/congruent subscale). We expect that higher levels of clinician competence will be related to higher levels of broaching behavior.

Organizational/Institutional Religious/Spiritual Competence as a Moderator

Therapist context plays a role in therapist behavior. Utilizing Bronfenbrenner's (1979, 1992) Ecological Theory we can conceptualize the therapist as one component within a system of interdependent levels. Bronfenbrenner's theory, initially developed to understand human development, posits the following systems interacting to influence, in a bi-directional manner, the individual: microsystem; mesosystem; exosystem; macrosystem; chronosystem. Lau and Ng (2014) used Bronfenbrenner's theory to review the importance of "learning/training environment" on graduate counseling student trainees. The authors acknowledge the impact of the microsystem (classroom; clinical experience; university/college, community), mesosystem (multi-setting participation; inter-setting communication; inter-setting knowledge), exosystem (student-client-client's other; student-faculty-faculty's other; student-supervisor-supervisor's other; student-classmate/coworker-classmate/co-worker's other), macrosystem (political culture; laws and ethics; economics; multiculturalism), and chronosystem (social-historical; current/up-to-date) in shaping the graduate counseling student's experience. Similar to the conceptualization made by Lau and Ng (2014), we aim to use our study to understand how the therapist's organizational/institutional environment, in particular competence in the area of religion/spirituality, is associated with the therapist's broaching behavior.

Drawing on research concerning cultural competence (Sue, 2006; Lo & Fung, 2003; Owen et al., 2017), we propose that organizational/institutional spiritual competence will strengthen the relationship between the predictor (clinician spiritual competence) and outcome (broaching behavior) variables.

Few studies have explored the relationship between organizational spiritual competence and clinician behavior. A study by Lu et al. (2019) examined predictors of counselor-in-training

spiritual competence. One variable of interest was the counselor's perception of whether their training environment was open to incorporation of spirituality and religion as part of learning about diversity. Lu et al. (2019) found the more counselor's-in-training perceived their counseling training program as being open to religion and spirituality in teaching, supervision, and research, the higher they rated their spiritual competence. This finding, linking institutional spiritual competence with counselor spiritual competence provides empirical support for our proposed moderation relationship between clinician spiritual competence and broaching behavior in that this association would be even stronger with high (vs. low) levels of institutional spiritual competence.

Statement of Problem

Overall, given the previous literature that has identified lack of training and low levels of competence as explanations for clinicians not integrating religion and/or spirituality into therapy sessions, this study aims to assess the relationship of clinician religious/spiritual competence and broaching behavior by including training/work environment, in particular, organizational R/S competence as a moderator in the relationship between R/S competence and broaching.

Research Questions

The questions posed are: (a) How is the predictor variable (e.g., clinician religious/spiritual competency) related to the outcome variable of clinician's broaching of religion/spirituality in therapy? (b) How does organizational/institutional religious/spiritual competence moderate the relationship between the predictor and outcome variables? (c) Will high versus low levels of organizational/institutional religious/spiritual competence have varying effects on broaching behaviors?

Hypothesis

This study proposes a moderation model for understanding the relationship between clinician spiritual competence and clinician broaching behaviors. I expect that the relationship between the predictor variables (spiritual competence) and outcome variable (broaching behavior) will be moderated by the variable, organizational/institutional spiritual competence.

Hypothesis 1: Clinician spiritual competency will be positively associated with broaching behaviors.

Hypothesis 2: In the presence of high levels of organizational/institutional spiritual competence (i.e., moderator), the relationship between clinician spiritual competency and broaching behavior will be stronger. In the presence of low levels of organizational/institutional religious/spiritual competence, the relationship between clinician spiritual competency and broaching behavior will be weaker.

Summary

The current study examined the broaching behaviors of clinicians with regard to addressing client's religion and/or spirituality in clinical practice. Specifically, the study utilized a moderation model in exploring how organizational/institutional spiritual competence moderates the relationship between clinician spiritual competence and broaching behavior. In brief, this study examined the interrelationships of clinician spiritual competence, organization/institutional spiritual competence, and clinicians' behavior when discussing religious and/or spiritual matter in clinical practice.

CHAPTER TWO

INTRODUCTION

The focus of this chapter is to provide an understanding of broaching, theoretical frameworks for how it pertains to understanding clinician behavior, and a review of religious/spiritual competence at both the individual and organizational levels. This chapter will provide a definition of broaching, the development of the broaching construct and how it is conceptualized, and a scale for measuring broaching behavior. Multiple theories are utilized to provide a context for how clinicians' broaching behavior is understood. The theory of planned behavior is an overarching framework for conceptualizing the fit of the study variables. The multicultural orientation framework and ecological model of multicultural counseling are utilized as additional theories for understanding clinician behavior. Following review of the theoretical underpinnings of this study, this chapter focuses on defining and providing rationale for the independent variable (individual's religious and spiritual competence) and the moderator (organizational/institutional religious and spiritual competence). Additionally, the conceptualization and measurement of both variables are provided. The overall aim of this of this chapter is to detail a comprehensive understanding of the rationale for this study and how it addresses gaps in current literature.

Broaching

Broaching Definition

Broaching is a term for describing a clinician's behavior during treatment with a client. This study operationalized broaching according to two definitions. First, "the counselor's efforts to initiate or respond to racial, ethnic, and cultural stimuli that arise during treatment; translate the client's sociocultural and sociopolitical realities into meaningful counseling practice; and subsequently promote client empowerment, coping, problem solving, resilience, and more effective functioning" (Day-Vines et al., 2013). Second, "the counselor's efforts to have explicit discussions about the extent to which racial, ethnic, and cultural factors that impact the client's presenting concerns" (Day-Vines et al., 2018). These particular definitions of broaching are important for this study for two reasons. First, this study's focus is on broaching as a behavior rather than an attitude or as a basic set of knowledge. Attitude and knowledge are important however, and the role of attitude in predicting behavior (Ajzen, 1991; Ajzen, 2020) will be covered further along. This study is most interested in clinician's actual behavior with clients. Second, the definitions presented above each emphasize the "counselor's effort" as the key mechanism of action within the therapeutic relationship. When discussing broaching in this study, this study is most focused on how active and engaged the clinician is in both initiating and responding to "racial, ethnic, and cultural stimuli." However, it is worth noting that across the broaching literature, other definitions exist, which help to provide a more complete understanding of broaching. Broaching can also have attitudinal or dispositional components. Regarding attitude, previous descriptions of broaching have emphasized the role of clinician "willingness" to broach, "comfort" with broaching, and clinician's possessing a consistent, genuine, openness to discussions of race, ethnicity, and culture as instrumental components of

effective clinician behavior (Day-Vines et al., 2018; Day-Vines et al., 2007). In operationalizing broaching for this study the aim was to understand the behavioral component. The literature provides support for the importance of assessing clinician attitudes towards cultural competence. However, studies have demonstrated that both student trainees and professional clinicians report either a perceived deficit in their skills (Farmer et al., 2013;) or the importance of the application of counseling skills (Furr & Carroll, 2003).

It is important to understand that broaching represents a continuum of behavior (Day-Vines et al., 2013; Day-Vines et al., 2020). This conceptualization of the continuum of broaching behavior will be explored in the next section. Prior to this exploration it is worth providing some clarification. When this study mentions or describes broaching, it is not explicitly or implicitly stating that the client educate the clinician on factors related to race, ethnicity, and culture or that the client speak on behalf of all people of a particular identity. Broaching is meant to describe the clinician's effort to invite the client to share their experience related to the area of race, ethnicity, and culture, and furthermore, to understand the client within a culture context.

Broaching Conceptualization

Day-Vines et al. (2013) developed the conceptual framework for broaching as a means of placing language around a noticeable and important component of the clinician's intervention repertoire. Development of the broaching framework allowed for clinicians to have a shared language and meaning when referring to the importance of engaging clients in discussion of the intersection between presenting problems/concerns and race, ethnicity, and culture. Day-Vines et al. (2007) theorized that having explicit language to describe clinician effectiveness related to discussions of race, ethnicity, and culture would help combat "silence and shame" and "denial and repression" that exists in our society around speaking about these topics and their hope was

that the hesitance to discuss these topics in society would no longer be replicated in the psychotherapy space or clinician-client relationship.

Broaching has been conceptualized as a “continuum” of behavior (Day-Vines et al., 2007; Day-Vines et al., 2013). Day-Vines et al. (2007) originally identified five orientations that encapsulate the range of broaching behaviors: *avoidant*, *isolating*, *continuing/incongruent*, *integrated/congruent*, and *infusing*. During development of the Broaching Attitudes and Behavior Survey (BABS), statistical support was not found for the isolating subscale, it was deemed an overlap of the avoidant subscale, and was eliminated. This left the continuum of broaching behavior with four categories. On one endpoint or terminus of the continuum is avoidant broaching behavior. Avoidant behavior describes clinicians who either do not address or neglect the significance of racial, ethnic, and cultural issues in the therapy room. These clinicians may deflect attention from those concerns and steer conversations towards more generic topics. Clinicians in the continuing/incongruent category are likely to broach in a mechanical manner and tend to lack the verbal ability to talk explicitly about client’s racial, ethnic, cultural concerns or to explore those concerns in an in-depth manner. Clinicians in the integrated/congruent category are effective in their broaching ability. Effective behavior resembles a clinician who is able to assist clients towards making connections between their presenting problems and race, ethnic, and cultural issues, as appropriate. Clinicians in this category of broaching are also consistent in their efforts to broaching typically broaching early in the therapeutic relationship. The other endpoint of the broaching continuum is the infusing style. Clinicians who demonstrate an infusing style of broaching typically view broaching, addressing injustice and inequality, and advocacy as part of their lifestyle and have integrated this into their professional identity.

Consideration was given to using the entire Broaching Attitudes and Behaviors Survey (BABS) or utilizing one or more of its subscales. Following review of each BABS subscale, the items comprising the subscale, and the behavior it aspired to capture, it was determined that use of the “integrated/congruent” subscale would be sufficient. The Integrated/Congruent subscale represents an honest portrayal of effective clinician broaching behavior and therefore will be the only BABS subscale utilized for this study. The “Avoidant” and “Continuing/Incongruent” subscales represent ineffective or incompetent broaching behaviors and would therefore not provide valuable information about study participants. The purpose of the present study is to understand actual behaviors of therapists as opposed to attitudes and knowledge; therefore use of the “Infusing” subscale would not be beneficial towards this aim.

According to Day-Vines et al. (2013) questions on the “Integrated/Congruent” subscale assess the clinician’s ability consistently initiate and respond to the client’s concerns in a culturally relevant manner and have the ability to accurately discern psychopathology from culturally-related concerns. Thus, given the importance of cultural competence within the mental health field, it was imperative this study find a manner of measuring skill behavior on the part of the clinician, and the integrated/congruent subscale offered a sound and accurate measure.

Theories for Understanding Clinician Behavior

The focus of this study is to understand how specific factors (e.g. individual and contextual) are related to clinician broaching behavior. Specifically, how individual R/S competence and organizational R/S competence relate to clinician’s ability to “consistently initiate and respond to” matters related to religion and spirituality and assist clients in making connections between R/S and their presenting concerns. Overall, this study deals with the intersection of behavior, environment, and culture. As such, this section presents three theories,

with each providing an in-depth understanding of an element of focus for this study. The three theories are theory of planned behavior (TPB), multicultural orientation framework (MCO), and ecological model of multicultural counseling. Each theory was selected for its ability to highlight pivotal aspects of clinician behavior. Theory of planned behavior will be used to conceptualize the roles of clinician R/S competence, organizational R/S, and R/S affiliation in predicting clinician broaching behavior. Multicultural orientation framework will be useful for describing aspects of the clinician-client interaction that are potentially meaningful for understanding broaching behavior. These factors relate to competence and include the clinician's ability to recognize relevant cultural content as it arises in psychotherapy sessions, feel comfortable with conversations about culture, and adopt a stance of cultural humility. Finally, the ecological model of multicultural counseling will identify possible systemic level factors worth examining when it comes to clinician behavior.

Theory of Planned Behavior

Theory of planned behavior takes a cognitive approach to understanding human behavior (Ajzen, 1991). The aim of TPB is to predict and explain human behavior in specific contexts (Ajzen, 1991; Ajzen, 2020). The basic model for TPB states that behavior is explained and predicted by the person's intention to engage in said behavior; the stronger the intention the more likely the person is to engage in the behavior (Ajzen, 2020). The relationship between behavior and intention is moderated by the actual control the person has over engaging in the behavior. For example, circumstances such as skills deficit, lack of support or money, and insufficient resources and training can act as contributing factors which strengthen or weaken the relationship between intention and behavior (Ajzen, 2020). According to TPB, intention to engage in behavior is determined by three factors: perceived behavioral control, subjective norm

concerning the behavior, and attitude toward the behavior. To be specific, strongly perceived behavioral control, supportive subjective norm, and a favorable attitude toward the behavior are the ingredients for accurately predicting strong intention and thereby determining whether a person engages in a specific behavior (Ajzen, 2020). Each of these three factors will be described below.

Theory of planned behavior describes perceived behavioral control as the perceived ease or difficulty of performing the behavior (Ajzen, 1991). Control beliefs are connected to perceived behavioral control (Ajzen, 1991; Ajzen, 2020). Control beliefs are focused on the presence of factors that can facilitate or impede performance of the behavior (Ajzen, 2020). Examples of control factors include required skills and abilities, cooperation by other people, availability of time, energy, money, etc. (Ajzen, 2020). When considering broaching R/S a clinician may look to their actual behavior for a reference point, but in the absence of adequate actual experience, they may consider the perceived behavioral control to make a determination about whether sufficient factors (skill, ability, knowledge, etc.) exists in order to broach R/S. The current study views perceived behavioral control as akin to clinician R/S competence. Clinician who perceives broaching R/S would be a clinician who identifies as competence in the domain of R/S and a clinician who perceives broaching R/S as difficult would represent someone who identifies as being deficient in the area of R/S competence.

