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Spiritually Conscious Psychological Care

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There is increasing recognition of the importance of identifying and perhaps incorporating into psychological services the spiritual and religious beliefs and practices (SRBP) of patients. Research suggests that psychologists are reluctant to address the SRBP of their patients, because they are unsure how to do so without contravention of ethical standards. Moreover, numerous approaches have been published and promoted, and psychologists may feel overwhelmed by the profusion of advice. We organize the suggested approaches into four categories and place them on a continuum, and we discuss the ethical concerns related to each. At one end is spiritually avoidant care, which entails the attempt to avoid conversations with patients about their SRBP. Given the importance of these issues to psychological health and to understanding the patient, this approach is untenable. At the other end of the continuum, spiritually directive psychotherapy is characterized by an explicit attempt to maintain or change the SRBP of patients. Spiritually integrated psychotherapy entails utilizing SRBP to ameliorate patients' emotional distress. We suggest that psychologists should at least engage in spiritually conscious care, which we characterize as the explicit assessment of the general importance of SRBP to the patient, its influence on the presenting problem, and the potential of SRBP as a resource to help recovery. Specific suggestions are presented for how spiritually conscious care might be implemented. Finally, the need for better training in both basic and specific competencies needed to address patients' SRBP is reviewed.

Keywords: religion, spirituality, psychotherapy, ethics, competence

There is increasing recognition of the importance of identifying and perhaps incorporating into health care the spiritual and religious beliefs and practices of patients, including growing literature on how spiritually related issues might be integrated into psychotherapy (e.g., Pargament, 2007). These trends are related to the profusion of research suggesting a positive association between measures of spiritual and religious beliefs and practices (SRBP) and measures of medical and psychological health, and to increased realization that these are essential aspects of individual and cultural diversity (see review by Cornah, 2006). In this paper, we discuss the challenges that confront psychologists when they consider addressing the SRBP of patients, especially the challenge of incorporating these issues into psychological practices while maintaining appropriate professional boundaries related to roles and competencies.

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In what follows, we review the rationale for evaluating spiritual and religious issues in the process of mental health care, including research into the association between SRBP and health, evidence that patients might want their SRBP at least acknowledged, and the importance of communicating to patients respect and appreciation of their SRBP.

We then review approaches to addressing spirituality and religion in psychotherapy and place them on a continuum ranging from outright avoidance to direct and explicit focus (see Figure 1). One end of the continuum entails spiritually avoidant care, where the psychologist attempts to avoid issues related to a patient's SRBP. At its extreme, the psychologist avoids SRBP entirely, even when a patient indicates a need or desire to discuss them. At the other end of the continuum, spiritually directive psychotherapy is characterized by the psychotherapist's explicit and deliberate focus on the SRBP of patients, with the end goal of helping patients resolve psychological problems either by maintaining or transforming those beliefs and behaviors. Situated in between these approaches, spiritually integrated psychotherapy focuses on patients' SRBP but does not seek explicitly to either maintain or transform them. In this approach, SRBP may be the object of focus because they have a role in the cause, maintenance or amelioration of psychological problems, which are the primary focus of treatment. We review how the latter two approaches, although they overlap considerably, present unique challenges, including ethical concerns.

Finally, we suggest that psychologists should always engage, at the least, in spiritually conscious care with all patients. This entails assessing SRBP in a respectful and sensitive manner to determine their salience to the patient and the patient's problems. Spiritually conscious care entails its own ethical challenges, including being competent to recognize when a patient is in need of spiritually

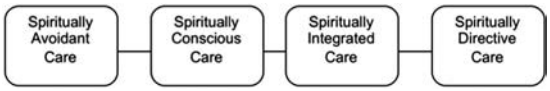

Figure 1. Continuum of spiritual care in psychotherapy.

integrated or even spiritually directive psychotherapy and, if the psychologist cannot provide such care competently, how to refer appropriately. Suggestions for a practicable and nonspecific (with regard to belief systems) assessment of a patient's SRBP that is consistent with a spiritually conscious approach are provided.

Please note that, in this article, we use either the term "spirituality" or "spirituality and religion," depending on the contextual need. The concept spirituality is inclusive of religion. It denotes a person's thoughts, feelings, and behaviors related to concern about, a search for, or a striving for understanding and relatedness to the transcendent (Hill et al., 2000). Thus, spirituality encompasses both religious and nonreligious strivings. The concept of religion is narrower, as it refers to a particular system of beliefs and behaviors that is formally sanctioned by an external entity, such as a church body (Hill et al., 2000; Koenig, McCullough, & Larson, 2001). For most people, spiritual thoughts, feelings, and behaviors are related to an identifiable religion, but they can be pursued outside the auspices of a specific religion.

