Enhancing Practice-Based Evidence for Spiritually Integrated Psychotherapies: An Interdisciplinary Big Data Project

Request for Proposals (RFP)

The Consortium for Spiritually Centered Psychology and Education, which resides in the David O. McKay School of Education at Brigham Young University in Provo, Utah, is pleased to announce a three-year research project, Enhancing Practice-Based Evidence for Spiritually Integrated Psychotherapies: An Interdisciplinary Big Data Project, supported with funding from the John Templeton Foundation. This research initiative is dedicated to creating an international interdisciplinary collaborative network of researchers and practitioners to contribute to research and practice concerned with spiritually integrated psychotherapies.

The project will focus on spiritually integrated psychotherapy approaches that are grounded in either a major world religion or a nontraditional spirituality that is clearly oriented toward something of sacred or transcendent value. Its purpose is to fund studies that use practice-based research designs revealing what practitioners routinely do in spiritually integrated practice during the course of individual, marital, or group therapy treatment. Research will investigate how mental health professionals use spiritually integrated psychotherapy approaches as they work with clients who are struggling with emotional, spiritual, and relationship problems.

Randomized controlled trials (RCTs) will not be funded by this project, nor will studies limited to pastoral counseling or spiritual direction or studies involving only mindfulness-based approaches in the absence of additional spiritual interventions (e.g., conducting spiritual assessment, including spiritual imagery, reading sacred writings). Finally, the project will not fund studies that propose to investigate purely secular psychotherapies even if these approaches are conducted by clinicians who accept religion and spirituality as important aspects of human diversity. More information about the focus of the project is provided in Appendix 3 of this document.

The project will investigate three general research questions:

1. What types of spiritual approaches and interventions do mental health professionals use in their practices during the course of treatment?

2. When and how often do mental health professionals use spiritual approaches and interventions during the course of treatment??

3. How effective are spiritual approaches and interventions with different types of clinical issues and patients?

Grant applicants are encouraged to propose their own specific research questions or hypotheses that are relevant to their treatment site in addition to one or more of these three general questions.

I. Who Can Apply?

The Principal Investigator must have a doctoral degree (or equivalent) and be affiliated with an accredited college or university, some other research institution, and/or a mental health treatment facility (e.g., community mental health center, hospital, private practice setting). Applicants can only have their name on one proposal for this competition. Proposed projects are encouraged but not limited to scholars, practitioners, and educators in the disciplines of psychology, psychotherapy, marriage and family therapy, clinical social work, psychiatry, medicine, education, pastoral counseling, chaplaincy, theology, and religious studies.

II. What Procedures Are Required?

Form a multidisciplinary team

Principal investigators should form a multidisciplinary team composed of at least one qualified individual who can each contribute conceptually and practically to the project in each of the following areas: researcher, practitioner, mental health educator, and pastoral/religious professional/clergy person. We require multidisciplinary teams for these projects because we recognize that such teams facilitate high quality research, publications, and training materials, which will enable us to reach important stakeholder groups that can participate in mainstreaming spiritually integrated psychotherapies. Individuals comprising each team should have commonly accepted professional credentials and experience for fulfilling their roles. For example, mental health educators must have an appropriate degree and experience providing graduate training in an accredited public or private institution of higher education.

If necessary, one person can fulfill up to two roles if qualified in both. For example, one team member can fill the research and practitioner roles if he/she currently engages in both, or a team member can fill both the research and educator roles if he/she is currently functioning in both areas. Teams that are unable to formally include a pastoral professional or clergy person can fulfill the requirement by consulting about their proposal and research design with a qualified pastoral professional or clergy person who is recommended or provided by the project directors and/or Scientific Advisory Board. Principal investigators who need assistance in finding collaborators for their multidisciplinary teams may contact the project director for guidance and potential contacts.

Join the Bridges Practice Research Network

All research teams that receive funding from the international grant competition will become members of the Bridges Practice Research Network (PRN). Technological resources available through Bridges enable grant recipients to connect and collaborate with one another in multiple ways. A *Bridges* website, Bridges listserv, and WebEx videoconference account will enable grant recipients to share resources and support each other and their collaborating treatment sites. Through collaboration in the *Bridges* PRN, grant recipients will contribute to establishing a "big database" on the outcomes of spiritually integrated psychotherapies. Both practitioners and

scholars will benefit from this collaboration, and the database on spiritually integrated psychotherapies will rapidly expand.

Use the Bridges online psychotherapy research system

Grant recipients will benefit from the *Bridges* online psychotherapy research system for conducting practice-based process and outcome research. The Bridges online assessment system has its own psychometrically validated outcome and process measures, but it is dynamic in that its measures can be adapted or tailored to fit the unique needs of each treatment site, clinician, and client. The online system includes three core measures, two of which are client self-report outcome scales.

The Clinically Adaptive Multidimensional Outcome Survey (CAMOS), a self-report scale that takes about five minutes to complete, assesses clients' distress and concerns in five areas, stated as psychological distress, relationship distress, therapy expectations, spiritual distress, physical health distress, and work/school distress.

The Clinical Outcomes in Routine Evaluation (CORE-10) is a client outcome measure developed and validated by Michael Barkham and his colleagues in the United Kingdom (Barkham, Mellor-Clark, C. Evans, R. Evans, & Margison, 2010). The CORE measures and the system effectively measure, monitor, and manage quality evaluation in the psychological therapies (Barkham, Hardy, & Mellor-Clark, 2010). The 10 items of the CORE 10 assess depression, anxiety, functioning (social, close relationship, physical, and general functioning), trauma, and risk. The battery of CORE measures, including the CORE-10, have been used extensively in the UK and other countries with thousands of patients. Using the CORE-10 in our project provides access to a wealth of normative material and data that will allow us to benchmark and compare the outcomes of spiritually integrated psychotherapies with other psychotherapy approaches.

The Therapist Session Checklist (TSC) is a therapist process survey that can be completed in approximately one or two minutes after each treatment session, allowing therapists to record what they did during the session (e.g., topics discussed, interventions used, therapeutic intentions). Sample items for these measures are provided in Appendix 2 of this document.

Research teams and treatment sites will be allowed to add their own unique measures that can be administered either during each session (up to 12 items) or as pre- and post-test measures. All patients will be asked at their intake session to complete a one-time brief background/demographic questionnaire. Therapists will need to take care that completing the assessment measures does not place undue time burdens on patients. Also all therapists will also be asked to complete a one-time professional background/demographic questionnaire requesting information about what types of training they have received in religious/spiritual competencies, how much (if any) training has been documented, where they received it, and how long ago.

Participate in online training webinars with project directors

Several online webinars will be hosted by the project directors (Richards, Judd, and Allen) during the three-year project in order to provide (1) opportunities for grant applicants who

have been invited to submit a full proposal to ask questions and receive guidance regarding the three-year collaborative project along with suggestions for preparing and refining their proposals; (2) training to grant recipients and their treatment sites regarding how to successfully launch their research studies and implement and use the online assessment system in their treatment sites; (3) opportunities for grant recipients to ask questions and receive guidance and support for resolving challenges and problems that may have come up during the data collection phase of their projects; and (4) support and guidelines to help grant recipients successfully share their research findings at the international conference and with the media and other stake holder groups.

Conduct a one-year psychotherapy process/outcome research study concerning spiritually integrated psychotherapy in a mental health treatment site.

Each funded research team is required to conduct a psychotherapy study using practice-based evidence to evaluate the processes and outcomes of spiritually integrated treatment as it occurs naturally in a mental health treatment site. Theproject expects to fund multiple treatment modalities (e.g., individual therapy, group therapy, couples and family therapy, inpatient treatment). By using the common outcome and process measures described above, each research team will contribute to a shared big data set that will enable the investigation of research questions that would not be possible to explore without such group collaboration. Because of the flexibility of the online assessment system, grant recipients will also be able to address questions that are unique to their interests and context by adding process and outcome measures of their own.

The online system will provide a low-cost, efficient, and flexible way for grant recipients to collect data. Even though practice-based evidence studies are less expensive to conduct than some other research approaches, they have the potential to yield large quantities of rich process and outcome data. For example, a relatively small-scale practice-based evidence study we recently conducted during an eight-month period with eight therapists at a cost of less than $20,000 yielded data on over 1000 psychotherapy sessions involving 300 clients.

We estimate that the 20–30 studies we fund through the grant will enable us to collaboratively produce a set of approximately 450–500 psychotherapists, 20,000–22,000 patients, and 70,000–75,000 psychotherapy sessions. The collaborative efforts of multiple researchers and practitioners from treatment settings around the world will provide an unparalleled opportunity to cost-efficiently collect big data on a rich diversity of psychotherapists and patients who use and receive spiritually oriented treatment approaches. During the third year of the project, we will invite proposals from grant recipients (and perhaps other researchers) to receive small supplemental grants ($5000–$10,000) to assist in analyzing and publishing findings from the big data set.

Attend an international conference in a major US city in early March 2020 to present the findings of your research study.

All grant recipients will present their research findings on spiritually oriented psychotherapies to scholars and to the general public at an international conference in a major US city (to be announced). The international conference will be publicized to attract local, national, and

international media coverage (print, internet, radio, and television) to help inform professionals and the general public about the effectiveness and availability of spiritually oriented treatment approaches for mainstream healthcare.

Assist in disseminating the findings of your psychotherapy research study and the collaborative big data set to multiple stakeholder groups.

To succeed at bringing spiritually oriented psychotherapies more fully into mainstream healthcare, this project must impact multiple stakeholders, including the media, general public, professional organizations, accreditation bodies, and healthcare policy makers. Figure 1 in the Appendix illustrates our conception of how this collaborative research project can contribute to achieving this goal. Changing the practice of mental health care begins with high quality research that will be stimulated by the grant competition. Mainstreaming spiritually oriented treatment approaches must begin with a strong evidence base to provide credibility and leverage for all other change efforts.

We must inform and influence practitioners as well as researchers. Funded project teams are strongly encouraged to publish their findings in journals and books directed to practitioners as well as those dedicated to a research audience. It is also crucial to influence mental health educators to help ensure that future generations of practitioners receive training that concerns spiritual aspects of diversity and treatment. We need to provide information to pastoral professionals and develop resources for members of religious communities. Of course we will use all available media outlets to inform the general public about the availability and effectiveness of spiritually integrated approaches. It is also essential to influence professional accreditation bodies and other healthcare policy makers so that spiritually integrated approaches are allotted equality and influence in training programs and in healthcare practice. Grant applicants should include a plan explaining how they will use their grant and research findings to help influence these stakeholders.

