

RELIGIOUS TRAINING AND COMPETENCE  
IN APA-ACCREDITED  
GRADUATE CLINICAL PSYCHOLOGY PROGRAMS

By

NATHANIEL JOHN COONEY

Bachelor of Science in Psychology  
Wright State University  
Dayton, Ohio  
2006

Master of Science in Psychology  
Oklahoma State University  
Stillwater, Oklahoma  
2009

Submitted to the Faculty of the  
Graduate College of the  
Oklahoma State University  
in partial fulfillment of  
the requirements for  
the Degree of  
DOCTOR OF PHILOSOPHY  
December, 2013

RELIGIOUS TRAINING AND COMPETENCE  
IN APA-ACCREDITED  
GRADUATE CLINICAL PSYCHOLOGY PROGRAMS

Dissertation Approved:

James W. Grice, Ph.D.

---

Dissertation Adviser

John M. Chaney, Ph.D.

---

Maureen A. Sullivan, Ph.D.

---

Dale R. Fuqua, Ph.D.

---

## DEDICATION

To my guide and faithful companion, Fisher “Valdez,”  
my truest friend who has remained always by my side;  
accompanying my every step on this great and challenging journey  
from beginning to completion.

## ACKNOWLEDGMENTS

In submitting this work – the final magnum opus of my graduate studies – there are many to whom thanks is due. Although it would be impossible to articulate the depth and breadth of gratitude that is owed to so many people, there are a select few whose influences on my work and on my life have been indelible. For these reasons and others, my thanks to these individuals cannot go without specific mention.

To my LORD God to whom all glory and honor are due: I am nothing apart from His grace and I am eternally grateful for the blessings He has poured into my life. He has guided my steps to and through this challenging journey of graduate school and life; and He has been with me every step along the way.

To my parents Terence and Deborah, and to my sister Elizabeth: No other people in my life have shown me more love, sacrificed more on my behalf, or tolerated my many inadequacies throughout my lifetime. There is no doubt I would never have made it this far, nor likely ever even embarked on this journey were it not for all that they have done for me. Though I undoubtedly fail to express them as often as I should, they will forever have my love and my thanks.

To my fiancé Anna Joy: You are the love of my life and you never fail to bring out the best in me. Your belief in me throughout this project has been a tremendous encouragement in helping me to see it through to completion, and I

am so grateful that as this project closes one chapter in my life, that you will be by my side as I begin the next.

To Allen and Kelly: Through your own actions, you constantly reminded me of the true meaning of friendship. I have been immensely blessed by both of you; and you both came through for me in so many ways, with respect to this project, to graduate school, and most importantly in life. I can only hope that with time I can repay the kindness you have shown me.

To Suzi and Misty: Your unwavering encouragement and support were bulwarks for me during the most difficult of times. Even more than this, each of you played a tremendous role in both my professional and personal development. I am grateful for the training, supervision, mentoring, and friendship you both have offered me.

To my colleagues in the Personality Research Laboratory – Stephanie, Jim, Liz, and Erika: Your contributions during the early stages of this dissertation and in particular to the development and refinement of the measures used herein dramatically improved this study. More importantly, you all reminded me to never underestimate the value to be found in even a small group of thoughtful, committed, and supportive individuals working together toward the same end.

To the many graduate students across the nation who participated in this study, and the training directors who assisted in disseminating it to them: Thank you for taking the time to assist me in my research, and for your contribution to this body of work which will hopefully better inform the field as a whole on this subject-matter.

To my committee members Drs. Sullivan and Fuqua: I am so very grateful for the time and thoughtful consideration you invested in this project. The input you each provided was an invaluable contribution in shaping the final outcome of this project; and the project would not have been possible without your involvement.

To my clinical advisor Dr. Chaney: As one of the very few people who has been involved in every dimension of my clinical training – from coursework, to clinical supervision, to comprehensive exams committees and research committees – I have learned so much from you both professionally and personally. I am so very grateful for all of the support you have provided through the years and expect I will always look upon you as one of my mentors.

To my graduate mentor Dr. Grice: Last but certainly not least, no person has done more to support my efforts both on this project specifically and in my graduate training more generally. More than any other, you have challenged me to think critically in and out of the classroom; and you have been a steadfast model of tenacity, integrity, and virtue. You also have been a part of my training from day one and continued to offer your support through to the very end. Among all those who have provided some form of mentorship to me over the last few years, you have easily secured your place at the top of the list. I can only hope that if I ever find myself in the role of mentor, that I would emulate the very qualities you have shown me. Thank you for all that you have done for me.

Name: NATHANIEL JOHN COONEY

Date of Degree: DECEMBER, 2013

Title of Study: RELIGIOUS TRAINING AND COMPETENCE IN APA-ACCREDITED GRADUATE CLINICAL PSYCHOLOGY PROGRAMS

Major Field: PSYCHOLOGY

Abstract:

The 20<sup>th</sup> century ushered in a new era for psychology that shifted away from philosophical realism in favor of logical positivism and empiricism. Consequently, the field abandoned its deep shared historical roots with religion. Despite that the religious landscape of North America is becoming increasingly diverse, and that decades of research have consistently documented that approximately 90% of North Americans believe in God, psychologists overall report lower levels of religiosity than those they serve. Further, a vast majority of psychologists report a lack of training and competence in religion and its relationship to mental health, despite holding beliefs that religion influences treatment outcomes. While it remains the official policy of the American Psychological Association that graduate clinical psychology programs require formal training and competence in multicultural issues including religion, training directors report that inclusion of this subject-matter is unsystematic and highly variable at best.

Based on these findings, the current investigation examined the attitudes, perceptions, and formal training experiences related to religion, of students in APA-accredited doctoral clinical psychology programs. It further explored students' self-ratings of religious competence, and attempted to conform their competence ratings to their formal training and personal experiences with religion, utilizing Observation Oriented Modeling to analyze the patterns observed in the data. A diverse sample of 250 students from accredited programs across North America participated in this study. Regarding training, two out of three participants reported that religion was given less attention than any other dimension of cultural diversity overall, and one in three reported a training environment that was not respectful of religion. One out of three students reported that their programs did not offer a single course that addressed religion in any context; and only one in four reported that religion was given substantive attention in at least one course. Finally, three out of four students who denied any exposure to religion through graduate coursework nonetheless rated themselves as competent or proficient in this domain. In contrast, personal religious identification did predict competence in three out of five participants. Implications of the current study as well as potential future directions are explored.

## TABLE OF CONTENTS

Chapter	Page
I. INTRODUCTION .....	1
II. REVIEW OF THE LITERATURE .....	5
Overview .....	5
The religious roots of psychology .....	6
Modern psychologists' perspectives on religion .....	8
Religion and its relationship with health .....	12
Religious attitudes and affiliation in the general population.....	20
Religious attitudes and affiliation among modern psychologists .....	21
Religious issues and clinical training.....	24
Religion as a dimension of cultural competence .....	26
Summary and aims of current study.....	28
III. METHOD .....	32
Procedure .....	32
Participants .....	33
Measures .....	35
General characteristics.....	35
Training experiences .....	36
Respondent Religiosity.....	37
Competence .....	38
IV. ANALYSES AND RESULTS.....	41
Overview of analyses .....	41
Training Opportunities.....	43
Comparisons across cultural dimensions .....	44
Attitudes and perceptions.....	45
Conforming competency to training.....	46
V. DISCUSSION .....	53
Religious Competency .....	55
Methodological limitations .....	59
Summary and future directions .....	63



APPENDIXES.....	66
Tables .....	67
Figures.....	71
Institutional Review Board Approval Letter .....	91
Recruitment Email .....	92
Study Information and Informed Consent .....	93
Measures.....	95
REFERENCES.....	106
NAME INDEX .....	115

## LIST OF TABLES

Table	Page
1. Competence as predicted by religious coursework .....	67
2. Competence as predicted by personal religiosity .....	68
3. Competence as predicted by coursework crossed with religiosity .....	69
4. Competence as predicted by graduate training .....	70

## LIST OF FIGURES

Figure	Page
1. Participant gender .....	71
2. Participant ethnicity .....	72
3. Terminal degree sought by participant .....	73
4. Type of graduate institution attended by participant .....	74
5. Geographic representation of participants' graduate institutions .....	75
6. Religious orientation of participants .....	76
7. Statistical models conforming competence to training & experiences .....	77
8. Percentage of participants reporting coursework with religious content ..	78
9. Boxplot – Overall percentage of attention paid to selected dimensions of cultural diversity .....	79
10. Perceived religiosity of others involved in graduate programs.....	80
11. Perceived learning environment of graduate programs .....	81
12. Perceived religious attitudes within graduate programs .....	82
13. Perceptions of relationships between religion and mental health .....	83
14. Multigram – Competence conformed to coursework having a primary focus on religion.....	84
15. Multigram – Competence conformed to coursework having a major content area in religion.....	85
16. Multigram – Competence conformed to coursework addressing religion only in the context of other broad topics .....	86
17. Multigram – Competence conformed to current personal religiosity .....	87
18. Multigram – Competence conformed to significant personal identification with current religiosity.....	88
19. Multigram – Competence conformed to coursework (primary, major content, or broad topics) crossed with current personal religiosity .....	89
20. Multigram – Competence conformed to number of years completed in current graduate program.....	90

## CHAPTER I

### INTRODUCTION

In providing an overview of the psychology of religion, David Wulff had the following to say in his introductory statements: “No other human preoccupation challenges psychologists as profoundly as religion. Whether or not they profess to be religious themselves – and many do not – psychologists must take religion into account if they are to understand and help their fellow human beings” (Wulff, 1996, p. 43). This is likewise an appropriate introduction to the current paper, as it identifies a number of the salient issues that will be presented in the chapters that follow. These include the fact that religion is an influential force in human behavior; that understanding and assisting those who identify with a particular religious or non-religious orientation necessitates consideration of religion as an aspect of one’s cultural make-up; that many psychologists tend not to identify with religion themselves; and that religion on a broad level poses many challenges for the field of psychology. To this, I will add that an appropriate appreciation for religion as a cultural construct is not merely an issue of personal preference, but one of professional competence that necessitates the acquisition of knowledge through formal training and experience. Unfortunately, results of numerous investigations into both training and competence suggest that psychologists overall are lacking in both areas (Brawer, Handal, Fabricatore,

Roberts, & Wajda-Johnston, 2002; Russell & Yarhouse, 2006; Shafranske & Malony, 1990).

Despite that formal studies of both psychology and religion have deep and overlapping historical roots in philosophical studies; the two have long been at odds (Wulff, 1996). This has especially been true since the late 19<sup>th</sup> and early 20<sup>th</sup> century as the emergence of psychological laboratories and formal programs of academic study ushered in an era that shifted away from philosophical realism in favor of empiricism and logical positivism. Shafranske and Malony noted that “Our training as social and behavioral scientists has been dominated by ‘methodological atheism’ at best and a ‘materialistic bias’ at worst. Both are understandable. They reflect our scholarly heritage and current understanding of behavioral causation” (1996, p. 577).

While the field of psychology overall has shown increased acceptance toward issues of religion, as can be seen in the burgeoning empirical literature on the subject, there still remains significant skepticism and criticism among many psychologists toward religion. Within the sub-discipline of clinical psychology, where religion is very often a part of the cultural make-up of the clients being served, a majority of psychologists and psychotherapists have reported a lack of training and competence in issues related to religion and their relationship to mental health (Shafranske & Malony, 1996). A small minority of psychologists continue to report beliefs, despite evidence to the contrary, that religion in any form is harmful to mental health. This position was evidenced as recently as spring 2011 on the discussion listserv for the Division of Clinical Psychology

within the American Psychological Association. There, a psychologist quoted the Nobel Laureate Steven Weinberg as saying: “Anything we scientists can do to weaken the hold of religion should be done and may in the end be our greatest contribution to civilization.” The psychologist (who in a separate communication reported having previously served a committee assignment in APA governance) went on to assert this position as “perfectly consistent” with the mission of the APA to “advance the creation, communication and application of psychological knowledge to benefit society and improve people’s lives” (Cantor, 2011).

Despite these views, it remains the policy of the American Psychological Association to require both formal graduate training and professional competence in a broad range of multi-cultural issues, including religion (APA, 2002, 2003, 2009). However, despite these mandates, two recent surveys of training directors at graduate clinical programs and internship sites have reported that the training in religion is highly variable; is only rarely systematically incorporated into formal training; and most often is covered in clinical supervision and only then in response to specific client concerns (Brawer et al., 2002; Russell & Yarhouse, 2006).

These findings raise questions as to the type and extent of training student clinicians receive in the area of religion, and how competently they can address these issues when they arise in a therapeutic context. It is the goal of the current study to explore these questions, and to attempt to identify relationships between graduate training experiences in religion and self-rated competence in this domain. Specifically, it is hypothesized that students who report higher levels of

formalized training in religion through graduate coursework will be more likely to rate themselves as competent in this domain. Further, based on previous findings suggesting that degree of personal religious identification may play a role in psychotherapists' willingness to address issues of a religious nature in a clinical setting; this construct may also influence self-rated competence (Shafranske & Malony, 1990). Therefore, a second hypothesis of this study is that students who report a particular religious orientation as being a significant part of their own cultural identity, and who also report higher levels of formal graduate training in issues related to religion, will also be more likely to rate themselves as competent to address religion in psychotherapy. In order to investigate these hypotheses, Observation Oriented Modeling (Grice, 2011) will be used to examine the extent to which the predicted effect of self-rated competency conforms to the hypothesized causes of formal training and/or personal religious identification. Additionally, exploratory analyses consisting primarily of response counts and proportions will be used to describe the current trends in religious training within graduate clinical psychology programs as reported by students.

## CHAPTER II

### REVIEW OF THE LITERATURE

#### *Overview*

While psychologists have yet to develop a unified approach to the conceptualization or study of religion, research into this domain of human experience has grown in recent years. The current paper seeks to build upon the specific branch of this research investigating the relationship between graduate training and professional competence with respect to religion in the clinical practice of psychology.

In the review that follows, an effort will be made to connect a variety of relevant dimensions of religion and psychology, to provide a proper context for understanding the current gap in the published literature, and to provide a basis for how this study aims to bridge that gap. A historical context will first be provided to establish both the connections and divisions that exist between the fields of psychology and religion. In providing this background, both historical and modern perspectives of psychologists and their views and practices with respect to religion will be provided. A case will then be made for the association between religion and mental health, based on summary findings of the body of research that has explored this domain. Once the association has been established, an examination of issues related to professional training and competence will be provided. Finally, an introduction to the current investigation



will be presented in an effort to synthesize the relevant aspects from each of the aforementioned areas in a coherent manner, such that the need and goals for the current study will be established.

### *The religious roots of psychology*

Psychology and religion have throughout their histories been inextricably interconnected with one another (Vande Kemp, 1996). Yet, despite their shared history, the two have also long been deeply divided. To better understand psychology's religious roots, a brief exploration of the origins of the term "psychology" is useful. While both the root and suffix of the term are of Greek derivation ( $\psi\upsilon\chi\eta$  or psyche meaning soul; and  $-\lambda\omicron\gamma\iota\alpha$  or  $-\logia$  meaning the science or study of), the word itself, according to Francois Lapointe, first appeared in usage in its Latin form "psychologia" by German psychologist Philipp Melanchton early in the sixteenth century (Lapointe, 1970).

In this early usage of the term, psychologia referred to one of three subdivisions of the science of pneumatology (the study of spiritual beings). Whereas the other two divisions – theology and angelology/demonology – concerned themselves with God and intermediate spiritual beings, respectively; psychology was principally concerned with the understanding of the human spirit (Vande Kemp, 1996). With the end of the sixteenth century, however, came a paradigm shift both in the usage and meaning of the word largely through the works of Otto Casmann. Interested in a broader understanding of man, Casmann introduced the term anthropologia as the science of man. Under this new umbrella term, he distinguished between the body (somatologia) and mind

(psychologia), a distinction that would forever color much of the historical usage and understanding of the word (Lapointe, 1970).

Thus, sometime after the term had come into popular usage, but still long before psychology would emerge in its modern context as an independent scientific discipline, the term psychology had already come to take on a number of meanings; and the separation of psychology from its historically religious origins had already come to pass. In his eighteenth century work, *The Philosophy of Rhetoric*, George Campbell denounced this dissociation on the basis that both psychology and religion were, as he argued, understood only through the same means of observation and experience. Specifically, he wrote that all rational or deductive evidence was derived either through demonstration or moral reasoning. The latter of these he further subdivided into four forms of evidence, chief among them being that of experience (Campbell, 1776).

[the evidence of experience] is, besides, the principal organ of truth in all the branches of physiology, (I use the word in its largest acceptance,) . . . Under the general term I also comprehend natural theology and psychology, which, in my opinion, have been most unnaturally disjoined by philosophers. Spirit, which here comprises only the Supreme Being and the human soul, is surely as much included under the notion of natural object, as body is, and is knowable to the philosopher purely in the same way, by observation and experience (Campbell, 1776, p. 143).

More than a half-century after Campbell's critique, but following in the anthropological tradition that preceded it, Frederick Rauch in 1840 authored the

first text to be published in English that bore the term psychology in its title: *Psychology, or a View of the Human Soul, including Anthropology* (Lapointe, 1970). A number of additional such texts would soon follow, ushering-in widespread acceptance of the term and its continuing reference to the human soul (as conceptualized by Casmann in the anthropological context of referring to the human mind). Shortly thereafter the field witnessed the emergence of the first psychology laboratories which brought with them a growing emphasis on empiricism over the rationalism of the past, presumably widening the schism that differentiated the new psychology from its historically religious roots. The irony of this timing was not lost on Lapointe, who concluded his etymology of the term psychology with the observation that the word “gained currency precisely at the time when psychology was about to become anything but the ‘study of the soul ’” (1970, p. 645). Indeed, psychology was about to abandon its philosophical roots in favor of the positivistic tradition and empiricism of the modern natural sciences (Shafranske & Malony, 1996).

#### *Modern psychologists’ perspectives on religion*

In a modern context, one does not have to look far to observe the diverse and often adamant perspectives of prominent 20<sup>th</sup> Century psychologists on the topic of religion. Among those favoring some aspects of religion as assets were William James, Carl Jung, Erik Erikson, and Gordon Allport. Conversely, well-known detractors included Sigmund Freud, Albert Ellis, and B. F. Skinner (Wulff, 1996).

In his popular work: *The Varieties of Religious Experience; A Study in Human Nature* (1902), William James called religion “an essential organ of our life, performing a function which no other portion of our nature can so successfully fulfill” (p. 49). He believed the true value of the religious experience existed not in the verifiable evidence (or lack thereof) of religion, but in the individual’s subjective experience of it; and like all other forms of experience, this form too could and should be studied empirically ([a position similar to that of Campbell’s articulated earlier]; James, 1902). Jung associated religion with the potential for excellence; but saw it as one of many facets in the full range of human experience, which when properly understood can lead to a greater sense of wholeness. Erikson adopted a more developmental approach toward the religious experience, crediting it with the potential for fostering trust, hope, and wisdom that he viewed as crucial virtues in the attainment of human maturity. Perhaps most influential of the aforementioned in the specific study of the psychology of religion was Gordon Allport. A religiously committed psychologist himself, Allport was interested in understanding both the positive and negative relationships between religion and other domains of psychological interest such as prejudice. His focus on intrinsic versus extrinsic religious orientations remains an influential area of interest among contemporary researchers of the psychology of religion. Despite these generally favorable positions toward religion, it is important to note that these psychologists were not without criticisms toward religion; and most adopted approaches that considered both the assets and

liabilities of religion (particularly when religious behaviors appeared either as deficiencies or excesses of the normal human experience; Wulff, 1996).

Not all psychologists have viewed religion so favorably, however. In fact, many well-known psychologists have been quite critical of religion; and some have gone so far as to consider most if not all forms of religion to be harmful to the individual (and in some cases to society at large). Consistent with many of his theories, Freud associated religious beliefs with childhood needs and wish-fulfillment. In that light, he is credited with having described religion as infantile, illusory, and even neurotic; and with stating that only through the abandonment of religion can one progress beyond these immature stages (Wulff, 1996). Ellis, who identified himself as a probabilistic atheistic clinician, and who suggested that this belief system “may well constitute the majority of modern psychotherapists,” stated that religiously committed persons tend to be inflexible, and by extension are prone to irrational thought processes and emotional disturbances (1980, p. 635). Ellis therefore concluded religious dogma to be irrational and harmful to individuals; though he did make room for the potential benefits of certain religious beliefs provided they were not considered as absolutes. Other influential criticisms have been offered from the strict or radical behaviorists such as B. F. Skinner. Consistent with their theories of behavior generally, their criticisms of religion were often less about the perceived irrationality of religious practices so much as their observation that the concept of religion was itself not necessary for explaining these practices. To radical behaviorists, the practices did not differ from any other non-religious behaviors,

and were similarly strengthened through the reinforcements that followed. Skinner was, however, personally critical of organized religions for setting-up what he viewed to be primarily self-serving schedules of punitive consequences designed to control the behavior of followers (Wulff, 1996). His own view was made clear in his book *Beyond Freedom and Dignity*, wherein Skinner proclaimed “God is the archetype pattern of an explanatory fiction” (1971, p. 201).