Spirituality Is Relevant to Psychological Care

There is growing recognition of the importance of spiritual and religious issues to patients in both medical and mental health care settings. Several psychology publications have devoted special issues to the topic (e.g., Pargament & Saunders, 2007), and numerous health care professions explicitly encourage providers to address issues of SRBP with patients (e.g., Campbell & Britton, 2008). This reflects increasing (a) recognition of the association between measures of spirituality and both physical and mental health, (b) acknowledgement that patients expressly desire to discuss spirituality-related issues with care providers, and (c) realization that spirituality and religion are essential aspects of individual and cultural diversity.

Spirituality, Religion, and Health

Measures of SRBP, especially measures of religious involvement, are associated with better health outcomes, greater longevity, better coping skills, and better quality of life in patients with terminal illness (see review by Cornah, 2006). Research also suggests a positive association between measures of spirituality and mental health. Measures of SRBP have been associated with lower levels of anxiety, depression, suicide, substance abuse, and psychological distress, increased hope, well being, and optimism, and enhanced capacity to cope with stress (e.g., Rew & Wong, 2006). Conversely, research also shows that SRBP can be associated with or even part of psychological problems, such as increased guilt, anxiety, and religious obsessions and compulsions (e.g., Exline & Rose, 2005).

Patient Preferences

The United States is a highly spiritual and religious country. Over 80% of Americans say that religion is "fairly" or "very" important in their lives (Gallup Organization, 2009). It should not be surprising, then, that patients desire that their SRBP be asked about, acknowledged, and possibly accommodated in the course of medical and psychological care. Many patients believe doctors should talk to them about spiritual issues and matters of faith, because they influence their decisions regarding medical treatment (MacLean et al., 2003). Although the research is more limited, patients in mental health settings have expressed similar sentiments. Findings from several small surveys indicate that patients believe that discussing spiritual issues in psychotherapy is appropriate or even desirable (e.g., Rose, Westefeld, & Ansley, 2001). Moreover, some persons express reluctance to seek mental health treatment out of fear that their SRBP would not be respected (American Association of Pastoral Counselors, 2005).

Spirituality and Culturally Competent Care

Patients' SRBP are integral to ethnic and cultural identity (Ponterotto, Casas, Suzuki, & Alexander, 2001). Principle E of the APA Ethics Code states that "psychologists are aware of and respect cultural, individual, and role differences," including those based on religion, and "consider these factors when working with members of such groups" (American Psychological Association [APA], 2002, p. 1063). SRBP influence not only worldview but also social functioning and expressions of distress (Hathaway, Scott, & Garver, 2004), and they are essential considerations when trying to identify an appropriate intervention that will engage a patient in treatment and foster an effective therapeutic alliance (Knox, Catlin, Casper, & Schlosser, 2005).

Clinicians' Concerns About Addressing Spiritual and Religious Issues in Treatment

Despite research suggesting its importance, surveys of APA members indicate that practicing psychologists may feel hesitant and uncertain when considering whether they can or should address spiritual and religious issues with patients. Surveys (Delaney, Miller, & Bisonó, 2007; Frazier & Hansen, 2009; Hathaway et al., 2004) found that most psychologists recognize that SRBP are both generally beneficial to mental health and relevant to treatment. However, on average, psychologists reported discussing SRBP with only 30% of their patients, and less than half ask about SRBP at least half of the time during the assessment process (Hathaway et al, 2004). Clinicians seem to have concerns about competence, undue influence, and other potential ethical issues. We review the general concerns here, whereas we discuss specific concerns about different approaches to addressing SRBP with patients in subsequent sections.

