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Improving Psychotherapists' Spiritual and Religious Competencies: Evaluation of a Live Videoconferencing Training Program

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This study evaluated the effectiveness of a live videoconferencing training program in spiritually integrated psychotherapy offered by ACPE: The Standard for Spiritual Care and Education (ACPE). We used a quasi-experimental one-group pretest–posttest group design to investigate whether participants' religious/spiritual competencies (self-efficacy, attitudes, and skills) improved and whether their use of spiritual interventions increased after completing the training program. We also assessed whether their perceptions of the barriers to practicing spiritually integrated treatment in their practice setting changed after training. The research participants were 84 adult men and women from diverse spiritual backgrounds, mental health specialties, and geographic locations who completed the measures before and after the training program. A repeated measures multivariate analysis of variance and follow-up *t*-tests revealed that the participants' spiritual competency and usage of spiritual interventions during treatment sessions significantly increased after the training program. Most Cohen's *d* effect sizes were large or moderately large, indicating that the improvements were educationally and clinically meaningful. The study provides preliminary evidence that ACPE's live, videoconferencing spiritually integrated psychotherapy training program enhanced the spiritual competencies of the participating mental health and pastoral professionals.

Clinical Impact Statement

Question: Do mental health and pastoral professionals who complete a live, videoconferencing training program in spiritually integrated psychotherapy (SIP) report improvements in their spiritual and religious (S/R) competencies after completing the training? ***Findings:*** The study shows that participants generally improved in spiritual competence from pre- to posttraining, but these improvements were not strongly influenced by their training level (15 hr vs. 30 hr). This suggests that the training program had a broad effect across participants regardless of their starting level or intensity of training. ***Meaning:*** Mental health and pastoral professionals who wish to enhance their competencies in S/R aspects of diversity and treatment may benefit from ACPE's live videoconferencing SIP training program. ***Next Steps:*** Research about the effectiveness of other available SIP training programs is needed. Studies that investigate how many training hours are needed to effectively promote competency in basic and advanced S/R attitudes, knowledge, and skills are needed.

Keywords: spirituality, religion, training, multicultural competence

Many spiritually integrated psychotherapies (SIPs) have been developed during the past few decades (Pargament, 2007; Richards & Bergin, 2005, 2014; Sperry & Shafranske, 2005). In the *APA Handbook of Psychology, Religion, and Spirituality*, Sperry (2013, p. 227) defined SIPs as:

> Approaches that are sensitive to the spiritual dimension. These approaches range from non-Christian approaches and transpersonal psychotherapies … to theistic … and various Christian approaches … spiritually integrated psychotherapy is distinct from pastoral counseling and spiritual direction in its emphasis and treatment focus. It draws on spiritual resources in addressing spiritual issues and struggles to resolve psychological and relational problems.

There is growing evidence that SIPs are effective in treating a wide variety of psychological and spiritual problems (Captari et al., 2018,

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2022; Currier, McDermott, et al., 2024; Currier, Swift, et al., 2024; Richards, Allen, & Judd, 2023; Richards & Barkham, 2022). Several narrative and meta-analytic reviews have concluded that SIPs outperform no-treatment control conditions and are generally equivalent in efficacy to secular treatments for psychological outcomes (Captari et al., 2018; Hook et al., 2010; Smith et al., 2007; Worthington et al., 2011; Worthington & Sandage, 2001). There is also evidence that SIPs have better spiritual outcomes than secular approaches (Captari et al., 2018). However, many SIPs have not been empirically evaluated, so more outcome research is needed to understand better which approaches are most effective for different clients and clinical issues (Richards, Allen, & Judd, 2023; Richards & Worthington, 2010).

Despite the growing evidence concerning the effectiveness of SIPs, one major deficiency in this domain of psychotherapy is that training in spiritual and religious (S/R) competencies of SIP treatment is not yet adequately included in mental health graduate education or professional continuing education opportunities for mental health professionals (Currier, 2024; Oxhandler et al., 2015; Pearce et al., 2020; Richards & Bergin, 2014; Richards, Currier, et al., 2023; Vieten & Lukoff, 2022). Although multicultural competencies are a necessary and helpful foundation for the effective treatment of religious and spiritual clients, specialized S/R attitudes, knowledge, and skills are also required to be fully effective in this domain of treatment (Pargament, 2007; Pargament & Exline, 2022; Richards & Bergin, 2005, 2014). Research has revealed that most students and mental health practitioners received little or no training in S/R competencies, and most do not feel confident in this treatment domain (Currier, 2024).

The lack of training opportunities in S/R competencies has contributed to several problems in the mental health professions. First, many religious people and religious leaders are aware of the historical alienation between religion and psychology and fear that mental health professionals will ignore, ridicule, and/or seek to undermine their religious values (Bergin, 1980, 1983; Richards & Bergin, 2005; Richards, Allen, & Judd, 2023). Second, psychotherapists' lack of training in S/R competencies has sometimes resulted in ethical violations and treatment failures with religious clients (Richards & Bergin, 2005, 2014; Richards, Pargament, et al., 2023). Third, public awareness of the historical alienation and treatment failures has contributed to an underutilization of mental health services among religious people, especially among those who are more devout (Richards & Bergin, 2014).

Much clinical and theoretical work has been done to identify and describe S/R competencies for effectively working with S/R clients and practicing SIP treatment (e.g., Hathaway, 2013; Richards & Bergin, 2005, 2014; Vieten & Lukoff, 2022). Building upon this work, Vieten et al. (2013, 2016) conducted two surveys of mental health professionals and asked them to rate the relative importance of various S/R competencies. They found a high agreement (73.0%–94.1%) about 16 S/R competencies that the respondents believed were important for competent psychotherapy practice. These competencies included three in the domain of Attitudes (e.g., empathy and respect for S/R diversity), seven in the domain of Knowledge (e.g., awareness of religious and spiritual resources that may support treatment), and six in the domain of Skills (e.g., identifying and addressing religious and spiritual problems during treatment). These studies provide evidence of much agreement among mental health professionals about what S/R competencies are essential for competent and ethical practice (Vieten & Lukoff, 2022).

Despite agreement about what S/R competencies are needed for effective psychotherapy, more information is needed about the focus and effectiveness of continuing education training opportunities for mental health practitioners. Although a few studies have been done about S/R competency training programs in other health-related fields (e.g., physicians, nurses, psychiatrists, physiotherapists; Awaad et al., 2015; Grabovac et al., 2008; Osório et al., 2017), relatively little is known about the effectiveness of training programs in S/R competencies for mental health professionals.

A recent book chapter published by the American Psychological Association (Richards, Currier, et al., 2023) described four S/R competency training opportunities for mental health professionals. Two are live, videoconferencing training programs offered by ACPE: The Standard for Spiritual Care and Education (ACPE; https://acpe.edu/) and the Solihten Institute (https://solihten.org/). The chapter also described two prerecorded, self-paced training courses: one is Pearce and her colleagues' Spiritual Competency Training in Mental Health (SCT-MH) online course (Pearce et al., 2020), which consists of 8 hr of multimedia content offered through the edX platform (https://edx.org/), and the other is an online course offered by the Bridges Institute for Spiritually Integrated Psychotherapies (https://bridgesinstitutesip.com/). In addition to these four training options, the Spiritual Competency Academy offers prerecorded online webinars and videos (https://spiritualcompetencyacademy.com/), and the American Psychological Association provides book-based continuing education options (e.g., https://www.apa.org/education-career/ce/spiritual-diversity-psychotherapy).

