Short Title: SPIRITUAL AND RELIGIOUS COMPETENCIES IN PSYCHOTHERAPY

Examining the Role of Spiritual and Religious Competencies in Psychotherapy: A Registered Report

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Abstract

Religion and spirituality (R/S) are core areas of identity, intersectionality, and psychological functioning that can be highly relevant for promoting clients' engagement and flourishing in psychotherapy. However, when considering the basic attitudes, knowledge, and skills for effectively addressing spiritual and religious dimensions of clients' lives, lack of research in R/S competencies leads many mental health training programs and service organizations to omit clients' R/S from routine training activities and clinical practice. To our knowledge, research has not examined the association between specific facets of R/S competence and multicultural competence in general or whether the acquisition of R/S competencies are linked with treatment outcomes. In this Registered Report (RR), we will test trajectories of clients' ratings of their psychological distress along with perceptions of their clinicians' R/S competence and cultural humility. In total, a minimum of 200 adults pursuing psychotherapy in a community-based behavioral health clinic in the Southeastern United States will complete session-to-session assessments of these outcomes over a four-month period. We will use multivariate growth modeling to test two hypotheses: (H1) Clients will, on average, demonstrate decreases in psychological distress over the course of treatment; and (H2) Clinicians' trajectories of R/S competence will be uniquely linked with their clients' experiences of cultural humility, stronger working alliance, and decreased psychological distress. Drawing upon the RR format, this practice-based evidence study will generate foundational scientific knowledge regarding the role of R/S competencies in psychotherapy.

A substantive evidence base affirms the cultural and clinical relevance of attending to peoples' religious faith and/or spirituality (R/S) in mental health care. Roughly 80% of the U.S. population affiliates with an organized religion (Gallup, 2020), and "spiritual, but not religious" persons comprise an increasingly large subset of non-affiliated persons (Ellison & MacFarland, 2013). Nationwide surveys also revealed 8 in 10 Americans indicate religion is at least somewhat important in their lives, 9 in 10 believe in a "God or Universal Spirit," and over half pray daily and/or experience spiritual well-being at least weekly (Gallup, 2020; Pew Research Center, 2015). These findings might partly explain why clients reported that, generally, they prefer clinicians to assess, discuss, and explore integrating their R/S in care (Abernethy et al., 2020; Currier et al., 2020; Oxhandler et al., 2021; Rosmarin et al., 2015). Advances in translational research also support the utility of clinical practices that attend to helpful (Koenig et al., 2012) and harmful (Bockrath et al., 2021) consequences of R/S on mental health. Specifically, there are validated assessments to assess many intersectional aspects of R/S, including tools for religious minorities and non-religious spiritualities (Hill & Edwards, 2013), and a sizeable research literature supporting the effectiveness of psychotherapies that incorporate perspectives and content from clients' R/S in culturally congruent ways (often termed "spiritually integrated psychotherapies"; Captari et al., 2018). Nonetheless, other work indicates limited awareness, knowledge, and skills related to R/S leads clinicians to neglect clients' R/S in their routine clinical practice (Delaney et al., 2007; Oxhandler et al., 2015; Oxhandler & Parrish, 2018).

Several systemic barriers hinder clinicians' development of foundational competencies for addressing this area of diversity and psychological functioning. Because most graduate and post-graduate programs in mental health professions do not formally address R/S in coursework, practica, or internship training (Crook et al., 2012; Oxhandler et al., 2015; Oxhandler & Parrish,

2018; Schafer et al., 2011; Vogel et al., 2013), clinicians might overlook the relevance of R/S or feel inadequate for discussing their clients' R/S (Rudolfsson & Milstein, 2019). Lack of consensus about competencies related to R/S also restricts training and practice in most professions (Vieten & Lukoff, 2021). For example, R/S are mentioned across American Psychological Association's (APA) Professional Practice Guidelines; however, these domains are typically only named in lists of sources of identity (e.g., race, gender), such that clinicians have little guidance about how to address R/S in their work. Finally, research has not examined whether clinicians' capability to address spiritual and religious dimensions of peoples' lives might influence treatment outcomes. Without such evidence, many training programs and professional organizations lack a warrant for devoting resources to promoting the acquisition of specific facets of R/S competence. Therefore, this practice-based evidence study will describe and compare trajectories in clinicians' R/S competence and clinical outcomes by focusing on session-to-session assessments of religiously diverse clients engaging in psychotherapies in a community-based behavioral health clinic.