Research suggests that psychologists worry about competence when considering addressing issues related to spirituality and religion. Plante (2007) cautioned mental health professionals against "using their spiritual and religious knowledge with their patients in a manner that appears that they are experts in their faith tradition" (p. 899). The respondents to Frazier and Hansen's (2009) survey indicated that it was between "somewhat" and "very" important to self-assess their "competence to counsel clients regarding religious/spiritual issues" (p. 83). Psychologists' concern about their competence in dealing with matters of spiri-

tuality and religion is likely related to lack of training. Surveys of directors of APA-accredited clinical programs and internships (Brawer, Handal, Fabricatore, Roberts, & Wajda-Johnston, 2002; Russell, 2006) found that few addressed religion and spirituality systematically, that some did not cover these issues at all, and that issues of religion and spirituality tended to be addressed only in clinical supervision (if the patient introduced them). Patients have expressed similar worries about their clinicians' competence in this regard. For example, Martinez, Smith, and Barlow (2007) surveyed patients whose clinicians, with whom the patients shared a common religion, had utilized a religious intervention. One in four patients found the intervention ineffective or even objectionable, most often because it had seemed condescending and simplistic.

Psychologists may fear that broaching the topic of a patient's SRBP will appear to patients as proselytizing or judgmental (Gonsiorek, Richards, Pargament, & McMinn, 2009), with the potential for undue influence. Research suggests this can happen. Martinez et al. (2007) found that some patients felt anxious and guilty, and some perceived the clinician as judgmental, when their clinician used a religious intervention. In another study, subjects reported preference for a potential clinician (viewed on videotape) who ignored his patient's religious beliefs to a clinician who challenged beliefs (McCullough, Worthington, Maxey, & Rachal, 1997).

Finally, psychologists may hesitate to address SRBP because of ethical concerns related to integrity and respect (cf. Plante, 2007). Integrity (*General Principle C*) concerns the duty to act only in one's professional role and to maintain the integrity of psychological practice (APA, 2002). Psychologists and patients alike deem that it would be inappropriate for psychologists to usurp the role of the clergy by assuming expertise and knowledge to address ecclesiastical issues. Examples from the literature include psychotherapists' indicating the correctness of a person's faith, interpreting scripture, and encouraging patients to confess transgressions (e.g., Knox et al., 2005; Richards & Potts, 1995). Common reactions by patients included feeling ashamed, confused, angry, and judged (Knox et al., 2005; Richards & Potts, 1995). Psychologists must likewise show *respect* for the SRBP of patients (*General Principle E*; APA, 2002). Several authors have suggested that assuming competence in such matters trivializes patients' belief systems (Gonsiorek et al., 2009; Sloan et al., 2000). Trivialization might likewise occur if psychologists ignore or disregard as irrelevant the immense variability of beliefs, attitudes, and behaviors within supposedly similar faith systems. For example, the designation "Protestant" might be used to indicate Southern Baptist, Methodist, Presbyterian, Lutheran, or any number of other faiths that have, in fact, distinctive doctrines. There is perhaps even greater within-person variability of faith, and these differences must also not be trivialized. As Richards and Potts (1995) assert, even if the clinician and patient share the same religious faith, "therapists should seek to understand each patient's unique religious understandings" (p. 169). Finally, psychologists might be properly cautious about trivializing SRBP by using them like any other tool of psychotherapy. For example, meditation is a sacred undertaking for some, and the suggestion that meditation might help reduce stress might be offensive to some patients. This is likely also true of the activity of prayer.

Approaches to Including Spirituality and Religion in Psychological Care

We discuss approaches to addressing SRBP in psychological practice and place them on a continuum ranging from avoidance to explicit focus. We discuss the ethical concerns (related to competence, undue influence, integrity, and respect) that may be particularly relevant to each.

Spiritually Avoidant Care

Spiritually avoidant care describes the explicit or implicit attempt, on the part of a psychologist, to avoid conversations with patients about their SRBP. It appears that many psychologists choose this approach (Frazier & Hansen, 2009; Hathaway et al., 2004), but it is difficult to justify. As we have reviewed, SRBP is important to psychological health and could be a valuable resource for addressing problems (Pargament, 2007), and to understand fully a patient requires understanding his or her SRBP (Josephson & Peteet, 2004). Because competent attention to all factors that influence patients' lives requires exploration of the relevance of spiritual and religious issues, we suggest that spiritually avoidant care is inappropriate.

