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Operationally Defining A Spiritually Competent Orientation: A Modified E-Delphi Study

Kenson Hiatt
William & Mary - School of Education, kensonhiatt@gmail.com

OPERATIONALLY DEFINING A SPIRITUALLY COMPETENT ORIENTATION: A MODIFIED E-DELPHI STUDY

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Kenson G Hiatt

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OPERATIONALLY DEFINING A SPIRITUALLY COMPETENT ORIENTATION: A MODIFIED E-DELPHI STUDY

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Kenson G Hiatt

Approved June 2022 by

Daniel Gutierrez, Ph.D.
Chairperson of Dissertation Committee

Craig Cashwell, Ph.D.

Jesse Fox, Ph.D.

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ABSTRACT

The purpose of this mixed methods dissertation study is to determine an operational definition for a new construct: a spiritually competent orientation (SCO). The SCO construct has emerged in recent literature but has only been defined theoretically. An exploration of the literature from which it emerged implies the possibility of improving the way clinicians approach religion and spirituality (R/S) in mental health services. A broader review of relevant R/S literature revealed possibilities for understanding and beginning to define SCO, but there was not a consensus among scholars about the components of SCO. A mixed methods modified e-Delphi (or online Delphi) panel of 13 experts in R/S integration responded to questions designed to gather input and seek consensus about the possible components of SCO. Six domains, 16 themes, and 101 items of SCO stemmed from the first round of questions to the panel. The panelists reached consensus for 77 items in the second-round survey by rating their level of agreement that each item was part of SCO. The six domains include the following: (1) Ethical; (2) Humility; (3) Comfort; (4) Opportunities; (5) Growth; and (6) Constructivism. Discussion of findings includes implications, strengths, and limitations of the study, as well as possible future directions for studying SCO.

KENSON G HIATT

DEPARTMENT OF SCHOOL PSYCHOLOGY AND COUNSELOR EDUCATION

THE COLLEGE OF WILLIAM & MARY IN VIRGINIA

OPERATIONALLY DEFINING A SPIRITUALLY COMPETENT ORIENTATION: A MODIFIED E-DELPHI STUDY

CHAPTER 1: INTRODUCTION

The Preamble to the *Code of Ethics* for the American Counseling Association (ACA) includes an important definition: "Counseling is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals" (ACA, 2014, p. 3). Clinicians have a responsibility to help empower their clients to accomplish wellness and healthy living (Barden et al., 2015). Implied in that responsibility is the potential for failing to empower toward healthy living, which also implies the potential for harming clients. Professional organizations that govern the counseling profession provide ethical guidance as well as educational and training standards for practicing in the profession, which can help counselors reduce the potential for harming clients. The ACA (2014) and the National Board for Certified Counselors (NBCC, 2016) provide ethical guidance for counseling professionals through distinct ethical codes provided by each organization. The Council for Accreditation of Counseling and Related Educational Programs (CACREP) provides and enforces educational and training standards for the profession through accreditation for counseling programs. Accreditation training standards are meant to support the profession's goal of competent practice, which can prevent harm to clients and improve the likelihood of helping them.

Broadly, competence is defined as the capability and demonstrated ability to perform job or role functions as determined by the education and training requirements established by the profession (Kaslow, 2004). More specifically to the health professions, Epstein and Hundert (2002) proposed the following definition: "The habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice

for the benefit of the individual and community being served; [it relies on] habits of mind, including attentiveness, critical curiosity, awareness, and presence" (p. 227). The Epstein and Hundert (2002) definition has also been adopted by the mental health professions (see, e.g., Rubin et al., 2007). Bernard and Goodyear (2019) have noted that the improvement of definitions of competence suggests that in addition to knowledge and skills, competence includes the exercise of judgment. As suggested in the Epstein and Hundert definition of competence, exercising judgment requires clinicians to have attuned habits that work for the benefit of those being served. Judgment that is attuned to the benefit and welfare of those being served is consistent with the goal of competent professional practice. However, forming the habits that comprise competence requires clinicians to be properly trained in several areas of competence. One of the areas of clinical competence is multicultural competence, which is essentially the ability to serve clients with a variety of cultures, backgrounds, and identities in a way that avoids harm.

Multicultural Competence

The ACA (2014) *Code of Ethics* Preamble contains five core values of the counseling profession, one of which is "honoring diversity and embracing a multicultural approach in support of the worth, dignity, potential, and uniqueness of people within their social and cultural contexts;" (p. 3). The ACA defines culture as "membership in a socially constructed way of living, which incorporates collective values, beliefs, norms, boundaries, and lifestyles that are cocreated with others who share similar worldviews comprising biological, psychosocial, historical, psychological, and other factors" (p. 20). According to the professional training standards of CACREP, counselors are to be taught and trained to value the uniqueness of their clients, including diverse lived experiences and cultural identities. In the *2016 CACREP*

Standards, "Social and Cultural Diversity" is one of the eight common core areas of "foundational knowledge required of *all* entry-level counselor education graduates" (CACREP, 2016, section 2.F). Multicultural competence has become a fundamental part of counselor training and the mental health professions in general.

Multicultural Competencies (MCCs)

Clinicians have the duty to attend to cultural diversity thoughtfully and sensitively to practice competently. To help clinicians learn to provide competent service to a variety of cultures, Sue and colleagues (1982) developed a model of Multicultural Counseling Competencies (MCC), which later evolved into the standard of practice for multicultural competence in the counseling profession after being adopted by the Association for Multicultural Counseling and Development (AMCD) in 1991 and the American Association for Counseling and Development in 1992 (Sue et al., 1992a; Sue et al., 1992b). The MCC model consists of three components: (a) attitudes/beliefs, (b) knowledge, and (c) skills. Sue and colleagues assert the process of acquiring MCC to be a continuous one in which we deepen our understanding of cultural diversity, recognize our own cultural limitations, and seek improvement over time.

Multicultural and Social Justice Counseling Competencies (MSJCC)

After the MCCs served as a standard of practice in the field for more than two decades, Ratts and colleagues (2016) revised the MCCs to form the Multicultural and Social Justice Counseling Competencies (MSJCC), adding a fourth component—action—to the original three of the MCC and adding a quadrant. The MSJCC quadrant encourages clinicians to examine the intersection of cultural identities and experiences of oppression and privilege between themselves and their clients. Furthermore, the MSJCCs added four developmental domains to "reflect the different layers that lead to multicultural and social justice competence: (1) counselor

self-awareness, (2) client worldview, (3) counseling relationship, and (4) counseling and advocacy interventions" (Ratts et al., 2016, p. 3).

Religion and Spirituality as Components of Culture

One of the core values of the counseling profession in the *ACA Code of Ethics* (American Counseling Association [ACA], 2014) includes "honoring diversity and embracing a multicultural approach in support of the worth, dignity, potential, and uniqueness of people within their social and cultural contexts; [and] promoting social justice" (p. 3). In addition to promoting multicultural competence, the ACA also proclaims the ethical responsibility of counselors not to "condone or engage in discrimination" based on "age, culture, disability, ethnicity, race, religion/spirituality," or other characteristics of identity (p. 9). According to the ACA (2014), culture refers to "membership in a socially constructed way of living, which incorporates collective values, beliefs, norms, boundaries, and lifestyles that are cocreated with others who share similar worldviews comprising biological, psychosocial, historical, psychological, and other factors" (p. 20). Broadly, multiculturalism includes religion and spirituality, so they are expected to be an inherent part of multicultural counseling training (Sue & Sue, 2013).

Religion or Spirituality?

Religion and spirituality are defined in several ways across various professions and fields of study. Typically, professional disciplines define religion and spirituality differently than they are defined in theology and religious studies (e.g., Paloutzian & Park, 2005). In mental health professions, religion is usually viewed as a subset of the larger concept of spirituality (e.g., Koenig, 2005). Some view spirituality as private and individualized as opposed to the public and often socialized experience of religion (Russinova et al., 2002). Pargament (2013) argued that

"spirituality is the core function of religion" (p. 271). Young and Cashwell (2020) define spirituality as "the universal human capacity to experience self-transcendence and awareness of sacred immanence, with resulting increases in self-other compassion and love" (p. 12). Further, they define religion as an "institutional and creedal" structure for spirituality that is "socially defined" and typically includes "narratives, symbols, beliefs, and practices that are embedded in ancestral traditions, cultural traditions, or both" (p. 13).

The distinctions between religion and spirituality are important and will impact the process and likely the outcomes of therapy, so it is important that clinicians match the language and concepts within their client's frame of reference (Young & Cashwell, 2020). As noted by Young and Cashwell, most clients will fall somewhere on a continuum of perspectives regarding religion and spirituality. Some will see them as inseparable concepts which are a strong part of their identity and might even see them as one and the same concept; some will see them as necessarily distinct because they identify with one and not the other concept or they are even antagonistic about one or both concepts; and some might see them as either inseparable or separate but have neutral feelings about one or both concepts. Of course, it is important for mental health professionals to understand and work from the client's frame of reference for religion and spirituality, including the ways in which clients distinguish between the two concepts. However, for the sake of simplicity in addressing this topic, the researcher will address them as one concept herein: religion/spirituality (R/S). In some cases, depending on who or what is being referenced, the researcher may separate the concepts again.

Prevalence of R/S

In society. Religion and spirituality (R/S) continue to be a prominent part of the lives of most American adults. About three-quarters claim religion to be at least somewhat important to

them, 89% claim a belief in God or a universal spirit, 72% claim belief in heaven, and 60% viewing sacred texts to be the word of God (Pew Research Center, 2015). Generally, spirituality is important to many people (de Jager Meezenbroek et al., 2012) and most young people view spiritual development as important (Benson & Roehlkepartain, 2008). In many cultures, spirituality is a major part of life, implanted into customs, norms, language, and symbols (Benson & Roehlkepartain, 2008; Chickering et al., 2006). Expectedly, most clients express desires to include their R/S in clinical settings (Diallo, 2013; Gockel, 2011, Harris et al., 2015; Knox et al., 2005; Morrison et al., 2009; Plumb, 2011; Post & Wade, 2014; Rose et al., 2008). As noted by Oxhandler and colleagues (2021), many clients also consider R/S an important discussion topic in counseling and often prefer their clinicians introduce the topic (Cragun & Friedlander, 2012; Harris et al., 2016; Leitz & Hodge, 2013; Lyon & Wimmer, 2005; Morrison et al., 2009; Oxhandler et al., 2018; Rose et al., 2001; Stanley et al., 2011; Tepper et al., 2001; Weld & Eriksen, 2007). These findings about client R/S preferences have been discovered in individual counseling (Erickson et al., 2002; Lindgren & Coursey, 1995; Lyon & Wimmer, 2005), marital counseling (Bannister et al., 2015), and group counseling (Post et al., 2014).

In the profession. Unfortunately, a trend in the clinical literature highlights a lack of training for addressing R/S in clinical settings (e.g., Adams, 2012; Magaldi-Dopman, 2014; Saunders et al., 2014; Young et al., 2007). Vieten and colleagues (2013) noted barriers to R/S competence in psychology, including (a) R/S being generally less important to clinicians than the public, (b) emphasis on psychology being a scientific disciple leading to insecurity about acknowledging R/S, and (c) uncertainty about the role of R/S in clinical practice. Many clinicians have indicated reluctance to address R/S due to a lack of adequate R/S training (Pargament, 2007; Sperry, 2012; van Asselt & Senstock, 2009; Vieten et al., 2013). Several

clinical trainers in the field expressed uncertainty about integrating R/S into training or coursework and perceived knowledge of R/S traditions to be outside the realm of clinical competence (Schulte et al., 2002). Another study revealed that several clinical directors did not expect to include R/S in future clinical training (Russell & Yarhouse, 2006). In an interesting contrast, research has revealed a significant interest among mental health profession students for adding a course to their training that addresses R/S (Schafer et al., 2011). Another study revealed that a majority of sampled counseling students believed clients need to have religious issues addressed at least some of the time (Saunders et al., 2014). Still, it remains that although R/S is a component of culture and, by extension, multicultural competence, it is under-represented in professional training (Adams et al., 2015; Canda & Furman, 2010; Hage et al., 2006; Oxhandler et al., 2015; Schafer et al., 2011; Vogel et al., 2013) and in research (e.g., Amer & Bagarsa, 2013) while also being less affirmed than other components of culture and multicultural competence such as gender, sexual orientation, race, and ethnicity (Magaldi-Dopman, 2014; Pieterse et al., 2009; Robertson, 2010; Sue & Sue, 2013).

Russell and Yarhouse (2006) suggested that faculty members' low interest in R/S is likely contributing to the minimal R/S training they provide, which is a fair conclusion given that personal interest was related to training levels in a study by Saunders and colleagues (2014). Perhaps providing further support to that conclusion, a study revealed that mental health professionals generally have lower rates of religious affiliation and belief than the public (Gross & Simmons, 2009). Another reason for the lack of R/S training could be the finding that many mental health professionals view R/S as pathological, neurotic, or unscientific, and therefore they avoid identifying with R/S (Cornish et al., 2012; Garner et al., 2017; Lucchetti & Lucchetti, 2014; Parker, 2009). It is also possible that some mental health professionals might consider R/S

discussions with clients to be an unethical imposing of the clinician's personal agenda or values upon their clients (Gutierrez et al., 2020). Whatever the reasons, there are clearly gaps between clients, clinical students or trainees, and clinical educators when it comes to client R/S needs and clinical R/S training.

Benefits of Addressing R/S

There is evidence that addressing clients' R/S benefits their wellbeing (Bormann et al., 2012; Fukui et al., 2012; Harris et al., 2015; Rowold, 2011; Snider & McPhedran, 2014). Implementing R/S into treatment has demonstrated improvement in physical and mental health, improved coping, and decreases in depression, anxiety, and suicide (Mueller et al., 2001; Sharma et al., 2017; Sherman et al., 2015; Sherman et al., 2018). Additionally, implementing R/S has made a positive impact on quality of life (Flannelly et al., 2006; Sharma et al., 2017; Sherman et al., 2015; Sherman et al., 2018), improved states of happiness (Sharma et al., 2017; Sherman et al., 2015; Sherman et al., 2018), and better psychological adjustment (Ano & Vasconcelles, 2005; Evans et al., 2018). Vieten and colleagues (2016) noted that many R/S beliefs and practices are positively related to psychological health (George et al., 2002; Green & Elliott, 2010; Koenig et al., 2012; Miller & Kelley, 2005; Miller & Thoresen, 2003; Oman & Thoresen, 2005; Pargament et al., 2013; Park & Paloutzian, 2013; Plante & Sherman, 2001; Seybold & Hill, 2001; Wong et al., 2006). R/S is also an important resource for clients to draw upon as they seek to promote and maintain wellness (Myers & Williard, 2003). Of course, R/S can also provide challenges in therapy, such as when it becomes spiritual bypass (e.g., Cashwell et al., 2007; Fox et al., 2020) or when a client has experienced the trauma of religious abuse (Cashwell & Swindle, 2018). Nevertheless, R/S is still largely prevalent, is preferred in therapy by many

clients (Butts & Gutierrez, 2018; Hagedorn & Gutierrez, 2009), has strong potential for benefiting client wellbeing, and is part of the ethical burden of multicultural competence.

History of Addressing R/S in Mental Health Professions

Considering the clear need for and benefits of competently addressing R/S with clients, it is essential for mental health professions and professionals to pursue R/S competence. However, the mental health professions have had a long, divisive history with R/S. Many prominent theorists in the professions have held and expressed oppositional or antagonistic views of R/S, including Freud, Watson, Skinner, Ellis, and others (Blazer, 1998). Freud categorized R/S as neurotic (Blazer, 1998) and an illusion, which distanced psychology from religion (Burke et al., 2005). Ellis asserted R/S to be irrational (Bergin, 1991). Despite the opposition and antagonism, other theorists recognized the importance of R/S and gave it a place in the literature (e.g., Allport, 1960; Erikson, 1966; Frankl, 1963; James, 1902/1985; Jung, 1958; Maslow, 1971). Several modern and postmodern movements in the mental health professions have been more accepting of R/S and the R/S research literature has been expanding rapidly in the medical, social, and behavioral sciences (see Koenig, 2012). Nonetheless, mental health professionals should be aware that spiritual/religious/nonreligious identity exploration and self-awareness have been found not only to be inadequately addressed in training but also sometimes discouraged (Magaldi-Dopman, 2014; Magaldi-Dopman et al., 2011). The mental health professions still have much room for improvement regarding training of and attitudes toward R/S.

Limitations of the Focus on Competence

Despite the field's established focus on beliefs, knowledge, and skills, recently MCC/MSJCC researchers have shifted the focus toward the specific cultural processes between client and therapist (Hook et al., 2013, 2016; Owen et al., 2011b, 2016, 2017). There are several

limitations of the focus on competence indicated in the literature and these limitations have provided support and rationale for this change of focus. Empirical research has revealed that the mental health profession's focus on competence has not produced better psychotherapeutic outcomes (Mosher et al., 2017). Additionally, the therapist's previous knowledge of cultural beliefs or values may fail when the therapist utilizes stereotypes while working with clients (Mosher et al., 2017). Some have revealed measurement flaws with current multicultural competence scales (Drinane et al., 2016; Owen et al., 2011b). Others have noted the lack of practical guidance for clinical practice with existing multicultural competence models (Ponterotto et al., 2000). The lack of specificity in the term *multiculturalism*, which could include a plethora of variables (Helms, 1994a), may contribute to the lack of guidance. Furthermore, some have noted confusion about multiculturalism as a construct because it remains poorly defined (Chu et al., 2016; Whaley & Davis, 2007) and it is not yet adequately operationalized (Ridley et al., 2021). Considering the large number of cultural characteristics encompassed by MCC/MSJCC, competency for a specific characteristic is best defined by standards associated to that specific characteristic of diversity (Constantine et al., 2002). Moreover, as noted by Mosher and colleagues (2017), "the utility of competence-based models may be limited when addressing the intersectionality of marginalized identities" (p. 222). The literature also generally points to this major problem with the focus on competence: the goal of focusing on competence is to increase the likelihood of helping clients and reduce the likelihood of harming them, yet an unintended consequence of the competence focus is that clinicians may assume knowledge about clients rather than humbly pursuing knowledge of each client's uniqueness while prioritizing the therapeutic relationship.

In an extensive review of cultural competence literature, Johnson and Munch (2009) discovered four contradictions at the conceptual foundation of cultural competence: (a) knowing about cultures, (b) collective identities, (c) group rights, and (d) cultural competence is achievable. First, knowing about cultures involves having accurate information about cultural groups that can be competently applied to working with clients, which can enhance the clinician's work and the therapeutic relationship (e.g., Anderson, 2003; McGoldrick et al., 2005). However, assuming knowledge and expertise can lead to bias, prejudice, and stereotyping, contradicting the openness to the client that is part of most modern and postmodern counseling approaches. Second, collective identities are a limiting and flawed notion that contradicts both the reality of individual identity as well as the fluid landscape of multiculturalism which has a rate of change that outpaces its ability to be wholly measured and understood. Third, the ethical codes of helping professions have not yet reconciled the contradictions between the rights of individuals to have dignity and worth and the harms imposed upon individuals by certain collective groups to which individuals belong (e.g., groups who practice female genital mutilation or murder as punishments, and government justice systems with institutional racism). Fourth, and perhaps the most conspicuous contradiction, is that there is strong doubt—based on several relevant factors—as to whether cultural competence is even possible to achieve. Fittingly, Manoleas (1994) once noted the "irony [in] seeking a degree of objectivity within the subjectivity of difference" (p. 54).

As part of their closing arguments, Johnson and Munch (2009) drew a contrast by pointing to Tervalon and Murray-Garcia's (1998) assertion that rather than striving for cultural competence, helping professionals should strive for *cultural humility*, which is defined as follows:

> A process that requires humility as individuals continually engage in self-reflection and self-critique as lifelong learners and reflective practitioners, it requires humility in how physicians bring into check the power imbalances that exist in the dynamics of physician-patient communication by using patient-focused interviewing and care, and it is a process that requires humility to develop and maintain mutually respectful and dynamic partnerships with communities. (p. 118)

Paradigm Shift from Competence to Orientation

Recently, scholars in the field have advocated for and supported a paradigm shift from a focus on competency to a focus on orientation (see Owen, 2013; Owen et al., 2011b). Criticism of multicultural competence such as that of Johnson and Munch (2009) and appealing alternatives or supplements in the literature like cultural humility have contributed to this shift. Researchers have argued that the focus on competence has not produced better clinical outcomes and that a focus on orientation emphasizes the uniqueness of the client and the therapeutic relationship (Dillon et al., 2016; Moon & Sandage, 2019). A focus on the client's uniqueness may also better serve the goal of competent practice to avoid harming clients. Vieten and colleagues (2016) considered the constructs of R/S integration (Pargament, 2007) and R/S orientation (Sperry & Shafranske, 2005) to represent more advanced levels of proficiency compared to the constructs of R/S sensitivity, R/S consciousness, and R/S competence. The distinction between competence and orientation is respectively about psychotherapists' ability to effectively provide therapeutic intervention as compared to the ways in which psychotherapists conduct therapy (Barber, 2009). For example, one may consider oneself to be an existentialist (orientation) but may or may not be skilled with existential approaches (competence). With this distinction in mind, it is possible that studies investigating psychotherapists' MCC (Constantine,

2002; Fuertes et al., 2006; Owen et al., 2011a) were in reality assessing MCO (Owen et al., 2011b). While competence is understood as a lifelong pursuit of improving cultural knowledge, skills, and awareness, orientation is defined as the philosophy, inclinations, values, and therapist factors through which competence is conveyed in therapy (Owen et al., 2011b).

Competence can be characterized as "a way of doing therapy" while orientation can be understood as the therapist's "way of being" with clients (Owen, 2013, p. 25; Davis et al., 2018; Hook et al., 2017a). Furthermore, competence can be understood as drawing upon previously obtained knowledge, skills, and awareness while orientation can be understood as a more spontaneous, relational approach which depends upon the clinician and client to connect and co-construct an understanding of the client's culture. In terms of measuring outcomes, the emphasis for competence is upon the knowledge, skills, awareness, and actions of the clinician, while the emphasis for orientation is upon the clinician's awareness of gaps in their knowledge of the client's culture and their willingness to respect and learn from the client. Competence is a clinician-centered, positivist, behavioral approach in which the clinician seeks to build expertise and avoid cultural missteps. Orientation is a client-centered, constructivist, contextual approach in which the clinician seeks to build the counseling relationship, identify gaps in their knowledge of the client's culture or worldview, and to expect and learn from cultural missteps.

Despite their differences, competence and orientation are not necessarily in opposition. Both competence and orientation have a focus on differences between client and clinician cultures and worldviews with a goal to avoid imposing values or causing harm to the client. In both competence and orientation, it is important for the clinician to learn the client's culture and worldview while maintaining awareness of the clinician's own internal struggles with the differences between them. Both competence and orientation are important and relevant

considerations for serving the public. Nevertheless, there are important distinctions, and the literature has provided a strong case that the focus on competence is not enough to achieve the desired outcomes of multiculturally competent practice. Recalling Epstein and Hundert's (2002) definition of competence, it is useful to consider that competent practice depends upon "habits of mind, including attentiveness, critical curiosity, awareness, and presence" (p. 227). However, because competency standards are aspirational as well as enforceable (Alexander, 2018), it may be useful to consider competencies to be the destination professionals seek while orientation is the method for traveling to the destination. In other words, orientation may be understood and treated as the "habits of mind" to which Epstein and Hundert (2002) alluded.

Multicultural Orientation (MCO) Approach

The construct of orientation is applied to the helping professions' standards for multicultural competence through the framework of the multicultural orientation (MCO) approach, which consists of three primary components: cultural humility (Hook et al., 2013; Tervalon & Murray-Garcia, 1998), cultural comfort (Owen et al., 2017), and cultural (missed) opportunities (Owen et al., 2016). Cultural humility is an attitude of curiosity, respect, and non-superiority (Davis et al., 2011) and it is characterized by an openness to diverse beliefs, values, and worldviews as one successfully challenges the tendency to hold one's own beliefs, values, and worldview as superior (Hook et al., 2013). Cultural comfort is the modulation of anxiety and discomfort (Owen, 2013; Owen et al., 2017) that can arise from cultural conversations (Day-Vines et al., 2018; King & Jones, 2019) while seeking to create a sense of safety and trust around cultural interactions (Gutierrez et al., 2020; Watkins et al., 2019). Cultural (missed) opportunities are the occasions in therapy when therapists can either prioritize cultural discussion or choose

alternative conversational paths, either consciously or unconsciously (Owen, 2013; Owen et al., 2016; Strokoff et al., 2016).

So far, research indicates the focus on orientation is producing positive outcomes from the perspective of clients. Studies have shown positive associations between clients' perceptions of their therapists' MCO and clients' ratings for session quality, working alliance, therapist empathy, and therapist general competence (Constantine, 2002, 2007; Fuertes & Brobst, 2002; Fuertes et al., 2006; Kim et al., 2002; Li & Kim, 2004). The three components of the MCO have been studied individually with many findings providing evidence of their importance for culturally competent pursuits in helping relationships. For example, clients who perceived their therapists to have less cultural humility (Hook et al., 2013; Owen et al., 2014, 2016), to have missed cultural opportunities (Owen et al., 2016), and who had less cultural comfort (Owen et al., 2017), also generally found therapy to be less effective (Kivlighan et al., 2019). Several psychometrically sound measures have been developed due to the findings of MCO studies, including the Cultural Humility Scale (CHS; Hook et al., 2013), Cultural Missed Opportunities (Owen et al., 2016), and the Cultural Comfort Scale (CCS; Owen et al., 2017; Slone & Owen, 2015). Kivlighan and colleagues (2019) combined the three measures into the MCO Inventory and demonstrated validity for the inventory in a group counseling setting, thus creating the MCO-Group Version (MCO-G). With the MCO approach in mind, it is important to explore its potential application to religion and spirituality, beginning with the current state of the pursuit of religious/spiritual competence in the literature.

The Pursuit of Spiritual Competence

The American Counseling Association (ACA) and the Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC, 2009) have officially endorsed a set of spiritual

competencies. These spiritual competencies serve as a standard for R/S training and practice in the field and their aim is to promote the spiritual competence of counselors. According to Cashwell and Watts (2010), spiritual competence is defined as awareness, knowledge, and skills in the R/S domain that "would support counselors in serving clients from various religious and spiritual traditions" (p. 2). However, a survey of 335 counseling interns revealed that only 43 of them (13.9%) were familiar with the ASERVIC spiritual competencies (Dobmeier & Reiner, 2012). It has also been established that clinicians, counselor educators, and trainers often lack the training for addressing R/S with clients, students, and trainees (Bernard & Goodyear, 2019; Hage et al., 2006; Young et al., 2002; Young et al., 2007).

Measuring Spiritual Competence

There remains an evident need for clinical educators and trainers to improve spiritual competency training. With improving spiritual competency through measurement in mind, Robertson (2010) created the Spiritual Competency Scale (SCS), which demonstrated validity for the ASERVIC spiritual competencies. Robertson also found that MCC-based training was not adequate for producing spiritual competency, but those who felt their training programs had prepared them to address R/S had higher SCS scores. Also, those who had a course in R/S felt more prepared than those who addressed R/S as part of another course. Perhaps the most significant limitation of the Robertson study was that it did not establish a relationship between SCS scores and spiritually competent practice or positive therapeutic outcomes for clients. Rather, SCS scores indicate clinicians' self-reported spiritual competency.

In a follow-up study, Dailey and colleagues (2015) revised the SCS and again found validation for the ASERVIC spiritual competencies while also confirming the factor structure of the SCS. However, the new study still did not establish a relationship between SCS scores and

spiritually competent practice or positive outcomes for clients. The research team also found that diversity training in the field seems to be improving cultural proficiency in counselor trainees but there are still significant deficits in R/S proficiency (Dailey et al., 2015). In both the Robertson (2010) and Dailey et al. (2015) studies, SCS scores were lower than expected for counselors with factors that were expected to increase SCS scores, such as experience level (i.e., student, clinician, educator) and increased MCC training. Dailey and colleagues (2015) found membership in ASERVIC to be positively correlated with higher SCS scores, despite the additional finding that ASERVIC members still scored lower than expected. Their findings also revealed participants who identified as "neither spiritual nor religious" had the lowest scores, suggesting that some level of R/S interest improves R/S competence. In a systematic review of R/S training in counseling and clinical psychology programs, Jafari (2016) found that most programs infrequently implement R/S training, most training happens outside curriculum-based settings, training is not tailored to enhance R/S proficiency, and when training is offered it is generally part of other forms of diversity training rather than being specific to R/S. Jafari (2016) also found supervisory consultation to be the primary method of training support for R/S, which matches similar findings from Miller and colleagues (2006) as well as Russell and Yarhouse (2006). Consistent with a finding from the Dailey et al. (2015) study, Jafari (2016) found personal interest in R/S to be related to perceived importance of R/S training.

Lu and colleagues (2020) conducted a study to explore variables that affect the R/S competence of counselors-in-training (CIT). The variables included institutional religious affiliation, CIT training level, counselor self-efficacy, MCC, and counselor program R/S training environment. In a departure from Robertson's (2010) findings that there was no difference in R/S competence based on institutional religious affiliation or CIT training level, Lu and colleagues

(2020) found positive effects from both religious affiliation and training level. Lu's team asserted that the religious emphasis in the missions of religiously affiliated institutions likely contributes to higher scores for their students. The reason for the difference in training level remains unclear, though it is likely related to the more advanced training in doctoral programs versus that of master's level programs. Ultimately, the development of measures for R/S competence has yet to be connected to better outcomes for clients, and this limitation is likely to remain because of the clinician-focused nature of competence and its measures.

Statement of the Problem

A particularly important finding from reviewing the current R/S competence literature is this: much like the failings of focusing on practical or behavioral competence with MCC, R/S competence—as measured by the SCS and its newer forms—has yet to be linked to spiritually competent practice through therapeutic outcomes for clients. Additionally, some have raised doubts about whether competence is even achievable (e.g., Johnson & Munch, 2009). Thus, it is essential to explore alternatives to pursuing the outcomes envisioned by ASERVIC and proponents of R/S competence. An obvious alternative is to follow the path of researchers who shifted the focus away from MCC and toward MCO. Because R/S is a component of multiculturalism, it seems logical to include it within MCC/MCO approaches. However, the uniqueness of R/S as a component of culture denotes the need for a unique approach to addressing it. Therefore, R/S competence is uniquely different than MCC and R/S orientation seems unlikely to exactly resemble MCO. As noted by King (2003), R/S is interlaced with culture and R/S identity qualities resemble those of other components of cultural identity (e.g., race, ethnicity, gender), providing clear social and ideological contexts for understanding self (Stewart-Sicking et al., 2019). Nevertheless, there are unique considerations for R/S as compared

to other components of cultural identity. Stewart-Sicking and colleagues (2019) noted that R/S is different from other components of culture in that it moves beyond "everyday categories" of culture such as "gestures, conversational norms, or collectivism" and "points…toward ultimacy" (p. 130). They go on to explain that cultural experiences like eye contact can be viewed outside one's own perspective by stepping into "a more universal, etic perspective" in which we grasp the relativism of those experiences (p. 130). In contrast, R/S experiences cannot be relativized in the same way because the pluralism encountered in R/S forces the acceptance of paradox. Stewart-Sicking and colleagues (2019) provide this narrative example: "I can accept rather easily that eye contact is seen as disrespectful in another culture; if I were a committed atheist and want to affirm that my client experiences the truth and not delusion through Islam, I would have to come to terms with a paradox" (p. 130).