Summarizing the profession’s long-standing attitudes toward religion, Seymour Sarason, former President of the APA’s Division of Clinical Psychology and a self-described agnostic, indicated that religion was often seen at best as being of little interest to most psychologists and at worst as indicative of the kinds of neuroses reflected in Freud’s positions (1993). In his centennial address to the Association, he stated the following:

I think I am safe in assuming that the bulk of the membership of the APA would, if asked, describe themselves as agnostic or atheistic. I am also safe in assuming that any one or all of the ingredients of the religious world view are of neither personal nor professional interest to most psychologists. And there are more than a few psychologists who not only have difficulty identifying with any of those ingredients but who also regard adherence to any of them as a reflection of irrationality, of superstition, of an immaturity, of a neurosis. Indeed, if we learn that someone is devoutly religious, or even tends in that direction, we look upon that person with

puzzlement, often concluding that that psychologist obviously had or has personal problems. (Sarason, 1993, p. 187).

Interestingly, Sarason's comments came in the context of arguing that the profession's historical treatment of the significance of religion (in a broad context) was in error. This, he attributed in part to the process of self-selection through which pupils have been brought into the discipline. This process, he argued, produced "both conformity and uniformity" within the field, and rendered students "insensitive" to many areas considered off-limits (e.g. religion, community, and transcendence). Both through that which is discussed and that which is not, students learn of the domains that should and should not concern psychologists (Sarason, 1993).

#### *Religion and its relationship with health*

It is both interesting and telling that religion would be considered a domain with which psychologists should not be concerned. Whether it is considered in the context of its potential benefits or as a form of pathology in its own right, the fact that human behavior is often demonstrably influenced by religion cannot be denied. Indeed, the published literature on the association between religion and both physical and mental health is vast. It has spanned more than a century and has prompted the publication of numerous volumes on this very topic in recent decades (e.g. Griffith, 2010; Plante & Sherman, 2001; Shumaker, 1992). While the patterns of these associations (both positive and negative) appear to be fairly robust; the conclusions that can be drawn from the literature are far from definitive. This is largely a function of methodological issues found throughout

the body of research that have yet to be resolved, including the fact that most of the available evidence is correlational rather than experimental, tends to be cross-sectional, and generally relies heavily on self-reports of the subjects. These limitations notwithstanding, patterns indicative of a relationship between religion and health have been observed repeatedly in both research and clinical settings, suggesting the subject should not be ignored. In light of this, a brief overview highlighting some of the more general of those observations is warranted.

A vast majority of the available research points to the potential benefits of religion with respect to mental health (Levin & Chatters, 1998). These benefits go beyond guarding against and coping with psychopathology, to include other factors such as quality of life (Ferriss, 2002; Fredrickson, 2002), and overall psychological well-being (Chamberlin & Zika, 1992; Ellison, 1998). Some researchers have suggested that the benefits of religion may reflect the positive emotional influences of faith (e.g. Ellison, 1998); while others have suggested alternative explanations including value systems that discourage health-risk behaviors (e.g. substance abuse, high-risk sexual practices, etc.), as well as increased social aspects of religious involvement (i.e. connectedness and activity through regular church attendance) that promote more adaptive functioning and improved coping strategies (e.g. Donohue & Benson, 1995). However, not all of the positive effects observed between religion and mental health can be attributed to social support or involvement. Loewenthal and colleagues (2001) found that higher levels of personal religious devotion through private beliefs and



practices (e.g. prayer) were reported by subjects to be more beneficial to coping processes than religious activities of a social nature (Loewenthal, Cinnirella, Evdoka, & Murphy, 2001).

In a comprehensive meta-analysis, Smith and colleagues (2003) reported a very robust association (of moderate size) between religious participation and the absence of depressive symptoms, not moderated by other factors. In addition to the principle protective effects of religion reported in this analysis, the researchers also observed a buffering effect against new or increased life stressors. Their review of the literature included more than a dozen database searches, utilizing multiple permutations of key terms, and repeated independently a minimum of three times by different members of the research team. Additional studies were identified by examination of the reference lists of studies identified from the database searches; as well as direct solicitation to authors identified in the above searches. These follow-ups also resulted in identification of unpublished studies (which accounted for 24% of all studies included in the meta-analysis). Studies identified by February 2000 were included in the analysis, provided that their respective operational definitions of religion and depression were consistent with definitions used in the meta-analysis, and provided that each study included at least one measure of depressive symptoms and one measure of religiosity for each participant (using bivariate association at the level of the person and not the aggregate). Using these criteria, 147 studies with a combined 98,975 non-overlapping participants were included in their meta-analysis, which yielded an overall random effects

weighted average effect size of -0.096 ( $p < 0.000001$ , 95% CI = -0.11 to -0.08). To control for possible publication bias (an inflated effect size due to increased likelihood of only significant results making it to publication), the researchers compared the published and non-published studies included in the analysis and found the difference to be less than one correlation point which was statistically non-significant. They concluded that there is solid evidence for a modest but robust relationship between higher levels of religiousness and lower levels of depression (Smith, McCullough, & Poll, 2003).

A second systematic review of the literature utilized a levels of evidence approach and was limited to studies published the top 25% of psychiatry journals (based on ISI Index and impact factor scores) between the years 1990-2010. Forty-three studies were included in the analysis, each rated for its quality of methodological design and statistical analyses. The associations between religion and mental health were then rated as having good evidence (being supported by 2 out of 3 published studies and confirmed by at least 3 high-quality studies), some evidence (supported by 2 out of 3 studies and confirmed by 1 high-quality study), insufficient evidence (positive findings that fell short of above criteria), or no evidence (no positive associations observed or no studies completed). Overall, the analysis found that 72% of studies examined reported positive associations between religion and mental health, consistent with prior reviews. Good evidence was observed for an association between increased religiousness and decreased depression, suicidality, and substance use. Some largely positive evidence was observed for organic disorders (e.g. dementia) and

stress-related disorders. Insufficient evidence was observed for Schizophrenia and Bipolar disorders; the studies in both areas yielding mixed results. No evidence was observed for other mental health diagnostic categories, principally due to lack of published studies in top-tier psychiatric journals (Bonelli & Koenig, 2013).

In conducting the current literature review, a number of studies were identified that included results for diagnostic categories not captured in the reviews above. These studies collectively yielded mixed results and therefore provide less support for a positive or negative religion-mental health association at the present time. First, some studies have examined the relationship between religious beliefs and practices with other mood disorders (i.e. bipolar disorder) and reported that patients endorsing religious commitment also endorsed better coping techniques and symptom management compared to non-religious patients (Mitchell & Romans, 2003). Research findings in the domain of anxiety and related disorders presents a more ambiguous relationship between religion and health. In a review of the literature, Gartner (1996) found approximately equal numbers of studies reporting increased anxiety among religious subjects, decreased anxiety among religious subjects, and no association between anxiety and religiosity. Garter proposes that these mixed findings are likely a function of different forms of religious involvement interacting uniquely with different manifestations of anxiety. Supporting this hypothesis are studies by Bergin and colleagues, which found that intrinsic versus extrinsic religious orientation was differentially related to anxiety (with extrinsic associated with higher levels of

anxiety; Bergin, Masters, & Richards, 1987); and studies demonstrating a relationship between higher levels of religious involvement and lower levels of mortality-related anxiety (e.g. Richardson, Berman, & Piwowski, 1987).

In examining the relationship between religion and physical health, Powell and colleagues conducted a levels-of-evidence critical review (see Miller & Thoresen, 2003) examining nine distinct hypotheses, most of which yielded null-associations (Powell, Shahabi, & Thoresen, 2003). In lieu of a meta-analytic approach which would have yielded an aggregated result for all published studies meeting criteria for inclusion, the levels-of-evidence approach instead provided a more critical individualized analysis of those studies that met more rigorous methodological standards (e.g. excluding studies that were cross-sectional rather than longitudinal in nature, that failed to control for possible confounds, that failed to adequately operationalize and measure specific dimensions of religion or physical health, and other statistical shortcomings such as failing to control for chance in analyses or multiple tests). This critical review failed to yield supporting evidence for protective factors of religion in the following areas: cancer mortality (two studies reviewed), slowed cancer progression (six studies reviewed), disability (three studies reviewed), improved coping for life longevity (two studies reviewed), or overall mortality in relation to depth of religiosity (ten studies reviewed). The researchers also failed to support the hypothesis that religion improves recovery from acute illness (five studies reviewed), but instead found some limited evidence that religion may in some cases impede recovery, which was associated with negative religious coping styles. One hypothesis that did

yield consistent evidence favoring a positive association examined the hypothesis that being prayed for improved physical health recovery from acute illness (three studies), though the lack of any identifiable scientific mechanism of action in this association limits the inferences that can be made. A second hypothesis examined the potentially protective factors of religion in the development of cardiovascular disease. Four studies were examined with a range of 2,812 – 21,204 participants and follow-up of 7-31 years. These studies yielded consistent evidence that regular church involvement protected against cardiovascular disease – a result that has frequently been attributed in the available literature to the impact of religion in promoting generally healthy lifestyle choices. The final hypothesis tested in this analysis, and the one garnering the most consistent evidence (either for or against an association) examined the relationship between church attendance and incidence of mortality. This analysis consisted of nine studies having 819 – 21,204 healthy participants conducted on population-based samples, and having longitudinal follow-up ranging from 4 – 31 years. Of these studies seven (78%) found a statistically significant and positive association even after controlling for demographic, socioeconomic, and health-related factors. Six of these (67%) continued to find a significant and positive relationship after further controlling for healthy lifestyle, existing risk and protective factors, social support, and depression. The researchers reported that on average, regular church attendance was associated with a 30% reduction in mortality (after the aforementioned adjustments), and increasing levels of church attendance were further associated with decreasing risk of mortality. Overall, the

authors concluded that robust relationships between religion and health do exist, but are more complex than has been suggested by prior researchers and warrant significantly more attention before definitive conclusions can be made either supporting or refuting this claim (Powell et al., 2003).

Beyond these systematic reviews, a number of other general trends between religion and physical and mental health have been fairly consistently reported in the literature. According to a review by Gartner (1996), these trends have routinely revealed associations between religion and improved physical health outcomes and overall well-being; as well as lower rates of depression, mortality, substance abuse, criminal behavior, and divorce. Religion was further found to be related to increased psychopathology when considering dimensions of authoritarianism, extreme rigidity, low tolerance of ambiguity, and self-actualization. Areas revealing mixed results or ambiguous associations between religion and mental health included anxiety, schizophrenia and related disorders, sexual disorders, and prejudice (which has demonstrated a robust curvilinear relationship such that low and high levels of religious commitment have yielded lower levels of prejudice whereas moderate commitment has yielded higher levels of prejudice; Gartner, 1996). Gartner also cautions, however, that most of the results linking religion with psychopathology have been identified primarily through self-report inventories (e.g. personality measures) that often attempt to quantify latent constructs. Conversely, most of the results linking religion with healthier outcomes tend to rely more on objective and verifiable behaviors (hospital admissions, divorces, suicide completions, etc.) suggesting improved

reliability by comparison (Gartner, 1996). While the body of literature overall tends to show favorable contributions of religion to mental health, it also shows that some dimensions of religion can contribute to psychopathology; and that the specific influences of religion depend on the interplay between the specific culture, religion, and area of health under investigation (Miller & Kelley, 2005). Another caution to be considered is the possibility that studies revealing null-associations may have failed to make their way into the published literature, a phenomenon commonly referred to as “the file-drawer effect” (Rosenthal, 1979); though at least one large-scale review attempted to control for this effect and found it to be negligible (Smith et al., 2003).

#### *Religious attitudes and affiliation in the general population*

Beyond the robust associations between religion and mental health, the enigmatic tension between the two is even more puzzling when considering the prevalence of religious beliefs in the United States (and around the world). The Gallup organization, which conducts research-based public polling on a variety of social issues, has consistently found that more than nine out of every ten Americans endorse a personal belief in God. This question was first asked in 1944 with 96% responding affirmatively. Although slight increases and decreases have been observed in the years since, the percentage of respondents affirming this belief has remained near 90% in every poll since, with the most recent data being reported in May 2013 at 87% (Gallup, 2013). Among the many religious orientations held worldwide, the largest is Christianity (33%), followed by Islam (20%), Hinduism and non-religious (13% each). For North

America, 85% of individuals in the general population are reported to identify with Christianity (approximately 257 million people) – more than ten times any other religious or non-religious identification (Richards & Bergin, 2000). However, more than 700 non-Christian religious traditions have also been identified in the United States alone (Melton, 1996), and religious diversity is continuing to increase as a result of immigration and the effects of higher education (Hoge, 1996). Stated succinctly by Richards and Bergin, “Religious diversity is a cultural fact, and most mental health professionals *will* encounter it in their practices” (emphasis added; 2000, p. 5).

#### *Religious attitudes and affiliation among modern psychologists*

The earlier characterizations by Ellis and Sarason that a majority of psychologists and psychotherapists may identify with a nonreligious or atheistic perspective may be somewhat of an overstatement. They are not, however, entirely without merit. Beyond the perspectives of those notable few psychologists already mentioned in the previous sections, national studies have consistently demonstrated that psychologists and psychotherapists tend to identify with traditional religious ideas at levels that are much lower than observed in the general population. The most recent known survey of clinician members of the American Psychological Association found that when compared with the general population, psychologists endorsed lower levels of engagement in religious practices overall, and were five times as likely to deny the existence of God (Delaney, Miller, & Bisonó, 2007).



Not surprisingly, these findings are not new. Perhaps one of the most-cited studies in the domain of psychotherapist religiosity was conducted by Bergin and Jensen in 1985. This national study with a representative sample of psychotherapists from multiple disciplines (i.e. clinical psychology, psychiatry, clinical social work, and marriage and family therapy) found that while 80% of therapists surveyed reported some religious affiliation, only 41% reported regular attendance at religious services (Bergin & Jensen, 1990). These numbers were contrasted with survey data collected through the national Gallup poll of the same year which demonstrated a higher level of religious preference among the general U.S. population (91%) but a comparable level of regular participation in religious services (40%). Among the other findings reported in the study were differences between the four therapeutic disciplines for both religious preference and involvement. Specifically, clinical psychologists and psychiatrists included higher percentages of respondents (32% and 25% respectively) who characterized their religious preferences as agnostic, atheistic, other, or none when compared to marriage and family therapists and clinical social workers (16% and 11% respectively). Additionally, psychologists and psychiatrists reported lower levels of regular attendance at religious services (33% and 32%) compared with family therapists and social workers (50% and 44%). One surprising finding of the study was that only 29% of psychotherapists surveyed viewed religious matters as having importance to their treatment efforts with their clients (Bergin & Jensen, 1990).

Consistent with these findings, a separate investigation within the American Psychological Association's Division of Clinical Psychology yielded similar results regarding psychologists' attitudes and practices related to religion. This study, conducted by Shafranske and Malony (1990), found that while 97% of the respondents reported having been raised in a particular religious orientation, only 71% reported current religious affiliation and 41% reported attendance at religious services. A majority (51%) of respondents further characterized their spirituality as alternative and not associated with organized religion. The current study went beyond the previous, however, in also assessing respondents' attitudes toward religious clients and religious interventions; as well as their training experiences and competencies to address religion in psychotherapy. On the whole, psychologists believed that knowledge of their clients' religious backgrounds was important (87%) with approximately two out of three believing their clients' backgrounds influenced the course of therapy (64%). Despite that half of the respondents described spirituality as relevant to their professional roles and their clients' presenting problems; two thirds reported that psychologists in general lack the knowledge and skills to assist clients in this domain. Finally, while 62% identified training and supervision in addressing religion in psychotherapy as desirable, 85% reported having never or only rarely discussed religious issues throughout their educational experiences (Shafranske & Malony, 1990).

### *Religious issues and clinical training*

The perception by psychologists that discussion of religious issues in their clinical training was sparse is one that has thus far been supported through further investigation. Two studies in particular shine light on the issue of religious training in clinical psychology. Both surveyed clinical training directors with the first focusing specifically on those of APA-accredited doctoral programs and the second on those of APA-accredited pre-doctoral internship centers. Overall, the results of both studies suggest that a majority of training programs and internship sites offer little or no formal training in issues of religion and spirituality; and that when the issue does arise it typically occurs at the impetus of the trainee, and in the context of clinical supervision in response to specific client needs. The findings of both studies are elaborated upon below.

Brawer and colleagues (2002) surveyed training directors at all APA-accredited doctoral clinical programs, of which 51% (n=98) responded. They found that approximately equal numbers of programs reported systematically incorporating religion/spirituality into training (17%) compared with those that reported no coverage at all (16%); with the remaining respondents reporting varying degrees of less systematic coverage. Of those reporting at least some coverage, more than three quarters (77%) indicated that religion/spirituality were most commonly addressed in the context of clinical supervision; although one quarter of these respondents provided written comments indicating that the coverage was inconsistent and highly variable (Brawer et al., 2002). One possible explanation that has been posited by some researchers is that

supervisors in clinical psychology training programs may themselves lack competence in how to address these issues (Aten & Hernandez, 2004). Other interesting findings from the study included that two out of five training directors reported having students in their program whose major interest was in the domain of religion/spirituality and one out of five reported having been approached by students requesting coursework for the same (Brawer et al., 2002).

The second study, conducted by Russell and Yarhouse (2006) sought to mirror the aims of the former, but with the specific focus on the prevalence and format of religious/spiritual training within APA-accredited internship sites. Four hundred thirty three training directors were contacted yielding a 32% return rate (n=139). Although only 35% reported opportunities for didactic training in spiritual issues, 90% reported that the topic is addressed through clinical supervision, with a large majority of those indicating the same pattern identified in pre-internship training programs – that the issue is most commonly raised in response to clients' concerns and/or cultural identity.

Despite the lack of systematic integration of religion into clinical training as detailed above, a majority of psychologists surveyed support inclusion of the topic in clinical training and coursework. In a survey of 340 members of the American Psychological Association from divisions 12 (Clinical Psychology), 36 (Psychology of Religion), and 45 (Society for the Psychological Study of Ethnic Minority Issues), two out of three psychologists agreed or strongly agreed that religious and spiritual issues should be included in training, and should be taught

in multicultural coursework. Three out of four agreed or strongly agreed that issues in these domains are inadequately addressed in current clinical training paradigms. Of note, members of divisions 36 and 45 reported higher levels of prior training in issues related to religion and spirituality, and scored significantly higher on a measure of multicultural sensitivity than did members of division 12. Among those who did not believe religion should be included in multi-cultural coursework, participant comments indicated that many psychologists consider religion and spirituality less important than other dimensions of cultural diversity (Crook-Lyon et al., 2012; see also Hage, Hopson, Siegel, Payton, & DeFanti, 2008).

#### *Religion as a dimension of cultural competence*

Given that professional competence is an ethical imperative in all aspects of a psychologist's work, and that religion has been explicitly identified by the American Psychological Association as a dimension of cultural identity for which competence is required (APA, 2002), it is interesting that only 17% of graduate programs have reported systematically incorporating religion into their training (Brawer et al., 2002). Campbell and colleagues have conceptualized competence as being subdivided into skills-based competence and relational competence, the first of which necessarily requires acquisition of skills through formalized training (Campbell, Vasquez, Behnke, & Kinscherff, 2010). Reports from clinical training directors and clinician psychologists taken collectively suggest that the degree and methods for providing religious training is highly variable. Consequences for failing to provide such training cannot be

understated. Many have argued that the lack of training in this area increases the risk that the religiously uninformed therapists may be insensitive to the religious dimension of their patients' cultural identities and experiences; and may also risk inadvertently imposing their own values upon them (Schulte, Skinner, & Claiborn, 2002; Walker, Gorsuch, & Tan, 2004); though some have argued against the latter finding (Hage, 2006).

It is very likely that the observed paucity and variability of religious training reflects the fact that while the APA's commission on accreditation has identified specific guidelines as to what must be covered in graduate training, it leaves the methods of implementation up to the individual programs (APA, 2009). Beyond the guiding principles for accreditation, the APA has also published Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists (APA, 2003). These guidelines characterize culture as "the embodiment of a worldview through learned and transmitted beliefs, values, and practices, including religious and spiritual traditions" (APA, 2003, p. 380). Despite this explicit inclusion of religion, a more thorough examination of the guidelines is demonstrative of the relative emphasis given to religion and other dimensions of cultural identity relative to one another, and in particular, relative to constructs of race and ethnicity. Searches were conducted within the multicultural guidelines for key terms (in multiple permutations) for each of the cultural dimensions identified in the APA Code of Ethics. This search yielded the following results. Terms related to race and ethnicity were mentioned  $\geq 140$  times each; whereas sex/gender were mentioned only 17 times, economic status 13

times, age 12 times, sexual orientation 11 times, disability 8 times, and religion 7 times. The term “minority” appeared 66 times, 64 of which were specific to race and/or ethnicity (the other two times as a general reference). Further, terms for all dimensions other than those related to race and/or ethnicity received mention primarily (if not exclusively) only in the context of lists or parentheticals defining aspects or examples of culture in a broader context. Additionally, a broader review of APA policies revealed these general multicultural guidelines to be supplemented by population-specific policies and guidelines for each of the cultural dimensions previously identified, except for social economic status and religion.