To date, of the S/R competency training programs mentioned, only Pearce's SCT-MH course has been empirically evaluated (Pearce et al., 2020, 2024; Salcone et al., 2023). In Pearce et al. (2020) pioneering evaluation of the SCT-MH course, 169 licensed mental health professionals (psychologists, psychiatrists, marriage and family therapists, clinical social workers, and professional counselors) who finished the course completed pre- and post-training measures of religious and spiritual competency. After course completion, the participants reported increased competency in all S/R attitudes, knowledge, and skills measures. The participants also reported high satisfaction with the content and format of the online training program (Pearce et al., 2020). Salcone et al.'s (2023) study replicated and expanded the findings from Pearce's initial evaluation and provided further evidence that mental health practitioners completing the SCT-MH online course report improvements in their S/R competencies.

Pearce et al.'s (2024) study evaluated whether integrating the SCT-MH curriculum into existing graduate school classes (e.g., multicultural, practicums, internships) in counseling, psychology, and social work would enhance students' S/R competencies. Their study employed a hybrid approach to the SCT-MH curriculum by combining didactic online materials with in-person discussions and role-playing. Additionally, more time was allocated for training—15 hr instead of the 8 hr required in the edX version of the program. The findings demonstrated that the hybrid version of the SCT-MH course effectively increased S/R competencies, with observed Cohen's *d* effect sizes ranging from 0.562 to 3.462 on the S/R competency measures. Furthermore, both quantitative and qualitative feedback from the graduate students who participated indicated they found the training materials helpful and relevant and that the course

would positively influence their future integration of spiritually integrated therapy techniques.

These pioneering research studies by Pearce and her colleagues have advanced our understanding of training approaches that can be used effectively with practitioners and graduate students. Their studies provide much incentive for further research in this domain of mental health training. Research about other existing training approaches in SIP competencies is needed. Although the prerecorded, online SCT-MH course and curriculum may be convenient, inexpensive, and scalable, it may not appeal to or be effective for all practitioners. Book-based and prerecorded video and webinar courses may also be practical and appealing to some practitioners. Training approaches that use live, personalized instruction may appeal to many practitioners and, in our view, have the potential to promote more advanced S/R competencies. Additional research is needed to help practitioners decide which training programs best meet their needs and provide them with a stronger incentive to seek such training.

As mentioned earlier, an alternative to the SCT-MH online course is the training program offered by ACPE. ACPE's training approach features live webinar presentations that encourage interactions with instructors and other students rather than relying solely on prerecorded, noninteractive videos and written content. ACPE's training program is more intensive than the edX version of the SCT-MH course, offering two 15-hr training (Levels 1 and 2) for a total of 30 training hours, compared to just 8 hr. Moreover, ACPE's program provides connections and ongoing mentoring opportunities with other professionals and can be tailored to meet the needs of helping professionals from diverse religious, spiritual, and professional backgrounds.

Brief History of ACPE

ACPE began its SIP training program in 2020, but its lineage and values are in the seven-plus-decades-old pastoral counseling movement. In 1964, pastoral counselors across the United States founded the American Association of Pastoral Counselors (AAPC). Its initial mission was to train ministers for psychotherapy. However, by the 2000s, AAPC was also training nonclerical psychotherapists who wanted to engage spirituality as part of their practice more effectively. AAPC training stressed therapists' nonproselytizing attention to the spiritual worldview of their clients, the value of the therapeutic relationship, therapists' use of self, and therapeutic presence; therapists' deep reflection on their own spiritual and theological perspectives and how these shape their understanding of clients, themselves, and the therapeutic process; and the importance of personal and professional formation and, relatedly, the value of ongoing learning in a community of colleagues and mentors.

AAPC dissolved in 2020, and a remnant of its members were welcomed into a sister organization, ACPE. Founded in 1967 as the Association for Clinical Pastoral Education, ACPE provides experience-based education for persons exploring ministry and chaplaincy. Most ACPE training occurs in hospitals and health care settings, but there are programs in prisons, the U.S. military, homeless shelters, congregations, and community-based service settings. Mindful of the spiritual and vocational diversity of its educators, students, and members, many of whom do not identify with the "pastor" title, ACPE changed its name in 2017 to "ACPE: The Standard in Spiritual Care and Education." Under both names, and throughout its almost 60-year history, ACPE training, like AAPC training, has valued nonproselytizing approaches to spiritual care, the importance of caregivers grounding themselves deeply in their spiritual tradition or frame of meaning, the power of a learning cohort, and the action-reflection-action model of education.

In 2020, ACPE welcomed pastoral counselors and spiritually integrated psychotherapists to its membership, expanding its mission to include education and professional formation for psychotherapists and other mental health professionals. ACPE now offers specialty training and certification for licensed and prelicensed mental health professionals (e.g., counselors, social workers, marriage and family therapists, pastoral counselors, psychologists, psychiatrists, psychiatric nurses, addiction specialists, life coaches, and more), as well as graduate students in the mental health disciplines.

Description of ACPE's Current SIP Training Program

Table 1 provides information about the focus and competency objectives of ACPE's training program. The curriculum consists of two levels of training, with each level including five 3-hr continuing education courses. The Level 1 and Level 2 training are offered primarily online via Zoom, but several in person training have occurred. The number of participants in training groups has ranged from as few as three to as many as 30 participants. Each course in the training groups is 3 hr: these are three clock hours, as stipulated in professional continuing education guidelines, not three academic hours. All participants across all training groups are presented with the same curriculum.

The courses utilize multiple modes of teaching and learning, including (a) interactive presentations, (b) case illustrations and case conceptualization, (c) small- and large-group discussion, (d) experiential exercises and prompts for personal reflection, and (e) role-plays and other skill-building exercises. Because of the group discussions, role-plays, and skill-building exercises, each training group has a life of its own.

ACPE offers a postcurriculum certification process (involving 20 hr of clinical consultation), communities of practice for ongoing connection and professional formation, and a Train the Trainer program to develop and support SIP trainers. ACPE sees its training program as more than a continuing education program. It is a multidisciplinary, interspiritual, multiracial community of persons gathered for education, connection, and formation in the work of SIP.

Because helping professionals self-select to take the ACPE training program, most of those who take the ACPE training program have strong interests in spirituality, or at least strong interests in developing S/R competencies. However, ACPE's training program welcomes participants representing the full range of religious and spiritual diversity, which includes professionals who do not identify as religious or spiritual and those who are atheistic and agnostic. The training program is designed to help professionals work effectively with clients representing the entire spectrum of religious and spiritual diversity, embracing all world religions (Western and Eastern) and other spiritual traditions (e.g., transpersonal, humanistic), including theists and nontheists, those who are devout or less devout, and those who consider themselves agnostic, atheistic, nonreligious, or religiously disaffiliated. Readers can find up-to-date information about the training program on ACPE's website (https://acpe.edu/).