Stewart-Sicking et al. (2019) note that R/S is "an ultimate framework for meaning" that "involves distinctive experiences beyond the everyday world" (p. 130). Further, cultural components such as race, ethnicity, gender, sexuality, and ability are central features of identity, but R/S comprises the potential for conversion—the "radical departure" from former identity prompted by experiences of discernment or insight that surpass normal experiences (p. 131). Thus, it is necessary for R/S identity to substantiate the uniqueness of R/S experience (MacDonald, 2009; Poll & Smith, 2003) and the susceptibility of identity to conversion and transcendence (MacDonald, 2009). When the R/S identities of counselor and client meet, they are "negotiating different social locations" as well as "different experiences of wisdom" (Stewart-Sicking et al., 2019, p. 131). It is necessary to have an approach that accommodates the uniqueness of addressing R/S. Therefore, it is rational to pursue approaches other than those intended to accommodate addressing other components of culture. Because the shift from

competence to orientation has yielded promising results and implications for multicultural competence, it is also rational to pursue a similar but distinct shift in R/S competence.

Purpose of the Study

The present study sought an operational definition for a spiritually competent orientation (SCO) to meet the unique need for R/S competence to shift toward R/S orientation just as multicultural competence has shifted toward multicultural orientation. The operational definition for SCO will enable the development of a measure of SCO and open the way to exploring SCO as a focus in clinical settings to see if it can produce better therapeutic outcomes than the focus on R/S competence. To pursue an operational definition for SCO, the researcher utilized a mixed methods Online Modified Delphi Method (ODM) or e-Delphi, which comprised assembling a panel of experts in R/S integration in mental health services to determine whether experts would reach consensus about identifying SCO and distinguishing it from R/S competence and MCO.

Research Questions and Hypotheses

Consistent with the study's purpose of seeking an operational definition for SCO, the researcher developed the following research questions:

1. How do experts of religious/spiritual (R/S) integration in mental health services define a spiritually competent orientation (SCO) in counseling through its components (i.e., domains, themes, and items)?
2. Do experts of R/S integration in mental health services believe SCO has different components than multicultural orientation (MCO)?
3. Will there be sufficient agreement among experts of R/S integration mental health services about SCO items, such that there are items that may form the basis for developing a measure of SCO?

For these research questions, the researcher hypothesized:

1. The input of experts in religious/spiritual (R/S) mental health services will contribute to an operational definition of SCO and these experts will identify relevant domains and themes that may form the SCO.
2. Experts in R/S mental health services believe SCO has different components than MCO.
3. There will be sufficient agreement ($Mdn \geq 4.0$, IQR ≤ 1.0) among experts in religious/spiritual (R/S) mental health services about SCO items, such that the items form the basis for developing a measure of SCO.

Summary

It is critically important for clinicians to practice competently to avoid harming clients and increase the chances of helping clients. Multicultural competence has become centrally important to the cause of competent practice in the mental health professions. Multicultural competence is understood as the attitudes/beliefs, knowledge, and skills of the counselor that support culturally competent practice. However, the literature indicates the focus on multicultural competence has not produced the desired outcomes for clients. Therefore, the focus has begun to shift from competence to orientation, which is a focus on the values, inclinations, philosophies, and factors of the clinician through which they convey competence. R/S is a component of culture, but it has unique qualities apart from the other components of culture. Previous efforts toward R/S competence have not been demonstrated to improve R/S competence in outcome-related ways. Therefore, it is logical to pursue a shift from R/S competence to spiritually competent orientation (SCO) in a way that honors the uniqueness of R/S as a component of culture and identity.

Chapter Two comprises a literature review of R/S competence, MCO, and constructs closely related to or resembling SCO. The literature supports the relevance of a shift from R/S competence to SCO. Chapter Three describes the methodology for the study, including an orientation to the Delphi method, types of Delphi, including the type used in the study, research questions and hypotheses, participant recruitment, retention, and panel size, data collection and participant profile, Delphi questionnaire and survey development, data analysis, validity, reliability, and ethical considerations. Chapter Four explains the procedures and findings of the study. Chapter Five offers a discussion of findings and conclusions derived therefrom, including implications, strengths, limitations, and recommendations for future research.

CHAPTER 2: LITERATURE REVIEW

Religion, Spirituality, and Mental Health

Research has revealed significant percentages of American adults associating or identifying with religion or spirituality, including 96% believing in a higher power, 90% praying, 69% claiming membership in a religious community (Princeton Religion Research Center, 2000) as well as 75% claiming religion to be at least somewhat important to them, 72% believing in heaven, and 60% supporting sacred texts as the word of God (Pew Research Center, 2015). Religion and/or spirituality (R/S) in the mental health professions is becoming increasingly recognized as an important topic to address in counseling and therapy. Nevertheless, R/S has a history of controversy and skepticism in mental health. Several prominent figures in the history of the mental health professions—such as Freud, Ellis, Skinner, Watson, and others—have been antagonistically critical of R/S (Blazer, 1998) while others have upheld its significance and potential for positive impact (e.g., Allport, 1960; Erikson, 1966; Frankl, 1963; James, 1902/1985; Jung, 1958; Maslow, 1971), including as a component of culture (Sue & Sue, 2013) and as a force for healing and change in therapy (e.g., Ano & Vasconcelles, 2005; Evans et al., 2018; Flannelly et al., 2006; Mueller et al., 2001; Myers & Williard, 2003; Sharma et al., 2017; Sherman et al., 2015; Sherman et al., 2018).

Over time, research has revealed clear benefits of R/S upon wellbeing (George et al., 2002; Green & Elliott, 2010; Koenig et al., 2012; Miller & Kelley, 2005; Miller & Thoresen, 2003; Oman & Thoresen, 2005; Plante & Sherman, 2001; Seybold & Hill, 2001; Wong et al., 2006) and in therapy, associating R/S with emotional, psychological, and physical wellness (Young & Cashwell, 2020). Despite the benefits, it must be acknowledged that there have been

many problems associated with R/S, including ungrounded spiritual experiences (Grof & Grof, 1989), toxic religious experiences such as religious abuse (Cashwell & Swindle, 2018), conflict and violence (Juergensmeyer, 2003; Zhang et al., 2015), and the increasingly prominent concept of spiritual bypass (see Cashwell et al., 2007; Fox et al., 2020). Still, research evidence reveals R/S can be perceived as a source of coping (Pargament, 1997) and benevolence (Johnson et al., 2013; Johnson et al., 2015), and R/S supports wellness and development (Stebnicki, 2006; Worthington, 1989) as well as the creation of values and the pursuit of transcendence that facilitates the development of the higher self (Clinebell, 1995). Citing Myers and Sweeney (2008), Young and Cashwell (2020) declare R/S to be "an important developmental phenomenon that is arguably a central aspect of wellness" (p. 17). Further, Young and Cashwell argue that attending to R/S is "highly consistent with counselors' developmental and wellness orientation" and that disregarding or rejecting R/S in therapy is "culturally insensitive, ignores important developmental factors, and, in some instances, may be judged as incompetent and unethical practice" (p. 17).

The case for attending to R/S is strengthened when considering Everts and Agee's (1994) argument that R/S beliefs and values have a substantial influence upon all aspects of life, including mental and physical health, intrapersonal development, vocational activities, and interpersonal relationships. To illustrate the point, the authors highlight that recognition of and deference to higher powers or other forms of the sacred can provide meaning, joy, hope, and a sense of empowerment in the face of illness and pain, while a lack of meaning, feelings of sadness, hopelessness, and helplessness can pervade when R/S is lacking in one's life. R/S profoundly influences self-efficacy, self-esteem, identity, personality, sexual orientation, and locus of control. Everts and Agee assert that R/S even affects the challenges, choices,

responsibilities, and decisions of employment, or lack thereof. R/S also impacts stress and emotional turmoil, life satisfaction and quality of life ratings, and perceptions of meaning and purpose in life. Further, R/S values are infused in relationships that affect attitudes toward life and death, birth and parenting, marriage and divorce, aspirations and goals, anger and forgiveness, and other essential life experiences. Psychotherapy or counseling is a course many undertake when problems arise in these spiritually imbued areas of life. Therefore, clinical professionals are frequently operating in R/S realms, whether they know and appreciate it or not. Additionally, clients with strong R/S beliefs are often strongly devoted to their worldviews, making it likely that conflict or hurt related to their R/S worldviews can be challenging to resolve in positive ways (Hodge et al., 2019). For example, those who have their R/S worldview criticized often retaliate (Van Tongeren et al., 2016). Thus, clinical professionals must learn to competently address R/S with clients to avoid conflict, reduce the chances of harm and retaliation, and support clients' use of R/S for positive outcomes in their lives.

History of Multicultural and R/S Competence in Counseling

Culture includes R/S, and multicultural counseling competencies (MCC) conceptually include R/S competence. Therefore, R/S in counseling generally have been treated as components of multiculturalism and, by extension, R/S competence generally has been treated as a component of MCC. However, the primary focus of the multicultural movement has been racial and ethnic differences, causing other aspects of diversity such as R/S to receive significantly less consideration in the MCC literature (Magaldi-Dopman, 2014; Pieterse et al., 2009; Robertson, 2010; Sue & Sue, 2013). As Robertson (2010) noted, the multicultural movement was the first to draw the attention of counseling professionals to issues of diversity

and it has been instrumental in drawing attention to R/S diversity. Therefore, the multicultural movement is a relevant part of the discussion of R/S competence.

Development of Multicultural Competency Standards

The helping professions largely developed through Western, Eurocentric philosophies and cultural perspectives, shaping an assumption that the theories, techniques, and interventions which developed were suitable for all clients (Sue, 1991; Sue et al., 1992b; Sue et al., 1996; Sue & Sue, 1990). Unfortunately, the accompanying biases of the dominant Eurocentric culture, including stereotypes, assumptions of genetic defects and racial inferiority, and the use of derogatory terms or phrases (e.g., "genetically deficient" and "culturally disadvantaged"), were previously—and inadvertently—adopted by the counseling profession (Robertson, 2010; Sue et al., 1982). Further, Sue et al. (1982) noted Eurocentric biased perspectives led counseling professionals to a tendency of pathologizing client perspectives or behaviors that are acceptable in the client's culture. Sue and colleagues challenged misunderstandings and myths regarding multicultural competence in the field of psychology, prompting the American Psychological Association (APA) to improve multicultural competency training in the field. The problems of a Eurocentrically dominant culture in the profession began to come to light and mental health professionals began to see the need for adjustments in education and practice to address the diversity of identities and cultures in society (Jackson, 1995; Sue, 1991).

A clinician with multicultural competence is one with the capacity to serve clients from diverse cultural identities and backgrounds with perception and care (Pope-Davis et al., 2003). Cultural identities and backgrounds—including gender, race, ethnicity, sexual orientation, age, socioeconomic status, R/S, and other factors—will inevitably form and influence clients' values, beliefs, worldviews, and biases. Pope-Davis and colleagues (2003) note these cultural factors

also influence the psychotherapeutic process at all levels, including research, assessment, treatment, interventions, and the therapeutic relationship. Because failure to understand and acknowledge these differences in cultural factors increases the risk of miscommunications, misinterpretations, and misdiagnosis, Sue and colleagues (1982) introduced MCC, which have since become recognized as training standards by the American Counseling Association (ACA), the Association for Counselor Education and Supervision (ACES), the Association for Multicultural Counseling and Development (AMCD), and the APA (Arredondo et al., 1996).

Measuring Multicultural Competence

The establishment of the MCC standards was undoubtedly a groundbreaking step toward multicultural competence in the mental health professions. However, the issue of determining whether the standards improved the multicultural competence of professionals remained to be seen. The next major step was the development of measures for MCC. Several measures were developed in the ensuing years, including the Cross-Cultural Counseling Inventory (CCCI) developed by Hernandez & LaFromboise (1985), the Multicultural Awareness-Knowledge-and Skills Survey (MAKSS) by D'Andrea et al. (1990), the Multicultural Inventory (MCI) by Sodowsky et al. (1994), the Multicultural Counseling Knowledge and Awareness Scale (MCKAS) by Ponterotto et al. (2002), and others. The development of measures for multicultural competence has facilitated the assessment of competence for students, trainees, and professionals, opening the way for developing methods to improve competence according to the results of the measures used.

Multicultural Competence and R/S

Although R/S are broadly recognized as important components of culture and identity, they have traditionally been overlooked because of a multicultural focus heavily slanted toward

race, ethnicity, and marginalized identities. When Sue and colleagues (1982) first established the MCC standards, R/S were not yet recognized for their relevance to multiculturally competent practice and were not mentioned in the original standards. When Sue and colleagues (1992) updated the standards ten years later, R/S values and beliefs were mentioned in terms of the importance for clinicians to have respect for them and their potential for impacting mental and physical functioning. Arredondo and colleagues (1996) mention R/S issues five times in their revision of the standards, inviting professionals to give even more consideration to R/S issues in the field. Despite these developments, the MCC standards remained primarily focused on issues of race and ethnicity. Helms (1994a) contended that multiculturalism as an empirical construct is effectively useless because it is so broad and encompasses so many components of diversity. Constantine and Ladany (2000) suggested that MCC instruments remained focused on self-perceived ability to serve people of color, and they, along with Constantine and colleagues (2002), emphasized the need for the development of instruments with foci in other areas of cultural diversity beyond those of race and ethnicity. Robertson (2008) seemingly heeded Constantine and colleagues' recommendation when creating a measure of spiritual competence based on the set of R/S competencies established by the Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC)—a national association and a division of ACA.

ASERVIC Competencies and Measuring R/S Competence

The ACA supports including and addressing religious/spiritual (R/S) beliefs in counseling. Including and addressing R/S begins with the clinician. In the introduction of the ACA (2014) *Code of Ethics*, counselors are instructed to "explore their own cultural identities and how these affect their values and beliefs about the counseling process" (p. 4). Undoubtedly, R/S values and beliefs affect counselors and their identities, which in turn affect the counseling

process. Section A.4.b of the *Code of Ethics* mandates counselors to avoid imposing their own values and beliefs upon clients and "seek training in areas in which they are at risk of imposing their values onto clients, especially when the counselor's values are inconsistent with the client's goals or are discriminatory in nature" (p. 5). Naturally, R/S values and beliefs between clinician and client will not always align, so it is essential for clinicians to be competent when addressing R/S. ASERVIC maintains a set of competencies for addressing R/S in counseling. The ASERVIC (2009) Competencies are endorsed by ACA, and they specify what counseling professionals must know, consider, and practice to competently address R/S in counseling. Presently, ASERVIC is the only ACA division singularly dedicated to promoting the integration of R/S and values diversity into counseling. The ASERVIC competencies are fundamental to R/S competence in the counseling profession and were validated through the development of Robertson's (2008) *Spiritual Competency Scale (SCS)*.

Spiritual Competency Scale (SCS)

Robertson (2008) pertinently highlighted the lack of universally integrated R/S training in counselor education curriculum (Cashwell & Young, 2004; Young et al., 2002), as well as the lack of empirical evidence for strategies and measures to integrate R/S training into counselor education curriculum. Robertson introduced the 90-item *Spiritual Competency Scale (SCS)* as a measure of R/S competence based on the ASERVIC Competencies. As noted by Lu and colleagues (2018), the development of the SCS contributed empirical support for the evaluation and teaching of spiritual competence in counseling. Another Robertson (2010) study affirmed the validity of the ASERVIC competencies while also demonstrating that MCC-based training did not sufficiently produce R/S competence. Robertson conducted an exploratory factor analysis (EFA) using 662 participant counseling students to examine the factor structure of the SCS. The

EFA produced a six-factor structure for the SCS, comprising 22 items with a 6-point Likert scale (1 = *high disagreement*, 2 = *midrange disagreement*, 3 = *low disagreement*, 4 = *low agreement*, 5 = *midrange agreement*, 6 = *high agreement*) with higher scores indicating higher levels of competency. Admitting the impracticality of expecting perfect scores of 6 all the way through the scale, Robertson suggested a cutoff score of 5, resulting in a total score of 110 (22 items x 5 points each) as a target toward which one can aim when pursuing R/S competency improvement. Robertson found a mean score of 97.8 for the participating counseling students (n = 662) in the study, signifying that the sampled participants did not gain high levels of R/S competency according to the predetermined cutoff scores. ASERVIC approved the six-factor model of the SCS, endorsing it as the framework for its current 14 R/S competencies (Cashwell & Watts, 2010).

As mentioned previously, a significant limitation of Robertson's (2010) findings from the SCS study is this: it did not establish a relationship between the SCS and spiritually competent outcomes. Rather, it established and validated a self-report instrument for clinicians to measure their own professed R/S competence. This limitation has become a focal point of the present study because of the attention drawn to a lack of positive outcomes for clients in addressing their R/S in mental health services. This limitation also exists in other studies of SCS and R/S competence.

SCS–R–II

Dailey and colleagues (2015) re-examined the 90-item SCS in a study with 246 participant members of ASERVIC. Their study emerged from two main concerns: (a) the 22-item version of the SCS was developed with participants who may not have been R/S competent, calling into question the content validity of the items; and therefore, (b) the six-factor structure of

the SCS was unverifiable until it could be examined further. Dailey et al. conducted an EFA, leading to verification of the six-factor structure but with 21 items rather than the 22 proposed by Robertson, and with alternation for several of the items. The new 21-item version of SCS was renamed SCS–R–II. Dailey et al. considered their participants' membership in ASERVIC to provide increased exposure to R/S topics and activities compared to Robertson's (2010) participants. Thus, Dailey et al. hypothesized an average rating of 5 or higher on each of the items in the SCS–R–II, which would indicate a minimum mean total score of 105 (21 items x 5 points each). Their hypothesis was supported as their study indicated a mean total score of 106. Subscales for the SCS–R–II include assessment, counselor self-awareness, diagnosis and treatment, human and spiritual development, culture and worldview, and communication. Respectively, the subscale internal reliabilities (Cronbach's alpha) were .85, .70, .71, .70, .61, and .60.

Compared to other groups in the study who had differing "levels of religiousness" ($F_{5,245} = 2.378$; $p < .05$; $n^2 = .05$), the participant group with the lowest mean score was comprised of those who identified themselves as "neither spiritual nor religious" ($M = 389$; $SD = 33$). Dailey and colleagues (2015) recalled this group to produce the lowest mean scores in Robertson's (2010) study as well. Participants who reported being "Intimately familiar" ($M = 451$; $SD = 36$) with the ASERVIC competencies scored significantly higher than those who reported being "Not familiar" ($M = 424$; $SD = 28$; $F_{2,245} = 10.66$; $p < .01$; $n^2 = .08$), suggesting personal interest in R/S supports R/S competence. Ultimately, Dailey and colleagues found support for a 21-item, six-factor solution that accounted for 61% of the variance and with higher content validity than the previous version of SCS. Further, they found that R/S competence did not depend on participant type (i.e., counselor educator, student, practitioner). Although membership in

ASERVIC improved scores, ASERVIC members still scored lower than expected in Robertson's original study, "reinforc(ing) the idea that core information regarding spiritual and/or religious phenomena is not being discussed effectively in counseling programs or continuing education curricula" (Dailey et al., 2015, p. 23).

Confirmatory Factor Analysis of SCS–R–II. Noting that Robertson (2010) and Dailey et al. (2015) only performed exploratory analysis methods to examine the factor structure of the SCS, Lu and colleagues (2018) conducted a confirmatory factor analysis (CFA) of the SCS–R–II to further validate it and to examine the relationship between R/S competencies and MCC. Their sample contained 176 participants including (a) 30 master's-level counseling students, (b) 44 doctoral-level counseling students, (c) 37 counseling practitioners, and (d) 65 counselor educators. Regarding R/S, participants were asked to identify themselves in one of four ways: (a) religious only, (b) spiritual only, (c) both spiritual and religious, and (d) neither spiritual nor religious. The categories contained the following numbers of participants: (a) 2 religious only, (b) 61 spiritual only, (c) 103 both spiritual and religious, and (d) 10 neither spiritual nor religious. Lu et al. found the following internal reliabilities (Cronbach's alpha) for the six subscales of SCS: assessment (.88), counselor self-awareness (.81), diagnosis and treatment (.82), human and spiritual development (.74), culture and worldview (.62), and communication (.69). The overall SCS–R–II scores ranged from 21 to 126 with higher scores signifying higher degrees of R/S competence.

Through the CFA, Lu et al. (2018) confirmed the six-factor structure and all 21 items of the SCS–R–II. They also affirmed the SCS–R–II to be, up to that point in time, "probably the only systematically developed and validated inventory to examine spiritual competencies in the field of counseling" (p. 231). Further, Lu et al. assert the "paramount meaning" of the SCS–R–II

is realized in counselor education. The usefulness of the SCS–R–II is most evident in two types of counselor education pursuits. First, the SCS–R–II provides "valid (tentatively) and concrete content areas" through its factor structure, which can be applied to developing a standalone course for teaching R/S, integrating R/S into other counseling courses and teaching agendas, and broadly guiding counselor educators' professional development and training related to R/S competence (p. 231). Second, the SCS–R–II offers a useful way to monitor and measure the R/S competence of counselors-in-training. When Lu et al. (2018) reviewed the limitations of their study, they admitted the findings from their analyses are "informative, but not conclusive" and that the longer 90-item SCS is "more informative than the 21-item SCS–R–II in guiding counselor training on spiritual competencies" (p. 232). They further cautioned that the SCS–R–II should not be viewed as a comprehensive portrayal of R/S competencies.

Neither the Dailey et al. (2015) study nor the Lu et al. (2018) study overcame the major limitation from Robertson's (2010) study that established and validated SCS: there has yet to be a direct relationship established between SCS or SCS-R-II and positive R/S-related treatment outcomes for clients. In each case, it appears the focus has been on measuring clinicians' own self-reported R/S competence. The general assumption seems to be that if self-reported R/S competence can be scored and the scores improved, it will lead to better clinical outcomes for clients. It also seems logical and fair that other limitations of competence already established in the literature would apply to studies focused on competence. One example of such a limitation of competence is the emphasis on building knowledge and avoiding missteps; in contrast, orientation signifies emphasis on awareness of knowledge gaps and expecting to learn from missteps.

Other R/S Competence-Focused Measures and Approaches

In recent years, some researchers have attempted to measure and improve R/S competence in ways adjacent to the ASERVIC competencies. Oxhandler and Parrish (2016) developed the *Religious/Spiritually Integrated Practice Assessment Scale (RSIPAS)*, which is a measure of R/S integration into social work practice. The RSIPAS is easily adapted for use with other mental health professionals (e.g., Pearce et al., 2020). Vieten and colleagues (2013, 2016) identified and verified a set of 16 basic R/S competencies for psychologists. Another example of an approach adjacent to the ASERVIC competencies is the *Spiritual Competency Training in Mental Health (SCT-MH)* program, which Pearce and colleagues (2020) designed to train professionals across the various mental health professions to provide basic spiritually competent care. SCT-MH is based on the 16 basic R/S competencies that Vieten and colleagues (2013, 2016) identified and verified, and it is intended to provide clinicians with those basic R/S competencies.

Religious/Spiritually Integrated Practice Assessment Scale (RSIPAS)

Oxhandler and Parrish (2016) developed the *Religious/Spiritually Integrated Practice Assessment Scale (RSIPAS)* to assess social work practitioners' abilities to integrate clients' R/S in clinical practice. Reviewing the only three instruments that preceded RSIPAS for measuring social workers' R/S integration, Oxhandler and Parrish noted the limitations of each. The three scales are: (1) the Role of Religion and Spirituality in Practice Scale (RRSP; Sheridan et al., 1992), (2) the Spiritually Derived Intervention Checklist (SDIC; Canda & Furman, 1999, 2010), and (3) the Religion and Prayer in Practice Scale (RRSP; Mattison et al., 2000). According to Oxhandler and Parrish, "all three scales have limited validity and reliability and have not demonstrated factorial validity" (p. 296). The three scales are also primarily focused two-

dimensionally on clinician attitudes and specific practices with clients—a decidedly competence-focused approach to R/S integration—and some of the specific practices, such as prayer and touching clients for healing purposes, have limited or no evidence to support their use with clients. Citing the adoption of evidence-based practice across the social work and related mental health professions, Oxhandler and Parrish argue against using measures or approaches that feature "unsupported R/S practice behaviors" and so few dimensions (p. 296). The RSIPAS is intended to provide a more evidence-based approach to selecting R/S interventions for clients and adding dimensions to improve understanding of R/S integration in practice. Oxhandler and Parrish added two more dimensions to attitudes and practices: self-efficacy and feasibility. Nevertheless, the added constructs of self-efficacy and feasibility do not resemble constructs related to orientation in the literature.

The RSIPAS contains 43 items across four dimensions/domains, with each item being measured with a Likert-type scale with five points. The "Attitudes" dimension contains 14 items, "Behaviors" contains 10, "Self-Efficacy" contains 13, and "Feasibility" contains six. Oxhandler and Parrish (2016) reported sending a survey to test items and received 470 usable responses (N = 470), most of whom were White (87%) and female (79%) participants. The average participant in the sample was seasoned. The mean age of the sample was 57 years (SD = 11.00) and there was an average of 23 years (SD = 11.28) of clinical experience among participants. After accounting for missing data, Oxhandler and Parrish (2016) assessed for univariate normality and used a reflected logarithm transformation to reduce issues of kurtosis and skewness (Abu-Bader, 2010; Tabachnick & Fidell, 2007). The authors then used the weighted least squares means and variance adjusted (WLSMV) approach in Mplus, finding the assumption of linearity met by testing with bivariate scatterplots. The authors conducted a CFA in Mplus to

eventually establish a 40-item model with good to excellent factor loadings (.55 or higher) for all but three items that were determined fair (.45–.54) according to Comrey and Lee (1992). The authors determined the model to have good convergent validity with four subscale factor loadings ranging from .87 to .92 and good discriminant validity with four subscale correlations between .73 and .83 (Kline, 2005). Although the RSIPAS instrument was validated in the study and is therefore useful for measuring R/S-integrated practice, the theoretical foundations of RSIPAS more closely resemble R/S competence than SCO.

R/S Competencies for Psychologists

Recognizing the lack of R/S training in psychology, Vieten et al. (2013) proposed a list of R/S competencies for psychologists based on the results of (a) a comprehensive literature review, (b) a focus group of clinical and scholarly experts, and (c) a survey of 184 clinical and scholarly experts of R/S integration in psychology. Based on the recommendation of Kapuscinski and Masters (2010) to use both deductive and inductive methods for developing R/S instruments, Vieten and colleagues conducted a literature review to deduce 24 provisional R/S competencies, followed by a focus group of 15 clinical and scholarly experts in R/S integration who inductively revised the provisional competencies to build consensus. Two more phases of the study included an online survey of experts to provide further evaluation of content, followed by qualitative and quantitative analyses of responses and item revisions from a set of meetings for building expert consensus. The final list of competencies from their study includes 16 items across three domains: Attitudes (3 items), Knowledge (7 items), and Skills (6 items).

Vieten et al. (2013) declared three purposes for developing the R/S competencies in their study: (a) to help clinicians avoid providing inappropriate, inadequate, or biased care when addressing R/S; (b) to empower clinicians to recognize R/S issues and integrate client R/S

resources for better outcomes; and (c) to provide content for clinical supervision and training purposes. As indicated in the purposes, questions, framework, and findings of their study, Vieten and colleagues were clearly focused on R/S competence and adopted the competence framework of attitude, knowledge, and skills. Therefore, the findings from their study face many of the same limitations as other studies and theories based on the competence framework. Chiefly, as noted previously, researchers have not produced sufficient evidence that the focus on competence has produced better outcomes for clients (Dillon et al., 2016; Moon & Sandage, 2019). Fittingly, Vieten and colleagues recognize this limitation to a certain extent in their discussion of the study: "As in any domain of psychotherapy, knowledge and technique are no substitute for a psychotherapist's personal qualities that foster the therapeutic relationship (Patterson, 2004)" (p. 139). Recalling that orientation includes philosophy, inclinations, values, and therapist factors (Owen et al., 2011b) and a focus on the therapeutic relationship (Dillon et al., 2016; Moon & Sandage, 2019), the "personal qualities" and "foster(ing) the therapeutic relationship" mentioned by Vieten et al. (2013, p. 139) are consistent with orientation.

In a follow-up to the 2013 study reviewed above, Vieten and colleagues (2016) created and distributed a survey to psychology professionals to determine whether a broader population would accept the 16 R/S competencies published previously. 272 total participants responded and 222 held a graduate degree and licensure to practice psychotherapy. The authors focused on the subset of those 222 participants ($N = 222$), which included an average of 23.3 ($SD = 13.2$) years of clinical experience, an average age of 55.1 ($SD = 13.2$) years, and were largely White/Caucasian (87.8%) and 50% female. The R/S affiliations in their sample included 41% as "spiritual but not religious," 37% as "both religious and spiritual," 18% as "neither spiritual nor religious," and approximately 3% as "religious but not spiritual." Through the survey, the

authors asked participants to indicate whether they believed psychologists should be trained and demonstrate competence in each of the 16 proposed R/S competencies. The authors also invited participants to use 5-point Likert-type scales to indicate (a) how much training they received for each competency, (b) how well they have practiced each competency, and (c) how important they consider each competency in relation to clinical practice.

Vieten et al. (2016) reported a "very large degree of support for the proposed competencies" with over 70% to 90% of participants agreeing that psychologists should be trained and demonstrate competence in each of the 16 R/S competencies (p. 99). Further, they confirm the findings of the study indicate a large majority of clinicians considered the 16 competencies to be acceptable, important, and relevant. Based on their findings, Vieten and colleagues offered their approval of Richards and Bergin's (2005) assertion that general multicultural training does not sufficiently prepare clinicians to address R/S with clients. Additionally, they supported Brownell's (2014) argument that psychotherapists who ascribe suffering and weak-mindedness to R/S are neither ethical nor competent to serve clients with R/S beliefs and practices. Like the studies about the ASERVIC competencies, the studies by Vieten and colleagues (2013, 2016) confirm R/S competence is a desirable destination for which we do not yet have a clear path or method of travel.