#### *Summary and aims of current study*

In piecing together the evidence from the available research on psychology and religion, several themes emerge which contribute to a more complete picture of areas where the field can benefit from further research. Psychology has a long and complicated history with philosophy and religion from which it takes its roots. However, with the emergence of modern psychology as an independent discipline around the turn of the twentieth century, came significant paradigmatic shifts. Under the influence of logical positivism, the field divorced itself from its roots in an effort to align itself instead with the natural sciences (Pargament, 2007). Viewed as incompatible with proper scientific inquiry, and falling prey to criticism from notable leaders in the field, psychology as a field came to view religion with less openness and greater hostility (Pargament, 2007).

Recent decades have seen resurgence in openness toward and interest in the relationship between psychology and religion, as evidenced by the large and growing body of research devoted to religion within the discipline. This research is replete with evidence for a relationship between religion and mental health, making a strong argument for increased attention being paid to this dimension of cultural identity. Since the 1992 revision of the Code of Ethics for psychologists, the APA has been more explicit in identifying religion as a cultural dimension that necessitates attention and professional competence. Given that formal training is the principle means through which skills-based competence is acquired, it is surprising that an astonishingly large proportion of psychologists report receiving little to no training regarding religion, and fully two thirds of clinician psychologists have reported a general lack of competence regarding religious issues, despite recognizing these issues as both important to the clients they serve and influential in treatment outcomes.

Despite a clear mandate from the APA for formally integrating religion in clinical training, preliminary surveys of clinical training directors have revealed that only a small number of graduate programs and internship training centers have been systematic in their approach to including it. To the contrary, reports seem to indicate that the methods for inclusion have in fact not been formalized and are highly variable both within and between training programs. This finding is not surprising, however, given that the same guidelines that mandated inclusion and integration, provided little guidance and left up to the individual programs how this goal should be accomplished. Further, the apparent lack of



emphasis for some aspects of cultural identity relative to others at the level of APA governance (as evidenced in the governing documents) is likely not unrelated to a similar lack of emphasis as reported by individual psychologists and training programs.

As Shafranske and Malony have noted, religion is both a cultural fact and an important variable in mental health and the clinical practice of psychology (1996). This builds upon an oft-cited axiom in Bergin and Jensen's 1990 work that every therapeutic encounter represents a cross-cultural experience, and it is an ethical imperative of psychologists to be both aware of and sensitive to the cultural makeup of their clients. Researchers have taken initial steps toward investigating the current state of professional training (Brawer, et al., 2002; Russell & Yarhouse, 2006); but as noted by these researchers, the findings reported represent only preliminary results derived from the input of training directors.

Further investigation is warranted to ascertain the extent to which trainees *themselves* consider their exposure to religious issues adequate for developing their professional competence. This also includes closer examination of trainees' understanding of what the available evidence indicates regarding the relationship between religion and mental health; attitudes and beliefs held both by psychologists and the populations they serve regarding both; and the trainees experiences related to the context and environment in which their cultural training is provided. In fact, Crook-Lyon and colleagues have specifically called for such an investigation, noting that graduate students' experiences of training in these

domains were necessary for understanding and refining graduate training curricula (2012). It is the aim of the current study to investigate these issues, and to attempt to identify links between personal religious experiences, formal training experiences, and perceived competence in the domain of religion in psychotherapy.

## CHAPTER III

### METHOD

#### *Procedure*

A list of all currently accredited doctoral-level programs in clinical psychology is maintained on the website of the American Psychological Association (APA, 2012). At the time of participant recruitment, 237 accredited programs were identified. Training directors for each program were then identified from their institution's respective websites, and were contacted by electronic mail with a description the study, as well as a request that they forward the invitation to participate to eligible students in their programs. Eligible participants in this study potentially included any students (to include pre-doctoral interns) currently enrolled in doctoral level clinical psychology programs accredited by the American Psychological Association at the time data was collected. An age restriction of 18 years or older was imposed to simplify the consent process and Institutional Review Board approval, though such a restriction was not believed to have any appreciable impact on the population of interest as it was expected that nearly all students in graduate-level study would meet this criteria. No other demographic restrictions or exclusionary criteria were applied.

Of the 237 accredited programs, the training directors for six could not be identified, and eight additional programs failed to provide valid contact

information for their training directors. The remaining 223 training directors were contacted, with three responding that their programs had elected not to forward research requests, and one program indicating it would not participate as it intended to not seek re-accreditation with the APA in the coming year. No specific data is available regarding the total number of training directors who forwarded the invitation, or the number of eligible students who may have received it.

After providing consent for participation, students were asked to complete an online survey with an expected completion time of less than thirty minutes. Compensation for participation included \$75 gift cards awarded to five participants who were randomly selected following completion of the study. Up to five additional gift cards in the amount of \$25 were also offered to participants selected at random who were identified by other participants as having referred them to the study (though no such identifications were made as all participants indicated that they learned of the study based upon e-mails forwarded by clinical training directors rather than other students).

### *Participants*

A total of 250 graduate students completed the study (after which time data collection was discontinued, having reached the maximum number of responses permitted by the IRB). Participants predominantly identified as female (n=194, 77.6%; Figure 1) and white/European-American (n=192, 76.8%; Figure 2); and having a median age of 26 years. Participants reported having completed a median of two years in their current graduate programs, and a slight

majority of participants (n= 130, 52%) reported the Masters degree as the highest degree currently attained. A majority of participants described their graduate training programs as having the PhD as the terminal degree (n=173, 69%; Figure 3); and having scientist-practitioner training models (n=152, 60.8%) with cognitive-behavioral theoretical orientations (n=147, 58.8%). These programs were housed primarily in public universities (n=149, 59.6%; Figure 4), with geographic representation that included thirty-two U.S. states, Puerto Rico, the District of Columbia, and two Canadian Provinces (Figure 5).

The sample was exactly equally divided among individuals identifying as currently associated with a particular religion versus those who were not; although only 32% of all participants reported that they were currently a member or regular participant of an organized religious congregation. Of those identifying as not presently religious, 74.4% of participants indicated that they had at some point in the past associated with a particular religion, whereas the remaining 25.6% indicated that they had never associated with any religious orientation. When asked in an open-ended question to describe their current religious orientations, approximately two out of five participants identified with Protestant or Catholic Christianity; two out of five identified as Agnostic, Atheist, or Non-Religious; and one out of five identified with an orientation reflective of demographically smaller (relative to the aforementioned) groups in North America (to include: Apatheist, Bahai, Buddhist, Deist, Hindu, Jewish, Mormon, Muslim, Native American, Pagan, Pantheist, Secular Humanist, Taoist, and Unitarian; Figure 6). After identifying the aforementioned orientations,

participants were asked to respond to statements regarding the significance of this orientation with respect to their own cultural identities and life approaches. Approximately two out of three participants (65.6%) agreed with the statement “[My identified religious orientation] is a significant aspect of my identity;” three out of five (60.8%) agreed with the statement “I try to live my life according to my religious beliefs;” and just over half (51.6%) agreed with the statement “My approach to life is based on my religious beliefs.”

### *Measures*

Two principle aims were identified for the present study: first, to describe the training experiences graduate students report receiving in religion/spirituality; and second, to explore the relationship between training and other experiences and self-reported competence in the domains of religion/spirituality as they relate to the clinical practice of psychology. The measures utilized in this study can be categorized within four broad domains: general characteristics, training experiences, respondent religiosity, and competence. Measures are described below within these domains.

**General characteristics:** General characteristics were included in this study for purposes of describing the make-up of the sample. This domain included two measures assessing characteristics of the respondent (appendix E1) and characteristics of the respondent’s current graduate program (appendix E2). Respondent characteristics included basic, non-identifiable demographics as well as levels of formal education attained. Program characteristics were

broader and included such descriptors as type of university, type of degree program, training model, theoretical orientation, size of typical cohort, and others.

Training experiences: Consistent with previous studies examining training from the perspectives of training directors (Brawer, et al., 2002; Russell & Yarhouse, 2006); the current study included measures to assess if and how religion is covered within the graduate program. These measures (appendices E3-E4) included items that assessed the extent to which religion may be covered both formally (e.g. didactic training) and informally (e.g. clinical supervision); as well as the extent to which religious training is offered relative to other dimensions of cultural diversity. Such training is required for program accreditation as outlined in the Guidelines and Principles for Accreditation of Programs in Professional Psychology (section III.A.D.2.) which states: “The program has and implements a thoughtful and coherent plan to provide students with relevant knowledge and experiences about the role of cultural and individual diversity in psychological phenomena as they relate to the science and practice of professional psychology” (APA, 2009; p. 10). Also assessed as a part of the training experience were the respondent’s perceptions regarding the training environment, including the perceived attitudes of faculty and other students toward religion, as well as perceptions of psychologists’ attitudes generally (Appendix E6). These items also are consistent with the Guidelines and Principles (III.A.D.1.) that requires [the program] “acts to ensure a supportive and encouraging environment appropriate for the training of diverse individuals and

the provision of training opportunities for a broad spectrum of individuals” (APA, 2009; p. 10).

Respondent Religiosity: A national study by Shafranske and Malony (1990) found that psychologists’ attitudes and experiences with religion in their personal lives, as well as the nature of their religious affiliation and participation were the primary influences on their attitudes and usage of religiously-related interventions in their professional roles as psychotherapists. They further indicated that “the type of religiousness also influenced the therapist’s view of their competence to provide counseling regarding these religious and spiritual issues” (Shafranske & Malony, 1990, p. 76). In light of these findings it was important to explore the attitudes, behaviors, past and present experiences, and religious affiliations and involvement of graduate trainees; in order to ascertain the nature and extent of the relationship between these personally held beliefs and their self-assessed competence in their professional roles as clinicians-in-training.

Although several measures have already been published that assess dimensions of personal religiosity and/or spirituality, none were found to be suitable for purposes of this study. However, two measures in particular were used to inform the domains for item development in the present study. The Religious Background and Behavior Questionnaire reported two factors that included “God consciousness” (thoughts/prayers about God; and religious self-description) and “formal practices” (Connors, Tonigan, & Miller, 1996). Another measure – the Santa Clara Strength of Religious Faith Questionnaire – is



intended to measure matters of faith independent of religious affiliation, by examining the significance of and commitment to a particular faith orientation (Freiheit, Sonstegard, Schmitt, & Vye, 2006). Taken together, these measures informed the development of respondent religiosity items (appendix E7) that assessed religious identification and significance, past and present experiences with religion, and extent of involvement in practices commonly associated with religion.

Competence: The central question of this study is how a graduate student's experiences with religion/spirituality in training relate to her/his perceived competence for addressing these issues in a therapeutic context. Self-appraisals of competency in this study were assessed using two items that asked respondents to rate their competence to address a variety of cultural dimensions both with clients who are similar to themselves (with respect to those dimensions) and with clients who differ from themselves (appendix E5). Ratings included qualitative descriptors of "less than competent, competent, proficient, and unsure."

As has previously been mentioned, questionnaires related to the domains of interest in this study either were not found within the published literature, or were found not to be suitable for addressing the questions put forth in this study. Consequently, all measures were developed specifically for this study, with several considerations taken into account during the process of item selection and development. First, item content was informed by the existing body of published literature as well as relevance to the current study. Second, items

were assessed and modified based on clarity and face validity, to eliminate (wherever possible) any ambiguity that might skew interpretation by the respondent in completing the questionnaire. Third, the items were structured to be consistent with judgments that are considered to be categorical or ordinal in nature rather than structured as continuous quantities. For example, Likert-type items were avoided because they often imply continuous latent variables. Fourth, the process included subjecting the questionnaires to a minimum of three rounds of scrutiny by one psychologist (with a doctoral degree and specialization in quantitative methods) and four advanced level graduate student members of the Personality Research Laboratory at Oklahoma State University.

Finally, in developing measures for the current study, the determination was made not to attempt to separate the related constructs of religion and spirituality. Although the terms often include overlapping meanings they are also not generally considered to be interchangeable. However, as the field has yet to reach a unifying consensus as to how best to define each of the terms (see Richards & Bergin, 2000), it was beyond the scope of the current study to attempt to do so. Instead, measures in this study tended to utilize the terms not as interchangeable, but in combination with one another. The pairing of these terms is consistent with their usage in the APA's Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists (2003); as with the vast majority of the currently published literature pertaining to the subject (e.g. Hage, 2006; Shulte et al., 2002). Some researchers have in fact noted that when it has not been specifically necessary to

separate the terms, their paired usage as described above may be appropriate for achieving maximum inclusiveness, particularly in the absence of universally accepted definitions distinguishing them (Shulte et al., 2002). To further enhance inclusiveness, items including references to religion and spirituality were carefully constructed so as not to promote any particular religious or non-religious orientations, traditions, or values over others. Though such an approach can have potential drawbacks, insofar as the characteristics that differentiate specific faith orientations may often outweigh the potential similarities, these nuances were also considered outside the scope of the current investigation, and secondary to the need for neutrality and inclusiveness as stated above (Blazer, 2009).

## CHAPTER IV

### ANALYSES AND RESULTS

#### *Overview of analyses*

Consistent with prior studies surveying clinical training directors, a primary aim of the present study was to provide a simple descriptive analysis of questionnaire responses regarding religious training in graduate clinical psychology programs. In this study, however, the questionnaire responses were provided by *the students* in APA-accredited training programs rather than by the program coordinators. The present study also sought to establish a link between these training (and other prior) experiences and the students' self-rated competency to address religious issues in clinical contexts.

Traditional statistical analyses commonly employed in the social sciences tend to rely on computed aggregates and the estimation of population parameters (see Grice, 2011). The validity of such estimates often depends upon a number of assumptions, including normality of population distributions or measurement errors, linearity of relationships, independence of observations, and continuous quantitative structure of measured variables. Grounded in the philosophical realism of Aristotle and St. Thomas Aquinas, Observation Oriented Modeling ([OOM]; Grice, 2011) provides a philosophically and mathematically sound alternative to these traditional methods that requires fewer assumptions and does not require observations to be structured as continuous quantities.

Eschewing aggregates, OOM also examines the extent to which a given set of ordered observations fit a predicted cause-effect model.

In the present study, the links between training (and other prior) experiences and the students' self-rated competency to address religious issues in clinical contexts were analyzed with OOM. Specifically, as represented in Figures 7a and 7b, the level of competency (effect) endorsed by respondents were brought into conformity with prior experiences of the respondents (causes; e.g. personal religiosity and formal training). The results from the OOM software primarily entail an index of the percentage of correctly classified cases, the PCC index, according to this cause-and-effect relationship. It was expected that this index would exceed 50% (a majority) for each set of ordered observations. The OOM software also yields a probability value, referred to as a c-value (chance-value) that indicates the robustness of a given set of linked observations. The c-value is derived from a randomization test, and in this study 10,000 trials were used for each analysis. When the observed data conform well to the proposed model, it is expected that the observed c-values would all be low (e.g.,  $< .10$ ).

In review, the analyses of the present study were two-fold. First simple descriptive statistics including response counts and proportions of responses were used to describe current trends with respect to religious training in graduate clinical psychology programs, as reported by graduate students. Second, this study sought to conform self-reported competence to its hypothesized causes (formal religious training and personal religious experiences) as illustrated in Figures 7a-7b using Observation Oriented Modeling.

### *Training Opportunities*

Participants were asked to respond to a series of questions designed to broadly characterize the training opportunities offered by their graduate programs with respect to religion as a dimension of multicultural perspectives in psychology. As graduate coursework holds a central role in the structured training curriculums through which programs meet training (and accreditation) objectives, this was the principle domain explored in the current investigation. Because the exact nature of the coursework can be highly variable within and between programs, participants were presented with three broad categories that sought to capture and operationalize training with increasing levels of depth and breadth. Specifically, participants were asked whether their programs offered coursework that addressed religion in the context of other broad diversity topics (e.g. ethics courses), as a major content area of a course (included on the course syllabus and given comparable attention to other course topics; as in a multicultural course), or as the primary focus of the course (e.g. psychology of religion). The results of these questions revealed that 65% of respondents (n=163; Figure 8a) indicated that their programs offered coursework that addressed religion in a broad context, 24% (n=59; Figure 8b) indicated coursework that included religion as a major content area, and 10% (n=26; Figure 8c) indicated coursework with a primary focus on religion. As coursework is not the only training modality within clinical programs, participants were also asked to rank order a variety of common training modalities for addressing religion. Results indicated that structured coursework was the highest ranked

modality for religious training, followed by clinical supervision, clinical practicum, special seminars, research, and other.

### *Comparisons across cultural dimensions*

While the principle cultural dimension being investigated in the current study was religion, such an investigation would be incomplete without at least a cursory exploration of how this construct was described in the context of other dimensions commonly addressed in multicultural psychology. One way that this was explored in the present study, was in asking participants to rate the relative percentage of overall attention paid by their graduate programs to a number of common cultural constructs. The results of these ratings revealed that fully two out of every three participants ( $n=166$ ; see Figure 9) reported the least attention paid to issues concerning religion and spirituality. Exactly the same number of participants reported the greatest attention paid to issues concerning race and ethnicity.

The median percentages reported across dimensions are as follows: race/ethnicity = 25%; gender = 15%; age, sexual orientation, and socioeconomic status = 10% each; religion and disability = 5% each; other/undefined = 2%. When examining cumulative frequencies, and using a cut-point equal to the overall median reference of  $\geq 10\%$  as a baseline for comparison, the following observations are made. Ninety-six percent of respondents reported a significant ( $\geq 10\%$ ) focus on issues of race/ethnicity; 76% reported a significant focus on gender issues; 69% for age-related issues; 66% for socioeconomic status; and 63% for issues related to sexual orientation. By contrast, only 39% reported a

significant focus on disability-related issues; and just over one in three participants (36%) for issues of religion/spirituality. When excluding participants from faith-based institutions where religion was identified as an integral part of the required course curriculum, this figure dropped to slightly less than one in three (32%). These data are displayed graphically as a boxplot in Figure 9.

### *Attitudes and perceptions*

Based on previous findings reported in the literature regarding both positive and negative attitudes commonly held by psychologists toward religion, students were also asked to respond to statements regarding their perceptions as to the religious identifications and attitudes held by faculty and students in their graduate programs, as well as the field more broadly. A plurality of participants reported that faculty (48%; Figure 10a) and students (54%; Figure 10b) in their graduate programs are not likely to be themselves religious (the remaining classifications divided between “religious” and “no basis for judgment”). However, approximately two out of three participants agreed that both faculty and students (assessed independently) in their graduate programs contribute to a classroom environment that is respectful of religion (Figure 11) and that both groups (faculty and students assessed independently) value religion as an important aspect of cultural diversity (Figure 12). Despite that 82% of participants reported that the available research literatures suggests that overall, religion is most likely helpful to mental health (11% reporting irrelevant and <1% reporting harmful; Figure 13a); only 68% held this belief personally (with 21% believing it to be irrelevant and 6% believing it harmful; Figure 13b).



Perceptions continued to shift even further when asked about the views believed to be held by psychologists in general concerning the relationship between religion and mental health. Here, fewer than half (48%) reported that psychologists are likely to view religion as helpful, compared with 34% who believe psychologists view it as irrelevant and 13% as harmful (Figure 13c).

#### *Conforming competency to training*

The second major area of focus for the current investigation was to examine the relationship between formal graduate training experiences, namely structured coursework with a primary or major focus in religion, and self-rated competency to address religious issues (for persons principally of a religious orientation that differs from that of the student-clinician) in a therapeutic context. As training is a core underpinning of competency, it was predicted that self-rated competency should conform to training received. That is, it was expected that those students who endorsed structured, religion-specific coursework, would rate themselves more highly on a scale of competence compared with those who did not. Due to the small number of observations present in a number of the units of observation (i.e., response categories), and the ambiguity that can sometimes result when the number of units in the target orderings (the cause) exceed the number of units in the conforming orderings (the effect; see Grice, 2011), some orderings were simplified to increase the clarity of the results. Specifically, the number of religion-focused courses completed, which was presented to participants as an open-ended question, was simplified to reflect “no courses completed” or “one or more courses completed.” The levels of competency were

likewise simplified to reflect two units that included “less than competent” and “competent or proficient,” based on the presumption that competency is inclusive of higher proficiency. These simplifications resulted in zero ambiguously classified observations in any of the final analyzed models.

In examining coursework specifically, competency did not conform to completed religion-specific coursework (primary focus or major content area) as predicted. As can be seen in Figure 14, all of the 16 individuals who reported completing one or more courses focused on religion judged themselves as competent or proficient working with individuals of a different orientation than self; however, of the 226 students who reported to never have completed a single course focused on religion, 175 (77%) still judged themselves as competent or proficient and were thus classified incorrectly by the model. Most of these latter students were expected to rate themselves as less than competent. The overall model consequently yielded a PCC value of only 27.69 (c-value = 0.46; see Table 1).

A similar pattern of results was obtained for courses with a major content area in religion. As can be seen in Figure 15, 40 of the 49 students (82%) who completed at least one such course rated themselves as competent or proficient, consistent with expectation. However, 151 of the 193 students (78%) who did not complete such a course still judged themselves as competent or proficient, and the model yielded an overall PCC index of only 33.88 (c-value = 0.84; see Table 1). Thus, self-rated competency did not conform to training based on any model of coursework with significant inclusion of religion. Each of these models

failed to accurately classify even half of the observations and all yielded high chance values with repeated randomization trials.