III. How Much Funding Can I Request?

We plan to award a total of 1.8 million dollars to grant applicants. We will award a large number of major research grants (about 20–25 grants ranging from $20,000 to $250,000, with an average amount of approximately $80,000). We will set aside $150,000 out of the 1.8 million to fund doctoral dissertation grants for student dissertation projects with small grants for up to $15,000 per project. In addition we anticipate designating $50,000 to offer big data set grants of up to $10,000 each to fund researchers who wish to assist us in the statistical analysis and publication of findings from the big data set. The budget cap for all grants offered includes any institutional indirect costs.

We encourage proposals from a large pool of potential applicants, including small teams of researchers and practitioners who are capable of contributing to the evidence base on spiritually oriented psychotherapies. In general we expect that a $20,000 investment (grant) should obtain data from about five therapists, 250 patients, and 800 therapy sessions during a 12-month period. We anticipate that a $40,000 investment should provide approximately twice the data as a $20,000 project: data from about 10 therapists, 500 patients, and 1600 therapy sessions.

Accordingly, we assume that a $200,000 investment should provide approximately ten times the amount of data as a $20,000 project: data from approximately 50 therapists, 2500 patients, and 8000 therapy sessions.

IV. What Expenses Are Covered?

When needed, grant applicants may wish to provide in their budget monies for any or all of the following:

1. Salaries or stipends for research team members

2. Stipends to compensate practitioners and treatment sites for their time and contributions to the research

3. Student wages

4. Fees for statistical consultation and data analysis

5. Travel and lodging expenses for a maximum of four research team members to attend the international conference in March 2020

6. Fees for process and outcome assessment measures unique to the research team (no charge for using the CAMOS and TSC measures)

7. Handheld devices (e.g., iPads or other tablets) for clients (and therapists if necessary) to assist with data collection: no more than 10% of the budget unless strong justification is provided, as the online assessment system can be used with multiple devices (e.g., desktop computers, laptop computers, smart phones, etc.) and teams are thus encouraged to ask treatment sites and therapists to use devices already available to them

8. Office and research supplies (e.g., books, copy paper, postage)

9. Institutional indirect costs: no more than 15% as the budget cap (total amount of money awarded) for all grants includes any indirect costs

10. Other essential expenses

V. Who Will Review the Proposals?

Proposals will be reviewed by the project directors and a Scientific Review Board composed of scholars and practitioners from a diversity of religious and professional backgrounds. The reviewers listed below are internationally recognized and respected scholars and practitioners with interests in approaches to spiritually integrated treatment. Additional scientific review committee members will be selected who represent aspects of religious and professional

diversity that will enhance and strengthen our capacity to include all of the major religious traditions of the world and various racial-ethnic groups.

Project Directors

P. Scott Richards, Brigham Young University
Daniel K Judd, Brigham Young University
G. E. Kawika Allen, Brigham Young University

Scientific Advisory Board Members

Everett L. Worthington, Virginia Commonwealth University
William Hathaway, Regent University
Joshua Hook, University of North Texas
Nathaniel Wade, Iowa State University
Len Sperry, Florida Atlantic University
Steven Sandage, Boston University, Danielson Institute
Ken Pargament, Bowling Green University
Lisa Miller, Columbia University
Reverend George Handzo, Healthcare Chaplaincy, New York City

Consultants

Michael Barkham, Professor, The University of Sheffield, Sheffield, UK
Tyler VanderWeele, PhD, Harvard University

Additional Reviewers

Archpriest George Morelli, PhD, Antiochian Orthodox Christian Archdiocese of New York
Zari Hedayat-Diba, Antioch University, Los Angeles, CA
Pratyusha Tummala-Narra, Boston College
Mark Finn, North Central Bronx Hospital, New York
Ofra Mayseless, University of Haifa, Israel
Jeff King, PhD, Western Washington University, Center for Cross-Cultural Psychology

VI. What Evaluation Criteria Will Be Considered?

Criteria for Eligibility

1. The research team is a multidisciplinary group, including a researcher, mental health practitioner, pastoral professional/clergy person, and mental health educator. When necessary, one person can fill two of these roles if qualified in both. If a team has difficulty finding a person for the pastoral professional/clergy role, they can fulfill this requirement by consulting about their proposal and research design with a pastoral professional recommended by the project director.

2. The research investigation uses a practice-based evidence design that routinely monitors treatment outcomes and processes (e.g., each session or once a week).

3. The research study investigates the processes and outcomes of spiritually integrated psychotherapy in a mental health treatment setting for one year.

4. The spiritually integrated psychotherapy approach to be studied is grounded in either a major religious tradition (e.g., Christianity, Judaism, Islam, Buddhism, Hinduism) or a nontraditional spirituality that is clearly oriented toward something of sacred or transcendent value.

5. The research team agrees to share their data to contribute to the collaborative "big data set" by using the CAMOS, CORE-10, and TSC outcome and process measures.

6. The research proposal includes a plan for adding assessment measures unique to the treatment team's collaborating treatment setting. Up to 12 additional routine outcome monitoring items and one or two pre- and post-treatment assessment measures may be included.

7. The proposed budget does not exceed $250,000.

8. The research proposal includes a dissemination plan for sharing findings and influencing stakeholders.

Criteria for Competitiveness

1. Significance

- Does the study address an important problem or question about spiritual treatment approaches?

- How will this project impact future research on spiritually oriented treatments?

2. Cost effectiveness

- Does the proposal provide a strong rationale justifying its anticipated budget?

- Is the projected number of therapists, patients, and sessions commensurate with the proposed budget?

- Is the monetary request for handheld devices (e.g., iPads, Kindles) for data collection less than 10% of the total budget?

4. Approach and methods

- Is the practice-based evidence design adequately developed and rigorous for the purpose of the study and commensurate with the research question(s) addressed?

- Do the researchers have a solid commitment of participation from a mental health treatment site that has practitioners who practice spiritually integrated forms of treatment?

- Will the study seek to explore and/or link processes and outcomes of spiritually oriented treatment?

- Have the researchers specified criteria for judging the effectiveness of the treatment approaches (e.g., effect sizes, clinical cutoffs, benchmarks)?

- Do the researchers include a plan to assess the spiritual outcomes of treatment, along with other important outcomes?

- Do the researchers have a plan to address religious and spiritual aspects of diversity in the design of their study?

- Do the researchers have a plan to conduct follow-up assessment after treatment ends (3–12 months)?

4. Potential influence

- Do the researchers have strong publication records?

- Do the researchers have a workable plan for publishing their findings in mainstream scholarly journals?

5. Capacity for success

- What qualifications do the investigators bring to the project?

- Have the investigators described a convincing plan for carrying out the project in a timely manner?

- Have the investigators explained their plan for effectively disseminating their findings to both academic and nonacademic audiences?

VII. What Application Procedures Are Required?

Letter of Intent (LOI) Stage

The LOI, which is **due on March 24, 2017**, can be submitted online at http://bridgesconsortium.com/.

In addition to a contact information cover sheet, the LOI should include (a) a title for the proposed project (150 characters maximum), (b) a description of the research (7000 characters maximum), (c) an explanation of how the proposed project fits within the overall initiative (4000 characters maximum), (d) a description of the type of spiritually integrated psychotherapy approach(es) the team expects to study (2000 characters maximum), (e) information on the project's methodology and procedures (8000 characters maximum), (f) the budget required to complete the research (no more than 15% to cover indirect costs), and (g) a brief bio for each member of the research team (10,000 characters maximum).

Casual inquiries are not invited. The LOIs will be reviewed and evaluated by the scientific review committee, which will select the most promising and appropriate of the proposed projects.

Applicants are encouraged to familiarize themselves with recent scholarship on spiritually oriented psychotherapies by reading significant background papers listed below.

For questions about the LOI or the RFP in general, please contact the project director, P. Scott Richards, PhD, at scott_richards@byu.edu.

Full Proposal Stage

Principal investigators who are invited to submit a full proposal based on their LOI will be notified by **April 28, 2017**. **Full proposals must be received by June 30, 2017**; in order to be considered they must follow the format and guidelines below. Further details on the proposal submission process will be communicated to PIs who advance to that stage. **Applicants will be notified whether they have been awarded a grant by August 11, 2017.**

All proposals must be submitted in English in 12-point Times New Roman font, single-spaced, with 1 inch margins. Proposals that do not follow these font and margin specifications will not be accepted. Completeness and clarity of content should be emphasized. The full proposal must include all of the information specified.

The following documents are required for all full proposal submissions:

1. Cover Sheet
2. Table of Contents
3. Summary of Project
4. Description of Project
5. Description of Spiritually Integrated Psychotherapy Approach(es)

6. Timeline for Completion
7. Plan for Dissemination/Publicity
8. Description of Multidisciplinary Team
9. Curriculum Vitae of Team Members
10. Details of Budget
11. Narrative of Budget

VIII. Timeline for Proposals and Funded Projects

Year One

1. The letter of intent is due on March 24, 2017.
2. Notification of invitations to submit full proposals will be sent on April 28, 2017.
3. Those accepted will participate in an online webinar on May 25, 2017 with the project directors to ask questions and receive guidance on planning the three-year collaborative project and on preparing and refining proposals.
4. Full proposals are due on June 30, 2017.
5. Grant awards will be announced on August 11, 2017.
6. Research teams will participate with project directors in an online webinar on September 15, 2017 to receive training in how to successfully launch the research study and to implement and use the CAAS in their treatment site.
7. Research teams must submit their first progress report by December 15, 2018.

Year Two

1. Research teams should begin data collection for their studies no later than January 12, 2018.
2. Research teams will participate in an online webinar with project directors on January 25, 2018 to ask questions and receive guidance and support for resolving challenges and problems that may have surfaced during the data collection implementation phase of the project.
3. Research teams submit their second progress report by June 29, 2018.
4. Research teams end participant (client) recruitment by December 21, 2018.
5. Research teams submit another progress report by December 31, 2018.

Year Three

1. Research teams submit proposal requests by February 15, 2019 for big data grants to assist with data analysis of the large data set collected collaboratively by the research teams.
2. Research teams finish data collection by February 28, 2019.
3. Research teams begin data analysis for their projects by March 4, 2019.
4. Research teams submit progress reports and a preliminary manuscript reporting their research findings by May 31, 2019.