The second of three factors that predict and explain behavior is subjective norms. Subjective norms refer to the social pressure to perform or not perform the behavior. Similar to how attitude towards behavior is connected with behavioral beliefs, subjective norms is connected with normative beliefs. There are two types of normative beliefs, injunctive and descriptive (Fishbein & Ajzen, 2010). An injunctive normative belief is the expectation or

subjective probability that an important referent person or group (includes coworkers, supervisors, peers, family, friends, clients, partner, etc.) would approve or disapprove of performing the specific behavior (Ajzen, 2020; Ajzen 1991). Descriptive normative beliefs are a subjective probability that the important referent people (includes coworkers, supervisors, peers, family, friends, clients, partner, etc.) themselves perform the behavior in question. In the case of broaching R/S, a clinician may imagine a respected colleague or supervisor and envision whether that individual would approve or disapprove of the clinician's broaching R/S with a client (injunctive). The clinician may also hold a belief about whether other clinicians, within their environment or community, broach R/S in psychotherapy sessions (descriptive) and this belief can increase or decrease the likelihood of the target behavior.

This study considers subjective norm to be equivalent to organizational R/S competence. The clinician will look to their environment for cues as to whether broaching R/S is an appropriate, acceptable, supported, or endorsed behavior. If the clinician perceives broaching R/S to be a norm for the environment or a behavior observed in others, they will be more likely to broach R/S themselves. If the clinician perceives broaching R/S to not be the norm behavior for clinicians in the environment, they will be less likely to broach R/S.

Theory of planned behavior puts forward "attitude towards the behavior" as the third predictive factor of behavior. Attitude is viewed as the extent to which a person has a favorable or unfavorable view appraisal of the behavior at hand (Ajzen, 1991). People are deemed to have behavioral beliefs about behaviors under consideration and those behavioral beliefs can be positive or negative regarding what will occur if the behavior is engaged in (Breslin et al., 2001). Simply stated, the attitude towards the behavior is a function of readily accessible beliefs the individual has regarding the behavior's likely outcome. The behavioral belief is the individual's

subjective probability that a behavior will lead to a certain outcome or experience (Ajzen, 2020). Utilizing the current study as an example, a clinician may hold the belief that increasing knowledge or skills (behaviors) in the area of R/S would lead to better therapeutic interventions (outcome) with a client or result in time being wasted (experience) acquiring the knowledge and skills. A study conducted by Olsen (2007) regarding doctoral counseling students' interest in incorporating R/S into training revealed that training in R/S must encourage the exploration of attitudes and beliefs related to R/S. Olsen (2007) found that whether the individual's attitudes towards R/S were positive or negative, personal exploration of those beliefs was necessary because they could impact the course of treatment, especially if R/S issues became salient. Understanding clinician attitudes and beliefs are important when understanding their broaching behavior. Another interpretation of the attitude construct, is that the clinician's R/S affiliation or identity, is indicative of attitude towards broaching R/S. Literature is sparse on the role of clinician R/S on broaching behavior. However, one study (Magaldi-Dopman et al., 2011) found that clinicians with strong R/S identity and those who identified as atheist/agnostic were more likely to broach R/S. Magaldi-Dopman et al. (2011) interpreted this finding to mean those clinicians with an R/S affiliation valued R/S and had positive attitude towards it and therefore made space in psychotherapy for clients to explore. Those clinicians who identified as atheist/agnostic, were concerned about neglecting R/S, and therefore made space to explore in an effort to avoid being neglectful of a potentially important identity of the client. The current study believes that clinicians with an R/S affiliation will be those clinicians who have a positive or favorable attitude towards R/S. Clinicians without an R/S affiliation (atheist, agnostic, apostate) will be those with unfavorable R/S attitude.

Ajzen (1991) stated that the importance of all three factors, attitude towards behavior, subjective norms, and perceived behavioral control are expected to vary across situations and specific behaviors. Meaning that when a clinician is making a decision regarding broaching R/S, in some situation the clinician's attitude towards the behavior will have the strongest predictive ability, in others it may be subjective norms or the influence of important reference individuals or groups, in others perceived behavioral control, and possibly a combination of two out of three or all three depending on the context.

To date, TPB has not been used extensively to study clinician behavior. A study by Breslin et al. (2001) examined whether the constructs of TPB were predictive of counselor behavior when it came to the adoption of a specific addiction treatment program following training. The study looked at both intention to adopt the treatment and actual clinician behavior. Theory of planned behavior constructs, in particular, attitudes towards behavior and social norms, predicted 56 percent of the variance in intention to adopt (at baseline) the addiction treatment program. However, the three TPB constructs accounted for 19 percent of variance in the actual adoption of behavior (at 6-month follow-up). These findings are meaningful for the current study because my aim is to assess the individual clinician and their environment and determine how these factors interact to result in actual clinician behavior in-session.

Astle et al. (2022) utilized the TPB framework to examine parents' intentions to talk with their children about topics related to sex. Astle et al. (2022) found that the majority of parents intended to discuss sex with their children but were less likely to intend to discuss topics related to sex that were considered to be sensitive (e.g. pleasure or masturbation). Perceived behavioral control was most consistently and strongly associated with intention to talk with children about sex, followed by an attitude that viewed discussing sex with their children as the parents'

responsibility. These findings are interesting in the context of the current study for two reasons. First, similarly to how certain aspects of sex were deemed too sensitive to discuss, literature has shown that R/S at times is viewed as inappropriate or unethical to be discussed by clinician and client. Second, when discussing sensitive topics, the individual tasked with having the discussion will rely most prominently on perceived behavioral control. This component can be reflective of the individual's resources, which can include skills and abilities. Therefore, competence matters when engaging in a difficult conversation or one related to sensitive content.

Theory of planned behavior offers a perspective on individual clinician behavior. The current study is interested in clinician behavior as it relates to the client, in particular, the clinician's ability to address R/S in a competent manner with the client. To understand the dynamics at play between clinician and client we turn to the MCO.

Multicultural Orientation Framework

Clinicians are encouraged during training and practice to operate from a theoretical orientation. The rationale for adopting an orientation is that it will guide the clinicians' conceptualization of the client's presenting problem, will aid in treatment planning, and can shape the interventions chosen. The multicultural orientation framework (MCO) is one choice for clinicians. The MCO was meant to be a compliment to existing models of psychotherapy. Furthermore, it was developed as a means of explaining the cultural dynamics that occur between therapists and clients (Owen, 2013; Owen et al., 2011).

According to Davis et al. (2018) the MCO "articulates a 'way of being' in session for therapists (e.g. cultural humility), a way of identifying and responding to therapeutic cultural markers in sessions (e.g. cultural opportunities), and a way of understanding the self in these moments (e.g. cultural comfort)." The above description of the MCO framework mentions the

three significant constructs which comprise it. The constructs are cultural humility, cultural (missed) opportunities, and cultural comfort (Owen, 2013).

Cultural humility is considered the predominant or overarching value of the MCO framework. Cultural humility, in the context of the MCO framework, refers to the clinician's ability to maintain an interpersonal stance that is open to the cultural identities most significant to the client (Hook et al., 2013). Davis et al. (2018) outline four reasons why cultural humility can be difficult to implement and why it is an important concept for psychotherapy. First, therapists need to be able to engage clients in a collaborative and non-defensive manner. This can require the skillful navigation of worldview differences and distress that arises from perceived or real differences between clinician and client. Second, the clinician's own emotional regulation difficulties when traversing cultural situations in therapy that threaten the clinician's sense of confidence or self-efficacy can pose a challenge. Third, therapy is inherently culturally laden and the clinicians' manner of interacting in session is shaped by "broader social and cultural norms" (Davis et al., 2018, p. 92). Fourth, clinicians can experience a conflict between their personal values and professional obligations. When considering the role of cultural humility in MCO, clinicians are being asked to behave in a manner that conveys awareness of cultural similarities and differences, professional ethics and personal values, and the possible influence of a values and norms of the broader system surrounding the clinician.

The remaining two constructs of the MCO are cultural opportunities and cultural comfort. Cultural opportunities and cultural comfort represent behavioral expressions of cultural humility (Davis et al., 2018). A justification for using the MCO to understand clinician behavior and guide the selection of variables for this study is the fact that the MCO considers the clinicians' behavior in session as part of effective multicultural counseling. Cultural opportunities are

indicators that occur in-session that denotes the client's cultural identity could be explored (Owen et al., 2016). According to Davis et al. (2018) clinicians can take advantage of cultural opportunities in one of two ways. Either, when clients mention their beliefs, values, or other details related to their cultural identities or when clinicians initiate or engage clients in conversation around racial, ethnic, and cultural issues when salient to the client's problem. The challenge for clinicians in this area is to converse with clients in a manner that feels either natural or authentic, while still attending to the racial, ethnic, and cultural information in an appropriate manner (Davis et al., 2018). This description aligns with Day-Vines et al.'s (2007) understanding of integrated/congruent broaching behavior, which is viewed as "effective" and "natural." For clinicians to broach, they must possess an awareness of cultural opportunities and be able to recognize and grasp opportunities as they are continuously present within the therapeutic relationship (Davis et al., 2018). This study is most interested in using the broaching construct to understand clinicians' actual ability to identify and seize cultural opportunities.

Cultural comfort represents the last pillar of the MCO. Cultural comfort refers to the clinicians' thoughts and feelings prior to, during, and after conversations with clients regarding their cultural identities. Clinicians who display cultural comfort are typically present with a sense of ease and composure as they navigate with the client cultural identities as well as cultural similarities and differences between themselves and the client (Davis et al., 2018). Furthermore, Gafford et al. (2019) found that the clinician's engagement with cultural opportunities involved being regularly attuned to cultural factors and adopting a willing stance towards taking risks in-session and engaging racial, ethnic, and cultural factors, rather than getting succumbing to fear or inaction.

The MCO framework is proposed to have multiple benefits in the psychotherapeutic relationship. These benefits include positive psychotherapy outcomes via improved therapeutic relationship (Paniagua, 2013; Sue, 2003), enhanced therapeutic alliance by providing culturally congruent explanations of illness (Wampold, 2007), and an increased sense of trust and safety as a result of the clinicians' attention to salient cultural factors (Owen et al., 2011). Additionally, Owen et al. (2016) found a positive correlation between clients' perception that their therapists had missed opportunities for cultural discussion and exploration and clients' reporting worse therapy outcomes. The implication here is unacknowledged cultural opportunities potentially result in worse psychotherapy treatment outcomes. This provides evidence of the importance of attending to and broaching culturally relevant information.

Utilizing the MCO as a framework for understanding clinician behavior as it pertains to discussing cultural factors in psychotherapy is important because the MCO was developed to capture dynamic cultural processes that occur between clients and therapists (Owen, 2013; Owen et al., 2011). The MCO was used in two studies (Gafford et al., 2019; Winklejohn Black et al., 2021) examining the integration of R/S into psychotherapy. Gafford et al. (2019) found that integration of R/S into clinicians' case conceptualization was necessary when R/S was themes or R/S identity was related to presenting issues. However, in order to determine whether R/S issues were salient, Gafford et al. (2019) reported clinicians needed the skills and abilities to perform adequate assessment that included determining how R/S is correlated, either positively or negatively, with psychological well-being. Juxtaposing the finding from Gafford et al. (2019) is a finding from Winklejohn Black et al. (2021) that cultural discomfort can impede clinicians' ability to initiate conversations about R/S. Winklejohn Black et al. (2021) stated clients were

more likely to raise R/S issues if they perceived their therapists as being culturally humble. It is evident that MCO impacts discussion of R/S in psychotherapy sessions.

Owen et al. (2011) suggests that the MCO, as a “way of being” can be complimented by multicultural competencies. The MCO framework can be conceptualized as a “way of being,” and multicultural competencies as “ways of doing” or perhaps how well a therapist engages in and implements her or his multicultural awareness and knowledge while conducting therapy (Owen et al., 2011). With this idea in mind as well as this study’s aim of exploring clinician behavior, it was determined that an exploration of R/S competencies (both individual and organizational) would provide the best indicators of factors that may influence clinician behavior.

The next section will provide a brief review of the ecological model and how it provides an understanding of human behavior as a by-product of personal and environmental factors. Following presentation of the ecological model, a detailed review of R/S competence at the individual and organizational levels will be provided.

Ecological Model of Multicultural Counseling

Neville and Mobley (2001) developed an ecological model of multicultural counseling psychology processes based on Urie Bronfenbrenner’s (1977) original ecological model. Bronfenbrenner (1977) posited that understanding human behavior required an understanding of four interrelated subsystems: (a) *microsystem*, or the interpersonal interactions within a given environment; (b) *mesosystem*, consisting of interactions between an individual’s school and home environments; (c) *exosystem*, or the linkages between subsystems that indirectly influence individuals; (d) *macrosystem*, consisting of ideological components of a given society, such as norms and values. Neville and Mobley’s (2001) model differs from Bronfenbrenner’s in a few notable ways. First, Neville and Mobley identified a fifth interrelated subsystem, the

individual/person system. This system is generally comprised of factors such as personality style, age, self-esteem, and level of education as well as sociocultural factors such as race, ethnicity, sexual identity, R/S identity, and level of multicultural competence. Second, their model acknowledges the influence of culture on human behavior. Third, Neville and Mobley identify social structures (race, gender, class, sexual identity, etc.) that shape the entire system. Within the model, subsystems interact, and it is rarely possible to discuss one subsystem without discussing or considering other subsystems.

In utilizing Neville and Mobley's (2001) model, it aids in better understanding the clinician's behavior as potentially being shaped by multiple subsystems. However, for the purpose of this study, the focus was on the impact of two specific subsystems on clinician behavior. Those subsystems include the individual/person system and the microsystem. As noted above, the individual/person subsystem of the model includes factors relevant to this study such as level of cultural competence and R/S identity. Neville and Mobley (2001) made a conscious effort to include general, sociocultural, and counseling factors relevant to each subsystem in their descriptors of each system. The microsystem generally contains family, neighborhood, and school, as well as sociocultural factors such as level of cultural competence of specific systems, and counseling related factors such as one's training environment (Neville & Mobley, 2001).