As has previously been mentioned, a third level of coursework was also explored in this study, which included courses that addressed religion only in the broad context of other topics (but not as a major topic of discussion itself). As shown in Figure 16, the results were similar to those above. While 109 of the 131 students (83%) who completed such a course judged themselves as competent or proficient, and were thus classified correctly, 82 of the 111 students who did not complete such a minimal course (74%) nonetheless judged themselves as competent or proficient in treating clients with religious beliefs different from themselves. The model yielded an overall PCC index of 57.02 ( $c$ -value = 0.05; see Table 1).

Beyond training received, another area previously described in the literature as having a statistical relationship with self-rated competence was personal religiosity (Shafranske & Malony, 1990). Two models were designed to predict this relationship. The first attempted to conform competence to an individual's current self-identification with religion. The second attempted to take the relationship further by adjusting the model for the extent to which the participant viewed her/his religion as a significant aspect of her/his personal identity. Figure 17 shows the results for the first model. As can be seen, of the 143 students identifying as currently religious, 119 (83%) judged themselves as competent or proficient, whereas of the remaining 99 participants identifying as not presently religious, 27 (27%) judged themselves as of less than competent.

The majority of participants (146 of 242) were hence classified correctly by the model in a manner consistent with the direction of the predicted effect (see Table 2), PCC = 60.33, c-value = 0.03.

In examining the second model shown in Figure 18, 128 of 157 participants who endorsed the statement “my religious orientation is a significant aspect of my identity” also rated themselves as competent or proficient and were classified correctly. Only 21 of 81 participants who disagreed with the statement were correctly classified as less than competent. Although this model correctly classified 62.61% of the observations, a similar pattern of results may have been randomly seen in these observations by chance >10% of the time (c = 0.12; Table 2). One final model concerning personal religiosity examined the potential interaction between present religious identification and coursework completed. As statistical models for both personal religiosity and completed coursework were each found to predict self-rated competence (as described above), it was further expected that the combination of these ordered observations would also predict competence. A new ordering was created comprised of four units: (1) students who completed any one of the three types of courses with religious content and who also self-identified as religious; (2) students with some course exposure who identified as non-religious; (3) students with no course exposure who identified as religious; and (4) students with no course exposure who identified as non-religious. Results shown in Figure 19 (see Table 3 also) indicate that a large majority (82 of 96, 85%) of religious students who also reported some course exposure to religiosity rated themselves as competent or proficient. These

students were correctly classified by the model. Majorities of students in the other three groups, however, also reported competence or proficiency in treating clients with religious identities different from their own. The smallest majority was found for the non-religious students with no course exposure; consequently, the 14 students in this group who reported low competence were classified correctly. All other observations were classified incorrectly, partly due to the asymmetry between the cause and effect orderings, yielding a low PCC index (39.67) which nonetheless was accompanied by a low c-value (.05).

Several additional models were analyzed to examine other potential aspects of training in relation to competence. No other model in the current analyses was found to yield a significant relationship to competence. These included, for example: type of graduate institution (e.g. faith-based vs. not faith based); terminal degree being sought (e.g. Ph.D., Psy.D., etc.), or training model of program (e.g. practitioner-scholar, scientist-practitioner, clinical scientist, etc.). Results for each of these models are presented in Table 4, but are not elaborated upon here (as they are provided only as exploratory and supplementary to the primary models previously described). One exception that will be elaborated upon is the number of years completed in the current graduate program. If competency is presumed to increase as degree of training increases, it would be expected that the higher the number of years completed by participants in their respective graduate programs, the more highly they would rate their competence (compared to those with fewer years of training). This pattern was not observed in the observations derived from this study. As can be

seen in Figure 20 (see also Table 4), the competency observations were organized into their three original units (less than competent, competent, proficient) for this analysis. The numbers of years were also ordered into three units: 0-1 years, 2-3 years, and 4+ years. The results indicate that the largest proportion of students who rated themselves as proficient also reported the fewest years of training (26 of 54 students, see Figure 20). While the model classified these observations as correct, this result is contrary to prediction. Students with 4+ years of training should have been the majority of those who rated themselves as proficient and consequently classified as correct by the model. The pattern of results for those who judged themselves as less than competent or competent students fit expectations. The largest proportion of less than competent students reported the fewest years of training, and the competent students reported training of 2 to 3 years (PCC = 43.49, c-value = .001). Still, the results also indicate that the majority of students, regardless of years of training, consider themselves to be competent or proficient in working with clients with different religious perspectives.

In each of the aforementioned statistical models, the conforming ordering of observations was based on self-rated competency for addressing religious issues with persons of a different religious orientation than the respondent. However, participants were also asked to rate their competence for working with individuals of a similar religious orientation to themselves. In each case, the overall patterns of observations were similar. The most notable distinction between the two sets of models (similar vs. different religious orientations) was

observed in the PCC values in models where the target ordering was based on training experiences. A small number of participants were more likely to provide higher competence ratings for similar religious orientation than different, regardless of formal training experiences, resulting in a higher degree of misclassification. Findings for individual models are presented in Tables 2-5 alongside the results for those models previously described above. Overall, these results are consistent with prior research finding that personal religiosity predicts self-rated competence for addressing religious issues in a therapeutic context. However, the results were inconsistent with expectations that higher levels of graduate training related to religion would result in higher self-ratings in competence for the same. In fact, the expected pattern was observed only when religious training was conceptualized in the broadest possible terms (to include training where religion was specifically not considered a major topic in formal coursework, but instead covered only in the context of other broad topics).

## CHAPTER V

### DISCUSSION

Religious diversity is a cultural fact and one that it is incumbent upon clinical psychologists to understand if they are to engage in competent and culturally sensitive work (whether in research, teaching, clinical practice, or other professional ventures). Prior research involving clinical training directors both for doctoral programs and pre-doctoral internship sites have indicated that the integration of religious training into these programs has been non-systematic and highly variable at best. Not surprisingly, this observation held true in the current survey of graduate students as well. However, while training directors tended to indicate that this training was most likely to occur in the context of clinical supervision, students tended to rank coursework as the number one modality for religious training, followed by supervision, then practicum and other modalities. Despite holding the top spot in this list, the availability of coursework that offered training in religion was also found to be highly variable. One out of every three respondents reported that their training programs offered no courses providing any coverage of religion in any context (even in the context of other broadly defined cultural topics). Approximately one in four students did report coursework that included religion as one of many content areas, and one in ten reported coursework offerings where religion was the primary focus. When considered in the context of other selected dimensions of cultural diversity,



religious training did not fare well. Two out of three respondents reported that religion received less attention within their programs overall than any other aspect of diversity included in the survey, and only one in three reported spending 10% or more of the time allocated to diversity on topics related to religion.

In one of his texts on psychology and religion, William Miller recounted his own experiences from when he began graduate school in 1969. He observed that religion was a taboo subject – that students were perhaps better not to have thoughts or beliefs on the subject, but if they must think such things, the thoughts were better kept to themselves (Miller, 2005). Results of the current study suggest much progress has been made in the intervening decades since. The fact that two out of three students in this study perceived their training environments as respectful of the subject is cause for cautious optimism. However, that the optimism is qualified here as cautious is equally relevant, in that there is still much work to be done. The complimentary finding that one out every three students surveyed did not perceive their training environments as respectful of religion remains a troubling observation, particularly given the mandates pertaining to cultural diversity that the APA has issued in its ethical and training guidelines (APA, 2002, 2009). Attitudes toward religion were also assessed in the broader context of the perceived relationship between religion and mental health. Despite that 82% of respondents reported believing that the available research supports the conclusion that religion is most likely beneficial to

mental health overall, only 68% held this belief personally, and less than half (48%) attributed this belief to psychologists generally.

### *Religious Competency*

Perhaps the most noteworthy findings of the current study were observed in the context of competence. Based on the premise that training is a core component in the acquisition of competence (Campbell, et al., 2010), this study sought to conform students' self-ratings of competence to their graduate training experiences, particularly as these experiences related to coursework. This is believed to be the first such study to define and test a causal model linking training and competence in this domain. Contrary to expectations, religious competency was found not to conform to graduate training experiences overall. Specifically, 77% of students who had never completed a single course focused on religion, and 78% of students who had never completed a single course that included religion as a major content area nevertheless rated themselves as competent or proficient in working with individuals of religious orientations different than themselves. Although a third model of coursework which examined religious training in its broadest possible context (to include any mention of religion in any context) did correctly classify more than half of the respondents (57%), fully 74% of participants who denied even this minimal level of exposure to religion through coursework also still rated themselves as competent or proficient in this domain.

Interestingly, the number of years completed by students in their current graduate programs also failed to accurately predict self-rated competency. In

this model, the majority of those students rating themselves as proficient in working with clients of diverse religious orientations, were also those with the fewest years of graduate training experiences (0-1 years completed). Competency also could not be brought into conformity with any of the assessed aspects of the students' training programs, including for example the type of graduate institution, model of training program, or terminal degree being sought. Overall, 79% of students rated themselves as competent or proficient working with clients of differing religious orientations, regardless of their graduate training experiences. This reflects a much higher proportion of students who considered themselves competent in this area than has been reported among professional psychologists in other studies (e.g. Shafranske & Malony, 1990). The magnitude of the above stated trend is rather alarming. However, the fact that competence was not found to conform to training (although troubling in itself) is consistent with prior studies conducted among practicing psychologists. Specifically, results reported in the existing body of literature indicate that personal religious orientation, and not prior training experiences, is related to a clinician's self-rated competence (Shafranske & Malony, 1990). This was also found to be the case in the present study. Here, 60% of participants were correctly classified by a model conforming competence ratings to current religiosity. Even in this latter model which correctly classified a majority of the participants in this study, a large number (two out of five) remained incorrectly classified; with other tested models correctly classifying participants at even lower rates. A more complex model consisting of a combination of current religiosity along with prior training

experiences yielded a high rate of misclassification, which was attributed at least in part to the asymmetry in the resulting structures of the cause and effect orderings.

As previously stated, participants in the present study identified formal coursework as the training modality through which religion was most likely to be addressed in their graduate programs. Yet, one third reported that no such course offerings were available in their programs, and approximately three quarters of those who never completed such coursework nonetheless rated themselves competent or proficient. These results raise a number of questions. Are students' self-assessments pertaining to competence reflective of actually attained competence? If they are indeed accurate, what experiences apart from formalized graduate instruction contributed to that competence? This study sought to explore alternative explanations through an optional open-ended question given to participants asking them to describe their experiences with religious diversity apart from graduate coursework. However, fewer than 5% (n=12) elected to respond. Those responses that were provided included completion of undergraduate courses relevant to religion as well as personal interactions with peers of different religious groups.

Alternate explanations (of which there are likely many) include the possibilities that students in the present study either made inaccurate self-appraisals concerning their degree of competence attained, or that they simply did not wish to endorse lower levels of competency in this study, regardless of how they internally assessed themselves on this dimension. If the provided

competency ratings do indeed reflect a response bias, this bias might be reduced in future studies through further refinement of the item content. In the present study, students were presented with the options “less than competent, competent, or proficient.” While this wording was intended to be judgment-neutral, it is possible that respondents perceived the language in the first option as negatively skewed and therefore did not wish to self-identify in that manner. Alternate language such as “competence not yet attained” or “beyond the scope of current competence” may elicit more forthright responding from graduate trainees and professionals alike, given that these latter characterizations suggest not a personal deficiency, but rather a particular set of skills that simply has yet to be acquired or refined. However, the possibility that students may have simply made faulty self-appraisals also cannot be ignored. Indeed, competence is often an ill-defined construct even to the seasoned psychologist. As stated by Kitchener (2000),

It is easier to require psychologists or counselors to be competent than it is to define what competence means. As with other ethical constructs, competence is sometimes easier to identify in its absence than it is to specify what a proficient level of practical or scientific competence or expertise involves (p. 88).

But this issue raises questions of its own. Are graduate programs adequately training students in areas of self-awareness and self-appraisal so that they are prepared to assess their own competence (particularly as they progress in their autonomy toward independent practice)?

### *Methodological limitations*

One limitation for the current study, and indeed much of the literature in the area of religion and spirituality, is that these two dimensions are widely accepted as being independent but often overlapping constructs. While religion tends to be understood and operationalized in terms of its formal organization and practices, spirituality is a much more nebulous construct and therefore much more difficult to operationalize. Given that the two constructs have very often been examined in consort with one another, the current study adopted a similar approach. While the study's principle focus was the domain of religion, efforts were made to be inclusive of spirituality where it was appropriate to do so. When applicable, efforts were also made to attend to the specific nuances of one or the other (for example, asking about congregational membership in the context of religion but not spirituality), though no specific efforts were made to purely isolate one of these constructs to the exclusion of the other.

It is worth noting that some of the challenges posed by the similarities and differences between these constructs are not unique to this area of study. One could consider similar dyads such as sex and gender, or ethnicity and race. Whereas an individual's biological sex or ethnicity may best be understood in terms of genotypes; her/his gender and race are more likely to be operationalized in terms of phenotypes or socio-cultural identifications. In many ways, the delineations among the two sides of these dyads could make them quite unique (and at times, seemingly at odds with one another). Consider the examples of an individual whose biological sex is male but her gender identification is female; or

the person whose phenotypic expression of race is white even when his ethnicity is more commonly associated with a non-white phenotype. Clearly, to presume these overlapping constructs as equivalent would be a grievous error. Likewise, to presume that one has no influence whatsoever on the other may be an equally grievous error. Until the constructs of religion and spirituality are more clearly defined (and widely accepted) and their shared and unique attributes are better understood, it is likely that for better or for worse many more studies will continue to examine these constructs in conjunction with one another, as was the case in the current investigation. This notwithstanding, it is also evident in the existing literature (as well as in the present study), that many in the field are increasingly distinguishing between religion and spirituality in their own cultural identifications. As this trend continues, it will likewise be important to continue to understand and operationalize these distinctions in the ever-expanding body of literature on the subject.

Another limiting factor for the current study was that it was necessarily somewhat narrow in its scope. Although much information was gathered concerning aspects of cultural diversity other than religion, information was not collected at the same level of detail regarding the respondents' specific training experiences in those other cultural domains. Instead, this was a study about religion. The decision to assess other dimensions of diversity was made not to expand the scope of the current investigation into those areas (which are worthy of investigation in their own rights), but to provide additional context, thereby allowing the reader to more fully understand how the depth and breadth of

religious training compares with that of training in other cultural domains, as perceived by the students.

Despite having a narrow focus on religious training, there were a number of content areas addressed in previous studies on religious training that were not included in the present investigation, and for which the student perspective would be a welcome addition to the literature. For example, the current study did not explicitly query whether students believed knowing or understanding their clients' religious backgrounds was important, or whether they believed a client's background may directly or indirectly influence the course of treatment. Nor did this study specifically probe students' perceptions as to the extent their personal graduate training experiences thus far had prepared them for working with religiously diverse individuals. However information related to each of these questions was assessed indirectly through other items concerning student attitudes and perceptions regarding religion more generally. Here the decision to include or exclude some of these very specific items was made not due to lack of importance or relevance of the omitted items, but out of the need to balance the depth and breadth of the study's content with the its overall length and required time for completion.

In attempting to conform self-rated competency to training, the models in this study emphasized coursework over other training experiences. Because training directors previously tended to characterize religious training as unsystematic and highly variable, this study sought to examine primarily those religious training experiences of students that could be characterized as



structured and formal, and operationalized for consistent responding. This approach would seem supported by the premises that one of the principle means for attaining competence is through formal instruction (as previously identified), and that formal instruction is mandated by the training guidelines for the APA. Further support for this approach was elicited from within the current study. Students reported they were more likely to address religion in coursework than through other training modalities, contrary to impressions reported by training directors previously. Thus, while the models of training and competence in the current study did not capture all potential causal pathways (such as informal training or supervision, for example), they were selected for theoretical and methodological soundness; and did yield important findings pertaining to formal training and competence in this domain.

Finally, although this study achieved the maximum number of responses afforded to it through institutional review, the total number of participants is perhaps the most notable limitation in that it is likely to be relatively small when compared to the number of students currently enrolled in APA-accredited doctoral-level clinical psychology programs across North America. While every effort was made to send the invitation for participation to all accredited programs, there remains no sure way of knowing how many students in total received the invitation; and no way of comparing responders to non-responders for determining the representativeness of this study's participants. It was likewise impossible to ascertain how many unique graduate programs were represented in the study. While it may have been possible to make such a probe while

collecting other information related to program characteristics, it was believed that doing so may pose either an actual or perceived threat to the anonymity of the respondents, and by extension to the integrity of the data obtained; and therefore no such probe was made.

Notwithstanding these limitations, the heterogeneity observed in the reported demographics of the participants suggests that at least moderately diverse representation was obtained for this study. Participants represented graduate programs from approximately 35 different states, territories, and provinces from across North America. Diversity was also observed in the level of graduate education completed, highest degree already attained, terminal degree currently being sought, type of graduate institution attending, and training model and primary theoretical orientation of current graduate program. Less diversity was observed for dimensions of gender and ethnicity, with a large majority of participants self-identifying as female and European-American. Perhaps most important to the current investigation was that participants were observed to be religiously diverse, including representation from majority religious (40%), minority religious (20%), and non-religious (40%) orientations; with more than 20 distinct religions, religious denominations, and non-religious orientations represented in total.

#### *Summary and future directions*

Psychology has become the science of human behavior, and on the whole, has attempted to shift its focus to those phenomena that can be evoked, observed, tested, and (even if only in theory more so than in practice) replicated

within the presumed controlled confines of the laboratory setting. Somewhere along the way, however, the field not only shifted its focus in a new direction, but some also would argue, turned its back on its own historical roots. As aptly stated by one researcher, “during the 20<sup>th</sup> century, psychology lost first its soul and then its mind” (Miller, 2005). A review of the history of psychology would seem to suggest that both fell prey to the field's quite noble pursuit of scientific inquiry – a pursuit that many within the field would argue leaves no room for topics such as religion that are less easily observed and quantified (Wulff, 1996).

And yet, this argument quickly falls apart when one examines other psychological constructs that have been equally difficult to observe and quantify but remain centrally important to the field's ongoing efforts to understand human nature. Consider intelligence – psychology's own unicorn – an illusory latent construct that has been an integral part of the fabric of psychology throughout its developing years as a scientific discipline, despite that there remains no unified consensus concerning what “it” is or how best to measure “it.” Yet, enough of the field recognizes that intelligence exists (even if it has yet to be accurately defined), that it influences behavior, and it is worthy of continued inquiry. By extension, one can argue that like intelligence, memory, motivation (and many others), religion and spirituality need not be outside the realm of psychology simply because they may originate internally. Whether in study, in clinical practice, or elsewhere, psychologists will encounter persons with different cultural make-ups than their own, and these differences will almost assuredly at times include religious orientation (Richards & Bergin, 2000). Professional ethics

demand that when this occurs, psychologists work within a framework of multicultural competence whenever possible.

Recent studies have provided descriptive analyses of religious training offered in graduate programs and pre-doctoral internships as reported by clinical training directors. Other studies have reported on the perceptions and experiences of psychologists regarding the intersection of religion with the practice of clinical psychology. However, no studies were identified in the current body of literature that reported on the unique perspectives and experiences of current graduate students; and none has yet been observed to test causal links between training experiences and competency with respect to religious diversity. The present study sought to fill these gaps. However, the results of this investigation have perhaps raised even more questions than the study originally sought to answer. To what extent are training programs meeting the spirit of the APA's guidelines for training in cultural diversity (to include diversity of religion)? What barriers remain in place as programs work to meet these challenges? What progress has yet to be made in order to create a welcoming environment for the one in three students who still perceive religion as an unwelcome topic of conversation? On what basis are students making self-assessments of competence; and are students adequately trained in self-awareness to make these appraisals? These are some of the many questions to which the field must continue to seek answers as it progresses forward in this important area of inquiry.

