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REGULAR ARTICLE

Practice-Based Evidence for Spiritually Integrated Psychotherapies: Examining Trajectories of Psychological and Spiritual Distress

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Abstract

Objective: The aims of this practice-based evidence study were to (1) examine clients' trajectories of psychological and spiritual distress over the course of spiritually integrated psychotherapies (SIPs) and (2) explore the role of varying types of spiritual interventions in these outcomes. **Method**: In total, 164 practitioners of SIPs from 37 settings in a practice-research network administered the Clinically Adaptive Multidimensional Outcome Survey (Sanders et al., 2018) at each session with 1227 clients and reported their use of theoretical orientations and spiritual interventions on an after-session summary checklist. **Results**: Focusing on sessions over an initial 12-week period, latent growth curve modeling analyses revealed that clients, on average, experienced significant reduction of psychological distress during their engagement in SIPs with improvements occurring most sharply in the first month. Further, other findings revealed a salient reciprocal interplay with spiritual distress throughout treatment, such that clients who were struggling with their religious faith and/or spirituality (R/S) were more psychologically distressed and displayed a more attenuated and gradual pattern of symptom reduction. In such cases, clinicians frequently utilized spiritual interventions involving Basic Skills (e.g., spiritual assessment), Virtues (e.g., discuss self-control), and Religious Attachment (e.g., encourage acceptance of divine love) that were uniquely associated with clients' rate and duration of decline in psychological and spiritual distress. **Conclusions:** The present findings affirm the routine effectiveness of SIPs along with highlighting the potential value of certain spiritual interventions in supporting holistic recovery among clients who want clinicians to be culturally responsive to their spiritual and/or religious identities.

Public Significance Statement

Clients who engaged in spiritually integrated psychotherapies typically experienced clinical improvement with the sharpest changes in psychological distress occurring in the first month of treatment. Clinicians' use of certain spiritual interventions (e.g., spiritual assessment, exploring religious questions/doubts) was generally favorably linked with clients' rate and duration of changes in psychological and spiritual distress over the course of their psychotherapy.

Keywords: Spirituality, Religion, Psychotherapy, Practice-Based Evidence, Spiritual Competence

Author Note

This article is based on an aggregated dataset of 18 practice-based evidence studies of spiritually integrated psychotherapies (SIPs) from a larger practice research network. To date, findings and methods for individual studies have been published in peer-reviewed journals (e.g., REMOVED FOR BLIND REVIEW) and an edited book (REMOVED FOR BLIND REVIEW). This is the first attempt to disseminate any findings or other information for the overall, aggregated dataset.

Religion and spirituality[1] (R/S) are core areas of diversity and psychological functioning for many people who seek psychotherapy. Over 80% of the global population affiliate with an organized religion (Pew Research Center, 2022), and "spiritual, but not religious" persons comprise a growing subset of non-affiliated persons. In total, nearly 80% of Americans view religion as at least somewhat important in their lives, 90% believe in a "God or Universal Spirit," and over half pray daily and/or experience spiritual well-being at least weekly (Pew Research Center, 2015). In such cases, most clients want clinicians to be open, curious, and respectful about their spiritual and/or religious identities and possibly tailor their treatment accordingly (Rosmarin et al., 2015). Further, a large evidence base has revealed numerous pathways by which R/S may strengthen well-being, reduce risk for psychopathology, and support recovery and growth when such issues occur (for review, see Koenig et al., 2022). For example, R/S frequently shapes beliefs, values, and relationships that promote a sense of purpose and cohesion along with adaptive ways of coping and making meaning of trauma and other stressors (Park, 2013; Pargament et al., 2013). Research has also found people who participate in religious congregations commonly have a high quantity and quality of social relationships (VanderWeele, 2017). Beyond these communal expressions of R/S, clients might also engage in prayer and meditation practices that support positive emotions, regulation of painful emotions, mindfulness, and awareness of divine love (Ladd & Spilka, 2013; Wachholtz & Austin, 2013).

Notwithstanding these strengths and resources, R/S can also be a source of distress that diminishes many clients' well-being and likelihood of recovery and growth in psychotherapy. When considering the problems related to R/S that clinicians might encounter (e.g., scrupulosity,

[1]There are numerous definitions of spirituality in psychology and other mental health professions. Drawing upon the seminal work of Pargament (2007, 2013), Davis et al. (2023) defined spirituality as peoples' "search for meaning and connection with whatever they perceive as sacred, typically including supernatural entities (e.g., deity/deities, saints, ancestors, karma, or fate/destiny) or aspects of life viewed as a manifestation of the divine (e.g., close human relationships) or as having transcendent or divine-like qualities (e.g., nature or the universe)." Relatedly, religion refers to peoples' "search for sacred meaning (sense of transcendent significance, purpose, and coherence) and connection in the context of culturally sanctioned codifications (e.g., beliefs, values, and morals), rituals (e.g., prayer, meditation, collective worship), and institutions (e.g., families, faith communities, organizations)." Given the common overlap between religion and spirituality (R/S) in many peoples' lives, we will use "R/S" throughout the paper unless there is a reason to refer to one term or the other specifically.

religious-motivated violence or oppression, religiously themed psychopathology), an increasing number of studies attest to the clinical relevance of spiritual struggles (for reviews, see; Bockrath et al., 2021; Exline, 2013; Pargament & Exline, 2023). Occurring when "something in a person's current [R/S] belief, practice, or experience is causing or perpetuating distress" (Exline, 2013, p. 459), spiritual struggles can entail feeling distant or abandoned by God, judged by one's family or community because of R/S concerns, or feeling guilty for not attaining standards of moral perfection or violating sacred beliefs or values. When such issues are present, a meta-analytic review of 32 longitudinal studies revealed spiritual struggles were prospectively associated with worse mental health symptoms (e.g., depression, anxiety) over time (Cohen's d = .16; Bockrath et al., 2021). Although these findings highlight the potential need for clinicians to attend to these issues, research has not examined spiritual distress as an outcome in psychotherapy or clarified the probable interplay with psychological distress. Focusing on session-to-session assessments from clients and clinicians from a practice-research network, the aims of this study were to examine trajectories of psychological and spiritual distress in spiritually integrated psychotherapies and explore the role of spiritual interventions in these outcomes.

Defining Spiritually Integrated Psychotherapies

Many spiritually integrated psychotherapies (SIPs) have been developed to attend to strengths and struggles related to clients' R/S in treatment (e.g, Pargament, 2007; Richards & Bergin, 2005; Richards et al., 2023; Sandage & Strawn, 2022). SIPs encourage clinicians to seek understanding of the multifaceted role of R/S in many clients' lives, discuss clients' spiritual and/or religious concerns when clinically relevant, and use culturally responsive language and possible interventions that respect clients' R/S. Ranging from religion-specific approaches (e.g., Religiously Integrated Cognitive Behavioral Therapy [R-CBT]; Koenig et al., 2016) that tailor psychological treatments for clients who identify with major religions (e.g., Buddhist, Hindu, Christian, Jewish, Muslim) to general approaches that can be flexibly delivered with clients from personally and/or culturally diverse backgrounds (including secular or non-religious), SIPs based on prominent systems of psychotherapy (e.g., cognitive-behavioral, humanistic, psychodynamic)

have been implemented with numerous clinical issues and client populations. In such cases, clinicians do not necessarily attempt to promote spiritual transformation or change aspects of a client's R/S. Instead, SIPs incorporate a client's beliefs, practices, and/or relationships in the treatment process for the primary purpose of achieving clinical outcomes, such as reducing depression, anxiety, or other distress symptoms that lead many clients to seek treatment.