Across multiple studies examining the integration of R/S into psychotherapy, the academic and training environments are mentioned as needing focus and development to help clinicians improve their overall competence and ability to intervene when R/S is related to the presenting problem. Henriksen Jr. et al. (2015) conducted a qualitative study of counseling trainees' perceptions of the R/S training they received and found 58.7% of participants their awareness of and sensitivity to R/S issues was not enhanced as a result of training and 67.3% did

not have the opportunity to engage in self-discovery of their own personal perceptions, beliefs, and values as they related to R/S issues. Olsen (2007) found that doctoral student trainees may read into the absence of R/S content in their training programs as evidence that issues related to R/S do not warrant discussion or the absence may lead to a desire to avoid discussion of R/S if it arises in the future. McClincey (2015) conducted a mixed methods study of doctoral psychology students' multicultural competency. One finding was that number of courses in multiculturalism taken was positively correlated with multicultural competence. To date, the literature has not explored the environment of mental health professionals and their ability to integrate R/S into psychotherapy. A study by Drew et al. (2022) examined mental health professional's comfort/discomfort integrating R/S into clinical practice. Approximately 75-85% were comfortable integrating R/S with 15-25% rating themselves as uncomfortable. Unfortunately, additional information was not gathered regarding the factors resulting in the clinicians feeling comfortable or discomfort around integrating R/S.

The ecological model of multicultural counseling psychology process is a beneficial framework for conceptualizing clinician's broaching behavior as a byproduct of multiple interrelated systems. Historically, focus on the counseling training environment has been neglected (Lau & Ng, 2014). When attention is given to the academic environment of counseling trainees, it is primarily focused on input (factors such as Graduate Record Exam scores, letters of recommendation, and prior grade point average) and how these factors predict how successful students are in terms of navigating their counseling program (e.g., the environment) in order to reach the successful outcome of graduating, earning a degree, and obtaining employment (the outcome). Lau and Ng (2014) proposed institutions focus more attention on the training environment (e.g., academic program, courses, policies, faculty, peers, etc.). Neville and Mobley

(2001) suggested counselors-in-training go through a “psychosocial cultural adaptation process” in developing cultural competence and put forward five questions for training programs to consider when training counselors of varied racial/ethnic/sexual identities. Those questions could easily be modified to reflect R/S identities. The questions are as follows (Neville & Mobley, 2001): (1) To what extent are values and norms of academic training programs congruent or incongruent with [various R/S identities, including atheism and agnosticism], (2) How do stereotypes and perceptual biases related to [R/S discrimination and privilege] affect trainees’ personal [R/S identity] as well as professional counselor identity development, (3) To what extent do trainees [who identify with an R/S minority] experience cultural mistrust in their working relationships with peers [who identify with R/S majority] within the training environment, (4) To what degree will [those who identify with an R/S minority identity] experience other students and faculty as allies, establish close relationships, and/or self-disclose personal information related to their [R/S identity] (5) For [trainees who identify with majority R/S identity], who themselves reflect a rich cultural diversity, to what extent do multicultural training approaches and experiences influence their personal cultural identity and professional counselor identity development.

Environment is a meaningful contributor to shaping and guiding behavior (Olsen, 2007; Lau et al., 2019; Gloria & Pope-Davis, 1996; McClincey, 2015; Jones & Branco, 2020). Furthermore, Jones and Welfare (2017) described broaching as one of the behaviors that conveys cultural competence on the part of the clinician. The next section will describe the concept of competence, both at the individual and organizational levels.

Competence

Cultural Competence

The concept of cultural competence entered the field of psychology's zeitgeist in the 1960s (DeAngelis, 2015). Despite the concept's decades long existence, the field of psychology's ability to define and apply cultural competence continues to be a work in progress (DeAngelis, 2015).

Scholars have formulated multiple definitions of cultural competence. Cross (1989), credited with the first use of the term cultural competence, provided the following definition, "Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations." Stanley Sue (1998) provided what may be the simplest definition of cultural competence, when he stated cultural competence is effectiveness in psychotherapy. López (1997) considered cultural competence to be the clinician's ability to navigate multiple cultural perspectives in understanding the client. D.W. Sue and Torino (2005) adopted a view of cultural competence from an ecological perspective and frame the concept as the ability to engage in actions or create conditions that result in two circumstances: (1) maximize the optimal development of the client and (2) maximize the optimal development of the client systems. Sue and Sue's (1990, 1999) description of cultural competence incorporated an acknowledgement of the significance of skill, knowledge, and an attitude of openness. Additionally, Sue and Sue (1990, 1999) viewed cultural competence as both an active and an ongoing process is a lifelong journey. Whaley and Davis (2007) provided a definition of cultural competence from a systemic/organizational perspective, stating:

culturally competent care has been defined as a system that acknowledges the importance of and incorporates culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of interventions to meet culturally unique needs at all levels of service (p. 564).

Across definitions of cultural competence there are some commonalities. Most definitions include an acknowledgment that knowledge, skills, and attitude are significant in the development and demonstration of culturally competent practice, both at the individual and systemic levels. Cultural competence may be applied to race/ethnicity, gender, sexuality, socioeconomic status, ability, military identity, and religion and spirituality. This is by all means not an all-inclusive or exhaustive list; it does however represent the identities that are most often acknowledged when discussing cultural competence in mental health. Though religion and spirituality are acknowledged as important aspects of cultural competence for clinicians (Vieten et al., 2013) they are at times viewed as an “afterthought” (Magaldi-Dopman, 2014).

The discounting and overlooking of religion and spirituality as concepts of importance within cultural competence has practical implications. First, it may impede the development of scales to measure or assess religious/spiritual competence. Second, clinician development in terms of exploring religious/spiritual struggles and strengths with clients may be stifled. Third, the mental health professions will lack a standard or basic agreement of what constitutes religious/spiritual competence for professional practitioners and trainees.

For this study, the aim was to assess religious and spiritual competence. In reviewing the previously provided definitions of competence, it was clear that cultural competence exists in both the individual and organizational forms. The aim of religious/spiritual competencies, as outlined by Vieten et al., (2013, 2015) are to help clinicians increase in effectiveness in their clinical work by decreasing instances of bias, inappropriate practice, and improving clinician’s

ability to utilize R/S problems and R/S strengths. In addition to the body of literature related to cultural competence, Vieten (2013, 2015) consistently draws connections between clinician competence and clinician behavior. Therefore, to more completely understand clinician broaching behavior in relation to religion and spirituality, an understanding of religious and spiritual competence at the individual and organizational levels is imperative.

Individual R/S Competence

Individual religious/spiritual competence will serve as the predictor variable for this study. Organizational religious/spiritual competence will serve as the moderator variable and will be discussed in the upcoming section. Individual R/S competence was selected as the predictor variable because previous studies have linked individual competence to both clinician behavior and psychotherapy outcomes. A study by Constantine (2001) using transcribed intake sessions from 52 counselor-client dyads demonstrated that counselors' quantity of multicultural training was linked with objective observers' rating of counselors' multicultural competence the transcribed session. Worthington et al. (2000) found self-reported multicultural knowledge (a subset of competence) was a predictor of observed multicultural competence in a study of counselors engaged in counseling simulation activity. The common thread with the aforementioned studies is that a slight relationship exists between counselor ratings of cultural competence and observed counselor behavior. Huey Jr. et al. (2014) conducted a review to examine what is known about the role of cultural competence in the implementation of evidenced based treatments. A recommendation from their review was that cultural competence be examined in conjunction with actual therapist behavior. The current study explored the relationship between individual cultural competence and clinician behavior (broaching) within the psychotherapy session.

Religious and/or spiritual competence is an important aspect of overall multicultural competence (Sandage & Strawn, 2022). There is also empirical evidence that R/S competence among clinicians is associated with humility and relational maturity (Crabtree et al., 2021). Hodge (2016) outlines five of reasons for clinicians to focus on R/S competence: increasing religious diversity within US society; learning to negotiate differences in values, enhancing insight into clients' challenges, improving clinical rapport and outcomes, and accessing spiritual strengths.

To date, no studies have examined the connection between clinician's R/S competence and their behavior in session. However, Olsen (2007) found that among doctoral level counseling trainees, multicultural competence was positively correlated with the perceived importance of integrating R/S. Understanding individual R/S competence is an undertaking within itself. From the perspective of counseling and clinical psychology doctoral students who were surveyed during a study (Saunders et al., 2014), it was found that most respondents associated basic R/S competence as asking about the salience of R/S issues. For those clients who indicated salience, doctoral students further believed R/S competence involved follow-up where the clinician would ask about R/S affiliations, whether R/S issues are related to the problem, and how R/S related resources might be helpful in addressing the problem (Saunders et al., 2014). This perspective on individual R/S competence is practical, however, simply defining individual R/S competence as the ability to ask clients about salient R/S issues is not sufficient.

Definition of Individual R/S Competence

Hodge (2004, 2016) offered a comprehensive, three-dimensional definition of R/S competence. The first of the three dimensions is comprised of a balance where one maintains an awareness of their values and worldview while simultaneously being mindful of the assumptions,

limitations, and biases associated with their particular worldview. Worldviews offer individuals concepts and structures for understanding and interpreting life experiences and as it pertains to this study, worldviews may be secular or spiritual in nature (Hodge, 2016). According to Hodge (2016) the benefit of having an awareness of one's assumptions, limitations, and biases, as a clinician, is that it provides one with an understanding of the ways in which they may attend to or neglect specific pieces of clinical information during the treatment process.

The second of the three dimensions of R/S competence involves the clinician adopting an empathic, strengths-based understanding of the client's spiritual worldview. The implication here is that it is beneficial if the clinician is able to develop an appreciation of the client's worldview and the strengths inherent in their worldview (Segal & Wagaman, 2015). Hodge (2016) notes that the clinician's appreciation of the client's worldview is not akin to agreement, it implies only a recognition of the worldview's significance to the client as well as the strengths available through the worldview.

The third of the three dimensions of individual R/S competence is the ability to create and implement intervention strategies that are appropriate, relevant, and sensitive to the client's spiritual worldview (Hodge, 2016). This dimension is a collaborative process between client and clinician where they construct interventions that build upon or reflect the concepts and structures inherent to the clients' belief system (Hodge et al. , 2009).

Measure of Individual R/S Competence

Defining and measuring competence are different processes. The measurement of R/S competence has been difficult. Current methods of assessing competence tend to involve looking at a list of RS competencies and utilize a Likert scale to measure participants' agreement with or the item or feeling that they can demonstrate the competency (Oxhandler & Pargament, 2018).

Robertson (2010) first developed the Spiritual Competency Scale (SCS) (Lu et al., 2018). The SCS was developed as a measure of R/S competence at the individual level. Robertson (2010) designed the SCS so that higher scores would suggest competency. Robertson's (2010) first SCS was 22-items, on a six-point Likert scale with a possible total score of 132. It was impractical to expect perfect scores (i.e., 6 points for each item), so the cutoff was set at 5 (Robertson, 2010). Based on this cutoff, Robertson (2010) suggested a total score of 110 in the 22-item SCS (5 points X 22 items) as a target score respondents could pursue when using this scale to monitor improvements of their spiritual competency (Lu et al., 2018).

Following creation of the SCS, Dailey et al. (2015) conducted a re-examination of the original Spiritual Competency Scale. The two primary reasons for re-exploring the SCS stemmed from: (a) the original SCS was studied based on counseling students who might not have been spiritually competent. Therefore, the understanding of it as a valid measure of competence may not be reflected due to the test sample's competence being uncertain; and (b) the six-factor structure found during the initial scale creation (Robertson, 2010) needed to be validated. Dailey et al. (2015) confirmed the accuracy of the six-factor structure, however, instead of 22-items, the scale was found to have 21-items. The content areas of the SCS-R-II (which are the same as the original SCS) are: assessment, counselor self-awareness, diagnosis and treatment, human and spiritual development, cultural and worldview, and communication (Lu et al., 2018).

Following this study, the SCS was renamed SCS-R-II. According to Lu, Woo, & Huffman (2018), the SCS-R-II is probably the only systematically developed and validated inventory, within the field of counseling, to examine spiritual competencies. The statement is not entirely true (Oxhandler & Pargament, 2018). Multiple other scales exist for measuring R/S competence, however due to double-barreling concerns (Young et al., 2002; Dobmeier & Reiner,

2012; Fluellen, 2007), not fully assessing reliability and validity (Vieten et al., 2013), or insufficient criterion or factorial validity (Sheridan et al., 1992) the SCS-R-II was selected for use in this study.

Organization R/S Competence

Organization R/S competence served as the moderator variable in this study. It is believed that organizational R/S competence will explain the link between individual R/S competence and broaching behavior. Across the literature, a consistent and oft cited point is the need for organizations and institutions to improve R/S training in hopes of improving clinician/trainee R/S competence (Hodge, 2016; Vieten et al., 2013; Magaldi-Dopman, 2014; Magaldi & Trub, 2018; Crook-Lyon, 2012) and behavior/skills in session (Evans & Nelson, 2021; Saunders et al., 2014;. Dailey et al. , 2015)

Participation in multicultural training activities has been linked to therapists' self-reported multicultural counseling competence (Constantine et al., 2001; Neville et al., 1996; Ottavi et al., 1994; Pope-Davis et al., 1994,1995; Sadowsky et al., 1994, 1998). The implication here is that competent organizations and institutions provide training for clinicians/trainees around R/S topics. According to Constantine (2001) R/S training is critical in helping counselor trainees to consider important cultural variables and more effectively meet the needs of culturally diverse populations in their work with clients. Currently, few training programs address R/S needs and issues (Crook-Lyon et al., 2012). This is true, not only for academic institutions, but also for professional institutions as well.

When Crook-Lyon (2012) surveyed APA-affiliated psychologists, 76% believed their graduate training programs inadequately addressed R/S issues in their training. Schulte et al. (2002) found 82% of counseling psychology training directors reported that religious and

spiritual issues were not regularly discussed as issues of diversity or considered as important as other kinds of diversity in their programs. Amongst social workers, 87% reported taking no courses on R/S and 74% reported receiving no content on R/S in their field or clinical training (Oxhandler et al., 2015; Hodge, 2016). The data demonstrates a disconnect between the mental health field's insistence that R/S be incorporated into training and professional programs and the lack of integration. As a result of the focus on organizational R/S competence, this study selected it as a moderating to examine if it strengthens the relationship between individual R/S competence and broaching behavior. Similar to individual R/S competence, it is necessary to define organizational R/S competence and discuss the measure used.