Spiritually Directive Psychotherapy

At the other end of the continuum is what we call spiritually directive psychotherapy, wherein treatment focuses on a patient's SRBP as the explicit object of attention. The potential outcome of spiritually directive psychotherapy might be the conservation or perhaps the transformation of SRBP (Sperry & Shafranske, 2005). Using this approach, the patient might be aided in evaluating or even reconstructing his or her faith perspective. The patient and psychotherapist might address the potential negative effects of certain religious views or the incongruence of a patient's beliefs and the teachings of the patient's religious community (Tan & Johnson, 2005). Some versions of spiritually directive psychotherapy are explicit with regard to spiritual and religious assumptions. For example, the core assumptions of "theistic psychotherapy" are grounded in the worldview of the major theistic world religions, that is, that God exists, that humans are created by God, and that there are spiritual processes by which the link between God and humanity is maintained (Richards & Bergin, 2005). Indeed, spiritually directive psychotherapy may make assumptions about what are proper SRBP. For example, Ball and Goodyear (1991) surveyed Christian psychologists and found that the teaching of theological concepts was one of the most frequently endorsed interventions.

Spiritually directive psychotherapy can engender ethical concerns related to competence, role boundaries, and respect (cf. Plante, 2007). Clergy and similarly trained and positioned professionals within (or even outside of) the patient's belief system might claim competence to help someone conserve or transform his or her SRBP, but it seems problematic for mental health professionals to do so. Doing so might likewise cause considerable role confusion, and psychologists are cautioned that the integrity of their professional role might be comprised if they attempt to address directly spiritual problems (Plante, 2007). Spiritually directive psychotherapy, in particular, has the potential to lead

psychologists to be perceived by patients as imposing a certain perspective. In its most extreme (and perhaps absurd) form, spiritually directive psychotherapy can entail inappropriate comments about SRBP and be detrimental to a patient's well-being. Knox et al. (2005) give examples of one psychotherapist who told a patient she was "too Catholic" and another who told a patient that she had "holes in her aura" (p. 296).

This has led various authors to caution psychologists to hold the patient's faith perspective sacrosanct if engaging in this approach (e.g., Tan & Johnson, 2005). However, even if psychologists are careful to not intrude on the patient's perspective on SRBP, spiritually directive psychotherapy has the potential to engender role confusion when the psychologist focuses on spirituality as an end in itself. Psychologists are consulted because of their expertise in the scientifically based endeavor of alleviating psychological problems, but SRBP are not based on science. The direct confrontation of spiritual and religious issues is perhaps best left to those persons and entities whom patients chose as their spiritual and religious guides. In this way, patients, not clinicians, choose whether specific beliefs, doctrines, practices, and rituals are right for them. Moreover, there is evidence that spiritual and religious professionals would prefer that we not engage their spiritual charges in such a way. In an informal survey of pastors, Richards found that they desired that psychologists consult with or refer to them when issues of SRBP surfaced, such as religious beliefs contributing to emotional problems, feelings of guilt because of violations of religious beliefs, expressions of desire to reconnect to religious beliefs or communities, questions about God, and desire for a religious ritual (see Gonsiorek et al., 2009).

The issue of whether a psychologist is competent to address the substance of SRBP is not straightforward, however. SRBP are often intimately interconnected with psychological issues (both problems and potential solutions). For instance, sometimes SRBP are manifestations of severe mental illness, such as schizophrenia and religious delusions or OCD and excessive scrupulosity (e.g., Huppert, Siev, & Kushner, 2007). Thus, competent care might require that a psychologist question explicitly the legitimacy of certain beliefs or practices. Even in less severe illnesses, attempts to change psychological health may cause change in SRBP (Gonsiorek et al., 2009). In all cases, however, including the most severe, a psychologist must be aware of concerns about competency to focus directly on maintaining or changing the SRBP of patients.

Psychologists must also be aware of the potential to trivialize, ignore, deny or misunderstand differences between faiths (both corporate and personal) when engaging in spiritually directive psychotherapy (cf. Sloan et al., 2000). Sometimes these distinctions are quite drastic. For example, the three premises upon which Richards and Bergin's (2005) theistic psychotherapy is based are profoundly different between the three religions that are the basis of this approach (i.e., Judaism, Christianity, and Islam). Sometimes the differences are more subtle. For example, Tan and Johnson (2005) describe a Christian approach to CBT that includes the goal of "growing to be more Christ-like" (p. 83): while many persons of Christian faith might accept that goal, other persons of Christian faith might reject it as profane. Other examples of subtle but essential differences are plentiful (e.g., some but not all Christian churches practice infant baptism, some but not all preach the doctrine of trinity, etc.). Consider also the differences between the Shi'a and Sunni denominations of Islam. A psychologist risks the offense of disrespect if he or she speaks collectively of Catholicism, Christianity, Islam, or any other belief system. Risk is also present even when presuming to understand, based on personal or professional knowledge of a corporate faith, a patient's personal faith (Martinez et al., 2007; Richards & Potts, 1995). Thus, psychotherapists who are engaging in spiritually directive care must be cautious when working explicitly with patients' SRBP.