5. Research teams receiving big data grants submit report and preliminary manuscript discussing their findings for the big data analysis by July 31, 2019.
6. Research teams participate in an online webinar with the project directors on August 30, 2019 to receive support and guidelines for sharing their research findings at the international conference and for preparing to present and publish in other venues.
7. Research teams submit the proposal for their international conference presentation(s) by September 30, 2019.
8. Research teams participate in the international conference on spiritually oriented psychotherapies on March 20–21, 2020.
9. Research teams submit their final progress report by March 27, 2020.

IX. Significant Background Papers

Below are references to some seminal articles and books relevant to the science of spiritually oriented psychotherapies and practice-based evidence research.

American Psychological Association. (2006). Evidence-based practice in psychology. *American Psychologist, 61,* 271–285.

Barkham, M., Hardy, G. E., & Mellor-Clark, J. (2010). *Developing and delivering practice-based evidence: A guide for the psychological therapies*. West Sussex, England: Wiley-Blackwell. doi:10.1002/9780470687994

Barkham, M., Stiles, W. B., Lambert, M. J., & Mellor-Clark, J. (2010). Building a rigorous and relevant knowledge base for the psychological therapies. In M. Barkham, G. E. Hardy, & J. Mellor-Clark (Eds.), *Developing and delivering practice-based evidence: A guide for the psychological therapies* (pp. 21-61). West Sussex, England: Wiley-Blackwell. doi:10.1002/9780470687994

Castonguay, L., Barkham, M., Lutz, W., & McAleavey, A. (2013). Practice-oriented research: Approaches and applications. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (6th ed., pp. 85-133). New York, NY: Wiley.

Hook, J. N., Worthington, E. L., Davis, D. E., Jennings, D. J., Gartner, A. L., & Hook, J. P. (2010). Empirically supported religious and spiritual therapies. *Journal of Clinical Psychology, 66,* 46–72.

McMinn, M. R., Chaddock, T. P., Edwards, L. C., Lim, B. R. K. B., & Campbell, C. D. (1998). Psychologists collaborating with clergy. *Professional Psychology: Research and Practice, 29,* 564-570.

Oppenheimer, J. E., Flannelly, K. J., & Weaver, A. J. (2004). A comparative analysis of the psychological literature on collaboration between clergy and mental-health professionals—perspectives from secular and religious journals: 1970-1999. *Pastoral Psychology, 53,* 153-162.

Pargament, K. I. (2007). *Spiritually integrated psychotherapy: Understanding and addressing the sacred*. New York. NY: Guilford Press.

Richards, P. S., & Bergin, A. E. (2005). *A spiritual strategy for counseling and psychotherapy* (2nd ed.). Washington, DC: American Psychological Association.

Richards, P. S., & Bergin, A. E. (Eds.). (2014). *Handbook of psychotherapy and religious diversity* (2nd ed.). Washington, DC: American Psychological Association.

Richards, P. S., Sanders, P. W., Lea, T., McBride, J. A., & Allen, G. E. K. (2015). Bringing spiritually oriented psychotherapies into the health care mainstream: A call for worldwide collaboration. *Spirituality in Clinical Practice, 2*(3), 169-179. DOI: 10.1037/scp0000082

Richards, P. S., & Worthington, E. L., Jr. (2010). The need for evidence-based, spiritually oriented psychotherapies. *Professional Psychology: Research and Practice, 41*, 363-370.

Sanders, P. W., Richards, P. S., McBride, J. A., Lea, T., Hardman, R. K., & Barnes, D. V. (2015). Processes and outcomes of theistic spiritually oriented psychotherapy: A practice-based evidence investigation. *Spirituality in Clinical Practice, 2*(3), 180-190. DOI: 10.1037/scp0000083

Sperry, L., & Shafranske, E. P. (Eds.) (2005). *Spiritually oriented psychotherapy*. Washington, DC: American Psychological Association.

Worthington, E. L., Jr., Hook, J. N., Davis, D. E., & McDaniel, M. A. (2011). Religion and spirituality. In J. C. Norcross (Ed.), *Relationships that work* (2nd ed., pp. 402-419). New York, NY: Oxford University Press.

X. Additional Resources

The Bridges website: http://education.byu.edu/consortium/bridges

Literature Review

Jackson, R., Richards, P. S., Wheatley, A., Crowton, S., & Rees, M. (2016). Religion and spirituality in psychotherapy: A 20-year review and proposed research agenda. (Unpublished manuscript available on the Bridges website)

XI. Contact Information

Primary Contact Persons

Project Director
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Appendix 1

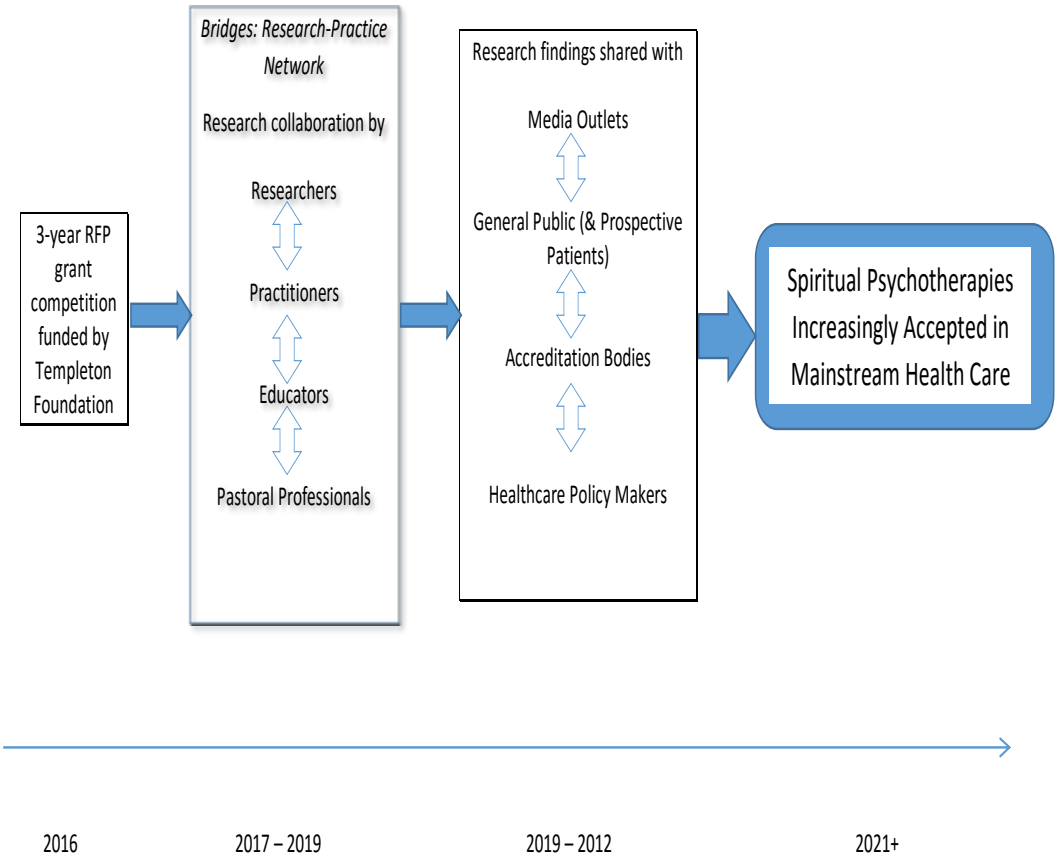

Figure 1: Theory of Change

Appendix 2: Samples of CAMOS, CORE-10, TSC, and WAI Outcome and Process Measures

CAMOS 2.0 Items

The CAMOS is a brief questionnaire for helping you and your counselor better understand how you have been doing during the past week. Responding to the questions based on your first impressions will usually provide the most accurate information. If you have any questions about the CAMOS, please feel free to discuss them with your counselor. You may proceed with completing the survey.

Items asking for Demographics and Attitudes about Spirituality (Intake Session Only)

When is this survey being taken?

- ❍ Before session
- ❍ After Session

My age is

My gender is

- ❍ Male
- ❍ Female

Ethnicity

- ❍ Alaskan Native
- ❍ American Indian
- ❍ African American/Black
- ❍ Asian
- ❍ Latino/a
- ❍ White/Causasian
- ❍ Polynesian
- ❍ Multiracial
- ❍ Other (please specify) _____

What is your current religious affiliation (if any)?

- ❍ Buddhist
- ❍ Eastern Orthodox
- ❍ Hindu
- ❍ Jewish
- ❍ Latter-day Saint
- ❍ Muslim
- ❍ Protestant Christian
- ❍ Roman Catholic
- ❍ Seventh-day Adventist
- ❍ Other
- ❍ None

Job Are you currently employed?

- ❍ Yes
- ❍ No

Is religion or spirituality important in your life?

- ❍ Yes
- ❍ No
- ❍ Somewhat

Do you wish to discuss religious or spiritual issues in counseling when it is relevant?

- ❍ Yes
- ❍ No
- ❍ Uncertain

Do you believe that religion has hurt you or contributed to some of your challenges?

- ❍ Yes
- ❍ No
- ❍ Uncertain

Are you willing to consider trying religious or spiritual suggestions from your counselor if it appears this could be helpful?

- ❍ Yes
- ❍ No
- ❍ Maybe

Is there anything else you would like to tell your counselor about your religion or spirituality?

CAMOS Items (25 Item Form)

(Participants rate these items on a 6-point Likert Scale
(*never, rarely, sometimes, frequently, almost always, always*)

Concerns about Therapy Items

During this past week

Items shown at intake session I had concerns about beginning therapy.
I felt anxious about beginning therapy.
I felt uncertain about whether I can be fully honest and open with my therapist.
I had doubts about whether my therapist will understand my concerns.
Items shown at second session and thereafter
I felt concerned about my therapy progress.
I felt anxious about coming to therapy.
I had doubts about whether my therapist understands my concerns.
I felt uncertain about whether I can be fully honest and open with my therapist.

Relationship Distress Items

During this past week

I felt irritated and angry towards others.
I felt hurt or disappointed by how my loved ones or friends behaved.
I felt misunderstood by my loved ones and friends.
I felt concerned about my relationships (with family, partner/spouse, and/or friends).
I felt accepted by my friends and loved ones.
I hurt others with my words or actions.

Psychological Distress Items

During this past week

I felt sad or depressed.
I felt worried, agitated, fearful, or tense.
I felt worthless or "not good enough."
I felt powerless or stuck in my problems.
I thought about past personal failures/mistakes.
I had difficulty concentrating or remaining focused on a task.
I had thoughts or images that I couldn't get out of my head.

Physical Health Distress Items

During this past week

I experienced physical pain or discomfort.
I had a stomach ache or other gastro-intestinal problems.
I felt physically well and healthy.
I felt light headed, weak, or fatigued.