Table 1
ACPE Level 1 and Level 2 Courses and Competency Objectives

Course	Competency objective
Training Level 1 (15 hr)	
Course 1.1: Foundations and Ethics of Spiritually Integrated Psychotherapy	• Demonstrate the benefits of integrating spirituality and religion in psychotherapy when done well. • Define a holistic understanding of humans: biopsychosocial spiritual. • Recognize different models for integrating spirituality and religion in psychotherapy. • Summarize the ethical principles that guide how therapists integrate spirituality and religion in therapy. • Comprehend how therapists can ethically draw upon their own spirituality as a resource.
Course 1.2: Developing Spiritual Conversations	• Demonstrate spiritual conversations in therapy in a collaborative rather than directive manner. • Understand the difference between explicit and implicit spiritual language. • Recognize and respond to spiritual openings that clients offer. • Initiate spiritual conversations.
Course 1.3: Spiritual Assessment	• Identify clients' spiritual and religious resources. • Identify clients' spiritual struggles. • Assess whether clients' spirituality is helping or hurting. • Recognize "heart of the matter" spiritual issues affecting the client's well-being. • Determine whether spirituality will be an explicit part of the therapy process.
Course 1.4: Spiritual Interventions: Working with Spiritual Resources, Part 1	• Conduct spiritual assessment. • Help clients deepen existing spiritual resources. • Help clients reconnect with forgotten spiritual resources. • Help clients develop new spiritual resources.
Course 1.5: Spiritual Interventions: Working with Spiritual Struggles	• Identify elements of harmful spirituality or religion. • Discuss how spirituality and religion become harmful. • Discuss strategies for countering the impact of harmful spirituality or religion. • Apply strategies for countering the impact of harmful spirituality or religion to a clinical example.
Training Level 2 (15 hr)	
Course 2.1: Spiritual Interventions: Working with Spiritual Resources, Part 2	• Demonstrate the spiritual interventions in four dimensions rubric. • Identify explicit spiritual practices that can be integrated into psychotherapy. • Identify implicit spiritual practices that can be integrated into psychotherapy. • Incorporate spiritual interventions in therapeutic practice with beginning competence.
Course 2.2: Spiritual Interventions: Working with Harmful Spirituality and Religion	• Recognize and describe spiritual struggles. • Identify spiritual struggles commonly encountered in psychotherapy. • Identify therapeutic strategies for addressing spiritual struggles in ethical and effective ways. • Apply therapeutic strategies for addressing spiritual struggles to a clinical example.
Course 2.3: Spirituality and Belief System of the Therapist	• Recognize the connection between their spirituality and therapeutic presence. • Identify ways their spiritual beliefs impact how they understand clients, the therapeutic relationship, and the therapeutic process. • Investigate areas of spiritual countertransference that may influence the therapeutic process. • Identify personal examples of spiritual countertransference.
Course 2.4: Spiritually Integrated Case Consultation, Part 1	• Describe connections between spirituality and biopsychosocial factors. • Recognize the "heart of the matter" spiritual issues implicit in clinical symptoms and client personality styles. • Name strategies to distinguish between spiritual issues and mental health issues. • Describe elements of a spiritually integrated case conceptualization.
Course 2.5: Spiritually Integrated Case Consultation, Part 2	• Describe elements that distinguish a spiritually integrated case conceptualization from a case conceptualization that does not include attention to spirituality. • Identify ways their own spiritual perspectives can ethically inform case conceptualization and clinical practice. • Describe core competencies of spiritually integrated psychotherapy. • Identify skills for use in posttraining spiritually integrated professional development. • Describe and demonstrate skills for giving/receiving spiritually integrated feedback according to professional best practices.

Study Aims and Hypotheses

This article reports the first empirical evaluation of ACPE's live videoconferencing training program. In doing so, it makes a valuable contribution to existing research, which until now has focused solely on the SCT-MH course. Our findings will help inform the design of future SIP training programs and research and promote the integration of S/R competencies into mental health education.

The present study investigated whether the S/R competencies (self-efficacy, attitudes, and skills) of the participants in the ACPE training program improved and whether their use of spiritual interventions increased during the program. We also assessed whether their perceptions of the barriers to practicing spiritually integrated treatment in their practice setting changed after training. We hypothesized that:

Hypothesis 1: Participants' spiritual competency scores will significantly increase from pre- to posttraining during the ACPE training program. Specifically, participants' scores on (a) self-efficacy about using S/R skills, (b) attitudes about the importance of SIP approaches, and (c) frequency with which they use S/R interventions during treatment will increase from pre- to posttraining. We also hypothesized that the participants' belief in the feasibility of engaging in SIP in their treatment setting would be stronger after completing the training.

Hypothesis 2: Participants' spiritual competency scores and belief in the feasibility of engaging in SIP who completed 30 hr (Levels 1 and 2) of ACPE training will increase significantly more than participants who completed only 15 hr (Level 1) of training.

Hypothesis 3: The frequency with which participants report using four types of S/R interventions in their practices during the past month (i.e., basic spiritual intervention skills, encouraging spiritual practices, discussing virtues, and facilitating religious attachment) will significantly increase from pre- to posttraining.

Hypothesis 4: Participants who completed 30 hr of ACPE training will report using the four types of S/R interventions significantly more often in their practices during the past month than participants who completed only 15 hr of training.

Method

Procedure

We used a quasi-experimental one-group pretest–posttest design. Participants learned about the ACPE training program (described above) and registered in the usual ways. After registering for the training, they were informed about and invited to participate in the research study via a standardized letter. This letter was attached to a pretraining orientation email from the SIP trainer leading the Level 1 training. The recruitment letter informed potential research participants that the study aimed to evaluate the effectiveness of the ACPE training program in SIP. The recruitment letter also contained a link to Qualtrics that gave respondents access to the online electronic packet of research materials, which included an informed consent document and the research measures.

The informed consent document explained that a research study was being conducted by Russell S. Jones, ThD, LCMHCS, (ACPE), P. Scott Richards, PhD, and Peter W. Sanders, PhD on behalf of ACPE: The Standard for Spiritual Care and Education. The consent document said that ACPE endorsed the research study and that the protocol for the research study had been reviewed and approved by the Institutional Review Board committee of the American Institute for Behavioral Research and Technology (https://aibrt.org/).

The consent document also told the participants that if they agreed to participate in the research study, they would be asked before beginning the ACPE training program—and again when they finished the training program—to complete several measures designed to assess their skills and attitudes about the practice of SIP. The participants were informed that participation in the research study was voluntary and that choosing not to participate would not affect the quality of the ACPE SIP training they would receive. The consent document explained that it should take 10–15 min to complete the pretraining survey and 5–10 min to complete the posttraining survey.

After completing the Level 1 training, participants were invited to decide whether to continue and take the Level 2 training. Following the training, the trainer sent a follow-up email requesting that participants complete the posttraining questionnaire.

Sample Description

Between September 1, 2021, and June 30, 2024, 190 people registered for ACPE's training program and attended at least Level 1 of the training. Participants learned about the training program in various ways, such as online searches for training in psychotherapy and spirituality, social media outreach shared by ACPE and individual SIP Trainers, and word-of-mouth recommendations from colleagues and friends.

Of the 190 who registered for the training program, 143 consented to participate in the research study and completed the pretraining research measures. Eighty-four participants completed the research measures before and after the training program, providing a response rate of 58.7% for statistical analyses that required scores on both pre- and posttraining measures. We conducted a power analysis for the $N = 84$ sample size, which revealed that the statistical power for an estimated effect size of .30 was .86. This provided evidence that our sample size was adequate for our planned pre- to posttraining statistical analyses.

Thirty-seven participants completed only Level 1 (15 hr) of the ACPE training program, and 47 chose also to complete Level 2 (an additional 15 hr for a total of 30 hr). We conducted a power analysis for the $N = 37$ and $N = 47$ sample sizes, which revealed that the statistical power for a moderate effect size of .55 was 0.80. This indicated that our sample sizes were adequate for statistical comparisons between participants who completed 15 versus 30 hr of ACPE training, assuming moderate differences between these two groups but inadequate for smaller differences.