A growing number of randomized controlled outcome studies indicate that SIPs can be ethical and effective options for clients who want to include their R/S in treatment (for reviews, see Captari et al., 2018, 2021). When compared to no-treatment groups and groups receiving non-integrated forms of the treatments, meta-analytic findings from 97 experimental and quasi-experimental studies showed SIPs are usually equally effective in promoting psychological outcomes (e.g., decreased psychological distress) and more effective in facilitating spiritual outcomes (e.g., better spiritual well-being; Captari et al., 2018). In particular, the magnitude of post-treatment and follow-up effect sizes ranged from .71-.81 for comparisons with no-treatment groups and .13-.34 for non-integrated approaches (Captari et al., 2018). Without overlooking limitations in many of these studies (e.g., reliance on small sample sizes, failure to use random assignment, treatment fidelity checks, or validated outcome measures), these findings led American Psychological Association's (APA) 3rd Interdivisional (Divisions 12 and 29) Task Force on Evidence-Based Relationships and Responsiveness to conclude adapting psychotherapy according to clients' R/S is a "demonstrably effective" method of maximizing their responsiveness to psychotherapy (Norcross & Wampold, 2011). However, research has not examined the specific ways by which practitioners of SIPs adapt or tailor the implementation of psychotherapy along these lines.

Practice-Based Evidence Research for SIPs

Building on findings from controlled outcome studies, practice-based evidence (PBE) research is needed to examine how practicing clinicians actually attend to their clients' R/S in sessions and whether varying types of spiritual interventions are linked with clinical outcomes (Captari et al., 2021; Richards & Barkham, 2022; Richards et al., 2015). Developed as a research

strategy to complement RCTs that evaluate a specific treatment package for a particular condition (e.g., R-CBT for major depression disorder; Koenig et al. 2016), PBE studies utilize information from real-time, session-to-session assessments from clinicians to understand psychotherapy in the context of their routine practice (Barkham et al., 2010; Castonguay et al., 2021). Rather than using a top-down approach wherein researchers prescribe specific interventions or treatment packages that might be relevant for clients from a particular religious group, PBE studies of SIPs assume a bottom-up approach to understanding what clinicians normally do (practice as usual) with a fuller range of clients. In keeping with APA's statement on evidence-based practice (APA Presidential Task Force on Evidence-Based Practice, 2006), examining treatment processes and outcomes in clinics, private practices, and other ecologically valid settings wherein SIPs are routinely practiced complements data drawn from tightly controlled RCTs. In addition, PBE studies of SIPs provide a unique opportunity to gather descriptive information about clinicians' in-session behavior and clinical decision-making about the use of varying types of spiritual interventions throughout the treatment process.

Practitioners of SIPs might indeed incorporate a range of strategies for addressing strengths and struggles related to their clients' R/S. At a basic level, clinicians might simply inquire about a client's R/S, listen empathically to spiritual issues, discuss spiritual dimensions of clients' problems/solutions, or explore religious doubts or questions of ultimate meaning. In other cases, clinicians could encourage clients to engage in practices that align with the clients' R/S (e.g., prayer, meditation, reading sacred texts, journaling, service) or discuss virtues with potential spiritual significance (e.g., forgiveness, gratitude, hope, self-control, compassion, humility). When treating clients who value a sacred connection with God or divine, clinicians might also affirm clients' divine worth or attempt to trust God, encourage clients to accept divine love or reconcile their beliefs about the divine with their pain and suffering, and identify pathways for clients to maintain or restore connection with God or the divine. From a multicultural orientation view, any of these interventions could represent as "cultural opportunities" related to R/S in which clinicians engage in purposeful dialogue about core sources of a client's identity and

modify their language and techniques accordingly (Owen et al., 2016; Winkeljohn Black et al., 2021). However, when considering the varying levels of psychological and spiritual distress that practitioners of SIPs might encoutner, PBE research needs to clarify conditions under which spiritual interventions are most commonly implemented and their role in clinical outcomes.

Study Aims and Hypotheses

The overarching purpose of this study was to clarify processes and outcomes of SIPs being practiced across a range of geographic locales and practice settings in a larger practice-research network. First, we used multivariate latent growth curve modeling to determine average trajectories of change in psychological and spiritual distress as well as links between the clients' baseline levels (i.e., intercept of trajectory) and degree of change in these outcomes over the course of SIPs (i.e., slope of trajectory). In so doing, we tested a linear pattern of change that would evaluate the overall effectiveness of SIPs as well as non-linear trajectories that might reveal possible periods in the treatment in which SIPs were particularly beneficial to clients. Although a lack of PBE research on SIPs precludes our ability to make predictions about non-linear models, three hypotheses were addressed in these primary analyses:

- H1: Clients will, on average, demonstrate significant decreases in psychological and spiritual distress over the course of engaging in SIPs.
- H2: Clients with greater baseline spiritual distress will be more psychologically distressed throughout the treatment process.
- H3: Clients rate of reduction in spiritual distress will be simultaneously associated with improvement in psychological distress.

Focusing on four categories of possible spiritual interventions (Basic Skills, Spiritual Practices, Discuss Virtues, and Religious Attachment), the secondary aims of this study were to describe routine ways in which clinicians attended to clients' R/S in the sessions and explore whether/how these interventions were linked with clients' trajectories of psychological and spiritual distress.

Method

Transparency and Openness

We report how the sample size was determined, all data exclusions, manipulations, and measures in the proceeding sections. The study design and analyses were not preregistered. Materials and analysis code for this study are not currently available via a repository; please contact the first author if interested in accessing the data or other study materials. To date, findings and methods from several research teams in the larger practice-research network have been published in peer-reviewed journals (e.g., REMOVED FOR BLIND REVIEW) and an edited book (REMOVED FOR BLIND REVIEW). Drawing upon a common routine outcome monitoring (ROM) system used across the research sites, this study is the first attempt to analyze an aggregated dataset from the independent investigations in the practice-research network.

Sample Description

This study focused on aggregated data from clients and clinicians from 14 countries who participated in PBE studies of SIPs across 18 sites in a larger practice-research network between 2018 and 2020. Figure 1 outlines the process for identifying clients to address the primary and secondary aims of this study. Of the 4949 clients who participated in these PBE studies, we excluded 3491 because they had not received individual therapy (n = 643), clinical outcomes were not assessed at the first session (i.e., no true baseline for examining trajectories; n = 1207), outcomes were assessed at only one or two sessions (i.e., inadequate dosage of SIPs; n = 976), we could not discern a probable need for a clinical intervention (i.e., did not meet the clinical cutoff score for psychological distress at baseline; n = 748), and/or clients exclusively completed other outcome measures (n = 15). Of the 1227 clients who met these inclusion criteria for the primary analyses, 246 of their clinicians did not complete after-session checklists to track their implementation of possible theoretical orientations and spiritual interventions over the treatment process. Further, of the 981 clients with clinicians who adhered to this component of the PBE design, 101 clinicians only completed the checklists after one or two sessions. To ensure we could accurately track clinicians' in-session behavior over the treatment period, we focused our secondary analysis on the 880 clients for whom we could aggregate information from clinicians' after-session checklists for 3 or more their sessions.

The average client age in the overall sample was 26.73 years (*SD* = 10.76) and the gender distribution was 64.9% cisgender female, 34.4% cisgender male, and less than 1% other gender identities. Although clients predominantly self-identified as White (76.8%) in their racial/ethnic backgrounds, Latinx (8.1%), Black (6.1%), Asian or Asian American (5.1%), and persons from other minority groups (3.9%) were also represented. Roughly half of the sample was employed at the start of treatment (54.3%) and clients reported these religious affiliations: Christian = 85.2%, Muslim = 2.3%, non-religious or atheist = 3.3%, other religious traditions and groups = 9.2%. At the first session, 92.3% of the clients reported that R/S was important to them, 91.4% wished to discuss religious or spiritual issues in their treatment, 53.4% indicated religion had hurt them or contributed to challenges that possibly led them to seek care, and 92.9% were willing to consider religious or spiritual suggestions from clinicians. Importantly, when compared to clients who did not meet the criterion for 3 or more clinician after-session checklists, those who were included in the secondary analysis did not differ in any of these demographic or R/S background factors.