Spiritually Integrated Psychotherapy

We define spiritually integrated psychotherapy as an approach that utilizes a patient's SRBP in the treatment of emotional problems (cf. Pargament, 2007). This approach entails the psychotherapist focusing on a patient's SRBP to facilitate the goals of psychotherapy, which are the alleviation of distress and impairment. Examples of spiritually integrated psychotherapy include helping the patient to reidentify and reinvigorate activities related to what he or she considers sacred, suggesting to the patient that he or she consider the problems within the context of his or her SRBP, and suggesting potentially helpful spiritual or religious activities that the patient identifies as consistent with his or her faith perspective. Some proposals for spiritually integrated psychotherapy attempt to utilize spiritual or religious concepts and activities generically or ecumenically, such as the long-standing integration of nonspecific spiritual issues in the treatment of alcohol problems. For example, Margolin, Schuman-Oliver, Beitel, Arnold, Fulwiler, and Avants (2007) integrated cognitive therapy with Buddhist principles into a treatment that does endorse Buddhism but "tailors the therapy to each patient's own spiritual/religious beliefs" (p. 982). Tarakeshwar, Pearce, and Sikkema (2005) developed a "spiritually oriented" group intervention for HIV-positive adults that emphasizes diverse interpretations of spirituality and how SRBP might be used as a means of coping with stress.

There is overlap between spiritually directive and spiritually integrative psychotherapy. The difference is in whether SRBP is the focus of change efforts. Because SRBP and psychological health are intimately interrelated, spiritually integrative psychotherapy may lead to change in a patient's SRBP (e.g., more frequent prayer). However, this approach will not focus on the legitimacy of SRBP, nor will it seek to transform or maintain them per se. Delaney, Forcehimes, Campbell, and Smith (2009) illustrate this distinction as the difference between the Latin words "ducere," which means to draw out and consider, and "docere," which means to inform or to instill knowledge. For example, a psychologist embracing the spiritually integrative approach might suggest that a client pray or consult scripture, but would not tell the patient what or how to pray, which scripture to read, or how to interpret the words of the reading. Spiritually integrative psychotherapy might lead a patient to modify his or her SRBP, not because this was the focus of treatment, but rather because the patient chose to do so.

Because it does not focus directly on maintaining or transforming SRBP, we suggest that there are, in general, fewer ethical concerns with spiritually integrated psychotherapy than with spiritually directive psychotherapy. There nonetheless remain concerns about competence and proper training. As with spiritually directive psychotherapy, this approach (as well as the approach described next) requires competence in psychotherapy, compe-

tence with spiritual and religious issues, and competence in combining the two without compromising the integrity of either (Pargament, 2007). Psychologists must be comfortable addressing SRBP in session, which some might not be, especially given the dearth of training in this area (Brawer et al., 2002; Russell, 2006). Indeed, in some versions, spiritually integrated psychotherapy also requires agreement of faith between patient and clinician, such as when praying with Devout Muslims (e.g., Azhar, Varma, & Dharap, 1994).

As with spiritually directive psychotherapy, there are also issues of respect that need consideration. The psychologist must be careful to evaluate and confirm the patient's SRBP, and be open to and respectful towards spiritual and religious beliefs that might deviate from his or her own (Pargament, 2007). In both approaches, the psychotherapist must be careful to get the assent and approval of the patient to address SRBP within the psychotherapeutic setting (e.g., Margolin et al., 2007). For example, Murray-Swank and Pargament (2005) included only individuals who believed in some form of God or a higher power and who were comfortable using spiritual approaches in their spiritually integrated treatment for sexual abuse.

Spiritually Conscious Care

Most of the literature on addressing spiritual and religious issues within psychological care has comprised spiritually directive and spiritually integrated approaches, which perhaps explains the widespread hesitation to engage SRBP issues (e.g., Hathaway et al., 2004). Psychologists might determine that a spiritually directive approach is better left to a patient's spiritual leader, and they might not feel competent or comfortable with a spiritually integrated approach. However, eschewing spiritually directive or spiritually integrated approaches does not justify spiritually avoidant care. The information gained by asking about a patient's SRBP is necessary for competent care, including the importance of such issues to the patient's self-concept, family and social values, and psychosocial functioning. It is also essential for understanding whether a patient's SRBP may impact treatment, including whether it contributes to the current problems or whether SRBP-related resources might aid in coping with the problem (McCord et al., 2004). Moreover, research indicates that respectfully evaluating issues of spirituality and religion improves rapport and may enhance the effectiveness of treatment (Martinez et al., 2007).