Definition of Organizational R/S Competence

Hodge (2007) created the Spiritual Competence Scale (SCS) to assess R/S competence at the programmatic level. Hodge (2007) described the SCS as pinpointing foundational beliefs or values dimensions of Sue et al.'s (1992) three-dimensional conceptualization of cultural competence. Sue et al. (1992) proposed a three-dimensional model for understanding competence, which included beliefs, knowledge, and skills. In consulting Hodge's (2007) work regarding the creation of the SCS, the nearest to a definition of organizational R/S competence is when he describes a culturally competent environment as one that has values associated with an atmosphere conducive to cultural competence. The values key to an atmosphere of cultural competence include acceptance of culturally different perspectives, respect and sensitivity for different cultures and their associated beliefs and narratives, openness to learning about different cultures, the assignment of value or worth to different cultures, and the desire to understand culturally different views (Hodge, 2007).

Measure of Organizational R/S Competence

The organizational R/S competence measure was designed to be an effective assessment across settings. Hodge created the measure so that slight changes in item terminology would make it application to a school setting, classroom setting, hospital setting, social work setting, etc. Hodge (2007) wrote that unlike scales that assess competence at the individual level, this measure of competence at the organizational level is less susceptible to social desirability bias. The SCS is comprised of 16 items that were indicative of the existence of spiritual competence in the realm of spirituality and religion (Hodge, 2007).

Hodge (2007) developed the SCS to assess the ability of organizations to engage in culturally competent practice with spiritual and religious believers through the incorporation of the following values: openness, acceptance, respect, and sensitivity, along with a desire to understand and assign value to different spiritually-based cultures, perspectives, worldviews, beliefs, and narratives. The SCS is 8-items and uses an 11-point response key ranging from -5 to +5. Hodge (2007) makes an important note about the SCS, it was developed at the macro level and measures perceptions of competence, rather than actual competence. Currently, the SCS may be the only developed and validated measure of R/S competence at the organizational level.

Present Study

The present study will use a moderation model to examine the role of cultural competence in clinician broaching behavior. The current study fills a sizeable gap in the literature in two ways: first, it addressed R/S within psychology, which is a growing area of interest but still fairly under-examined (Weaver et al., 2006) and second, this study used the broaching scale, which has primarily been used to examine broaching behavior related to race and ethnicity, and is now being used to examine broaching related to R/S.

Of particular importance is this study's use of the theory of planned behavior, multicultural orientation framework, and ecological model of multicultural counseling to determine the variables selected for this study and their relationship to one another (e.g. predictor, moderator, and outcome). Utilizing the three theories helps this study to move away from the usual conceptualization of a specific input (e.g. clinician competence) leading to a specific outcome (e.g. clinician broaching behavior). This study's framework takes an encompassing view of clinician behavior as involving "input-environment-outcome" (Astin, 1993). The current study is assessing clinician R/S competence via a measure that primarily focuses on clinician attitude towards R/S and incorporates some assessment of knowledge and practice towards R/S. This measure aligns with TPB literature which states "attitude toward behavior" can be a significant contributor to intention to behave in a specific manner (e.g. R/S broaching).

The current study is interested in R/S broaching behavior as the outcome variable. Multicultural orientation framework fits with broaching because it is interested in describing the dynamic process that occurs between clinician and client in the therapy space. The MCO proposes three factors as important to the dynamic between client and clinician and those are, cultural humility, cultural opportunities, and cultural comfort. Jones and Branco (2020) stated that broaching might be viewed as cultural humility in action. Utilizing the broaching framework to explore clinician behavior is meaningful because the broaching measure assesses clinician ability to take an active and engage role in R/S discussions (e.g. cultural comfort) and to be prepared with questions and look for opportunities to inquire about R/S (e.g. cultural opportunities). Additionally, the broaching scale asks about whether broaching behavior has been integrated into one's professional identity. This matters because TPB has demonstrated a positive relationship between self-identity and intention to behave in a specific manner (Hagger

& Chatzisarantis, 2006; Sparks & Guthrie, 1998). The implication here is potentially adopting an identity, as a clinician who broaches R/S, will increase the likelihood of broaching behavior.

As previously stated, this study aims to expand the understanding of behavior from input-outcome to input-environment-outcome (Astin, 1993). In order for clinicians to increase R/S competence and adopt a professional identity as a clinician who broaches R/S, this study theorizes that there needs to be a supportive environment in place for this to occur. Supportive, in the context of this study is defined as one where there are favorable attitudes towards R/S (e.g. fosters sensitivity and respect for R/S), knowledge is shared (e.g. the organization respects varied R/S perspectives and it is acceptable to share R/S views), and skills are taught (e.g. R/S is learned about within the organization) (Hodge, 2007). The combination of the aforementioned factors equates to an environment with high R/S competence. In the current study, the hypothesis is that the relationship between clinician R/S competence and broaching behavior will be moderated by organizational R/S competence. Neville and Mobley (2001) proposed the ecological model of multicultural counseling to describe the interaction between person, environment, and behavior. According to Neville and Mobley's (2001) model, cultural competence exists at both the individual/person systems level (e.g. clinician and/or client) and the microsystem level (e.g. training program; mental health or counseling center).

Specifically, this study aims to take a novel approach to answer the following research questions: (a) How is clinician R/S competence (e.g. predictor) related to clinician's broaching behavior (e.g. outcome) (b) How does organizational R/S competence moderate the relationship between the predictor and outcome variables? (c) Will high versus low levels of organizational R/S competence have varying effects on broaching behaviors?

CHAPTER THREE

METHODOLOGY

This chapter includes a description of the study's data collection procedures, summary of sample characteristics, and summary and psychometric properties of the instruments used to measure the study variables. Also enclosed is the data analysis procedure.

Participants

Participants were identified as individuals who met the following criteria: licensed mental health professionals, pre-licensed mental health professionals (i.e. psychologists, counselors, social workers, marriage and family therapists who have graduated from their program of study but have yet to be licensed in their state of practice), and graduate students-in-training (i.e. those currently enrolled in mental health training programs) who have at least one semester of clinical experience. Graduate students-in-training with no clinical experience did not meet inclusion criteria. Licensed professionals will include the following professions: psychologist (clinical/counseling – LCP), social worker (LCSW), marriage and family therapist (LMFT) and counselor (LCPC/LPC).

The inclusion criteria were: (a) currently perform therapy as a licensed mental health clinician (e.g., LCSW, LCPC/LPC, LCP, LMFT) or perform therapy under the supervision of a licensed mental health professional or as a graduate student trainee under the supervision of a licensed supervisor (for at least one semester); and (b) currently perform a minimum of two hours of individual or group therapy per week. Participants also need to be 18 years of age or

older.

A total of 201 participants completed the online study survey. Fifty-four participants were excluded from the study as a result of not completing one or more of the study measures. Of the remaining 147 participants, two participants were missing responses to one question each from the BABS. In scoring the BABS, mean scores were taken and, as a result, the two cases missing a question each were retained. A final sample of 147 participants was included in the data analysis.

The mean age of the participants was 33.14 years ($SD = 8.89$). One hundred nine (74.1%) participants identified as female, 33 (22.4%) as male, three (2.0%) as non-binary/third gender, and two (1.4%) chose to specify their gender as “non-binary woman” and “cis woman.” Regarding race/ethnicity, 96 (65.3%) participants identified as Caucasian/White, 17 (11.6 %) as Asian/Pacific Islander, 15 (10.2%) as Hispanic/Latinx, 8 (5.4%) as African-American/Black, 5 (3.4%) as biracial/multiracial, and 6 (4.1%) chose to specify their race/ethnicity as “a race/ethnicity not listed here” (this included “Asian Indian,” “South Asian,” “White and Hispanic,” and two individuals who wrote “Middle Eastern”). Religious/Spiritual identity of participants included: 57 (38.8%) Christian (includes Protestant, Catholic, and other Christian faiths), 24 (16.3%) Spiritual but not religious, 23 (15.6%) Agnostic, 11 (7.5%) chose to specify their affiliation (these included “Baha’I,” “Excommunicated Mormon,” “Humanistic Jewish (culturally Jewish and religiously atheist),” “Mysticism,” “Half Catholic,” “Jainism,” “Pagan,” “Secular Buddhist,” “The Church of Jesus Christ of Latter-Day Saints (LDS/Mormon),” and two “Unitarian Universalist”), 11 (7.5%) Atheist, 8 (5.4%) Unaffiliated with specific religion or spirituality, 7 (4.8%) Jewish, 3 (2.1%) Muslim/Islam, 2 (1.4%) Buddhist, 1 (0.7%) Apostate.

Seventy-seven (52.4) of participants identified as a “mental health professional and 70 (47.6%) identified as a “student/trainee.” For a full breakdown of participant demographics, see Table 1.

Table 1. Participant Information

Age	<i>M</i> =33.14 (<i>SD</i> =8.89, Range 22 - 72)	
	Frequency	Percentage
Gender		
Female	109	74.1%
Male	33	22.4%
Non-binary / third gender	3	2.0%
Gender identity not listed	2	1.4%
Racial/Ethnic Identity		
African American / Black	8	5.4%
Asian / Pacific Islander	11	11.6%
Caucasian / White	96	65.3%
Hispanic / Latinx	15	10.2%
Biracial / Multiracial	5	3.4%
Race / Ethnicity not listed	6	4.1%
Religious/Spiritual Identity		
Agnostic	23	15.6%
Apostate	1	0.7%
Atheist	11	7.5%
Buddhist	2	1.4%
Christian	57	38.8%
Jewish	7	4.8%
Muslim / Islam	3	2.1%
Spiritual but not religious	24	16.3%
Unaffiliated with specific religious or spiritual teaching	8	5.4%
Other	11	7.5%
	Mental Health Professional	Student / Trainee
	Frequency (Percentage)	
	77 (52.4%)	70 (47.6%)
Professional Identity		
Counseling	34 (23.1%)	13 (8.8%)
Marriage and Family Therapy	2 (1.4%)	1 (0.7%)
Psychology	20 (13.6%)	56 (38.1%)
Social Work	18 (12.2%)	0 (0%)
Other	3 (2.0%)	0 (0%)
Clinical Setting		
College/University/Community College	8 (5.4%)	27 (18.4)
Community Mental Health	12 (8.2%)	11 (7.5%)
Detention Center, Jail, Prison	0 (0%)	2 (1.4%)
Group Private Practice	36 (24.5%)	8 (5.4%)
Hospital (including VA, AMC, State, etc.)	13 (8.8%)	13 (8.8%)
Inpatient or Outpatient Treatment Program	4 (2.7%)	6 (4.1%)
Other	4 (2.7%)	1 (0.7%)
Licensed Professional	63	-
Unlicensed Professional	13	-
	Mean (<i>SD</i>)	
Years of Clinical Experience	9.91 (<i>SD</i> =8.89)	3.65 (<i>SD</i> =1.75)

Procedures

This study utilized online, web-based data collection. The study sample was drawn from mental health professionals and students who were electronically accessible (e.g., via email, electronic posting). Possible participants were informed of this study through academic and research listservs, company/organization website, through academic institutions via their Director of Clinical Training, and personal contacts. This study utilized snowball sampling, where participants and possible participants were asked to share study information and link with other potential participants. The study survey was made and housed with Qualtrics, a web-based survey research software. Potential study participants were given a link to the Qualtrics survey and upon accessing the survey website they were prompted to review and provide informed consent. Individuals who provided informed consent and agreed to participate were then directed towards the study survey, which began with questions about demographic information and then proceed to the study questionnaires. Incentives were not provided for participation in this study. All study participant data, both complete and incomplete, were collected and stored using Qualtrics. Following data collection, the data were downloaded and stored in a SPSS file, in a password-protected database.

Instruments

Survey questionnaires administered for this study are outlined in detail in this section. A brief demographics survey and three survey questionnaires were used. The three questionnaires included. The Spiritual Competency Scale Revised (SCS-R-II; Dailey et al., 2015) was used to measure the predictor variable; the Broaching Attitudes and Behavior Survey (BABS; Day-Vines et al., 2013) was used to record the dependent variable; the Spiritual Competence Scale (SCS;

Hodge, 2007) was used for the moderator variable.

Demographics

Participants were asked to provide information about their race, gender, age, type of degree program and training setting (if currently graduate student), type of professional licensure and/or professional affiliation and work setting (if currently a mental health professional), number of months/years training or practicing psychotherapy, and religious/spiritual identity/orientation.

Instruments

Predictor Variable (Spiritual Competence)

The Spiritual Competency Scale (SCS-R-II; Dailey et al., 2015) measured the self-perceived religious and spiritual competence of clinicians. The word “counselor” was changed to “clinician” on relevant scale questions. This change towards one unifying title for professionals was made to increase the sense of inclusivity of the various mental health trainees and professionals completing this study (e.g. LCSWs, LMFTs, LCPCs, and students in training). The revised version of the SCS (Dailey et al., 2015) used in this study has 21-items, rated on a six-point Likert scale ranging from 1 (*Strongly Disagree*) to 6 (*Strongly Agree*). A neutral option or “*Don’t Know*” was intentionally omitted to prevent potentially ambiguous responses. Overall, total scores range on the revised SCS from 21 to 126. Higher scores were indicative of greater spiritual competence. A cutoff score of 105 was recommended as a marker of spiritual competency (Dailey et al., 2015); however, this study did not use a cutoff score. Participant responses were converted to a mean score and considered on a continuum.

The original SCS (Robertson, 2010) was comprised of 90-items rated on a six-point Likert scale ranging from 1 (*High Disagreement*) to 6 (*High Agreement*). The 90-items were derived from ASERVIC's original nine spiritual competencies (Cashwell & Young, 2005; Miller, 1999). A revised SCS (Dailey et al., 2015) was developed from the 90-item version of the original SCS (Robertson, 2010). Using item-to-total correlation and principal components analysis, 21 items were retained from the initial set of 90-items. The final 21 items yielded six factors. The factors were identical to those in the original version of the SCS developed by Robertson (2010). Factor information is as follows: Assessment ($\alpha = .85$), three items (ex. "Inquiry into spiritual or religious beliefs is part of the intake process"); Counselor self-awareness ($\alpha = .70$), four items (ex. "Counselors who have not examined their spiritual or religious values risk imposing those values on their clients"); Diagnosis and Treatment ($\alpha = .71$), three items (ex. "Prayer is a therapeutic intervention"); Human and Spiritual Development ($\alpha = .70$), three items (ex. "There is a relationship between human development and spiritual development"); Culture and Worldview ($\alpha = .61$), five items (ex. "Spiritual or religious beliefs impact a client's worldview"); and Communication ($\alpha = .60$), three items (ex. "Addressing a client's spiritual or religious beliefs can help with therapeutic goal attainment"). The current Cronbach's alpha for the final 21-item instrument was .90.