Religion, Spirituality, and Mental Health Care

Spiritually competent care aligns with ongoing shifts in organizational values and strategies within the mental health care system. Honoring clients' characteristics, culture, and preferences is a pillar of evidence-based practice (APA Presidential Task Force on Evidence-Based Practice, 2006). A new generation of frameworks for cultural identity have also emerged that more fully attend to the role of contextual factors and sources of privilege and well-being that go beyond a historic emphasis on race and gender (e.g., intersectionality). Mental health professions have also increasingly prioritized collaborative, personalized, and holistic strategies that pursue clients' input and empower them to make informed decisions about their care (e.g.,

patient-centered care, trauma-informed care). Further, spiritually competent care fits with a rising concern for social justice and overcoming structural racism. For example, when compared to European Americans, nationwide surveys revealed that African Americans are 20-30% more likely to report absolute certainty of belief in God, deem religion to be "very important," and regularly attend religious services, pray, meditate, read scripture, and/or interpret scripture as God's literal word (Pew Research Center, 2015). In combination, these movements within the mental health care system invite training programs and mental health service organizations to ensure that clinicians are equipped to honor clients' preferences by including R/S in treatment.

Saunders et al. (2010) described three ways of implementing spiritually competent psychotherapies. At one end of this spectrum, clinicians might offer spiritually integrated care that incorporates clients' R/S as a way of targeting distal outcomes across psychological (e.g., reduce mental health symptoms, enhance psychological functioning) and spiritual (e.g., grow closer to God, engage with faith community) domains. Although these approaches can be beneficial, this level of R/S integration might not fit for training programs or organizations that lack a religious affiliation, receive governmental funding, or serve religiously diverse persons. At the other end of this spectrum, clinicians may minimally screen and assess for R/S, and offer a spiritually supportive environment for clients from diverse R/S backgrounds. When compared to more directive approaches, research has documented that many religious and non-religious clients alike prefer this type of spiritually conscious care (Abernethy et al., 2020; Currier et al., 2020). As a third option, clinicians might tailor the treatment according to clients' R/S with the ultimate aim of promoting psychological outcomes. For example, in an effort to reduce depressive symptoms with a Muslim client who wants to incorporate their R/S in treatment, clinicians might encourage attendance at a religious service to generate behavior activation and

later incorporate imagery in meditative or reflective exercises that align with clients' sacred beliefs and values.

A sizeable evidence base has supported the clinical legitimacy of these types of strategies. Hundreds of studies have illumined psychological, social, behavioral, and physiologic pathways through which R/S can promote mental health and well-being (Koenig et al., 2012). Focusing on 97 experimental and quasi-experimental studies, meta-analytic findings also found spiritually integrated psychotherapies are equally effective in promoting psychological outcomes (e.g., decreased distress and increased psychological functioning) and more effective in promoting spiritual outcomes (e.g., better spiritual well-being) compared to non-integrated approaches (Captari et al., 2018). These findings converge with a growing number of practice-based evidence (PBE) studies conducted in naturalistic clinical settings where most therapists work (Captari et al., 2021). For example, session-to-session outcomes from 17 licensed clinicians with training in R/S integration revealed Christian clients generally experienced reductions in psychological distress that were associated with increases in their representations of a benevolent deity over the course of treatment (i.e., a core cultural-theological feature of Christianity; Currier et al., 2020). Further, another PBE study of 13 clinicians revealed clients were less likely to dropout from treatment and more likely to recover from mental health issues when clinicians honored their preferences for R/S integration (Swift et al., 2021). To date, PBE research has not directly examined the role of clinicians' R/S competence in psychotherapy.