Therefore, we suggest that psychologists should always engage, at the least, in spiritually conscious care with all patients. We define spiritually conscious care as an approach that assesses SRBP in a respectful and sensitive manner to determine its general importance to a patient, but also to assess the influence, if any, of SRBP on the presenting problem and the potential of SRBP as a resource to help recovery. Spiritually conscious care entails explicitly evaluating these issues during the formal evaluation of the intake phase of treatment, and remaining open to their emergence and potential influence as treatment progresses.

Several authors have suggested "opening" questions that might be asked in the conduct of a sensitive and competent evaluation of the spiritual and religious lives of patients. We integrate four published recommendations (Abernethy, Houston, Mimms, & Boyd-Franklin, 2006; Gorsuch & Miller, 1999; Lo, Quill, & Tulsky, 1999; Pargament, 2007) into the three categories shown in Table 1. The first category entails general questions about attitudes, beliefs, and behaviors. The second category asks about the interconnections between the current problems and SRBP (cf. Pargament, 2007). The last category concerns using the patient's spiritual or religious community as a resource for treatment of problems. All of the table's contents are questions, not directives (e.g., "Tell me about your spiritual life"), because questions are devoid of any assumptions that the patient holds beliefs or engages in behaviors (e.g., that a patient has a spiritual life). Note also that these might or might not lead to further questions. For example, if a patient responds to the question, "Are you a religious or spiritual person?" with a resounding, "No!", then the psychologist might choose not to ask more questions (or might choose to follow up with questions about the vehemence of the answer). We also do not suggest presumptively using the term "God," but rather the more generic "higher power." If the higher power is specified, that term should be used. Finally, we note that although some of the questions within categories are synonymous, others are quite distinct.

Table 1
Questions That Might Be Asked When Assessing Religion and Spirituality With Patients

General questions about beliefs and behaviors
- Are you a religious or spiritual person? How important is spirituality or religion in your daily life? Has spirituality or religion been important to you in your life?
- What things are most important to you? Are there things in your life that are sacred to you? What gives your life purpose or meaning?
- Do you believe in a higher power?
- Are you part of a spiritual or religious community? Do you practice a religion currently? Are there spiritual or religious practices that you follow regularly?

The relationship between the problem and spirituality/religion
- Has your current problem affected your relationship with your higher power?
- Has the problem for which you are seeking help affected your religious or spiritual life?
- Are spirituality or religion important to this problem?
- Has your religion or spirituality been involved in your attempts to deal with this problem?
- Are you worried about possible conflicts between your beliefs and your treatment?

Potential resources
- Are members of your spiritual or religious community (such as a spiritual leader) a potential resource for you in trying to deal with this problem? Is there someone you can talk to about spiritual or religious matters as they relate to this problem?
- Is there anything that I can do to help you access such resources? Would it be helpful if I consulted with your spiritual leader?

For example, "What things are most important to you?" is not the same as "Are you a religious or spiritual person?"

Spiritually conscious care is not exempt from ethical concerns, of course. A concern for all of the approaches is competence, such as properly identifying and addressing spiritual and religious issues that are relevant. Spiritually conscious care requires identifying when SRBP per se are a concern, which itself might require consultation with local religious or spiritual leaders (Edwards, Lim, McMinn, & Dominguez, 1999). For example, it might be necessary to determine whether a patient's concerns about "sinful behavior" is consistent with the teachings of his or her faith community. Moreover, if concerns need to be formally addressed, competent care obligates either addressing them (e.g., by shifting to spiritually integrated or spiritually directive psychotherapy) or referring to appropriate resources where they can be addressed. This might necessitate referral back to the patient's spiritual leader in particular. If that person is not appropriate for some reason (e.g., the leader is part of the problem), then the psychologist should help the patient identify another spiritual leader, who may or may not represent the patient's faith tradition, from whom assistance might be obtained. Most authors, regardless of which approach they advocate, describe the likely need for collaboration with spiritual leaders. Several authors discuss the qualifications necessary for competent collaboration with clergy, including respect, tolerance, openness, and professionalism (e.g., McMinn, Aikins, & Lish, 2003).