Outcome Variable (Broaching Behavior)

The Broaching Attitudes and Behavior Survey (BABS; Day-Vines et al., 2013). This BABS consists of four subscales: Avoidant, Continuing/incongruent, Integrated/congruent, and Infusing. Each subscale measured a different type of broaching behavior, ranging from avoidance to clinicians who are advocates and work for systemic change. This study was solely

interested in clinician broaching behavior that was deemed “effective.” Therefore, the “Integrated/Congruent” subscale was used. This subscale assessed the clinician’s ability to initiate or respond to the client’s religious and/or spiritual concerns, in-session (Day-Vines et al., 2013).

The BABS subscales were originally developed to address issues of race and ethnicity in therapy. Therefore, where applicable, wording was changed from references to race/ethnicity to “religion and spirituality.” In two questions, references to frequency of broaching behavior was changed from “several times” or “one or two times” to “multiple times.” Wording changes were made for the purpose of making subscale questions relevant to the present study, which addressed issues of religion and spirituality.

The Integrated/Congruent subscale included 10-items, was measured on a 5-point Likert scale, and had responses ranging from 1 (*Strongly Disagree*) to 5 (*Strongly Agree*). The subscale score were calculated as an item-level mean, with higher scores representing higher levels of broaching behavior. Sample items include, “I initiate discussions that help my clients understand that their problems may be connected to issues such as [religion and/or spirituality]” and “I generally broach [religious and/or spiritual] factors throughout my counseling sessions with clients”. The Integrated/Congruent subscale was found to be internally consistent ($\alpha = .80$), with acceptable factor loadings of the items (ranged from .44 to .70;) (Pett et al., 2003). The current Cronbach’s alpha for the subscale of integrated/congruent was .87.

Moderator Variable (Organizational Competence)

The Spiritual Competence Scale was used to measure the spiritual competence of the organization that the study participant is currently affiliated. For those participants who were

trainees, they were asked to rate the spiritual competence of their clinical training site. For those participants who are licensed or unlicensed professionals, they were asked to rate the competency of the organization by which they are employed. The SCS is an eight-item measure of competence at the organization level. Items were developed following a review of literature concerning cultural competence (Sue et al., 1992; Sue & Sue, 1999; D'Andrea et al., 1991; LaFromboise et al., 1991; Pruegger & Rogers, 1994; Sadowsky et al., 1994). Literature review yielded a collection of common values suggestive of an atmosphere of cultural competence. The values used to create the items of the SCS include (Hodge, 2007): acceptance of culturally different perspectives, respect and sensitivity for different cultures and their associated beliefs and narratives, openness to learning about different cultures, the assignment of value or worth to different cultures, and the desire to understand culturally different views. Respondents were asked to select an option from an 11-point response key with responses ranging from -5 to +5. According to Hodge (2007), scores are calculated by adding a constant (i.e., 6) to eliminate negative integers and averaging the items together, resulting in a scale ranging from 1 to 11, with higher values indicating higher levels of spiritual competence. Sample SCS items include: "To what extent does the atmosphere in your social work program foster respect for religious and spiritual perspectives?"; "To what degree are religious or spiritual believers free to be themselves in your social work program?". The words "social work program" were changed to "your organization" as recommended by the creator of the SCS (Hodge, 2007). The final 8-item Spiritual Competence Scale obtained a Cronbach's alpha .923 with acceptable factor loadings of the items (.729 to .865; Hodge, 2007). The Cronbach's alpha from the current sample was .94.

CHAPTER FOUR

RESULTS

Data Cleaning

Data analysis was completed in SPSS. Data analysis began with data cleaning, which involved the removal of participants who answered “no” to the informed consent, working for an organization or in a group setting, having at least one semester of clinical experience, and/or did not conduct at least two hours per week of psychotherapy or intensive case management. Additionally, data from participants who did not complete all measures were removed from the final dataset. Two participants completed 11 of 12 questions on the BABS and their data was retained because BABS scores were examined as mean scores, not cumulative scores.

Preliminary Analysis

Frequency and percentage of all categorical demographic variables (i.e., gender identity, racial/ethnic identity, religious/spiritual identity, professional identity, clinical setting, and do you hold licensure in your profession) were examined. Second, survey measures were reviewed, and the necessary scores were reverse scored. Third, the mean, standard deviation, and range of all continuous (age and years of practice) demographic variables were examined (see Table 1). Additionally, mean, standard deviation, skewness, kurtosis, and Cronbach’s alpha for study variables (Broaching, Individual Competence, and Organizational Competence) were calculated (see Table 2). Preliminary data analysis confirmed that the assumption of normality (skewness < 2.0; kurtosis < 7.0) was met (West et al., 1995). For study variables, z-scores were created based

on mean scores. Raw scores were standardized in order to reduce potential problems with multicollinearity between the interaction term with the predictor and moderator variables (Aiken & West 1991; Frazier et al. 2004).

Bivariate correlations for all study variables (Broaching, Individual Competence, and Organizational Competence) were calculated. Correlation between Individual and Organizational Competences was .211 and was significant ($p < .05$). Correlation between Broaching and Individual ($r = .628$) and Organizational ($r = .261$) Competences were both significant ($p < .01$).

Table 2. Means, standard deviations, Cronbach's alpha, and correlations among variables

	1	2	3
1. Broaching	—		
2. Individual Competence	.628**	—	
3. Organizational Competence	.261**	.211*	—
Mean	3.23	4.57	8.38
Standard Deviation	.699	.562	1.72
Cronbach's Alpha	.898	.868	.939
Skewness	-.288	-.116	-.407
Kurtosis	-.596	-.082	-.460

Note: $N = 147$ for all study variables. * $p < .05$, two-tailed. ** $p < .01$, two-tailed

Main Analyses

This study performed a hierarchical multiple regression analysis to examine whether clinician broaching behavior was predicted by clinician spiritual competence and moderated by organizational/institutional spiritual competence. Prior to running hierarchical multiple regression, predictor and moderator variables were standardized. Variables (i.e., clinician's

religious/spiritual competence, organizational competence, and broaching) were standardized through the creation of z-scores. Following standardization, an interaction term was created. The standardized predictor variable was multiplied by the standardized moderator variable to create the interaction term.

In the first step in the regression analysis, demographic variables were entered as covariates. Age, years of practice/training, and whether the participant endorsed R/S affiliation (defined as yes or no) were entered as covariates. Controlling for these variables, Model 1 of the hierarchical multiple regression analysis did not contribute significantly to the regression model, $F(3, 61) = 1.786, p = .159, R^2 = .081$, and accounted for 8% of the variance in broaching behavior.

In the second step, the predictor variable, clinician's religious/spiritual competence was added to the model. Model 2 accounted for 60% of the variance in broaching behavior. The R^2 value increased by 52% when clinician religious/spiritual competence was added as the predictor of broaching behavior in Model 2, indicating a statistically significant change, $F(1, 60) = 78.407, p < .001, R^2 = .601$. In the third step of the model, the moderator variable, organizational religious/spiritual competence was added to the model. Model 3 accounted for 68% of the variance in broaching behavior. The R^2 value increased by 8% when organizational religious/spiritual competence was added as the moderator of broaching behavior in Model 3, indicating a statistically significant change, $F(1, 59) = 15.256, p < .000, R^2 = .683$. In the fourth step, the interaction term, which was created by multiplying the standardized predictor variable and standardized moderator variable, was added to the model. Model 4 accounted for 70% of the variance in broaching behavior. The R^2 value increased by 2% when the interaction term was added as the moderator of broaching behavior in Model 3, indicating non-significant change, $F(1,$

58) = 3.944, $p = .052$, $R^2 = .704$. Results of the hierarchical multiple regression are shown in Table 3.

Table 3. Testing Moderator Effect of Organizational R/S Competence Using Hierarchical Multiple Regression

Variable	<i>B</i>	<i>SE B</i>	β	<i>R</i> ²	Adj. <i>R</i> ²	ΔR^2	ΔF
DV: Broaching							
Step 1							
R/S affiliation	.225	.278	.100				
Age	.013	.021	.120				
Years of practice	.018	.025	.146	.081	.036	.081	1.786
Step 2							
R/S affiliation	.154	.185	.069				
Age	.010	.014	.095				
Years of practice	.006	.017	.048				
Clinician R/S Competence	.742***	.084	.733	.601	.575	.521	78.407***
Step 3							
R/S affiliation	.090	.167	.040				
Age	.021	.013	.192				
Years of practice	-.005	.015	-.036				
Clinician R/S Competence	.714***	.076	.705				
Organizational R/S Competence	.286***	.073	.295	.683	.657	.082	15.256***
Step 4							
R/S affiliation	.079	.163	.035				
Age	.018	.013	.163				
Years of practice	-.004	.015	-.034				
Clinician R/S Competence	.732***	.074	.723				
Organizational R/S Competence	.309***	.072	.318				
Clinician R/S Competence X Organizational R/S Competence	-.141	.071	-.148	.704	.673	.020	3.944

Note. *** $p < .001$, two-tailed

The findings supported the first hypothesis by showing that clinician spiritual competency was positively associated with clinician broaching behaviors. Although organizational/institutional spiritual competence positively predicted clinician broaching behaviors, differently from my hypothesis, it did not moderate the relationship between clinician spiritual competency and clinician broaching behavior. The next chapter will discuss the findings, clinical and research implications, future directions, and study limitations. Given the nonsignificant moderation effect, I did not conduct a follow-up analysis of single slope analysis.

Post-hoc Analyses

Post-hoc analyses revealed a handful of interesting findings. Professionals were found to broach more than student trainees ($t = -3.287, p < .001$). Within professionals, licensed clinicians tended to broach R/S more than unlicensed clinicians; however, the finding did not reach statistical significance ($p = .224$). When early career (0-10 years) was compared with all other career stages (11 years and beyond), those in the early career engaged in R/S broaching significantly less than others ($F(2,74) = 5.355, p < .01$).

Clinicians with R/S affiliation broached R/S significantly more than non-R/S affiliated clinicians ($F(2,145) = 1.119, p < .05$). Clinician broaching behavior tended to increase with clinician's age. Those grouped 60-79 years of age appeared to have the highest broaching average, while those grouped 20-29 years of age tended to have the lowest broaching average. However, such differences were not statistically significant.

CHAPTER FIVE

DISCUSSION

Main Findings

This study examined the relationship between clinician's R/S competence and clinician's broaching behavior. Overall, clinician's R/S competence was a significant predictor of clinician's broaching behavior. It was initially hypothesized that the relationship between clinician's R/S competence and broaching behavior would be moderated by organizational R/S competence. However, study data was not supportive of a moderating relationship. Organizational R/S competence was found to predict clinician's broaching behavior. The findings align with the theoretical frameworks initially presented for this study.

The theory of planned behavior was a framework presented for predicting and explaining clinician behavior. Theory of planned behavior proposes the construct of 'perceived behavioral control' is partially predictive of intention to behave and indirectly predictive of the behavior itself (e.g., broaching). Specifically, the clinician perceiving themselves as capable or competent in performing the behavior will increase the likelihood of the clinician engaging in the behavior. Religious/spiritual competence, in the context of the current study, is viewed as a form of perceived behavioral control. Clinicians endorsing a high level of R/S competence are endorsing a high level of perceived behavioral control. Clinicians in this study who indicate a high level of R/S competence were more likely to engage clients in discussion (e.g., broach) about the salience of R/S factors as related to their illness and wellness.

Results supported the first of two study hypotheses. Hypothesis one stated that clinician R/S competence would be positively associated with broaching behaviors. This hypothesis was supported, and clinician R/S competence accounted for approximately 52% of the variance in broaching behavior. There is a great deal of literature espousing the need for increased cultural competence, however, our field lacks the literature demonstrating the effect of clinician's cultural competence on the clinician's actual behavior in session. This study is novel, in that it provides tangible data demonstrating that when clinician's endorse cultural competence, specifically, R/S competence, they are more likely to behave in-session in a manner that is active, engaging, and responsive when it comes to R/S content. This is significant because historically, R/S content has been viewed as "taboo" (Bergen, 1980), anxiety provoking and burdensome (Magaldi-Dopman, 2014). The anxiety related to broaching R/S issues is related to what the MCO framework calls cultural (missed) opportunities and cultural (dis)comfort. When clinicians lack competence in a specific cultural domain, this has an impact on clinician behavior. When this finding is viewed through the lens of the MCO framework it is clear that clinician R/S competence is associated with improved recognition of cultural opportunities (e.g., an ability to recognize and grasp therapeutic content related to R/S) and cultural comfort (e.g., having an ease and comfort in navigating therapeutically relevant R/S content in-session).

Study results did not support the second hypothesis. The second hypothesis stated that in the presence of high levels of organizational R/S competence (i.e., moderator), the relationship between clinician R/S competence and broaching behavior would be stronger and that in the presence of low levels of organizational R/S competence, the relationship between clinician R/S competence and broaching behavior would be weaker. The interaction term indicated that the

proposed moderation model did not significantly contribute to predicting clinician broaching behavior. However, organizational R/S competence significantly predicted clinicians' broaching behavior.

Organizational R/S competence, while not a moderating variable in this study, does serve to predict clinician broaching behavior. This finding aligns with much of the current counseling literature that has encouraged increased focus on R/S training at the institutional level (Oxhandler & Pargament, 2018; Crook-Lyon et al., 2012; Magaldi-Dopman, 2014; Hodge, 2007). The results of this study provide evidence of a possible systemic mechanism for improving clinician ability to broach R/S content in sessions. This finding is particularly meaningful as it aligns with the ecological model for multicultural counseling presented in Chapter 2. Neville and Mobley's (2001) updated version of Bronfenbrenner's (1977) ecological model explains human behavior through the interactions of social constructs and identities that are occurring at different levels. This study offers concrete data demonstrating that clinician broaching behavior (e.g., this occurs at the individual/person system level) is directly related to environment (e.g., microlevel system), specifically the perceived level of organizational R/S competence. Clinicians have previously reported a belief that the "profession of psychology" stifles discussion of R/S and fears that if R/S is broached or discussed in a professional or training setting they would be labeled a "fanatic" (Magaldi & Trub, 2018).