Table 2 summarizes the sociodemographic characteristics of the 84 research participants who completed the pre- and posttraining research measures. The mean age of the research participants was 51.4 ($SD = 12.9$). There were 55 females, 24 males, and four who identified as nonbinary or transsexual. Fifty-three were White, 17 Black, three Asian, and four Hispanic/Latinx. Sixty-two (65.4%) were Christian (Protestant, Non-Denominational Christian, Roman Catholic, and Other Christian), but 22 (23.2%) were Jewish,

Table 2
Sociodemographic Characteristics of Research Participants (N = 84)

Characteristic	*N*	%	*M* (*SD*)
Age	82		51.4 (13.4)
Gender			
Female	55	57.9	
Male	24	25.3	
Other (nonbinary, trans)	4	4.3	
Race			
White/Caucasian	53	55.8	
African American/Black	17	17.9	
Asian	3	3.2	
Hispanic/Latinx	4	4.2	
Other	6	6.4	
Religious affiliation			
Protestant Christian	36	38.1	
Roman Catholic	6	6.3	
Christian (Non-Denominational)	12	12.6	
Other Christian	8	8.4	
Jewish	3	3.2	
Buddhist	4	4.2	
Agnostic	2	2.1	
Other (nonspecified)	13	13.7	
Religious beliefs important			
Definitely true	56	58.9	
Tends to be true	24	25.3	
Unsure	3	3.2	
Tends not to be true	0	0.0	
That is definitely not true	1	1.1	
Religious attendance			
More than once a week	27	28.4	
Once a week	26	27.4	
A few times a month	17	17.9	
A few times a year	9	9.5	
Once a year or less	3	3.2	
Never	1	1.1	
Highest degree			
PhD, EdD, or ThD	14	14.8	
MA, MS, or Med	45	49.5	
Other (MDiv, DMin, etc.)	22	14.3	
Licensed			
Yes	64	67.4	
No	19	20.0	
Provide professional counseling			
Yes	66	69.5	
No	18	18.9	
Professional specialty			
Mental health counselor	42	37.8	
Pastoral counselor	19	17.1	
Psychologist	4	3.6	
Social worker	21	18.9	
Marriage and family therapist	7	6.3	
Chaplain	5	4.5	
Other (e.g., nurse, clergy, educator)	13	11.7	
Geographic region			
Northeast	13	15.5	
Southwest	5	5.9	
West	14	16.7	
Southeast	37	44.0	
Midwest	13	11.7	
Employment setting			
Secular	116	93.5	
Faith-based	8	6.5	
Prior training in S/R integration			
Yes	27	32.1	
No	57	67.9	

Note. S/R = spiritual/religious.

Buddhist, agnostic, or religious others (nonspecified). Eighty (84.2%) indicated their religious beliefs were important to them, and 70 (73.7%) attended religious worship services at least a few times a month.

Regarding professional training and specialty, 45 of the participants indicated they had a master's degree, 14 a doctorate degree (e.g., PhD, EdD, ThD), and 22 other degrees (e.g., MDiv, DMin). Sixty-four of the participants indicated they are licensed, 66 provide professional counseling or therapy on a regular basis, 74 were mental health professionals (i.e., mental health counselors, psychologists, social workers, or marriage and family therapists), and 24 were pastoral counselors or chaplains. One hundred sixteen indicated they were employed in secular settings, and only eight were employed in faith-based settings. Regarding geographic location, 37 participants noted they reside in the Southeast region of the United States, 14 reside in the Western region, 13 in the Northeast region, 10 in the Midwestern region, and five in the Southwest region. Five participants indicated they do not reside in the United States. Twenty-seven participants said they had prior training in integrating spirituality into psychotherapy, and 57 had no previous training about this topic.

Trainers

Fourteen different SIP Trainers led the ACPE training during the research study. Twelve of the 14 had previously been certified by the American Association of Pastoral Counselors at the Fellow or Diplomate level. Nine were female, five were male, nine were Caucasian, four were African-American, and one was Korean-American. Seven were located in the southeastern United States, four in the Northeast, two in the Midwest, and one in California. The survey packet the trainees completed did not ask them to identify the person who led their training group.

Measures

Previous S/R Training

The Counselor Spirituality Preparation Survey (Dobmeier & Reiner, 2012) consists of six questions about participants' training in S/R competencies, including how often the topics of religion and spirituality were addressed in coursework, whether S/R were covered in a designated course or infused in multiple classes; what aspects of S/R were covered (e.g., world religions, S/R assessment, religious and spiritual aspects of diversity); and how many and what types of continuing education credits in S/R issues they have received during the last 4 years or since they graduated. We used the Counselor Spirituality Preparation Survey only for descriptive purposes and not as a validated measure of previous training.

Spiritual Competencies

The Religious/Spiritually Integrated Practice Assessment Scale (RSIPAS; Oxhandler & Parrish, 2016) is a 5-point Likert-type measure that was used to assess self-reported competencies in one attitude domain (attitudes about S/R integrated clinical practice [12 items], range 12–60), two skills domains (self-efficacy with S/R integrated clinical practice [13 items], range 13–65); (current

engagement in S/R integrated practice behaviors [nine items], range 9–45), and one feasibility domain (barriers to spiritually integrated practice [six items], range 6–30). Each subscale score was computed separately rather than as a single overall score. A validation study demonstrated excellent convergent and divergent validity for the four subscales and internal reliability, with subscale α coefficients ranging from .84 to .91 for the four subscales and .95 for the total scale (Oxhandler & Parrish, 2016). In the present study, the subscales had good internal consistency reliabilities (standardized Cronbach's α = .90 for S/R Self-Efficacy, .84 for S/R Attitudes, .89 for Engagement in S/R Practices, and .80 for S/R Feasibility).

Use of Spiritual Interventions in Practice

The Therapist Session Checklist (TSC; Sanders et al., 2015) is a psychotherapy process measure that includes a list of spiritual practices and interventions psychotherapists may encourage or use during treatment. The TSC is typically used for descriptive purposes to allow psychotherapists to report what interventions they used from session to session during treatment. In our study, we asked the participants (before and after their participation in the ACPE training program) to rate how often they used each TSC spiritual intervention during the past month in their treatment sessions on a 6-point scale (1 = *never*, 2 = *rarely*, 3 = *occasionally*, 4 = *often*, 5 = *very often*, 6 = *always*). The list of TSC spiritual interventions was tailored for the present study by adding some additional spiritual interventions recommended in the ACPE SIP training program.

A recent factor analysis of the spiritual intervention (SI) items on the TSC revealed that the items could be grouped into four general types or subscales, including (a) Basic S/R Skills, (b) Encouraging Spiritual Practices, (c) Discussing Virtues, and (d) Facilitating Spiritual Attachment (Sanders & Richards, 2022). In the present study, scores for the four TSC spiritual intervention subscales were calculated by summing each item associated with that subscale. In the present study, the TSC SI subscales had good internal consistency reliabilities (standardized Cronbach's α = .94 for Basic S/R Skills, .93 for Encouraging Spiritual Practices, .91 for Discussing Virtues, and .93 for Facilitating Spiritual Attachment).