Spiritual Competency Training in Mental Health (SCT-MH)

Pearce and colleagues (2020) created the Spiritual Competency Training in Mental Health (SCT-MH) program in response to a lack of professional training for addressing R/S in mental health services. Their aim was to train clinicians in basic R/S competence. Two of the authors (Michelle Pearce and Ken Pargament) developed the multidisciplinary curriculum for an 8-hour, 8-module online training course in basic R/S competence for all types of mental health

clinicians and therapeutic orientations (e.g., existential, psychodynamic, cognitive). They were informed by R/S literature in mental health services over the previous 15 years (e.g., Doehring, 2015; Griffith, 2010; Pargament, 2007; Pearce, 2016; Richards & Bergin, 2005; Vieten & Scammell, 2015). Two co-authors (Holly Oxhandler and Cassandra Vieten), five consultants from different mental health professions, and other experts in the field provided input and feedback on the training content. The authors designed a quasi-experimental one-group pretest-posttest study to evaluate the program's effect on clinicians' self-reported R/S competence. In all, 169 participants ($N = 169$) completed all eight modules of the program and the posttraining assessment used for the study. The authors assessed R/S competence with three instruments: (a) the RSIPAS (Oxhandler & Parrish, 2016), (b) the Spiritual Competency Questionnaire (SCQ) based on the 16 items developed by Vieten et al. (2016), and (c) the RS Knowledge Questionnaire. The authors found that participants significantly increased their scores on all three instruments from pre- to post-training. In a post hoc analysis, the authors tested for R/S demographic variables as predictors of score changes and found that the effectiveness of the program is not dependent upon participant levels of R/S.

Encouragingly, participants reported reductions in barriers to integrating R/S into clinical practice, with the largest reduction reported in participants' feeling that they were inadequately trained to integrate R/S into practice (Pearce et al., 2020). Many participants reported changes in their practice or clear plans for change, including routine and explicit assessment of R/S issues and using R/S strategies in treatment (e.g., religious CBT). Many also reported feeling more comfortable and confident addressing R/S and intended to contact clergy for consultation. The authors reported other promising findings related to clinicians' knowledge, attitudes, and skills connected to R/S competence. However, the authors also noted that they were unable to

determine whether the short-term changes from the training will become long-term changes. Additionally, they asserted that "the ultimate goal of competency training is to improve client care and outcomes" and they acknowledged more studies are needed to assess for long-term change in clinicians and impact on R/S-related outcomes for clients (p. 158). Like other competence-based studies, Pearce and colleagues seem to have assumed improving self-reported R/S competence in clinicians will likely improve R/S-related outcomes for clients, even if improved outcomes are not yet connected to improvements in competence.

Observations from the R/S Competence Literature

Perhaps the most glaring flaw that trends across the R/S competence literature is that researchers have not linked improved R/S competence to better R/S outcomes for clients. Largely, this flaw is an inherent one, as highlighted in the literature comparing competence and orientation. For example, Mosher and colleagues (2017) criticized the assumption in competence-focused practice that clinicians rely on knowledge previously obtained while in clinical situations, which may lead to clinicians relying on stereotypes, prejudice, or other biases. The assumption in orientation-focused practice is that the clinician lacks expertise about the client and should assume the role of a curious and humble learner rather than relying on previous knowledge. Johnson and Munch (2009) identified another inherent flaw in the assumptions of competence, and in this case, multicultural competence: that there is no evidence that multicultural competence—and by extension, R/S competence—is even achievable. For example, a clinician may seek knowledge about all major R/S systems, as directed by the first ASERVIC (2009) competency. However, that directive is likely to be less achievable for clinicians in general than assuming a humble stance and admitting what they do not know about

less familiar R/S systems. In this example, the outcomes of a competence stance toward knowledge are less in control than the outcomes of an orientation stance toward knowledge.

The competence literature is clinician-centered, as evidenced in the language, rationale, and focus of the competence-based studies reviewed herein. For example, each of the instruments reviewed is based on clinician's self-reporting of their own attitudes, behaviors, knowledge, skills, and other factors. Based on the MCO literature, it appears orientation has a more client-centered focus. For example, cultural humility is an attitude or stance focused on the client and it is demonstrated through openness, curiosity, respect, and non-superiority toward the client (Davis et al., 2011; Hook et al., 2013); cultural comfort requires the clinician to modulate their own anxiety and discomfort (Owen et al., 2013; Owen et al., 2017), but it is focused on creating safety and trust for cultural interactions with the client (Gutierrez et al., 2020; Watkins et al., 2019).

The competence literature seems to favor a positivist view. According to Mackenzie (2011), *positivism* refers to "the view that accepts a correspondence theory of truth, that there is a single reality independent of human beings, and that the methods of the natural sciences should be adopted in research on social, and…educational questions" (p. 534). The reviewed R/S competence studies seem to assume an objective reality that includes the possibility that clinicians can achieve an objectively competent level of practice with R/S. For example, the SCS-R-II subscales include assessment, counselor self-awareness, diagnosis and treatment, human and spiritual development, culture and worldview, and communication (Dailey et al., 2015). Each subscale represents objective standards that every clinician is expected to meet. By contrast, orientation appears to be more consistent with *constructivism*, or the view that clinician and client co-construct a shared reality in their relationship and interactions (Cottone, 2017). For

example, Gutierrez and colleagues (2020) suggested that MCO is consistent with the Cultural Third approach, in which clinical supervisor and supervisee—or, clinician and client—co-construct a safe space for cultural interaction based on humility and the other components of MCO.

Behaviorism is a thread in the R/S competence literature and it seems behavior is highly emphasized in terms of competent practice. For example, "Behaviors" is a dimension of items in the RSIPAS and, unsurprisingly, the items within that dimension are focused on the clinician's self-reported behaviors (Oxhandler & Parrish, 2016). Divergently, orientation seems to have greater emphasis on relational factors, such as healing ruptures through humility (e.g., Watkins et al., 2016) and emphasizing the intersectionality in clinical relationships (e.g., Gutierrez et al., 2020; Watkins et al., 2019). This trend of behavior versus relationship could be connected to the trend of clinician-centered focus in the competence literature versus the client-centered focus in the orientation literature.

What is Missing? Destination and Route

Each of the R/S competence studies reviewed above focused on producing evidence of R/S competence in the participants, treating R/S competence as a goal for clinicians to achieve for themselves. The assumption of R/S competence as a goal is not inherently unsound despite the limited evidence that the focus on competence is producing desired outcomes for clients in clinical settings. However, there is a lack of practical guidance for achieving the goal of competent R/S clinical practice. The RSIPAS, the Vieten et al. (2013, 2016) studies, and the SCT-MH demonstrated other approaches to R/S competence. Pearce et al. (2020) provided evidence that the SCT-MH program can improve the R/S attitudes, knowledge, and skills of mental health clinicians. However, as Pearce and colleagues noted in the limitations of their

study, there is not yet sufficient evidence to suggest that improving clinicians' R/S competence supports long-term changes in their R/S clinical practices or better outcomes for their clients. If R/S competence is seen as the goal or destination to be reached, the measures and studies for R/S competence confirmed that it is indeed a real and desirable destination but did not determine a clear path and method of travel for reaching that destination.

Method of Travel

Owen and colleagues (2011b) characterized competence as a lifelong pursuit of improving cultural knowledge, skills, and awareness. Johnson and Munch (2009) found a serious contradiction of competence in the MCC literature: there is strong evidence producing doubt that competence is even possible to achieve. With these notions in mind from Owen and colleagues as well as Johnson and Munch, competence can more accurately be viewed as a direction rather than a destination. In other words, the destination for which we strive may not actually be reachable, but current professional ethics and expectations in the field denote it is still important to attempt to reach it so that we come as close to competence as possible. A lifelong pursuit of competence fittingly reflects a destination that is not likely to be reached because of its loftiness or because it is always moving farther away as needs and expectations of competence change over time. Thus, it becomes important that the traveler trying to reach the destination (i.e., the clinician trying to be competent) is accurately oriented to the destination, moving in the correct direction toward it. Metaphorically, then, orientation is the method of pointing toward the correct destination and traveling toward it. However, it is not yet understood how to be properly oriented to R/S in an operational way. Now, the task at hand is to operationally define the spiritually competent orientation (SCO) so it may be formed into a measurable construct to test its viability as a direction and path toward positive R/S outcomes for clients of mental health clinicians.

Potential Paths to SCO in Existing Literature

Because SCO is a novel construct and the R/S competence literature is mostly referenced to identify gaps in the literature, it became necessary to review other R/S literature to inform the researcher's pursuit of potentially pre-existing paths to operationally defining SCO. Several potential paths existed in the literature already, as found in several theories and models that resemble proposed theoretical definitions of R/S orientation in the present review. Some paths more closely resembled a competence perspective, while others more closely resembled an orientation one. Some overlapped or resembled both. One possible alternative path to SCO would be applying the MCO framework to addressing R/S. Other alternatives pursue SCO through cognitive ability or behaviors. Still others are potential frameworks for SCO that more closely resemble the construct of orientation as defined in the MCO literature. The literature reviewed does not represent a comprehensive compilation of all relevant literature but rather the most relevant literature available to the researcher in the context of pursuing an operational definition of SCO.

Namaste Theory

Holly Oxhandler (2017) introduced Namaste Theory based on a theme that arose from the findings of a quantitative grounded theory study of Oxhandler's own work. Namaste Theory emerged from a three-part study of clinical social workers and their views and behaviors around R/S integration in clinical treatment with clients. Oxhandler identified clinicians' intrinsic religiosity (IR) as a prominent characteristic among clinicians who integrated client R/S in treatment. According to Allport and Ross (1967), intrinsically religious people are motivated by their religion and wish to fully internalize, embrace, and live their beliefs. Oxhandler found that IR and possibly other personal clinician R/S factors affected clinicians' tendencies to integrate

client R/S in treatment. According to Nambiar (1979), the term *Namaste* is formed from two Sanskrit words: *Namah* (to bow or bend) and *te* (to you). Nambiar further describes the attitude and spirit of Namaste as one of humility in which people recognize God, or the sacred, in each other when they meet.

Oxhandler (2017) proposed that Namaste provides a good explanation for the IR phenomenon observed in the studies about clinicians' R/S integration tendencies. Essentially, IR clinicians are more likely to be aware of, engage in, experience, and infuse their R/S beliefs into daily living. In turn, this will cause them to deepen their IR and become more attuned to the sacred within, and therefore, more likely to recognize the sacred in others. Nambiar's (1979) insight into Namaste indicates consistency with R/S orientation:

> *Namaste* in its true spirit helps our ego to surrender to the goal of our faith. With folded hands and with mind attuned to the feeling of the oneness of humanity, we slowly and steadily attain complete identification with God. In this manner, *Namaste* helps us break all the barriers in us and to become humble. This in turn makes us work as an instrument of God in the spiritual or social fields of our activities… When this knowledge grows in faith, it becomes wisdom and this is the goal of the simple *Namaste* greeting and therefore it is equally applicable to everybody alike, irrespective of caste, creed, colour, or nationality. (p. 20–21)

Oxhandler also clarifies that the true spirit of *Namaste* understands the sacred to be whatever transcends the self and engenders feelings of respect, devotion, or reverence (Hill et al., 2000). In this way, *Namaste* extends beyond R/S and includes what Agnostics and Atheists consider to be sacred. To honor the R/S of all clients, SCO will need to include a similar understanding of, and respect for, the sacred.

Soul Healing

Dorothy Becvar (1997) described an approach for addressing R/S in *Soul Healing*, a work largely based in an integration of theory, anecdotal personal experience, and secular and spiritual perspectives within and without the mental health professions. Becvar's own R/S beliefs are centered on a view of the sacred as the transcendent dimension of the universe or of a "great spirit" rather than an anthropomorphic God. She sets the tone in the following way: "I believe we all are part of that which is the divine, however we construe it, and I would rather leave room and respect for each person's conception. Indeed, to do so is part of my loving" (p. 37). Becvar conceptualizes R/S intersection in therapy as the Systemic/Spiritual Context in which both clinician's and client's R/S belief systems and experiences interact. What each understands and expresses regarding R/S is a result of the functional interaction between their own beliefs and experiences. Becvar describes these interactions as personal epistemologies that include assumptions about R/S and the role it plays in personal and systemic life, society at large, and in helping settings like therapy.

Becvar (1997) explained that she is always willing to disclose her own R/S "orientation" and how it has evolved, if it seems appropriate in the Systemic/Spiritual Context she creates with her clients. Advising self-awareness, Becvar described a cautious clarification of intent to avoid seeking to change the client's R/S while instead seeking to give permission for R/S conversations if they seem important to the client and useful for achieving therapeutic goals with the client. Becvar also explained the necessity of a desire and intent to respect the client's beliefs and solicit help or additional information when those beliefs are unfamiliar to the therapist. Becvar argues that at its core, soul healing comprises a clinician's awareness of the "transcendent dimension that provides the context for all relationships, all interactions, all that is…Further, each aspect of

the universe is considered to be an expression of the divine, to be infused with spirit, and thus to be sacred" (p. 47). Becvar continues by emphasizing that this awareness of the transcendent and sacred leads the clinician to grasp the greater meaning and purpose of life regarding the growth and development not only of individuals but of the whole world. Citing Sardello (1992), the theory expands to a global orientation: "Soul making, it seems to me, must be world-oriented rather than self-oriented; otherwise cultivation of soul is at the expense of the world. The tremendous force that comes about through the cultivation of the inner life can produce radical changes in the outer world, if it is oriented in that direction always" (p. 48).

Soul Care

Perhaps the most radical route to R/S competence in the present review is Thomas Moore's (1992) *Care of the Soul*, which is, at its core, an effort to spiritualize everyday life by recentering and reorienting life to the sacred. Moore characterizes soul as the intuitive, inner seeking for meaning through love, attachment, intimacy, community and other pursuits of heart. To highlight the difficulty of defining soul as compared to mind or intellect, Moore clarifies that intellect pursues the clear boundaries of a definition and soul prefers imagination. Soul is connected to a person's inner experiences of depth, genuineness, and inner illumination through "good food, satisfying conversations, genuine friends, and experiences that stay in the memory and touch the heart" (p. xi). Though much of Moore's philosophy can be applied to R/S competence and SCO, Moore is intentional about distinguishing soul care from psychotherapy.

> In the modern world we separate religion and psychology, spiritual practice and therapy. There is considerable interest in healing this split, but if it is going be bridged, our very idea of what we are doing in our psychology has to be radically re-imagined. Psychology

> and spirituality need to be seen as one. In my view, this new paradigm suggests the end of psychology as we know it altogether… (p. xv)

From Moore's perspective, psychology and psychotherapy are individualistic, ego-centered, secular, and emphasize science and objectivity; conversely, soul care is systemic and relational, egoless, sacred, and emphasizes meaning and subjectivity. Deepening the distinction, Moore later added: "Just as the mind digests ideas and produces intelligence, the soul feeds on life and digests it, creating wisdom and character out of the fodder of experience" (p. 205). In Moore's view, the split between mind and body—and perhaps the splits between left and right brain, and science and spirituality—can be healed with the cultivation of soul. Moore asserts that, from a soul perspective, art, memory, and love matter more than reason, planning, and understanding. Further, that soul inspires us to feel attachment to people and the world around us, to live from the heart as much as the head, and to have interest in the differences of individuals and cultures whom we encounter.

Moore's (1992) assertion of the sacredness of the everyday is consistent with those of Pargament and Mahoney (2005), who proclaimed that sacredness refers not only to God, higher powers, or transcendent realities but also, essentially, to any object or aspect of life infused with spiritual character. Moore's perspectives offer an insightful journey for counseling professionals to undertake as they explore their own sense of R/S and/or soul. Moore's arguments in favor of deepening one's sense of soul could be part of the solution for bridging the gap between clients' general preference for addressing R/S beliefs in therapy and clinicians' general incompetence for addressing R/S with clients. Moore's conceptualization of soul care as systemic, egoless, subjective, and meaning-focused is consistent with the notions of orientation in the MCO

literature, supporting its definition of the orientation construct as a potential route to R/S competence.

Countertransference and the Relational Paradigm

In *Shared Wisdom: Use of the Self in Pastoral Counseling*, Pamela Cooper-White (2004) outlines and describes an approach for understanding and utilizing countertransference, relational paradigm, and intersubjectivity in pastoral counseling. Much of the supporting literature for this approach comes from classic psychology and psychotherapy and the concepts are easily applicable to other forms of counseling. Cooper-White explains that for the entirety of its existence, countertransference has been conceptualized to some degree as the helpee's unconscious profoundly touching the helper's unconscious. Cooper-White's approach is deeply rooted in constructivist theory, which rejects the notion of an objective reality and embraces that of a co-constructed reality that is created through the interaction of observer and observed, self and other. Although constructivist perspectives are drawn upon in relational paradigm theory, relational analysts generally agree that there is at least a partial basis for a reality of tangible, external events in helpees' lives. Further, relational analysts generally agree "that not every statement is reducible to a purely subjective construction of reality, but that the meaning of such events is multiple, fluid, and continually under revision" (p. 47). Cooper-White asserts the dialectical and hermeneutic nature of therapeutic work in this approach, further clarifying the nature of subjectivity as "one of shared experience of reality in any given moment," forfeiting individual subjectivity in favor of *intersubjectivity* as the primary experience of reality between helper and helpee (p. 47).

In Cooper-White's (2004) approach, constructivist subjectivity is not solitary and it is not a deciphering of external reality but rather a deciphering of meaning.

> A constructivist framework for therapeutic and pastoral work does not imply that original events are being "made up" by helper and helpee. *What is constructed is not the core of experience, but what the experience comes to mean*. The process of meaning-making is not and should not be viewed as moving toward some single, incontrovertible truth or concrete certainty. The "truth" of an experience, when given an open, nonleading, and noninstrusive exploration in a context of mutual, empathic curiosity, will usually become increasingly rich, complex, and multiple over time (p. 52).

Essentially, in Cooper-White's approach, the constructivist intersubjectivity between helper and helpee facilitates a mutual, empathically curious, perhaps even humble, co-construction of meaning related to the sacred. Cooper-White's conceptualization of countertransference is a rejection of the classic, positivist view in which the helper sought to achieve objectivity, prioritizing their own expertise as objective observer, and treating the helpee as the subjective object to be observed. Instead, Cooper-White embraces a model in which helper and helpee are both subjects that observe and are observed, sharing rational and emotional knowledge in a co-constructed space which both occupy "in the 'between' of their shared interaction" (p. 55). Therefore, the helper uses their own *self* as both an outlet of their own inner experience and knowledge and "as an empathic receiver of the other's affective state and the shared meaning that is emerging between them" (p. 56). Perhaps the clearest indication of Cooper-White's approach as a useful consideration in transitioning from R/S competence to SCO is the distinction between the emphasis on control, ownership, and technique in previous approaches and the emphasis on integrity, authenticity, and growth in Cooper-White's approach. The focus in the former very much resembles the positivist, behavioralist focus on competence while the focus in the latter fits in the realm of the constructivist focus of orientation.

Religious Location

Kathleen Greider (2015) theorized the construct of *religious location* as the embodiment of "attitudes and positions toward religion that affect clinical work" and "whether or not we are religious, all persons inhabit a particular location relative to religion" (p. 235). Further, Greider draws attention to our complex cultural identities, including many other aspects of identity (e.g., race, ethnicity, gender, sexuality) that are constantly interacting with our religious locations in dynamic ways. Emphatically asserting that declarations of being or not being religious are not aligned with "self-knowledge sufficient for clinical practice," Greider continues:

> Even if we are not religious—humanist, agnostic, spiritual, atheist—our attitudes and experiences relative to religion constitute a location, a position, that influences our clinical work. In part because religion is a dominant and often volatile aspect of human relations, our religious location merits the deep self-reflexivity we have learned to bring to our social and personal locations (p. 237).

Pointing to the vast diversity of religious locations that clinician and client bring into the counseling relationship, Greider invites consideration of various positions within and toward religious upbringing, religious education, religious communities, marginalization in religious groups, attitudes toward religion and spirituality, and status of religious groups such as indigenous groups and groups that may consider to be a "cult."

Regarding the challenge of client and clinician interacting therapeutically from different religious locations, Greider (2015) suggests that religious difference and disagreement occur in all clinical relationships and religious agreement is not required for clinical success in therapy. To have healthy clinical relationality even amid religious difference or disagreement requires clinicians "to be open to the *possibility* that there is something of value in religious locations

other than our own, even when we disagree vehemently" (p. 238). This challenge is always present for clinicians and it becomes an even greater challenge when clients condemn the clinicians' religious locations or other identities. Greider poses "an intense question for contemplation: What values and practices will cultivate such openness, when we are impelled to judge, withdraw, strike back" (p. 238)?

Greider (2015) proposes self-reflexivity as a primary medium for maintaining the proper openness for examining and responding to religious location in counseling. Due to its controversial and personal nature, much of self-reflexivity occurs in the safety of personal, private reflection. Greider reminds that clinical responsibility requires more than just private reflection. The potential for unconscious defenses (e.g., projection and denial) signifies the need for supplementing private reflection with relationships of accountability, such as those utilized in supervision and consultation. Thus, clinicians are expected to engage in self-reflexivity in these relationships of accountability. Greider suggests the following three domains for engaging in self-reflexivity of religious location: (a) "personal and familial domains," (b) "the historical, sociopolitical, economic, and global terrain in which we are religiously located," and (c) "our appraisal of religious plurality."

Personal and familial domain. Clinicians begin with seeking to understand their personal worldview or philosophy and the beliefs within it. Obviously, this will include an appraisal of personal beliefs about and related to R/S. It will also include consideration of familial aspects of R/S. Greider (2015) suggests utilizing a spiritual genogram because it follows the pattern of family genograms, which are widely used in the field already (Frame, 2000), to unpack the nuances of family history relative to R/S. Creating and discussing a spiritual genogram in counseling, supervision, or consultation settings can provide useful insight into

religious location (Greider, 2015). Two additional tools that can be useful for understanding religious location are spiritual life maps and spiritual histories. Hodge (2003) notes these two tools are designed for use with clients but can easily be modified for use with clinicians to explore personal and familial religious location. Other commonly used tools for self-reflexivity can also be used by clinicians, including prayer, meditation, journaling, expressive arts, and retreats (Greider, 2015).

Historical, sociopolitical, economic, and global terrain. Greider (2015) describes the practice of self-reflexivity in this domain as an investigation of roles "played by people of our religious location in the long record of interactions between groups inhabiting different religious locations. Especially, when and with whom were people of our religious location agents of violence and injustice or targets" (p. 249)? It is also important to understand the losses and gains of economic and sociopolitical power of people or groups in religious locations like our own. Equally important, because "migration globalizes almost all of our interactions," is the consideration of our current location relative to the history and the current situation of R/S worldwide (p. 249). Once again, Greider (2015) points to Hodge's (2003), suggestion to modify client-intended tools for clinician use—namely those of ecograms and spiritual ecomaps—so that they can help chart the aspects of religious location within this domain.

Our appraisal of religious plurality. Greider (2015) poses an important question for self-reflexivity in this domain: "How do you understand the relationship between the many religious and spiritual traditions, with their sometimes conflicting truth claims" (p. 250)? Education in religious and theological studies is necessary for self-reflexivity in this domain. Greider (2015) suggests Knitter's (2008) *Introducing Theologies of Religions*—which examines and charts limits and strengths of "diverse Christian attitudes toward religious plurality" in a

diverse R/S world—as a potential prototype for people from other theological traditions to examine and chart their own limits and strengths of attitudes toward plurality in their own locations. As Greider (2015) affirms, self-reflexive study of works such as Knitter's will support our efforts to avoid adopting "cheap" R/S tolerance that clients tend to easily perceive and find isolating.

Applying MCO Framework to R/S Competence

Some researchers have examined R/S themes with components of the MCO (e.g., Gafford et al., 2019; Owen et al., 2014) or MCO components with supervision (e.g. Hook et al., 2016; Patallo, 2019). As noted by Gutierrez and colleagues (2020), the literature features an abundance of research studies on R/S competence (e.g., Johns, 2017; Lu et al., 2019; Reiner & Dobmeier, 2014) but currently there is a scarcity of research involving R/S competence and orientation or MCO. Gutierrez and colleagues created a supervision model that combined a spiritual application of the *Cultural Third*—which is a supervision approach based on the MCO (see Watkins et al., 2019)—with the ASERVIC spiritual competencies. This model, the Spiritually Competent Orientation (SCO), seeks to define a spiritual orientation in supervision via the MCO framework of the Cultural Third in ways that promote the ASERVIC spiritual competencies. To date, this is the extent of the R/S competence and MCO literature.

The components of the MCO framework have collectively and individually been supported with empirical research (e.g., Hook et al., 2013; Kivlighan et al., 2019; Owen et al., 2014, 2016; Owen et al., 2017) and have individually been investigated with R/S themes (e.g., Gafford et al., 2019; Owen et al., 2014). However, the problems of applying MCC to R/S competence also pertain to the application of MCO to R/S competence. The main problem is the lack of compatibility between culture and R/S in relation to identity. As articulated by Stewart-

Sicking et al., (2019), R/S is different than other components of culture based on the way R/S impacts our uncommon, transcendent experiences as well as our frameworks for meaning-making. Other components of culture like cultural customs and behaviors can be understood from an outside perspective in which we comprehend their relativism and pluralism, but R/S functions differently in that it cannot be understood in the same way because it would unrealistically force us to embrace paradox when we accept R/S beliefs different than our own. Other components of culture also tend to be more centralized and stable pieces of our identity, while R/S always holds the potential for conversion, or a fundamental departure from our previous R/S identity. R/S must be treated distinctly from other components of culture and identity. Therefore, it is crucial to have an approach that is unique to R/S. The history of overlooking or ignoring R/S in MCC/MCO in the profession (e.g., Magaldi-Dopman, 2014; Magaldi-Dopman et al., 2011; Pieterse et al., 2009; Sue & Sue, 2013; Vieten et al., 2013) also suggests R/S needs a separate and unique treatment distinct from MCO.

Religious Intellectual Humility

Over the last two decades, humility as a construct has become increasingly prominent in the literature of the mental health professions. The development and validation of the cultural humility construct has contributed to the paradigm shift from competence to orientation in the multicultural competence literature, as outlined in chapter 1 of the present study. As noted by Hodge and colleagues (2019), research literature about the relationship between humility and religion generally trends in two directions: (a) intellectual humility, and (b) spiritual humility. Intellectual humility (IH) is understood as accurate perception of one's own intellectual strengths and weaknesses, coupled with the ability to negotiate diverse ideas in interpersonally respectful ways (Hook et al., 2015). In a religious context, IH entails acknowledging the limitations of

one's own religious views while being open to others' diverse religious views (Hodge et al., 2019). Notably, IH regarding diverse religious values and beliefs has been associated with religious tolerance (Hook et al., 2017b) and forgiveness of religious conflict (Hook et al., 2015; Zhang et al., 2015). Spiritual humility (SH) involves being humble in relation to God, humanity, nature, cosmos, or whatever the person regards to be Sacred (Davis et al., 2010). Although Davis and colleagues (2010) developed a measure for SH, the research about SH is scarce and less related to R/S competence than IH. Overall, in terms of pursuing R/S competence, IH appears to be more about cognitive ability and respect than a genuine orientation to R/S, though it may fit within the realm of SCO.

Drawing From Spiritually Oriented Psychotherapy

Shafranske and Sperry (2005) provided an overview and insight into *spiritually oriented psychotherapy*, which begins with the consideration that science can offer understanding of observable and physical reality, but offers limited ability for understanding the transcendent, the sacred, and, as William James (1902/1985) described it, the "reality of the unseen" (p. 53). Spiritually oriented psychotherapy attends to the existential and global meanings which science cannot ascertain. According to Shafranske and Sperry (2005), existential meanings are meanings that reflect one's innermost desires, invigorate daily life, and provide purpose and significance to life. Global meanings refer to the central human questions about the meaning of life in general and the meaning of one's own life, which denote one of the fundamental human problems—how to relate to the grand scheme of things (Shafranske & Sperry, 2005; Smith, 2001). Spiritually oriented psychotherapy is intended to support the client's exploration of their own striving for, and commitments in, R/S pursuits through a proper understanding of R/S in therapeutic settings and efforts. Ultimately, spiritually oriented psychotherapists "do not impose the incorporation of

the spiritual dimension within treatment but rather recognize the potential contribution of spirituality within a holistic understanding of the patient's presenting concerns, symptoms, resources, and life narrative and history" (Shafranske & Sperry, 2005, p. 19).

According to Shafranske and Sperry (2005), there are three broad types of clinical situations that require spiritual sensitivity and spiritually oriented psychotherapy: (a) spirituality as a resource in therapy, (b) conservation and transformation of spirituality in therapy, and (c) the spiritual quest in therapy. Spirituality as a resource involves the client's R/S dimension, which forms beliefs and attitudes that engage in the construction and perception of subjective experience (Shafranske, 2001). Conservation and transformation of spirituality entails the client preserving, re-evaluating, or re-creating the foundations of their wellness-supportive R/S dimension after it has been challenged, disrupted, or damaged by a loss of coherent meaning (Shafranske & Sperry, 2005). The spiritual quest is essentially the client's pursuit of meaningful understanding of the self, the universe, and their relationship with God or another Higher Power. Therapy can be an avenue for exploring transcendent realities and/or the sacred, which provide resources for the client to develop a meaningful existence (Shafranske & Sperry, 2005).

Shafranske and Sperry (2005) assert that spiritually oriented psychotherapy builds upon Habermas' (1971) notion of *historical-hermeneutic* science. Contrasting the observation of facts in *empirical-analytical* science, historical-hermeneutic approach in concerned with meanings. Therefore, spiritually oriented psychotherapy requires the clinician to listen to the client to grasp their meanings (Shafranske & Sperry, 2005). With these ideas in mind, Shafranske and Sperry offer this idea at the center of spiritually oriented psychotherapy:

> Spiritually sensitive psychotherapists offer a particular kind of listening, a listening that is receptive to the meanings of psychological difficulties within a broad range and

> transcendent context. [The various approaches to spiritually oriented psychotherapy contained in this volume provide readers] an opportunity to learn how others, with varying theoretical commitments, listen for the full spectrum of meaning and address spirituality in psychotherapy as patients search for significance in ways related to the sacred (p. 25).

In pursuit of an operational definition for SCO, the notion of listening receptiveness to R/S meanings individualized to the client to address the client's R/S needs in therapy appears to be consistent with R/S competence and potentially SCO.

Cultural Identity Development Theory and R/S Competence

Stewart-Sicking and colleagues (2019) proposed applying cultural identity development theory to R/S competence with four R/S identities of increasing R/S competence, much like stage development theories. The four R/S identities are found in both client and clinician and manifest themselves in distinct ways for each. Their framework links components of MCC and MSJCC to the ASERVIC competencies with an emphasis on pluralism. The focus on identity is consistent with the "way of being" asserted in the orientation literature as compared to the focus on practicality and behaviors in the competence literature.

Stewart-Sicking et al. (2019) remind that Sue and Sue (2013) articulated three strengths of an identity development lens through which to explore and enact multicultural counseling. First is the reminder about how much variation there is within groups because part of identity development is the struggle with cultural norms and stereotypes. Second, models of identity development can illuminate best paths for cultivating counseling relationships because cultural interactions in therapy are dependent upon individual identity development and not merely group

membership. Finally, identity development theory continually highlights the impact of political and social forces upon minority identities.