There are also many theoretical reasons to predict that clinicians' competence to address spiritual and religious aspects of clients' lives will lead to better outcomes (e.g., Sandage et al., 2020; Pargament, 2007; Stewart-Sicking et al., 2019). As one example, meta-analytic findings from 66 studies revealed that sanctification (i.e., process via which aspects of life are perceived

as having divine character and significance) was positively linked with indices of positive psychosocial functioning (e.g., positive affect, gratitude) and inversely associated with negative functioning (e.g., anxiety, depression; Mahoney et al., 2021). Sanctification theory holds that people are more likely to invest in pursuits that hold ultimate value, attempt to protect such aspects of their lives when threatened, and derive greater satisfaction from pursuing objects, goals, and relationships that have been imbued with spiritual meaning (Pargament et al., 2005; Pargament, 2007). When treating clients for whom R/S has shaped their identity and represents a valued area of psychological functioning, clinicians should anticipate they will be more likely to engage and derive benefit in interventions that are contextualized according to their sacred beliefs and values. However, in cases of trauma, addiction, and other mental health issues that lead clients to seek psychotherapy, sanctification theory would also predict they will experience worse suffering when sacred aspects of life are perceived as lost or desecrated in some manner. In keeping with amassing findings for the adverse consequences of spiritual struggles (Bockrath et al., 2021), clinicians should also expect that resolution of mental health issues will sometimes necessitate attending to manifestations of distress related to R/S (Pargament, 2007).

Spiritual and Religious Competencies and Psychotherapy

Defined as "a specific form of cultural competence that deals with R/S, specifically clients' individually constructed spiritual worldviews" (Hodge, 2016, p. 2), absence of agreed upon sets of spiritual and religious competencies limits most clinicians' ability to address their clients' R/S in psychotherapy (Vieten & Lukoff, 2021). Of the fields that train and license the most psychotherapy providers in the U.S. (marriage and family therapy, counseling, psychology, social work; SAMHSA, 2012), counseling is the only one to formalize a consensus set of R/S competencies. Spanning across six areas (Culture and Worldview, Counselor Self-Awareness,

Human and Spiritual Development, Communication Assessment, Diagnosis and Treatment), the Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC, 2009) established 14 Competencies for Addressing Spiritual and Religious Issues in Counseling that have served as benchmarks for this profession for over a decade. Drawing on ratings from two samples of mental health professionals on clarity and relative importance, Vieten et al. (2013, 2016) also identified 16 competencies that signify facets of awareness, knowledge, and skills that may inform training and practice. Like the ASERVIC competencies, Vieten et al.'s competencies are not intended to denote areas of specialization or advanced expertise; instead, they represent basic features of ethical and effective practice that every psychologist will ideally pursue over their career. Notwithstanding the overwhelming landscape of R/S traditions and concepts, the work of ASERVIC and Vieten et al. affirm that it is possible to drill down to basic competencies that might prepare clinicians to treat clients for whom R/S is a salient dimension of their identity.

With this said, research has not examined many of the essential questions for establishing a scientific basis for integrating these benchmarks into training and practice. Focusing on a professionally diverse group of 169 clinicians, Pearce and colleagues (2019, 2020) recently documented the effectiveness of an eight-module online program, called "Spiritual Competence Training in Mental Health" (SCT-MH), in facilitating acquisition of competencies in Vieten et al.'s (2013, 2016) framework. However, this study focused strictly on clinicians' perceptions of their own competence and did not incorporate reports from another informant (e.g., client report) or clinical outcomes. To our knowledge, research has also not directly tested associations between clients' and clinicians' ratings of R/S competence, whether clinicians' spiritual and religious competencies might facilitate clients' treatment engagement and outcomes, and whether attending to certain facets of R/S competence are particularly crucial for training and practice. For example,

findings from an analogue study of 135 college students suggest that assessing R/S at start of treatment might strengthen the therapeutic alliance and clients' willingness to discuss sacred beliefs and values in later sessions (Terepka & Hatfield, 2020). By including multiple informants in the present study, we will explore construct validity of self-report measures of clinicians' R/S competence with clients' ratings of such competence as well as session-to-session outcomes.

Research has also not examined the association between multicultural competence in general and particular competencies related to addressing clients' R/S in mental health care. Building on the many advances in multicultural training and practice over recent decades, the multicultural orientation (MCO) framework was developed to specifically illumine how cultural dynamics influence the process and outcomes of psychotherapy (Owen et al., 2011; Owen, 2013). Defined as "the ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important for the client" (Hook et al., 2013, p. 354), cultural humility is one of three components of the MCO framework with particular relevance to R/S that has also received the most empirical scrutiny. For example, culturally humble clinicians might view R/S as a vital area of diversity, are aware of how their own R/S backgrounds influence their practice as well as demonstrate empathy, respect, and curiosity with religious and non-religious persons. To date, research has revealed that clinicians' cultural humility appears to increase the likelihood of cultural issues being discussed in treatment in ways that strengthen the therapeutic alliance and facilitate restorative processes and outcomes (Davis et al., 2018; Zhang et al., 2021). Further, Owen et al. (2014) found clients with a strong spiritual and/or religious identity reported better treatment outcomes when their clinicians were culturally humble. However, these studies have been primarily cross-sectional in nature and not explored the potential interplay between cultural humility and R/S competence in particular.