Spiritual Distress Items

During this past week

I felt concerned about my religious or spiritual life.
I felt a loss of inspiration or spiritual direction.
I felt distant in my relationship with God or my Higher Power.
I felt guilt and regrets over mistakes that were inconsistent with my religious beliefs.

Critical Items (optional if treatment sites and/or therapists wish to include them)

During the past week

I had thoughts of ending my life.
I thought about harming myself (cutting, scratching, burning etc.).
I thought about harming others.
I abused harmful substances (e.g. alcohol, drugs, tobacco etc.).

CORE-10 Items

This form has 10 statements about how you have been OVER THE LAST WEEK. Please read each statement and think how often you felt that way last week. Then tick the box which is closest to this.

Over the last week

1. I have felt tense, anxious or nervous.

2. I have felt I have someone to turn to for support when needed.

3. I have felt able to cope when things go wrong.

4. Talking to people has felt too much for me.

5. I have felt panic or terror.

6. I made plans to end my life.

7. I have had difficulty getting to sleep or staying asleep.

8. I have felt despairing or hopeless.

9. I have felt unhappy.

10. Unwanted images or memories have been distressing me.

Barkham, M., Mellor-Clark, J., Evans, C., Evans, R., & Margison, F. (2010). Clinical outcomes in routine evaluation (CORE)—The CORE measures and system: Measuring, monitoring and managing quality evaluation in the psychological therapies. In M. Barkham, G. E. Hardy, & J. Mellor-Clark (Eds.), *Developing and delivering practice-based evidence: A guide for the psychological therapies* (pp. 175 - 247). West Sussex,England: Wiley. Blackwell.

Therapist Session Checklist
TSC 2.0

The purpose of the Therapist Session Checklist (TSC) is to allow psychotherapists to quickly record the client issues they worked on, the theoretical approaches they used, the interventions they used, and their therapeutic intentions during the therapy session. Information recorded on the TSC can serve as the therapist's case notes or as a supplement to hand-written case notes if preferred, Once the therapist has tailored the TSC response options/checklists to fit his or her orientation, completing the TSC checklists should take no more than two minutes. Thank you for taking the time to record this information about your session.

Date:

DSM Diagnosis:

Other Diagnostic Impressions:

What therapeutic approach(es) did you use in today's session? Please check all that apply.

- ❑ Acceptance and Commitment Therapy
- ❑ Behavior Therapy
- ❑ Christian Counseling
- ❑ Client-Centered
- ❑ Cognitive-Behavioral
- ❑ Diagnostic Interview and Assessment
- ❑ Emotion-Focused Therapy
- ❑ Existential-Humanistic
- ❑ Gestalt
- ❑ Interpersonal
- ❑ Narrative
- ❑ Psychodynamic
- ❑ REBT
- ❑ Reality Therapy
- ❑ Relational/Psychodynamic
- ❑ Solution-Focused
- ❑ Spiritual-Theistic
- ❑ Spiritual-Integrated
- ❑ Transpersonal
- ❑ Other _____

What counseling topics or issues did you and your client work on today? Please check all that apply.

- ❑ Abuse: physical
- ❑ Abuse: sexual
- ❑ Abuse: emotional
- ❑ Academics
- ❑ Addictions
- ❑ Alcohol/drug use
- ❑ Career/life planning
- ❑ Child rearing/parenting
- ❑ Cultural diversity
- ❑ Discrimination
- ❑ Eating/body image
- ❑ Emotions: affiliation (love, liking)
- ❑ Emotions: rejection (disgust, dislike)
- ❑ Emotions: destruction (rage, anger)
- ❑ Emotions: protection (panic, anxiety)
- ❑ Emotions: self-affirmation (joy, serenity)
- ❑ Emotions: reintegration (grief, depression)
- ❑ Emotions: orientation (surprise, confusion)
- ❑ Emotions: exploration (anticipation, curiosity)
- ❑ Employment
- ❑ Legal concerns
- ❑ Living conditions/housing
- ❑ Moral/ethical concerns
- ❑ Perfectionism
- ❑ Physical health
- ❑ Political issues
- ❑ Problem management/coping
- ❑ Relationships: family of origin
- ❑ Relationships: marriage/partner/dating
- ❑ Relationships: co-workers/supervisor
- ❑ Relationships: friends/acquaintances
- ❑ Relationships: other
- ❑ Religion/spirituality
- ❑ Self-esteem/identity
- ❑ Sexuality
- ❑ Self-injury
- ❑ Sleep disturbance
- ❑ Suicide
- ❑ Therapy progress
- ❑ Therapeutic relationship
- ❑ Violence

Please check what your three or four most important therapeutic intentions were for the therapy session you just completed.

- ❑ Set expectations for treatment
- ❑ Get information
- ❑ Give information/ psychoeducation
- ❑ Create a supportive environment
- ❑ Focus the session
- ❑ Elaborate on vague/contradictory content
- ❑ Instill hope
- ❑ Facilitate catharsis
- ❑ Identify problematic thought patterns
- ❑ Identify and/or provide feedback about client behaviors
- ❑ Increase self-control
- ❑ Explore/deepen emotions
- ❑ Facilitate insight
- ❑ Explore ways to change
- ❑ Recognize and/or reinforce positive change
- ❑ Work through resistance
- ❑ Challenge thoughts, emotions, or behaviors
- ❑ Work through ruptures in the therapeutic relationship
- ❑ Set expectations for treatment
- ❑ Get information
- ❑ Give information/ psychoeducation
- ❑ Create a supportive environment
- ❑ Focus the session
- ❑ Elaborate on vague/contradictory content
- ❑ Instill hope
- ❑ Facilitate catharsis
- ❑ Identify problematic thought patterns
- ❑ Identify and/or provide feedback about client behaviors
- ❑ Increase self-control
- ❑ Explore/deepen emotions
- ❑ Facilitate insight
- ❑ Explore ways to change
- ❑ Recognize and/or reinforce positive change
- ❑ Work through resistance
- ❑ Challenge thoughts, emotions, or behaviors
- ❑ Work through ruptures in the therapeutic relationship

What spiritual interventions did you use or encourage today? Please check all that apply.

- ❑ Encouraged acceptance of God's Love
- ❑ Affirmed client's divine worth
- ❑ Encouraged charitable service
- ❑ Affirmed client confession/repentance
- ❑ Encouraged personal prayer
- ❑ Discussed forgiveness
- ❑ Encouraged listening to the heart
- ❑ As therapist, engaged in silent prayer
- ❑ Used religious bibliotherapy
- ❑ Used spiritual assessment
- ❑ Used spiritual confrontation
- ❑ Encouraged spiritual journal writing
- ❑ Encouraged spiritual meditation
- ❑ Engaged in spiritual relaxation or imagery
- ❑ Encouraged spiritual self-disclosure
- ❑ Affirmed trusting God
- ❑ Referred to religious community
- ❑ Listened to spiritual issues
- ❑ Discussed the spiritual dimensions of problems and solutions
- ❑ Explored religious questions and doubts
- ❑ Explored questions about ultimate meaning
- ❑ Helped in discerning God's will
- ❑ Clarified thoughts about evil
- ❑ Encouraged reconciling beliefs in God with pain and suffering
- ❑ Identified pathways to God or the sacred
- ❑ Other _____

Important client insights/changes

Psychotherapy notes

Optional Interventions (presented only for therapists who have indicated when tailoring the TSC that they use these therapy orientations)

Please tell us what specific **ACT interventions** you used in session today.

- ❑ Confronted agenda of emotional control
- ❑ Developed diffusion skills
- ❑ Encouraged acceptance
- ❑ Encouraged committed action
- ❑ Encouraged present-moment awareness
- ❑ Made contact with observing self
- ❑ Used mindfulness exercises
- ❑ Used metaphors
- ❑ Clarified values
- ❑ Other _____

Please tell us what specific **behavior therapy interventions** you used in session today. Please check all that apply.

- ❑ Assertiveness training
- ❑ Self-monitoring
- ❑ Exposure and response prevention
- ❑ Modeling
- ❑ Progressive relaxation
- ❑ Positive behavior reinforcement
- ❑ Systematic desensitization
- ❑ Token economy
- ❑ Other _____

Please tell us what specific **existential/humanistic interventions** you used in session today. Please check all that apply.

- ❑ Discussed fear of death/life
- ❑ Encouraged acceptance of the givens of life
- ❑ Encouraged awareness of ultimate concerns
- ❑ Encouraged authentic being
- ❑ Focused on accepting responsibility directing client's life
- ❑ Helped client find a purpose beyond self
- ❑ Helped client make meaning of experience
- ❑ Illuminated the here and now
- ❑ Other _____

Please tell us what specific **CBT interventions** you used in session today. Please check all that apply.

- ❑ Assigned homework
- ❑ Used behavioral activation
- ❑ Challenged cognitive distortions
- ❑ Provided decision-making training
- ❑ Affirmed exposure/response prevention
- ❑ Used guided imagery
- ❑ Identified automatic thoughts
- ❑ Identified emotions
- ❑ Modified beliefs
- ❑ Dealt with problem solving
- ❑ Used role play
- ❑ Applied skills training
- ❑ Taught mindfulness
- ❑ Taught new responses to automatic thoughts
- ❑ Tracked moods and behavior
- ❑ Other _____

Please tell us what specific **gestalt interventions** you used in session today. Please check all that apply.

- ❑ Developed experiment with client
- ❑ Engaged in enactment
- ❑ Encouraged bodily awareness
- ❑ Used exaggeration
- ❑ Used guided fantasy
- ❑ Applied internal dialogue exercise
- ❑ Applied "I take responsibility for" exercise
- ❑ Used loosening and integrating techniques
- ❑ Engaged in making the rounds
- ❑ Engaged in playing the projection
- ❑ Engaged in the rehearsal exercise
- ❑ Other _____

Please tell us what specific **interpersonal therapy interventions** you used in session today. Please check all that apply.

- ❑ Engaged in communication analysis
- ❑ Engaged in directive exploration
- ❑ Discussed client's immediate affect
- ❑ Discussed interpersonal incidents
- ❑ Discussed the therapeutic alliance
- ❑ Facilitated recognition of affect
- ❑ Engaged in non-directive exploration
- ❑ Discussed problem solving
- ❑ Engaged in role playing
- ❑ Other _____

Please tell us what specific **narrative therapy interventions** you used in session today. Please check all that apply.