Organizational R/S competence, as measured by this study, examined whether the clinicians' perceived their organization as being aligned with values or holding beliefs that are supportive or positive towards R/S. Theory of planned behavior proposed that a construct called subjective norms is directly predictive of intention to behave in a specific manner and indirectly

predictive of the performing said behavior (e.g., broaching R/S). Organization competence may be viewed as a construct that is related to or has overlapping qualities with TPB's subjective norms. Subjective norms describe the individual person's perception of how favorable or unfavorable their behavior will be viewed by others in their environment or their belief about how important others (e.g., respected colleagues or a supervisor) would behave within a specific environment. These perceptions and beliefs shaped the individual's behavior, which in the case of this study would refer to broaching. The finding from this study offers support for the theory that clinician's perception and belief about how others in their environment relate to R/S content, specifically, if they view others as respectful, open, and sensitive to R/S content, they are more likely to themselves be respectful, open, and sensitive to R/S content (e.g., engage in broaching behavior).

Post-hoc Findings

This study found that years of practice was related to increased broaching behavior. It appears that the more time a person has spent as a clinician, the more comfortable they become navigating and actively engaging with R/S topics. It is unclear if this is the result of an increase in personal sense of comfort with R/S or as individuals progress in their career, they fill in knowledge gaps via training, consultation, and supervision. Magaldi & Trub (2018) found three reasons clinician avoided discussion and self-disclosure of R/S. First, R/S represents "an aspect of their identity that was yet unresolved," second was "feelings of personal discomfort," and third, clinicians did not discuss for the sake of the client (Magaldi & Trub, 2018). Potentially, as one increases in professional seniority, one may have enough experiences grappling with

unfamiliar content in psychotherapy and slowly resolve feelings of “persona discomfort” and solidify an understanding of one’s personal R/S identity.

Additionally, this study found that R/S affiliation was related to broaching behavior. Specifically, that those clinicians who identified as affiliated with R/S were more likely to broach. This finding is aligned with Magaldi-Dopman et al. (2011) who found that those psychologists with strong R/S affiliation and those who identified as atheist/agnostic were most likely to “make space” for R/S discussion in therapy sessions. Those who were “mildly” associated with R/S were least likely. Findings from this study are different from Magaldi-Dopman et al. (2011) in that non-RS affiliated clinicians were less likely to broach R/S than their R/S affiliated counterparts. Magaldi-Dopman et al. (2011) noted that non-RS clinicians would consistently broach R/S out of a fear that due to their non-affiliation, they would be likely to miss relevant R/S content. It was as if clinicians who were not R/S affiliated were more vigilant about the need to attend to and broach R/S factors. In the current study, however, R/S affiliated clinicians broached R/S significantly more than non-RS affiliated. I proposed in chapter 2 of this study that R/S affiliation may be viewed in the same vein as TPB’s “attitude” construct. In TPB, a person’s positive attitude towards the behavior was likely to increase the chance of the person performing the behavior, and vice versa. In this study, R/S affiliation (e.g., a positive attitude towards R/S) was predictive of broaching. This study did not use R/S affiliation in its main analysis; however, it demonstrates relation to R/S broaching. It would be interesting to consider both R/S affiliation and intensity of R/S affiliation to ascertain if they are predictive of R/S broaching. This study did not measure the intensity of R/S affiliation, yet this variable may further predict or moderate the relationship between R/S affiliation and R/S broaching. A case

can be made that intensity of R/S affiliation or disaffiliation is more closely aligned with the attitude construct of TPB.

Limitations and considerations for future research

A critical limitation for this study is the small sample size. Power analysis conducted prior to study recruitment recommended a minimum sample size of 226. The current study retained useable data from 147 participants. The limited sample size is especially significant in light of the non-significant finding ($p = .052$) for the moderator variable in step 4 of the regression analysis. With a larger sample size, the moderation analysis and several of the post-hoc analyses may have reached statistical significance.

A second limitation involved the manner in which data was collected. Measures assessing R/S competence are in their infancy and as a result they either have not been heavily used in research or previously validated (Oxhandler & Pargament, 2018). The aim of this study was to examine how R/S competence relates to broaching behavior. Because competence represents a complex construct, some measures assess attitudes that are indicative of competence, some assess a combination of attitudes, knowledge, and skills, and others simply present a list of competencies and assess the degree to which the respondent agrees with competencies (Oxhandler & Pargament, 2018). Ideally, this study would have assessed R/S competence as it pertains to “skills” because broaching behavior is considered a skill. However, an adequate measure of skills was not available (Oxhandler & Pargament, 2018). Additionally, there currently exists one measure of R/S competence at the organizational level. As a result, this study’s measure of individual R/S competence was primarily focused on attitudes towards R/S

and the organizational R/S competence was primarily focused on the perceived beliefs and values of the organization. Neither of these is related to skills.

A third limitation is the use of snowball sampling to collect data. While snowball sampling allowed the possibility of collecting data from a variety of individuals, it may have resulted in a response bias. There is the potential that those who elected to respond to the current study were those individuals who preferred topics related to religion and spirituality. If that were the case, the current sample may not be truly representative of the population of clinicians in our field. Another issue related to data collection involves the current sample being restricted to clinicians training and practicing in the United States. It is possible that clinicians practicing and training outside of the United States would present with different and important views on broaching R/S in psychotherapy.

Future research is needed to clarify R/S competence at the individual and organizational levels. This study provides data demonstrating the correlation between R/S competence and broaching behavior; however, a clarification of the competence construct will allow for a superior understanding of the aspects of competence that are worth measuring in order to understand clinician behavior in-session. Improved understanding of the construct of R/S competence may lead to the creation and validation of more accurate measures. Future research is needed to further clarify the constructs R/S and non-R/S affiliation. The current study found a link between R/S affiliation and broaching, however, past research found links between strong R/S and strong non-R/S affiliation and clinician willingness to discuss R/S (Magaldi-Dopman et al. (2011)). The current study did not find a link between non-R/S affiliation and broaching. Additionally, this study did not examine the intensity of the clinician R/S affiliation. Viewing

R/S affiliation as a more robust variable and inquiring about both R/S affiliation and intensity/nature of the affiliation may yield helpful data regarding R/S salience and meaning. Finally, future research can further explore this study's finding related to age and R/S broaching. Obtaining an understanding of whether increased R/S broaching behavior is related to length of time as a professional clinician, if it is related to aging and improved comfort with self, or if an undiscovered variable is contributing to the relationship.

In addition to clarifying R/S competence, future research would benefit from defining the concepts of "religious" and "spiritual." The concepts are challenging to define and conceptualize due to their incredibly personal nature and variety of expression across cultures. For some clients, broaching R/S may include discussions where the word "God" is explicitly used or where they have the opportunity to identify within psychotherapy as "atheist" or "agnostic." For other clients, asking about their "12-step" participation or meditation practice, may constitute a broach of R/S. R/S are constructs that can encompass an incredibly wide variety of meanings. Without standard agreement about what constitutes R/S, it is possible that there is no unified understanding of the wide range of topics which may constitute broaching R/S.

Finally, future studies may want to consider the complexity of broaching R/S and note that there may be a multitude of variables at play that were not addressed by this study. Religion and spirituality can be sensitive topics and the clinician's ability to broach may be related to factors such as the in the moment, interpersonal dynamics between clinician and client, the clinician's level of readiness for confrontation, or the clinician may have difficulty identifying how and where R/S is important to the client if it is not obviously tied to the presenting problem. This study offers an initial foray into understanding clinician broaching behavior as it pertains to

R/S in psychotherapy, however, more research is needed to make sense of a potentially nuanced topic where multiple other factors may contribute to determining whether clinicians broach R/S.

Implications for clinical practice and training

Findings from this study have significant implications at the individual and organizational levels as it relates to the importance of R/S training for graduate student clinicians and professional clinicians. It is imperative clinicians have R/S competence and that clinicians perceive their places of work and/or places of training as institutions that have a positive attitude towards and value for R/S in clinical work.

At the individual level, it is important that clinicians who either have an interest in R/S or those who work/train in settings where R/S issues are salient to presenting problems or treatment engage in practices to increase R/S competence. This can include seeking trainings, enrolling in coursework related to R/S, engaging in practices of personal reflection related to one's own R/S beliefs and biases, seeking supervision related to R/S, consulting with colleagues and/or R/S professionals such as chaplains, clergy, pastors, spiritual teachers, etc., and joining professional organizations (e.g., Division 36). Additionally, our study found that R/S competence is particularly important for clinicians who are "younger" in age (below 40 years of age) and those clinicians who are in their "early career" (10 years of work or less). Our findings demonstrated that clinicians who fall into those two groups are much less likely to broach R/S factors. Targeting trainings and workshops to clinicians in this area is likely to result in the greatest improvements in R/S competence and therefore R/S broaching behavior.

It is imperative to note that the responsibility for increasing R/S competence and R/S broaching does not fall squarely on the shoulders of the individual clinician. Our study found that

environmental factors (e.g., organizational competence and support for R/S) lead to an increase in culturally competent behavior on the part of the clinician. This implies that organizations (including training sites, academic institutions, and places of work) would benefit from improving their handling of R/S issues. A starting point for many academic institutions, training sites, and professional organizations may include simply acknowledging the importance of R/S and possible involvement in the case conceptualization with client issues. Organizations can offer clinicians opportunities to complete trainings related to R/S, engage in didactics, and have their own personal beliefs and biases examined. Neville and Mobley (2001) put forward questions for organizations to examine in relation to how their environment handles cultural issues and identities and those questions (stated in Chapter 2) were re-written to speak specifically to R/S. The importance of environment is supported by current literature. Saunders et al. (2014) found that if mental health trainees and professional psychologists lack exposure to R/S from their environment or organization, they may develop the perception over time that issues related to R/S are not relevant to clients or clinical work. It is almost as though early career functions as a critical period where exposure to R/S will inform its importance in clinical work.

Generally, clinicians may want to consider where they fall on the broaching continuum when it comes to broaching R/S in psychotherapy. It may be easy for clinicians to have a dichotomous view of their broaching behavior. Either they are “comfortable” or “uncomfortable” with broaching R/S or they “do” or “do not” broach R/S. However, the broaching construct encompasses four styles of broaching behavior and offers clinicians and organizations a more nuanced view of how clinicians approach R/S discussions with clients.

Findings from this study may be of benefit to clients who have R/S issues that are salient to their presenting problem(s). As clinicians and organizations improve their R/S competence, they will be better equipped to provide clinical services to individuals who have elements of R/S as part of their clinical picture.

Conclusion

This study utilized a moderation model to explore how organizational R/S competence moderates the relationship between clinician R/S competence and broaching behavior. Findings support the importance of developing clinician R/S competence and that organizations would be better served finding ways of incorporating R/S into clinical work or training. Both clinician's R/S competence and organizational competence were significantly correlated with broaching behavior. The idea that the environment influences the clinician's behavior is supported by the ecological model of multicultural counseling and TPB. This study utilized the aforementioned theoretical frameworks, along with MCO, in order to more thoroughly and comprehensively understand clinician's behavior in the psychotherapy session. Behavior is a complex process and by utilizing elements of the MCO (e.g., cultural opportunities and cultural comfort), TPB (e.g., attitudes towards behavior and subjective norms), and ecological model of multicultural counseling (e.g., individual/person level system and microlevel systems) provided an incredibly encompassing overview of factors that impact clinician behavior. In conclusion, broaching R/S appears to represent an important area of development for clinicians and is correlated with R/S competence at the individual and organizational levels.

APPENDIX A
INFORMED CONSENT

CONSENT TO PARTICIPATE IN RESEARCH

Project Title: Broaching the Topics of Religion and Spirituality in Therapy

Researcher(s): Papa Adams, M.S. and Eunju Yoon, Ph.D.

You are being asked to take part in a research study being conducted by Papa Adams, a doctoral student in Counseling Psychology at Loyola University Chicago, under Dr. Eunju Yoon's supervision. You are being asked to participate because we would like to examine the factors that influence whether therapists broach the topics of religion and spirituality in therapy. If you are a licensed mental health professional (social worker, counselor, marriage and family therapist, or psychologist), a pre-licensure mental health professional, or a graduate student-in-training (currently enrolled in a mental health training program with at least one semester of clinical experience) and perform at least two hours a week of individual or group therapy, you may participate in this study. Approximately 200-300 individuals will be asked to participate in this study. Please read this form carefully and ask any questions you may have before deciding whether to participate in the study.

Purpose: The purpose of this study is to examine the factors that influence whether therapists broach the topics of religion and spirituality in therapy.

Procedures: If you agree to be in the study, you will be asked to answer a set of questionnaires about your demographic information, level of competence in the areas of religion/spirituality, level of competence of the organization your work/train with towards religion/spirituality, and your attitudes and behaviors towards broaching the topics of religion/spirituality. It should take you approximately 8-12 minutes to complete the survey.

Risks/Benefits: There are no foreseeable risks involved in participating in this research beyond those experienced in everyday life. There are no direct benefits to you, but you may be motivated to consider the role of religion/spirituality in the practice of psychotherapy. You will also be helping psychology professionals by providing a better understanding of the intricate relations among mental health, psychotherapy, and religion/spirituality (which includes atheism and agnosticism).

Compensation: Participation in this study will not be compensated

Confidentiality: Information obtained as a result of this survey will be kept confidential. There is no way a participant can be identified in this study. Worker IDs are kept in confidential and secure, are not lined back to survey data, and are deleted after use.

Voluntary Participation: Participation in this study is voluntary. If you do not want to be in this study, you may simply disregard this invitation. Even if you decide to participate, you are free not to answer any question or to withdraw from participation at any time without penalty.

Contacts and Questions: If you have questions about this research study, please contact Papa Adams at (847)-712-6299 or padams4@luc.edu or my research supervisor Dr. Eunju Yoon at (312) 915-6461 or eyoon@luc.edu. If you have questions about your rights as a research participant, you may contact the Loyola University Office of Research Services at (773) 508-2689.

Statement of Consent: By completing the survey, you are agreeing to participate in the research. Your completion of the survey will indicate consent for an informed participation. If you decide not to participate in this study, you may simply disregard this survey. Thank you very much for your time and effort.