At present, it is not apparent whether specific areas of awareness, knowledge, and skill related to R/S contribute uniquely to clinical outcomes beyond the general cultural humility of the clinician. When considering onerous accreditation demands for training programs, clinicians' own responsibility to pursue multicultural competence over their careers, and the sheer vastness of R/S as areas of diversity, some experts have asserted it might not be realistic to target the acquisition of R/S competence as a proximal goal for training and practice (e.g., Winkeljohn Black et al., 2021). Instead, developing R/S competence might emerge more gradually from pursuing cultural humility and deeply engaging in MCO processes with religiously diverse clients. Although this approach might be sufficient for promoting awareness facets of R/S competence, others have asserted that clinicians might benefit from proactively developing basic knowledge about the complex roles of R/S in mental health and the necessary skills to address strengths and struggles associated with their clients' R/S (Vieten & Lukoff, 2021). Namely, consistent with other sources of cultural identity, R/S are linked with privilege, interact with other domains of intersectionality, and can shape peoples' relationships, beliefs, values, and morality in powerful ways. However, unlike other sources of diversity, R/S also represents a unique domain of functioning for many people that can become inextricably intertwined with suffering and recovery from mental health issues (Bockrath et al., 2021; Koenig et al., 2012). To our knowledge, this study represents the first attempt to examine the viability of these complementary views for the probable association between cultural humility and R/S competence in psychotherapy.

Study Aims and Hypotheses

With this background in mind, the overall aim of this practice-based evidence study will be to examine the role of R/S competence in cultural humility, working alliance, and psychological distress among religiously diverse clients who are pursuing psychotherapy in a

community-based behavioral health clinic. Clients will report their levels of psychological distress along with perceptions of clinicians' cultural humility, working alliance, and competence to address R/S aspects of their lives as part of routine outcome monitoring (ROM) procedures. Focusing on selected areas of awareness and skill from ASERVIC (2009) and Vieten et al. (2013, 2016), we will utilize multivariate latent growth curve modeling to test whether clinicians' session-to-session levels of R/S competence are related with their cultural humility and improvements in their clients' psychological distress and working alliance. In so doing, we will determine average trajectories of change in the three ROM measures as well as associations between baseline levels (i.e., intercept of trajectory) and degrees of change in these variables over the course of treatment (i.e., slope of trajectory). Two primary hypotheses will be addressed in the study:

H1: Clients will, on average, demonstrate decreases in psychological distress over the course of treatment.

H2: Clinicians' trajectories of R/S competence will be uniquely linked with their clients' experiences of cultural humility, stronger working alliance, and decreased psychological distress.

The secondary aim of this study will be to explore the predictive validity of clinician-rated R/S competence in client-rated R/S competence and clinical outcomes. In combination, examining these aims will advance foundational knowledge about the role of clinicians' R/S competence in psychotherapy that may inform theory, research, practice, and training in this under-studied area.

A Registered Report (RR) format offers advantages for addressing the confirmatory (primary) and exploratory (secondary) aims of this study (for a detailed discussion of RRs, see Chambers & Tzavella, 2022). Although we relied upon existing theoretical and empirical sources

in conceptualizing and designing this study, lack of research on R/S competencies creates special challenges for measurement, estimating effect sizes, identifying an adequate sample size, as well as determining model specification and ideal ways of analyzing the data. As such, a novel study of this sort could be subject to hindsight bias in generating hypotheses or selectively reporting statistical results. By taking steps of preregistration and peer-review of our rationale, hypotheses, methods, and statistical analyses before collecting any data, we hope to reduce bias and improve validity/reliability of research procedures and findings. For example, if we do not support our second hypothesis that clients' session-to-session ratings of clinicians' R/S competence will be linked with cultural humility and clinical outcomes, publication of null findings will still advance understandings about the association between R/S competence and multicultural competence and other pressing issues in this area. Further, by seeking feedback from expert reviewers before the data collection occurs, we hope the research methods will be as sound and accurate as possible. When compared to typical research reports in the psychology of R/S literature, we believe these strengths of the RR format will advance our overarching aim of promoting a scientific basis for equipping clinicians to attend to their clients' R/S as core areas of diversity, identity, and functioning that can be enhancing and/or diminishing of well-being, healing, and recovery.