## APPENDIXES

Appendix A	Tables
Appendix B	Figures
Appendix C	Institutional Review Board Approval
Appendix D	Participant Recruitment Email
Appendix E	Study Information Informed Consent
Appendix F	Measures

Appendix A

*Tables*

Table 1: Competence as predicted by religious coursework

	Competence – Religion Different from Self				Competence – Religion Similar to Self			
	CO	CC	PCC	C	CO	CC	PCC	C
Courses Primary	242	67	27.69	0.46	243	40	16.46	0.66
Courses Major	242	82	33.88	0.84	243	66	26.75	1.00
*Courses Broad	242	138	57.02	0.05	243	138	56.79	0.06

CO Classified Observations

CC Correct Classifications

PCC Percent Correct Classifications

C Chance Value (based on 10,000 Randomization Trials)

\* Pattern conformed to predicted model

Appendix A

*Tables*

Table 2: Competence as predicted by personal religiosity

	Competence – Religion Different from Self				Competence – Religion Similar to Self			
	CO	CC	PCC	C	CO	CC	PCC	C
*Religious Identity	242	146	60.33	0.03	243	148	60.91	0.05
Religion Significant	238	149	62.61	0.12	239	151	63.18	0.55

CO Classified Observations

CC Correct Classifications

PCC Percent Correct Classifications

C Chance Value (based on 10,000 Randomization Trials)

\* Pattern conformed to predicted model

Appendix A

*Tables*

Table 3: Competence as predicted by coursework crossed with religiosity

	Competence – Religion Different from Self				Competence – Religion Similar to Self			
	CO	CC	PCC	C	CO	CC	PCC	C
Religion ^ Courses	242	96	39.67	0.05	243	100	41.15	0.04

CO Classified Observations

CC Correct Classifications

PCC Percent Correct Classifications

C Chance Value (based on 10,000 Randomization Trials)

\* Pattern conformed to predicted model



Appendix A

*Tables*

Table 4: Competence as predicted by graduate training

	Competence – Religion Different from Self				Competence – Religion Similar to Self			
	CO	CC	PCC	C	CO	CC	PCC	C
School Type	241	77	31.95	0.58	242	52	21.49	0.59
Program Model	240	114	47.50	0.16	241	94	39.00	0.40
Terminal Degree	241	94	39.00	1.00	242	85	35.12	0.81
Years Completed	242	105	43.39	0.00	243	94	38.68	0.28

CO Classified Observations

CC Correct Classifications

PCC Percent Correct Classifications

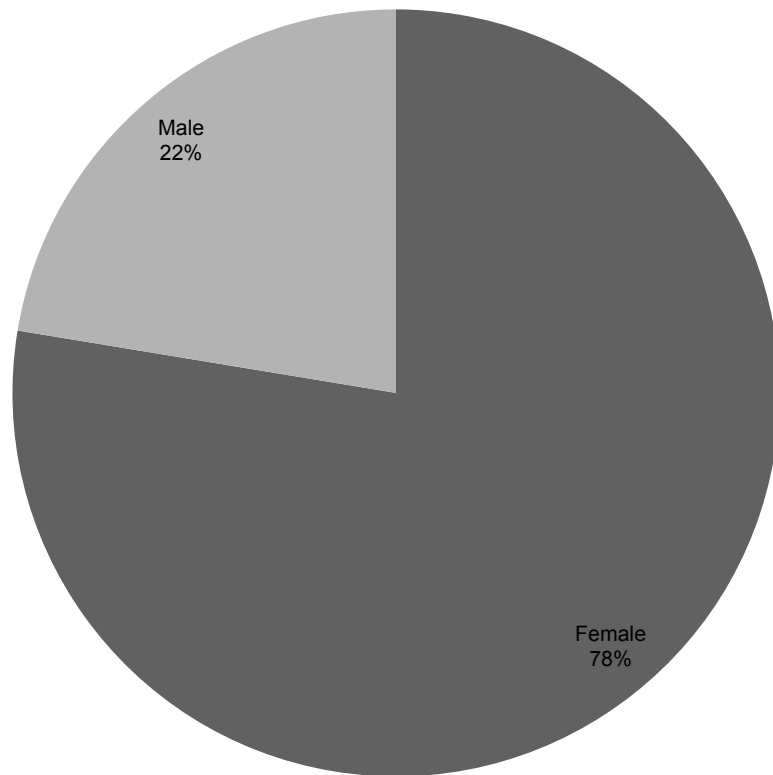
C Chance Value (based on 10,000 Randomization Trials)

\* Pattern conformed to predicted model

Appendix B

*Figures*

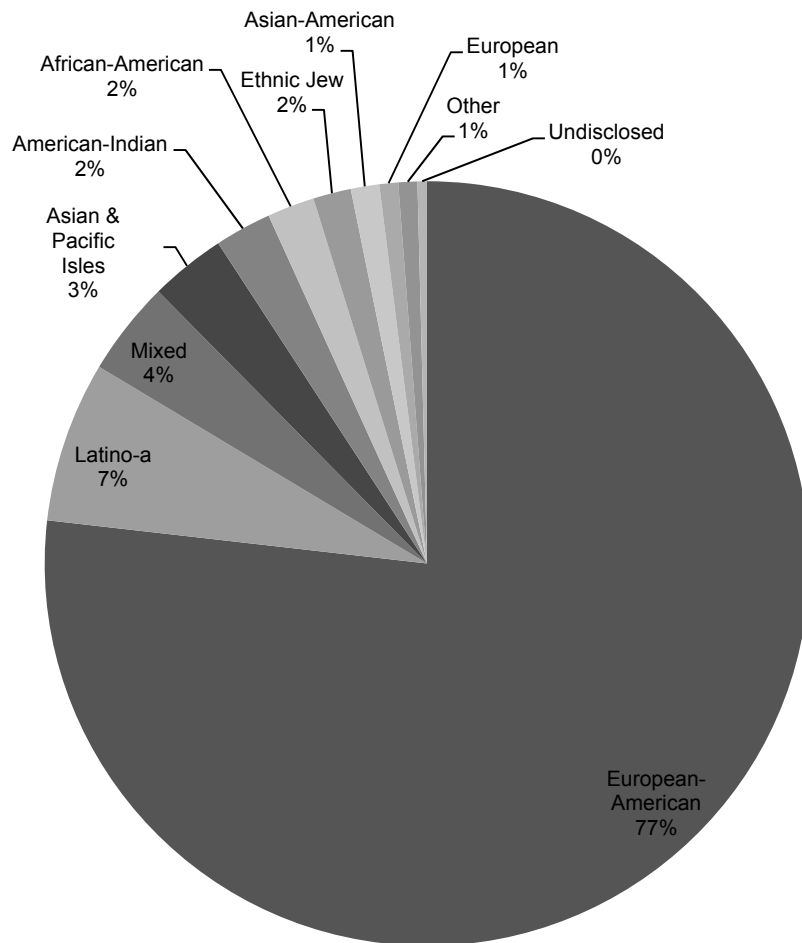
Figure 1: Participant gender



Appendix B

Figures

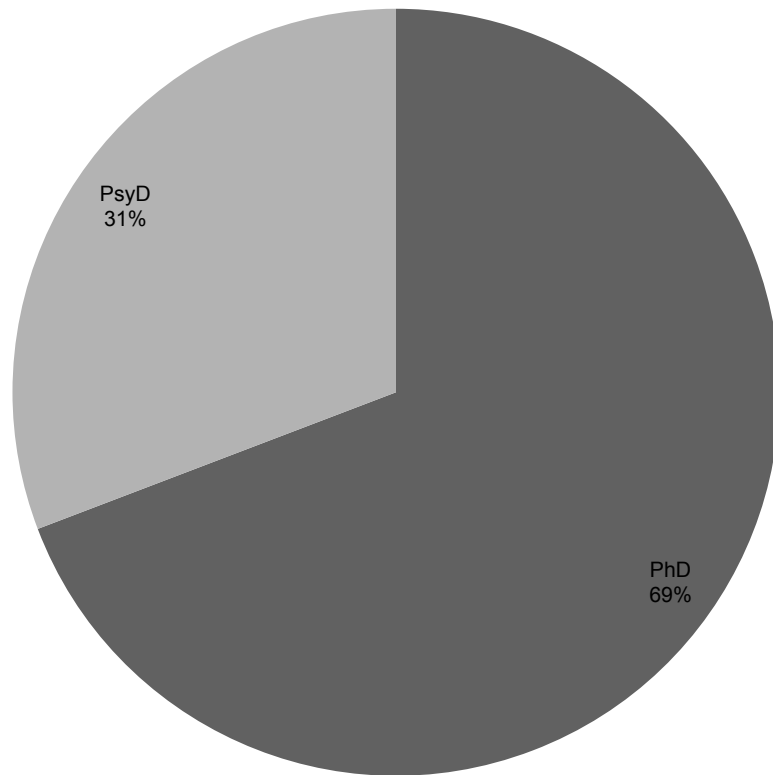
Figure 2: Participant ethnicity



Appendix B

*Figures*

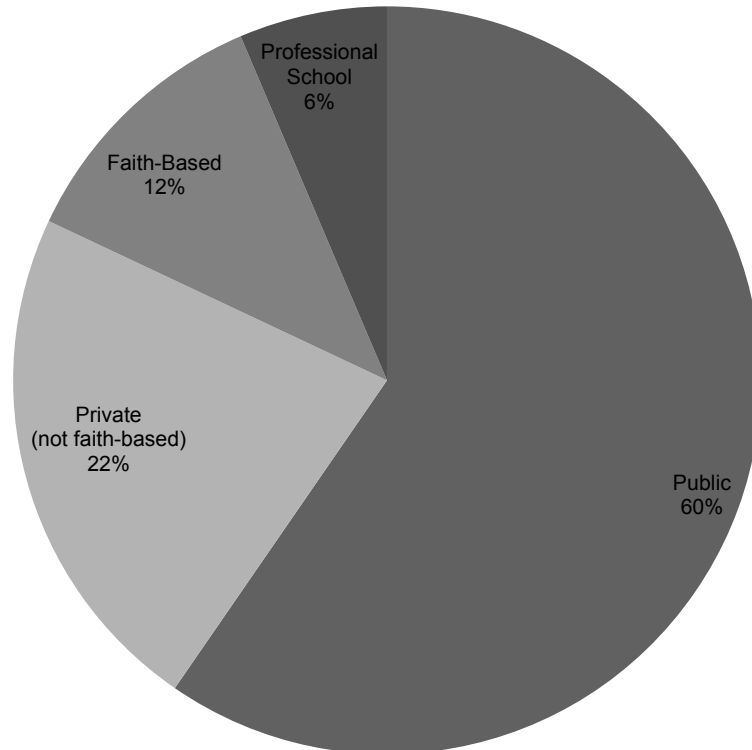
Figure 3: Terminal degree sought by participant



Appendix B

*Figures*

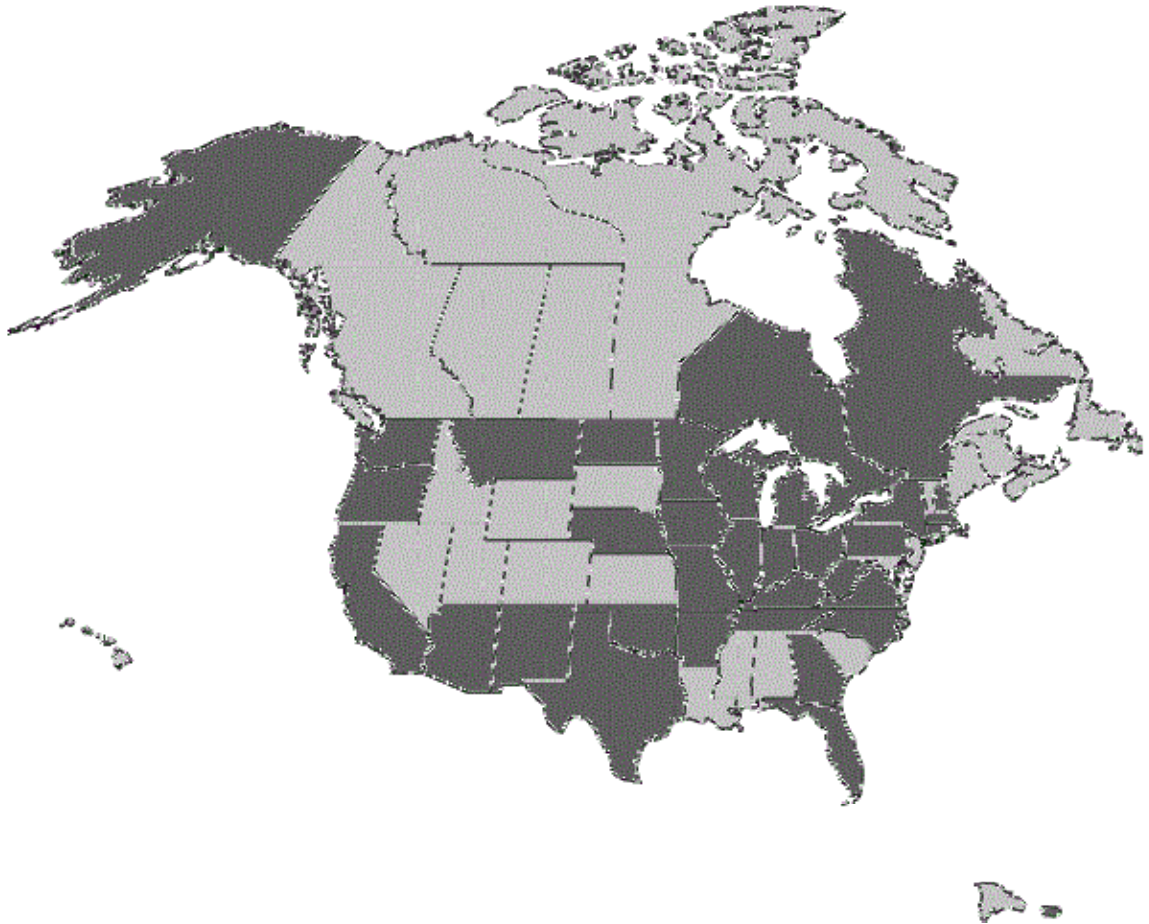
Figure 4: Type of graduate institution attended by participant



Appendix B

*Figures*

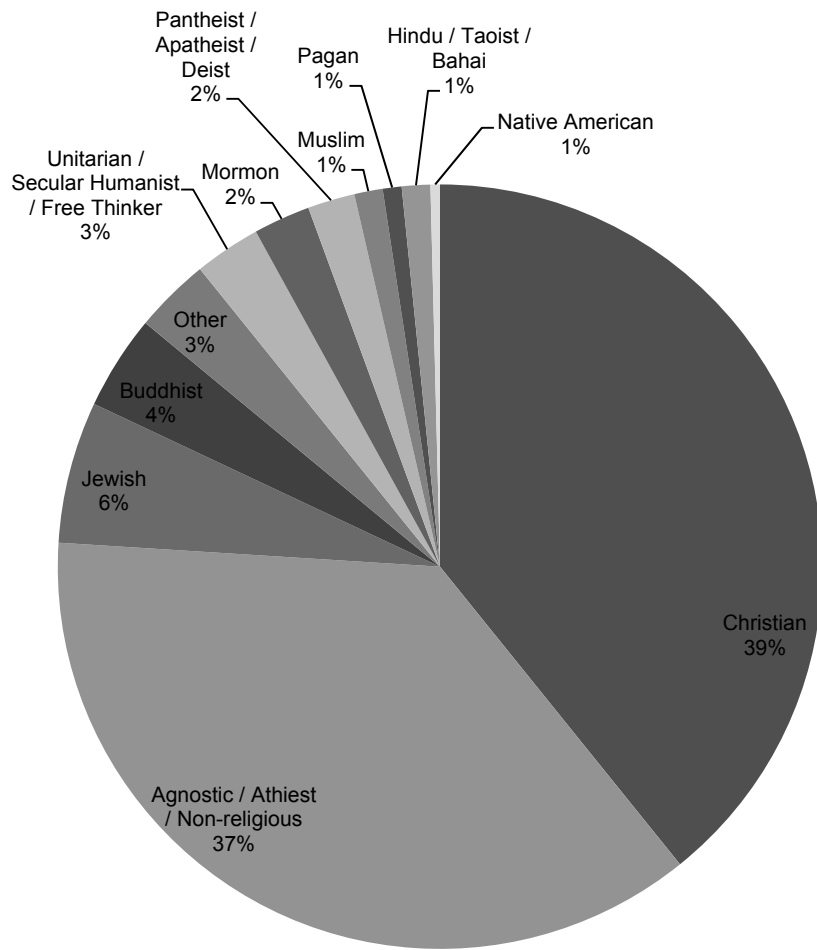
Figure 5: Geographic representation of respondents' graduate institutions



Appendix B

Figures

Figure 6: Religious orientation of participants

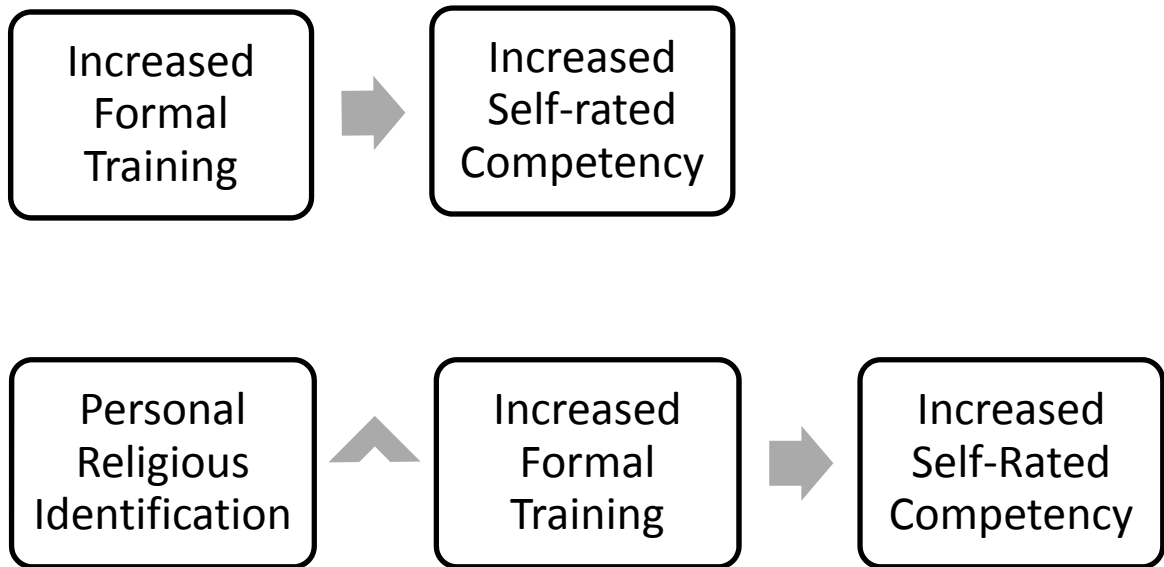


Appendix B

*Figures*

Figure 7a: Model - Competence conformed to training

Figure 7b: Model - Competence conformed to training crossed with religiosity



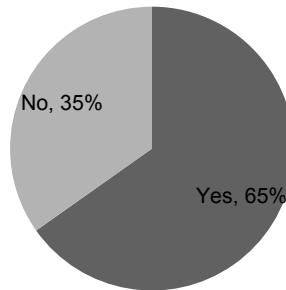


Appendix B

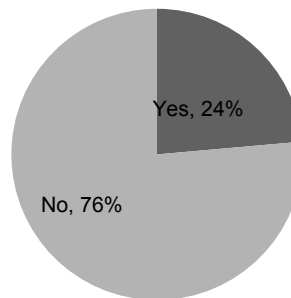
*Figures*

Figure 8a-c: Percentage of students reporting course offerings with religious content

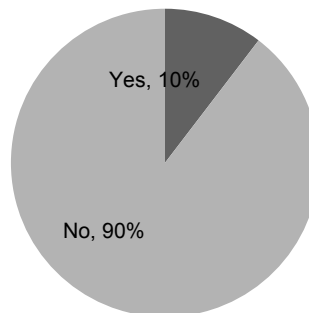
a. religious content only in the broad context of other topics.



b. religious content as a major content area.



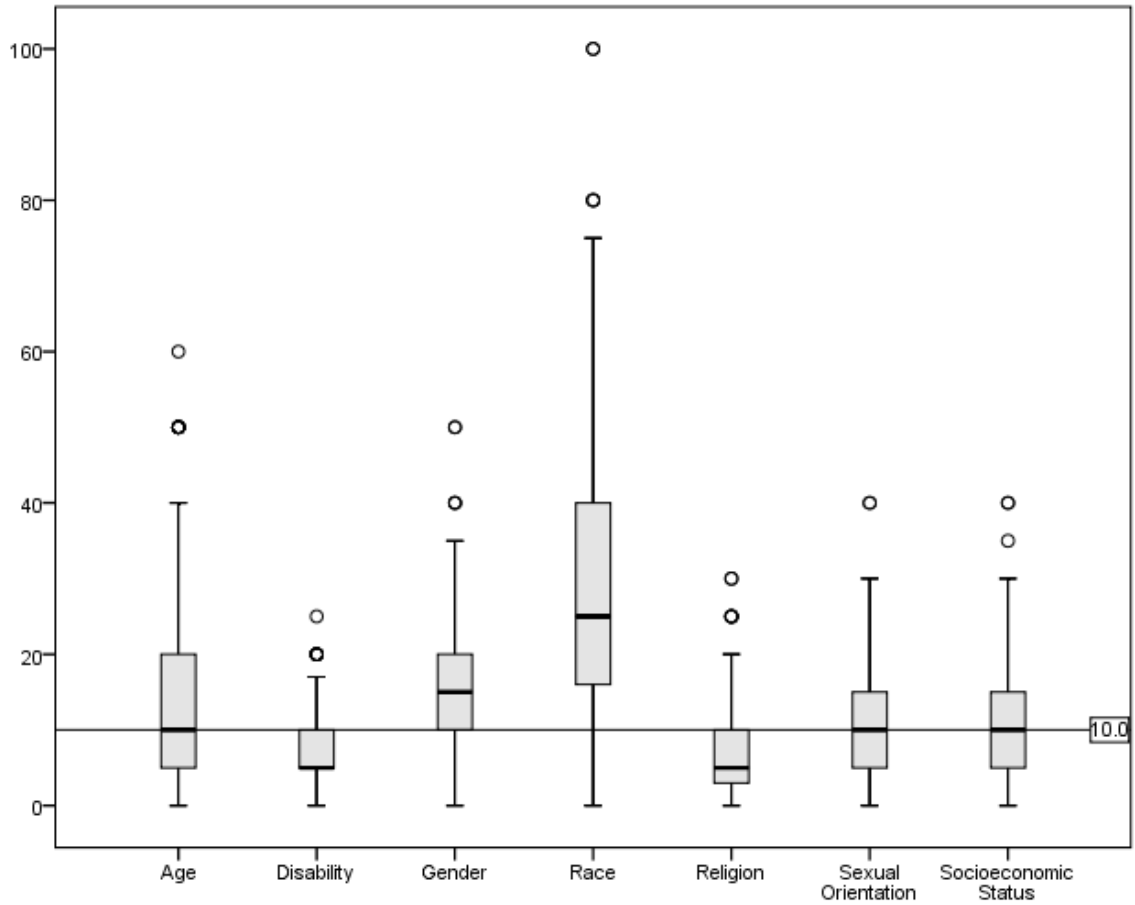
c. religious content as a primary focus.