Practice Settings

The 18 research teams who contributed data to the primary analysis comprised 164 clinicians who were included in the overall sample delivering SIPs across 37 clinics or other practice settings from the practice-research network. Specifically, clinicians treated clients in a university counseling center (52.7%, n = 646), private practice (42.1%, n = 516), jail (3.1%, n = 38), or inpatient setting (2.0%, n = 25). Locations of these practice settings were mainly based throughout the U.S. (91.8%, n = 1124); however, researchers also recruited smaller numbers of clients from spiritually integrated practice settings in Uganda (2.7%, n = 33), India (1.6%, n = 20), South Korea (1.1%, n = 13), Canada (.7%, n = 8), Colombia (.3%, n =4), Italy (.3%, n = 4), Malta (.3%, n =4), Philippines (.2%, n =3), Vietnam (.2%, n = 3), America Samoa (.2%, n =3), Belarus (.1%, n =2), Mexico (.1%, n = 2), and Kenya (.1%, n = 2).

Measures

Client measures

The Clinically Adaptive Multidimensional Outcome Survey (CAMOS; Sanders et al.,

2018) was ideally administered with clients at each session. Given the aims of this study, we focused on the psychological and spiritual distress subscales of the CAMOS. The psychological distress scale includes seven items assessing emotionally troubling symptoms of depression, anxiety, and posttraumatic stress over the past week (example items include "I felt sad or depressed," "I felt worried, agitated, or tense," "I had images or thoughts I couldn't get out of my head"). The spiritual distress scale includes four items assessing ways that clients might have struggled with their R/S over the past week (example items include "I felt concerned about my religious or spiritual life," "I felt distant in my relationship with God or Higher Power," "I felt guilt and regrets over mistakes that were inconsistent with my religious beliefs"). Items were scored on a six-point scale in which 1 = *Never* and 6 = *Always,* and we used the total scores for each week of treatment in our analyses. In so doing, we used Sanders and Richards' (2016) recommended cutoff score of 21 or higher on the psychological distress scale to identify clients with a probable need for treatment. Cronbach's alphas for psychological and spiritual distress were .87 and .82 at the first session, respectively.

Clinician measures

After each treatment session, clinicians were asked to complete a Therapist Session Checklist (TSC)[2] documenting the theoretical orientation(s) that guided the session and any spiritual interventions that were possibly implemented (Richards et al., 2014; Sanders et al., 2015). Theoretical orientations included four CBT-based approaches (Cognitive Behavioral Therapy [CBT], Behavior Therapy, Acceptance and Commitment Therapy [ACT], and Rational Emotive Therapy), four humanistic approaches (Client-Centered, Existential, Gestalt, and Emotion-Focused Therapy), and two psychodynamic approaches (Psychoanalysis, Relational

[2]The overall Therapist Session Checklist (TSC) from the routine outcome monitoring system included five sets of items that might apply to psychotherapy practice: (a) Theoretical Orientations (e.g., CBT, Client-Centered, Acceptance and Commitment Therapy); (b) Counseling Topics (e.g., Relationships, Addictions, Emotions); (c) Interventions for the selected theoretical orientations; (d) Intentions (e.g., Gather information, Explore ways to change, Instill hope); and (e) Spiritual Interventions described above. If a clinician's particular approach or option was missing for any of these checklists, they could create customized items for their specific clinic or practice setting. To address the present aims and not add undue length to the paper, we focused our analyses on the standard Theoretical Orientations and Spiritual Interventions that were included in the overall TSC.

Psychodynamic). Spiritual interventions included five approaches involving Basic Skills (examples include "Used spiritual assessment," "Discussed spiritual dimensions of problems and solutions," "Explored religious questions and doubts"), six approaches involving Spiritual Practices (examples include "Encouraged personal prayer," "Encouraged spiritual meditation," "Encouraged religious bibliography"), six approaches to Discuss Virtues (examples include "Discussed humility," "Discussed gratitude," "Discussed forgiveness"), and six ways of supporting Religious Attachment (e.g., "Affirmed client's divine worth," "Encouraged acceptance of divine love," "Affirmed trusting God"). Each of the items were scored as 0 = *No* and 1 = *Yes* at the end of each session, depending on whether the clinicians had endorsed using the particular theoretical orientations and spiritual interventions during the preceding session. Namely, if a clinician did not endorse using a particular item or left the box for that item blank, we coded the item as 0 = *No.* Given the naturalistic aims of a practice-based evidence study of this sort, clinicians were not required to modify their routine practice or use any of the theoretical orientations or spiritual interventions in the TSC.

Drawing upon these dichotomous ratings across the treatment period for clients in the secondary analysis, we created two sets of variables from clinicians' TSCs. First, of the sessions in which clinicians completed the TSC, we calculated the percentage of these sessions that were guided by the varying theoretical orientations and/or included the spiritual interventions. Each of the TSC items therefore had an index value estimating the total percentage of sessions in which the specific theoretical orientations and spiritual interventions were used. Second, we created higher-order variables for individual items on the TSCs that were grouped according to major systems of psychotherapy (CBT, Humanistic, Psychodynamic) and four categories of spiritual interventions (Basic Skills, Spiritual Practices, Discuss Virtues, Religious Attachment) that were tracked in the practice-research network.

Research Procedures

Principal investigators (PIs) at each site received grant funding for a larger Request for Proposals (RFP) competition to lead multidisciplinary research teams composed of qualified

individuals to contribute conceptually and practically to their PBE studies in these areas: researcher, clinician, mental health educator, and/or pastoral professional (e.g., clergy person, chaplain). Each team joined the larger practice-research network, which offered technological resources for collaboration with the other researchers (e.g., website, videoconference account). The teams also used a web-based survey administration platform that collects data from clients and clinicians to study naturally-occurring processes and outcomes of SIPs within clinics and other treatment settings in their selected locales. Although compensation procedures varied from site-to-site, PIs were highly encouraged to use a portion of their grant budgets to offer stipends or other forms of compensation to clinicians, staff, and clients for supporting the collection of these routine outcome monitoring assessments.

Before data collection began at each research site, the PIs obtained approval from the institutional review board (IRB) of their university or sponsoring institution. In addition, each team offered training to their participating clinicians and possible staff regarding procedures for PBE research, including (1) protecting clients' anonymity and confidentiality, (2) obtaining informed consent and sociodemographic information from clients, (3) administering the routine outcome monitoring surveys in a standardized manner, and (4) completing the clinician after-session summary checklist. Researchers did not assign clients to work with particular clinicians, but rather allowed clients to self-select their own clinicians or simply progress through routine procedures within the clinic or practice setting in which they voluntarily pursued treatment. When the clients presented for the first psychotherapy session, their clinician or a staff person informed them that a PBE study was being conducted to assess the processes and outcomes of the routine SIPs that were being offered at the site. Clients then received an informed consent document and/or other information sheet that described the study in detail and highlighted that participation was voluntary and would not affect their access to care in any way. Hence, clients had not advantage or disadvantage for taking part in the research.

Plan of Analysis

Following our screening of the data, calculation of effect sizes for pre- to post-treatment changes in clinical outcomes, and other preliminary analyses, we first utilized a combination of univariate and multivariate latent structural equation modeling (SEM) analyses to examine trajectories of spiritual and psychological distress over 12 weeks with the 1227 clients in the overall sample. Specifically, after aggregating the clients' outcomes to the week-level, our primary analyses consisted of latent growth curve modeling (LGCM; Burant, 2016; Ferrer & McArdle, 2003) of baseline (i.e., intercept) and direction/rate of change (i.e., slope) factors for psychological and spiritual distress. First, to ascertain the pattern of change for psychological and spiritual distress over the time, we subjected clients' responses to the CAMOS Psychological Distress scale and CAMOS Spiritual Distress scale to a series of univariate LGCMs. For each construct, we compared the model fit of a linear LGCM (i.e., specifying a consistent rate of change over time) and a quadratic LGCM (i.e., conditioning the linear rate of change over time). If a quadratic model evidenced a superior fit compared to a linear model, then the rate of change was deemed to be non-linear. Second, we examined the associations between psychological and spiritual distress in a multivariate LGCM interrelating psychological and spiritual distress. These latter analyses allowed us to examine the associations between changes in psychological and spiritual distress over time.