Method

Sample Description

This study will focus on adults seeking individual psychotherapy with a community-based behavioral health organization in the Southeastern United States that offers evidence-based psychotherapies, primary care, and peer support to persons who are struggling with mental health and/or substance use disorders via an inter-disciplinary and trauma-informed care approach. The outpatient clinic in which this study will be conducted is staffed by psychologists, counselors,

social workers, and graduate student clinicians from a doctoral program in clinical/counseling psychology and Master's program in clinical mental health counseling. The clinic is certified as an outpatient substance abuse treatment program by the mental health department in the state in which it is located and recently received a Certified Community Behavioral Health Clinic (CCBHC) Expansion Grant from SAMHSA. Although the organization specializes in caring for military service members, veterans, first responders, and family members, the clinic also serves persons who did not serve in the military. The organization also serves clients from religiously diverse backgrounds (including non-religious), such that clinicians honor clients' preferences, needs, goals, and cultural beliefs and values in all cases.

The sponsoring organization recently launched an initiative to implement the Community Outreach and Professional Engagement (COPE) Model (Milstein et al., 2008, 2010) as a way of addressing R/S in prevention, treatment, and recovery services. County-level data suggest that over one-third of persons in the catchment area of the clinic are affiliated with Christian Evangelical churches, 15% are committed to Roman Catholicism, and equal subsets of 8-10% are affiliated with mainline and Black Protestant groups. This area also has multiple Latter Day Saints communities, Jewish communities, and a growing Muslim population. Further, estimates suggest that over one-third of persons in the area are not religiously affiliated. Given this R/S diversity of potential clientele for whom R/S is a salient part of their identity, clinicians are trained in the COPE Model and are encouraged to complete Pearce et al.'s (2019, 2020) SCT-MH program. The organization also hired a chaplain who coordinates the implementation of the COPE Model; in addition to providing education/training in the community and outreach to clergy, faith-based organizations, local hospitals, and healthcare clinics, this chaplain provides

consultation to clinicians and adjunctive spiritual care with psychotherapy clients as a member of the inter-disciplinary clinical team.

Procedures

Clients will complete these screening items about their R/S backgrounds as part of routine intake procedures based on existing approaches (e.g., Pargament, 2007; Puchalski & Romer, 2000; Richards et al., 2015): (1) Do you view yourself as a spiritual and/or religious person?; (2) Are you connected with a spiritual and/or religious community?; (3) Has your spirituality and/or religious faith been a source of strength in your life?; (4) Has your spirituality and/or religious faith contributed to some of your problems?; and (5) Would you like to explore ways of including your spirituality in your care? In cases when R/S is an important part of clients' cultural backgrounds, clinicians are trained and supervised to explore the possibility of tailoring their treatment according to beliefs, practices, and relationships related to this domain.

Based on intake assessments over the past six months (September 2021 to March 2022), roughly half of the 70 new clients who were enrolled in this period indicated a preference for incorporating spiritual and/or religious aspects of their lives in treatment. In other cases, research suggests that R/S could sometimes be clinically relevant in psychotherapy. Namely, given the spiritual and existential consequences of stressful life events (Bockrath et al., 2021), some clients who are not interested in R/S integration might have experienced changes in their spiritual or religious identity that are important for clinicians to understand. Further, given high rates of religiousness and limited capacity for mental health services in the area in which this study will be conducted, some clients first seek help from a faith leader or attempt spiritual solutions on their own. When such approaches are not successful, they can feel ambivalent about discussing their R/S in treatment and request a more secular approach. With this background in mind,

clinicians are trained and supervised to assess clients' R/S backgrounds to understand these types of concerns, conceptualize the role of R/S in the presenting problem(s) and needed solution(s), and include R/S in treatment in ways that honor their clients' preferences and needs.