Plan of Analysis

Inferential statistics, including *t*-tests and repeated measures multivariate analysis of variance (RM-MANOVA), were used to test the hypotheses that participants' perceptions of their spiritual competencies, therapeutic use of spiritual interventions, and the feasibility of spiritually integrated treatment improved during the training program. When conducting the repeated measures multivariate analysis of variance, we tested whether the interaction between the Time of Testing (pre- vs. posttraining) and Training Level (15 hr vs. 30 hr) was statistically significant. We also computed Cohen's *d* effect sizes between the training level groups to understand better the magnitude of the differences based on training level. Finally, we conducted several analyses to clarify whether there were any important sociodemographic differences between survey completers and noncompleters and Level 1 and Level 2 training groups. We also used a multiple regression analysis to examine whether sociodemographic variables predicted increased S/R competencies and spiritual intervention use.

Transparency and Openness

We report how the sample size for statistical analysis was determined, data exclusions, and measures. The study design and analyses were not preregistered. Materials and analysis code for this study are unavailable via a repository. Please contact the corresponding author to request access to the data or other study materials. Data were analyzed using SPSS Version 30.0.0.0. Our data met the statistical assumptions required for the statistics we used; that is, the data on our spiritual competency and spiritual intervention measures met the assumptions required for the inferential statistical analyses we conducted (i.e., normality, equality of variances).

Results

Sociodemographic Analyses

Survey Completers and Noncompleters

Because of the relatively low response rate of those who completed both the pre- and posttraining research measures, we compared those who completed both pre- and posttraining measures (i.e., Pre–Post Survey Completers) on their sociodemographic characteristics with those who completed only the pretraining measures (i.e., the Pre-Only Survey Completers) to see if there were any meaningful differences between these two groups of participants. We found no differences between the Pre–Post Survey Completers group and the Pre-Only Survey Completers group on age, gender, highest degree, religious affiliation, religious commitment, and number of clients seen per week in treatment. However, those in the Pre–Post Survey Completers group were significantly more likely to be licensed (χ^2 = 13.3, $p < .001$) and provide professional counseling services (χ^2 = 4.33, $p < .05$).

Training Level Groups

Because participants who completed Level 1 training and both Levels 1 and 2 training were not randomly assigned to the level of training they completed, we compared the sociodemographic characteristics of these two groups of participants to help us better understand our findings on differences (or lack thereof) on the S/R competency measures. We found no significant associations between the training level groups on age, gender, license status, years licensed, practitioner status (seeing clients or not), number of clients seen per week, religious devoutness, frequency of church attendance, and prior training in S/R competencies. There were also no significant differences between the training level groups on any pretraining RSIPAS or TSC subscales. There was a small but statistically significant tendency for those who completed Level 2 training to spend more time in private S/R activities (e.g., prayer, meditation, reading sacred texts; $\chi^2 = 13.7$, $df = 5$, $p = .017$).

Predictors of Spiritual Competencies and Interventions

We conducted stepwise multiple regression analyses to determine whether the participants' total RSIPAS competency scores and their use of TSC spiritual interventions could be predicted by gender, age, licensure status, years since licensure, provision of professional counseling services, the number of clients seen weekly, highest degree attained, religious devoutness, frequency of private religious activities, church attendance, the frequency with which S/R was

Table 3

Multivariate Repeated Measures Analyses for Change in RSIPAS Spiritual Competencies and TSC Spiritual Interventions Usage

Measure	*F*	*df*	*p*	Hotelling's trace
RSIPAS Spiritual Competencies				
Within-subjects				
(Time testing: pre to post)	48.3	3, 69	<.001	2.10
(Time testing by training level)	0.20	3, 69	.90	0.01
TSC Spiritual Interventions				
Within-subjects				
(Time testing: pre to post)	18.0	4, 60	<.001	2.20
(Time testing by training level)	2.26	4, 60	.07	0.15

Note. The RSIPAS Spiritual Competencies include the three subscales from the RSIPAS: S/R Self-Efficacy, S/R Attitudes, and Engagement in S/R Practices. The TSC measure includes four subscales: Basic Skill Spiritual Interventions, Encouraging Spiritual Practices, Discussing Virtues, and Facilitating Religious Attachment. RSIPAS = Religious/Spiritually Integrated Practice Assessment Scale; TSC Spiritual Interventions = Therapist Session Checklist Spiritual Interventions; time testing = pre- to post spiritually integrated psychotherapy training; training level = Level 1 (15 hr) versus Level 2 (30 hr); *df* = degrees of freedom.

addressed in graduate coursework, or whether S/R integration in psychotherapy was covered in coursework. We found that "greater frequency of private religious activities" ($\beta = .31$, $t = 2.96$, $p = .004$), "female gender" ($\beta = .23$, $t = 2.20$, $p = .031$), and "more advanced degree" ($\beta = .22$, $t = 2.08$, $p = .041$) significantly predicted higher total RSIPAS competency scores. The "frequency with which S/R was addressed in coursework" ($\beta = .34$, $t = 3.22$, $p = .002$) was the only statistically significant predictor of the total usage score for TSC spiritual interventions.

Multivariate and Univariate Analyses of RSIPAS and TSC

Table 3 presents the results from the RM-MANOVA. The RM-MANOVA within-subjects (Time of Testing) *F*-test for the three RSIPAS spiritual competencies subscales was statistically significant, $F(3, 70) = 50.2$, $p < .001$, revealing that participants' scores on at least one of these measures significantly changed from pre- to posttraining. The RM-MANOVA within-subjects (Time of Testing) *F*-test for the four TSC Spiritual Interventions subscales was statistically significant, $F(4, 60) = 17.9$, $p < .001$, revealing that the research participants' scores on at least one of these measures significantly changed from pre- to posttraining. Because the statistically significant multivariate *F*-tests on the RSIPAS and TSC subscales did not tell us which subscales the participants' scores changed on, follow-up univariate comparisons were needed to determine where the statistically significant changes occurred. These comparisons are reported in Table 4.

The interaction between Time of Testing and Training Level was not statistically significant for the three RSIPAS spiritual competencies subscales, $F(3, 69) = 0.20$, $p = .90$. The Time of Testing × Training Level interaction for the four TSC spiritual interventions subscales was also not statistically significant, $F(4, 60) = 2.26$, $p = .07$. Due to the statistically nonsignificant interactions between Time of Testing × Training Level on the RSIPAS spiritual competencies subscales and TSC spiritual interventions subscales, we did not conduct univariate *t*-tests on each of these subscales. However, we did compute Cohen's *d* effect sizes on the pre- to posttraining comparisons for each subscale to better understand the magnitude of the differences (or lack thereof) between participants who completed only Level 1 of the training compared to those who completed both Level 1 and Level 2.

The Cohen's *d* effect sizes for the posttraining comparisons between the two Training Level groups on the RSIPAS spiritual competencies subscales were relatively small: RSIPAS Self-Efficacy ($d = .17$), RSIPAS Attitudes ($d = .03$), RSIPAS Skills ($d = .17$), and RSIPAS Feasibility ($d = .31$; Barkham & Lambert, 2021; Cohen, 1992). The Cohen's *d* effect sizes for the posttraining comparisons between the two Training Level groups on the TSC spiritual interventions subscales were also relatively small: TSC Basic S/R Skills ($d = .21$), TSC Spiritual Practices ($d = .09$), TSC Discussed Virtues ($d = .35$), and TSC Religious Attachment ($d = .04$; Barkham & Lambert, 2021; Cohen, 1992).