After completing these analyses, we focused on the 880 clients whose clinicians completed enough TSCs to provide a clear picture of their theoretical orientation(s) and use of spiritual interventions over the treatment process (i.e., three or more TSCs). After outlining frequencies of these approaches, we explored associations between psychological and spiritual distress, theoretical orientations, and spiritual interventions across a series of LGCMs. Given the exploratory nature of these analyses, we first regressed the latent intercept, slope, and quadratic factors for psychological and spiritual distress on the index scores for categories of theoretical orientations (CBT, Humanistic, and Psychodynamic) and spiritual interventions (Basic Skills, Spiritual Practices, Discuss Virtues, and Religious Attachment) via a multivariate LGCM. These analyses allowed us to identify which theoretical orientations and spiritual interventions were

uniquely associated with baseline scores and changes in psychological and spiritual distress throughout treatment. When the overall index scores were associated with clinical outcomes, we conducted another multivariate LGCM in which the items within each category were entered individually to clarify which interventions were possibly influencing the outcomes.

Following best practice recommendations for SEM (Kline, 2023), we evaluated each model in our primary and secondary analyses via several absolute and relative fit indices. Specifically, a statistically non-significant chi-square value indicated a model with a nearly perfect fit. However, given that the chi-square test statistic is highly sensitive to minor model misspecifications in large samples, we also consulted the Comparative Fit Index and Tucker-Lewis Index (CFI, TLI; values greater than .95 often indicate acceptable model fit), Root Mean Square Error of Approximation (RMSEA: values of .05 or less indicate acceptable fit in most instances), and the Standardized Root Mean Residual (SRMR; values of .08 or less often indicate acceptable fit). All models used full information estimation and a sandwich estimator to adjust standard errors for clustered data.

Results

Preliminary Analyses

We initially screened our data for missing values, normality assumptions, and univariate and multivariate outliers. Of the 1227 clients in the overall sample, not every client was seen weekly over the 12-week period. As such, we first aggregated the clients' outcomes to the week-level for the less than 2% of data points in which clients completed more than one assessment. In so doing, 93% of clients provided outcomes for 3 to 9 weeks in this treatment period with a mean number of 5.49 weekly assessments (SD = 2.24). Because many clients were seen every other week or had longer intervals between certain sessions, we sectioned the 12 weeks of outcomes into six observations consisting of the average of observations over each two-week period. Across these six observations, covariance coverage of available data ranged from 100% at baseline to approximately 35.9% at the end of the treatment period. Independent sample t-tests did not reveal differences between clients with complete versus missing values on CAMOS

Psychological Distress (t[1225] = -1.36, p = .174) or CAMOS Spiritual Distress (t[1225] = -1.42, p = .157) at baseline. Thus, we used full information maximum likelihood estimation to address missing values in the LGCM analyses. Further, the number of univariate and multivariate outlier cases (defined as z-scores greater than absolute value of three and significant Mahalanobis distance values, respectively) ranged from four to six. Lastly, CAMOS scores at each time point were deemed to approximate a normal distribution (i.e., skew and kurtosis values below the absolute value of one).

Prior to running our primary and secondary analyses, we also calculated descriptive statistics for observed scores on the outcomes measures along with effect sizes and rates of reliable change on the outcome measures. When compared to clients' mean score on the CAMOS Psychological Distress scale at baseline (M = 27.12, SD = 4.83), they generally reported a lower score at their last session (M = 21.10, SD = 6.15; paired samples t[1226] = 34.93, p < .001; Cohen's d = .997). Following the guidance of Jacobson and Truax (1991) for determining reliable change, 58.4% of clients displayed reliable improvement in psychological distress, 38.4% had no reliable change, and 3.2% demonstrated a reliable deterioration or worsening of psychological distress over the course of treatment. As a group, clients similarly demonstrated a statistically significant decline on CAMOS Spiritual Distress from baseline (M = 12.91, SD = 4.31) to their last session (M = 10.35, SD = 4.38; paired samples t(1226) = 20.78, p < .001; Cohen's d = .593). However, only 22.8% of the sample displayed reliable improvement in spiritual distress, 74.7% had no reliable change, and 2.4% demonstrated a reliable increase in spiritual distress over their treatment process.

Primary Analyses

Table 1 displays model fit of linear and quadratic univariate LGCMs for psychological and spiritual distress scores over the 12 weeks. For each variable, a quadratic model evidenced a superior fit, which is consistent with the non-linear trajectory of observed means over time (see Figure 2). For psychological distress, the latent growth curve started at a latent mean value of 26.18 (SE = .02, p < .001) and evidenced a negative slope suggesting that symptoms improved

over time (M = -2.61, SE = .14, p < .001). However, this significant decrease in psychological distress was tempered by the quadratic function, such that the rate of decline slowed after the fourth week of treatment (M = .32, SE = .02, p < .001). A similar trend was observed for spiritual distress, with the curve starting at a latent mean of 12.40 (SE = .16, p < .001), decreasing significantly over time (M = -1.07, SE = .10, p < .001), but also tempered via the quadratic function (M = .13, SE = .02, p < .001). Thus, we retained the quadratic LGCM specification for the subsequent multivariate analyses.

The multivariate quadratic LGCM of psychological and spiritual distress evidenced excellent fit, χ^2 (45) = 90.84, p < .001, CFI = .992, TLI = .988, RMSEA = .029, 90% CI [.020, .037], and SRMR = .039. Overall, greater baseline psychological distress was significantly correlated with greater baseline spiritual distress (r = .42, p < .001), a slower linear rate of decline in spiritual distress (r = .39, p < .001), and less leveling off from the quadratic function for spiritual distress over the treatment process (r = -.48, p < .001). Likewise, greater baseline spiritual distress was associated with a slower linear rate of decline in psychological distress (r = .24, p < .001) and a reduction in the leveling-off effect represented by the quadratic function for psychological distress over time (r = -.23, p < .001). Increases in the rate of improvement in spiritual distress were also associated with decreases in psychological distress (r = .67, p < .001) and less leveling off for psychological distress over the course of treatment (r = -.52, p < .001).

Secondary Analyses

Focusing on the 880 clients whose clinicians completed three or more TSCs over the 12-week period, Table 2 outlines the relative frequencies of theoretical orientations and spiritual interventions that were implemented in the SIPs. In total, clinicians implemented one or more theoretical orientations and/or spiritual interventions with 94.2% and 89.5% of their clients, respectively. Clinicians reported they were guided by theoretical orientations at these mean percentages of sessions: Cognitive-Behavioral = 81.1%, Humanistic = 63.3%, Psychodynamic = 33.6%. On average, clinicians used one of more spiritual interventions across the four general categories at these rates: Basic Skills = 54.7%, Spiritual Practices = 49.1%, Discuss Virtues =

75.5%, and Religious Attachment = 66.4%. Notably, for theoretical orientations and spiritual interventions, most of the clinicians reported using interventions from multiple categories (i.e., why the percentages add up to more than 100% for the two sets of variables).

Next, we specified a multivariate LGCM with psychological and spiritual distress as the dependent variables and index scores for theoretical orientations and spiritual interventions as the predictor variables. Overall, the model was also an excellent fit, χ^2 (87) = 128.89, p =.002, CFI = .991, TLI = .984, RMSEA = .023, 90% CI [.014, .032], and SRMR = .027. When reviewing the individual predictors in the model, none of the index scores for theoretical orientations or spiritual interventions were uniquely linked with the intercept, latent slope, or quadratic factors for psychological distress. None of the theoretical orientations were similarly uniquely associated with clients' trajectories of spiritual distress. In contrast, greater spiritual distress at baseline (R^2 = .02) was associated with clinicians implementing spiritual interventions entailing Basic Skills (β = .12, SE = .05, p = .015). Further, whereas the linear rate of change in spiritual distress (R^2 = .06) was attenuated when clinicians used spiritual interventions involving Basic Skills (β = .15, SE = .06, p = .006) and Discussing Virtues (β = .15, SE = .06, p = .006), and greater focus on Religious Attachment was associated with sharper linear decline over the treatment process (β = -.17, SE = .08, p = .039). Further, regarding the quadratic factor for spiritual distress (R^2 = .05), other results revealed greater use of Basic Skills interventions was associated with a slower leveling-off effect (β = .13, SE = .05, p = .007) whereas interventions focusing on Religious Attachment were associated with a stronger leveling-off effect (β = .13, SE = .05, p = .007).