- ❑ Constructed a history of the preferred story
- ❑ Practiced creating an audience
- ❑ Used deconstructing questions
- ❑ Used "effects" questions
- ❑ Practiced finding an alternative story
- ❑ Used opening space questions
- ❑ Used possibility questions
- ❑ Used preference questions
- ❑ Used problem construction and externalizing questions
- ❑ Used reauthoring/self-redefinition
- ❑ Other _____

Please tell us what specific **client centered therapy interventions** you used in session today. Please check all that apply.

- ❑ Communicated unconditional positive regard
- ❑ Facilitated congruence
- ❑ Focused on creating a warm and supportive environment
- ❑ Focused on the therapeutic relationship
- ❑ Reflected on feelings
- ❑ Shared authentic reactions with the client
- ❑ Other _____

Please tell us what specific **psychoanalytic interventions** you frequently use. Please check all that apply.

- ❑ Attuned self to client's emotion
- ❑ Engaged in defense interpretation
- ❑ Discussed the therapeutic relationship
- ❑ Engaged in dream interpretation
- ❑ Explored repressed feelings
- ❑ Used free association
- ❑ Identified how family dynamics influence current behavior
- ❑ Facilitated interpretation of early memories
- ❑ Facilitated transference interpretation
- ❑ Provided support to client
- ❑ Practiced reflective listening
- ❑ Other _____

Please tell us what specific **REBT interventions** you used in session today. Please check all that apply.

- ❑ Assigned homework
- ❑ Challenged "*should*s, *must*s, or *ought*s"
- ❑ Changed language about problems
- ❑ Decatastrophized worst case scenario
- ❑ Discussed worst case scenario/decatastrophizing
- ❑ Disputed irrational beliefs
- ❑ Encouraged unconditional acceptance
- ❑ Used rational–emotive imagery
- ❑ Engaged in role playing
- ❑ Used shame-attacking exercises
- ❑ Used ABC model
- ❑ Other _____

Please tell us what specific **reality therapy interventions** you used in session today. Please check all that apply.

- ❑ Built rapport
- ❑ Encouraged commitment
- ❑ Focused on current behavior
- ❑ Helped client(s) develop an action plan
- ❑ Instilled hope
- ❑ Invited client(s) to evaluate behavior
- ❑ Refused to accept excuses
- ❑ Other _____

Please tell us what specific **relational/psychodynamic therapy interventions** you used in session today. Please check all that apply.

- ❑ Connected in-session behavior with previous relational experience
- ❑ Dealt with conflict between client and therapist
- ❑ Discussed how client's actions have emotionally impacted the therapist
- ❑ Disembedded from relational patterns
- ❑ Engaged in empathic exploration
- ❑ Encouraged mindfulness
- ❑ Explored relational meaning of client's symptoms
- ❑ Explored ruptures in the therapeutic relationship
- ❑ Explored the therapist's role in ruptures
- ❑ Identified client's withdrawal behaviors
- ❑ Engaged in meta-communication
- ❑ Provided an explanation for a task or goal
- ❑ Other _____

Please tell us what specific **emotion-focused therapy interventions** you used in session today. Please check all that apply.

- ❑ Engaged in dialogue about alliance ruptures
- ❑ Engaged in empathic affirmation
- ❑ Engaged in empathic exploration
- ❑ Implemented empty-chair
- ❑ Encouraged compassionate self-soothing
- ❑ Encouraged experiential focusing
- ❑ Explored problematic reaction point (systematic evocative unfolding)
- ❑ Engaged in meaning creation work
- ❑ Encouraged trauma retelling
- ❑ Engaged in two-chair dialogue
- ❑ Other _____

Please tell us what specific **solution focused interventions** you used in session today. Please check all that apply.

- ❑ Asked about improvement since last meeting
- ❑ Co-created homework assignments
- ❑ Complimented client
- ❑ Discussed potential "relapse"
- ❑ Explored previous solutions
- ❑ Looked for exceptions
- ❑ Used the miracle question
- ❑ Reframed client concerns
- ❑ Guided scaling
- ❑ Took a break/reconvened
- ❑ Other _____

Working Alliance Inventory (WAI-Short Revised Form)

(These items will be administered to clients every second or third session)

Goal Scale

___and I are working towards mutually agreed upon goals.
We agree on what is important for me to work on.
___and I collaborate on setting goals for my therapy.
We have established a good understanding of the kind of changes that would be good for me.

Task Scale

What I am doing in therapy gives me new ways of looking at my problem.
I feel that the things I do in therapy will help me to accomplish the changes that I want.
As a result of these sessions I am clearer as to how I might be able to change.
I believe the way we are working with my problem is correct.

Bond Scale

I believe___likes me.
___and I respect each other.
I feel that___appreciates me.
I feel___cares about me even when I do things that he/she does not approve of.

Note: Clients are instructed to substitute (mentally) therapist's name for ''___''.

Appendix 3: RFP Background Document

Enhancing Practice-Based Evidence for Spiritually Integrated Psychotherapies:
An Interdisciplinary Big Data Project

I. Definitions and Research Design Issues

Spiritually Integrated Psychotherapies

A variety of terms are used to describe spiritual treatment approaches in the mental health context, including *spiritually integrated psychotherapies*, *spiritually oriented psychotherapies*, *religiously accommodative psychotherapies*, *spiritually sensitive psychotherapies*, and *spiritual psychotherapies*. Not all of these labels mean the same thing to everyone, but often they are used interchangeably. For this RFP we prefer to use *spiritually integrated psychotherapies*, for the reasons we discuss below.

We wish to be clear about the focus of our RFP. We plan to study spiritually integrated psychotherapy approaches that are grounded in either a major religious tradition (e.g., Christianity, Judaism, Islam, Buddhism, Hinduism) or a nontraditional spirituality clearly oriented toward something of sacred or transcendent value. In the *APA Handbook of Psychology, Religion, and Spirituality* (Pargament, Mahoney, & Shafranske, 2013), Len Sperry (p. 227) provided further insight into such approaches:

> Spiritually integrated psychotherapy is a term that broadly characterizes a variety of psychotherapeutic approaches that are sensitive to the spiritual dimension. These approaches range from non-Christian approaches and transpersonal psychotherapies (Cortright, 1997; Karasu, 1999) to theistic (Richards & Bergin, 1997) and various Christian approaches (Sperry, 1998, 2001, 2002, 2005; Steere, 1997), including Christian counseling and evidence-based religious accommodative forms of psychotherapy. . . . Individuals seeking explicitly spiritually integrated psychotherapy range from relatively healthy spiritual seekers to disordered clients presenting with symptomatic distress or impairment in one or more areas of life functioning (Sperry, 2002). . . . spiritually integrated psychotherapy is distinct from pastoral counseling and spiritual direction in its emphasis and treatment focus. It draws on spiritual resources in addressing spiritual issues and struggles to resolve psychological and relational problems. Although it can also foster spiritual change and growth, spiritually integrated psychotherapy accomplishes this as a by-product that accompanies psychological change.
>
> The goals of treatment vary according to client presentation and need. They may include help with spiritual struggles and emergencies, spiritual growth, increased psychological well-being, self-fulfillment or individuation, or the reduction of symptomatic distress and

the restoration of baseline functioning (Sperry, 2002). The therapeutic relationship typically involves collaboration [and] . . . respect for the client's spiritual values and concerns.

Various psychotherapeutic and psycho-spiritual interventions are utilized depending on client need and indication (Miller, 1999). If indicated, referral for a psychiatric evaluation for medication or hospitalization may occur. Spiritual interventions are also involved. These include spiritual practices, such as prayer and meditation, and when indicated, collaboration with or referral to clergy or chaplain (Sperry, 2001).

Below is a helpful table from Sperry (2013, p. 229) that compares and contrasts spiritually integrated psychotherapy with pastoral counseling and spiritual direction.

	Pastoral counseling	Spiritual direction	Spiritually integrated psychotherapy
History	Arose as an alternative to spiritual direction for Protestant, Jews and others seeking help	Long history as a spiritual activity for monks, priests, and religious; rediscovered recently by spiritual seekers from all walks of life and religious faiths, including Buddhism	Arose from expectation of clients to have their spiritual values and issues recognized in therapy; alternative to pastoral counseling and spiritual direction
Emphasis	Primarily religious or spiritual change, secondarily psychological change	Primarily spiritual change, secondarily psychological change	Primarily psychological change, secondarily religious or spiritual change or growth
Intent and function	Coping with a physical, emotional, or spiritual stressor, struggles, or a crisis of meaning; personality change (in pastoral psychotherapy)	Facilitating spiritual growth, may include coping with spiritual struggles or emotional problems	Coping with a serious physical or emotional stressor; resolving psychological symptoms; dealing with a crisis of meaning or spiritual struggle; or facilitating spiritual growth with spiritual resources
Practice pattern	Brief situational (one session), or short term (two to five sessions) versus long term (1 year or longer and referred to as *pastoral psychotherapy*)	Usually monthly sessions ongoing for years	Usually weekly sessions for short term or long term

Typical clientele	Troubled individuals often concerned with moral concerns or religious issues; clients often from same denomination as counselor	Usually relatively healthy spiritual seekers	Varies from relatively healthy spiritual seekers to troubled or disordered individuals with emotional, religious, or spiritual concerns

Note: Reproduced from Sperry, L. (2013). Distinctive approaches to religion and spirituality: Pastoral counseling, spiritual direction, and spiritually integrated psychotherapy. In K. I. Pargament (Ed.), *APA handbook of psychology, religion, and spirituality: Vol. 2. An applied psychology of religion and spirituality* (pp. 223-238). Washington, DC: American Psychological Association.

We want to investigate how mental health professionals use spiritually integrated psychotherapy approaches as they work with clients who are struggling with emotional, spiritual, and relationship problems. Ideally the spiritually integrated psychotherapists who will participate in our project do the following with many of their clients: (a) conduct a spiritual assessment to understand clients' spiritual background, concerns, and needs, (b) ensure that their clients' spiritual concerns and needs are addressed during treatment, and (c) when clinically indicated, use spiritual practices, interventions, and resources to facilitate treatment processes and outcomes (Koenig, 2013; Richards & Bergin, 2005; Vieten et al., 2015). Our project will not fund studies of pastoral counseling or spiritual direction; also excluded are those that involve only mindfulness-based approaches without additional spiritual interventions (e.g., providing spiritual assessment, using spiritual imagery, reading sacred writings). Finally, studies that propose to investigate purely secular psychotherapies will not be funded, even if these approaches are conducted by clinicians who accept religion and spirituality as important aspects of human diversity.