Appendix B

Figures

Figure 9: Boxplot – Overall percentage of attention paid to selected dimensions of cultural diversity

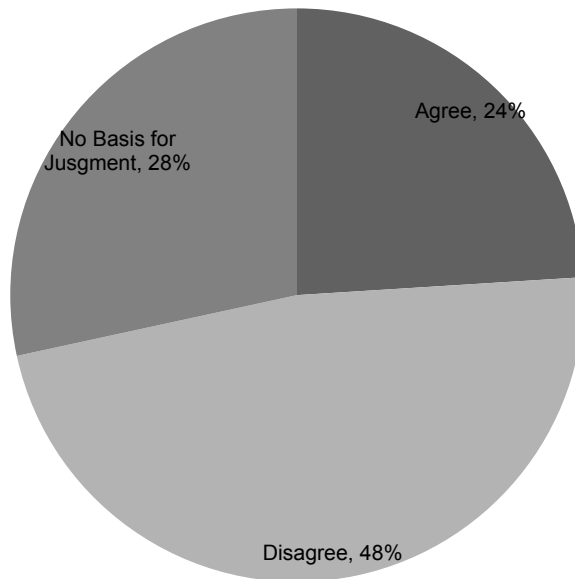


Appendix B

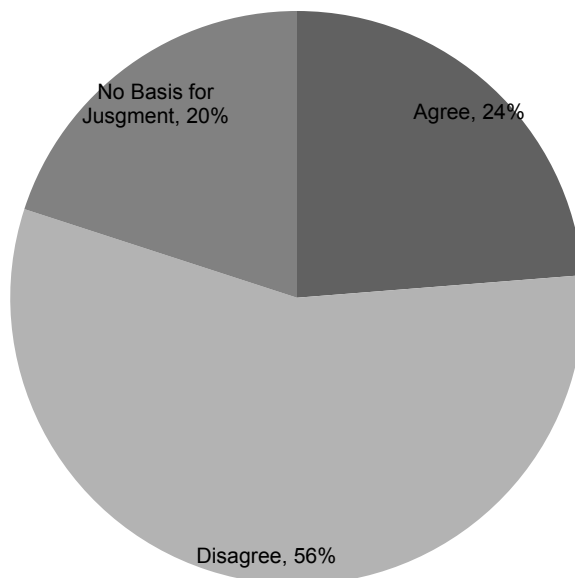
Figures

Figure 10: Perceived religiosity of others involved in graduate program

a. Faculty in my program are more likely than not to be religious/spiritual individuals



b. Students in my program are more likely than not to be religious/spiritual individuals

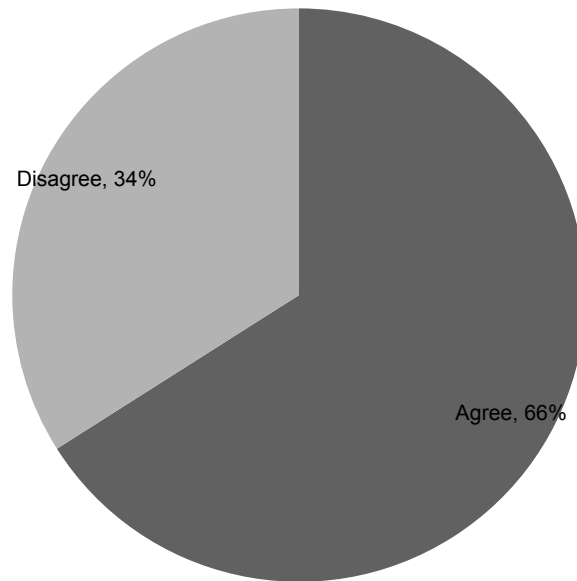


Appendix B

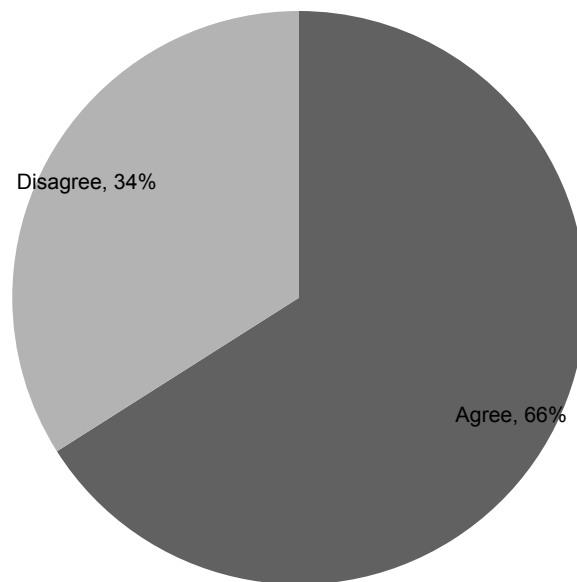
*Figures*

Figure 11: Perceived learning environment of graduate program

a. Faculty in my program contribute to a learning environment that is open / respectful of religion/spirituality



b. Students in my program contribute to a learning environment that is open / respectful of religion/spirituality

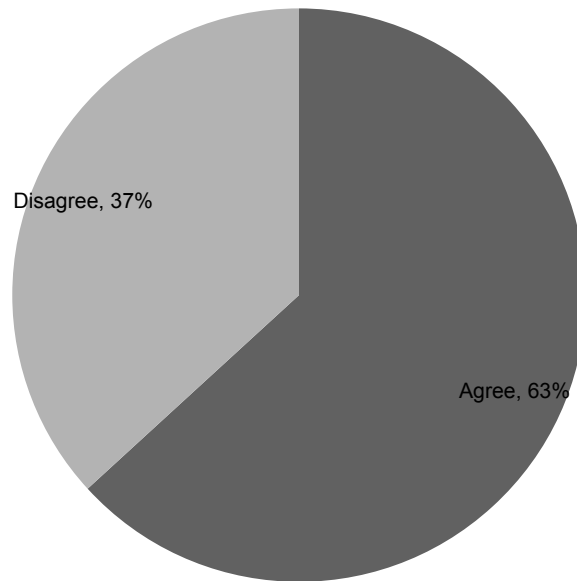


Appendix B

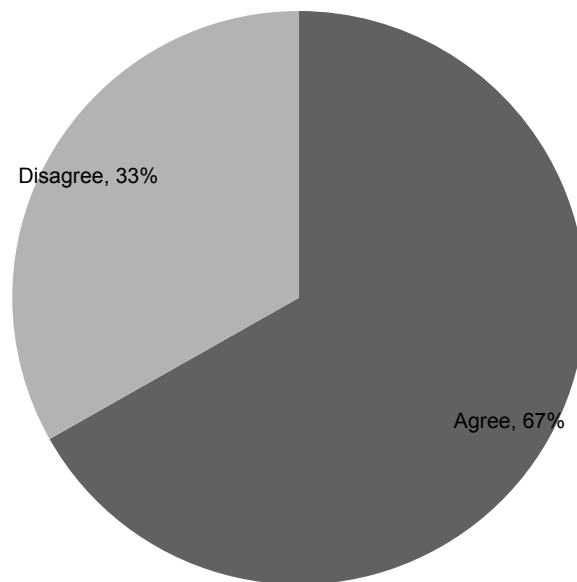
*Figures*

Figure 12: Perceptions of religious attitudes within graduate program

a. Faculty in my program value religion / spirituality as an important multicultural dimension



b. Students in my program value religion / spirituality as an important multicultural dimension

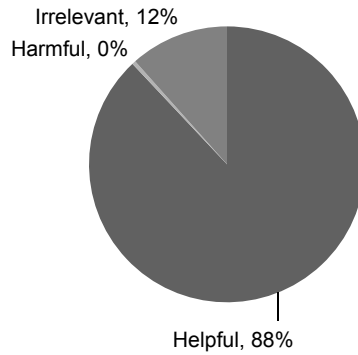


Appendix B

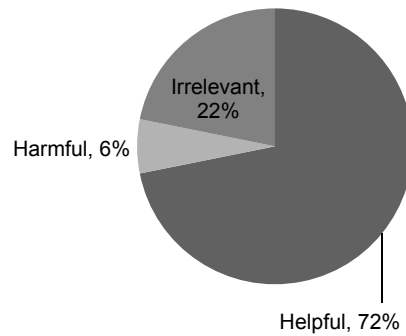
Figures

Figure 13: Perceptions of relationship between religion and mental health

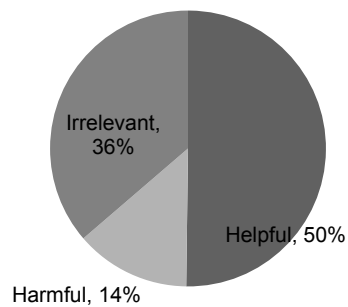
a. Overall, the available literature suggests that religion is most likely \_\_\_ to mental health.



b. I personally believe that religion is most likely \_\_\_ to mental health.



c. Psychologists in general believe that religion is most likely \_\_\_ to mental health.



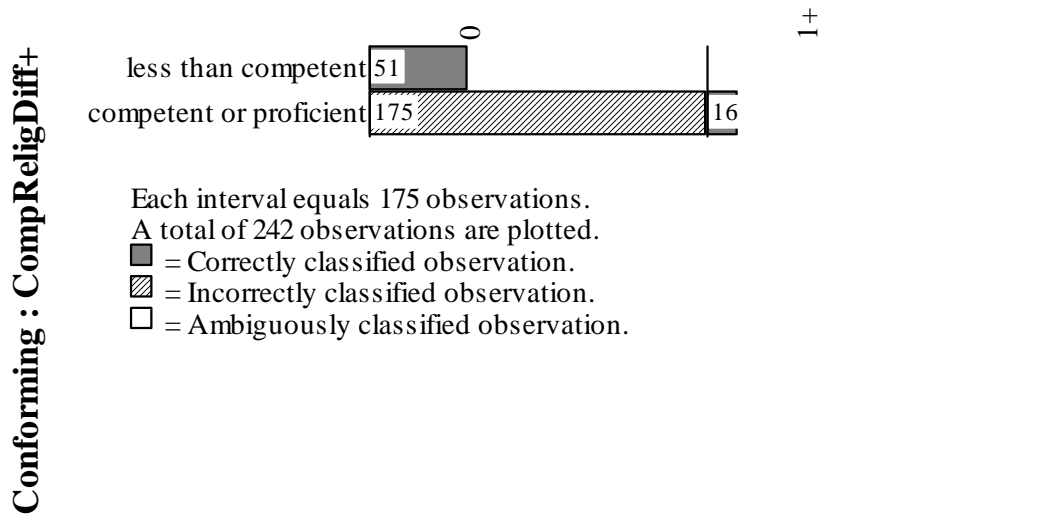
Appendix B

Figures

Figure 14: Multigram – Competence conformed to coursework having a primary focus on religion

**Multi-Unit Frequency Histogram**

**Target : CoursesPrimary+**



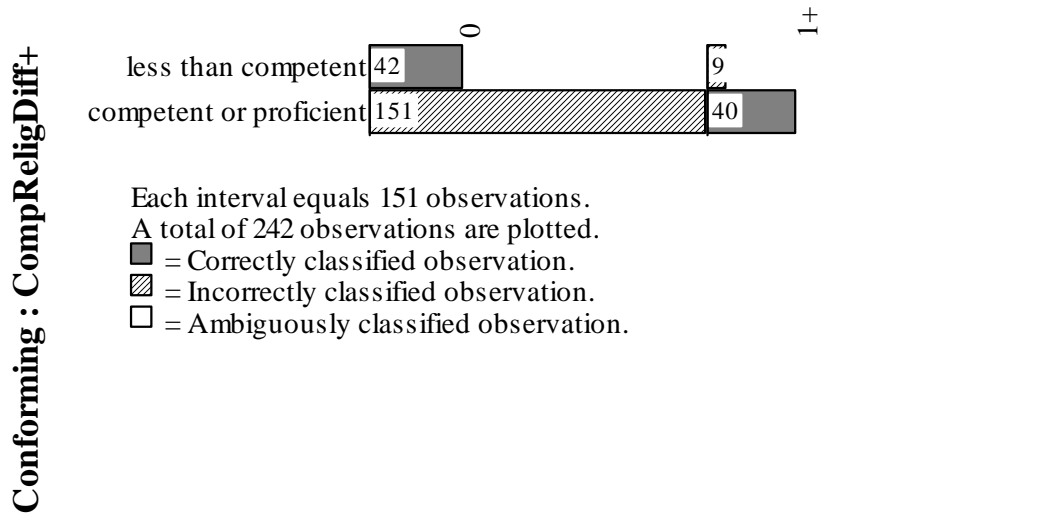
Appendix B

Figures

Figure 15: Multigram – Competence conformed to coursework having a major content area in religion

**Multi-Unit Frequency Histogram**

**Target : CoursesMajor+**





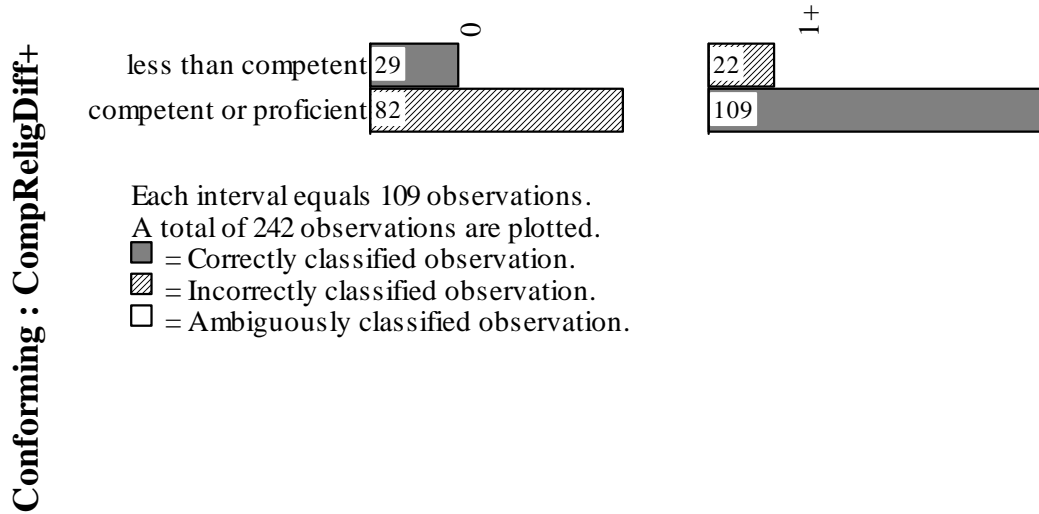
Appendix B

Figures

Figure 16: Multigram – Competence conformed to coursework addressing religion only in the context of other broad topics

*Multi-Unit Frequency Histogram*

**Target : CoursesBroad+**



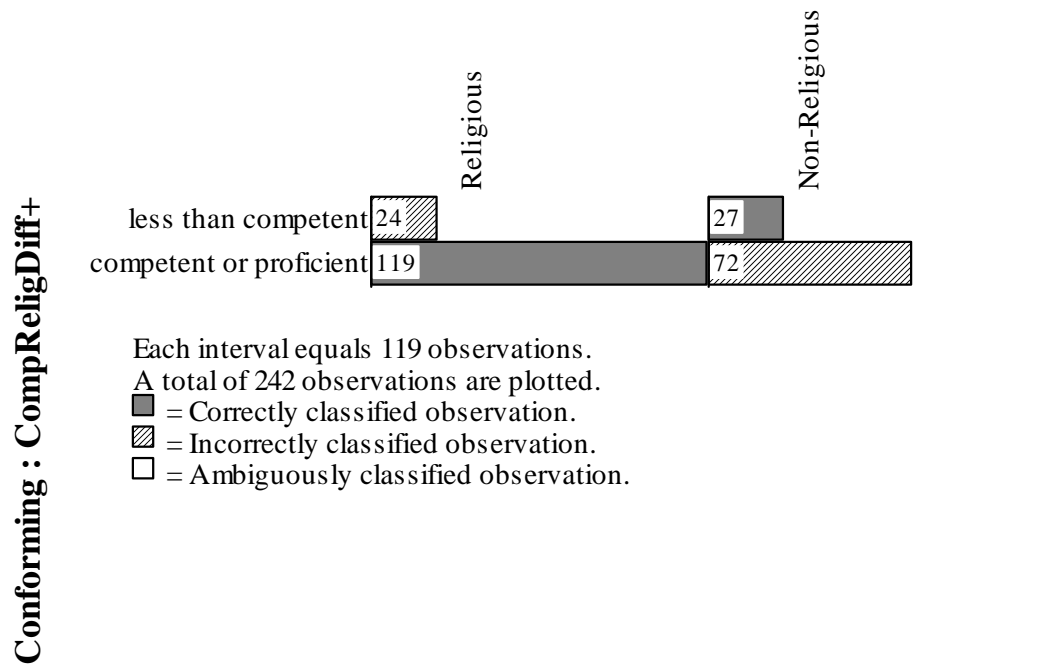
Appendix B

Figures

Figure 17: Multigram – Competence conformed to current personal religiosity

*Multi-Unit Frequency Histogram*

**Target : Relig**



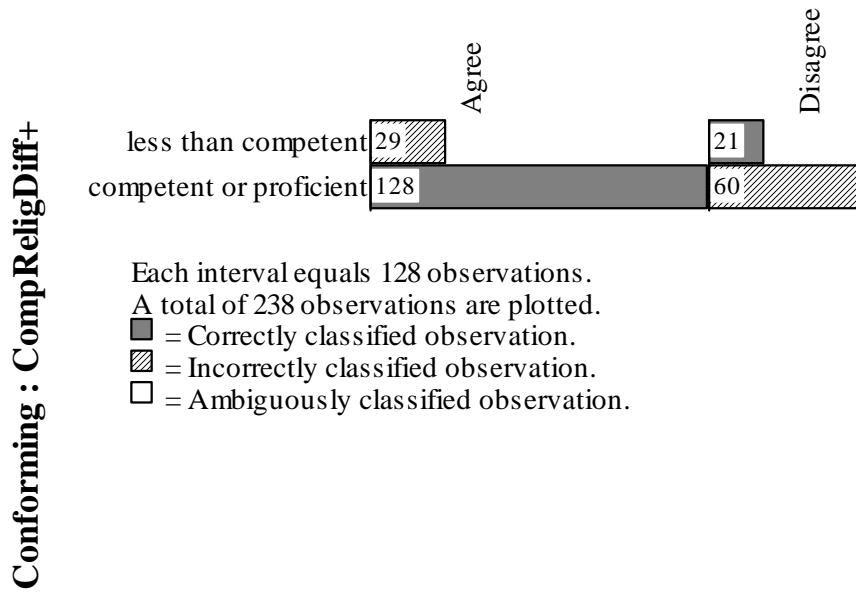
Appendix B

Figures

Figure 18: Multigram – Competence conformed to significant personal identification with current religiosity

*Multi-Unit Frequency Histogram*

Target : ReligSigIdent



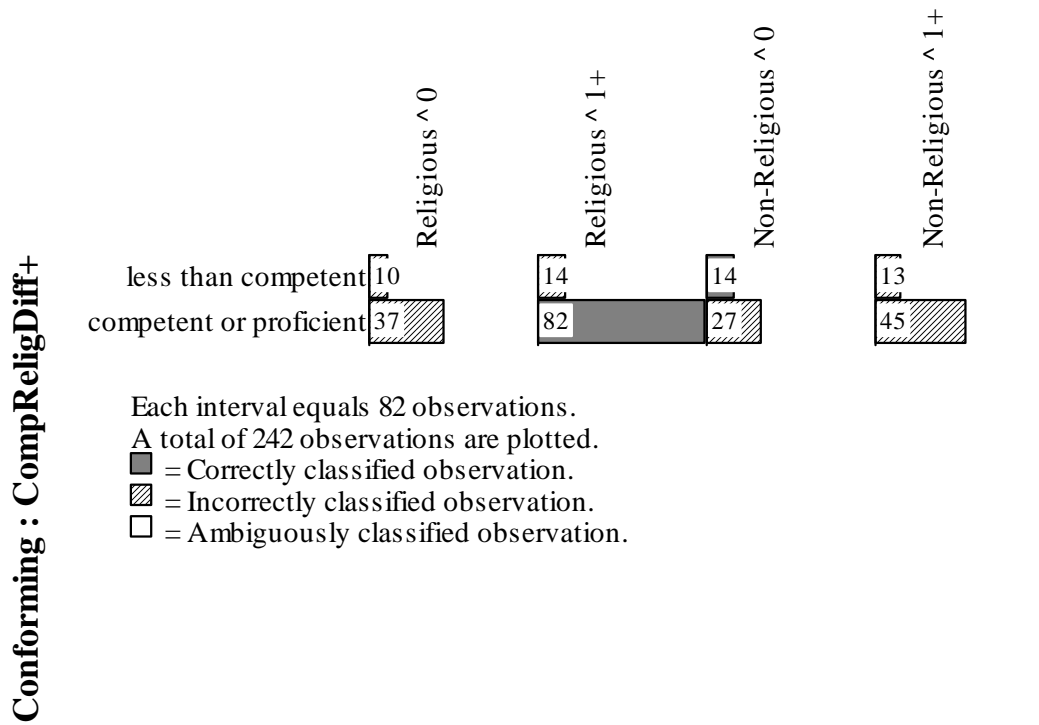
Appendix B

Figures

Figure 19: Multigram – Competence conformed to coursework (primary, major content, or broad topics) crossed with current personal religiosity

*Multi-Unit Frequency Histogram*

Target : Relig { ^ } Courses\_PMB



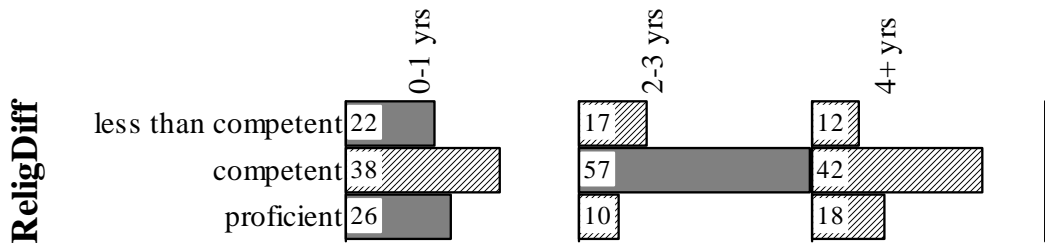
Appendix B

Figures

Figure 20: Multigram – Competence conformed to number of years completed in current graduate program

**Multi-Unit Frequency Histogram**

**Target : YrsGrdProg+**



**Conforming : CompReligDiff**

Each interval equals 57 observations.  
 A total of 242 observations are plotted.  
 ■ = Correctly classified observation.  
 ▨ = Incorrectly classified observation.  
 □ = Ambiguously classified observation.