Table 4 presents the results of the follow-up univariate *t*-tests on each of the RSIPAS and TSC Spiritual Interventions subscales. It can be seen that participants' scores on the RSIPAS subscales all significantly improved during training. Cohen's *d* effect sizes for the

Table 4

Univariate Follow-Up Analyses for Change in RSIPAS Spiritual Competencies and Feasibility of S/R Treatment and TSC Spiritual Interventions Usage

Measure	*N*	Pre *M* (*SD*)	Post *M* (*SD*)	MD	*df*	*t*	*p*	Cohen's *d*
RSIPAS Spiritual Competencies								
RSIPAS Self-Efficacy	79	47.0 (8.5)	58.4 (5.5)	11.4	78	13.2	<.001	1.48
RSIPAS Attitudes	78	52.4 (4.5)	56.0 (3.8)	3.6	77	6.8	<.001	0.77
RSIPAS Practices	79	29.4 (6.8)	35.1 (5.8)	5.7	78	8.8	<.001	0.99
RSIPAS Perceived Barriers								
Greater Feasibility	81	22.6 (4.0)	26.1 (3.0)	3.5	80	8.4	<.001	0.94
TSC Spiritual Interventions Usage								
Basic SI Skills	74	40.7 (13.4)	50.6 (12.4)	9.9	73	7.5	<.001	0.88
Encouraging Spiritual Practices	72	51.6 (17.8)	61.2 (16.0)	9.6	71	5.6	<.001	0.66
Discussing Virtues	77	23.9 (5.8)	25.4 (6.0)	1.5	76	2.4	<.011	0.27
Facilitating S/R Attachments	76	26.0 (10.3)	30.8 (9.5)	4.9	75	5.2	<.001	0.60

Note. RSIPAS = Religious/Spiritually Integrated Practice Assessment Scale; TSC Spiritual Interventions = Therapist Session Checklist Spiritual Interventions; pre *M* = pretraining mean; post *M* = posttraining mean; MD = mean difference; Cohen's *d* = effect size; SI = spiritual intervention; *df* = degrees of freedom; S/R = spiritual and religious.

RSIPAS subscales were large (ranging from 0.82 to 1.48; Cohen, 1992). The participants' S/R self-efficacy, attitudes, and skills were much more positive after completing the ACPE training program. The participants' scores on the RSIPAS Feasibility subscale also significantly increased during training, and Cohen's *d*-effect size was 0.89. Thus, the magnitude of the observed changes on the RSIPAS subscales appear clinically and educationally meaningful (Barkham & Lambert, 2021; Cohen, 1992).

The research participants' TSC Spiritual Interventions subscales scores significantly increased during training. The Cohen's *d* effect sizes for three subscales were moderately large (Encouraging Spiritual Practices subscale = 0.66 and Facilitating Religious Attachment subscale = 0.60) or large (Basic S/R Skills = 0.88). In contrast, Cohen's *d* for the Discussing Virtues subscale was relatively small (0.27) but still educationally and clinically meaningful (Barkham & Lambert, 2021).

Table 5 presents pre- and posttraining means, standard deviations, mean differences, and effect sizes for each specific TSC spiritual intervention item. This table allows us to see the relative frequency with which the participants use specific spiritual interventions in

Table 5

Pre- and Posttraining Frequency of the Use of Specific TSC Spiritual Interventions During Treatment Sessions the Past Month

Spiritual intervention	Pretraining *M* (*SD*)	Posttraining *M* (*SD*)	MD	Cohen's *d*
Basic SI Skills				
1. Listened to spiritual issues	4.12 (1.3)	4.71 (1.1)	0.60	0.46
2. Discussed the spiritual dimensions of problems and solutions	3.53 (1.5)	4.40 (1.1)	0.87	0.64
3. Explored questions about ultimate meaning	3.64 (1.5)	4.38 (1.2)	0.74	0.57
4. Validated and engaged in a spiritual struggle	3.70 (1.4)	4.35 (1.2)	0.66	0.47
5. Helped client deepen an existing healthy spiritual resource	3.61 (1.4)	4.35 (1.2)	0.74	0.55
6. Explored religious questions and doubts	3.56 (1.4)	4.24 (1.3)	0.69	0.49
7. Helped client connect with currently unused spiritual resource	3.19 (1.2)	3.96 (1.2)	0.77	0.62
8. Helped client connect with a new spiritual resource	2.94 (1.2)	3.76 (1.2)	0.82	0.65
9. Conducted a religious–spiritual assessment	2.46 (1.5)	3.62 (1.5)	1.15	0.84
10. Engaged in spiritual self-disclosure	2.82 (1.3)	3.47 (1.3)	0.65	0.47
11. Affirmed healthy experience of guilt	2.63 (1.3)	3.41 (1.4)	0.56	0.35
12. Discussed harmful spiritual or religious practice	2.63 (1.3)	3.19 (1.4)	0.71	0.48
13. Clarified thoughts about evil	2.45 (1.4)	3.01 (1.4)	0.56	0.45
Encouraging spiritual practices				
1. Encouraged spending time in nature as a spiritual resource	3.72 (1.4)	4.41 (1.2)	0.69	0.47
2. Discussed, encouraged, or offered instruction about mindfulness	3.85 (1.4)	4.29 (1.2)	0.44	0.35
3. Used mindfulness with client without calling it mindfulness	3.47 (1.4)	4.11 (1.4)	0.65	0.41
4. Discussed, encouraged, or offered instruction about client meditation	3.39 (1.4)	3.81 (1.4)	0.42	0.29
5. Encouraged service or altruism as a spiritual resource	3.09 (1.5)	3.65 (1.4)	0.56	0.41
6. Encouraged use of music as a spiritual resource	3.12 (1.6)	3.64 (1.4)	0.52	0.36
7. Encouraged meditation about spiritual matters to promote growth	2.95 (1.5)	3.58 (1.4)	0.63	0.41
8. Asked client to journal concerning spiritual struggles and experiences	2.71 (1.5)	3.58 (1.5)	0.87	0.62
9. Encouraged client private prayer	3.05 (1.6)	3.51 (1.5)	0.46	0.31
10. Encouraged charitable service	2.94 (1.5)	3.43 (1.4)	0.49	0.34
11. Engaged client in conversation about a sacred text from their tradition	2.78 (1.4)	3.38 (1.4)	0.60	0.49
12. Employed the client's religious community as an extratherapy resource	2.83 (1.4)	3.24 (1.5)	0.41	0.23
13. Used guided spiritual imagery during session	2.35 (1.4)	3.04 (1.5)	0.68	0.50
14. Prayed before or during a session	2.62 (1.7)	2.91 (1.7)	0.30	0.20
15. Referred to client's religious leader or clergy person	2.40 (1.3)	2.82 (1.3)	0.42	0.33
16. Gave client religious and spiritual literature to read	2.36 (1.2)	2.69 (1.3)	0.33	0.27
17. Therapist and client vocal in session prayer	2.08 (1.4)	2.41 (1.5)	0.33	0.28
18. Consulted with client's religious leader or clergy person	1.65 (1.0)	1.72 (1.0)	0.06	0.07
Discussing virtues				
1. Discussed hope	4.38 (1.2)	4.68 (1.0)	0.30	0.24
2. Discussed compassion	4.32 (1.1)	4.62 (1.1)	0.30	0.28
3. Discussed gratitude	4.18 (1.1)	4.55 (0.9)	0.37	0.33
4. Discussed forgiveness	3.71 (1.2)	4.04 (1.2)	0.33	0.28
5. Discussed self-control	3.87 (1.2)	3.99 (1.3)	0.12	0.08
6. Discussed humility	3.37 (1.2)	3.58 (1.4)	0.21	0.16
Facilitating spiritual attachments				
1. Affirmed client's divine worth	3.92 (1.6)	4.57 (1.5)	0.65	0.44
2. Encouraged listening to the heart	4.00 (1.4)	4.51 (1.1)	0.51	0.38
3. Affirmed trusting of the divine	3.57 (1.6)	3.97 (1.5)	0.40	0.30
4. Encouraged acceptance of divine love	3.23 (1.7)	3.96 (1.5)	0.73	0.48
5. Encouraged reconciling beliefs in the divine with pain and suffering	3.00 (1.5)	3.74 (1.4)	0.74	0.53
6. Helped in discerning divine guidance	2.82 (1.5)	3.64 (1.5)	0.82	0.60
7. Identified pathways to the divine or sacred	2.91 (1.5)	3.54 (1.5)	0.63	0.47
8. Facilitated conversation between client and God/Higher Power	2.33 (1.5)	2.67 (1.6)	0.33	0.25