APPENDIX B
DEMOGRAPHICS QUESTIONS

Inclusion/Exclusion Questions

1. How do you identify within the mental health field?
 - Trainee
 - Contractor
 - Employee of an organization (either a hospital, school, college/university, community mental health agency, or employed by a group practice)
 - Solo practitioner (private practice)

2. Do you provide at least two hours per week of mental health case management or individual or group therapy services to clients?
 - Yes
 - No

Demographics

1. Age: _____

2. What is your gender identity?
 - Cisgender male
 - Cisgender female
 - Transgender male
 - Transgender female
 - Gender non-binary
 - A gender not listed here
 - Prefer not to say

3. What is your Race/Ethnicity?
 - African-American/Black
 - Asian/Pacific Islander
 - Caucasian/White
 - Hispanic/Latinx
 - Native American/Alaskan Native/Indigenous
 - Biracial/Multiracial
 - Other, please specify

4. Are you a student/trainee or mental health professional?
 - Student/trainee

_____Mental health professional

4a. For students/trainees: What is your current field of study/training?

_____Social work

_____Counseling (including clinical mental health, community, school, college student development)

_____Psychology (including clinical, counseling, and school)

_____Marriage and Family Therapy

_____Other

4b. For mental health professionals: What is your professional affiliation?

_____Social work

_____Counseling (including clinical mental health, community, school, college student development)

_____Psychology (including clinical, counseling, and school)

_____Marriage and Family Therapy

_____Other

4c. For mental health professionals: Are you a licensed mental health professional?

_____Yes

_____No

5. What type of setting is your work/training site (check the most applicable one)?

_____Hospital (including VA, Academic Medical Center, State)

_____Community Mental Health

_____College/University/Community College

_____High School/Middle School/Elementary School

_____Group Private Practice

_____Other, please specify

6. What is the name of your work/training site (this information will not be used to identify individual participants but will be used in aggregate for data analysis)?

7. Please describe your religious/spiritual identity

- Agnostic
- Apostate
- Atheist
- Buddhist
- Christian (includes Protestant, Catholic, and other Christian faiths)
- Hindu
- Islam
- Jewish
- Muslim
- Sikh
- Spiritual but not religious
- Unaffiliated with specific religion or spiritual teaching
- Prefer not to say
- Other (please specify)

APPENDIX C
PARTICIPANT RECRUITMENT SCRIPT

Broaching the Topics of Religion and Spirituality in Therapy

Dear Participant,

I am a doctoral student in Counseling Psychology Program at Loyola University Chicago. **I am conducting a survey study to examine the factors that influence whether therapists broach the topics of religion and spirituality in therapy.**

This study is being conducted under the supervision of Dr. Eunju Yoon. Your participation in this study will be a great service towards providing the field of psychology a better understanding of the intricate relations among mental health, psychotherapy, and religion/spirituality (which includes atheism and agnosticism). **The survey will take approximately 8-12 minutes to complete.**

To participate in this study you must be either a *licensed mental health professional* (social worker, counselor, marriage and family therapist, or psychologist), a *pre-licensure mental health professional*, or a *graduate student-in-training* (currently enrolled in a mental health training program with at least one semester of clinical experience); *perform at least two hours a week of individual or group therapy*. There is no compensation for participation in this study.

If you are interested in this research, please click the link below:

https://luc.co1.qualtrics.com/jfe/form/SV_9ny1Y8zELI3cuPA

.....

Your participation is greatly appreciated.

Sincerely,

Papa Adams, M.S.
Doctoral Student
Counseling Psychology, Loyola University Chicago

Eunju Yoon, Ph.D.
Associate Professor
Counseling Psychology, Loyola University Chicago

REFERENCE LIST

- Aiken, L. S., & West, S. G. (1991). Multiple regression: Testing and interpreting interactions.
- Ajzen, I. (1991). The theory of planned behavior. *Organizational behavior and human decision processes*, 50(2), 179-211.
- Ajzen, I. (2020). The theory of planned behavior: Frequently asked questions. *Human Behavior and Emerging Technologies*, 2(4), 314-324.
- Astin, A. W. (1993). Diversity and multiculturalism on the campus: How are students affected?. *Change: The Magazine of Higher Learning*, 25(2), 44-49.
- Astle, S., Toews, M., Topham, G., & Vennum, A. (2022). To talk or not to talk: An analysis of parents' intentions to talk with children about different sexual topics using the theory of planned behavior. *Sexuality Research and Social Policy*, 19(2), 705-721.
- Barron, G., & Yechiam, E. (2002). Private e-mail requests and the diffusion of responsibility. *Computers in Human Behavior*, 18(5), 507-520.
- Belavich, T. G. (1995, August). The role of religion in coping with daily hassles. Paper presented at the 103rd Annual Convention of the American Psychological Association, New York, NY.
- Breslin, C., Li, S., Tupker, E., & Sdao-Jarvie, K. (2001). Application of the theory of planned behavior to predict research dissemination: A prospective study among addiction counselors. *Science Communication*, 22(4), 423-437.
- Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American psychologist*, 32(7), 513
- Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Harvard university press.
- Bronfenbrenner, U. (1992). *Ecological systems theory*. Jessica Kingsley Publishers.
- Brown, O., Elkonin, D., & Naicker, S. (2013). The use of religion and spirituality in psychotherapy: Enablers and barriers. *Journal of Religion and Health*, 52(4), 1131-1146.

- Cashwell, C. S., & Young, J. S. (Eds.). (2005). *Integrating spirituality and religion into counseling: A guide to competent practice*. Alexandria, VA: American Counseling Association.
- Cohen, J. (1992). A power primer. *Psychological bulletin*, *112*(1), 155.
- Constantine, M. G. (2001). Multicultural training, theoretical orientation, empathy, and multicultural case conceptualization ability in counselors. *Journal of Mental Health Counseling*, *23*(4), 357.
- Crabtree, S. A., Bell, C. A., Rupert, D. A., Sandage, S. J., Devor, N. G., & Stavros, G. (2021). Humility, differentiation of self, and clinical training in spiritual and religious competence. *Journal of Spirituality in Mental Health*, *23*(4), 342-362.
- Crook-Lyon, R. E., O'Grady, K. A., Smith, T. B., Jensen, D. R., Golightly, T., & Potkar, K. A. (2012). Addressing religious and spiritual diversity in graduate training and multicultural education for professional psychologists. *Psychology of Religion and Spirituality*, *4*(3), 169.
- Cross, T. L. (1989). Towards a culturally competent system of care: A monograph on effective services for minority children who are severely emotionally disturbed.
- D'Andrea, M., Daniels, J., & Heck, R. (1991). Evaluating the impact of multicultural counseling training. *Journal of Counseling & Development*, *70*(1), 143-150.
- Dailey, S. F. (2012). Competency 10: Quantitative Assessment of the spiritual domain. *Washington: Argosy University. ACA site*, 28.
- Dailey, S. F., Robertson, L. A., & Gill, C. S. (2015). Spiritual competency scale: Further analysis. *Measurement and Evaluation in Counseling and Development*, *48*(1), 15-29.
- Davis, D. E., DeBlaere, C., Owen, J., Hook, J. N., Rivera, D. P., Choe, E., ... & Placeres, V. (2018). The multicultural orientation framework: A narrative review. *Psychotherapy*, *55*(1), 89.
- Day-Vines, N. L., Wood, S. M., Grothaus, T., Craigen, L., Holman, A., Dotson-Blake, K., & Douglass, M. J. (2007). Broaching the subjects of race, ethnicity, and culture during the counseling process. *Journal of Counseling & Development*, *85*(4), 401-409.
- Day-Vines, N. L., Bryan, J., & Griffin, D. (2013). The Broaching Attitudes and Behavior Survey (BABS): An exploratory assessment of its dimensionality. *Journal of Multicultural Counseling and Development*, *41*(4), 210-223.

- Day-Vines, N. L., Booker Ammah, B., Steen, S., & Arnold, K. M. (2018). Getting comfortable with discomfort: Preparing counselor trainees to broach racial, ethnic, and cultural factors with clients during counseling. *International Journal for the Advancement of Counselling, 40*(2), 89-104.
- Day-Vines, N. L., Cluxton-Keller, F., Agorsor, C., Gubara, S., & Otabil, N. A. A. (2020). The multidimensional model of broaching behavior. *Journal of Counseling & Development, 98*(1), 107-118.
- DeAngelis, T. (2015). In search of cultural competence. *Monitor on Psychology, 46*(3), 64.
- Dobmeier, R. A., & Reiner, S. M. (2012). Spirituality in the counselor education curriculum: A national survey of student perceptions. *Counseling and Values, 57*(1), 47-65.
- Drew, D. and Banks, J., "Religion and Spirituality in Clinical Practice: An Exploration of Reluctance Among Practitioners." (2019). Electronic Theses, Projects, and Dissertations. 858.
- Drew, D., Banks, J., & Joseph, R. (2022). Religion and spirituality in clinical practice: an exploration of comfort and discomfort among practitioners. *Journal of Religion & Spirituality in Social Work: Social Thought, 41*(1), 104-120.
- Evans, A. L., & Nelson, J. K. (2021). The Value of Adapting Counseling to Client's Spirituality and Religion: Evidence-Based Relationship Factors. *Religions, 12*(11), 951.
- Farmer, L. B., Welfare, L. E., & Burge, P. L. (2013). Counselor competence with lesbian, gay, and bisexual clients: Differences among practice settings. *Journal of Multicultural Counseling and Development, 41*(4), 194-209.
- Faul, F., Erdfelder, E., Buchner, A., & Lang, A.-G. (2009). Statistical power analyses using G*Power 3.1: Tests for correlation and regression analyses. *Behavior Research Methods, 41*, 1149-1160.
- Fishbein, M., & Ajzen, I. (2010). Predicting and changing behavior: The reasoned action approach, New York, NY: Psychology Press.
- Fluellen, S. J. (2007). *Development of the Spiritual and Religious Competency Assessment (SARCA): An instrument to measure competency in supervisees*. Oklahoma State University.
- Fontana, D. (2003). *Psychology, religion, and spirituality*. Oxford: Bps Blackwell.
- Frazier, P. A., Tix, A. P., & Barron, K. E. (2004). Testing moderator and mediator effects in counseling psychology research. *Journal of counseling psychology, 51*(1), 115.

- Freud, S. (2012). *The future of an illusion*. Broadview Press.
- Furr, S. R., & Carroll, J. J. (2003). Critical incidents in student counselor development. *Journal of Counseling & Development, 81*(4), 483-489.
- Gafford, J., Raines, T. C., Sinha, S., DeBlaere, C., Davis, D. E., Hook, J. N., & Owen, J. (2019). Cultural humility as a spiritually focused intervention in correctional settings: The role of therapists' multicultural orientation. *Journal of psychology and theology, 47*(3), 187-201.
- Gallup. (2015). Religion. Retrieved from <http://www.gallup.com/poll/1690/religion.aspx>.
- Gloria, A. M., & Pope-Davis, D. B. (1997). Cultural ambience: The importance of a culturally aware learning environment in the training and education of counselors.
- Graham, S., Furr, S., Flowers, C., & Burke, M. T. (2001). Research and theory religion and spirituality in coping with stress. *Counseling and Values, 46*(1), 2-13.
- Hagger, M. S., & Chatzisarantis, N. L. (2006). Self-identity and the theory of planned behaviour: Between-and within-participants analyses. *British Journal of Social Psychology, 45*(4), 731-757.
- Hathaway, W. L., Scott, S. Y., & Garver, S. A. (2004). Assessing religious/spiritual functioning: A neglected domain in clinical practice?. *Professional Psychology: Research and Practice, 35*(1), 97.
- Henriksen Jr, R. C., Polonyi, M. A., Bornsheuer-Boswell, J. N., Greger, R. G., & Watts, R. E. (2015). Counseling students' perceptions of religious/spiritual counseling training: A qualitative study. *Journal of Counseling & Development, 93*(1), 59-69.
- Hodge, D. R. (2004). Spirituality and people with mental illness: Developing spiritual competency in assessment and intervention. *Families in Society, 85*(1), 36-44
- Hodge, D. R. (2007). The spiritual competence scale: A new instrument for assessing spiritual competence at the programmatic level. *Research on Social Work Practice, 17*(2), 287-294.
- Hodge, D. R., & Gillespie, D. F. (2007). Phrase completion scales: a better measurement approach than Likert scales?. *Journal of Social Service Research, 33*(4), 1-12.
- Hodge, D. R., Limb, G. E., & Cross, T. L. (2009). Moving from colonization toward balance and harmony: A Native American perspective on wellness. *Social work, 54*(3), 211-219.
- Hodge, D. R. (2018). Spiritual competence: What it is, why it is necessary, and how to develop it. *Journal of Ethnic & Cultural Diversity in Social Work, 27*(2), 124-139.

- Hook, J. N., Davis, D. E., Owen, J., Worthington Jr, E. L., & Utsey, S. O. (2013). Cultural humility: Measuring openness to culturally diverse clients. *Journal of counseling psychology, 60*(3), 353.
- Huey Jr, S. J., Tilley, J. L., Jones, E. O., & Smith, C. A. (2014). The contribution of cultural competence to evidence-based care for ethnically diverse populations. *Annual review of clinical psychology, 10*(1), 305-338.
- James, W. (1961). *The varieties of religious experience: A study in human nature*. London: Collier Books.
- Joinson, A. N., & Reips, U. D. (2007). Personalized salutation, power of sender and response rates to Web-based surveys. *Computers in Human Behavior, 23*(3), 1372-1383.
- Jones, C. T., & Welfare, L. E. (2017). Broaching behaviors of licensed professional counselors: A qualitative inquiry. *Journal of Addictions & Offender Counseling, 38*(1), 48-64.
- Jones, C. T., & Branco, S. F. (2020). The interconnectedness between cultural humility and broaching in clinical supervision: Working from the multicultural orientation framework. *The Clinical Supervisor, 39*(2), 198-209.
- Jung, C. G. (1959). *The basic writings of C. G. Jung*. Modern Library.
- Lau, J., & Ng, K. M. (2014). Conceptualizing the counseling training environment using Bronfenbrenner's ecological theory. *International Journal for the Advancement of Counselling, 36*(4), 423-439.
- Lau, J. M., Ng, K. M., & Vallett, D. B. (2019). The counseling training environment scale: initial development and validity of a self-report measure to assess the counseling training environment. *Measurement and Evaluation in Counseling and Development, 52*(4), 255-273.
- LaFromboise, T. D., Coleman, H. L., & Hernandez, A. (1991). Development and factor structure of the Cross-Cultural Counseling Inventory—Revised. *Professional psychology: Research and practice, 22*(5), 380.
- Lo, H. T., & Fung, K. P. (2003). Culturally competent psychotherapy. *The Canadian Journal of Psychiatry, 48*(3), 161-170.
- Lopez, S. R. (1997). *Cultural competence in psychotherapy: A guide for clinicians and their supervisors*.
- Lu, J., Woo, H., & Huffman, K. (2018). Spiritual competency scale: A confirmatory factor analysis. *Measurement and Evaluation in Counseling and Development, 51*(4), 219-234.