Focusing on all psychotherapy clients in the outpatient clinic over a two-year period**,** study analyses will be based on session-to-session ratings from clients regarding psychological distress and perceptions of their clinicians' R/S competence and cultural humility. Depending on clients' comfort with technology, ROM measures will be administered via a HIPPA-compliant online survey (REDCap) or paper-and-pencil version before the start of each and every session. Occurring on a twice-weekly to monthly basis, this information will be collected in at least four sessions over a four-month period of engagement in psychotherapy. In addition, clinicians who opt to participate in the study will also be asked to complete a set of validated tools for assessing their R/S backgrounds and perceived competence to address their clients' R/S in clinical practice. All research procedures will be approved by the [name of IRB was blinded for peer review] and pre-registered on the Open Science Framework before data collection is initiated.

Client measures. Clients will be asked to complete three measures at the start of each session as part of ROM procedures in the outpatient clinic:

First, clients will complete Barkham et al.'s (2013) 10-item CORE-10. Assessed on a five-point scale with anchor points of 0 = "Not at all" to 4 = "Most or all of the time," items on this well-established instrument for tracking outcomes in psychotherapy capture symptoms of anxiety (e.g., "I have felt tense or anxious"), depression (e.g., "I have felt despairing or hopeless"), suicide risk (e.g., "I made plans to end my life"), and psychological and relational functioning (e.g., "I have felt able to cope when things go wrong, "I have felt that I have someone to turn to when needed" [reverse scored]). Total scores of 10 or higher suggest

clinically significant levels of psychological distress symptoms. The CORE-10 has been used extensively in practice-based evidence research and also yielded strong internal consistency in a similar practice-based evidence study (Cronbach's alphas in range of .71 –.91; Currier et al., 2020)

Second, clients will complete the seven-item positive subscale of the Cultural Humility Scale (CHS; Hook et al., 2013) to assess perceptions of their clinician's cultural humility from the previous session (e.g., "My clinician . . . . . "is respectful, is open to seeing things from my perspective"). Specifically, clients will be given these instructions before completing the items: "Thinking back to your last counseling session, please rate the degree to which you agree with the below items." Items will then be rated on a 5-point scale in which 1 = "Strongly Disagree" and 5 = "Strongly Agree," such that higher scores indicate greater cultural humility. The full 12-item version of the CHS has demonstrated internal consistency (Cronbach's alphas in range of .86 –.93) and construct validity, such as positive associations to client-reports of the working alliance and other clinical outcomes (Hook et al., 2013). We will omit the five-item subscale of negatively-worded items in the ROM assessment as a way of reducing the burden on clients and front desk staff in the clinic who will be responsible for gathering the data. The total score of this seven-item version of the CHS will be used in analyses.

Third, clients will complete a 5-item measure to assess basic areas of awareness and skill based on Vieten et al.'s (2013, 2016) set of R/S competencies. The items include: "My clinician discussed spirituality or religious faith in a way that worked for me"; "My clinician respected the value of spirituality or religious faith in my life"; "My clinician helped me to identify resources or strengths related to my spirituality or religious faith"; "My clinician helped me to explore issues or struggles related to my spirituality or religious faith"; "My clinician was willing to

collaborate with a clergy member, spiritual or religious leader, chaplain, or other ministry professional." Before completing these items, we will present these instructions: "Please rate the degree to which you agree with the below items based on your last session. Please feel free to mark 'Does Not Apply' to any question that is not relevant to your care." Items will be rated on a five-point scale with anchor points of 1 = "Strongly Disagree" and 5 = "Strongly Agree." Given a commitment to person-centered care and diversity of clientele served in the clinic, an additional option of "Does Not Apply" will be included for clients who are not interested in including R/S in their sessions. These latter items will be recoded as 1s and the total score will be used in the statistical analyses.

Lastly, the quality of the working alliance was measured with the Working Alliance Inventory-Short Form (WAI-S). This tool consists of 12 items, reflecting clients' judgment on the level of agreement on (a) therapeutic tasks (4 items), (b) treatment goals (4 items), and (c) the strength of the affective bond (4 items). The items are scored on a 5-point scales with responses ranging from 1 = "Never or rarely" to 5 = "Very often." Given concerns about multicollinearity between affective bond and cultural humility, a need to maintain brevity in the ROM assessment, and evidence suggesting a two-factor model for the WAI-S (Smits et al., 2015), we will use the eight items that capture the task-goals components of the working alliance.