## Appendix C

### Institutional Review Board Approval Letter

#### Oklahoma State University Institutional Review Board

Date: Monday, March 26, 2012  
IRB Application No: AS1224  
Proposal Title: Training and Attitudes Regarding Religiosity & Spirituality Among Graduate Students in APA-Accredited Clinical Psychology Programs  
Reviewed and Processed as: Exempt

**Status Recommended by Reviewer(s): Approved Protocol Expires: 3/25/2013**

Principal Investigator(s):

Nathaniel J. Cooney	James Grice
011 N. Murray	416 N. Murray
Stillwater, OK 74078	Stillwater, OK 74078

---

The IRB application referenced above has been approved. It is the judgment of the reviewers that the rights and welfare of individuals who may be asked to participate in this study will be respected, and that the research will be conducted in a manner consistent with the IRB requirements as outlined in section 45 CFR 46.

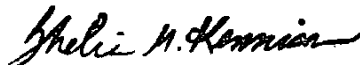
The final versions of any printed recruitment, consent and assent documents bearing the IRB approval stamp are attached to this letter. These are the versions that must be used during the study.

As Principal Investigator, it is your responsibility to do the following:

1. Conduct this study exactly as it has been approved. Any modifications to the research protocol must be submitted with the appropriate signatures for IRB approval.
2. Submit a request for continuation if the study extends beyond the approval period of one calendar year. This continuation must receive IRB review and approval before the research can continue.
3. Report any adverse events to the IRB Chair promptly. Adverse events are those which are unanticipated and impact the subjects during the course of this research; and
4. Notify the IRB office in writing when your research project is complete.

Please note that approved protocols are subject to monitoring by the IRB and that the IRB office has the authority to inspect research records associated with this protocol at any time. If you have questions about the IRB procedures or need any assistance from the Board, please contact Beth McTernan in 219 Cordell North (phone: 405-744-5700, beth.mcternan@okstate.edu).

Sincerely,



Shelia Kennison, Chair  
Institutional Review Board

## Appendix D

### Recruitment Email

#### Recruitment Materials (1 of 1)

Dear [Clinical Training Director]

The Personality Research Laboratory at Oklahoma State University is conducting research on the experiences of Graduate Students related to religion/spirituality in APA-accredited Clinical Psychology Programs. This study has been reviewed and approved by the Institutional Review Board at Oklahoma State University (Approval #). Please consider forwarding this invitation for participation to students in your program.

Thank You,

Nathaniel John Cooney, MS  
James W. Grice, PhD

#### About the Study:

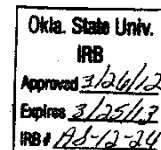
This study is seeking participants of all religious/non-religious backgrounds and affiliations to report on their experiences related to issues of religion/spirituality within their graduate clinical psychology programs. This survey is expected to take approximately 20-30 minutes to complete. Responses are anonymous and there are no known risks to participation. Participants may withdraw at any time without penalty.

Five (5) participants will be randomly selected to receive \$75 Amazon gift credits for participation. Additionally, up to Five (5) additional gift credits will be awarded to randomly selected students who refer other participants (one entry per completed referral).

To participate in the study, select the link below (or copy and paste the url into your web browser). Once you begin the survey, you will also have the option of saving your work and returning to complete it at a later time if necessary.

[survey link here]

Please direct any questions you may have about this study to Nathaniel Cooney  
[ncooney@ostateemail.okstate.edu](mailto:ncooney@ostateemail.okstate.edu).



Appendix E

Study Information and Informed Consent (page 1)

Okla. State Univ.  
IRB  
Approved 3/26/12  
Expires 3/25/13  
IRB # 12-12-24

Study Information & Consent (1 of 2)

**Training and Attitudes Regarding Religiosity & Spirituality  
Among Graduate Students in APA-Accredited Clinical Psychology Programs**

You are invited to participate in a research study on the attitudes and training experiences relating to religion and spirituality among clinical and counseling psychology graduate students. This study is being conducted by Nathaniel J. Cooney, MS, under the direction of James W. Grice, PhD in the Department of Psychology at Oklahoma State University.

**Purpose and Process:** This study involves exploratory research seeking to examine graduate students' training experiences, attitudes, beliefs, and competencies related to religion and spirituality and their integration into the clinical practice of psychology. You have been invited to participate in this study because you have been identified as a currently enrolled student in an APA-accredited doctoral program in clinical or counseling psychology. Completion of the study is expected to take 20-30 minutes of your time, and consists of responding to survey questions about your perceptions and experiences regarding religion and your graduate training. Possible outlets of dissemination may include presentations at professional meetings and/or publication in scientific journals.

**Risks of Participation:** There are no known risks associated with this project which are greater than those ordinarily encountered in daily life.

**Benefits:** Although your participation in this research may not benefit you personally, this study aims to further inform the field of psychology regarding training and competency with respect to religious and spiritual issues in clinical practice. Your experiences as a graduate trainee provide an important aspect to better understanding these issues and future students may benefit from your contributions.

**Confidentiality:** All records of this study will be kept strictly confidential. No names or any other personally identifiable information (including email or IP addresses) will be collected as a part of this study. Any results of this study will discuss group findings and will not include any information that can identify any individual respondent personally. Research records will be stored securely in password protected files on servers that comply with and are certified by SafeHarbor™ privacy protection standards; and only researchers and individuals responsible for research oversight will have access to these records. These servers are maintained by SurveyGizmo.com and their partner Viawest and are located in an off-site high-security data center. The data centers are monitored 24 hours per day and guarded by both on-and-off-site security personnel. Electronic security measures include firewall protection, HackerSafe™ daily security scanning, and 256-bit Advanced Encryption Standard security. Further, Surveygizmo will, at the request of the researchers, completely remove and destroy all data from their servers after a period not to exceed five years following completion of the study. It is possible that the consent process and data collection will be observed by research oversight staff responsible for safeguarding the rights and well-being of people who participate in research.



## Appendix E

### Study Information and Informed Consent (page 2)

#### Study Information & Consent (2 of 2)

**Compensation:** Five (5) participants will be selected at random (via random # generator) to receive a \$75 Amazon gift credit as thanks for participation in the study. Additionally, Five (5) gift credits in the amount of \$25 each will be awarded to randomly selected recipients who were identified by other participants as having referred them to the study. Odds of being selected for either/both awards will depend upon the number of participants who opt-in to the compensation opportunity. In order to be eligible for the compensation, participants must provide a valid email address (in a separate electronic form that is not in any way tied to the participant responses) in order that they may be contacted should they be selected. Completion of the study is not required to be eligible for compensation, though required contact information must be provided following submission of the survey. Gift credits will be sent electronically directly from Amazon.com to the email addresses provided by the randomly selected participants following completion of data collection. No information will be provided to Amazon.com in processing of the awards except for the email address provided by the participant for this purpose and the award amount. Immediately upon completion of award disbursements, all email addresses provided for the purposes of the award drawing will be permanently deleted.

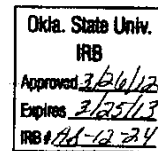
**Participant Rights:** Your decision to participate or decline participation in this study is completely voluntary and you have the right to terminate your participation at any time without penalty. You may skip any questions you do not wish to answer. In a small number of cases, questions are marked as required in order to advance through the survey. In these instances, you are provided with the option "prefer not to respond" as a response choice. If you want do not wish to complete this survey you may close your browser at any time.

**Questions/Comments/Concerns:** If you have questions about this project, you may contact Nathaniel Cooney or Dr. James Grice through the Department of Psychology at Oklahoma State University, 116 N. Murray Hall, Stillwater, OK 74078, 405-744-6027 (or by email [nathaniel.cooney@okstate.edu](mailto:nathaniel.cooney@okstate.edu); [james.grice@okstate.edu](mailto:james.grice@okstate.edu)). If you have questions about your rights as a research volunteer, you may contact Dr. Shelia Kennison, IRB Chair, 219 Cordell North, Stillwater, OK 74078, 405.744.3377 (or by email [irb@okstate.edu](mailto:irb@okstate.edu)).

<<< Please print a copy of this consent form for your records. >>>

#### **Voluntary Consent to Participate\***

- I have read and understand the above information; I certify that I am 18 years old or older and; by selecting the option button to the left, I indicate my willingness to voluntarily take part in the study.



## Appendix F: *Measures*

### F1. Characteristics of Respondent

#### **Characteristics of Respondent (1 of 1)**

---

1) What is your gender?

---

2) What is your ethnicity?

---

3) What is your age?

---

4) Highest degree attained to date (e.g. BA, BS, MS, etc.)

---

5) Number of years completed in CURRENT graduate program

---

## F2. Characteristics of Graduate Program

### Characteristics of Graduate Program (1 of 1)

---

- 6) Which of the following best characterizes the institution in which you are currently enrolled?
- |  |   |
|--|---|
| <input type="radio"/> Public University                    | <input type="radio"/> Seminary            |
| <input type="radio"/> Private University (not faith-based) | <input type="radio"/> Professional School |
| <input type="radio"/> Private University (faith-based)     | <input type="radio"/> Other: _____        |
- 7) State, Province, or Territory in which the institution of your current graduate program is located
- \_\_\_\_\_
- 8) What is the terminal degree (highest degree attainable) of the graduate program in which you are currently enrolled (e.g. PhD, PsyD, EdD, DSc, etc.)?
- \_\_\_\_\_
- 9) Discipline or specialty of degree being sought in current graduate program (e.g. clinical psychology, counseling psychology, etc.)
- \_\_\_\_\_
- 10) Which of the following training models best describes the nature of your current graduate program?
- |  |  |
|--|--|
| <input type="radio"/> Scientist-Practitioner | <input type="radio"/> Clinical Scientist |
| <input type="radio"/> Practitioner-Scholar   | <input type="radio"/> Practitioner       |
| <input type="radio"/> Other: _____           |  |
- 11) Which of the following BEST characterizes the primary theoretical orientation of your GRADUATE PROGRAM?
- |  |                                   |  |
|--|-----------------------------------|--|
| <input type="radio"/> Behavioral           | <input type="radio"/> Existential | <input type="radio"/> Humanistic           |
| <input type="radio"/> Cognitive            | <input type="radio"/> Feminist    | <input type="radio"/> Psychodynamic        |
| <input type="radio"/> Cognitive-Behavioral | <input type="radio"/> Gestalt     | <input type="radio"/> Integrative/Eclectic |
| <input type="radio"/> Other: _____         |                                   |  |
- 12) Which of the following BEST characterizes YOUR PERSONAL primary theoretical orientation?
- |  |                                   |  |
|--|-----------------------------------|--|
| <input type="radio"/> Behavioral           | <input type="radio"/> Existential | <input type="radio"/> Humanistic           |
| <input type="radio"/> Cognitive            | <input type="radio"/> Feminist    | <input type="radio"/> Psychodynamic        |
| <input type="radio"/> Cognitive-Behavioral | <input type="radio"/> Gestalt     | <input type="radio"/> Integrative/Eclectic |
| <input type="radio"/> Other: _____         |                                   |  |
- 13) What do you estimate the average size of a typical cohort in your graduate program to be (for this question, a cohort refers to a group of students who entered the program at the same time; e.g. first-year students, second-year students, etc.)?
- \_\_\_\_\_

### F3. Graduate Coursework Questionnaire (page 1)

#### Graduate Coursework (1 of 4)

---

#### PLEASE READ BEFORE PROCEEDING

The next few items will ask you to consider the various ways in which religion/spirituality may be included in your graduate coursework. These items are described below in the order in which they appear in the survey, and are intended to be non-overlapping categories (use your best estimation in classifying your courses).

1. Primary Focus: Specific Courses dedicated to addressing religion/spirituality
2. Major Content Area: Courses in which religion/spirituality appear on the course syllabus and are given comparable time/attention relative to other course topics
3. Broader Context: Courses in which religion/spirituality are covered in the context of other broader topics

F3. Graduate Coursework Questionnaire (page 2)

**Graduate Coursework (2 of 4)**

14) My program offers one or more courses whose PRIMARY FOCUS is Religion/Spirituality.\*  
 Yes       No       Not sure       Prefer Not to Respond

15) Estimate the TOTAL number of courses offered in your program whose PRIMARY FOCUS is religion/spirituality \_\_\_\_\_

16) How many of these courses have you completed?\*\_ \_\_\_\_\_

17) Please list course offerings whose PRIMARY FOCUS is religion/spirituality (whether you have completed them or not; select up to three that you consider most relevant).

Course 1: \_\_\_\_\_

Course 2: \_\_\_\_\_

Course 3: \_\_\_\_\_

18) For the courses identified, please select the most appropriate response:

	Course is Required	Course is Elective	Unsure
(Piped Response #1)			
(Piped Response #2)			
(Piped Response #3)			

19) For the courses identified, please select the most appropriate response:

	I have Completed this course	I am currently taking this course	I plan to take this course	I do not plan to take this course	Unsure
(Piped Response #1)					
(Piped Response #2)					
(Piped Response #3)					

F3. Graduate Coursework Questionnaire (page 3)

**Graduate Coursework (3 of 4)**

20) *Not including courses identified as having Religion/Spirituality as the primary focus;* Religion/Spirituality is covered as a MAJOR CONTENT AREA in one or more courses in my graduate program (for this question, a major content area is defined as being included in the course syllabus and given comparable time/attention relative to other course topics).\*  
 Yes       No       Not sure       Prefer Not to Respond

21) Estimate the TOTAL number of courses offered in your program that include religion/spirituality as a MAJOR CONTENT AREA \_\_\_\_\_

22) How many of these courses have you completed? \* \_\_\_\_\_

23) Please list course offered in your program that include religion/spirituality as a MAJOR CONTENT AREA, (whether you have completed them or not; select up to three you consider most relevant; exclude courses previously identified as having religion/spirituality as the "primary focus")

Course 1: \_\_\_\_\_  
 Course 2: \_\_\_\_\_  
 Course 3: \_\_\_\_\_

24) For the courses identified, please select the most appropriate response:

	Course is Required	Course is Elective	Unsure
(Piped Response #1)			
(Piped Response #2)			
(Piped Response #3)			

25) For the courses identified, please select the most appropriate response:

	I have Completed this course	I am currently taking this course	I plan to take this course	I do not plan to take this course	Unsure
(Piped Response #1)					
(Piped Response #2)					
(Piped Response #3)					

F3. Graduate Coursework Questionnaire (page 4)

**Graduate Coursework (4 of 4)**

26) Excluding courses previously identified where religion/spirituality were identified as either a primary focus or major content domain; Religion/Spirituality is covered IN THE CONTEXT OF OTHER BROAD TOPICS in one or more courses in my graduate program.\*

- Yes       No       Not sure       Prefer Not to Respond

27) Estimate the TOTAL number of courses offered in your program that cover religion/spirituality in the CONTEXT OF OTHER BROAD TOPICS \_\_\_\_\_

28) How many of these courses have you completed?\* \_\_\_\_\_

29) Please list course offerings that cover religion/spirituality IN THE CONTEXT OF OTHER BROAD TOPICS. (whether you have completed them or not; select up to three that you consider most relevant; exclude courses previously identified as including religion/spirituality as the primary focus or major content domain).

Course 1: \_\_\_\_\_  
 Course 2: \_\_\_\_\_  
 Course 3: \_\_\_\_\_

30) For the courses identified, please select the most appropriate response:

	Course is Required	Course is Elective	Unsure
(Piped Response #1)			
(Piped Response #2)			
(Piped Response #3)			

31) For the courses identified, please select the most appropriate response:

	I have Completed this course	I am currently taking this course	I plan to take this course	I do not plan to take this course	Unsure
(Piped Response #1)					
(Piped Response #2)					
(Piped Response #3)					

F4. Questionnaire of Multicultural Training Experiences (page 1)

**Multicultural Comparisons (1 of 2)**

---

32) Please indicate the extent to which SPECIFIC COURSES are offered for each of the following cultural dimensions (Examples might include: psychology of aging, child studies, women's studies, religious studies, etc.).

	Not Offered	Offered but not required	Required	Unsure
Age				
Disability				
Race / Ethnicity				
Religion / Spirituality				
Gender				
Sexual Orientation				
Socioeconomic Status				
Other				

33) Considering your graduate training OVERALL (including coursework, research, practicum, clinical supervision, etc.), estimate the percentage of attention given to each of the following cultural dimensions relative to one another (total should equal 100%)

- \_\_\_\_\_ Age
- \_\_\_\_\_ Disability
- \_\_\_\_\_ Race / Ethnicity
- \_\_\_\_\_ Religion / Spirituality
- \_\_\_\_\_ Gender
- \_\_\_\_\_ Sexual Orientation
- \_\_\_\_\_ Socioeconomic Status
- \_\_\_\_\_ Other

[ 0% ] *auto-summed in real-time by survey website for participant*



F4. Questionnaire of Multicultural Training Experiences (page 2)

**Multicultural Comparisons (2 of 2)**

34) Listed below are several domains in which religion may have been raised as an aspect of your graduate training. Arrange the items from Highest to Lowest based on level of attention religion has received in each domain. If religious issues have never been covered in a particular domain, exclude it from your rank-ordered list.

- ⇅ Coursework
- ⇅ Research
- ⇅ Special Seminars
- ⇅ Practicum
- ⇅ Clinical Supervision
- ⇅ Other



35) Select the option that best describes your TYPICAL practices in assessing each of the following cultural dimensions with your clients

\*for this question, please answer separately for clients who present primarily for assessment/evaluation (column 1) and those presenting primarily for treatment/intervention (column 2)

	Assessment/Evaluation	Treatment/Intervention
Age		
Disability		
Race / Ethnicity		
Religion / Spirituality		
Sex / Gender		
Sexual Orientation		
Socioeconomic Status		
Other		

Options for each dimension presented in drop-down menus (choices shown below)

Please Select	▾
never (or almost never)	
when initiated by the client	
when suggested by a supervisor	
when external cues suggest relevance	
always (or almost always)	

## F5. Cultural Competency Questionnaire

### Competency (1 of 1)

- 36) Based on your OWN PERCEPTIONS, indicate the rating that best describes your LEVEL OF COMPETENCY to address each of the following cultural dimensions in the therapeutic context WITH CLIENTS SIMILAR TO YOURSELF on each domain (e.g., same sexual orientation or same religion, etc.)

	less than competent	competent	proficient	Unsure
Age				
Disability				
Race / Ethnicity				
Religion / Spirituality				
Sex / Gender				
Sexual Orientation				
Socioeconomic Status				
Other				

- 37) Based on your OWN PERCEPTIONS, indicate the rating that best describes your LEVEL OF COMPETENCY to address each of the following cultural dimensions in the therapeutic context WITH CLIENTS DIFFERENT THAN YOURSELF on each domain (e.g., different sexual orientation or different religion, etc.)

	less than competent	competent	proficient	Unsure
Age				
Disability				
Race / Ethnicity				
Religion / Spirituality				
Sex / Gender				
Sexual Orientation				
Socioeconomic Status				
Other				

- 38) Please describe any exposure you have had outside of your graduate training that contributes to your knowledge of religion/spirituality (e.g. undergraduate courses, self-directed readings, friends from other cultures, etc.)?