Research studies have documented that most mental health professionals do not conduct pastoral or religious counseling. They conduct psychological therapy integrating spiritual perspectives and practices into their approach in a treatment-tailoring fashion. Spiritually integrated psychotherapies do not supplant mainstream therapeutic approaches such as REBT, CBT, IPT, etc.; rather, they represent culturally tailored adaptations of mainstream approaches that are sensitive to and draw upon the religious and spiritual resources in clients' lives. At least this is what clinical writings and empirical research tell us at this time. Our project will give much more insight into how spiritually integrated forms of psychotherapy actually take place in practice and how much variability may occur with therapists from different theoretical orientations and religious and spiritual backgrounds. The focus of our project is NOT to attempt to document whether spiritual treatment is better than secular treatment approaches. Our research will focus on describing and better understanding the nature of spiritually integrated psychotherapy as currently practiced by mental health professionals and investigating how effective these approaches are with various types of clinical issues and clients.

We agree with Pergament's explanation (personal communication, 2016):

> Therapists who attend to spirituality in psychotherapy do many things that go beyond the application of specific spiritual practices; they assess spirituality, listen with sensitivity to

spiritual issues, discuss the spiritual dimension of problems and solutions, explore religious questions and doubts, explore questions about ultimate meaning, help to discern God's will, clarify thoughts about evil, reconcile beliefs in God with pain and suffering, and identify pathways to God or the sacred in clients' lives.

A variety of process and strategic issues that are essential for the effective integration of spirituality into mental health treatment are described in Dr. Richards book *A Spiritual Strategy for Counseling and Psychotherapy* (2005). We ask grant applicants to describe how they will investigate specific spiritual practices, interventions, and process skills and strategies that enable therapists to conduct effective spiritually integrated treatment. How therapists respond to clients' spiritual struggles is also, of course, a major part of conducting effective spiritually integrated psychotherapy, and grant applicants are asked to study both the up side and down side of religious and spiritual life. The CAAS system and the client and therapist outcome and process measures (CAMOS, TSC, and CORE-10) are designed to collect both quantitative and qualitative data about the clinical issues and the therapy interventions and processes involved in each session. These data will provide rich insight into how psychotherapists address spiritual issues and problems during treatment.

Because we will fund practice-based evidence designs, the studies in this project will leave room for therapists and clients to define for themselves which practices and interventions during therapy they regard as spiritual and/or sacred. The question of what makes a practice spiritual is fascinating. In our own therapy practices, we have found that this depends on the therapeutic context, the therapist's views, and the client's views. Pargament's (1997, 1999) theory that people bestow or attribute sacred qualities to certain experiences and practices is helpful and relevant.

The Therapist Session Checklist (TSC) that we ask all grant recipients to use contains a list of spiritual practices and interventions based on theological perspectives and empirical research: for example, spiritual practices such as praying for clients, conducting a spiritual assessment, discussing spiritual concepts and sacred writings, using spiritual imagery, encouraging forgiveness and repentance, referring clients to religious leaders, etc. It includes additional spiritual interventions, such as listening with sensitivity to spiritual issues, discussing the spiritual dimension of problems and solutions, exploring religious questions and doubts, exploring questions about ultimate meaning, helping to discern God's will, clarifying thoughts about evil, reconciling beliefs in God with pain and suffering, and identifying pathways to God or the sacred. But the TSC list provides only a well-considered starting point for describing and documenting the use of spiritual practices and interventions in mental health treatment. The adaptive nature of the CAAS system and measures will provide therapists with ample opportunities to describe and monitor practices and interventions that they personally may regard as spiritual and/or sacred and that are most relevant to their treatment site and to the religious clientele they serve.

Practice Based Evidence Studies

The project will invite and fund primarily studies designed to gather practice-based evidence, involving the routine monitoring of treatment processes and outcomes of spiritually integrated

treatment approaches as they naturally occur in actual mental health treatment sites. Research centered on practice-based evidence is less intrusive to implement, produces findings that are more valid and generalizable to real life treatment settings, and enables researchers to link naturally occurring therapeutic processes with treatment outcomes (Barkham, Hardy, & Mellor-Clark, 2010). Table 1 provides additional information about the characteristics of designs centered on practice-based evidence, as does the "Key Background Papers" section of the RFP text.

Table 1

Principles of Practice-Based Therapy Research

I.	Practical: Employ inexpensive and easy-to-use instruments that can enhance therapy rather than interfere with it.
II.	Stakeholder-based: Actively involve therapists (and clients where possible) in the selection of research questions and methods.
III.	Focused: Instead of trying to be comprehensive, start by measuring key elements of therapy process and outcomes (e.g., therapeutic alliance, client problem severity).
IV.	Incremental: Once the key elements are in place, consider adding measures of other important concepts (e.g., interpersonal problems).
V.	Methodologically pluralist: Encourage the use of a variety of research methods (qualitative and quantitative, group and single case).
VI.	Collaborative: Create research networks of training sites using similar, pan-theoretical instruments, in order to make planning more efficient and to create opportunities for data sharing.

Note: Reproduced from Parry, G., Castonguay, L. G., Borkovec, T. D., & Wolf, A. W. (2010). Practice research networks and psychological services in the UK and USA. In M. Barkham, G. E. Hardy, & J. Mellor-Clark (Eds.), *Developing and delivering practice-based evidence: A guide for the psychological therapies* (p. 290). West Sussex, UK: Wiley-Blackwell.

Rather than using a top-down approach by which the researchers tell practitioners the spiritual approaches and interventions to use, in this project researchers will use a ground-up approach investigating and describing what practitioners actually do in their practices. With this emphasis, studies that comprise the project will give rich descriptive insight into what types of spiritual approaches and interventions practitioners of different theoretical orientations and religious backgrounds actually use in their work, how often they use them, and with what clinical issues and client populations they use each. The project will yield a large body of process and outcome data from a diversity of clients and practitioners concerning spiritually integrated treatment approaches and interventions. It will make an important contribution to the field by increasing understanding about how practitioners from different theoretical and spiritual backgrounds actually go about integrating spirituality into mental health treatment.

The project will NOT fund large-scale RCTs of spiritually integrated treatment approaches. Although RCTs can be important in testing the efficacy of psychotherapy approaches, they are not a panacea. RCTs have may weaknesses: (1) they are costly, (2) they are intrusive to

implement in real life practice settings, (3) they frequently lack external validity or generalizability to real life treatment settings, and (4) despite their goal of exerting experimental control over all extraneous variables, they invariably do not succeed at ruling out all confounds and alternative explanations for their findings (Barkham, Stiles, Lambert, & Mellor-Clark, 2010). The field is becoming aware that there is no universal best method for developing an evidence base in the field of psychotherapy but that multiple research designs are needed for the evidence base to be adequate, including qualitative research, systematic case studies, single-case experimental designs, practice-based studies in naturalistic treatment settings, process studies, and discovery-oriented studies (APA, 2006; Barkham, Stiles, Lambert, & Mellor-Clark, 2010; Cartwright, 2007).

Practice-based evidence research designs can be a crucial component because they can document the effectiveness of spiritually integrated treatments as they are actually implemented in the day-to-day work of practitioners through the use of routine outcome monitoring of treatment processes and outcomes (APA, 2006; Barkham, Stiles, Lambert, & Mellor-Clark, 2010). The effectiveness of treatment in PBE designs can be judged on the basis of effect sizes, clinical cutoff scores, and benchmarks of effective treatment available for established treatment protocols and sites (Barkham, Hardy, & Mellor-Clark, 2010). Major strengths of PBE research designs are they are less intrusive to implement than randomized controlled trials (RCTs), their findings are more valid and generalizable to real life treatment settings, and they make it possible to link naturally occurring therapeutic processes with treatment outcomes (Barkham, Hardy, Mellor-Clark, 2010). Table 2, reproduced from Barkham, Stiles, Lambert, and Mellor-Clark (2010), provides a helpful summary of the hallmarks of both RCTs and practice-based studies. The book chapter from which it was taken also describes strengths and weaknesses of RCTs and practice-based designs, making clear how researchers can use these two research approaches in a complementary relationship as they seek to develop an evidence base for psychotherapy.

Table 2
Hallmarks of Randomized Controlled Trials and Practice-Based Studies

Trial/study feature	**Randomized controlled studies**	**Practice-based studies**
Design	• Formal: design provides the overarching rationale and framework for the trial/research • Control and/or contrast components of design are crucial	• Informal: design is placed 'over' already existing routinely collected data collection • Focus can be on translational work (i.e. testing efficacy findings in practice settings), investigation of quality or safety components, or process issues

Philosophy and policy	• Top-down approach: invariably initiated by policy makers, funding agencies and researchers	• Bottom-up approach: driven and owned by practitioners in service of quality agenda
Hypotheses	• Usually focused on a single 'main' scientific question	• Can focus on single or complex questions
Investigator allegiance	• Researcher usually an expert in candidate treatment being investigated	• More focused on delivery and service issues
Sample	• Highly selected: targeted according to specific hypotheses • Stringent inclusion and exclusion criteria applied to protect internal validity construct	• Unselected: initial sampling frame comprises all clients or practitioners • Study sample can comprise total pool of data or a selected subsample to focus on specific issues or subgroup
Treatment(s)	• Single/specific treatment(s) • Manualized • Additional training for therapists usual prior to study • Adherence ratings/checks	• All treatments delivered in practice • Not manualized • No additional training other than would occur in fulfilment of continuing professional development • Adherence checks only as naturally adopted procedures within the service (i.e. not imposed by study requirements)
Location	• Not usually associated with specific service/delivery locations because focus is 'science' rather than 'practice' • Increasingly multisite implementation in order to yield required N of clients	• Often associated with local service(s) in order for feedback to be utilized • Can be single or multiple services-depending on common methodology and question(s) being asked
Measurement	• Single primary outcome	• Outcome and service

	measure usually the standard with additional secondary outcomes	parameters defined by common methodology
Ethics	• Ethics approval always required incorporating informed consent	• Ethics approval is usually best secured but use of routinely collected aggregated data should not raise concerns for review boards
Relation of measurement to sample	• Rich data on focused (small?) N of clients	• Rich data on large N of clients and practitioners although any study can be selective about what data to include

Note: Reproduced from Barkham, M., Stiles, W. B., Lambert, M. J., & Mellor-Clark, J. (2010). Building a rigorous and relevant knowledge base for the psychological therapies. In M. Barkham, G. E. Hardy, & J. Mellor-Clark (Eds.), *Developing and delivering practice-based evidence: A guide for the psychological therapies* (pp. 21-61). West Sussex, England: Wiley-Blackwell. doi:10.1002/9780470687994

II. Historical and Scholarly Background

The alienation that had persisted between mainstream psychology and religion for nearly 100 years began to wane near the end of the 20th century as a more spiritually open zeitgeist (spirit of the times) emerged. Hundreds of articles on spiritual issues in mental health and psychotherapy were published in professional journals. There were numerous presentations on these topics at professional conferences. Many books were published on the relevance of religion and spirituality to psychological theory and clinical practice. Mental health organizations for the first time acknowledged explicitly in their ethical guidelines that religion is one type of diversity that professionals are obligated to respect (Richards & Bergin, 2005).