Although there are several theories of cultural identity development (e.g., Atkinson et al., 1979; Cross et al., 1991; Kim, 2012; Phinney, 1989), it is Marcia's (1966) ego identity statuses that are reflected in all of them (Phinney, 1990). According to Marcia (1966), *exploring* and *committing* are the two essential dimensions of identity development, and the two interact to produce four identity statuses: diffusion, foreclosure, moratorium, and achievement. As noted by Stewart-Sicking et al. (2019), successive research has provided validation for the structure of the four statuses, including to spiritual identity (Kiesling et al., 2006) and ethnic identity (Quintana & Mallinckrodt, 2007). However, Quintana and Mallinckrodt (2007) found that identity development may not faithfully follow Marcia's (1966) described sequence. Thus, the statuses are useful classifications and not exactly a developmental theory (Stewart-Sicking et al., 2019).

According to Stewart-Sicking et al. (2019), working toward achieved identity is a sign of multicultural competence for clinicians. They further expound:

> [Clinicians] must recognize dimensions of identity that many take for granted, struggle with their dissonance, and move toward reintegration. Often, this kind of formation is part of the experiences in multicultural counseling courses, and it is understood that it is never really finished. This same logic applies to engaging in competent counseling regarding R/S issues. [Clinicians] need to have the ability to see beyond those ideas we take for granted about R/S and actively struggle to construct an R/S identity—which does not necessarily have to include adherence to any group—that can notice and affirm difference rather than unjustly paper it over (p. 132).

The wrestle with dissonance and movement toward reintegration of identity development, as well as the ability to observe and support difference instead of ignoring, downplaying, or hiding from difference, are all potentially useful considerations or contributions that could fit within an operational definition of SCO. Stewart-Sicking and colleagues (2019) integrated the identity statuses with R/S and the integrated statuses may also provide useful considerations for operationally defining SCO.

Diffused R/S identity. A person in a diffused status lacks a sense of having choice over their identities and lacks attempts or willingness to make commitments (Marcia, 1980). Stewart-Sicking and colleagues (2019) assert that those with a diffused status are unaware of "social forces that have a real impact on one's life and the lives of others" and thus will have limited "ability to understand how those forces are at work in a therapist's or client's life" (p. 133). Due to growing levels of R/S identity disaffiliation, it has become increasingly common for individuals in the Western world to be diffused. Clients with diffused R/S identities are unlikely to see R/S as important and may engage with R/S themes in therapy but are unlikely to see how those themes relate to their identity. Therapists with diffused R/S identities will struggle to connect with clients who value R/S more than their therapists and although they might be able to connect with diffused clients, "they are not culturally competent to work in a pluralistic society" (Stewart-Sicking et al., 2019, p. 134).

Foreclosed R/S identity. Individuals with foreclosed identity conform to the dominant values and opinions of the group(s) to which they belong (Phinney, 1990) and do not challenge the identity others assign to them (Stewart-Sicking et al., 2019). Those with foreclosed R/S identity will have few questions about their identity, choosing instead to focus on passing their identity to their children (Kiesling et al., 2006). In other words, foreclosed identities are content

with maintaining status quo, are uncomfortable with the thought of their traditions dying, and do not seek changes to conformist self-understanding (Stewart-Sicking et al., 2019). Clients with foreclosed R/S identity may be distrustful of secular therapists, wanting assurance that their therapists will meet expectations of the clients' worldviews (Harris et al., 2016). Foreclosed clients with R/S beliefs may seek advice about their therapy from R/S authority figures to ensure their therapy is consistent with their preferred doctrines or theology. Foreclosed atheists may hold "an uncritical opposition to R/S in treatment" (Stewart-Sicking et al., 2019, p. 135). Like foreclosed clients, foreclosed therapists with or without R/S beliefs are likely to seek conformity with their R/S beliefs and avoid therapeutic opportunities or explorations that fall outside the bounds of their orthodoxy (Stewart-Sicking et al., 2019).

R/S Moratorium. According to Marcia (1980), identity moratorium occurs when crisis challenges self-understanding to the point of re-evaluating R/S choices or other R/S options, yet there is still a lack of willingness to make a commitment. The time of moratorium may include moments of discouragement when challenged as well as moments of hope and excitement when searching for answers or responses to the challenge (Stewart-Sicking et al., 2019). Clients in R/S moratorium experience challenge to their conventional or received R/S beliefs, leading them to investigate alternatives (Kiesling et al., 2006) and their own faith (Westerhoff, 2012). Challenge may be provided by crises or other negative experiences or simply by encountering different R/S beliefs or traditions (Stewart-Sicking et al., 2019). Those in moratorium may wish for R/S discussion "but can be led astray by the impulse to try everything or reject everything" (Stewart-Sicking et al., 2019, p. 136). Therapists in moratorium may be excessively affirming of clients exploring beyond their R/S traditions or excessively critical of clients holding onto orthodoxy.

Thus, it is important to be mindfully open to and present with clients rather than simply pursuing all paths the client wishes to try (Stewart-Sicking et al., 2019).

Achieved R/S identity. Once emerging on the other side of crisis, one may have an achieved identity, which forms by affirming solid properties of one's identity while rejecting others (Marcia, 1980). "A mature identity knows how valuable this self-affirmation can be and remembers the struggle of getting there. Therefore, it is not merely saying yes to what one is, but also saying no to those forces that prevent others from making the same journey (Stewart-Sicking et al., 2019, p. 137). Achieved R/S identity features active and intentional choices which may diverge from conventional or given R/S tradition (Kiesling et al., 2006), and it is "actively chosen, not given" (Stewart-Sicking et al., 2019, p. 137). For clients, achieved R/S identity provides a foundation for deriving meaning from life's experiences and seeing R/S identity progress. For therapists, achieved R/S identity means respecting and supporting the client's R/S journey while having sufficient security in one's own identity to allow for others' identities to amiably coexist (Nouwen, 1998; Stewart-Sicking et al., 2019).

Choosing a Path Forward

The literature reviewed up to this point reveals a metaphorical fork in the road toward improving R/S competence in the current R/S counseling and mental health literature. Based on the implications of the orientation literature, the most promising path to spiritual competence in the current literature is through the development of a R/S orientation, or spiritually competent orientation (SCO). Recalling that orientation is a "way of being" with clients rather than simply a "way of doing therapy" (Owen, 2013, p. 25; Davis et al., 2018; Hook et al., 2017a) and that competence is about one's ability to provide therapy (Barber, 2009), a focus on SCO implies a focus on those variables that impact a clinician's way of being. The SCO focus entails creating a

path to competence that travels through the clinician's R/S self in relation to the client's R/S self in a contextual and relational approach. Though none of the literature reviewed as potential paths to SCO have explicitly described SCO, there are common threads that are consistent with the researcher's findings from the literature. These threads were discussed previously, but they include orientation's emphases on constructivism, client-centeredness, and relationship.

Establishing Definitions

If SCO can indeed create positive R/S-related outcomes for clients, it needs to be efficaciously defined so there can be consistent understanding of it across the disciplines who will use it. An operational definition of SCO will provide a conceptual framework that can pave the way for developing a measure of SCO, leading to future research endeavors, including the impact of SCO upon client R/S-related outcomes in clinical settings. Theory is at the root of defining most constructs in the mental health professions and other social sciences. However, unlike the broad, unifying, comprehensive definitions physical scientists pursue, social scientists are more inclined to rely on many theories or models that concern narrowly delineated phenomena (DeVellis, 2017). Defining a construct in the social sciences typically begins with theory, continues with ontology and measurement, and evolves into studies that confirm or challenge understanding of the construct while improving predictions of the construct in practice. For SCO, many supportive or complementary theories already exist in the literature, as demonstrated in the present literature review. What is needed next is ontological clarity, beginning with a clear definition of SCO that can lead to the development of a measure for SCO and improvements for understanding the SCO construct in practice. In a summary of a workshop on metrics in social sciences at the National Research Council (2011), Norman Bradburn noted the distinction between more traditional, scientific constructs and "Ballungen" constructs—

examples of the former include age and weight, while examples of the latter feature imprecise boundaries such as those in personal happiness and cultural beliefs. Ballungen constructs feature a loose set of criteria which are used for categorizing based on what Wittgenstein referred to as "family resemblance," or similarities that sensibly group them into the construct. The literature implies SCO is a Ballungen construct, which means that, rather than "explicit definition (e.g., formulas, such as income = consumption + savings)," it is likely to be defined "by implicit definition (e.g., from scientific uses or attempting axiomatic definitions), or by operational definition (e.g., IQ)" (p. 54). If SCO were to resemble MCO, it would be sensible to seek an axiomatic definition based on MCO. However, given the unique considerations of R/S compared to other multicultural considerations, there is a lack of support for seeking axiomatic definition. Therefore, seeking an operational definition is perhaps the only logical approach for defining SCO.

Operational Definitions

Operationalism began with the physicist Bridgman (1927/1953), who recognized the profound change Einstein's theory of relativity brought upon the logic under which the concepts of physics were devised. Bridgman claimed Einstein changed "the criteria on which concepts were based by showing that the meaning of a concept was relative to the physical operations of the observer in determining its values and conditions of occurrence" (Ribes-Iñesta, 2003, p. 112). In a summary of the context and relevance of Bridgman's view of operational analysis, Houts (1994) expounds:

> The major shift of thinking that Bridgman perceived and attempted to illustrate…was a shift from taking concepts to refer to properties of objects to taking concepts to refer to activities of the physicist. In this sense, concepts such as length and velocity were

> achievements of humans acting on the world rather than signifiers of properties of the world. Concepts were therefore never fixed, but were instead subject to constant change as a function of new experimental and measurement procedures… Bridgman rejected the idea that the domains of logic and mathematics held some a priori truth criteria apart from their practical utility as rules for guiding action with respect to physical operations… Each of these basic tenets of operations analysis were on Bridgman's view themselves reflexively subject to revision and change through further operational analysis. In other words, operational analysis was itself a relativistic enterprise constrained by the limits of human activity in relationship to the physical world. (pp. 111–112)

Bridgman (1927/1953) asserted concepts to be equivalent to their "corresponding set(s) of operations" (p. 36), whether the concept is physical or mental/linguistic. He also asserted concepts to be inexorably linked to human experience, making them synonymous with the practices or experiences in which they are applied. According to Stevens (1935)—one of the original proponents of operationalism/operationism and operational definitions—an operational definition should incorporate observable outcomes of the operation being defined. Stevens (1951) also theorized that definitions should prescribe the interaction between concepts and processes related to objects and their observed outcomes (Ribes-Iñesta, 2003).

There are stark differences between the conceptions of Bridgman and Stevens. Bridgman saw concepts as ambiguous or accurate rather than true or false. As opposed to criteria or rules for definitions (or even definitions at all, in the traditional sense), Bridgman referred to the operations (i.e., physical or verbal actions) that occur when a concept is in use, holding operational analysis to be *a posteriori* and descriptive. Divergently, Stevens saw operational

definitions as criteria to determine a concept's validity and function "to the extent that it was correlated with a set of procedures and outcomes conceived as operations" (Ribes-Iñesta, 2003, p. 115). From Stevens' (1935) perspective, operational definitions should include denoting and an observed outcome in the form of *discrimination*, which Stevens perceived to be the *sine qua non* of all operations and the "fundamental operation of all science" (p. 324). For Bridgman (1927/1953), operational analysis was a matter of pragmatics, or the ways in which words are used in the contexts of research practice and theory. Stevens, however, held operational analysis to be related to the denotation of events and objects, using definitions for the criteria of semantic relationship between objects and words (Ribes-Iñesta, 2003). Essentially, Bridgman understood operational analysis in terms of pragmatics, and Stevens understood operationism in terms of semantics.

Chronologically, B. F. Skinner and his take on operationism came after Bridgman and Stevens, and it was Stevens who initially influenced Skinner's ideas about the validity and meaning of scientific concepts (Ribes-Iñesta, 2003). Skinner (1945/1961) associated operationism with Stevens' assertions regarding the truth value of propositions, yet, according to Ribes-Iñesta (2003), Skinner misinterpreted to an extent: "From Stevens' suggestion that terms that could not be reduced to concrete operations were not meaningful to science, it was incorrect to conclude that the phenomena or events referred by such terms were nonexistent and, hence, could never be studied by science" (p. 118). Flanagan (1980) argued that Skinner's opinions about behaviorism (his theoretical focus and expertise in the field) were metaphysically or ontologically driven rather than methodologically driven. In other words, that Skinner was largely driven by propositions "about *what there is* and the *way it is*, and not by any theses about the way psychologists should use their language…" (p. 2). Skinner's perspective aligned more

closely with Stevens' semantic, ontological focus, which is also consistent with the conception of operational definitions for Ballungen constructs (such as SCO).

Operationalizing Multicultural Constructs in Counseling

As Ridley et al. (2021) pointed out, the need for operational definitions in counseling, and particularly in multicultural counseling competence and its related multicultural constructs, has a lengthy history (Beagan, 2018; Constantine & Ladany, 2001; Helms, 1994b; Huey et al., 2014; Johnson, 1990). Regarding the broad construct of multicultural competence, DeAngelis (2015) noted the abundant speculation about the construct among psychologists, who frequently debate its fundamental components. Ridley and colleagues (2021) emphasized that while "imprecise language may characterize the early stages of construct development, prolonged linguistic inattention is unacceptable" and that limitations of imprecise language are not exclusive to multiculturalism (p. 505). Deficient operationalizations and definitions have stalled the evolution of other constructs in mental health professions (e.g., Hill et al., 2017). Deficient operationalization of constructs is likely a pattern in the mental health professions because, as Shanteau (1992) and Tracey et al. (2014) have argued, expertise is easier to identify and develop with constructs or practices that have more availability of feedback and greater predictability of outcomes (e.g., information technology). Constructs and practices in the mental health professions tend to have less available feedback and less predictability, thus there may be an inherent limitation in seeking to operationalize multiculturalism constructs, given their particular lack of normalized performance outcomes and lack of predictability. Nevertheless, the Delphi method has been successfully applied to competency-related research in mental health professions (e.g., Clark, 2019; Swank & Houseknecht, 2019; Wester & Borders, 2014), offering

evidence that it may adequately serve to explore R/S competence and/or SCO in ways that support operationalization.

Delphi Studies to Establish Definitions

In their report for a decennial Delphi poll, Norcross and colleagues (2021) emphasized that Delphi has become an established, robust research method in health sciences (e.g., Blease et al., 2020; Donohue, 2012; Sündermann et al., 2019) and in psychological sciences (e.g., Bedi & Duff, 2014; James & Roberts, 2009; Taylor et al., 2019). In recent years, the Delphi method has been successfully used to establish operational definitions in medicine and health science (e.g., Rodríguez-Mañas et al., 2013; Vogel et al., 2019; Yoon et al., 2021) as well as psychology and counseling (e.g., Kraines et al., 2020; Underwood, 2020; Wallis et al., 2009). Delphi studies recently have been used in counseling research to establish competencies for various techniques and approaches to therapy (e.g., Clark, 2019; Turner et al., 2020; Underwood, 2020). Clearly, there is precedent for utilizing Delphi to pursue consensus for an operational definition of a counseling competency-related construct such as SCO.

Purpose of the Study

Based on the findings, suggestions, and implications of the literature in the present review, the researcher sought to establish an operational definition for SCO based on the consensus of R/S subject experts. The experts in the present study comprised an expert panel and were invited to respond to proposed definitions derived from relevant literature and open, qualitative questions to gather input for a definition. Once qualitative feedback was gathered and analyzed, the author created a survey based on the analysis of the feedback. The survey was sent to each member of the panel and then the results of the survey were quantitatively analyzed to

determine whether there was sufficient agreement among panelists to reach consensus for an operational definition of SCO.

CHAPTER 3: RESEARCH METHODOLOGY

This chapter contains descriptions and explanations for the methods that were used in the study. This chapter includes descriptions of the purpose and design of the study, the research questions, hypotheses, participants and sampling methods, data collection methods, instrument development procedures, data analysis, and the limitations of the methodology.

Orientation to Research Design

Spiritually competent orientation (SCO) is a novel concept and not yet established in the research literature as an operationally defined construct. Nevertheless, the paradigm shifts and new direction of the multicultural competence, multicultural orientation, and spiritual competence literature indicated it was a construct worth exploring and attempting to define operationally. Therefore, it had become pertinent to seek an operational definition for SCO. This study sought an operational definition of SCO, which would open the way for further research and clinical applications in the future. To establish a fitting definition for the construct, the author chose a Delphi study with a mixed methods design. The specific type of mixed methods design is exploratory sequential design.

Mixed Methods Design

Mixed methods or multimethod design is often used in health science research to expand comprehension of specific topics by hearing participant voices and stories (Guetterman et al., 2015). The rationale for using a mixture of qualitative and quantitative data is derived from the recognition that neither qualitative nor quantitative methods alone are adequate for capturing the details and trends of a phenomenon (Clark, 2019; Ivankova et al., 2006). The researcher gathered qualitative input about the nature of SCO from a panel of experts. The qualitative data was used

to construct a survey for rating items to decide which items should be included in, or excluded from, the operational definition of SCO. The current study was qualitatively driven, meaning the qualitative portion drove the foundation of the study (Mason, 2006) to "cast a wider net" in search of a more complete understanding of the topic from various and, perhaps differing, perspectives (Hesse-Biber et al., 2016, p. 8).

Exploratory Sequential Design

As indicated in the name, exploratory sequential design seeks to explore a topic in sequences. The researcher first obtained and analyzed qualitative data to establish themes, then the themes informed the creation of a quantitative survey for further exploring the research problem or question (Creswell & Plano Clark, 2007). The sequence included two stages of data analyses: the first qualitative stage for thematic and content analysis, and then a quantitative stage for statistical analysis (Creswell & Plano Clark, 2007). A considerable challenge of the exploratory sequential design is the potential for a significant time commitment from participants (Creswell & Plano Clark, 2007). However, Creswell and Plano Clark (2007) note the Delphi method compensates for the issue of time commitment because data can be gathered remotely at the participants' convenience. Remote data gathering may also reduce the time commitment for the researcher who is not compelled to gather data through individual meetings or interviews.

Brief History of the Delphi Method

Named for the famous oracle of Delphi, the Delphi method was first developed by researchers of the RAND Corporation in the 1950s and 60s as a technique for technological forecasting (Hasson et al., 2000). Its purpose was to gather expert opinions or "informed judgment" on the potential future for certain fields of study, or to examine long term trends. Essentially, it is a method for assembling and analyzing the suppositions of several experts of a

particular topic to advance toward knowledge of that topic (Dawson & Brucker, 2001). Ziglio (1996) asserted the Delphi method to be the pursuit of organizing and detailing some information (of which there is evidence but not yet knowledge) to reach informed decision-making and judgments. Since its inception, the Delphi method has become a widely used method for spawning novel ideas and knowledge about complex problems and questions in social and educational research (Landeta, 2006; Rowe & Wright, 2011). It has also been successfully applied to counseling research in various ways, including competency-related research (e.g., Clark, 2019; Swank & Houseknecht, 2019; Wester & Borders, 2014).

Notably, the founders of the Delphi method understood truth to be relative, clarifying that the method does not seek to procure truth (Stone Fish & Busby, 1996). In a discourse of the philosophical foundations of truth in Delphi methodology, Scheele (1975) reaffirmed the necessity of researchers assuming relative "truth" when using the Delphi method, recognizing that results change over time as reality is constantly renegotiated (Dawson & Brucker, 2001). Despite being used by numerous researchers in numerous fields of study, there is still some confusion about the components of the Delphi method (Dawson & Brucker, 2001). Turoff and Hiltz (1996) asserted that the Delphi method is not meant to provide quick solutions, quantify judgment in group settings, decrease the need for lengthy discussion, or predict the future. They clarified:

> The Delphi method is a communication structure aimed at producing detailed critical examination and discussion, not at forcing a quick compromise. Certainly, quantification is a property of the method, but only insofar as it serves the goal of quickly identifying agreement and disagreement in order to focus attention on significant issues (pp. 56–57).

Advantages of Delphi

The Delphi method has several advantages that justify its use. As a well-recognized method for building consensus (Hsu & Sandford, 2007), the Delphi method integrates the best of current scientific evidence with collective expert wisdom (Murphy et al., 1998) and allows experts to provide anecdotal perspective and personal experience in ways that enable effective decision making for clinical practice (Balasubramanian & Agarwal, 2013). Additionally, the Delphi method can be used in circumstances with limited or incomplete evidence (Hasson et al., 2000) and facilitates anonymous or confidential—and therefore, less biased—input from study participants (Weise et al., 2016). Rotondi and Gustafson (1996) have identified several more advantages for using the Delphi method, as summarized by Akins and colleagues (2005): (a) time and cost effectiveness; (b) the ability to address broad and complex problems that are not so easily addressed with many other methods; (c) the ability to facilitate communication between experts who may not have a history of discussing the topic of their expertise; (d) participants may respond at their own convenience while taking the time they need to brainstorm and produce ideas; (e) the process produces a record of participants' thoughts and ideas for future review if needed; (f) the preservation of confidentiality allows participants more freedom to convey their positions and ideas; (g) the method has an established history of effective application for various fields, situations, and problems.

Limitations of Delphi

Several limitations of the Delphi method have been identified in the literature. Among those limitations is the risk of bias among participants if they have poor knowledge and/or skills in the subject area of the study. The likelihood of bias increases if the researcher uses an existing or known network of experts, if the dropout rate through the rounds of the study is high, or if the

response rate is low (Weise et al., 2016). Additional risks are incurred if the time requirement for participation is too lengthy, if there is not a predetermined definition of consensus, and if the researcher and/or other participants have potential for influencing the opinions of others involved in the study process (Balasubramanian & Agarwal, 2013; Frewer et al., 2011; Hsu et al., 2007; Rowe & Wright, 2011; Weise et al., 2016). Weise and colleagues (2016) identified more potential limitations from the literature review for an Online Modified Delphi Method study they conducted. First, high levels of agreement among the expert panel in the first round may challenge the utility of quantitative measures for investigating the convergence of group consensus through successive rounds of the study. Additionally, complete participant anonymity may reduce bias in participant responses as compared to quasi-anonymity, but complete anonymity also creates challenges for collecting sample characteristics. Finally, it is important for researchers to clearly delineate the intent of the Delphi survey and how the results will inform practice, such as clinical training or future research.

If the researcher did not adequately address the potential limitations and risks of the methods, the validity and utility of the findings might be threatened. Thus, the researcher addressed as many of the potential limitations and risks as possible, beginning with recruiting participants with expertise in R/S integration in mental health services. To address the possibility of recruiting through an established network of experts, the researcher recruited participants from multiple mental health professions with the expectation that a larger and more professionally diverse pool of participants would reduce the chances of bias through an established network. Addressing high dropout or low participation rates was more challenging since many factors—including some that cannot be controlled—typically contribute to those rates. However, some factors that limit participation or increase dropout cannot be controlled, such as the length of

time required for participation. The researcher kept the Delphi survey relatively short and incentivized participation by offering gift cards to each participant for each round of the study they completed.

One possibly unavoidable limitation is the lack of a predetermined consensus definition since the SCO construct is new and almost non-existent in the literature. However, the researcher briefly reviewed the potential definitions or components of the construct from the literature as a starting point for the survey. Participants were encouraged to express their level of agreement with proposed survey items with a 5-point Likert-type scale (1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, 5 = strongly agree). This type of scale has been successfully utilized in previous studies for defining professional competencies (Barry et al., 2012; Bzowyckyj & Janke, 2013) and it offers a neutral option for those who are undecided about certain survey items (Weise et al., 2016). Furthermore, participants will be encouraged to provide qualitative input to comment on the proposed ideas, recommend changes to the ideas, and identify additional ideas not currently under consideration in the survey. Another unavoidable limitation is the lack of a team for the current study, which is recommended for improving the quality of qualitative data analysis (Hays & Singh, 2012; Miles & Huberman, 1994). Naturally, a dissertation study is a solo project and does not allow for a team. Nevertheless, the researcher attempted to follow all other recommendations for grounded theory data analysis.

Types of Delphi Methods and Their Characteristics

According to Keeney and colleagues (2011), there are at least ten prominent types of Delphi methods in the Delphi research literature. *Classical Delphi* features an open, qualitative first round for eliciting ideas and opinion as well as gathering consensus through three or more rounds, either through postal mail or email. *Modified Delphi* typically replaces the open first

round with a focus group or live interviews and could use less than three rounds. *Decision Delphi* usually follows the Classical process but seeks decision rather than consensus. *Policy Delphi* pursues consensus on future policy for a particular topic. *Real Time Delphi* is like Classical except the experts may gather in the same room and consensus is sought in real time. *e-Delphi* is a Classical format conducted via online survey or email. *Technological Delphi* is like Real Time but with technology rather than in person and the technology often provides real time statistics for immediate feedback. *Online Delphi* resembles Classical but questionnaires are completed and submitted online. *Argument Delphi* is a non-consensus type derived from Policy Delphi and it focuses on producing factual arguments relevant to the topic. The last type, *Dissaggregative Delphi*, uses cluster analysis and forms various scenarios of the future for non-consensus-seeking discussion.

Hybrid Type: Online Modified Delphi Method (e-Delphi)

Based on findings from a review of Delphi method literature, the researcher decided to proceed with an Online Modified Delphi Method (ODM), or Modified e-Delphi, that utilizes both quantitative and qualitative inquiry. ODM is a hybrid of Modified and Online Delphi (or *e-Delphi*) types, integrating the potential for a classic approach of fewer than three rounds with the functional capability of gathering consensus online. Fundamentally, ODM is a process for group communication that allows a panel of experts to build consensus on a specific area of study (Hsu & Sandford, 2007; Johnson et al., 2021). Within the ODM process, the researcher gathered feedback from the expert panel in two rounds of qualitative questions and survey items. In the first round, the researcher sent to each participant a list of definitions related to the construct based on available literature and open-ended questions to gather feedback about the construct. To begin the second round and any further rounds, researchers typically send to each participant “a

statement of the position of the whole group and the participants' own position" (Ludwig, 1994, p. 55). Should the study have extended beyond the two planned rounds, the researcher would have invited participants to provide ratings and feedback on the proposed items that were derived from the questions in the first round and the feedback compiled from previous rounds.

The researcher chose ODM for this study for several reasons: (a) its success in studies with various sample sizes (e.g., Johnson et al., 2021; Weise et al., 2016); (b) it has been demonstrated that using both quantitative and qualitative questions tends to improve the rigor of the study (Hasson & Keeney, 2011; Weise et al., 2016); (c) contrasting other methods of gathering and analyzing data, Delphi employs multiple iterations (i.e., the feedback process; Ludwig, 1994) or rounds of gathering to build consensus (Hsu & Sandford, 2007); (d) the feedback process is controlled (Hsu & Sandford, 2007); (e) it can alleviate many limitations of traditional methods for pooling opinions (e.g., pressure of group/social conformity, noise, dominant influences) (Dalkey, 1972); (f) the process of gathering, synthesizing, and disseminating feedback to the panel allows participants to become aware of the range of opinions and then reassess their own (Ludwig, 1994), which will likely improve and refine the group consensus over the course of the study; (g) there are a variety of statistical analysis techniques for interpreting the data (Dalkey, 1972; Douglas, 1983; Ludlow, 1975), which further reduces the influence of group/social conformity and enables a more impartial summarization of the collected data (Dalkey, 1972; Hsu & Sandford, 2007); (h) it provides a way for geographically scattered experts to combine their expertise (Gill et al., 2013); (i) analyzing data can be accelerated and assisted by importing data into a data management system (Toronto, 2017); (j) confidential participation encourages honest expression of opinions (Asselin & Harper, 2014);

and (k) modern Internet innovation has encouraged ODM applications that maximize its advantages and alleviate its limitations (Donohue, 2012).

Research Questions and Hypotheses

The main goal of the present study was to establish an operational definition for spiritually competent orientation (SCO). Therefore, the central question was: operationally, what is SCO? Defining SCO includes differentiating SCO from MCO and R/S competence, which implies the necessity of also differentiating orientation from competence. Operationally defining SCO also entails understanding its components such that it can be measured. Based on this main goal and central question to determine an operational definition for SCO, the researcher developed the following research questions:

1. How do experts of religious/spiritual (R/S) integration in mental health services define a spiritually competent orientation (SCO) in counseling through its components (i.e., domains, themes, and items)?
2. Do experts of R/S integration in mental health services believe SCO has different components than multicultural orientation (MCO)?
3. Will there be sufficient agreement among experts of R/S integration in mental health services about SCO items, such that there are items that may form the basis for developing a measure of SCO?

The researcher hypothesized:

1. The input of experts of religious/spiritual (R/S) integration in mental health services will contribute to an operational definition of SCO and these experts will identify relevant domains and themes that may form the SCO.

2. Experts of R/S integration in mental health services believe SCO has different components than MCO.
3. There will be sufficient agreement ($Mdn \geq 4.0$, IQR ≤ 1.0) among experts of religious/spiritual (R/S) integration in mental health services about SCO items, such that the items form the basis for developing a measure of SCO.

Participant Recruitment, Retention, and Panel Size

Consistent with the literature that emphasizes the need for high content knowledge among participants (Balasubramanian & Agarwal, 2013; Powell, 2003), this study included a panel with expert knowledge. The expert knowledge contributed to building consensus (Hsu & Sanford, 2007) about the construct of SCO through the collection and analysis of the opinions, experiences, and wisdom of SCO experts. However, given the novelty of the SCO construct and its similarities to the constructs of religious/spiritual (R/S) competence and multicultural orientation (MCO), there was a relatively small number of experts who had enough expertise to contribute to the study. A few definitions for *expert* have been identified in the literature. These definitions include being identified as a specialist in their field of study (Goodman, 1987), or being particularly informed (McKenna, 1994) or possessing knowledge about a specific topic (Davidson et al., 1997; Green et al., 1999; Lemmer, 1998). The researcher identified experts in R/S competence and MCO by examining the literature for each construct, prioritizing those acknowledged by the researcher's advisory committee to be experts in R/S counseling or mental health services. Each member of the researcher's advisory committee is a recognized or renowned R/S expert in a mental health services field, possessing a doctoral degree in counselor education, counseling psychology, social work, or a related field, and having many years of experience in R/S clinical work and scholarship. Murphy and colleagues (1998) suggested

heterogeneity in the expert panel, while Akins and colleagues (2005) suggested finding experts with similar training in case of a small sample size. Consistent with these suggestions, experts were recruited from multiple mental health professional groups trained in counseling theory and practice, including counseling, marriage and family therapy, psychology, and social work. Experts for the panel were recruited exclusively in the U.S. to decrease the complications of mismatches between participation criteria and potential participant qualifications, which can differ greatly according to participants' country of residence and licensure or certification for practice. Each participant possessed a doctoral degree in their profession and had significant experience in scholarship, clinical practice, and R/S integration into their practice.