Clinician measures. Clinicians will complete three sets of assessments at the start of the study and at monthly intervals that align with the measurement strategy used in Pearce et al.'s (2019, 2020) evaluation of the SCT-MH program:

First, clinicians will answer questions assessing their demographic background (e.g., age, gender, race/ethnicity), professional background (e.g., education, practice license held, prior training in R/S and mental health), and R/S background (e.g., religious preference, identification

as a religious or spiritual person, religious commitment). Responses to these questions will primarily be used for descriptive purposes.

Second, clinicians will complete the Religious/Spiritually Integrated Practice Assessment Scale (RSIPAS, Oxhandler & Parrish, 2016). This 40-item measure assesses self-reported competencies in one attitude domain (attitudes about R/S integrated clinical practice [12 items], two skills domains (self-efficacy with R/S integrated clinical practice [13 items]; current engagement in R/S integrated practice behaviors [nine items]), and one feasibility domain (feasibility to engage in R/S integrated clinical practice [six items]). Sample items include: "It is essential to assess clients' religious/spiritual beliefs in practice" (attitude); "I am comfortable discussing my clients' religious/spiritual struggles" (self-efficacy); "I use empirically supported interventions that specifically outline how to integrate my clients' religion/spirituality into treatment" (engagement); and "I have enough time to assess my clients' religious/spiritual background" (feasibility). Each subscale score will be computed separately, rather than as a single overall score, in exploring the role of clinicians' self-reported R/S competence in clients' outcomes. The RSIPAS has demonstrated excellent convergent and divergent validity across the four subscales, as well as internal reliability, with subscale alpha coefficients ranging from .84 to .91, in Oxhandler and Parrish's (2016) initial psychometric evaluation. Cronbach's alphas ranged from .77 to .90 across the four subscales in Pearce et al.'s (2020) recent study.

Third, clinicians will complete a Spiritual Competency Scale (SCS) that was also used in Pearce et al. (2020). This 16-item scale was designed to measure attitudes (three items), skills (seven items), and subjective knowledge (six items) that align with Vieten et al. (2013, 2016). Sample items include: "I pay attention to how my own spiritual and/or religious background may influence my clinical practice" (attitude), "I inquire about clients' religion and/or spirituality as a

standard part of my assessment process" (skill), "I can explain how some spiritual and religious experiences, practices, and beliefs may have the potential to negatively impact psychological health" (knowledge). Items are rated on a seven-point scale in which 1 = "Not at all true of me" and 7 = "Completely true of me," such that higher scores indicate more competency. Cronbach's alpha for the total score was .90 in Pearce et al.'s (2020) study; we will use the total score in the secondary analyses in this study.

Plan of Analysis

Preliminary analyses. Prior to performing the primary analyses, we will screen data for missing values, univariate outliers, deviations from normality, and calculate inter-correlations between variables and indices to determine whether our subsequent analyses need to be adjusted for clustering effects (i.e., clients will be nested within clinicians). We will restrict inclusion in the analyses to new clients who complete ROM assessments at a minimum of three sessions occurring at least monthly in frequency. Given the naturalistic conditions in which this study will be conducted, clients will engage in different numbers of sessions with varying intervals between them. However, in order to meet the assumptions of the longitudinal analytic strategy, repeated measures variables need to have equal time intervals between them. Based on our recent work on a similar practice-based evidence study using the same methodology (Currier et al., 2020), we will minimally use the average of available session data over four monthly time points; in turn, this approach will at minimum yield an aggregated score for the three outcomes in each month across the four months of treatment.

Because the data could be clustered at the therapist-level, we will also calculate the intraclass correlation coefficient (ICC) to determine how much variability can be explained by

the possible clustering effects. We will also adjust our standard errors to account for therapist-level effects in the primary analysis.

Primary analyses. We will use multivariate latent growth curve analysis (LGCA; McArdle and Epstein, 1987) as the method of testing the two hypotheses. LGCA is a form of longitudinal structural equation modeling (SEM) that will provide information about the trajectories of four core variables over four months of treatment: Psychological Distress (client self-report), Cultural Humility (client rating of clinician), R/S Competence (client rating of clinician), and Working Alliance (client self-report). Specifically, latent intercept (i.e., starting values) and latent slopes (i.e., direction and rate of change) variables will be generated based on data from repeated assessments of the same measures over the assessment period. Following best practices (Grimm et al., 2017), we will test the fit of a two-factor (slope and intercept) linear growth model against a quadratic model and a spline model (i.e., non-linear change). This approach will allow for basic inferences about the shape of each variable's growth trajectory. Then, we will examine means of the latent intercept and slope variables, as well as the relationships between intercept and slope factors, for the best fitting model to test the specific hypotheses.