## F6. Religious Attitudes Questionnaire

### Perceptions of Attitudes/Environment (1 of 1)

39) From MY point of view, FACULTY in my graduate program...

	Agree	Disagree	No Basis for Judgment
are more likely than not to be religious/spiritual individuals			
contribute to a classroom environment that facilitates the open and respectful exchange of ideas related to religion/spirituality when relevant.			
value religion/spirituality as an important multicultural dimension.			

40) From MY point of view, STUDENTS in my graduate program...

	Agree	Disagree	No Basis for Judgment
are more likely than not to be religious/spiritual individuals			
contribute to a classroom environment that facilitates the open and respectful exchange of ideas related to religion/spirituality when relevant.			
value religion/spirituality as an important multicultural dimension.			

41) Select the best answer choice for each item below:

	Harmful to Mental Health	Irrelevant to Mental Health	Beneficial to Mental Health
I personally think that being religious is most likely			
Psychologists in general, think that being religious is most likely			
The available research suggests that being religious is most likely			

## F7. Religious Background Questionnaire

### **Religious Background & Behaviors (1 of 1)**

---

42) Have you EVER identified/associated with a particular religion?

- Never
- Yes, In the past but I no longer do
- Yes, and I continue to do so

43) Which of the following best describes you at the present time?

- Spiritual
- Religious
- Both
- Neither

44) Describe your CURRENT religious orientation

(e.g. Agnostic, Hindu, Methodist, Native American Peyote, etc.).

---

45) The orientation described in the previous question is a significant aspect of my identity.

- Agree
- Disagree

46) I try to live my life according to my religious beliefs

- Agree
- Disagree

47) My approach to life is based on my religious beliefs

- Agree
- Disagree

48) Are you a member or regular participant of an organized religious congregation

(e.g. church, synagogue, mosque, etc.)?

- Yes
- No

49) During the past year, how often have you engaged in religious/spiritual practices

(e.g. prayer, meditation, attendance at religious services, reading religious texts, etc.)?

- Not At All
- Less Than Once Monthly
- At Least Once Monthly
- At Least Once Weekly
- At Least Once Daily

## REFERENCES

- American Psychological Association. (2009). Guidelines and principles for accreditation of programs in professional psychology. Washington DC: American Psychological Association Commission on Accreditation.
- American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologist*, *58*(5), 377-402. doi: 10.1037/0003-066x.58.5.377
- American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist*, *57*, 1060—1073. doi: 10.1037/0003-066X.57.12.1060
- American Psychological Association. (1992). Ethical principles of psychologists and code of conduct. *American Psychologist*, *47*, 1597—1611. doi: 10.1037/0003-066X.47.12.1597
- Aten, J. A., & Hernandez, B. C. (2004). Addressing religion in clinical supervision: A model. *Psychotherapy: Theory, Research, Practice, Training*, *41*, 152-160.
- Bergin, A. E., & Jensen, J. P. (1990). Religiosity of psychotherapists: A national survey. *Psychotherapy: Theory, Research, Practice, Training*, *27*(1), 3-7. doi: 10.1037/0033-3204.27.1.3

- Bergin, A. E., Masters, K. S., & Richards, P. S. (1987). Religiousness and mental health reconsidered: A study of an intrinsically religious sample. *Journal of Counseling Psychology, 34*(2), 197-204. doi: 10.1037/0022-0167.34.2.197
- Blazer, D. G. (2009). Religion, spirituality, and mental health: What we know and why this is a tough topic to research. *The Canadian Journal of Psychiatry, 54*(5), 281-282.
- Bonelli, R. M., & Koenig, H. G. (2013). Mental disorders, religion and spirituality 1990 to 2010: A systematic evidence-based review. *Journal of Religion and Health, 52*, 657-673. doi: 10.1007/s10943-013-9691-4
- Brawer, P. A., Handal, P. J., Fabricatore, A. N., Roberts, R., & Wajda-Johnston, V. A. (2002). Training and education in religion/spirituality within APA-accredited clinical psychology programs. *Professional Psychology: Research and Practice, 33*(2), 203-206. doi: 10.1037/0735-7028.33.2.203
- Campbell, G. (1776). *The philosophy of rhetoric* (Vols. 1-2). Edinburgh: George Ramsey & Co.
- Campbell, L., Vasquez, M., Behnke, S., & Kinscherff, R. (2010). Competence. In L. Campbell, M. Vasquez, S. Behnke & R. Kinscherff (Eds.), *APA Ethics Code commentary and case illustrations*. (pp. 45-74). Washington, DC: American Psychological Association.
- Cantor, J. (2011, March 20). RE: [DIV12APA] Imagine. Message posted to DIV12APA@LISTS.APA.ORG

- Chamberlin, K., & Zika, S. (1992). Religiosity, meaning in life, and psychological well-being. In J. F. Shumaker (Ed.), *Religion and mental health*, pp. 138-148. New York: Oxford University Press.
- Connors, G. J., Tonigan, J. S., & Miller, W. R. (1996). Measure of religious background and behavior for use in behavior change research. *Psychology of Addictive Behaviors, 10*(2), 90-96. doi: 10.1037/0893-164x.10.2.90
- Crook-Lyon, R. E., O'Grady, K. A., Smith, T. B., Jensen, D. R., Golightly, T., & Potkar, K. A. (2012). Addressing religious and spiritual diversity in graduate training and multicultural education for professional psychologists. *Psychology of Religion and Spirituality, 4*(3), 169-181. doi:10.1037/a0026403
- Delaney, H. D., Miller, W. R., & Bisonó, A. M. (2007). Religiosity and spirituality among psychologists: A survey of clinician members of the American Psychological Association. *Professional Psychology: Research and Practice, 38*(5), 538-546. doi: 10.1037/0735-7028.38.5.538
- Donohue, M. J., & Benson, P. L. (1995). Religion and the well-being of adolescents. *Journal of Social Issues, 51*, 145-160.
- Ellis, A. (1980). Psychotherapy and atheistic values: A response to A. E. Bergin's 'Psychotherapy and religious values.' *Journal of Consulting and Clinical Psychology, 48*(5), 635-639. doi: 10.1037/0022-006x.48.5.635
- Ellison, C. G. (1998). Introduction to symposium: Religion, health, and well-being. *Journal for the Scientific Study of Religion, 37*, 692-694.

- Ferriss, A. L. (2002). Religion and quality of life. *Journal of Happiness Studies*, 3, 199-215.
- Fredrickson, B. L. (2002). How does religion benefit health and well-being? Are positive emotions active ingredients? *Psychological Inquiry*, 13(3), 209-213.
- Freiheit, S. R., Sonstegard, K., Schmitt, A., & Vye, C. (2006). Religiosity and spirituality: A psychometric evaluation of the Santa Clara strength of religious faith questionnaire. *Pastoral Psychology*, 55(1), 27-33. doi: 10.1007/s11089-006-0029-y
- Gallup.com. (2013, June 30). Religion. Retrieved from: <http://www.gallup.com/poll/1690/Religion.aspx#2>
- Gartner, J. (1996). Religious commitment, mental health, and prosocial behavior: A review of the empirical literature. In E. P. Shafranske (Ed.), *Religion and the clinical practice of psychology* (pp. 187-214). Washington DC: American Psychological Association.
- Grice, J. W. (2011). *Observation oriented modeling: Analysis of cause in the behavioral sciences*. Burlington, MA: Academic Press.
- Griffith, J. L. (2010). *Religion that heals, religion that harms: A guide for clinical practice*. New York: Guilford Press.
- Hage, S. M. (2006). A closer look at the role of spirituality in psychology training programs. *Professional Psychology: Research and Practice*, 37(3), 303-310. doi: 10.1037/0735-0728.37.3.303



- Hage, S. M., Hopson, A., Siegel, M., Payton, G., & DeFanti, E. (2008). Multicultural training in spirituality: An interdisciplinary review. *Counseling and Values, 50*, 217-234.
- Hoge, D. R. (1996). Religion in America: The demographics of belief and affiliation. In E. P. Shafranske (Ed.), *Religion and the clinical practice of psychology*. Washington DC: American Psychological Association.
- James, W. (1902). *The varieties of religious experience: A study in human nature*. Cambridge, MA: Harvard University Press.
- Kitchener, K. S. (2000). Foundations of ethical practice, research, and teaching in psychology. Mahwah, NJ: Erlbaum.
- Lapointe, F. H. (1970). Origin and evolution of the term 'psychology.' *American Psychologist, 25*(7), 640-646. doi: 10.1037/h0029766
- Levin, J. S., & Chatters, L. M. (1998). Research on religion and mental health: An overview of empirical findings and theoretical issues. In H. G. Koenig (Ed.), *Handbook of religion and mental health*. (pp. 33-50). San Diego, CA: Academic Press.
- Loewenthal, K. M., Cinnirella, M., Evdoka, G., & Murphy, P. (2001). Faith conquers all?: Beliefs about the role of religious factors in coping with depression among different cultural-religious groups in the UK. *British Journal of Medical Psychology, 158*, 840-842.
- Melton, J. G. (1996). *Encyclopedia of American religions*. Detroit, MI: Gale Research.

- Miller, W. R. (2005). What is human nature? Reflections from Judeo-Christian Perspectives. In W. R. Miller & H. D. Delaney (Eds.), *Judeo-Christian perspectives on psychology*. (pp. 11-29). Washington DC: American Psychological Association.
- Miller, L., & Kelley, B. (2006). Spiritually Oriented Psychotherapy With Youth: A Child-Centered Approach. In E. C. Roehlkepartain, P. E. King, L. Wagener & P. L. Benson (Eds.), *The handbook of spiritual development in childhood and adolescence*. (pp. 421-434). Thousand Oaks, CA: Sage Publications, Inc.
- Miller, W. R., & Thoresen, C. E. (2003). Spirituality, religion, and health: An emerging research field. *American Psychologist*, *58*(1), 24-35. doi: 10.1037/0003-066X.58.1.24
- Mitchell, L., & Romans, S. (2003). Spiritual beliefs in bipolar affective disorder: the relevance for illness management. *Journal of Affective Disorders*, *75*(3), 247-257.
- Pargament, K. I. (2007). *Spiritually integrated psychotherapy: Understanding and addressing the sacred*. New York: Guilford Press.
- Plante, T. G., & Sherman, A. C. (2001). *Faith and health: Psychological perspectives*. New York: Guilford Press.
- Powell, L. H., Shahabi, L., & Thoresen, C. E. (2003). Religion and spirituality: Linkages to physical health. *American Psychologist*, *58*(1), 36-52. doi: 10.1037/0003-066X.58.1.36

- Richards, P. S., & Bergin, A. E. (2000). Toward religious and spiritual competency for mental health professionals. In P. S. Richards & A. E. Bergin (Eds.), *Handbook of psychotherapy and religious diversity*. (pp. 3-26). Washington, DC: American Psychological Association.
- Richardson, V., Berman, S., & Piwowski, M. (1983). Projective assessment of the relationships between the salience of death, religion, and age among adults in America. *Journal of General Psychology*, *109*(2), 149-156.
- Rosenthal, R. (1979). The "file drawer problem" and tolerance for null results. *Psychological Bulletin*, *86*, 638-641.
- Russell, S. R., & Yarhouse, M. A. (2006). Training in religion/spirituality within APA-accredited psychology predoctoral internships. *Professional Psychology: Research and Practice*, *37*(4), 430-436. doi: 10.1037/0735-7028.37.4.430
- Sarason, S. B. (1993). American psychology, and the needs for transcendence and community. *American Journal of Community Psychology*, *21*(2), 185-202. doi: 10.1007/bf00941621
- Shafranske, E. P., & Malony, H. N. (1996). Religion and the clinical practice of psychology: A case for inclusion. In E. P. Shafranske (Ed.), *Religion and the clinical practice of psychology* (pp. 561-586). Washington DC: American Psychological Association.

- Shafranske, E. P., & Malony, H. N. (1990). Clinical psychologists' religious and spiritual orientations and their practice of psychotherapy. *Psychotherapy: Theory, Research, Practice, Training*, 27(1), 72-78. doi: 10.1037/0033-3204.27.1.72
- Schulte, D. L., Skinner, T. A., & Claiborn, C. D. (2002). Religious and spiritual issues in counseling psychology training. *The Counseling Psychologist*, 30(1), 118-134. doi: 10.1177/0011000002301009
- Shumaker, J. F. (1992). *Religion and Mental Health*. New York: Oxford University Press.
- Skinner, B. F. (1971). *Beyond freedom and dignity*. New York: Knopf/Random House.
- Smith, T. B., McCullough, M. E., & Poll, J. (2003). Religiousness and depression: Evidence for a main effect and the moderating influence of stressful life events. *Psychological Bulletin*, 129(4), 614-636. doi: 10.1037/0033-2909.129.4.614
- Vande Kemp, H. (1996). Historical perspective: Religion and clinical psychology in America. In E. P. Shafranske (Ed.), *Religion and the clinical practice of psychology* (pp. 71-112). Washington DC: American Psychological Association.
- Walker, D. F., Gorsuch, R. L., & Tan, S.-Y. (2004). Therapists' integration of religion and spirituality in counseling: A meta-analysis. *Counseling and Values*, 49, 69-80.

Wulff, D. M. (1996). The psychology of religion: An overview. In E. P. Shafranske (Ed.), *Religion and the clinical practice of psychology* (pp. 43-70). Washington DC: American Psychological Association.

## NAME INDEX

### **A**

Allport, G..... 8  
 Anderson, J..... v  
 Aquinas, St. Thomas ..... 41  
 Aristotle ..... 41  
 Aten, J. A.....25, 106

### **B**

Badzinski, S.....v  
 Behnke, S..... 26, 55, 107  
 Benson, P. L..... 13, 108  
 Bergin, A. E ..... 17, 21, 22, 30,  
 106, 107  
 Berman, S ..... 17, 112  
 Bisonó, A. M ..... 21, 108  
 Blazer, D. G.....40, 107  
 Bonelli, R. M ..... 16, 107  
 Boyd, M .....v  
 Brawer, P. A ..... 1, 3, 24, 25, 26, 30,  
 36, 107  
 Brown, E.....v  
 Burks, S.....v

### **C**

Campbell, G..... 7, 9, 107  
 Campbell, L ..... 26, 55, 107  
 Cantor, J..... 107  
 Casmann, O ..... 6, 8  
 Chamberlin, K..... 13, 108  
 Chaney, J. M ..... ii, vi  
 Chatters, L. M ..... 13, 110  
 Cinnirella, M.....13, 14  
 Claiborn, C. D .....27, 113

Connors, G. J..... 37, 108  
 Cooney, D. A ..... iv  
 Cooney, E. S..... iv  
 Cooney, N. J .....i, vii  
 Cooney, T. J ..... iv  
 Crook-Lyon, R. E ..... 26, 30, 108

### **D**

DeFanti, E..... 26, 110  
 Delaney, H. D ..... 21, 108, 111  
 Donohue, M. J ..... 13, 108

### **E**

Ellis, A..... 8, 10, 21, 108  
 Ellison, C. G ..... 13, 108  
 Erikson, E ..... 8  
 Evdoka, G ..... 13, 14

### **F**

Fabricatore, A. N.....1, 3, 24, 25, 26,  
 30, 107  
 Ferriss, A. L ..... 13, 109  
 Fisher ..... iii  
 Fredrickson, B. L..... 13, 109  
 Freiheit, S. R..... 38, 109  
 Freud, S. S.....8, 10, 11  
 Fuqua, D. R .....ii, vi

### **G**

Gallup Organization ..... 20, 22, 109  
 Gartner, J.....16, 19, 20, 109  
 God ..... iv, vii, 6, 11, 20, 21, 37  
 Golightly, T..... 26, 30, 108

Gorsuch, R. L .....27, 113  
Grice, J. W..... ii, vi, 4, 41, 46, 109  
Griffith, J. L .....12, 109

## **H**

Hage, S. M.....26, 27, 39, 109, 110  
Handal, P. J.....1, 3, 24, 25, 26, 30,  
36, 107  
Hernandez, B. C.....25, 106  
Hoge, D. R.....21, 110  
Hopson, A.....26, 110

## **J**

James, W .....8, 9, 110  
Jensen, D. R..... 26, 30, 108  
Jensen, J. P..... 22, 30, 106  
Jung, C .....8

## **K**

Kavalier, K .....v  
Kelley, B .....20, 111  
Kinscherff, R .....26, 55  
Kitchener, K. S.....58, 110  
Knight, A. J .....iv  
Koenig, H. G .....16, 107

## **L**

Lapointe, F. H ..... 6, 7, 8, 110  
Levin, J. S.....13, 110  
Loewenthal, K. M..... 13, 14, 110  
LORD. See God

## **M**

Malony, H. N.....2, 4, 8, 23, 30, 37,  
48, 56, 112, 113  
Masters, K. S .....17, 107  
McCullough, M. E ..... 14, 15, 20, 113  
Melanchton, P.....6  
Melton, J. G .....21, 110  
Miller, L .....20, 111

Miller, W. R ..... 17, 21, 37, 54, 64,  
108, 111  
Mitchell, L..... 16, 111  
Murphy, P ..... 13, 14

## **O**

O'Grady, K. A..... 26, 30, 108

## **P**

Pargament, K. I..... 28, 111  
Payton, G..... 26, 110  
Piwowarski, M..... 17, 112  
Plante, T. G..... 12, 111  
Poll, J .....14, 15, 20, 113  
Potkar, K. A..... 26, 30, 108  
Powell, L. H..... 17, 19, 111

## **R**

Rauch, R..... 7  
Richards, P. S ..... 17, 107  
Richardson, V ..... 17, 112  
Roberts, R..... 2, 3, 24, 25, 26, 30,  
36, 107  
Romans, S ..... 16, 111  
Rosenthal, R ..... 20, 112  
Russell, S. R .....2, 3, 25, 30, 36, 112

## **S**

Sarason, S. B.....11, 12, 21, 112  
Schlimgen, L ..... v  
Schmitt, A ..... 38, 109  
Schulte, D. L ..... 27, 113  
Shafranske, E. P .....2, 4, 8, 23, 30,  
37, 48, 56, 109, 110, 112, 113, 114  
Shahabi, L..... 17, 19, 111  
Sheffield, A ..... v  
Sherman, A. C ..... 12, 111  
Shumaker, J. F..... 12, 108, 113  
Siegel, M..... 26, 110  
Skinner, B. F ..... 8, 10, 11, 113

Skinner, T. A.....27, 113  
Smith, T. B.....14, 15, 20, 26, 30,  
108, 113  
Sonstegard, K.....38, 109  
Sullivan, M. A.....ii, vi

### **T**

Tan, S.-Y .....27, 113  
Thoresen, C. E ..... 17, 19, 111  
Tonigan, J. S .....37, 108

### **V**

Valdez. See Fisher  
Vande Kemp, H .....6, 113  
Vasquez, M..... 26, 55, 107

Vye, C ..... 38, 109

### **W**

Wajda-Johnston, V. A ..... 2, 3, 24, 25,  
26, 30, 36, 107  
Walker, D. F ..... 27, 113  
Weinberg, S ..... 3  
Wulff, D. M ..... 1, 2, 8, 10, 11, 64, 114

### **Y**

Yarhouse, M. A..... 2, 3, 25, 30, 36, 112

### **Z**

Zika, S..... 13, 108



## VITA

Nathaniel John Cooney

Candidate for the Degree of

Doctor of Philosophy

Thesis: RELIGIOUS TRAINING AND COMPETENCE IN APA-ACCREDITED GRADUATE CLINICAL PSYCHOLOGY PROGRAMS

Major Field: Clinical Psychology

Biographical:

Education:

Completed the requirements for the Doctor of Philosophy in Clinical Psychology at Oklahoma State University, Stillwater, Oklahoma in December, 2013.

Completed the requirements for the Master of Science in Clinical Psychology at Oklahoma State University, Stillwater, Oklahoma in 2009.

Completed the requirements for the Bachelor of Science in Psychology at Wright State University, Dayton, Ohio in 2006.

Experience:

Clinical experience includes the Psychological Services Center, Marriage and Family Clinic, and the Alcohol and Substance Abuse Center at Oklahoma State University; the Behavioral Health Services Headquarters of the Cherokee Nation; and the VA Medical Center, Dayton, Ohio. Teaching Experience includes Introduction to Speech Communication, Introduction to Psychology, Abnormal Psychology, and Psychology and Human Problems at Oklahoma State University. Research Experience includes the Personality Research Laboratory, SCRAM Projects Coordinator for the Behavior Change Laboratory, and Back on TRAC Program Evaluator for Oklahoma State University.

Professional Memberships:

American Psychological Association (Div 12, & 40), Student Society of the Oklahoma Psychological Association (former member and past president) the OSU Psychology Graduate Students Association (member and past president), the OSU Graduate and Professional Students Government Association, Omicron Delta Kappa, Psi-Chi, Phi Kappa Phi, and Golden Key Honor Societies.