The current literature lacks agreement on acceptability or sufficiency (i.e., stability of expert panel responses; Akins et al., 2005) of sample size for a Delphi panel as well as what constitutes a "large" or "small" size (Akins et al., 2005; Fischer, 1978; Wilhelm, 2001; Williams & Webb, 1994). Akins and colleagues noted there is also "no criteria against which a sample size choice could be judged" (p. 38). They point to Reid (1988) who once found that up to that point in time, Delphi panel sizes in the healthcare research literature ranged from 10 to 1685. Further, they found that the sample size for Delphi studies has been specific to the situation and the researcher(s) involved as they have typically used convenience samples dependent upon the experts and resources available to them. Generally, the size and heterogeneity of the panel depends on the purpose and design of the project as well as the time frame for collecting and analyzing data (Goodman, 1987; Green et al., 1999; McKenna, 1994). With increasing frequency, Delphi researchers are using inclusion criteria to create appropriate boundaries around their expert panel (Keeney et al., 2001, 2006, 2011). These criteria typically include specific qualifications such as professional membership or licensure, number of publications in the topic

of interest, or years of experience in the topic of interest (Keeney et al., 2011). The researcher created a list of potential participants who were invited to participate in the study if they met the following inclusion criteria: a) academic degree, professional licensure/certification, or professional membership/affiliation of a religious or spiritual nature (e.g., Master of Divinity degree, Spiritual Counseling Certification, member of the Association for Spiritual, Ethical, and Religious Values in Counseling); b) at least two national or international refereed scholarly publications (e.g., journal article, book chapter, or edited book) in R/S, or at least two years of clinical, research, or other professional experience with R/S in their professional roles.

Akins and colleagues (2005) performed a study of a Delphi survey conducted with a panel of 23 experts in which the research team used bootstrap sampling to gather results for comparison of response characteristics between two larger, computer-generated samples. There were two significant findings related to Delphi sample size in their study. First, that experts with similar training and understanding in the field of interest allow for efficacy and reliability with "a small sample from a limited number of experts in the field of study" (p. 47). Second, in the case of limited availability of experts, "consistency of expert training may allow utilization of small numbers of experts in fields where many experts may be available but participation of a limited number of experts on the Delphi panel may be more practical" (p. 48). In other words, a small sample size is not likely to have a strong effect on the outcome of a Delphi study if the experts have similar training.

In a recent systematic analysis of qualitative health research over 15 years, Vasileiou and colleagues (2018) analyzed patterns of characterizations for sample sizes and found that researchers often characterized their sample sizes as 'small' despite claiming to reach data saturation. In the cases of those noting a small sample size despite satisfying their qualitative

criterion for sample size, there were implied assumptions that the audience or reader would adopt a quantitative perspective through which small sample sizes are often automatically viewed as problematic. Given the qualitative nature of the first round, more specifically, the need for collecting and analyzing qualitative data to inform the successive round(s), the researcher sought guidance from the literature for justification of sample size needed for qualitative content analysis. According to Vasileiou and colleagues (2018), data saturation is the most common method for justifying sample size when gathering and analyzing qualitative data. Data saturation also has a history of successfully justifying sample size (Vasileiou et al., 2018). Researchers have recommended that 12 is the minimum sample size required for reaching data saturation (Braun & Clarke, 2013; Fugard & Potts, 2014; Guest et al., 2006). Other researchers have indicated a Delphi panel of 11-30 members has been demonstrated to be effective and reliable (Akins et al., 2005; Dalkey, 1972; Woodcock et al., 2020). As noted by Keeney et al., (2011), some researchers (Brooks, 1979; Clayton, 1997; Delbecq et al., 1975; Fink et al., 1984) have warned that panel sizes beyond 30 have rarely been found to improve study results, as large panels are difficult to manage and often lead to high rates of attrition (De Villiers et al., 2005). Therefore, the researcher sought a panel of 12-30 members.

Data Collection and Participant Profile

The researcher recruited participants via individual emails (see Appendices A and B for emails sent to potential participants). In the first round of this study, the researcher distributed a definition of SCO and a questionnaire with demographic questions and open-ended questions created from a thorough review of the R/S competence and MCO literature. The definition and questionnaire were distributed individually to identified experts in the fields of R/S integration in mental health services. The identified experts were given two weeks to complete the

questionnaire with a reminder after one week, if necessary. The two-week timeframe was selected because of evidence that it has been the most successful timeframe (Delbecq et al., 1975; Hsu et al., 2007; Weise et al., 2016). The questionnaire was designed to gather opinions about the information in the SCO literature to synthesize and distribute it to the expert panelists for their review and feedback. A successful first round would reveal preliminary areas of agreement and disagreement regarding SCO and allow the researcher to perform a content analysis of responses to qualitative questions. A content analysis is the process most often used to analyze data from the first round (Fletcher-Johnston et al., 2011; Powell, 2003; Wester & Borders, 2014) and it is used for analyzing and coding text data into themes and categories (Krippendorff, 2013). The researcher coded the data from the qualitative responses to analyze for themes and recommendations for creating survey items for the second round. After the first round, the researcher analyzed the results and applied them to the creation of a survey for the second round. In the second round of the study, the researcher sent the themes, categories, and survey items derived from data of the first round to each expert panelist who participated in the first round. Each panelist was invited to respond to the revised survey items and provide further qualitative input if needed to ensure the quality and clarity of the items. Any panelist with survey item ratings outside a clear consensus would be asked to either revise their judgments or provide explanations for remaining outside the consensus (Hsu & Sandford, 2007).

The researcher initially invited participants to complete the Delphi survey via email with a message that contained (a) a description of the study's purpose, (b) criteria for inclusion in the study, (c) the researcher's contact information, and (d) a link to the questionnaire. The researcher protected the confidentiality of participants' responses to encourage deeper and more authentic expression of ideas and opinions and to limit bias from potentially pre-existing relationships

among participants. Participant profile information is included in the procedures and results section of this manuscript.

Delphi Questionnaire and Survey Development

The questionnaire for the first round began with a compilation of definitions found in scholarly articles for competence, MCC, R/S competence, orientation, MCO, and SCO. The definitions are as follows:

1. Epstein and Hundert (2002) proposed the following definition of *competence* for health professions: "The habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served; [it relies on] habits of mind, including attentiveness, critical curiosity, awareness, and presence" (p. 227).

2. Owen and colleagues (2011b) describe *multicultural competence (MCC)* as "ways of doing" in which the clinician "engages in and implements…multicultural awareness and knowledge" in clinical practice (p. 274-275). Sue and colleagues (1982) define MCC as a continuous process of deepening our understanding of cultural diversity, recognizing our own cultural limitations, and seeking improvement over time with cultural (a) attitudes/beliefs, (b) knowledge, and (c) skills.

3. According to Cashwell and Watts (2010*), religious/spiritual competence* is awareness, knowledge, and skills in the R/S domain that "would support counselors in serving clients from various religious and spiritual traditions" (p. 2). Stewart-Sicking et al. (2019) clarify

that R/S competence is distinct from multicultural competence because the latter emphasizes everyday experience and central features of identity while the former addresses ultimacy, transcendence, and the potential for conversion or "radical departure" from former identity (p. 131).

4. *Orientation* is defined as the philosophy, inclinations, values, and therapist factors through which competence is conveyed in therapy (Owen et al., 2011b). Whereas competence can be characterized as "a way of doing therapy," orientation can be understood as the therapist's "way of being" with clients (Owen, 2013, p. 25; Davis et al., 2018; Hook et al., 2017a).

5. The *multicultural orientation (MCO)* approach is a "way of being" with clients or patients in clinical practice, "guided primarily by (clinicians') philosophy or values about the salience of cultural factors…in the lives of (clinicians) as well as clients" or patients (Owen et al., 2011b, p. 274). MCO is defined and measured by three primary components: cultural humility (Hook et al., 2013; Tervalon & Murray-Garcia, 1998), cultural comfort (Owen et al., 2017), and cultural (missed) opportunities (Owen et al., 2016).

6. The author of the current study proposed the following preliminary conceptual definition of *spiritually competent orientation (SCO)* as a starting point for developing an operational definition for SCO: the clinician's philosophies and values that influence their interests in, and inclinations toward, religious/spiritual competence for themselves

> and their clients or patients. SCO must be distinct from MCO in ways that resemble the differences between multicultural competence and R/S competence, as noted by Stewart-Sicking et al. (2019): R/S experiences cannot be relativized in the same way as other multicultural experiences because the pluralism encountered in R/S forces the acceptance of paradox. For example, "I can accept rather easily that eye contact is seen as disrespectful in another culture; if I were a committed atheist and want to affirm that my client experiences the truth and not delusion through Islam, I would have to come to terms with a paradox" (p. 130). Further, R/S is different from other components of culture in that it moves beyond "everyday categories" of culture such as "gestures, conversational norms, or collectivism" and "points…toward ultimacy" (p. 130).

Following the definitions, there were open-ended questions with space for expert panelists to expound their opinions and ideas. The questions included the following: "How is orientation different than competence?" "What makes one oriented to R/S competence?" "What does/might a spiritually competent orientation (SCO) look like in practice?" "What mistakes do counselors or therapists commonly make around R/S issues in practice?" "How does/might a SCO address common counselor/therapist mistakes around R/S issues?" "What does/might it look like when a counselor or therapist is operating at high levels of SCO?" After the expert panelists completed and returned the questionnaire, the researcher analyzed the data and used the results of the analysis to create a quantitative survey for identifying potential components of SCO.

Statistical Analysis

To understand and solidify the potential SCO construct, consensus for that construct had to be built. The data gathered from this study informed the creation and revision of items that

represent expert consensus. These items either became included in, or excluded from, the SCO construct. Items included in the SCO construct are considered the factors of the construct that can be investigated for a future measure of SCO. Both qualitative feedback and quantitative survey item ratings informed the creation and revision of items, so both types of data needed to be analyzed in this study. The qualitative data was analyzed and used for creating survey items that were proposed to the expert panelists for consideration as part of defining the SCO construct. Qualitative data was also summarized for the expert panelists. The survey items were rated quantitatively and the quantitative data from the ratings was used to revise the items for future investigation. Items that did not meet the predetermined threshold percentage were excluded from the revised survey and therefore were rejected from consideration as factors of the SCO construct.

Qualitative

The first round of the study included open-ended questions to gather input and feedback about the SCO construct. The qualitative questionnaire was provided to expert panelists via the Qualtrics TM platform. The qualitative data gathered from these questions underwent content and thematic analyses, which are most often used in the first stage of Delphi studies (Fletcher-Johnston et al., 2011; Powell, 2003). Based in grounded theory qualitative analysis, the researcher used thematic coding to code the data. After the qualitative data was coded, it was analyzed for domains and themes that potentially crossed over the domains. The identified domains and themes provided insight into the potential factors of the SCO construct, facilitating the creation of survey items that were rated by the expert panelists. Panelists also provided additional qualitative feedback which was further analyzed and used to refine some of the survey items and support the exclusion of others that did not meet the threshold of group consensus.

Quantitative

Expert panelists completed the quantitative survey via the Qualtrics TM platform. Quantitative responses were then exported from Qualtrics to Statistical Product and Service Solutions (SPSS) for analysis. Measures of central tendency (median, mean, and mode) and level of dispersion (standard deviation) are the primary statistics for representing the consensus of the expert panelists in Delphi studies (Hasson et al., 2000; Hsu & Sandford, 2007). Although mean can be acceptable in some cases (Murray & Jarmon, 1987), median and mode are the preferred measures for Delphi studies (Hsu & Sandford, 2007). Based on Delphi survey literature, the researcher performed descriptive analyses to determine the percentage of agreement/disagreement among the expert panelists. The median score is a measure of central tendency and is recommended for the Delphi method and for Likert-type scales in general (Eckman, 1983; Hill & Fowles; 1975; Jacobs, 1996; Jamieson, 2004; Weise et al., 2016; Wester & Borders, 2014). Median scores are also suitable for small samples (Gall et al., as cited by Doughty, 2009) and minimize skewness in the distribution (Gravetter & Wallnau, 1996). The researcher used the median score to provide a midpoint in the frequency distribution while seeking to prevent an outlying score or judgment from skewing the final score (Wester & Borders, 2014). The researcher calculated interquartile range (IQR) because it is not influenced by extreme scores. The IQR is the distance between the first and third quartile, so it describes the middle 50% of the data when ordered from lowest to highest. IQR is measured by dividing the data into four parts and measuring the distribution of the middle 50% of scores.

Triangulation of Data

At the end of each round in the study, the researcher decided which items would be included for or excluded from consideration as part of the factor structure of SCO. The decision

to include or exclude was based on the predetermined quantitative threshold. The researcher reviewed the qualitative data for each item to determine whether it conflicts or supports the quantitative results. In the case of conflict between qualitative and quantitative data, the researcher evaluated individual cases to decide the best course of action (Weise et al., 2016). The researcher's decisions were guided by the overall aim of the study and the best knowledge available in the Delphi and SCO-related literature. Triangulating the data also supported the process of revising items based on the feedback from the expert panel.

Validity

Validity is an important consideration for any research study, and mixed methods and procedures often need their own section in research reports (Creswell, 2007). Validity is "the ability of the researcher to draw meaningful and accurate conclusions from all of the data in the study" (Creswell & Plano Clark, 2007, p. 146). Therefore, it is crucial to protect validity by addressing threats to validity. The researcher addressed threats to validity based on the literature for the methods employed in the study.

Threats Within Delphi Method

As noted by Hasson et al. (2000), Delphi methods are largely based on the notion of safety in numbers, which is the logical inference that several people are less likely than a single individual to make a wrong decision or arrive at an erroneous conclusion. Thus, part of validity is inherently built into the Delphi method and enhanced when the decisions made from expert panelist input are reasonably argued, with assumptions challenged and supporting evidence evaluated. Pressures for convergence of opinions or predictions are the primary threats to validity (Hill & Fowles, 1975) and are therefore a threat to the intended function of the Delphi method. Nevertheless, the participation of experts with high levels of interest and knowledge of the topic

in question improve content validity (Goodman, 1987) and the successive rounds of gathering input from the panel improve concurrent validity (Hasson et al., 2000). Attrition and response rates are threats to validity. The researcher followed recommendations from Hasson et al. (2000) to communicate consistently and clearly with participants, providing clear instructions and expectations for responses, including due dates and expected starts dates for subsequent rounds of the study. The researcher emphasized the role of participants in reaching consensus and provided a thorough explanation of the purpose of the present study to counter the potential for reactive effects, which are a type of threat to external validity.

Threats within qualitative methods. Trustworthiness is commonly understood to be the validity for mixed methods and qualitative research (Creswell, 2007). Credibility (or internal consistency) and confirmability (assumption of subjectivity) are the two primary criteria for trustworthiness in qualitative methods (Linstone & Turoff, 1975). The researcher sought to achieve trustworthiness in the present study by repeating the process of evaluative feedback—specifically, that of gathering, analyzing, and presenting feedback to the group so it may be reconsidered through each round of the Delphi process as consensus is sought. A trademark of trustworthiness in the Delphi method is the process of member checking (Clark, 2019). Participants had the convenience of checking and rechecking their responses before submitting feedback, as well as the convenience of comparing their responses to the consensus in the group afterward.

Researcher position and personal biases. My identity and experiences influence the lenses through which I view the topic of the current study. Because all research originates from a place of unique perspective and personal experience (Crotty, 2010), it is important to examine my own positions and biases as a researcher of the current study topic, and how these may affect

the validity and other outcomes of the study. Summarizing my position toward the topic is consistent with the practice of reflexive writing (Creswell, 2007), which supports protection against some of the bias and limitations that affect the study. For me, it begins with my identity. I am a white, straight, cisgender man with a Christian background and strong interest in and affiliation with religion and spirituality as well as transpersonal psychology. Although I maintain a Judeo-Christian view of God and the sacred, I do not identify with mainstream Christianity in many ways. I am open to the wisdom, traditions, and truths of many belief systems, giving little regard for the source. Despite my background in Western traditions, I draw upon many Eastern ones in my work as a counselor and counselor educator. I have respect for all belief systems, including those of atheism, agnosticism, pantheism, earth-based systems, or any other system or perspective with which a person may identify. I believe no one is exempt from belief altogether since none of us can produce enough evidence for our view of reality and ultimacy to satisfy everyone. In other words, I can accept that even belief systems that do not resonate with me have just as much potential to be truthful and meaningful as my own belief system.

I recognize I hold several majority identities and my R/S belief system generally aligns with the majority Christian systems in the United States where I reside, but I genuinely care about amplifying under-represented or marginalized R/S identities and systems. I also acknowledge that there is not a way to prove any belief system accurate or correct in any way that is satisfactory to all, so I believe it is important to develop tolerance and respect for all. As a citizen, I place high value on the freedom of religion. As a counselor and counselor educator, I seek to acknowledge and accommodate my clients' or students' spiritual and/or religious beliefs or views in our process—according to their preferences for doing or not doing so. Despite my interest in the topic and my belief in its importance to the profession, I approach the present

study with the questions and intent of a skeptic. The MCC research is shifting toward MCO and it seems logical for R/S competence to shift toward SCO. Nevertheless, I acknowledge this may not be the best or most sensible path according to experts in the field, and I am prepared to discover and accept whatever outcomes emerge from the present study.

Checks against researcher bias. Undoubtedly, my positions and biases have influenced the outcomes of the present study to a certain degree. However, I sought to minimize the influence of my positions and biases. I monitored the feedback received from participants and only challenged them to defend their position if it deviated from a clear norm in the data, which I explained to the participant(s) beforehand. To pursue diverse opinions in the expert panel, I sought experts with diverse demographics from many mental health and counseling-related professions, as described in the Data Collection section above. Given that they are all experts on religious and spiritual competence in counseling, my advisory panel members provided suggestions and feedback on my list of potential expert panelists.

Ethical Considerations

There are important ethical considerations for this study. Anonymity is a vital component of the Delphi method and it has been suggested that anonymity is a key feature that distinguishes Delphi from other consensus methods, such as nominal group technique (Hasson et al., 2000). As proposed by McKenna (1994), "quasi-anonymity" might be a more appropriate term for the level of anonymity in a Delphi study. However, it is important for participants to understand the parameters of preserving quasi-anonymity. Specifically, they needed to know the researcher connected their identities to their responses to track them, and participants could have incidentally discovered one another's identities. Nevertheless, the researcher maintained strict confidentiality for their opinions and judgments. The researcher used the term "confidentiality"

with participants and clarified that they would not be completely anonymous since their responses were tracked for the purposes of the study.

Summary

The Delphi method has a strong record of helping to build consensus about a topic. This chapter contains a brief history of the Delphi method, descriptions of its advantages and limitations, an explanation for addressing limitations in the study, and descriptions of the e-Delphi, or Online Modified Delphi Method (ODM). This chapter also contains descriptions of recruiting experts to serve on the expert panel, maintaining appropriate confidentiality or "quasi-anonymity" in the study, research questions and hypotheses, and collecting and analyzing data. The researcher has also discussed concerns related to the validity of study results as well as ethical considerations for the study.

CHAPTER 4: PROCEDURES AND RESULTS

The purpose of this Modified e-Delphi, or Online Modified Delphi Method (ODM) study was to answer the following research questions:

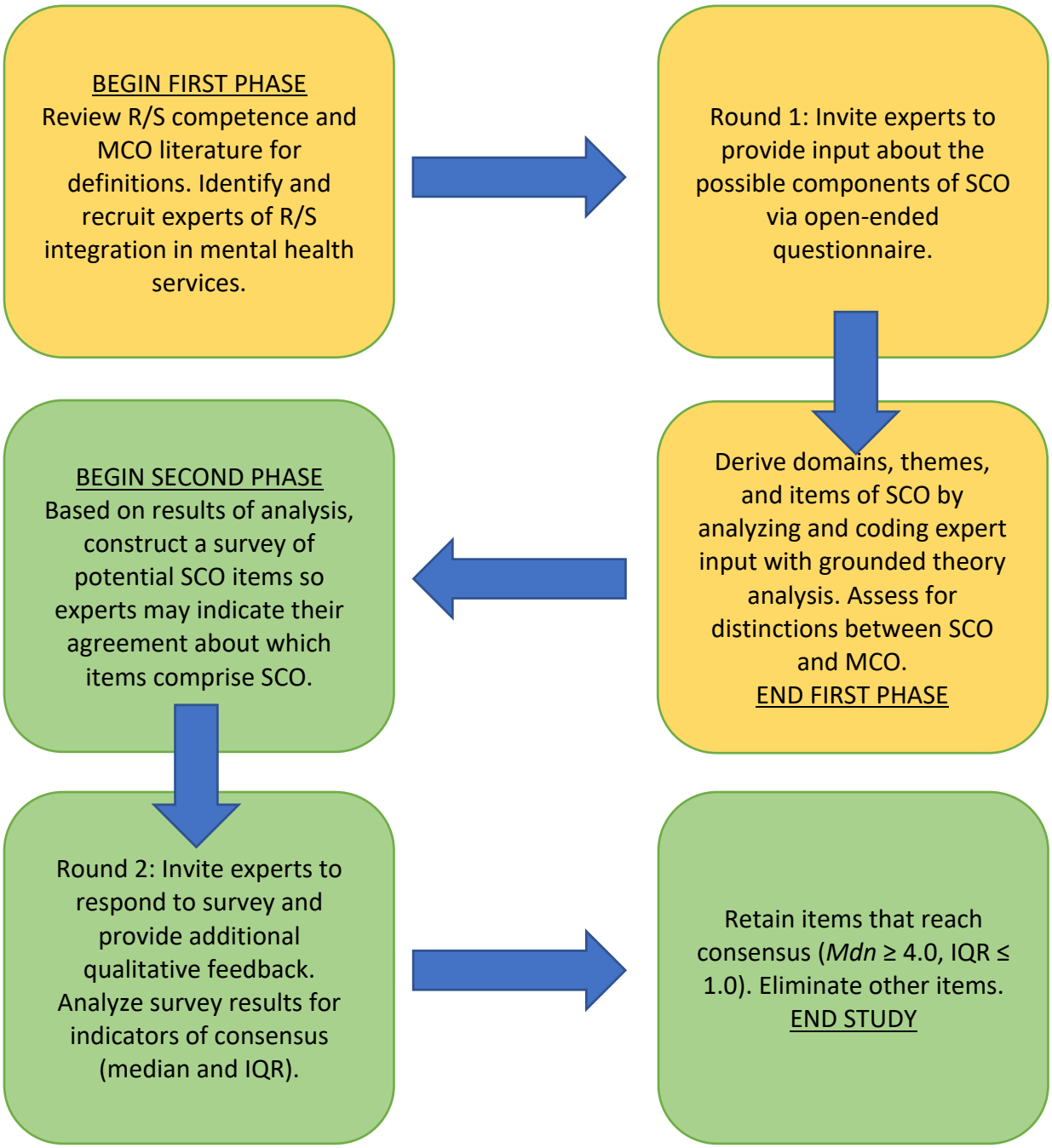
1. How do experts of religious/spiritual (R/S) integration in mental health services define a spiritually competent orientation (SCO) in counseling through its components (i.e., domains, themes, and items)?
2. Do experts of R/S integration in mental health services believe SCO has different components than multicultural orientation (MCO)?
3. Will there be sufficient agreement among experts of R/S integration in mental health services about SCO items, such that there are items that may form the basis for developing a measure of SCO?

Here are the researcher's hypotheses:

1. The input of experts of religious/spiritual (R/S) integration in mental health services will contribute to an operational definition of SCO and these experts will identify relevant domains and themes that may form the SCO.
2. Experts of R/S integration in mental health services believe SCO has different components than MCO.
3. There will be sufficient agreement ($Mdn \geq 4.0$, IQR ≤ 1.0) among experts of religious/spiritual (R/S) integration in mental health services about SCO items, such that the items form the basis for developing a measure of SCO.

Figure 1

Overview of the Flow of Procedures



Note. This figure displays the flow of procedures for the current study.

The current chapter will review the procedures and results of the study. The first section of the current chapter will present procedures and results from the first round, which included recruiting an expert panel and distributing a qualitative survey. The qualitative survey featured six definitions and seven open-ended questions (see Appendix D), which were presented to individual expert panelists via an online questionnaire. Through the qualitative questionnaire, the researcher gathered demographic information and descriptive data about the expert panelists who agreed to participate in the study. The second section of the chapter will present the development of the quantitative survey based on the findings of the qualitative questionnaire, followed by the procedures and results of administering the quantitative survey to the expert panelists.

First Phase Procedures and Results

In the first phase of the study, the researcher developed a list of definitions and questions (see Appendix D) to pursue consensus for an operational definition of SCO. An advisory panel—consisting of counselor education faculty with expertise in R/S competence—approved the definitions and questions before they were inserted into an online questionnaire via the Qualtrics platform. The questionnaire also gathered demographic data of those who responded. The researcher reviewed the R/S competence literature across mental health professions and compiled a list of 54 potential expert panelists who could participate in the study, based on the inclusion criteria in the previous chapter: a) academic degree, professional licensure/certification, or professional membership/affiliation of a religious or spiritual nature; b) at least two national or international refereed scholarly publications in R/S integration, or at least two years of clinical, research, or other professional experience with R/S in their professional roles. This list was also approved by the advisory panel. To avoid the possibility of exceeding the maximum recommended number of 30 participants for a Delphi study (Brooks, 1979; Clayton, 1997;

Delbecq et al., 1975; Fink et al., 1984; Keeney et al., 2011), the researcher invited participants in waves of 10-15 at a time. Potential participants were listed in a random order, but then some participants were prioritized in the first two rounds because of their diverse characteristics to further diversify the sample. The researcher sent an individualized email invitation to each potential participant. The email contained a message approved by the researcher's institutional review board (IRB) and a Qualtrics TM web link to the first-round questionnaire. If a potential participant did not respond to the initial email invitation within a week, the researcher sent a second and final invitation email, which contained a shorter message and an attachment containing the IRB-approved message in word document format.

From the first wave of 15 email invitations, four potential participants declared their inability to participate, five participants began responses to the questionnaire, and three completed their responses. For those who began responses but did not complete them right away, the researcher sent an email after one week to remind participants to complete their responses. From the second wave of 15 email invitations, three more potential participants could not participate, three more participants completed the questionnaire, and one participant committed to complete the questionnaire the following week. From the next two waves of email invitations—18 total—there were three who could not participate, two who expressed desire and willingness but were uncertain of their ability to participate, two who began the questionnaire but did not complete it, and four who completed the questionnaire. Overall, 29 potential participants were not reached or never responded the researcher's emails. Demographic information was collected from participants in the first round of the study but not the second because no new participants were added to the second round. The first phase of the study took approximately eight weeks to complete.

Round One Demographics

Using an online survey developed with Qualtrics Core XM software, for the researcher gathered demographic information from participants and produced charts and graphs with descriptive statistics about the demographics of the participants. The sample size (N=13) for the first round was just above the minimum 12 (Braun & Clarke, 2013; Fugard & Potts, 2014; Guest et al., 2006) recommended for data saturation. Of the 13 respondents in round one, 11 identified as white and two as biracial, one white and American Indian or Alaska Native and the other white and Hispanic/Latino. The sample included eight who identified as male and five who identified as female. There was professional diversity in the sample with eight identifying as counseling professionals, four as psychology, and one as social work. There was quite a range of direct clinical experience, with the minimum reported at two years and the maximum at 34, yielding a mean score $\overline{x}$ = 21.62 with standard deviation s = 8.57. For the length of time R/S has been an important part of their professional work, participants reported a minimum of 10 and a maximum of 40 years ($\overline{x}$ = 21.15, s = 8.54). Participants reported religious and spiritual demographics as well. Eight identified as both religious and spiritual (61.5%), four as spiritual but not religious (30.8%), and one as religious but not spiritual (7.7%). For religious affiliation, seven identified with Protestant Christianity (53.8%), one with Other Christianity (7.7%), two with Judaism (15.4%), two with mixed/other affiliations (15.4%), and one with no affiliation (7.7%). Spiritual affiliations were mixed and varied. Eight claimed Theism (23.5%), seven Contemplative (20.6%), five Relational (14.7%), five Mystical (14.7%), three Interfaith (8.8%), three Other (8.9%), two Earth/Nature/Ecotheological (5.9%), and one Non-theism (2.9%). Two also provided very specific information about their R/S affiliations that are omitted in this report

to help preserve the confidentiality of their identities. Table 1 below displays demographics for individual participants while Figures 2 to 6 display pie charts of group demographics.

Table 1

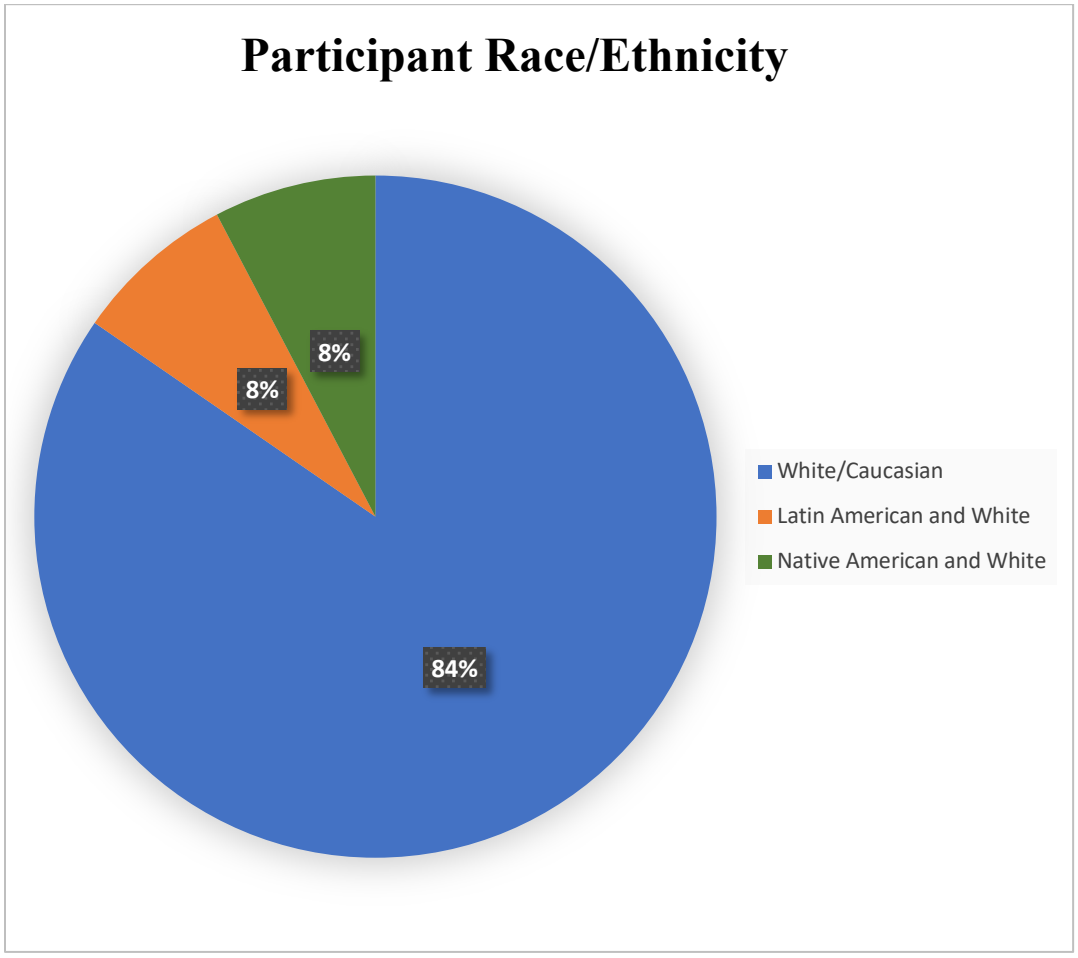
Individual Participant Demographics

Participant	Gender Race/Ethnicity R/S Identity	R/S Affiliation(s)	Years of Clinical Experience	Years of R/S Work Integration	Profession
1	Male, White/Caucasian, Religious and Spiritual	Protestant Christianity, Theism	16	16	Psychology
2	Female, White, Religious and Spiritual	Protestant Christianity, Theism, Interfaith, Mystical, Contemplative, Relational	2	15	Social Work
3	Female, White and Hispanic/Latino/a, Spiritual but not Religious	Judaism, Contemplative, Relational	30	22	Counseling
4	Female, White, Spiritual but not Religious	Metaphysical and Contemplative Christianity, Theism, Mystical, Relational	20	20	Counseling
5	Male, White, Religious and Spiritual	Protestant Christianity, Mystical, Contemplative	34	34	Counseling
6	Male, White, Religious and Spiritual	Protestant Christianity, Theism	20	10	Psychology
7	Male, White, Religious but not Spiritual	Protestant Christianity	33	12	Psychology
8	Female, White and Native American/Alaskan, Religious and Spiritual	Protestant Christianity, Theism, Interfaith, Earth/Nature/Ecotheological, Contemplative, Relational	23	23	Psychology
9	Male, White, Spiritual but not Religious	Judaism, Theism	15	15	Counseling
10	Male, White, Spiritual but not Religious	Unaffiliated, Mystical	20	40	Counseling
11	Female, White, Religious and Spiritual	Protestant Christianity, Theism	22	19	Counseling
12	Male, White, Religious and Spiritual	Other Christianity, Theism, Contemplative	31	31	Counseling
13	Male, White, Religious and Spiritual	Non-theism, Interfaith, Earth/Nature/Ecotheological, Mystical, Contemplative, Relational	15	18	Counseling

Note. This table contains demographics for each participant. Participants are listed by row.