Clinical and Training Implications: General and Specific Competencies

The three approaches that address patients' SRBP require basic competencies that are probably held by most well-trained practitioners, but also specific competencies that may need to be developed. Competent evaluations and interventions require skills in interviewing (respectful, appropriate questions; nonjudgmental, attentive listening), empathic understanding, and communicating genuineness (Kaslow, 2004). Likewise, with regard to spiritual and religious issues, "the skillful use of client-centered methods to draw out clients' own meanings and understandings is critical" (Delaney et al., 2009, p. 189), and this skill is probably widely held by professional psychologists. Other competencies of professional psychologists are especially relevant to spiritually directive, spiritually integrated, and spiritually conscious approaches, including: knowing, understanding, and properly applying ethical principles across situations and settings, such that integrity and respect are maintained; understanding and effectively addressing issues related to individual and cultural diversity, including respectful attention to spiritual issues; being aware of one's own attitudes, assumptions and biases, including one's attitudes towards issues of spirituality and religious faith; and the ability to work with other professionals, such as clergy, including understanding the unique expertise they contribute to the care of patients. We note that all such skills are required when psychologists competently evaluate particularly sensitive issues (e.g., sexual abuse, issues of ethnic identity), and so we suggest that most professional psychologists likely have already developed these basic competencies.

More advanced but still general competencies needed for addressing SRBP issues in particular are articulated by Pargament (2007), including openness and tolerance, self-awareness, and authenticity. Openness refers to the willingness to learn from each patient what spirituality means to him or her, and tolerance is the mindset of respecting the many forms of SRBP without either presumption or antipathy. Self-awareness includes attending to the influence that psychologists wield over their patients and consequently exercising caution when addressing spirituality and religion. Authenticity means that psychologists openly embrace their own beliefs and perspectives in relation to spirituality and religion, which reduces the likelihood of undue influence as both become aware that the psychologist's perspective is perhaps profoundly different from that of the patient.

More specific competencies are also needed, however. Competent psychologists may be capable of demonstrating similar respect and sensitivity to SRBP, but this should not be assumed or taken for granted (Gonsiorek et al., 2009). The profession has not assumed such competence with regard to other issues, such as sexual orientation, racial identity, or other areas of cultural diversity, and it should not do so with SRBP (APA, 2002). Psychologists need to develop competence in SRBP, in particular within the areas of spiritual and religious beliefs and their immense diversity. Indeed, some have proposed that there are levels of competence in working with clergy (McMinn et al., 2003). Ideally, competence in addressing SRBP would be obtained via training and supervision. This is currently largely absent from clinical psychology training programs, which needs to be remedied. For practicing psychologists, a commitment to ongoing professional development and to applying current scientific knowledge, including emerging research regarding the relevance of spiritual and religious issues to our patients' lives, should encourage psychologists to develop or improve professional competency in addressing these issues.

Conclusion

Psychologists hopefully recognize that spiritually avoidant care cannot be justified (APA, 2002), but there has been insufficient guidance regarding what psychologists should do with regard to their patients' SRBP. In this paper, we distinguish spiritually directive, spiritually integrated, and spiritually conscious approaches. Regarding spiritually directive psychotherapy, we have reiterated concerns about the explicit focus on a patient's SRBP, including concerns related to competence, role confusion, integrity, and respect. Spiritually integrated psychotherapy does not focus explicitly on a patient's SRBP, which poses less ethical risk than spiritually directive psychotherapy, but still poses concerns related to competence. Moreover, the distinction between focusing on spiritual and religious beliefs as objects of treatment and focusing on them as resources for treatment can be difficult.

We have suggested that psychologists may legitimately eschew spiritually directive and spiritually integrated approaches, but that they should always practice spiritually conscious care. This entails evaluating the salience of SRBP to the patient, to the patient's problems and to potential solutions, as well being able to refer to appropriate other resources when necessary. While we have suggested that psychologists probably already have the basic skills necessary to conduct spiritually conscious care, we have also argued that professional psychologists engaging in any of these approaches should strive to develop the specific competencies relevant to SRBP through adequate training and supervision. There are excellent resources for this (e.g., Pargament, 2007; Sperry & Shafranske, 2005), but more are needed.

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