Many factors have influenced the rise of this spiritual zeitgeist. Discoveries in physics, developments in the philosophy of science, research on the brain and human consciousness, the science and religion dialogue, research on religion and mental health, the multicultural movement, the positive psychology movement, and renewed societal interest in spirituality have all contributed. But at its core this recognition/tolerance of religious and spiritual issues has been fueled by an emerging belief among many scientists that the naturalistic, scientific worldview does not adequately account for the complexities and mysteries of the universe and that spiritual perspectives may enrich scientific understandings (Richards & Bergin, 2005).

Numerous scholars during the past two decades have challenged the historical commitment of psychology to naturalistic assumptions and have argued that spiritual perspectives have much to offer the behavioral sciences. For example, Bergin (1980) argued that mainstream psychological

theories and treatment approaches based on naturalistic assumptions are not sufficient or culturally sensitive for religious people. He also argued that religious values can help reform and rejuvenate our society. Jones (1994) encouraged the psychology profession to engage in a more constructive relationship with religion, suggesting that religious worldviews can contribute to new theories and interpretations of research data. Campbell (1975) argued that the moral principles and values taught by the great world religious traditions are "recipes for living that have been evolved, tested, and winnowed through hundreds of generations of human social history" (p. 1103).

We believe the great world religions are a rich source of ideas and insights about human beings that can lead to new theories, new research programs, and new and more effective therapeutic techniques and approaches. The grant competition will enable us to explore this big question: ***Can the wisdom, values, and spiritual practices of the world's great religious traditions improve the effectiveness of psychotherapy and other forms of mental health treatment?***

We hypothesize that competent mental health practitioners integrate a wide variety of spiritual interventions with standard psychological approaches. We hypothesize that the competent integration of spiritual perspectives and practices into mental health care significantly enhances treatment processes and outcomes, particularly for spiritually committed patients. We also hypothesize that spiritual approaches are effective with a wide variety of clinical issues and problems.

The rise of a more spiritually open *zeitgeist* in the behavioral sciences has been favorable to the development of spiritually and religiously accommodative treatment approaches (Pargament, 2007; Richards & Bergin, 2005, 2014; Sperry & Shafranske, 2005). Spiritual treatment approaches encourage psychotherapists to address clients' spiritual concerns when relevant and to use language and interventions that show respect for and honor the healing potential of their clients' faith. Buddhist, Hindu, Christian, Jewish, Muslim, and ecumenical theistic psychotherapy approaches have been described. Spiritual approaches have also been proposed based on Jungian, transpersonal, psychodynamic, cognitive, interpersonal, humanistic, and multicultural psychologies (Richards & Bergin, 2005, 2014; Sperry & Shafranske, 2005). Spiritual perspectives and interventions have also been used with a great variety of clinical issues and client populations (Richards & Bergin, 2005; Sperry & Shafranske, 2005).

Several survey studies of members of the American Psychological Association (e.g., Raphel, 2001; Shafranske, 2000; Shafranske & Malony, 1990), as well as studies of psychotherapists within specific faith traditions (e.g., Ball & Goodyear, 1991; Richards & Potts, 1995), have provided evidence that 30% to 90% of practitioners—depending on the group surveyed—incorporate spiritual interventions into their practices. Higher percentages of psychotherapists who are personally religious use spiritual interventions compared to therapists who are less religious, and they tend to use a wider variety of such interventions, but surprising numbers of non-religious psychotherapists also use them (Raphel, 2001; Shafranske, 2000). Most psychotherapists use spiritual approaches and interventions as part of an integrative approach that includes interventions from one or more of the mainstream secular therapeutic traditions (Richards & Bergin, 2004, 2005; Sperry & Shafranske, 2005; Worthington, Kurusu, McCullough, & Sandage, 1996).

Despite the proliferation of spiritually oriented approaches in clinical practice, outcome research concerning their effectiveness with various clinical issues and populations is lagging behind, although it has increased during the past two decades. In 1996, Worthington et al. reviewed 148 empirical studies on religion and psychotherapy; only eight were outcome studies. Since then five more outcome reviews have been done, including McCullough's (1999) meta-analysis of five outcome studies; Worthington and Sandage's (2001) narrative review of nine outcome studies; Smith, Bartz, and Richards' (2007) meta-analysis of 31 outcome studies; Hook, Worthington, Davis, Jennings, Gartner, and Hook's (2010) narrative review that examined which spiritually oriented psychotherapies meet evidence-based criteria for efficacy and specificity; and finally, Worthington, Hook, Davis, and McDaniel's (2011) meta-analysis of 61 outcome studies. The three meta-analysis reviews were consistent in providing quantitative support for the conclusion that spiritually-oriented psychotherapies tend to be effective overall with effect sizes that range from .27 to .75, depending on which studies were included in the analyses. These are comparable to effect sizes observed for many mainstream secular psychotherapy approaches (Wampold, Mondin, Moody, Stich, Benson, & Ahn, 1997). The reviewers also concluded that there is specific support for Christian and Muslim forms of cognitive (and rational-emotive) psychotherapy for depression and anxiety. Preliminary evidence supported the probable efficacy of a variety of other types of spiritually-oriented psychotherapies, including a Christian devotional meditation intervention for anxiety, a Chinese Taoist CBT approach for anxiety, a Christian group treatment for lack of forgiveness, a Christian CBT approach for marital issues, a theistic spirituality group for eating disorders, and a Buddhist CBT approach for anger (Hook et al., 2010). Overall, therefore, the meta-analytic findings based on primarily randomized control trials (RCTs) have generally found that spiritual treatments outperform control conditions and are equivalent in efficacy to secular treatments on psychological outcomes, with some evidence for improved spiritual outcomes.

This literature provides incentive for further use and empirical study of spiritually oriented psychotherapies. But despite the growth shown in these research findings, the evidence base in many regards is still inadequate (Anderson et al., 2015; Richards & Worthington, 2010). The conclusions about the effectiveness and efficacy of spiritual approaches must be tempered by recognition that most of the data-based outcome studies have significant methodological weaknesses (Anderson et al., 2015; Smith et al., 2007; Worthington, Wade, & Hight et al., 2011). But perhaps the most glaring weakness in the evidence base is that the vast majority of spiritual approaches described in the literature have never been empirically evaluated. In addition, because the majority of studies have focused primarily on outcome questions, many descriptive and process questions about the use of spiritually oriented approaches remain unclear. At this point more information is needed about best practices for professionals to use as they incorporate religion/spirituality into their clinical practice.

A plethora of questions emerge. What types of spiritual interventions do different types of psychotherapists use during the course of treatment? How often do they use these interventions? When do they use them (i.e., with what types of clients and clinical issues)? How do they go about implementing them? What types of clients prefer spiritually oriented treatment? What types of spiritual approaches do clients prefer, and which interventions do they perceive as most helpful? What spiritual interventions and approaches are most effective with different types of

clients and clinical issues? In order to answer such questions, more descriptive and process studies are needed on a greater variety of spiritual treatment approaches, with a greater variety of clinical issues, with clients and clinicians from a greater diversity of spiritual and cultural traditions (Richards & Bergin, 2005, 2014).

Given the current climate of managed care accountability and the evidence-based treatment movement (American Psychological Association, 2006), a more adequate research base is essential if spiritually oriented treatment approaches are to be accepted as essential components of mainstream mental health care. A larger and stronger evidence base will help ensure that spiritually oriented treatment is never again relegated to the fringes of the healthcare professions (Richards & Worthington, 2010). This will be a great blessing to religiously and spiritually committed people in the world, giving them better access to counseling and mental health services that honor the healing resources of their spiritual worldviews and communities.

The journal articles, books, training products, and media coverage produced by this project will help promote interest in spiritually oriented psychotherapies in the mental health field, hastening advances in research, practice, and training. The project will help ensure that spiritually committed people throughout the world have access to healthcare services that respect and honor the healing potential of their faith communities and spirituality.

III. Project Requirements and Guidelines

Theory of Change

We require grant applicants to form multidisciplinary teams (researchers, practitioners, educators, and pastoral/religious professionals) for their projects, considering the potential of this approach to facilitate research, publications, and training materials relevant to a broader group of stakeholders who are interested in bringing spiritually oriented treatment approaches into the healthcare mainstream.

To promote the acceptance of religious and spiritual approaches, this project must impact multiple stakeholders. Figure 1 illustrates our theory of change, portraying how various stakeholders can work synergistically to promote spiritually oriented psychotherapies as important mainstream healthcare options. By requiring team participation, the project will enable us to directly influence these four crucial stakeholder groups.

The grant competition was undertaken to stimulate high quality research that can become a foundation for changing the practice of mental health care. Due to the strong movement toward accountability and evidence-based practice in both medical and mental health fields (APA, 2006), this strong evidence base is necessary to provide credibility and leverage for all other change efforts.