Note. Response scale for spiritual intervention items was: 1 = *never*; 2 = *rarely*; 3 = *occasionally*; 4 = *often*; 5 = *very often*; 6 = *always*. TSC Spiritual Interventions = Therapist Session Checklist Spiritual Interventions; MD = mean difference; Cohen's *d* = effect size; Basic SI Skills = basic spiritual intervention skills.

their treatment sessions and how much this changed after they completed the training program. The TSC items in Table 5 are grouped by their subscale and rank-ordered within each subscale grouping based on their posttraining mean score. Spiritual interventions that participants use more frequently have higher rankings (e.g., No. 1 is a higher ranking than No. 10).

"Listened to spiritual issues" was the most frequently used spiritual intervention on the Basic SI Skills subscale. The posttraining mean score for "Listened to spiritual issues" was 4.71 ($SD = 1.1$), which indicates that, on average, the participants used this intervention often to very often. Table 5 shows that five additional "Basic SI Skills" items had posttraining mean scores greater than 4.00, indicating that these spiritual interventions were, on average, used often during treatment sessions. The least frequently used was "Clarified thoughts about evil."

Three of the "Encouraging Spiritual Practices" items had posttraining mean scores greater than 4.00, indicating that these spiritual interventions were, on average, used often during treatment sessions. The least frequently used intervention was "Consulted with client's religious leader." Four "Discussing Virtues" items had posttraining mean scores greater than 4.00, indicating that these spiritual interventions were, on average, used often during treatment sessions. The least frequently used "Discussing Virtues" intervention was "discussed humility." Two "Facilitating Spiritual Attachments" items had posttraining mean scores greater than 4.00, and two had posttraining mean scores that closely approached 4.00. The least frequently used "Facilitating Spiritual Attachments" intervention was "Facilitated conversation between client and God/Higher Power."

The Cohen's d effect size changes in how frequently the participants used the spiritual interventions from pre- to posttraining ranged from small ($d = 0.20$) to large ($d = 0.80$; Barkham & Lambert, 2021; Cohen, 1992). The average Cohen's d across all TSC spiritual intervention items was 0.40. For Basic S/R Practices, Cohen's d was 0.54; for Encouraging Spiritual Practices, 0.35; for Discussing Virtues, 0.23; and for Facilitating Religious Attachment, 0.43.

The TSC Spiritual Intervention items that participants reported the largest increases in use from pre- to posttraining were "conducted a spiritual assessment" ($d = .84$), "helped client connect with new spiritual resource" ($d = .64$), "discussed the spiritual dimensions of problems and solutions" ($d = .65$), "asked client to journal concerning spiritual struggles and experiences" ($d = .62$), "helped client connect with currently unused spiritual resource" ($d = .62$), and "helped in discerning Divine guidance" ($d = .60$).

Discussion

The study's most important finding is that the participants viewed their spiritual competencies much more positively after completing the ACPE SIP training program. The participants' S/R self-efficacy, attitudes about the importance of spiritual issues in treatment, use of S/R interventions, and belief in the feasibility of spiritually integrated practice increased after training. Furthermore, the magnitude of the changes in spiritual competencies is large and compares favorably with the average effect sizes reported for various psychological, medical, and educational interventions (Barkham & Lambert, 2021; Cohen, 1992). This provides preliminary support that the observed improvement was due to the ACPE training program. Although our quasi-experimental design does not conclusively rule out alternative explanations, as discussed in the Limitations section below, it lays the foundation for additional, more rigorously designed experimental outcome studies about ACPE's training program.

The types and magnitude of the improvement in spiritual competencies observed in our study are generally comparable to those reported in Pearce and her colleagues' pioneering studies of their SCT-MH curriculum (Pearce et al., 2020, 2024; Salcone et al., 2023). In examining the findings from Pearce's studies and comparing them with the present study, we noticed there is a consistent trend for the Cohen's d effect sizes to be somewhat larger in the two programs that require more training hours (i.e., ACPE's 15-hr program and SCT-MH's 15-hr hybrid program compared to the 8-hr SCT-MH online course). This raises the possibility that increasing training from 8 to 15 hr may have some added benefit for enhancing spiritual competencies. Such a conclusion should be viewed cautiously, given that these three training approaches have not been directly compared in a randomized controlled study.

The finding that the participants used various TSC spiritual interventions in their treatment sessions—both before and after they completed the ACPE training—is consistent with other research that has shown that many mental health practitioners integrate a wide variety of religious and spiritual interventions into their treatment sessions with clients (Plante, 2009; Richards & Bergin, 2005; Richards, Allen, & Judd, 2023; Sanders et al., 2015). Our study also showed that practitioners who completed the ACPE SIP training program reported using a variety of TSC spiritual interventions more often during treatment sessions than before receiving such training. They reported that their use of basic spiritual intervention skills increased the most. They also reported an increased frequency with which they encouraged clients to engage in spiritual practices during or after treatment sessions. They also used interventions to facilitate clients' relationships with God or their spiritual sources more frequently.

Future research is needed to see if increased use of specific spiritual interventions during treatment is associated with improved client treatment outcomes. We should not assume that the increased usage of spiritual interventions reported by the practitioners in this study proves they are now more effective or that their treatment outcomes are better. Simply increasing the frequency of spiritual interventions during treatment sessions does not appear to improve treatment outcomes (Sanders et al., 2015), nor should we expect it to do so. The timing of an intervention, client readiness, the nature of the clinical issue, and the skill with which the practitioner implements the intervention all potentially influence an intervention's effectiveness and client improvement.

Given the well-documented finding that a minority of psychotherapy clients get worse during therapy (Barkham & Lambert, 2021), we believe there is a need for research investigating whether SIPs adversely affect certain clients. For instance, clients who identify as atheistic, agnostic, or who are grappling with their religion or spirituality may have different, even harmful, experiences with SIP, especially if the psychotherapist does not create space during treatment to address spiritual doubts and struggles. We believe that S/R competency training programs must prepare psychotherapists to navigate such situations with sensitivity and competence.

Research shows that most spiritually integrative practitioners use spiritual interventions in a treatment-tailoring fashion, depending on the client's readiness, preferences, and needs (Richards & Bergin, 2005). Recent research provides evidence that using certain spiritual

interventions during treatment (i.e., assessing clients' S/R, exploring religious questions and doubts, discussing self-control, and encouraging acceptance of divine love) predicts improvements in clients' emotional and spiritual functioning (e.g., Currier, McDermott, et al., 2024). Further research is needed to investigate whether SIP training enhances practitioners' ability to implement specific spiritual interventions sensitively and effectively.