Because the overall indices for Basic Skills, Discuss Virtues, and Religious Attachment were linked with clinical outcomes, we specified a multivariate LGCM with psychological and spiritual distress as the outcomes and individual interventions within each category as separate predictors. Despite its complexity, this intervention-level model was also an excellent fit, χ^2 (147) = 196.91 p = .004, CFI = .990, TLI = .982, RMSEA = .020, 90% CI [.012, .026], and SRMR = .020. Overall, this intervention-level model explained five and four percent of the variance in intercepts for psychological and spiritual distress, respectively (R^2 = .05 and .04).

However, when focusing on the latent slope and quadratic factors for the two outcomes, use of spiritual interventions in the model explained between 8-10% of variance for these components of clients' trajectories (R^2 = .08-.10). As highlighted in Table 3, this finer-grained analysis revealed positive associations between severity of clients' psychological and spiritual distress at baseline and clinicians' likelihood of regularly affirming their clients' divine worth and listening to spiritual issues over the treatment process, respectively. Further, when accounting for effects of other predictors in the model, the following interventions from the three larger categories were uniquely associated with the latent slope and quadratic factors for psychological and/or spiritual distress in varying ways: spiritual assessment, exploring religious questions and doubts, discuss self-control, and encouragement to receive divine love (see Table 3 for statistical results)[3].

Discussion

Religion and spirituality (R/S) are core domains of diversity and psychological functioning that can be a source of strength and/or struggle among people who are contending with mental health-related issues that might lead them to seek psychotherapy. Practice-based evidence (PBE) research is needed to clarify processes and outcomes of spiritually integrated psychotherapies (SIPs) that are routinely implemented in the U.S. and worldwide (Captari et al., 2021; Richards & Barkham, 2022; Richards et al., 2015). Focusing on adult clients who were seeking to engage in SIPs across 37 clinics and other settings in a practice-research network, over 90% of these persons were affiliated with a religious tradition, deemed R/S as important to them, wanted to discuss their R/S in sessions, and/or were interested in suggestions of a religious or spiritual nature from clinicians. Overall, this pattern affirms that many clients prefer clinicians to be proactive about discussing R/S and, particularly when clients value R/S, they often want clinicians to tailor treatment according to spiritual or religious aspects of their lives (Rosmarin et al., 2015). Consistent with the high prevalence of spiritual struggles documented in other clinical

[3]We conducted a series of post-hoc power analyses via Monte Carlo Simulation using start and seed values from the univariate and multivariate quadratic LGCMs, respectively. These analyses indicated that power was strong across all models (i.e., greater than .95), likely because all models met or exceeded the standard of 10 participants for every freely estimated parameter.

samples (e.g., Currier et al, 2019), over half of the clients also indicated that religion had hurt them or somehow contributed to problems that possibly led them to seek care. In combination, these descriptive findings highlight the clinical and cultural relevance of attending to these clients' R/S in the treatment process.

Preliminary analyses with observed scores and latent growth curve modeling (LGCM) revealed clients who engaged in SIPs tended to have better therapy outcomes in the practice-research network. In keeping with prior PBE research (Captari et al., 2021) and controlled outcome studies (Captari et al., 2018), nearly 60% of clients experienced reliable improvement in psychological distress over the 12-week period. Our analyses similarly revealed a statistically significant decline in spiritual distress over the course of SIPs. However, when compared to psychological distress, only one-fifth of clients displayed reliable improvement in spiritual distress. In combination, this pattern supports the first hypothesis and align with prior research (e.g., Bockrath et al., 2021). Further, we found evidence of a quadratic or non-linear function in clients' trajectories of both forms of distress. Namely, rather than the same magnitude of changes in symptoms occurring over each two-week interval in our analyses, clients usually reported the sharpest improvement in psychological and spiritual distress in the first month of SIPs followed by a negative accelerating rate of symptom reduction over the next two months. The pattern mirrors a well-documented rate and shape of clinical improvement for routinely-delivered psychotherapies in similar settings (Bone et al., 2020; Robinson et al., 2019). Consistent with findings from other naturalistically-collected outcome studies, clients who are seeking SIPs, on average, similarly appear to experience the most symptom reduction in a time-limited period.

Other findings from the primary analyses also supported our anticipated associations between components of clients' trajectories of psychological and spiritual distress. In support of Hypothesis 2, clients who were more spiritually distressed at the start of treatment typically reported a higher severity of psychological distress. Building on prior longitudinal findings (Bockrath et al., 2021), spiritual distress at baseline was also predictive of a lower decline in psychological distress along with less leveling off of such changes over the course of treatment.

Namely, when clients were spiritually distressed at the first session, they appeared to need more time to attain a desired level of recovery from depression, anxiety, and/or other symptoms of psychological distress. Further, rather than reaching their limit on symptom change after the first month of treatment, clients who were struggling spiritually at baseline also generally reported steady reduction of psychological distress into the second and third months of engaging in SIPs. Importantly, this same pattern held for trajectories of spiritual distress; clients who were more psychologically distressed at baseline generally displayed less improvement in spiritual distress overall but were also more likely to experience gradual reductions in spiritual distress over the entire 12-week period. Finally, in keeping with Hypothesis 3, our primary analyses also revealed that clients' rates of decline in spiritual distress were simultaneously linked with reductions in psychological distress over the treatment process. This finding also aligns with prior research on concomitant changes in these forms of distress in other SIPs (e.g., Currier et al., 2019).

Drawing upon information from clinicians' after-session ratings, our secondary analyses first identified the types of interventions that were routinely implemented by the practitioners of SIPs across the research sites. Of the three major systems of psychotherapy, the vast majority of clients engaged in SIPs that were guided by a CBT and/or humanistic approach of some sort. Of the specific orientations within each category, clinicians appeared to utilize CBT and/or client-centered therapy with nearly half of the cases in the sample. Consistent with the commonality of psychotherapy integration among practicing clinicians (e.g., Norcross et al., 2002), these findings suggest practitioners of SIPs generally do not rely upon a single theoretical approach. Further, 90% of the clients also participated in one or more of the spiritual interventions in this study. In total, clinicians used spiritual interventions focusing on Basic Skills, Spiritual Practices, Discuss Virtues, and/or Religious Attachment with 50-75% of clients. Of the individual interventions in these four categories, clinicians listened to spiritual issues, discussed spiritual dimensions of problems and solutions, discussed compassion and hope, and affirmed clients' divine worth and attempts to trust God in 20-40% of the sessions. Delivered in the context of a theoretically eclectic or integrative approach to psychotherapy, these latter findings might highlight the most

common ways that practitioners of SIPs attend to their clients' R/S in sessions.

Beyond clarifying theoretical orientations and spiritual interventions that are routinely used in SIPs, we also explored whether any of these approaches were associated with the clients' trajectories of psychological or spiritual distress. These analyses did not suggest that clinicians who were guided by particular theoretical orientations were more effective than others. However, our secondary analyses found salient associations between clinical outcomes and clinicians' use of spiritual interventions across the categories of Basic Skills, Discuss Virtues, and Religious Attachment. Specifically, when clients were more psychologically and spiritually distressed at their first session, clinicians were more likely to listen to spiritual issues and affirm their clients' divine worth throughout the treatment process. Focusing on interventions involving basic skills, clients who regularly explored religious questions and doubts in sessions also, on average, displayed a more gradual and steady rate of improvement for psychological and spiritual distress. In contrast, clients who engaged in a spiritual assessment conducted by their clinicians generally displayed a sharper decline in both forms of distress that leveled off more quickly. The pattern for discussing self-control was similar to that observed for exploring religious questions and doubts; specifically, clients who discussed this virtue over the course of SIPs generally had a more gradual reduction in psychological distress that was not clearly attenuated by the quadratic function. Last, of the interventions for supporting religious attachment, encouraging acceptance of divine love was associated with a sharper decline in spiritual distress that was not associated with the quadratic function beyond the overall pattern documented in the primary analysis.