Figure 2

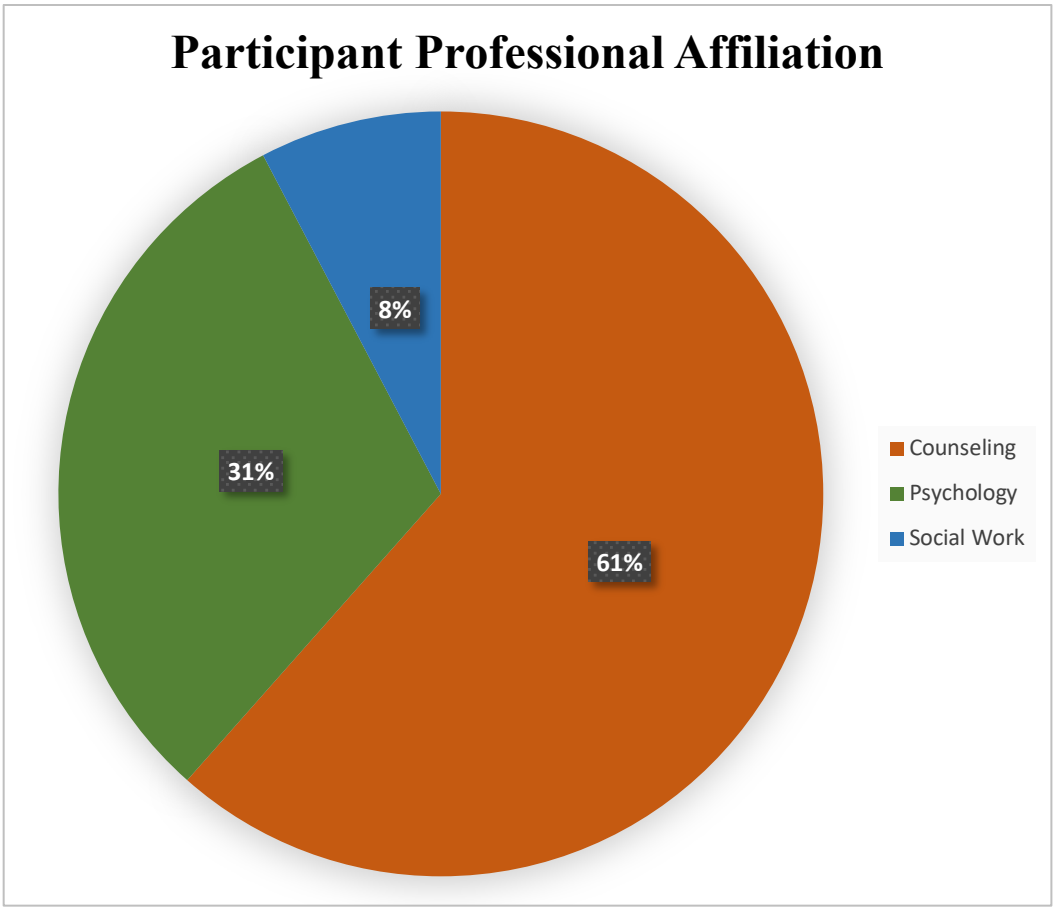
Participant Race and/or Ethnicity



Note. This figure presents the percentage of each listed race and/or ethnicity among participants.

Figure 3

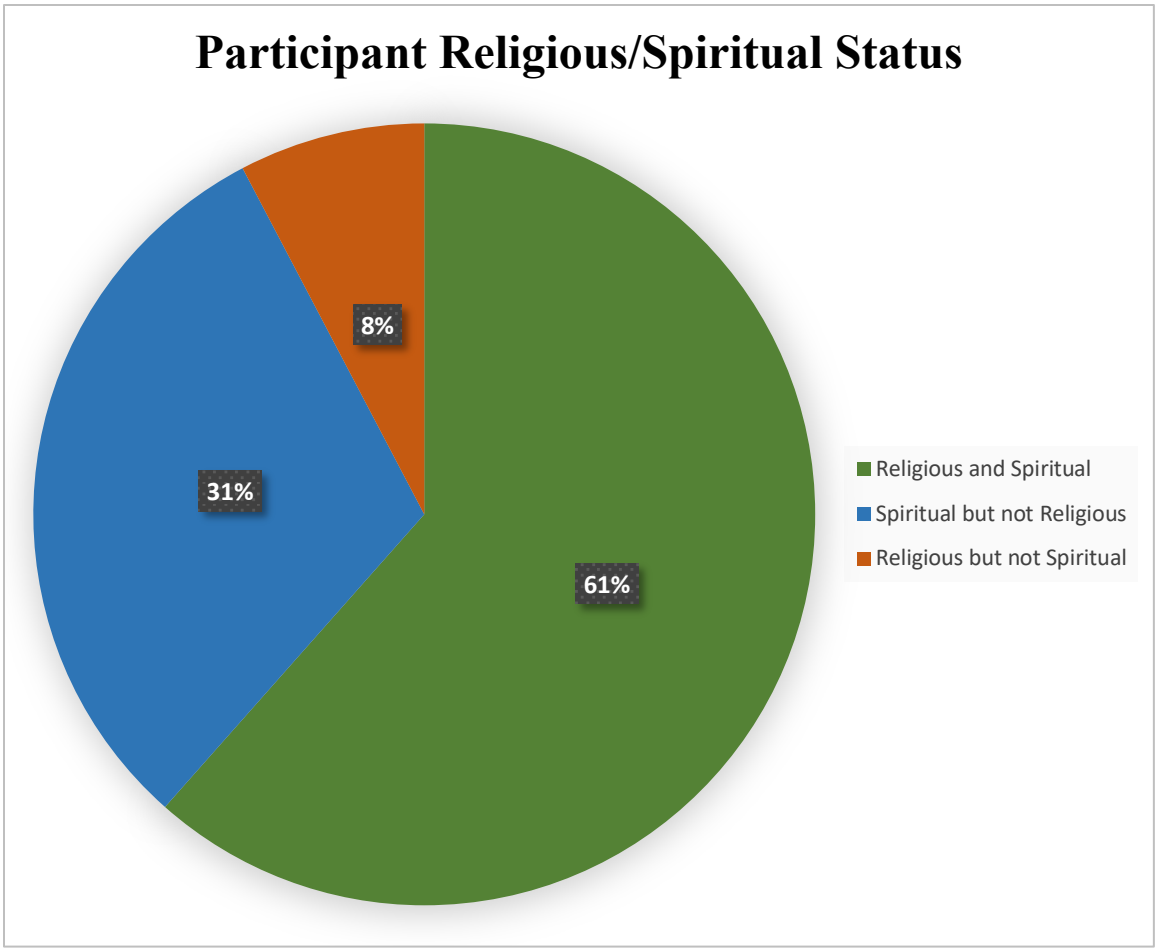
Participant Professional Affiliation



Note. This figure presents the percentage of each listed professional affiliation among participants.

Figure 4

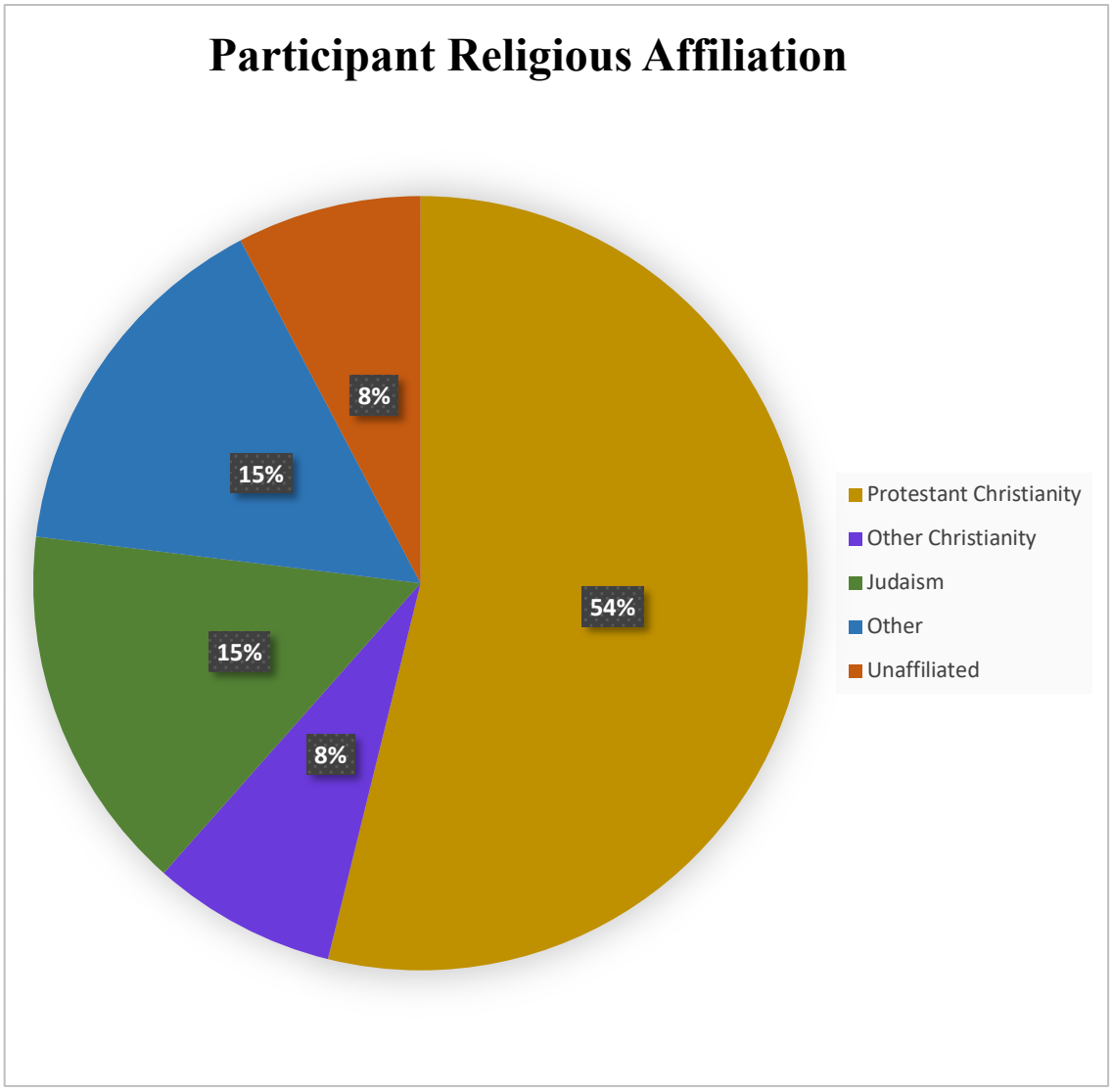
Participant Religious/Spiritual Status



Note. This figure presents the percentage of each listed religious/spiritual status among participants.

Figure 5

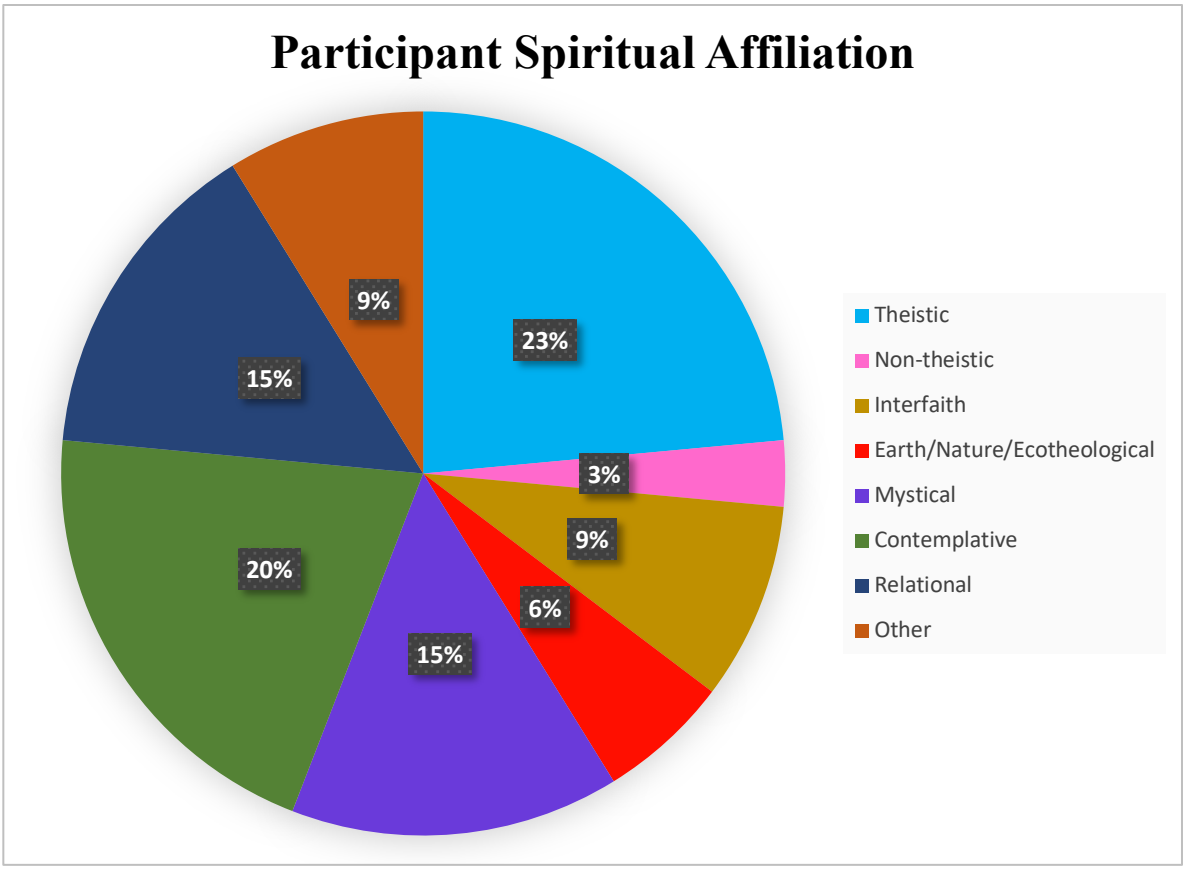
Participant Religious Affiliation



Note. This figure presents the percentage of each listed religious affiliation among participants.

Figure 6

Participant Spiritual Affiliation(s)



Note. This figure presents the percentage of each listed spiritual affiliation among participants.

Round One Procedures

The published round one questionnaire included six definitions to help inform participants before they were asked seven open-ended questions about SCO. After the definitions there were seven open-ended questions designed to gather input about various potential components or factors of SCO. See Appendix D for the definitions and open-ended questions included in the first-round questionnaire. Data gathered from participant responses to the questions above was initially backed up to an external drive and then assembled in a spreadsheet and organized by question (X axis) and participant (Y axis). The researcher utilized grounded theory qualitative analysis for coding data. First, the researcher reviewed the responses with an open coding process, identifying significant topics in the responses which could form domains (Corbin & Strauss, 2008; Hays & Singh, 2012). Responses were also analyzed via Text iQ—a text analysis tool in Qualtrics Core XM—by assigning topics derived from repeated words or phrases (i.e., codes) in the response data. The Text iQ data and a content analysis (Fletcher-Johnston et al., 2011; Powell, 2003) provided potential codes and themes to compare with the researcher's initial findings. Next, the researcher began axial coding to begin refining open codes and exploring relationships between them to deepen understanding of what the data revealed (Corbin & Strauss, 2008; Hays & Singh, 2012). Axial coding informed the creation of several themes or categories discovered in the open codes. Finally, the researcher used selective coding to further refine the codes gathered from the open and axial coding. Following advice from Corbin and Strauss (2008) for researchers to develop their own style when coding with grounded theory analysis, the researcher decided to color code domains and themes in a spreadsheet and then color code each response based on its matching domain and theme. Color coding the responses improved the researcher's ability to effectively track, codify, and categorize data.

Throughout the coding process, the researcher engaged in reflexive journaling (Merriam, 2009) for two main reasons: a) as a check against the researcher's biases and motivations, and b) to document the process of deciding, or challenging previous decisions about, codes. The researcher attempted to preserve the terminology and ideas of participants' responses as much as possible. The desire to preserve participants' responses during the coding process may have led to some items being confusing or convoluted, as noted in some of the participants' qualitative feedback in round two, which is discussed later in the round two results section of the current chapter. The researcher sought to determine whether the data from the first-round questionnaire had reached maximum usefulness for constructing a survey for the second round. Using Braun and Clarke's (2019) definition of data saturation as no new codes being revealed with successive coding, the researcher felt confident that data saturation had been achieved when no new codes were found after reviewing the results of selective coding.

Round One Results

The open coding procedures from the first round of the present study produced a total of 112 individual codes and 20 potential domains and/or themes. During axial coding, seven codes were eventually combined with other codes due to redundancies and two codes were eliminated because they were unrelated topics without clear definitions or purpose in the study. Ultimately, the author derived 101 items from coding. The selective coding process revealed six major domains, which include: a) Ethical; b) Humility; c) Comfort; d) Opportunities; e) Growth; and f) Constructivism. Several themes appeared in the domains, although two domains (Opportunities and Growth) each featured only one dominant theme. Table 2 below lists the six major domains and the prominent themes within each. Following each theme is the number of codes in that theme.

Table 2

Domains, Themes, and Number of Codes From Round One

Domain	Themes	Codes Per Theme	Codes Per Domain
Constructivism	Understands impact of their own R/S	7	
	Accurately conceptualizes and utilizes client R/S	4	
	Honors their own R/S	3	
	Honors client R/S	11	
	Prioritizes safe space, intersectionality, and constructivism/contextualism	9	34
Humility	Humility toward client R/S	6	
	Honors importance and dignity of R/S	5	
	Acceptance of and positivity toward R/S	7	18
Comfort	Comfort with R/S	3	
	Tolerates R/S complexity, mystery, and paradox	6	9
Opportunities	Recognizes, takes, and/or create opportunities for R/S dialogue	9	9
Growth	Makes efforts to facilitate, support, or move toward R/S growth or change for client	6	6
Ethical	Checks R/S biases and motivations	4	
	Ethical and competent R/S practice	5	
	Increases R/S knowledge and experience	3	
	Understands R/S impact upon DEI and MSJCC	5	
	Distinguishes R/S from culture	4	
	Understands and challenges harms of R/S	4	25
		Total Codes:	**101**

Note. This table lists each domain and theme derived from analysis of the questionnaire in round one. This table also lists the number of codes per theme, per domain, and total number of codes.

Second Phase Procedures and Results

The second phase of the study began with the researcher using the color coded, categorized participant responses from the qualitative questionnaire to create items for a quantitative survey in Qualtrics Core XM. Survey items were grouped into the six potential domains of SCO listed above. The domains were numbered on the survey so participants could more easily track their progress in the survey. Domain names were omitted on the survey to reduce chances of participant bias toward items within the domains. After creating the survey, the researcher sent an email to participants from the first round, inviting them to complete the Qualtrics Core XM survey. The survey was open for approximately 10 days. Ultimately, 12 of the 13 participants responded to the survey after one or two reminders. One participant did not respond after a few reminders, so the researcher was obligated to move forward to meet a deadline for completing the study. Therefore, the study experienced an attrition rate of 7.7% in the second round.

Round Two Procedures

After reviewing the items organized through color coding, the researcher grouped similar or related codes together to create domains and themes. During this process of grouping codes, the researcher engaged in more reflexive journaling (Braun et al., 2019; Merriam, 2009) to raise and answer questions about the possibilities for researcher bias affecting the study (e.g., How are my own cultural, professional, and R/S identities affecting the decision to include/exclude this code in this domain?). Once all codes were grouped into a domain, the researcher organized the domains and themes into a sequence that grouped similar domains and themes together. The researcher questioned whether each domain and theme should be combined with another similar domain or theme but found evidence and perceived strong rationale for maintaining the six

distinct domains and the various themes that were revealed from the coding process. The 12 remaining participants from the first round responded to another Qualtrics Core XM survey in the second round. The second-round survey featured a matrix table for each theme within the six domains mentioned previously (see Appendix E). Each matrix table presented statements representing the codes gathered from round one. Participants were asked to select their level of agreement with each statement when considering whether the statement is part of a spiritually competent orientation (SCO). Levels of agreement were rated on a Likert type scale of 1–5 from "Strongly Disagree" (1) to "Strongly Agree" (5).

Round Two Results

The researcher imported all survey data from the Qualtrics XM survey into IBM's SPSS version 27 for statistical analyses. Of the 101 individual items produced from the questionnaire in round one, consensus ($Mdn \geq 4.0$ and IQR ≤ 1.0) was reached for 78 of them, which is 77% of the total items. In total, 23 items (23%) were eliminated because they did not reach the pre-established thresholds ($Mdn \geq 4.0$ and IQR ≤ 1.0) for consensus and, therefore, retention for future consideration as components of SCO. 20 eliminated items had IQR > 1.0 while 10 eliminated items had medians < 4.0. Seven eliminated items had both IQR > 1.0 and medians < 4.0. Seven eliminated items came from the *Constructivism* domain, one from *Humility*, five from *Comfort*, three from *Opportunities*, two from *Growth*, and five from *Ethical*. The specific items eliminated are listed in Table 3 below in their respective domains and themes. Table 4 below includes the number and percentage of items eliminated per domain.

Table 3

Items Eliminated After Round Two Survey, Listed by Domain and Theme

Item(s) Eliminated	Min	Max	Median	IQR
SCO Domain 1 of 6 (Constructivism)				
Theme: Understands impact of their own R/S				
Recognizes their R/S attitudes and inclinations that existed long before meeting the client.	3	5	4	2
Theme: Honors their own R/S				
Approach to R/S with each client is true to clinician's own uniqueness.	1	5	3	2
Theme: Prioritizes safe space, intersectionality, and constructivism/contextualism				
Explores R/S intersectionality between clinician and client.	1	5	4	2
Explores similarities and differences between their own R/S and client's R/S.	1	5	3	2
Helps client feel empowered to enter a liminal space of learning about R/S.	2	5	3	1
Builds relationship with client that is deeply collaborative, co-constructive, and intersubjective with R/S.	2	5	3	1
Adopts a constructivist stance toward client R/S.	3	5	3	2
SCO Domain 2 of 6 (Humility)				
Theme: Honors importance and dignity of R/S				
Believes in the dignity and sacredness of R/S systems.	3	5	4	2
SCO Domain 3 of 6 (Comfort)				
Theme: Tolerates R/S complexity, mystery, and paradox				
Explores the complexity and paradox of R/S within themselves.	3	5	4	2
Fully present to R/S complexity in self and client.	3	5	5	2
Seeks to perceive and understand R/S mystery, paradox, and/or the unknown within self and client.	3	5	3.5	2
Tolerates the non-dual perspective of honoring client R/S as well as their own.	3	5	5	2
Open to having their own R/S views challenged.	1	5	4	3
SCO Domain 4 of 6 (Opportunities)				
Clearly and transparently articulates their R/S orientation to clients.	1	5	3	2
Includes information about their R/S orientation in written materials related to clinical work.	1	5	3	3
Does not limit R/S discussion to only asking about client R/S affiliation.	3	5	4.5	2

Table 3 (continued)

Items Eliminated After Round Two Survey, Listed by Domain and Theme

SCO Domain 5 of 6 (Growth)				
Item(s) Eliminated	Min	Max	Median	IQR
Seeks R/S growth or transformation for client when applicable.	1	5	3.5	2
Moves beyond pluralism of multiculturalism and into the realm of consciousness transformation.	1	5	3	1

SCO Domain 6 of 6 (Ethical)				
Theme: Checks R/S biases and motivations				
Item(s) Eliminated	Min	Max	Median	IQR
Recognizes when clinician or client might be conflating God's opinion with their personal opinion.	2	5	4	3
Theme: Ethical and competent R/S practice				
Item(s) Eliminated	Min	Max	Median	IQR
Possesses basic knowledge of major R/S systems.	3	5	4	2
Theme: Increases R/S knowledge and experience				
Item(s) Eliminated	Min	Max	Median	IQR
Explores emerging R/S research in clinician's area(s) of clinical practice.	2	5	4	2
Theme: Understands R/S impact upon DEI and MSJCC				
Item(s) Eliminated	Min	Max	Median	IQR
Can challenge or remove the defensiveness, hierarchy, and polarization between social justice and conservative R/S worldviews.	1	5	4	2
Theme: Distinguishes R/S from culture				
Item(s) Eliminated	Min	Max	Median	IQR
Understands R/S is more individualized than culture.	3	5	4	2

Note. This table lists the items eliminated after failing to meet consensus criteria ($Mdn \geq 4.0$ and IQR ≤ 1.0). Items eliminated are listed by domain and by theme, if applicable. Minimum and maximum ratings are included for each item, as well as median and interquartile range (IQR).

Table 4

Number and Percentage of Items Eliminated Per Domain

Domain	Items Eliminated	
	Number (out of total)	Percentage
Constructivism	7 (out of 34)	20.5%
Humility	1 (out of 18)	5.5%
Comfort	5 (out of 9)	55.5%
Opportunities	3 (out of 9)	33.3%
Growth	2 (out of 6)	33.3%
Ethical	5 (out of 25)	20%

Note. This table lists the number and percentage of items eliminated from each domain. Each number of items eliminated is listed next to the total number of items in parentheses.

Based on the percentage of items retained, here are the six SCO domains ranked by strength of consensus of items within each:

1. Humility (consensus: 94.5% of items)
2. Ethical (consensus: 80% of items)
3. Constructivism (consensus: 79.5% of items)
4. Opportunities (consensus: 66.6% of items)
5. Growth (consensus: 66.6% of items)
6. Comfort (consensus: 44.5% of items)

Table 5 below includes a full list of the items retained from the results of the survey in round two, including the minimum and maximum rating, the median, and the interquartile range (IQR) for each. Items are once again listed by domain and theme.