As revealed in Table 5, it was interesting that the participants often discussed virtues with their clients, even before completing the training program. The smaller mean change in Cohen's *d* effect sizes in Table 5 for the "discussed virtue" items from pre- to posttraining was not because the participants did not frequently use these spiritual interventions in their treatment sessions. On the contrary, several of these interventions (e.g., discussing hope, compassion, and gratitude) were among the most frequently used spiritual interventions before and after training. The finding that the mental health and pastoral professionals in our study often include the discussion of virtues during treatment sessions is consistent with previous research and reflects a growing trend toward using virtues-based interventions in mental health treatment (Peteet, 2023).

Because of our small sample size and low statistical power (Cohen, 1992), we were not surprised that the interaction effect for time of testing and training level (Table 3) was statistically nonsignificant. In addition, when we examined the Cohen's *d* effect sizes for posttraining differences between those participants who completed only Level 1 training and those who also completed Level 2, we were surprised that the effect sizes favoring the Training Level 2 participants were not larger. Although the RSIPAS Feasibility ($d = .31$), RSIPAS Self-Efficacy ($d = .17$), RSIPAS Skills ($d = .17$), TSC Basic S/R Skills ($d = .21$), and TSC Discussed Virtues ($d = .35$) training level differences favoring the Level 2 training group are not trivial (Barkham & Lambert, 2021; Cohen, 1992), they are relatively small and their educational and clinical implications are unclear.

One possible interpretation of our findings is that ACPE's Level 1 training is sufficient for helping practitioners acquire essential S/R competencies. Another possibility is that the RSIPAS and TSC measures we used were not sensitive to measuring improvements in more advanced knowledge, attitudes, and skills targeted by ACPE's Level 2 SIP training. Additional research that pays closer attention to the nuances of the specific knowledge, attitudes, and skills targeted by the ACPE Level 2 training and the spiritual competency measures used to assess training outcomes will be needed to resolve these questions. We are unaware of previous research that has experimentally examined whether the level or intensity of training in S/R competencies is associated with increases in such competencies. Such research is needed to provide insight into how much S/R competency training is necessary to help practitioners acquire basic and more advanced S/R competencies.

Limitations

Several limitations of the present study should be considered when interpreting and generalizing the findings. The completion rate for the pre- and posttraining surveys was somewhat low (58.7%). Although it is typical for mental health professionals to have low response rates to surveys, low response rates are problematic because they make it more difficult to generalize the findings of research studies to the population of interest. Smaller sample sizes may also reduce the statistical power needed for some analyses.

In this study, we wanted to generalize our findings to all participants who completed the ACPE SIP training program. Due to the low response rate, we can only safely make conclusions about the participants who completed the ACPE training program AND completed the pre- and posttraining measures. Our comparison of demographic and religious differences between participants who completed pre- and posttraining measures versus those who did not reveal that those who completed the measures before and after training were significantly more likely to be licensed and provide professional counseling services. Thus, the findings of our study can be more safely generalized to licensed, practicing mental health and pastoral professionals.

The quasi-experimental single-group pre- to posttraining research design does not permit us to make confident conclusions about whether the ACPE training program was responsible for improving the participants' spiritual competencies and practices. Although we think the most plausible explanation for why the participants' spiritual competencies and use of spiritual interventions changed so much is because the ACPE SIP training program is effective, we cannot conclusively rule out the possibility that there may be alternative explanations for the changes in spiritual competency scores. For example, perhaps social desirability influences caused the participants to report improvements in their spiritual competencies, even though they may not have benefited from the training program. Experimental studies with a no-training control group will be needed to rule out such competing explanations with certainty.

Participants who completed Level 1 training only, as opposed to those who completed both Level 1 and Level 2 training, were not randomly assigned since this was an evaluation of a "naturally occurring" training program. Participants registered through the standard procedures for the ACPE training program. They were informed about and invited to participate in the research study only after registering for the training. After finishing the Level 1 training, participants chose whether to proceed to the Level 2 training. Because participants were not randomly assigned to the training level groups, our findings regarding differences between these groups on the RSIPAS and TSC measures must be interpreted cautiously. Additionally, our relatively small sample size ($N = 84$) of participants who completed both the pre- and posttraining research measures resulted in inadequate statistical power for comparing those who completed Levels 1 and 2 training. Therefore, alternative explanations for the size and direction of the differences between the training groups are possible. A true experimental design, where participants are randomly assigned to training level groups and where each group has a larger sample size, is needed to clarify the extent to which ACPE Level 2 training enhances S/R competencies beyond what is achievable with Level 1 training.

Although we assessed changes in several essential S/R competencies in our study (i.e., S/R self-efficacy, S/R attitudes, S/R practice skills, S/R interventions), we did not assess changes in the participants' S/R knowledge. We considered using S/R knowledge tests constructed by Pearce et al. (2020) but decided not to because they do not cover the complete domain of knowledge in ACPE's training program. Thus, we thought they would not adequately measure the knowledge acquisition of those taking the ACPE program. Because ACPE did not have any tests to assess knowledge acquisition for their program, and our research team did not have the resources to prepare such exams, we did not assess knowledge acquisition.

The TSC is typically used as a treatment process measure, where psychotherapists are asked immediately following a treatment session to report (yes or no) what interventions they used during the session (Sanders et al., 2015). We broke new ground with the TSC by asking the participants to rate how often they used the spiritual interventions "during the past month" in their work. Although our application of the TSC appears methodologically sound, the TSC findings should be viewed tentatively until additional research is conducted to establish the validity of the TSC items and subscales for the purpose we used it.

Finally, our findings are limited in generalizability to people with at least some degree of religious and spiritual involvement. Only a minority of participants in our sample reported being uninvolved in S/R beliefs and practices. Furthermore, we found that participants who more frequently engage in private religious practices (religious devoutness) tended to have higher RSIPAS spiritual competency scores. It remains to be determined whether the ACPE training program would be as helpful to those less religiously and spiritually involved.

Implications and Future Directions

The most important implication of our study is that after completing 15–30 hr of the ACPE's SIP training program, the mental health and pastoral helping professionals' perceptions of their spiritual competencies and practice were much more positive, including their (a) self-efficacy about using S/R skills, (b) attitudes about the importance of SIP, (c) current engagement in S/R integrated practice behaviors, and (d) the frequency with which they use spiritual interventions during treatment sessions. It was also noteworthy that the participants felt more freedom and confidence about the feasibility of integrating spirituality into psychotherapy in their treatment settings after completing the training. Future research is needed to determine how the ACPE Level 2 training program may augment Level 1 training and to evaluate the effectiveness of other S/R competency training programs and approaches.

Conclusion

Research now provides preliminary evidence supporting the effectiveness of several SIP training approaches, including the SCT-MH online edX course for practitioners, the SCT-MH enhanced hybrid curriculum for graduate students, and ACPE's live videoconferencing approach for practitioners. More rigorously designed experimental outcome studies of these and other training programs are needed to provide additional insights into which SIP training approaches and dosages (i.e., training hours) are most effective in enhancing basic and advanced S/R competencies for helping professionals. We believe such an evidence base will help address the longstanding neglect of S/R training in the mainstream mental health professions (Currier, 2024; Richards, Currier, et al., 2023; Richards et al., 2015). As health care professionals demonstrate competency in S/R aspects of diversity and treatment, this will help further legitimize spiritually integrated treatment approaches, ensuring that spiritually minded individuals have more options for receiving effective treatment in alignment with their religious and cultural worldviews.

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