All models will be evaluated for global and local fit. For global fit, a nonsignificant $\chi 2$ goodness of fit statistic indicates a nearly perfect fit; however, the $\chi 2$ significance value is highly sensitive to sample size. Accordingly, we will use a more conservative alpha of .001 (Kline, 2016) and also evaluate several common supplemental global fit indices; the Comparative Fit Index (CFI) and the Tucker Lewis Index (TLI; values of at least 0.90 indicate acceptable fit, and those exceeding 0.95 indicate good fit for both the CFI and TLI); the root mean square error of approximation (RMSEA) with 90% confidence intervals (CI; low values of 0.06 or less and high

values less than 0.10 indicate acceptable fit), and the standardized root-mean-square residual (SRMR; values of 0.08 or less indicate a good fit). In addition, we will adhere to best practice recommendations (Goodboy & Kline, 2017; Kline, 2016) and examine the model for problems in local fit via a normalized correlation residuals matrix. Normalized correlation residuals less than the absolute value of two represent acceptable levels of local misfit (Goodboy & Kline, 2017).

The four variables will be entered simultaneously in the same model. Thus, to test the first hypothesis, latent slope and latent intercept factors will be examined to determine each variable's starting values at the first time point, and the direction and rate of change for each variable. A significant negative slope for Psychological Distress will provide full support for Hypothesis 1. Likewise, to test the second hypothesis, we will examine the association between the latent slope factors in the model. Significant negative associations between the slope of Psychological Distress, Working Alliance, and the slope of Clinician Cultural Humility and R/S Competence will provide full support for Hypothesis 2.

To our knowledge, research has not examined the hypothesized links between Psychological Distress, Cultural Humility, Working Alliance, and R/S Competence. We therefore utilized data from a recent practice-based evidence study of session-to-session outcomes of spiritually integrated psychotherapies that included the CORE-10 and R/S variables (e.g., God representations) to determine the minimum sample sizes for testing the two hypotheses (for details of this study, see Currier et al., 2020). Namely, we simulated the multivariate LGCM model to determine the minimal sample size necessary to detect relationships between latent variables at a power of .90 or greater using Mplus Version 8. Although a minimum of 150 clients will be necessary to have sufficient power to identify changes in slopes for each of the three variables (Hypothesis 1), 250 individuals will be needed

to capture a medium effect between the slope of Clinician Cultural Humility, Working Alliance, R/S Competence, and reductions in Client Psychological Distress (Hypothesis 2). We will therefore aim to recruit between 200 and 250 clients for the analyses; based on average numbers of new clients pursuing psychotherapy in the clinic (i.e., 12-15 per month), the project timeline for recruitment will be up to one year. In adhering to these details, we can be confident that any null or disconfirming findings can be deemed valid rather than being an artifact of not having adequate statistical power.

Exploratory analyses. We will also explore the predictive validity of clinicians' reports of their R/S competence in a second set of exploratory analyses. First, we will examine inter-correlations between clinician and client-rated assessments. Drawing upon the RSIPAS subscales and SCS, we will enter the factors as covariates in the LGCA to determine whether changes in Psychological Distress, Working Alliance, Cultural Humility, and R/S Competence could be predicted by scores on these clinician-rated assessments. We will use inter-correlations between these variables to determine whether they should be entered into the model simultaneously or separately. Namely, if moderate to strong collinearity is found between the RPIPAS and SCS scores, we will enter these variables into the LGCA separately. In doing so, we will examine the overall global fit of the model with the covariates included as well as changes in model fit using indices described in the preceding section. If the addition of covariates does not degrade the fit of the overall model, we will then explore specific links between individual covariates and specific outcomes assessed from session-to-session in the study.

Pilot Data

Data from Currier et al.'s (2020) practice-based evidence study was used for estimating the effect sizes for the power analysis described above. Although Currier et al. did not focus on

R/S competence or cultural humility, the CORE-10 was used as the primary clinical outcome. Further, consistent with the present study, Currier et al. focused on clients' session-to-session assessments over a four-month period of engagement in psychotherapy occurring in naturalistic settings. No other pilot data was used in developing this Stage 1 report.

Secondary Registrations

There are no secondary registrations to report for his Stage 1 report.

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