Clinical Implications

This overall pattern of findings may inform the practice of SIPs in several ways. In combination with other evidence (e.g., Captari et al., 2018, 2021), this study affirms the potential effectiveness of SIPs that might be accessible in communities throughout the U.S. and other countries for persons who want clinicians to attend to their R/S in the treatment process. Because reduction of psychological and spiritual distress occurred mostly in the first month for many clients, practitioners of SIPs might also anticipate the impact of treatment on reduction of

troubling symptoms could diminish following a time-limited period. Further, the reciprocal interplay between trajectories of psychological and spiritual distress reinforces the need to identify clients who are feeling distant or abandoned by God or struggling with their R/S in other ways that could diminish their responsiveness to treatment. In such cases, findings suggest that some clients appear to benefit form a greater duration or dosage of SIPs. When spiritual distress is not addressed adequately, these clients could be less likely to recover from depression, anxiety, and other symptoms of psychological distress. Importantly, we also found clients did not experience the same magnitude of improvement with spiritual distress compared to these symptoms. However, while the main goal of SIPs is not to resolve philosophical, theological, or cultural issues that could lead clients to struggle with R/S, secondary findings indicate clinicians often used certain types of spiritual interventions in these cases that were favorably associated with clinical outcomes. For example, assessing or inquiring about clients' R/S was predictive of decline in psychological and spiritual distress in the first month of SIPs whereas exploring religious questions and doubts, discussing self-control, and encouraging acceptance of divine love was linked with a steadier rate of improvement in the treatment period.

Defined as "markers or moments in therapy where the therapist and client can engage in purposeful and meaningful dialogue about the clients' cultural identity" (Owen et al., 2016, p. 31), these spiritual interventions might be viewed as distinct "cultural opportunities" related to a client's R/S within the multicultural orientation framework (Winkeljohn Black et al., 2021). Research has linked cultural conversations about other sources of identity (e.g., race, gender) with favorable outcomes in psychotherapy (Davis et al., 2018). Particularly for clients seeking SIPs, this study affirms the possible value of clinicians attuning to opportunities to understand a client's R/S and discuss/explore how these beliefs, values, practices, and/or relationships might engender strength and struggle. In such cases, research has supported the benefit of inquiring about a clients' R/S in the assessment process and initiating such conversations throughout the treatment process when indicated (Huguelet et al., 2011; Terepka & Hatfield, 2020). Drawing upon a stance of cultural humility, clinicians might also listen for spiritual or religious themes to

emerge in sessions and be prepared to attend to these aspects of a client's identity when helpful. Encouragingly, a growing volume of articles, books, and other training resources are available for clinicians to cultivate these basic competencies. For example, Spiritual Competency Training in Mental Health (SCT-MH) is an eight-module, online training program with a growing track record of acceptability, feasibility, and effectiveness in promoting basic awareness, knowledge, and skills related to R/S (Pearce et al., 2020, under review; Salcone et al., under review).

Limitations and Future Directions

Several limitations should be discussed before drawing conclusions from this study. Although the PBE design provided an opportunity to better understand SIPs, we cannot directly attribute clients' reduction of psychological and spiritual distress to these treatments. Further, while we observed statistically significant improvements throughout our analyses, the medium effect size and limited responsiveness for spiritual distress raises questions about whether clients who were struggling with their R/S benefitted to an extent that is customarily expected with professional interventions. However, because PBE research has not tracked spiritual distress as an outcome, comparisons with existing studies cannot be offered. In keeping with existing theory and research (Pargament & Exline, 2023), this pattern might indicate that spiritual distress is more deeply connected with clients' sacred beliefs that could be more trait-like and less responsive to psychospiritual intervention than mental health symptoms. Relatedly, while our secondary analyses revealed salient associations between certain spiritual interventions and clients' trajectories of psychological and spiritual distress, 90% or greater of variation across intercept, latent slope, and quadratic factors was nonetheless not explained in our LGCMs. Given the naturalistic conditions in which the study was conducted, some of the spiritual interventions that were favorably associated with clinical outcomes were also used with a minority of cases (e.g., clinicians conducted a spiritual assessment with less than 6% of clients). We also did not did not implement procedures to verify the clinicians' use of the spiritual interventions or assess all of the ways of attending to clients' R/S that might be helpful (e.g., refer to faith community, utilize R/S imagery or concepts in meditative exercises). As such, findings warrant replication

and expansion in other PBE studies in ways that will inform RCTs that might overcome these limitations and dismantle the benefits of utilizing spiritual interventions in psychotherapies.

Issues related to the generalizability of our findings also warrant some discussion. Despite the geographic diversity of the 37 practice settings in this study, three-quarters of the clients identified as Christian in their religious affiliation and over 90% rated R/S to be important for them. Overall, these features underscore preferences of many Judeo-Christian believers for mental health care that honors their faith (Currier et al., 2020; Rosmarin et al., 2015). However, when considering the growing numbers of persons who identify as atheist or agnostic, spiritually committed people who do not affiliate with an organized religion, and steady growth of Islam in the U.S. and other countries (Pew Research Center, 2015, 2022), our findings might not apply to the implementation of SIPs in such cases. Further, only 8% of the clients participated in SIPs outside the U.S., most of whom were among a small number of persons from their countries in the sample. As such, findings might also not generalize to SIPs being practiced outside the U.S. Because over three-quarters of clients also identified as White, this study might similarly not generalize to Black, Indigenous, and People of Color who want clinicians to thoughtfully attend to their R/S in treatment. Importantly, nationwide surveys suggest R/S often play a powerful role in shaping beliefs, lifestyles, and relationships among Latinx Americans, African Americans, and Asian Americans (Pew Research Center, 2015). As such, research will ideally illumine processes and outcomes of SIPs that are responsive to the needs and identities of secular or spiritual but not religious individuals, persons receiving SIPs outside the U.S., as well as religiously and racially minoritized clients who prefer to not compartmentalize their R/S from their psychotherapy.

Several methodological and multicultural considerations will need to be addressed if research on SIPs is to proceed in these directions. At present, psychology and other mental health professionals need to determine whether intervention strategies and measures are inclusive for clients who do not adhere to a theistic worldview or fall outside the Judeo-Christian mainstream. For example, most SIPs that have been studied to date entailed interventions that were tailored for theistic believers or clients from specific religious backgrounds (Captari et al., 2018, 2021).

Notwithstanding diversity of backgrounds and attitudes toward R/S among persons who do not adhere to a theistic worldview (e.g., Van Tongeren et al., 2023), measures of spiritual distress also commonly include items that assume a theistic worldview or religious identity or some sort (see the CAMOS items for examples). However, just as many religious persons do not want to integrate their faith in psychotherapy, research also suggests a subset of atheist and non-theistic clients want to engage with clinicians who are responsive to spiritual issues or concerns (e.g., Rosmarin et al., 2015). Ranging from clients who strongly align with an organized religion to those who identify as secular, agnostic, or atheist, future studies will ideally examine flexible and inclusive methods of attending to clients' R/S in psychotherapy and assessing spiritual distress that honor the full spectrum of religious diversity. Building on our findings, these studies might also include other process measures (e.g., therapeutic alliance) and assess the role of clinicians' formal training and experience in addressing R/S in their practice. In so doing, such studies may lead to a new generation of methods of training, research, and clinical practice that more fully honor the role of R/S within a broader framework of multicultural diversity.

Conclusion

Notwithstanding these limitations and directions for future research, this is the most comprehensive PBE study on SIPs conducted to date. Three major findings emerged: (1) clients who were engaging in SIPs across sites in the practice-research network generally displayed reductions in psychological distress with improvement occurring most strongly in the first month; (2) clients who were struggling with their R/S were usually also more psychologically distressed and displayed more attenuated and gradual trajectories of clinical improvement; and (3) attending to clients' R/S through implementation of certain spiritual interventions might enhance clients' rate and duration of symptom reduction. Looking ahead, the present findings will ideally advance psychotherapy research, training, and practice that enhances clinicians' responsiveness to clients' spiritual and/or religious identities in the context of psychotherapy.