- Lu, J., Li, C., Potts, C. A., & Ufomadu, J. (2019). An Exploration of Variables that Contribute to Counseling Students' Spiritual Competence Development: Implications for Counselor Education. *International Journal for the Advancement of Counselling*, 1-17.
- Magaldi-Dopman, D. (2014). An "afterthought": Counseling trainees' multicultural competence within the spiritual/religious domain. *Journal of Multicultural Counseling and Development*, 42(4), 194-204.
- Magaldi-Dopman, D., Park-Taylor, J., & Ponterotto, J. G. (2011). Psychotherapists' spiritual, religious, atheist or agnostic identity and their practice of psychotherapy: A grounded theory study. *Psychotherapy research*, 21(3), 286-303.
- Magaldi, D., & Trub, L. (2018). (What) do you believe?: Therapist spiritual/religious/non-religious self-disclosure. *Psychotherapy Research*, 28(3), 484-498.
- McClincey, S. (2016). *Multicultural training in APA-accredited clinical psychology doctoral programs* (Order No. 10246066). Available from ProQuest Dissertations & Theses Global. (1875605443).
- Miller, G. (1999). Spirituality, religion, and CACREP curriculum standards. *Journal of Counseling & Development*, 77, 251-256.
- Moodley, R., & Barnes, C. (2015). Multiculturalism, Religion and Counselling: Freedom to Heal. In *Therapy, Culture and Spirituality* (pp. 7-23). Palgrave Macmillan, London.
- Neville, H. A., Heppner, M. J., Louie, C. E., Thompson, C. E., Brooks, L., & Baker, C. E. (1996). The impact of multicultural training on White racial identity attitudes and therapy competencies. *Professional Psychology: Research and Practice*, 27(1), 83.
- Neville, H. A., & Mobley, M. (2001). Social identities in contexts: An ecological model of multicultural counseling psychology processes. *The Counseling Psychologist*, 29(4), 471-486.
- Neville, H., Spanierman, L., & Doan, B. T. (2006). Exploring the association between color-blind racial ideology and multicultural counseling competencies. *Cultural Diversity and Ethnic Minority Psychology*, 12(2), 275.
- Olson, E. A. (2007). *Religion and spirituality in counselor training: Perceived importance of counselor trainees* (Order No. 3281643). Available from ProQuest Dissertations & Theses Global. (304826082).
- Ottavi, T. M., Pope-Davis, D. B., & Dings, J. G. (1994). Relationship between White racial identity attitudes and self-reported multicultural counseling competencies. *Journal of counseling psychology*, 41(2), 149.

- Owen, J. J., Tao, K., Leach, M. M., & Rodolfa, E. (2011). Clients' perceptions of their psychotherapists' multicultural orientation. *Psychotherapy, 48*(3), 274.
- Owen, J. (2013). Early career perspectives on psychotherapy research and practice: Psychotherapist effects, multicultural orientation, and couple interventions. *Psychotherapy, 50*(4), 496.
- Owen, J., Tao, K. W., Drinane, J. M., Hook, J., Davis, D. E., & Kune, N. F. (2016). Client perceptions of therapists' multicultural orientation: Cultural (missed) opportunities and cultural humility. *Professional Psychology: Research and Practice, 47*(1), 30.
- Owen, J., Drinane, J., Tao, K. W., Adelson, J. L., Hook, J. N., Davis, D., & Fookune, N. (2017). Racial/ethnic disparities in client unilateral termination: The role of therapists' cultural comfort. *Psychotherapy Research, 27*(1), 102-111.
- Oxhandler, H. K., Parrish, D. E., Torres, L. R., & Achenbaum, W. A. (2015). The integration of clients' religion and spirituality in social work practice: A national survey. *Social work, 60*(3), 228-237.
- Oxhandler, H. K., & Giardina, T. D. (2017). Social workers' perceived barriers to and sources of support for integrating clients' religion and spirituality in practice. *Social work, 62*(4), 323-332.
- Oxhandler, H. K., & Parrish, D. E. (2016). The development and validation of the religious/spiritually integrated practice assessment scale. *Research on Social Work Practice, 26*(3), 295-307.
- Oxhandler, H. K., & Parrish, D. E. (2018). Integrating clients' religion/spirituality in clinical practice: A comparison among social workers, psychologists, counselors, marriage and family therapists, and nurses. *Journal of clinical psychology, 74*(4), 680-694.
- Oxhandler, H. K., & Pargament, K. I. (2018). Measuring religious and spiritual competence across helping professions: Previous efforts and future directions. *Spirituality in Clinical Practice, 5*(2), 120.
- Paniagua, F. A. (2013). *Assessing and treating culturally diverse clients: A practical guide*. Sage Publications.
- Park, J. S. (2015). *Assessing spiritually competent practice across mental health graduate students* (Doctoral dissertation, Regent University).
- Pett, M. A., Lackey, N. R., & Sullivan, J. J. (2003). Making sense of factor analysis: The use of factor analysis for instrument development in health care research. Thousand Oaks, CA: Sage.

- PEW Research Center. (2018). When Americans say they believe in God, what do they mean? Retrieved from <https://www.pewtrusts.org/en/trust/archive/fall-2018/when-you-say-you-believe-in-god-what-do-you-mean>
- Pope-Davis, D. B., Ottavi, T. M., & Ottavi, T. M. (1994). Examining the association between self-reported multicultural counseling competencies and demographic variables among counselors. *Journal of Counseling & Development, 72*(6), 651-654.
- Pope-Davis, D. B., Reynolds, A. L., Dings, J. G., & Nielson, D. (1995). Examining multicultural counseling competencies of graduate students in psychology. *Professional Psychology: Research and Practice, 26*(3), 322.
- Pruegger, V. J., & Rogers, T. B. (1994). Cross-cultural sensitivity training: Methods and assessment. *International Journal of Intercultural Relations, 18*(3), 369-387.
- Richards, P. S., Bartz, J. D., & O'Grady, K. A. (2009). Assessing religion and spirituality in counseling: Some reflections and recommendations. *Counseling and Values, 54*(1), 65-79.
- Robertson, L. A. (2010). The spiritual competency scale. *Counseling and Values, 55*(1), 6-24.
- Schulte, D. L., Skinner, T. A., & Claiborn, C. D. (2002). Religious and spiritual issues in counseling psychology training. *The Counseling Psychologist, 30*(1), 118-134.
- Segal, E. A., & Wagaman, M. A. (2015, January). Social empathy as a framework to infuse competency in advancement of social and economic justice in social work education. Society for Social Work and Research (SSWR) The Society for Social and Behavioral Importance of Increased Longevity Conference, New Orleans, LA.
- Sandage, S. J., & Strawn, B. D. (Eds.). (2022). Introduction: Spiritual diversity in psychotherapy. In S. J. Sandage & B. D. Strawn (Eds.), *Spiritual diversity in psychotherapy: Engaging the sacred in clinical practice* (pp. 3–15). American Psychological Association
- Saunders, S. M., Petrik, M. L., & Miller, M. L. (2014). Psychology doctoral students' perspectives on addressing spirituality and religion with clients: Associations with personal preferences and training. *Psychology of Religion and Spirituality, 6*(1), 1.
- Shannon, B. J. (2018). Perceived Clinician Competence to Work with Spiritual Issues in Supervision.
- Shaw, S. (2016). Practicing Cultural Humility. American Counseling Association, Counseling Today.
- Sheridan, M. J., Bullis, R. K., Adcock, C. R., Berlin, S. D., & Miller, P. C. (1992). Practitioners' personal and professional attitudes and behaviors toward religion and spirituality: Issues for education and practice. *Journal of Social Work Education, 28*(2), 190-203.

- Sodowsky, G. R., Taffe, R. C., Gutkin, T. B., & Wise, S. L. (1994). Development of the Multicultural Counseling Inventory: A self-report measure of multicultural competencies. *Journal of Counseling Psychology, 41*(2), 137.
- Sodowsky, G. R., Kuo-Jackson, P. Y., Richardson, M. F., & Corey, A. T. (1998). Correlates of self-reported multicultural competencies: Counselor multicultural social desirability, race, social inadequacy, locus of control racial ideology, and multicultural training. *Journal of Counseling Psychology, 45*(3), 256.
- Sparks, P., & Guthrie, C. (1998). Self-identity and the theory of planned behavior: Useful addition or unhelpful artifice? *Journal of Applied Social Psychology, 28*, 1393–1410
- Streib, H., & Klein, C. (2013). Atheists, agnostics, and apostates. In Pargament, K. I., Mahoney, A. E., & Shafranske, E. P. (Eds), *APA handbook of psychology, religion, and spirituality (Vol 2): An applied psychology of religion and spirituality* (pp. 713-728). American Psychological Association.
- Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Multicultural Counseling and Development, 20*(2), 64-88.
- Sue, S. (1998). In search of cultural competence in psychotherapy and counseling. *American psychologist, 53*(4), 440.
- Sue, D. W., & Sue, D. (1999). *Counseling the culturally different: Theory and practice*. John Wiley & Sons Inc.
- Sue, D. W., & Torino, G. C. (2005). Racial-cultural competence: Awareness, knowledge, and skills. *Racila-Cultural Psychology and Counseling, 1*.
- Sue, S. (2003). In defense of cultural competency in psychotherapy and treatment. *American Psychologist, 58*(11), 964.
- Sue, S. (2006). Cultural competency: From philosophy to research and practice. *Journal of community Psychology, 34*(2), 237-245.
- Tao, K. W., Owen, J., Pace, B. T., & Imel, Z. E. (2015). A meta-analysis of multicultural competencies and psychotherapy process and outcome. *Journal of Counseling Psychology, 62*(3), 337.
- Vieten, C., Scammell, S., Pilato, R., Ammondson, I., Pargament, K. I., & Lukoff, D. (2013). Spiritual and religious competencies for psychologists. *Psychology of Religion and Spirituality, 5*(3), 129.

- Vieten, C., & Scammell, S. (2015). *Spiritual and religious competencies in clinical practice: Guidelines for psychotherapists and mental health professionals*. New Harbinger Publications.
- Walker, D. F., Gorsuch, R. L., & Tan, S. Y. (2004). Therapists' integration of religion and spirituality in counseling: A meta-analysis. *Counseling and Values, 49*(1), 69-80.
- Wampold, B. E. (2007). Psychotherapy: the humanistic (and effective) treatment. *American Psychologist, 62*(8), 857.
- Weaver, A. J., Pargament, K. I., Flannelly, K. J., & Oppenheimer, J. E. (2006). Trends in the scientific study of religion, spirituality, and health: 1965–2000. *Journal of Religion and Health, 45*(2), 208-214.
- West, S. G., Finch, J. F., & Curran, P. J. (1995). Structural equation models with non-normal variables: Problems and remedies. In R. H. Hoyle (Ed.), *Structural equation modeling: Concepts, issues, and applications* (pp. 56–75). Sage Publications.
- Whaley, A. L., & Davis, K. E. (2007). Cultural competence and evidence-based practice in mental health services: a complementary perspective. *American Psychologist, 62*(6), 563.
- Winkeljohn Black, S., Drinane, J. M., Owen, J., DeBlaere, C., & Davis, D. (2021). Integrating spirituality as a multicultural component into time-limited psychotherapy: Two case studies. *Professional Psychology: Research and Practice, 52*(2).
- Worthington, R. L., Mobley, M., Franks, R. P., & Tan, J. A. (2000). Multicultural counseling competencies: Verbal content, counselor attributions, and social desirability. *Journal of Counseling Psychology, 47*(4), 460.
- Young, J. S., Cashwell, C., Wiggins-Frame, M., & Belaire, C. (2002). Spiritual and religious competencies: A national survey of CACREP-accredited programs. *Counseling and Values, 47*(1), 22–33.
- Zinnbauer, B. J. (2013). *Models of healthy and unhealthy religion and spirituality*. In K. I. Pargament, A. Mahoney, & E. P. Shafranske (Eds.), *APA handbooks in psychology®. APA handbook of psychology, religion, and spirituality (Vol. 2): An applied psychology of religion and spirituality* (p. 71–89). American Psychological Association

VITA

Papa Adams was born in Chicago, Illinois and raised in Evanston, Illinois. Before attending Loyola University Chicago, he attended the Williams College, in Williamstown, Massachusetts, where he earned a Bachelor of Arts in Psychology in 2005. From 2011 to 2014, he also attended DePaul University, where he received a Master of Science in Community Counseling.

While at Loyola, Mr. Adams served as a Teaching Assistant and member of multiple research teams. His research pursuits contributed to the publication of three peer-reviewed articles. He was awarded a travel award through the Student Development Committee to present a poster at the 2019 APA Annual Conference in Chicago, IL. He served as an adjunct lecturer for one semester of an undergraduate psychology course, Psychopathology. Mr. Adams also was awarded the Diversifying High Education Faculty in Illinois Fellowship during the 2019-2021 academic years. In 2018, Mr. Adams was selected as an alternate for the Albert Schweitzer Fellowship, which is awarded to students for designing and implementing a community-based prevention and intervention project. Additionally, Mr. Adams was of service to the School of Education from 2018-2021, as a speaker at the New Student Convocation where he was asked to provide new students with a perspective on the graduate student experience at Loyola.

Mr. Adams recently completed his pre-doctoral internship in psychology at the Captain James A. Lovell Federal Healthcare Center. He will be completing his post-doctoral fellowship

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