Table 5

Items Retained After Round Two Survey, Listed by Domain and Theme

SCO Domain 1 of 6 (Constructivism)				
Theme: Understands impact of their own R/S				
Statement	Min	Max	Median	IQR
Awareness of own R/S beliefs and values.	5	5	5	0
Awareness of how their R/S affects clients and therapy.	4	5	5	0
Awareness of how their own R/S affects their attention to and engagement with R/S.	3	5	5	1
Understands limitations of their own R/S beliefs and values.	3	5	5	1
Understands their own social R/S privileges and/or disadvantages.	4	5	5	1
Seeks to work through their own blind spots, resistance, or trauma that impede competent R/S practice.	4	5	5	1
Theme: Accurately conceptualizes and utilizes client R/S				
Statement	Min	Max	Median	IQR
Seeks to understand the impact of client's R/S upon important matters of life (e.g., death, marriage).	4	5	5	1
Does not ignore the benefits of client R/S, such as support and coping.	4	5	5	0
Uses client R/S to address focal problems in therapy.	2	5	4	1
Can accurately conceptualize client R/S.	3	5	5	1

Table 5 (continued)

Items Retained After Round Two Survey, Listed by Domain and Theme

Theme: Honors their own R/S

Statement	Min	Max	Median	IQR
Remains connected to their own R/S in clinical work.	2	5	4	1
Understands their own R/S before seeking to understand client R/S.	4	5	4.5	1

Theme: Honors client R/S

Statement	Min	Max	Median	IQR
Seeks to understand client R/S.	4	5	5	0
Connects clients to resources relevant to client's unique R/S.	3	5	4	1
Attends to the unique ultimacy and/or transcendence of client R/S.	2	5	4	1
Humbly seeks consultation when unfamiliar R/S issues arise for clients.	2	5	5	0
Avoids arguing, trying to persuade, or seeking to convert others to their own R/S.	4	5	5	0
Practices radical respect for client R/S.	4	5	5	1
Does not implicitly or explicitly demean client R/S.	4	5	5	0
Puts aside any personal agenda related to R/S.	3	5	5	0
Demonstrates ability to tailor their approach to each client's R/S.	2	5	4.5	1
Care is sensitive to, or consistent with, client's R/S values and beliefs.	4	5	5	0
Addresses most salient R/S factors for clients.	1	5	4	1

Theme: Prioritizes safe space, intersectionality, and constructivism/contextualism

Statement	Min	Max	Median	IQR
Addresses mistakes they make with client R/S (including healing relationship ruptures).	3	5	5	1
Listens without defensiveness to client's reaction to clinician's mistakes around R/S.	3	5	5	1
Recognizes understanding client R/S means better understanding other aspects of client's identity and culture.	4	5	5	1
Has expertise in facilitating sincere R/S dialogue even if they lack expertise in R/S content.	3	5	5	1

SCO Domain 2 of 6 (Humility)

Theme: Humility toward client R/S

Statement	Min	Max	Median	IQR
Curious about, open to, and receptive of others' R/S.	4	5	5	0
Demonstrates respect for R/S values and beliefs in action as well as word.	4	5	5	0
Demonstrates interest in client R/S through sincere curiosity.	4	5	5	0
Adopts the role of curious inquirer toward client R/S rather than the role of expert.	4	5	5	1
Broaches/discusses R/S with openness and non-judgment.	4	5	5	1
Asks questions instead of assuming knowledge about client R/S.	4	5	5	0

Table 5 (continued)

Items Retained After Round Two Survey, Listed by Domain and Theme

Theme: Honors importance and dignity of R/S

Statement	Min	Max	Median	IQR
Understands the impact of R/S upon wellbeing.	4	5	5	1
Acknowledges R/S to be important to many or most people.	2	5	4.5	1
Seeks to understand client R/S salience throughout clinical process.	4	5	4	1
Deeply invested in client's wellbeing, including their R/S.	4	5	4	1

Theme: Acceptance of and positivity toward R/S

Statement	Min	Max	Median	IQR
Exhibits positivity or openness to R/S.	2	5	5	1
Connects with clients who have diverse R/S backgrounds, beliefs, and values.	3	5	4.5	1
Demonstrates acceptance of client R/S.	4	5	5	0
Does not have a tendency to pathologize R/S.	4	5	5	1
Accepts clients' R/S experiences without disdain or judgment.	4	5	5	0
Affirms positive aspects of client R/S.	4	5	5	1
Accepting of, and seeks to be sensitive to, diverse R/S traditions and views.	3	5	5	0

SCO Domain 3 of 6 (Comfort)

Theme: Comfort with R/S

Statement	Min	Max	Median	IQR
Demonstrates comfort while having R/S discussions.	3	5	5	1
Does not avoid R/S discussion.	4	5	5	0
Demonstrates comfort through body language and willingness to engage in R/S discussion.	4	5	4.5	1

Theme: Tolerates R/S complexity, mystery, and paradox

Statement	Min	Max	Median	IQR
Demonstrates awareness of and tolerance for R/S paradoxes.	3	5	5	1

SCO Domain 4 of 6 (Opportunities)

Statement	Min	Max	Median	IQR
Recognizes and takes opportunities for R/S discussion.	3	5	5	1
Includes R/S in intake and/or assessment processes.	4	5	5	1
Routinely and/or frequently assesses R/S.	3	5	4.5	1
Addresses R/S when it emerges in client narrative.	4	5	5	0
Openly invites R/S discussion in therapy as appropriate.	4	5	5	0
Understands their responsibility to broach R/S with clients.	3	5	5	1

Table 5 (continued)

Items Retained After Round Two Survey, Listed by Domain and Theme

SCO Domain 5 of 6 (Growth)				
Statement	Min	Max	Median	IQR
Supports client's pursuit of R/S growth, change, or transformation.	3	5	5	1
R/S stance facilitates or supports client R/S transformation or enlightenment.	3	5	4	1
Promotes client reflection to engage with the client's perspectives of the sacred.	1	5	4	1
Addresses meaning, purpose, transcendence, and/or interconnectedness within client's R/S.	1	5	5	1

SCO Domain 6 of 6 (Ethical)				
Theme: Checks R/S biases and motivations				
Statement	Min	Max	Median	IQR
Awareness of R/S biases and motivations.	4	5	5	0
Can prevent their own R/S from interfering with therapy.	3	5	5	1
Understands when to avoid pushing R/S topics or discussions with clients.	4	5	5	0
Theme: Ethical and competent R/S practice				
Statement	Min	Max	Median	IQR
Explores the intersection between their R/S and the ethical codes they must follow.	3	5	5	1
Strives for ASERVIC and/or other related competencies in clinical practice	1	5	4	1
Can describe how to provide spiritually competent care.	3	5	4.5	1
Does not impose R/S values or beliefs on clients.	5	5	5	0
Theme: Increases R/S knowledge and experience				
Statement	Min	Max	Median	IQR
Makes efforts to deepen R/S knowledge and experiences to move toward R/S transformation.	1	5	4	1
Consults with local clergy or R/S leaders to improve their ability to respond to client R/S	3	5	4.5	1
Theme: Understands R/S impact upon DEI and MSJCC				
Statement	Min	Max	Median	IQR
Aware of R/S stereotypes.	4	5	5	1
Recognizes the R/S in multiculturalism and social justice issues.	3	5	5	0
Appreciates impact of R/S upon identity and diversity.	3	5	5	1
Open to or accepting of the idea of R/S privilege within dominant R/S affiliations.	3	5	5	1

Table 5 (continued)

Items Retained After Round Two Survey, Listed by Domain and Theme

Theme: Distinguishes R/S from culture

Statement	Min	Max	Median	IQR
Recognizes R/S as more than a source of identity or component of diversity and culture.	3	5	5	1
Distinguishes between cultural values and R/S values.	2	5	4	1
Does not confound their own values with client's values.	4	5	5	1

Theme: Understands and challenges harms of R/S

Statement	Min	Max	Median	IQR
Understands the potential for R/S to be problematic as well as helpful.	4	5	5	0
Understands the potential for R/S-related trauma.	4	5	5	0
Can appropriately challenge client R/S when it is connected to psychopathology.	4	5	4	1
Can confront client's harmful actions within a culturally responsive R/S framework.	4	5	4.5	1

Note. This table includes each of the items that met the criteria for consensus agreement by the expert panel ($Mdn \geq 4.0$ and IQR ≤ 1.0) and were therefore retained after the round two survey.

Several participants in round two offered additional qualitative feedback in the writing space provided after each matrix table on the survey. The feedback is useful for rephrasing, amending, or combining statements, adding clarity to complex or unfamiliar terms, and guiding the possible revision of SCO domains and items in a future study. This data was also compared with quantitative data for each item to confirm findings through data triangulation (Weise et al., 2016). Some of the themes and most pertinent items of feedback for each domain are summarized below:

1. Constructivism
    a. Some participants prioritized statements focused on ways of being and relating to clients.

b. Some participants emphasized contextualism over constructivism (emphasis on tailoring the approach to the client) and suggested allowing more room for those with positivist worldviews.
c. One participant suggested intersectionality of clinician and client R/S is anti-SCO.
d. One participant noted some items may be double-barreled.

2. Humility
    a. Some participants suggested items in this domain are particularly relevant to SCO.
    b. One participant suggested broaching R/S could be either disrespectful or respectful and thus may not be consistent with SCO.
    c. One participant noted some items may be double-barreled.
    d. One participant suggested humility and curiosity are more important and realistic than positivity.
3. Comfort
    a. One participant agreed that this domain featured essential SCO items but expressed concern that this domain features more advanced aspects of SCO and might be less accessible for many clinicians.
    b. One participant expressed concern that some items in this domain imply theological discussion, which is not considered an area of expertise for mental health professionals.
    c. One participant felt confusion about some items in this domain.
    d. One participant noted some items may be double-barreled.
4. Opportunities

a. Some participants felt it was unnecessary or even counterproductive for clinicians to be transparent about their own R/S affiliations or orientation. One participant suggested this could even discourage some clients from sharing their R/S or inappropriately influence those seeking new R/S affiliations.
b. One participant suggested clinicians should ask about clients' reasons for inquiring about their clinician's R/S affiliations before disclosing them.

5. Growth
    a. Some participants again expressed concern about conflating the roles of mental health professionals with theological guides.
    b. One participant emphasized the need to be sensitive to the "where/when" appropriateness of addressing growth and transcendence/transformation.
6. Ethical
    a. One participant questioned one item's focus on conservative R/S views and suggested conservative and liberal R/S views can be contrary to social justice.
    b. One participant noted some items may be leading and/or double-barreled.
    c. One participant noted confusion about whether some items referred to clinician or client.

Conclusion

In the present chapter, the researcher presented the procedures and results of the two rounds of the current SCO study. The broadest and most pertinent question that guided the study was: what is a spiritually competent orientation? The domains, themes, and items generated from the input of R/S counseling experts provides a way to answer that question and facilitate practical measurement and investigations of SCO. First, the researcher reviewed the purpose of

the study, the research questions, and the hypotheses. Next, the researcher presented the procedures and results of both phases of the study. In the first round, 13 participants served as expert panelists for the study. Each expert panelist reviewed several relevant definitions and provided open-ended answers to the research questions designed to lead to an operational definition of SCO. Expert feedback was intended to gather initial consensus about potential domains, themes, and items of SCO. The researcher's first-round analysis revealed 112 items across six domains with several relevant themes scattered throughout, all of which comprise an operational definition of SCO. The first two research questions were answered through the findings of the first round and the third research question was answered in the second round. In each case, the researcher's hypotheses were confirmed.

The second phase of the study involved creating a quantitative survey that grouped items together in domains unspecified to participants. The participants were invited to indicate their level of agreement with each item on a Likert-type scale ranging from 1 to 5, "Strongly Disagree" (1) to "Strongly Agree" (5). The researcher reviewed the procedures and results of the second round in which 12 of the 13 participants from round one responded to the quantitative survey created by the researcher. Consensus was reached for 79% of the items, resulting in the retention of 89 items and the elimination of 23 items. Participants also provided qualitative feedback for future improvement or clarification of some items. Additional revision to SCO items is needed before a measure of SCO can be developed in the future. For a full list of items retained and eliminated, along with maximum and minimum ratings, median, and IQR, please see Table 6 in Appendix F.

CHAPTER 5: DISCUSSION

The overall purpose of this study was to determine if experts come to consensus for an operational definition of a spiritually competent orientation (SCO) in counseling practice. The purpose of the study was accomplished in three ways: (a) gathering expert input about the components of SCO; (b) determining that experts agree SCO is distinct from MCO; and (c) determining that experts came to consensus about most items that comprise SCO. Utilizing the Online Modified Delphi Method (ODM; also known as *e-Delphi*), the researcher sought the feedback of experts in R/S counseling practice and research. Experts offered their feedback through two rounds of inquiry. The first round featured a qualitative questionnaire that gathered demographic information and posed open-ended questions to gather input about potential domains, themes, and items of SCO. The second round featured a quantitative survey created by the researcher to gather quantitative data about consensus for the domains, themes, and items revealed from the first-round qualitative data. The researcher hypothesized that through this approach, expert input would contribute to an operational definition of SCO. The findings reported in the previous chapter confirmed the researcher's hypotheses, revealing that experts perceived various components of SCO, determined SCO is distinct from MCO, and came to consensus about most of the components that comprise SCO.

In the present chapter, the researcher provides an overview of the study, reviews the findings for each research question, and examines the implications of the study in the context of relevant professional literature. The researcher also discusses the study's strengths, limitations, and recommendations for future SCO-related research and practice in mental health fields. Finally, the researcher concludes with a review of the chapter.

Overview of the Study

The current study was formed with the question: what is the operational definition of SCO in counseling? This guiding question arose from two major findings in the multiculturalism and spirituality literature: (a) the progression of the literature about multicultural competence as it shifted toward multicultural orientation, causing a change of focus from competence to orientation; (b) the lack of evidence connecting spiritual competence to positive R/S outcomes for clients in clinical settings. Through the study, the researcher sought consensus about an operational definition for SCO. The researcher recruited experts in R/S integration across four major mental health disciplines with the expectation that they would offer useful input about SCO with diversity of professional perspectives and experiences. Experts who agreed to participate in the study were given definitions to inform their understanding of constructs related to SCO and then were asked to respond to open questions designed to gather their expert input about SCO. The researcher analyzed the expert input about SCO and found domains, themes, and items that could potentially comprise the SCO construct. The researcher arranged these domains, themes, and items into a quantitative survey and asked each expert to provide Likert-type ratings of their level of agreement about each item's fit as a component or factor of SCO. In addition to the quantitative survey ratings, the experts were given opportunities to provide additional qualitative feedback about items in each section of the survey. After gathering responses to the quantitative survey and additional qualitative feedback, the researcher analyzed the quantitative data and used thresholds for median ($Mdn \geq 4.0$) and interquartile range (IQR $\leq$ 1.0) to determine levels of agreement for each item. The researcher triangulated data by comparing qualitative input and quantitative results for each item that emerged in the analyses of data, confirming the inclusion or exclusion of each item.

Summary of Findings

Expert panelists' comments and feedback underwent thematic and content analysis (Flecther-Johnston, 2011; Powell, 2003) through a grounded theory-based open coding process to isolate topics in the data that could form domains and themes (Corbin & Strauss, 2008; Hays & Singh, 2012). From the input of expert panelists in the first-round questionnaire, 101 items were developed, and six major domains emerged, along with 16 themes. In the second and final round of the study, expert panelists responded to a quantitative survey designed to identify items with sufficient consensus ($Mdn \geq 4.0$, IQR ≤ 1.0) to be considered part of SCO. Each of the three research questions was successfully answered by the end of the second round and the researcher's hypotheses were confirmed.

Table 7

Review of Findings by Research Question and Hypothesis

Research Question	Hypothesis	Finding
How do experts of R/S integration in mental health services define SCO by domains, themes, and items?	Experts will identify relevant domains, themes, and items that operationally define SCO.	Thematic and content analysis of expert input yielded six domains, 16 themes, and 101 items operationally defining SCO.
Do experts believe SCO has different components than MCO?	Experts believe SCO has different components than MCO.	Analysis of qualitative and quantitative input by experts indicates they believe SCO differs from MCO.
Will there be sufficient agreement among experts about SCO items, such that they may form the basis for developing a measure of SCO?	There will be sufficient agreement ($Mdn \geq 4.0$, IQR ≤ 1.0) among experts about a majority of SCO items.	Experts reached consensus for 78 of 101 SCO items (77%) and a majority of items ($\geq 66.6\%$) in five of the six domains.

Note. This table reviews each finding, stemming from its research question and hypothesis.

Findings by Research Question

The first research question is: How do experts in religious/spiritual (R/S) integration in mental health services define a spiritually competent orientation (SCO) in counseling through its components (i.e., domains, themes, and items)? This question was answered through the results of both rounds of the study. In the first round, analysis of input from the expert panelists suggested six major domains, about 20 themes, and 112 items of SCO. In the second round, five of the six domains retained at least a 66.6% majority of items while the remaining domain lost a majority 55.5% of items. In descending order, the highest retention rates for items in each domain (followed by domain name) were: 94.5% (Humility), 80% (Ethical), 79.5% (Constructivism), 66.6% (Opportunities), 66.6% (Growth), and 44.5% (Comfort). These retention rates indicate expert panelists in the study agreed on most items and domains that operationally define SCO. This finding blazes a new trail in the literature by solidifying SCO as a construct with distinct, observable characteristics that can contribute to making it a measurable construct as well. Further, it confirms that experts see value in shifting the focus from R/S competence to SCO, just as MCC/MSJCC has shifted to MCO (e.g., Owen, 2013; Owen et al., 2011b).

The second research question is: Do experts of R/S integration in mental health services believe SCO has different components than multicultural orientation (MCO)? One of the open questions in the first-round questionnaire addressed this research question directly: “Given that the multicultural orientation (MCO) has a broad focus on culture, and considering the uniqueness of R/S as a component of culture pointing to ultimacy and transcendence, how will SCO be different from MCO? What will be added, removed, or changed?” Only one panelist opined the congruency between MCO and SCO, claiming that SCO functioned as an application of MCO to

R/S. In other words, for this panelist, SCO was simply MCO applied to R/S. All other panelists agreed that SCO is qualitatively different than MCO in some notable ways. Some panelists directly mentioned the "ultimacy" and "transcendence" of R/S as discussed by Stewart-Sicking et al. (2019) and that SCO requires a different approach than is proposed in MCO. Others highlighted the connections of R/S to "meaning and purpose in life," "interconnectedness," personal and spiritual "transformation," family influence, "ultimate values," values-driven worldviews, significant life events (e.g., marriage and death), "pluralism," and "paradox." Panelist descriptions and explanations were largely in agreement that SCO moved beyond the MCO approach even though they also largely agreed that SCO included some of the components of MCO. Overall, panelists consented that SCO has different components than MCO. This finding is significant because it verifies the unique consideration of R/S as a component of client culture and identity, as indicated by Stewart-Sicking et al. (2019). This finding also confirms the necessity of addressing R/S apart from other components of culture because of the ways in which it transcends them.

The third research question is: Will there be sufficient agreement among experts of R/S integration in mental health services about SCO items, such that there are items that may form the basis for developing a measure of SCO? Through analysis of the results from the first-round questionnaire, the researcher found 101 items across six domains with 16 themes throughout the domains. After analyzing the results from the second-round survey, the researcher found consensus ($Mdn \geq 4.0$, IQR ≤ 1.0) for 78 of the 101 items (77%) and most items in five of the six domains, as discussed previously. These findings indicate there is enough agreement about most SCO items so that they form the basis for developing a measure of SCO. These findings also denote the need for a measure of SCO to test its roles and functions in relation to related

constructs (e.g., R/S competence and MCO) and client outcomes (e.g., client satisfaction with integrating R/S in therapy).

Implications

In the context of the literature for R/S competence in counseling, perhaps the most significant findings from the present study are that expert panelists in R/S counseling largely agreed SCO is a distinct construct and it should not be subsumed into MCO. These findings have strong implications for R/S integration research, training, and practice. Based on the consensus of the expert panelists in the present study, it appears that the focus on R/S competence may be due for a paradigm shift like that of the multicultural competence literature when it began to shift toward MCO (see Owen, 2013; Owen et al., 2011b).

Research

Several implications stem from the finding that SCO may be a measurable construct now that expert panelists have reached consensus for several domains, themes, and items that comprise SCO. The finding that SCO may be measurable implies the next logical step is to develop and validate a measure of SCO, which will allow for SCO to be studied for its impact upon R/S-related client outcomes in mental health services. Another finding comes from several expert panelists who suggested that some aspects of R/S competence are still part of SCO, such as knowledge of ethics, socially just R/S-related practice, and awareness of client and clinician R/S impact. This finding has several possible implications: (a) the use of the term "competent" in SCO is justified; (b) competence and orientation may still be more compatible and intertwined than some critics or opponents of competence suggest; (c) competence is linked to legal and ethical compliance in clinical practice and therefore R/S experts may consider R/S competence a non-negotiable standard that must remain connected to SCO; (d) SCO may include or work in

tandem with R/S competence (or some aspects of it) rather than being a complete shift away from R/S competence, which further reinforces the argument that both constructs deserve attention; (e) even if there might be a case for embracing orientation instead of competence, experts who embrace R/S competence as part of SCO may find it difficult to embrace orientation alone because competence still matters and it is interwoven in the mental health professions (e.g., multicultural and social justice counseling competencies and R/S competencies embraced by ASERVIC and ACA).

Although a significant implication of the present study is that SCO should not be subsumed into MCO, it is also significant that the expert panelists in the study generally agreed that the three major components of MCO—cultural humility, cultural comfort, and cultural (missed) opportunities—are still part of SCO. The definitions from the first-round questionnaire informed participants about competence, orientation, multicultural counseling competencies (MCC), MCO, R/S competence, and SCO (see Appendix D). The questions that followed the definitions invited participants to distinguish between R/S competence, MCO, and SCO (see Appendix D). As mentioned previously, most made clear distinctions between all three constructs while also aligning components of MCO with some of those in SCO. This finding provides more endorsement for MCO as accepted practice and supports the shift from a focus on competence toward a focus on orientation in the multicultural and R/S competence literature.

As mentioned in the literature review of the present study, the researcher noticed some trends and implications when comparing the literature for competence and orientation, one of which was that competence seems more consistent with positivist perspectives while orientation seems more consistent with constructivism. Although its definition has changed over time, as noted by Mackenzie (2011), the term *positivism* refers to "the view that accepts a correspondence

theory of truth, that there is a single reality independent of human beings, and that the methods of the natural sciences should be adopted in research on social, and…educational questions" (p. 534). In other words, positivists assert there is one objective reality that everyone shares, even in social and educational matters, and decisions are made based on the strength of the evidence that can be perceived and verified by others. On the other hand, *constructivism* refers to the view that people construct reality in the contexts of their relationships, where emphasis is placed on the psychology and intersections of identities, histories, and cultures involved in the constructing. In more extreme forms, such as Cottone's (2011) radical social constructivism (RSC), constructivism is not about constructing reality as much as it is about "deriving meaning of experiences through interaction with others" (p. 26). Essentially, it is about "constructing an understanding of shared experience and acting according to what is understood" (Cottone, 2017, p. 465). Based on the input of the expert panelists in the current study and the literature review for the study, SCO seems more consistent with constructivism than positivism. However, expert panelists also suggested constructivism as an overarching framework with positivist actions supporting the goals of SCO. Two panelists offered feedback about this finding. They suggested changing the language, adding an explanation, or adding items to SCO to clarify that constructivism is not the only acceptable view of reality in SCO, but rather the primary one that allows more room for being humble and honoring diverse client R/S. Positivists favor an objective, evidence-based reality that is perhaps less likely to propagate (a) the humility and respect of SCO, and (b) the tolerance for R/S complexity, mystery, and paradox of SCO, based on the input from panelists. The panelists also suggested a focus on *contextualism*, which is a philosophy like constructivism in that contextualists also reject a single, objective reality and focus on context of the event or situation at hand. Contextualists do not seek an objective

structure of reality but rather focus on the context of an event or situation for achieving a practical purpose (Fox, 2008), such as competently addressing the client's R/S in therapy. A contextualist seeking SCO would see client R/S in the context of the client's life for the purpose of achieving positivist (i.e., evidence-based) treatment goals. Steenbarger (1991) and Thomas (1996) categorized constructivism as a type of contextualism in counseling. Regardless of the relationship between constructivism and contextualism, each is generally more consistent with SCO than a positivist approach because they are more suitable for addressing the pluralism, relativism, ultimacy, and transcendence within the subjectivity of R/S.

Training and Practice

In terms of R/S integration into training and practice, R/S competence should not be the only focus. There should be room for R/S orientation (SCO), which is consistent with arguments of those who have argued in favor of focusing on the values, inclinations, philosophies, and therapist factors that convey competence rather than focusing solely on knowledge, skills, and awareness (Owen et al., 2011b). Expert consensus about SCO also supports the assertions of Stewart-Sicking and colleagues (2019) that R/S differs from other aspects of culture in terms of pluralism, paradox, ultimacy, transcendence, and meaning-making, thus requiring that R/S be treated separately and distinctly from other aspects of culture. Based on expert input, constructivism is the favored perspective for addressing the complexity of client R/S, and positivist actions are still appropriately placed within an overarching constructivist framework for understanding and integrating client R/S. In other words, educators and trainers will be consistent with findings of the current study if they teach a relational, constructivist approach to addressing R/S while still promoting positivist, evidence-based actions that support the clinician's relational, constructivist efforts with the client.

Another finding that is less relevant to the main focus of the study is found in the inclusion of the *Ethical* domain: one of the themes is *Challenges Harms of R/S*. Each item in this theme met or exceeded the pre-determined requirements for consensus in the current study, meaning expert panelists agreed they are part of SCO. This finding indicates awareness and agreement among experts of the potential harms of R/S as reflected in the literature, such as R/S beliefs and practice that impair wellbeing (e.g., Exline & Rose, 2005; Pargament, 1997; Pargament et al., 2005) and spiritual bypass (Cashwell et al., 2007; Cortwright, 1997; Fox et al., 2020; Welwood, 2000). Furthermore, this finding implies not only the ethical necessity of monitoring R/S harm, but that it must be part of clinicians' "way of being" (Owen, 2013, p. 25). Educators and clinicians should be appropriately informed about the potential for R/S harm, as well as how to prevent and respond to R/S harm.

Strengths

Much of the strength of this study lies in the novelty and rationale for the questions at its foundation. The main question of the study was particularly significant given the state of the multicultural and R/S competence literature as reviewed in the first two chapters of the study: How is SCO defined operationally, according to experts of R/S competence in counseling and mental health services? Posing information and questions to help answer this main question caused observable enthusiasm, interest, and thought provocation among many expert panelists. Several expert panelists expressed their enthusiasm for the present study as well as the future of SCO research. Offering additional opportunities for expert panelists to give qualitative feedback about each domain and item of SCO provided more material for refining SCO in current and future study. Another great strength of the study lies in the expert panelists themselves. Each panelist was an expert of R/S integration in mental health services according to the researcher's

advisory panel and the inclusion criteria for participation in the study: (a) possessed a doctoral degree in counselor education, counseling psychology, social work, or a related field, (b) had many years of experience in R/S clinical work and scholarship, and (c) resided in, and had licensure or certification for practice, teaching, or research in the United States so as to reduce the potential for complications due to mismatches between participant qualifications. The expertise of panelists in both clinical practice and scholarship strongly contributed to the relevance and utility of responses to questions in both rounds of the study. Given the scarcity of information and data about SCO in the literature and its novelty as a construct, defining it through the consensus of experts of R/S integration in mental health services was most appropriate. The Delphi methodology was most suitable for achieving a consensus operational definition for SCO.

Limitations

The researcher has identified several limitations for the present study. As with most studies that seek to define a construct, construct proliferation (e.g., Shaffer et al., 2016) is a risk. Shaffer and colleagues (2016) defined construct proliferation as "ostensibly different but potentially identical constructs representing organizations phenomena" (p. 80). The findings of the study indicate SCO is distinct from related constructs like MCC/MSJCC, MCO, and R/S competence. Another risk is attributed to using expert opinion to define a new construct. Opinions can be so numerous and diverse that it can be challenging to reach consensus. Certainly, opinions of the expert panelists in the study were numerous and diverse, resulting in several factors that some panelists uniquely contributed. The researcher was concerned about having so many unique factors, particularly from the qualitative data gathered in both rounds of the study. Contrarily, however, Whetten (1989) asserted that "when authors begin to map out the

conceptual landscape of a topic they should err in favor of including too many factors, recognizing that over time their ideas will be refined" (p. 490). The researcher trusts that despite the large number of factors and other inevitable flaws and limitations of this study, future studies and scholarship will provide greater clarity through refinement of the ideas, implications, and future directions offered in the current chapter. The findings and implications of the study indicate SCO is a unique construct and has great potential for exploration and application to R/S-related issues and outcomes for clients of mental health clinicians. Nevertheless, there are other limitations to consider.

As mentioned previously, the researcher sought to preserve the terminology, language, and ideas in participant responses as much as possible. The researcher's intent was to honor the opinions and perspectives of each participant for each response, to allow participants to express themselves freely, and to limit the researcher's influence on the outcomes of the study. However, maintaining the integrity of each response sometimes resulted in unintentionally allowing some confusion into the items derived from participant responses, reducing clarity for some items. For example, some items contained more than one idea because participants seemed to be thinking through ideas while writing, sometimes convoluting their meaning. The researcher may have needed to employ a method for reducing the confusion of items derived from convoluted ideas or language.

One unavoidable limitation is that the study had to be conducted by one researcher due to the nature of the requirements for completing the study. Several limitations stem from these requirements. Having only one researcher can limit the results of data analysis, particularly from the analysis of qualitative data gathered in both rounds of the study. There were no additional researchers to assist with coding and analysis, resulting in limited challenge to the researcher's

decisions in the study. Results, findings, and interpretations would likely change with input from additional researchers. Having only one researcher also limits the diversity of the research team, which may affect the study in other various ways, including but not limited to participant recruitment and inclusion criteria, recruitment of advisory panel members, selection of definitions and questions posed to expert panelists, coding data to determine domains and items, data analysis and interpretation, and even the selection of the study methods and the study topic itself. One possible way to address this unavoidable limitation would be to utilize an auditor or initial reviewer for the methodology, data, analysis, and/or findings of the study.

More limitations stem from the size and composition of the expert panel for the study. The size of the panel was consistent with recommendations in the literature that Delphi panels consist of 11-30 members to be effective and reliable (Akins et al., 2005; Dalkey, 1972; Woodcock et al., 2020), do not exceed 30 members (Brooks, 1979; Clayton, 1997; Delbecq et al., 1975; Fink et al., 1984), nor fall below 12 members (Braun & Clarke, 2013; Fugard & Potts, 2014; Guest et al., 2006). However, having more opinions, input, and feedback from additional panelists could have enriched content and contributed to stronger justification for including or excluding items of SCO in both rounds of the study, and particularly the second-round quantitative survey, which favors larger sample size. Although there was at least some diversity in race, gender, professional identity, duration of professional experience, and R/S affiliation, the diversity in professional identity, religious affiliation, and, most of all, in race and ethnicity, was limited. The expert panelists were mostly White/Caucasian (84.6%) with Christian affiliation (61.5%) and affiliation with the counseling profession (61.5%). Greater diversity in these areas could diversify, broaden, and deepen the perspectives and opinions offered about SCO and improve generalizability of results. Additionally, the lack of diversity in nationality may limit the

ability to relate findings to clinicians and their clients who practice and reside in nations outside the U.S.

Some other limitations pertain to the methodology and procedures of the study. Although the Modified e-Delphi methodology was very useful for gathering input to reach consensus about SCO, utilizing other means of gathering input besides the questionnaire and survey—such as interviews or group meetings—might have provided more opportunity for the expert panelists to hear one another's opinions and change their opinions along the way, possibly changing the consensus reached about SCO. It may have also been helpful to have more involvement from expert panelists in creating the final items of SCO. Adding more rounds to the study might have also affected the outcomes of the study. For example, adding a third round could have provided an opportunity for panelists to respond to modifications in the quantitative survey based on the qualitative feedback gathered from the second round. However, adding rounds to the study would have also increased the time commitment, costs, and risk of participant attrition.

Recommendations for Future Research

Until now, SCO has only existed theoretically in the R/S in counseling literature (see Gutierrez et al., 2020). A primary purpose for the present study was to determine whether SCO is a legitimate construct by operationally defining it. Experts and leaders in the field of R/S in mental health services have operationally defined SCO by identifying and initially agreeing upon its components. These experts and leaders were also invited to provide additional feedback about the components of SCO. The additional feedback they provided can be applied to future studies that can improve the clarity of SCO. Future studies could seek further consensus and feedback from more experts in R/S mental health services so that additional items could be considered for inclusion in SCO.

A natural next step is to develop and validate a measure of SCO based on the findings of the current study. An exploratory factor analysis (EFA) could validate items included in SCO from the current study and possibly add, clarify, or recategorize items. A formal survey for SCO could be developed and used as a tool for clinicians, trainers, or educators to identify areas of strength and growth regarding how they address R/S in clinical or training settings. Measures and surveys of SCO could be used to evaluate clinician performance in clinical, academic, and research areas. SCO could be used to improve classroom instruction, clinical training, and research about addressing R/S in mental health services. Future studies could investigate specific components of SCO such as the constructivist stance toward R/S. Furthermore, SCO could be investigated in broader contexts, such as its impact upon ethical decision making with R/S issues in clinical settings. If SCO is to be applicable to more professions and nations outside the U.S., it is important for researchers to study the utility of SCO in other professions and nations, possibly adapting SCO to make it more suitable for broader use.

There is not yet conclusive evidence that a focus on competence is more (or less) impactful or useful than a focus on orientation when addressing R/S in mental health services. The development of SCO could allow researchers to test and compare R/S competence and SCO in a more direct way than has been done previously. Researchers could also investigate the relationship and compatibility between R/S competence and SCO, which could help determine how much to focus on each. Exploring the relationship between R/S competence and SCO could also indicate whether SCO should replace R/S competence as the focus for clinicians and trainers seeking to address client R/S. If SCO leads to better outcomes for addressing client R/S, it would be important to develop and test trainings for clinicians to learn how to cultivate and utilize their own SCO

Conclusion

The present chapter presented the findings, implications, strengths, limitations, and future directions for the current study. The purpose of the current study was to establish an operational definition for SCO by determining whether SCO is distinct from MCO and whether experts agree on the items that could potentially help form a measure of SCO. The purpose of the study was achieved by seeking the input and consensus of professionals with expertise in addressing R/S in mental health services. The results and findings of the study indicate SCO is distinct from MCO and experts agreed on most items proposed to comprise SCO. As discussed in the literature review, the multicultural competence literature has not provided sufficient evidence of positive client outcomes to justify focusing on competence and has shifted toward MCO, which has demonstrated promising results so far in empirical studies. Similarly, the R/S competence literature has insufficient evidence to justify focusing on competence and seems due for a shift toward a focus on orientation. Expert panelists in the study verified SCO, implying it may be helpful for R/S competence to experience a comparable shift toward SCO. The current study is a contribution to the R/S competence literature and to the broader debate about competence versus orientation in the multicultural competence and MCO literature.