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Table 1

Model Fit of Univariate Linear and Quadratic Latent Growth Curves for Psychological and Spiritual Distress over 12 Weeks

Model	χ^2 (df)	*p*-value	CFI	TLI	RMSEA	90% CI RMSEA	SRMR
Psychological Distress – Linear	285 (16)	<.001	.852	.862	.117	.106, .129	.197
Psychological Distress – Quadratic	54.01 (12)	<.001	.977	.971	.053	.039, .068	.063
Spiritual Distress – Linear	184.59 (16)	<.001	.937	.940	.093	.081, .105	.118
Spiritual Distress – Quadratic	40.43 (12)	<.001	.989	.987	.044	.029, .059	.037

Note. N = 1227. CFI = Comparative Fit Index, TLI = Tucker-Lewis Index, RMSEA = Root Mean Square Error of Approximation, and SRMR = Standardized Root Mean Residual.

Table 2

Frequencies of Theoretical Orientations and Spiritual Interventions for Secondary Analyses (N = 880)

Theoretical Orientations (%)		Spiritual Interventions (%)	
Cognitive Behavioral		*Basic Skills*	
Acceptance and Commitment Therapy	28.3	Used spiritual assessment	5.6
Behavior Therapy	8.7	Listened to spiritual issues	27.8
Cognitive-Behavioral Therapy	48.2	Discussed the spiritual dimensions of problems and solutions	21.7
Rational Emotive Behavior Therapy	5.7	Explored religious questions and doubts	11.0
Humanistic		Explored questions about ultimate meaning	5.8
Client-Centered Therapy	44.9		
Existential Therapy	6.3		
Gestalt Therapy	3.9	*Spiritual Practices*	
Emotion-Focused Therapy	15.7	Affirmed client confession or repentance	5.4
		Encouraged personal prayer	17.8
Psychodynamic		Used religious bibliotherapy	8.3
Psychoanalysis	6.3	Encouraged spiritual meditation	6.5
Relational Psychodynamic	13.6	Encouraged spiritual journal writing	5.3
		Encouraged charitable service	3.7
		Discuss Virtues	
		Discussed forgiveness	12.0
		Discussed gratitude	11.9
		Discussed compassion	29.5
		Discussed hope	36.1
		Discussed self-control	15.3
		Discussed humility	6.0
		Religious Attachment	
		Affirmed client's divine worth	26.1
		Encouraged acceptance of God's love	18.3
		Affirmed trusting God	23.6
		Helped in discerning God's will	10.4
		Encouraged reconciling beliefs in God with pain and suffering	7.4
		Identified pathways to God or the sacred	7.3

Table 3

Regression Coefficients for Secondary Analysis of Psychological and Spiritual Distress in Relation to Spiritual Interventions (N = 880)

	Psychological Distress											
	Intercept				**Slope**				**Quadratic**			
	B	***SE B***	***β***	***p***	***B***	***SE B***	***β***	***p***	***B***	***SE B***	***β***	***p***
Basic Skills												
Used spiritual assessment	1.37	.04	.06	.171	**-2.54**	**.06**	**-.15**	**.011**	**2.99**	**.05**	**.16**	**.003**
Listened to spiritual issues	0.86	.05	.04	.391	-0.07	.06	.00	.947	-0.13	.06	.00	.990
Discussed the spiritual dimensions of problems and solutions	-0.87	.03	-.04	.385	-0.20	.09	-.02	.843	0.35	.09	.03	.725
Explored religious questions and doubts	0.72	.04	.03	.473	2.23	.06	.14	.026	-1.79	.08	-.14	.073
Explored questions about ultimate meaning	-1.52	.05	-.07	.130	1.11	.07	.08	.269	-0.72	.08	-.06	.470
Discuss Virtues												
Discussed forgiveness	-1.85	.05	-.08	.065	0.18	.07	.01	.859	-0.36	.08	-.03	.722
Discussed gratitude	-0.90	.06	-.06	.369	-0.04	.06	.00	.966	0.42	.08	.03	.677
Discussed compassion	1.50	.04	.06	.134	-0.01	.07	.00	.993	0.38	.08	.03	.704
Discussed hope	1.39	.04	.06	.165	-0.62	.08	-.05	.539	0.42	.09	.04	.678
Discussed self-control	-0.63	.06	-.04	.532	**2.13**	**.06**	**.13**	**.034**	**-2.13**	**.07**	**-.15**	**.034**
Discussed humility	1.01	.04	.04	.312	-1.10	.07	-.08	.271	0.85	.10	.09	.396
Religious Attachment												
Affirmed client's divine worth	**2.35**	**.04**	**.10**	**.019**	-1.63	.07	.08	.104	1.11	.07	.08	.267
Encouraged acceptance of God's love	1.76	.05	.09	.079	-1.09	.09	-.10	.277	0.71	.11	.08	.481
Affirmed trusting God	-1.35	.05	-.07	.176	0.09	.06	.01	.926	-0.10	.08	-.01	.924
Helped in discerning God's will	-1.16	.05	-.06	.247	0.03	.08	.00	.978	-0.46	.09	-.04	.646
Encouraged reconciling beliefs in God with pain and suffering	0.66	.06	.04	.508	-0.17	.07	-.01	.867	0.71	.08	.05	.478
Identified pathways to God or the sacred	-0.69	.05	-.04	.492	-0.17	.06	-.01	.862	-0.56	.07	-.04	.573

	Spiritual Distress											
	Intercept				Slope				Quadratic			
	B	***SE B***	***β***	***p***	***B***	***SE B***	***β***	***p***	***B***	***SE B***	***β***	***p***
Basic Skills												
Used spiritual assessment	0.18	.04	.01	.854	**-2.30**	**.05**	**-.11**	**.022**	**2.54**	**.06**	**.14**	**.011**
Listened to spiritual issues	**2.32**	**.05**	**0.11**	**.020**	-0.02	.05	.00	.978	-0.59	.06	-.03	.557
Discussed the spiritual dimensions of problems and solutions	-0.97	.05	-.05	.334	0.68	.08	.06	.496	-0.51	.08	-.04	.612
Explored religious questions and doubts	1.31	.05	.06	.187	**2.35**	**.07**	**.15**	**.019**	**-2.38**	**.08**	**-.19**	**.017**
Explored questions about ultimate meaning	0.36	.04	.01	.718	1.44	.06	.08	.150	-1.38	.07	-.10	.169
Discuss Virtues												
Discussed forgiveness	-1.42	.04	-.06	.155	1.41	.07	.10	.159	-1.06	.08	-.09	.290
Discussed gratitude	-1.18	.05	-.05	.240	0.35	.07	.02	.725	-0.32	.08	-.03	.753
Discussed compassion	-0.24	.04	-.01	.814	0.76	.05	.04	.450	-0.41	.07	-.03	.685
Discussed hope	-1.71	.04	-.08	.086	0.27	.07	.02	.790	0.44	.09	.44	.658
Discussed self-control	-.084	.04	.03	.401	0.74	.06	.04	.458	-1.22	.07	-.08	.222
Discussed humility	1.92	.03	.07	.055	0.04	.05	.00	.969	-0.13	.08	-.01	.897
Religious Attachment												
Affirmed client's divine worth	0.78	.04	.03	.438	-1.50	.06	-.09	.135	0.75	.08	.06	.456
Encouraged acceptance of God's love	1.61	.04	.07	.107	**-1.96**	**.05**	**-.10**	**.050**	1.24	.07	.08	.215
Affirmed trusting God	-0.40	.05	-.02	.691	-054	.06	-.04	.584	0.74	.08	.06	.457
Helped in discerning God's will	-0.32	.04	-.01	.746	-0.91	.06	-.06	.361	0.32	.07	.02	.746
Encouraged reconciling beliefs in God with pain and suffering	1.31	.04	.06	.191	0.20	.05	.01	.843	0.35	.06	.02	.726
Identified pathways to God or the sacred	0.04	.04	.00	.968	-1.35	.05	-.07	.176	0.70	.06	.04	.495

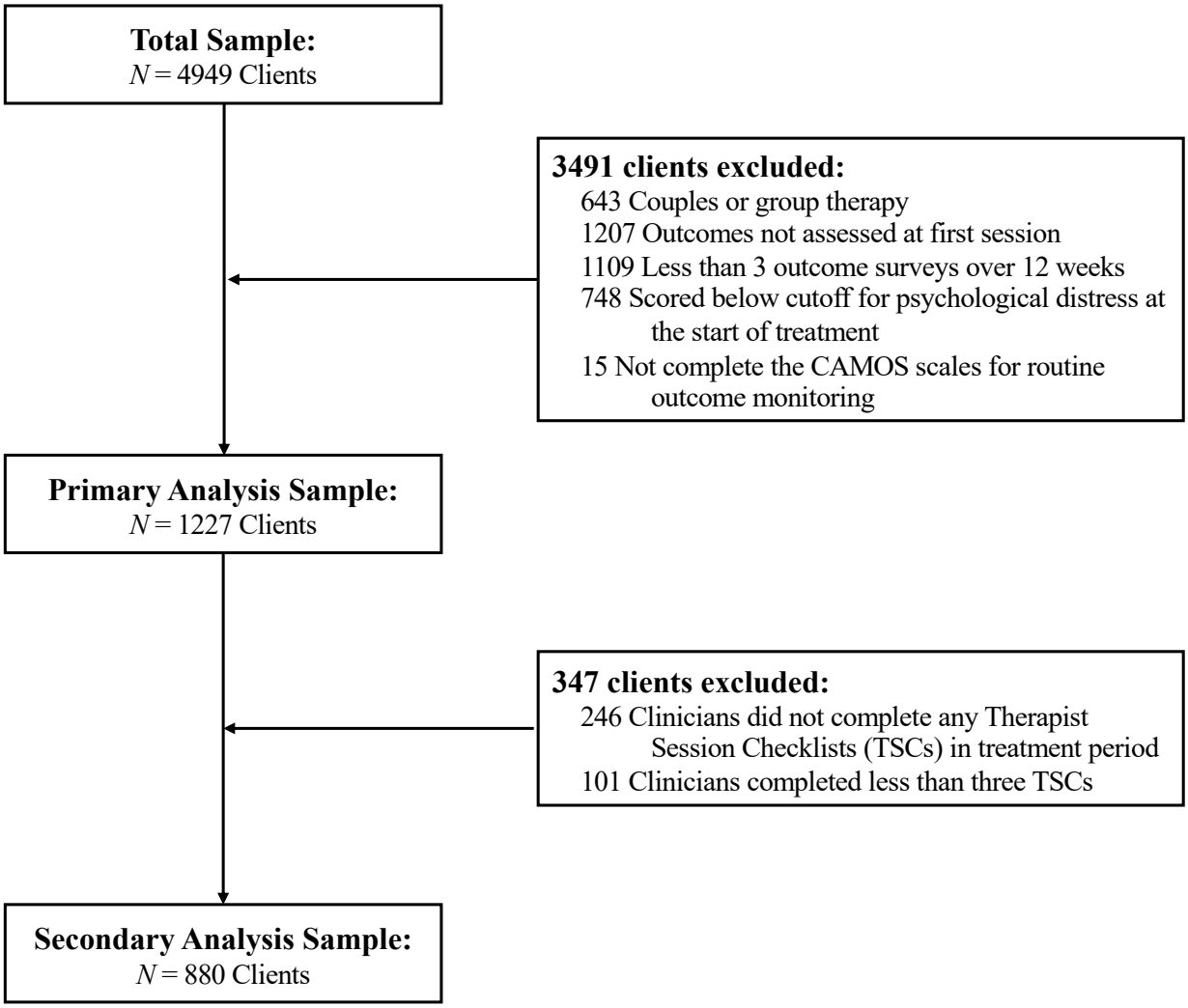

Figure 1. Flow diagram for selection of samples for primary and secondary analyses from the practice-research network.

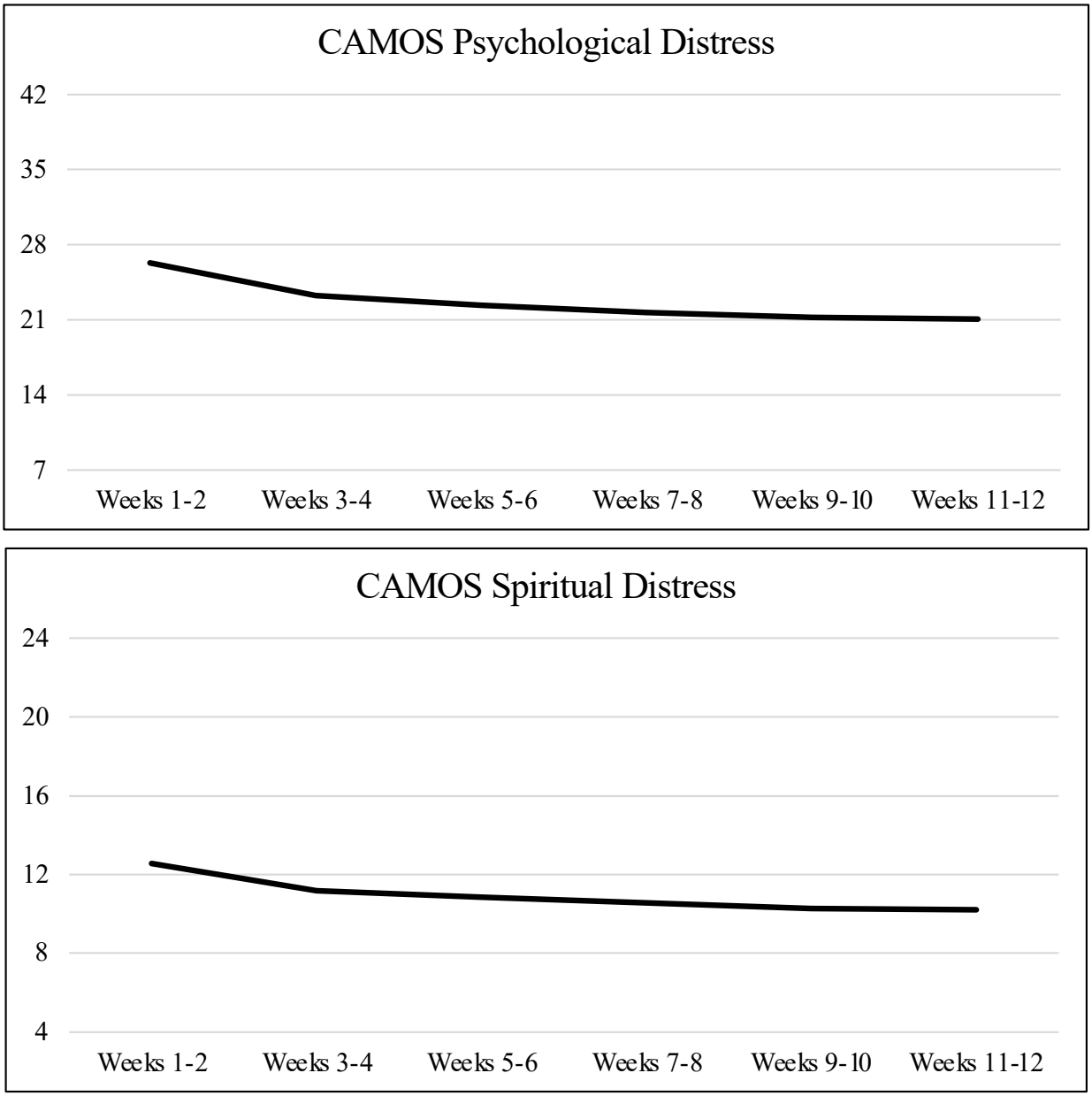

Figure 2. Observed means for CAMOS Psychological Distress and CAMOS Spiritual Distress over the 12-week period. Y axes are scaled for each measure based on the possible range of scores for each measure.