There are several strengths and limitations of the study to consider, which were discussed in the current chapter. Overall, the research questions are pertinent in the current landscape of the multicultural and R/S competence literature, the researcher utilized a suitable methodology to answer the research questions, and the expert panelists are well-qualified to offer their input about SCO. The study would have been stronger with more researchers involved, more rounds for gathering input and consensus, more methods of gathering input from the expert panelists, and a larger and more diverse expert panel. In future studies, researchers could focus on revising

and refining the items and domains of SCO, developing a measure for SCO, conducting an EFA for SCO items, investigating components of SCO, exploring SCO in broader contexts, and investigating the relationship and compatibility between R/S competence and SCO. More investigation and discourse about SCO could improve R/S-related outcomes for clients.

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Appendix A

FIRST PHASE RECRUITMENT EMAIL

Dear Dr. _____,

My name is Kenson Hiatt and I am a Ph.D. candidate in Counselor Education at William & Mary. I am conducting a dissertation research study that will seek the consensus of experts on religion and/or spirituality (R/S) in counseling/psychotherapy. The purpose of the study is to establish an operational definition for a spiritually competent orientation (SCO). Therefore, the central question is: operationally, what is SCO? Operationally defining SCO entails understanding its components such that eventually it can be measured. You are receiving this message because you have been identified as a potential expert panelist to participate in the study based on your scholarly or professional activities with R/S competence in a mental health discipline.

Your participation will involve confidentially responding to questions in two rounds—the first being qualitative and the second a quantitative survey. You will be given two weeks to respond in each round, with a reminder after one week if you have opted to participate but have not yet responded. For the qualitative first round, you will be given definitions of competence, multicultural competence, R/S competence, orientation, multicultural orientation, and a preliminary conceptual definition of SCO as a starting point. You will be asked to respond to a list of open-ended questions created from a thorough review of the R/S competence and MCO literature. The questions are designed to gather ideas and opinions about what distinguishes SCO from R/S competence and MCO and what elements of the SCO construct might factor into its

operational definition. After I gather responses from the first round, I will code and analyze them for domains and themes and I will confidentially present my findings to the panelists. Should any panelist's ideas or opinions deviate from a clear norm in the data, I will confidentially notify them and invite them to defend their position. The identified domains and themes from the first round will provide insight into a potential factor structure for SCO, which I will use to create a survey of Likert-type items to be quantitatively scored.

While I am analyzing first-round data, I will give panelists an expected timeline for beginning the second round. The second round will begin when I invite each expert panelist who participated in the first round to score each item on the survey. Once I receive survey responses, I will perform descriptive analyses to determine the percentage of agreement among the panelists and, once again, any panelist with opinions that deviate from a clear norm will be confidentially notified and invited to defend their position. When final positions have been made by each panelist, I will perform a final analysis and present my findings to the group.

I will keep your identity confidential, but due to the nature of the data-gathering process of this study, I will connect your identity to your responses so that I can track your responses. Let me emphasize again that your identities will not be revealed to anyone else at any point in the study or afterward. However, it is possible participants in the study may incidentally discover the identity of other participants. Nevertheless, the risk is a minor one. At the conclusion of the study, I will delete records of your responses except for one set that I will store on a secure flash drive. The flash drive will be kept in a locked cabinet when not in my custody. The results of the

study may be published but your name and any other identifying information will not be published. There are no other anticipated risks for participating in the study.

Benefits for participating include contributing to a growing area of research that has strong potential for positive impact—specifically, with mental health professionals' ability to address the R/S needs of their clients or patients. Additionally, your participation may contribute to the development of future research inquiries of related topics. Finally, as an incentive and an expression of gratitude, I offer $30 digital gift cards for those who participate in the first round and an additional $20 for those who participate in the second round—so each participant has the potential to earn $50 for participating in the entire study. After responding to the questionnaire, you will be asked to state your preferences for receiving the gift card (store/outlet and email address for delivery).

If you would like, I can provide a copy of the results at the conclusion of the study. You are not obligated to respond to all questions, and you may withdraw your consent and discontinue your participation in the study at any time by emailing me at khiatt@wm.edu or calling me at (###) ###-####. You may also contact me with any questions about this study. Questions or concerns about your rights as a study participant should be directed to The Chairperson, William & Mary, School of Education Institutional Review Board. By responding to the initial questionnaire, you are agreeing to participate in the study described above. Thank you for your consideration of this project! Please keep this letter for your records.

If you agree to participate, here is the link to the Qualtrics questionnaire: https://wmsas.qualtrics.com/jfe/form/SV_dbeFq3yX7FjJTOS

Sincerely,

Kenson Hiatt

Appendix B

BEGINNING SECOND PHASE EMAIL

Dr. _____,

Thank you for participating in the first round of this study about religious/spiritual orientation in counseling, otherwise known as spiritually competent orientation (SCO)! Your input was invaluable and much appreciated. Based on the input of all participants, I created a quantitative survey for you to rank how much you agree that each item might be part of SCO. I also created spaces at the end of each section for you to provide additional feedback, if you have any. As an expression of gratitude and if you'd like to accept it, I will send you another digital gift card for completing this survey. If not, that is perfectly fine, and you still have my thanks!

Here is the link to the survey: https://wmsas.qualtrics.com/jfe/form/SV_2fozNXog54OwzYO

Please reach out with any questions.

Gratefully,

Kenson Hiatt

Appendix C

FIRST ROUND DEFINITIONS AND OPEN-ENDED QUESTIONS

Definitions

1. Epstein and Hundert (2002) proposed the following definition of *competence* for health professions: "The habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served; [it relies on] habits of mind, including attentiveness, critical curiosity, awareness, and presence" (p. 227).

2. Owen and colleagues (2011b) describe *multicultural competence (MCC)* as "ways of doing" in which the clinician "engages in and implements…multicultural awareness and knowledge" in clinical practice (p. 274-275). Sue and colleagues (1982) define MCC as a continuous process of deepening our understanding of cultural diversity, recognizing our own cultural limitations, and seeking improvement over time with cultural (a) attitudes/beliefs, (b) knowledge, and (c) skills.

3. According to Cashwell and Watts (2010*), religious/spiritual competence* is awareness, knowledge, and skills in the R/S domain that "would support counselors in serving clients from various religious and spiritual traditions" (p. 2). Stewart-Sicking et al. (2019) clarify that R/S competence is distinct from multicultural competence because the latter emphasizes everyday experience and central features of identity while the former

addresses ultimacy, transcendence, and the potential for conversion or "radical departure" from former identity (p. 131).

4. *Orientation* is defined as the philosophy, inclinations, values, and therapist factors through which competence is conveyed in therapy (Owen et al., 2011b). Whereas competence can be characterized as "a way of doing therapy," orientation can be understood as the therapist's "way of being" with clients (Owen, 2013, p. 25; Davis et al., 2018; Hook et al., 2017a).

5. The *multicultural orientation (MCO)* approach is a "way of being" with clients or patients in clinical practice, "guided primarily by (clinicians') philosophy or values about the salience of cultural factors…in the lives of (clinicians) as well as clients" or patients (Owen et al., 2011b, p. 274). MCO is defined and measured by three primary components: cultural humility (Hook et al., 2013; Tervalon & Murray-Garcia, 1998), cultural comfort (Owen et al., 2017), and cultural (missed) opportunities (Owen et al., 2016).

6. The author of the current study proposes the following preliminary conceptual definition of *spiritually competent orientation (SCO)* as a starting point for developing an operational definition for SCO: the clinician's philosophies and values that influence their interests in, and inclinations toward, religious/spiritual competence for themselves and their clients or patients. SCO must be distinct from MCO in ways that resemble the differences between multicultural competence and R/S competence, as noted by Stewart-

Sicking et al. (2019): R/S experiences cannot be relativized in the same way as other multicultural experiences because the pluralism encountered in R/S forces the acceptance of paradox. For example, "I can accept rather easily that eye contact is seen as disrespectful in another culture; if I were a committed atheist and want to affirm that my client experiences the truth and not delusion through Islam, I would have to come to terms with a paradox" (p. 130). Further, R/S is different from other components of culture in that it moves beyond "everyday categories" of culture such as "gestures, conversational norms, or collectivism" and "points…toward ultimacy" (p. 130).

Questions

a. Based on the difference between multicultural competence and multicultural orientation (as clarified in the provided definitions), how does R/S competence differ from R/S orientation in a clinical setting?
b. How do we know a counselor/therapist is R/S oriented?
c. What does/might a spiritually competent orientation (SCO) look like in clinical practice?
d. What mistakes do counselors/therapists commonly make around R/S issues in their practice?
e. How does/might a SCO address common counselor/therapist mistakes around R/S issues?
f. What does/might it look like when a counselor/therapist is operating at high levels of SCO?
g. Given that the multicultural orientation (MCO) has a broad focus on culture, and considering the uniqueness of R/S as a component of culture pointing to ultimacy and

transcendence, how will SCO be different from MCO? What will be added, removed, or changed?

Appendix D

SECOND ROUND QUANTITATIVE SURVEY ITEMS

Instructions

This survey includes the same prompt for several different matrix tables featuring Likert scales for statements that describe qualities or behaviors of a clinician. The statements represent possible components or factors of a religious/spiritual orientation (or spiritually competent orientation [SCO]) in counseling. The statements are separated into tables that represent possible domains of SCO. Using the Likert scales, please indicate your level of agreement with each statement in each table. There will also be blank space at the end of each section for any additional feedback you have about any statement in that section.

After responding to statements in the last table, please continue to the last section where you may provide an email address to receive a $20 gift card or decline the gift card. Thank you for your participation!

SCO Domain 1 of 6 (Constructivism)

(Theme: Understands impact of their own R/S)

Please select your level of agreement with each statement below after considering whether it is part of SCO.

Statement	Strongly Disagree	Disagree	Neutral/ Unsure	Agree	Strongly Agree
Awareness of own R/S beliefs and values.					
Awareness of how their R/S affects clients and therapy in general.					
Awareness of how their own R/S affects their attention to and engagement with R/S.					

Recognizes their R/S attitudes and inclinations that existed long before meeting the client					
Understands limitations of their own R/S beliefs and values.					
Understands their own R/S privileges and/or disadvantages.					
Seeks to work through their own blind spots, resistance, or trauma that impede competent R/S practice.					

(Theme: Accurately conceptualizes and utilizes client R/S)

Please select your level of agreement with each statement below after considering whether it is part of SCO.

Statement	Strongly Disagree	Disagree	Neutral/ Unsure	Agree	Strongly Agree
Seeks to understand the impact of client's R/S upon important matters of life (e.g., death, marriage).					
Does not ignore the benefits of client R/S, such as support and coping.					
Uses client R/S to address focal problems in therapy.					
Can accurately conceptualize client R/S.					

(Theme: Honors their own R/S)

Please select your level of agreement with each statement below after considering whether it is part of SCO.

Statement	Strongly Disagree	Disagree	Neutral/ Unsure	Agree	Strongly Agree
Remains connected to their own R/S in clinical work.					
Understands their own R/S before seeking to understand client R/S.					
Approach to R/S with each client is true to clinician's own uniqueness.					

(Theme: Honors client R/S)

Please select your level of agreement with each statement below after considering whether it is part of SCO.

Statement	Strongly Disagree	Disagree	Neutral/ Unsure	Agree	Strongly Agree
Seeks to understand client R/S.					
Connects clients to resources relevant to client's unique R/S.					
Attends to the unique ultimacy and/or transcendence of client R/S.					
Humbly seeks consultation when unfamiliar R/S issues arise for clients.					
Avoids arguing, trying to persuade, or seeking to convert others to their own R/S.					
Practices radical respect for client.					
Does not implicitly or explicitly demean client R/S.					
Puts aside any personal agenda related to R/S.					
Demonstrates ability to tailor their approach to each client's R/S.					
Care is sensitive to, or consistent with, client's R/S beliefs and values.					
Addresses most salient R/S factors for clients.					

(Theme: Prioritizes safe space, intersectionality, and constructivism)

Please select your level of agreement with each statement below after considering whether it is part of SCO.

Statement	Strongly Disagree	Disagree	Neutral/ Unsure	Agree	Strongly Agree
Explores R/S intersectionality between clinician and client.					
Addresses mistakes they make with client R/S (including healing relationship ruptures).					

Listens without defensiveness to client's reaction to clinician's mistakes around R/S.					
Recognizes understanding client R/S means better understanding other aspects of client's identity and culture.					
Explores similarities and differences between their own R/S and client's R/S.					
Helps client feel empowered to enter a liminal space of learning about R/S.					
Builds relationship with client that is deeply collaborative, co-constructive, and intersubjective with R/S.					
Adopts a constructivist stance toward client R/S.					
Has expertise in facilitating sincere R/S dialogue even if they lack expertise in R/S content.					

SCO Domain 2 of 6 (Humility)

(Theme: Humility toward client R/S)

Please select your level of agreement with each statement below after considering whether it is part of SCO.

Statement	Strongly Disagree	Disagree	Neutral/ Unsure	Agree	Strongly Agree
Curious about, open to, and receptive of others' R/S.					
Demonstrates respect for R/S values and beliefs in action as well as word.					
Demonstrates interest in client R/S through sincere curiosity.					
Adopts the role of curious inquirer toward client R/S rather than the role of expert.					
Broaches/discusses R/S with openness and non-judgment.					
Asks questions instead of assuming knowledge about client R/S.					

(Theme: Honors importance and dignity of R/S)

Please select your level of agreement with each statement below after considering whether it is part of SCO.

Statement	Strongly Disagree	Disagree	Neutral/ Unsure	Agree	Strongly Agree
Believes in the dignity and sacredness of R/S systems.					
Understands the impact of R/S upon wellbeing.					
Acknowledges R/S to be important to many or most people.					
Seeks to understand client R/S salience throughout clinical process.					
Deeply invested in client's wellbeing, including their R/S.					

(Theme: Acceptance of and positivity toward R/S)

Please select your level of agreement with each statement below after considering whether it is part of SCO.

Statement	Strongly Disagree	Disagree	Neutral/ Unsure	Agree	Strongly Agree
Exhibits positivity or openness to R/S.					
Connects with clients who have diverse R/S backgrounds, beliefs, and values.					
Demonstrates acceptance of client R/S.					
Does not have a tendency to pathologize R/S.					
Accepts clients' R/S experiences without disdain or judgment.					
Affirms positive aspects of client R/S.					
Accepting of, and seeks to be sensitive to, diverse R/S traditions and views.					

SCO Domain 3 of 6 (Comfort)

(Theme: Comfort with R/S)

Please select your level of agreement with each statement below after considering whether it is part of SCO.

Statement	Strongly Disagree	Disagree	Neutral/ Unsure	Agree	Strongly Agree
Demonstrates comfort while having R/S discussions.					
Does not avoid R/S discussion.					
Demonstrates comfort through body language and willingness to engage in R/S discussion.					

(Theme: Tolerates R/S complexity, mystery, and paradox)

Please select your level of agreement with each statement below after considering whether it is part of SCO.

Statement	Strongly Disagree	Disagree	Neutral/ Unsure	Agree	Strongly Agree
Demonstrates awareness of and tolerance for R/S paradoxes.					
Explores the complexity and paradox of R/S within themselves.					
Fully present to R/S complexity in self and client.					
Seeks to perceive and understand R/S mystery, paradox, and the unknown within self and client.					
Tolerates the non-dual perspective of honoring client R/S as well as their own.					
Open to having their own R/S views challenged.					

Domain 4 of 6 (Opportunities)

Please select your level of agreement with each statement below after considering whether it is part of SCO.

Statement	Strongly Disagree	Disagree	Neutral/ Unsure	Agree	Strongly Agree

Recognizes and takes opportunities for R/S discussion					
Clearly and transparently articulates their R/S orientation to clients.					
Includes R/S in intake and/or assessment processes.					
Includes information about their R/S orientation in written materials related to clinical work.					
Routinely and/or frequently assesses R/S.					
Does not limit R/S discussion to only asking about client R/S affiliation.					
Addresses R/S when it emerges in client narrative.					
Openly invites R/S discussion in therapy as appropriate.					
Understands their responsibility to broach R/S with clients.					

SCO Domain 5 of 6 (Growth)

(Theme: Supports R/S growth or transcendence)

Please select your level of agreement with each statement below after considering whether it is part of SCO.

Statement	Strongly Disagree	Disagree	Neutral/ Unsure	Agree	Strongly Agree
Supports client's pursuit of R/S growth, change, or transformation.					
R/S stance facilitates or supports client R/S transformation or enlightenment.					
Seeks R/S growth or transformation for client when applicable.					
Promotes client reflection to engage with the client's perspectives of the sacred.					
Addresses meaning, purpose, transcendence, and/or interconnectedness within client's R/S.					
Moves beyond pluralism of multiculturalism and into the realm of consciousness transformation.					

SCO Domain 6 of 6 (Ethical)

(Theme: Checks R/S biases and motivations)

Please select your level of agreement with each statement below after considering whether it is part of SCO.

Statement	Strongly Disagree	Disagree	Neutral/ Unsure	Agree	Strongly Agree
Awareness of R/S biases and motivations.					
Recognizes when clinician or client might be conflating God's opinion with their personal opinion.					
Can prevent their own R/S from interfering with therapy.					
Understands when to avoid pushing R/S topics or discussions with clients.					

(Theme: Ethical and competent R/S practice)

Please select your level of agreement with each statement below after considering whether it is part of SCO.

Statement	Strongly Disagree	Disagree	Neutral/ Unsure	Agree	Strongly Agree
Explores the intersection between their R/S and the ethical codes they must follow.					
Possesses basic knowledge of major R/S systems.					
Strives for ASERVIC and/or other related R/S competencies in clinical practice.					
Can describe how to provide spiritually competent care.					
Does not impose R/S values or beliefs on clients.					

(Theme: Increases R/S knowledge and experience)

Please select your level of agreement with each statement below after considering whether it is part of SCO.

Statement	Strongly Disagree	Disagree	Neutral/ Unsure	Agree	Strongly Agree
Explores emerging R/S research in clinician's are of clinical practice.					
Makes efforts to deepen R/S knowledge and experiences to move toward R/S transformation.					
Consults with local clergy or R/S leaders to improve their ability to respond to client R/S.					

(Theme: Understands R/S impact upon DEI and MSJCC)

Please select your level of agreement with each statement below after considering whether it is part of SCO.

Statement	Strongly Disagree	Disagree	Neutral/ Unsure	Agree	Strongly Agree
Aware of R/S stereotypes.					
Recognizes the R/S in multiculturalism and social justice issues.					
Appreciates impact of R/S upon identity and diversity.					
Open to or accepting of the idea of R/S privilege within dominant R/S affiliations.					
Can challenge or remove the defensiveness, hierarchy, and polarization between social justice and conservative worldviews.					

(Theme: Distinguishes R/S from culture)

Please select your level of agreement with each statement below after considering whether it is part of SCO.

Statement	Strongly Disagree	Disagree	Neutral/ Unsure	Agree	Strongly Agree
Recognizes R/S as more than a source of identity or component of diversity and culture.					
Understands R/S is more individualized than culture.					

Distinguishes between cultural values and R/S values.					
Does not confound their own values with client's values.					

(Theme: Challenges harms of R/S)

Please select your level of agreement with each statement below after considering whether it is part of SCO.

Statement	Strongly Disagree	Disagree	Neutral/ Unsure	Agree	Strongly Agree
Understands the potential for R/S to be problematic as well as helpful.					
Understands the potential for R/S-related trauma.					
Can appropriately challenge client R/S when it is connected to psychopathology.					
Can confront client's harmful actions within a culturally responsive R/S framework.					

Appendix E

Table 6

Items Retained and Eliminated, Final List by Domain and Theme

SCO Domain 1 of 6 (Constructivism)

Theme: Understands impact of their own R/S

Statement	Min	Max	Median	IQR
Awareness of own R/S beliefs and values.	5	5	5	0
Awareness of how their R/S affects clients and therapy.	4	5	5	0
Awareness of how their own R/S affects their attention to and engagement with R/S.	3	5	5	1
Recognizes their R/S attitudes and inclinations that existed long before meeting the client. *(eliminated)*	3	5	4	2
Understands limitations of their own R/S beliefs and values.	3	5	5	1
Understands their own social R/S privileges and/or disadvantages.	4	5	5	1
Seeks to work through their own blind spots, resistance, or trauma that impede competent R/S practice.	4	5	5	1

Theme: Accurately conceptualizes and utilizes client R/S

Statement	Min	Max	Median	IQR
Seeks to understand the impact of client's R/S upon important matters of life (e.g., death, marriage).	4	5	5	1
Does not ignore the benefits of client R/S, such as support and coping.	4	5	5	0
Uses client R/S to address focal problems in therapy.	2	5	4	1
Can accurately conceptualize client R/S.	3	5	5	1

Theme: Honors their own R/S

Statement	Min	Max	Median	IQR
Remains connected to their own R/S in clinical work.	2	5	4	1
Understands their own R/S before seeking to understand client R/S.	4	5	4.5	1
Approach to R/S with each client is true to clinician's own uniqueness. *(eliminated)*	1	5	3	2

Theme: Honors client R/S

Statement	Min	Max	Median	IQR
Seeks to understand client R/S.	4	5	5	0
Connects clients to resources relevant to client's unique R/S.	3	5	4	1

Attends to the unique ultimacy and/or transcendence of client R/S.	2	5	4	1
Humbly seeks consultation when unfamiliar R/S issues arise for clients.	2	5	5	0
Avoids arguing, trying to persuade, or seeking to convert others to their own R/S.	4	5	5	0
Practices radical respect for client R/S.	4	5	5	1
Does not implicitly or explicitly demean client R/S.	4	5	5	0
Puts aside any personal agenda related to R/S.	3	5	5	0
Demonstrates ability to tailor their approach to each client's R/S.	2	5	4.5	1
Care is sensitive to, or consistent with, client's R/S values and beliefs.	4	5	5	0
Addresses most salient R/S factors for clients.	1	5	4	1

Theme: Prioritizes safe space, intersectionality, and constructivism/contextualism

Statement	Min	Max	Median	IQR
Explores R/S intersectionality between clinician and client. *eliminated)*	1	5	4	2
Addresses mistakes they make with client R/S (including healing relationship ruptures).	3	5	5	1
Listens without defensiveness to client's reaction to clinician's mistakes around R/S.	3	5	5	1
Recognizes understanding client R/S means better understanding other aspects of client's identity and culture.	4	5	5	1
Explores similarities and differences between their own R/S and client's R/S. *(eliminated)*	1	5	3	2
Helps client feel empowered to enter a liminal space of learning about R/S. *(eliminated)*	2	5	3	1
Builds relationship with client that is deeply collaborative, co-constructive, and intersubjective with R/S. *(eliminated)*	2	5	3	1
Adopts a constructivist stance toward client R/S. *(eliminated)*	3	5	3	2
Has expertise in facilitating sincere R/S dialogue even if they lack expertise in R/S content.	3	5	5	1

SCO Domain 2 of 6 (Humility)

Theme: Humility toward client R/S

Statement	Min	Max	Median	IQR
Curious about, open to, and receptive of others' R/S.	4	5	5	0
Demonstrates respect for R/S values and beliefs in action as well as word.	4	5	5	0
Demonstrates interest in client R/S through sincere curiosity.	4	5	5	0

Adopts the role of curious inquirer toward client R/S rather than the role of expert.	4	5	5	1
Broaches/discusses R/S with openness and non-judgment.	4	5	5	1
Asks questions instead of assuming knowledge about client R/S.	4	5	5	0

Theme: Honors importance and dignity of R/S

Statement	Min	Max	Median	IQR
Believes in the dignity and sacredness of R/S systems. *(eliminated)*	3	5	4	2
Understands the impact of R/S upon wellbeing.	4	5	5	1
Acknowledges R/S to be important to many or most people.	2	5	4.5	1
Seeks to understand client R/S salience throughout clinical process.	4	5	4	1
Deeply invested in client's wellbeing, including their R/S.	4	5	4	1

Theme: Acceptance of and positivity toward R/S

Statement	Min	Max	Median	IQR
Exhibits positivity or openness to R/S.	2	5	5	1
Connects with clients who have diverse R/S backgrounds, beliefs, and values.	3	5	4.5	1
Demonstrates acceptance of client R/S.	4	5	5	0
Does not have a tendency to pathologize R/S.	4	5	5	1
Accepts clients' R/S experiences without disdain or judgment.	4	5	5	0
Affirms positive aspects of client R/S.	4	5	5	1
Accepting of, and seeks to be sensitive to, diverse R/S traditions and views.	3	5	5	0

SCO Domain 3 of 6 (Comfort)

Theme: Comfort with R/S

Statement	Min	Max	Median	IQR
Demonstrates comfort while having R/S discussions.	3	5	5	1
Does not avoid R/S discussion.	4	5	5	0
Demonstrates comfort through body language and willingness to engage in R/S discussion.	4	5	4.5	1

Theme: Tolerates R/S complexity, mystery, and paradox

Statement	Min	Max	Median	IQR
Demonstrates awareness of and tolerance for R/S paradoxes.	3	5	5	1
Explores the complexity and paradox of R/S within themselves. *(eliminated)*	3	5	4	2

Fully present to R/S complexity in self and client. *(eliminated)*	3	5	5	2
Seeks to perceive and understand R/S mystery, paradox, and/or the unknown within self and client. *(eliminated)*	3	5	3.5	2
Tolerates the non-dual perspective of honoring client R/S as well as their own. *(eliminated)*	3	5	5	2
Open to having their own R/S views challenged. *(eliminated)*	1	5	4	3

SCO Domain 4 of 6 (Opportunities)

Statement	Min	Max	Median	IQR
Recognizes and takes opportunities for R/S discussion.	3	5	5	1
Clearly and transparently articulates their R/S orientation to clients. *(eliminated)*	1	5	3	2
Includes R/S in intake and/or assessment processes.	4	5	5	1
Includes information about their R/S orientation in written materials related to clinical work. *(eliminated)*	1	5	3	3
Routinely and/or frequently assesses R/S.	3	5	4.5	1
Does not limit R/S discussion to only asking about client R/S affiliation. *(eliminated)*	3	5	4.5	2
Addresses R/S when it emerges in client narrative.	4	5	5	0
Openly invites R/S discussion in therapy as appropriate.	4	5	5	0
Understands their responsibility to broach R/S with clients.	3	5	5	1

SCO Domain 5 of 6 (Growth)

Statement	Min	Max	Median	IQR
Supports client's pursuit of R/S growth, change, or transformation.	3	5	5	1
R/S stance facilitates or supports client R/S transformation or enlightenment.	3	5	4	1
Seeks R/S growth or transformation for client when applicable. *(eliminated)*	1	5	3.5	2
Promotes client reflection to engage with the client's perspectives of the sacred.	1	5	4	1
Addresses meaning, purpose, transcendence, and/or interconnectedness within client's R/S.	1	5	5	1
Moves beyond pluralism of multiculturalism and into the realm of consciousness transformation. *(eliminated)*	1	5	3	1

SCO Domain 6 of 6 (Ethical)

Theme: Checks R/S biases and motivations

Statement	Min	Max	Median	IQR

Awareness of R/S biases and motivations.	4	5	5	0
Recognizes when clinician or client might be conflating God's opinion with their personal opinion. *(eliminated)*	2	5	4	3
Can prevent their own R/S from interfering with therapy.	3	5	5	1
Understands when to avoid pushing R/S topics or discussions with clients.	4	5	5	0

Theme: Ethical and competent R/S practice

Statement	Min	Max	Median	IQR
Explores the intersection between their R/S and the ethical codes they must follow.	3	5	5	1
Possesses basic knowledge of major R/S systems. *(eliminated)*	3	5	4	2
Strives for ASERVIC and/or other related competencies in clinical practice	1	5	4	1
Can describe how to provide spiritually competent care.	3	5	4.5	1
Does not impose R/S values or beliefs on clients.	5	5	5	0

Theme: Increases R/S knowledge and experience

Statement	Min	Max	Median	IQR
Explores emerging R/S research in clinician's area(s) of clinical practice. *(eliminated)*	2	5	4	2
Makes efforts to deepen R/S knowledge and experiences to move toward R/S transformation.	1	5	4	1
Consults with local clergy or R/S leaders to improve their ability to respond to client R/S	3	5	4.5	1

Theme: Understands R/S impact upon DEI and MSJCC

Statement	Min	Max	Median	IQR
Aware of R/S stereotypes.	4	5	5	1
Recognizes the R/S in multiculturalism and social justice issues.	3	5	5	0
Appreciates impact of R/S upon identity and diversity.	3	5	5	1
Open to or accepting of the idea of R/S privilege within dominant R/S affiliations.	3	5	5	1
Can challenge or remove the defensiveness, hierarchy, and polarization between social justice and conservative R/S worldviews. *(eliminated)*	1	5	4	2

Theme: Distinguishes R/S from culture

Statement	Min	Max	Median	IQR
Recognizes R/S as more than a source of identity or component of diversity and culture.	3	5	5	1

Understands R/S is more individualized than culture. *(eliminated)*	3	5	4	2
Distinguishes between cultural values and R/S values.	2	5	4	1
Does not confound their own values with client's values.	4	5	5	1

Theme: Understands and challenges harms of R/S

Statement	Min	Max	Median	IQR
Understands the potential for R/S to be problematic as well as helpful.	4	5	5	0
Understands the potential for R/S-related trauma.	4	5	5	0
Can appropriately challenge client R/S when it is connected to psychopathology.	4	5	4	1
Can confront client's harmful actions within a culturally responsive R/S framework.	4	5	4.5	1

VITA

Full Name: Kenson G. Hiatt

Birthdate: 3 February 1987

Birthplace: Mount Airy, North Carolina, United States

Education

Doctor of Philosophy (Ph.D.), Counselor Education and Supervision; conferred August 2022

College of William & Mary – Williamsburg, VA

Master of Arts (M.A.), Marriage and Family Therapy; conferred May 2016

Liberty University – Lynchburg, VA

Bachelor of Arts (B.A.), Business Management and Leadership; conferred May 2012

Southern Virginia University – Buena Vista, VA

Licensure and Certification

Licensed Professional Counselor (LPC #0701008648), Virginia Board of Counseling

National Certified Counselor (NCC #1379258), National Board of Certified Counselors

Academic Positions

Assistant Professor, Department of Graduate Psychology, James Madison University

Harrisonburg, VA; August 2022

Adjunct Instructor, Counselor Education, School of Education, College of William & Mary

Williamsburg, VA; January 2021 – May 2022

Teaching Assistant and Graduate Assistant, School of Education, College of William & Mary

Williamsburg, VA; August 2019 – May 2022

Adjunct Instructor, Undergraduate Psychology, Southern Virginia University

Buena Vista, VA; August 2017 – May 2019