But research studies that are read only by researchers will not change mental health practice; we must inform and influence practitioners. If practitioners help design and conduct the research studies, they will be more invested in sharing and implementing the findings because the studies

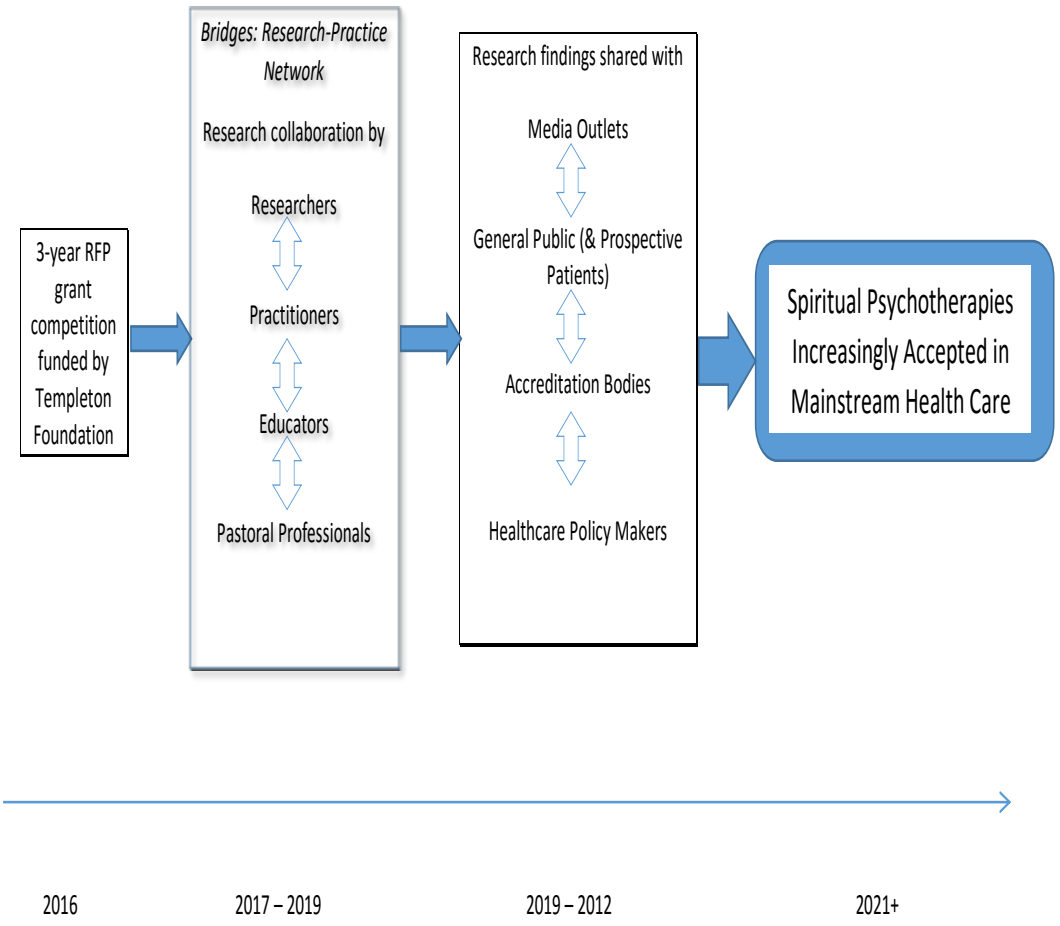

Figure 1: Theory of Change

will be more relevant to their work. Funded project teams are expected to publish their findings in journals and books which vary in their focus on research and/or practice.

Mental health educators are also crucial participants. Collaborating with healthcare educators will contribute to grant recipients' success at designing studies and developing products to impact education and training (e.g., textbooks, articles targeting mental health educators and supervisors, workshops and other continuing education materials). Influencing healthcare educators helps to ensure that future generations of practitioners will receive training in spiritual aspects of diversity and treatment so that these are never again neglected in the healthcare professions.

Informing and collaborating with pastoral professionals is also crucial. Clergy, chaplains, theologians, and pastoral counselors are front-line mental health workers in the sense that many people struggling with psychological and relationship problems consult them first when needing help (McMinn, Chaddock, Edwards, Lim, & Campbell, 1998; Oppenheimer, Flannelly, & Weaver, 2004). Pastoral professionals prefer to work with and refer to competent mental health professionals who are sensitive to religious and spiritual aspects of diversity and treatment (Richards & Bergin, 2014). By requiring that all projects include collaboration with a pastoral professional, we plan to support studies designed to generate research-based evidence and develop related products that will serve as resources for pastoral professionals and members of religious communities.

We also consider it crucial to use all forms of available media to inform and influence the general public (including prospective patients) about the availability and effectiveness of mental health care treatment that includes spiritual treatment approaches. Many forms of media can be used to educate and inform the general public, including print, television and internet news outlets, film documentaries, social media, websites, and online video offerings.
We anticipate that this publicity will help increase the public demand for such services. Increased public expectation and demand for access to these approaches will increase pressure on practitioners, educators and supervisors, accreditation bodies, and healthcare policy makers to ensure that such services are provided. Public recognition will give us powerful leverage to change stubbornly held professional attitudes and practice.

Additionally, we consider it essential to influence professional accreditation bodies and other healthcare policy makers. The increased evidence base supporting the effectiveness of spiritual approaches will give researchers, practitioners, educators, and pastoral professionals credibility and leverage to influence leaders in the healthcare and government structures.

In conclusion, bringing spiritually oriented treatment approaches more fully into the healthcare mainstream will require planning and effort by multiple stakeholders during the next decade. We ask that all grant applicants include a plan for using their research grant and findings to help influence the stakeholders discussed in our theory of change.

Bridges: A Practice-Research Network

On November 15 and 16, 2012 the Consortium for Spiritually Centered Psychology and

Education at Brigham Young University sponsored a think tank for researchers and practitioners interested in bringing spiritually oriented therapies into the healthcare mainstream. The think tank was attended by 29 outstanding researchers and practitioners representing seven academic institutions and twelve mental health treatment sites from around the United States. Participants agreed to create a practice-research network (PRN) dedicated to bringing spiritually oriented treatment approaches into mainstream healthcare availability. We titled the network *Bridges*, affirming its mission to build bridges between spiritual and secular approaches to psychotherapy and to help bridge the research-practice gap in the healthcare profession.

PRNs bring together "large numbers of practicing clinicians and clinical scientists . . . in collaborative research on clinically meaningful questions in the naturalistic setting" (Borkovec, 2002, p. 313). PRNs were first developed in the 1950s in nursing and medicine. During the past couple of decades, a variety of PRNs have been initiated in several mental health fields, including psychology, psychiatry, social work, and marriage and family therapy (Castonguay, Barkham, Lutz, & McAleavey, 2013; Parry, Castonguay, Borkovec, & Wolf, 2010). According to Castonguay et al. (2013),

> When based on a partnership of practitioners and researchers, PRNs involve, optimally, collaboration on all aspects of investigation: from the generation of ideas to the design, implementation, and publication of studies. This collaboration aims to foster a sense of equality, shared ownership, and mutual respect between researchers and clinicians, and promoting diversity of scholarship (i.e., different ways of understanding and investigating complex phenomena). It also capitalizes on the complementary expertise, knowledge, and experiences of each stakeholder to provide unique opportunities for two-way learning in order to conduct studies that are both clinically relevant and scientifically rigorous. (p. 109)

All research teams that receive funding from the international grant competition will become members of the Bridges PRN. We consider a PRN devoted to mainstreaming spirituality into healthcare practice to be a vital step in securing future understanding of the relevance, availability, and efficacy of spiritually oriented treatment approaches. We expect that a productive PRN will be especially important for advancing spiritually oriented psychotherapies that have often escaped the attention of mainstream empirical research agendas and funding.

The *Bridges*' Philosophy of Research

The principal investigators of this project anticipate that a more adequate evidence base will provide the foundation for developing successfully mainstreamed spiritually oriented treatment approaches, increasing feasibility of moving forward with education and training efforts along with outreach to accrediting bodies, policy makers, and the general public. Consistent with the APA task force report on evidence-based practice in psychology (APA, 2006), we believe a variety of research designs can contribute to an evidence base concerning the effectiveness of spiritually oriented psychotherapies. These designs include qualitative research, systematic case studies, single-case experimental designs, practice-based evidence designs, process-outcome studies, randomized controlled trials (RCTs), and meta-analytic reviews (APA, 2006).

Practice-based evidence (PBE) designs are particularly suited to facilitating collaboration between practitioners and researchers. PBE designs are significantly different from the traditional RCT methodology, but in many ways complementary with it (Barkham, Hardy, & Mellor-Clark, 2010). One of the main differences from RCTs is that PBE designs focus on collecting data in a naturalistic setting that significantly increases its generalizability, a significant limitation of RCTs. In PBE studies, therapists continue their treatment as usual; they are not asked to use a treatment manual approach. Additionally, the implementation of treatment does not need to be monitored to ensure that it meets a certain criterion or protocol.

Another feature of PBE designs is that all clients presenting for treatment are included in the study, which creates heterogeneity of personal characteristics as well as presenting problems. PBE designs allow faster data collection along with greater applicability of findings. Ownership by practitioners is an important PBE feature. Practitioners and site managers are the driving force behind the research questions, and they have primary ownership of the data, in stark contrast to RCTs in which the researchers make all decisions. Other important aspects of PBE designs include the focus on practice improvement, applicability for benchmarking, and generation of large data sets (Barkham et al., 2010).

PBE designs require routine outcome measurement (ROM) to monitor the progress of patients. ROM merely involves practitioners and researchers collecting quantitative and qualitative measurements of patient processes and outcomes during the course of treatment. ROM can help by establishing the effectiveness of treatment, documenting progress, and aiding in decision making for therapists (Barkham et al., 2010). But the paradigm of practice-based research additionally provides a foundation for optional implementation of additional research designs within the practice-based framework, including qualitative research, systematic case studies, process studies, and even RCT's (Barkham et al., 2010), all of which are endorsed by members of the APA task force report on evidence-based practice in psychology (APA, 2006).

Through collaboration in the *Bridges* PRN, grant recipients can contribute to establishing a big database on the outcomes of spiritual psychotherapies. Both clinicians and scholars will benefit from such collaboration, and the database on spiritual psychotherapies will increase rapidly.

Resources for Collaboration in *Bridges*

Since forming *Bridges*, participants have worked to create ways for practitioners and researchers throughout the world with interests in spiritually integrated treatment approaches to connect and collaborate. Technology makes this possible via the *Bridges* website, a WebEx videoconference account, and a Bridges listserv will enable grant recipients to share resources and support each other and their collaborating treatment sites.

Grant recipients will additionally benefit from the Bridges online psychotherapy research system for conducting practice-based process and outcome research. During the past four and one-half years the Bridges research team has adapted the online survey system Qualtrics (http://www.qualtrics.com) for doing research on psychotherapy processes and outcomes. During the past four years, the team has developed an online system which will be used to simplify data collection for those receiving grants for the project.

During the past five years our research team constructed and validated two research measures that are now part of this online system: First, the Clinically Adaptive Multidimensional Outcome Scale (CAMOS), which take clients less than 5 minutes to complete, has 25 items that assess clients' most salient concerns on five clinically relevant dimensions, including their psychological, spiritual, and relationship difficulties; their physical health; and their therapy progress and alliance concerns (Sanders, Richards, & McBride, 2017). Second, the Therapist Session Checklist (TSC) is a process measure that enables therapists to document in one or two minutes the clinical issues they explored and the interventions they used during each session (Richards, Sanders, McBride, & Lea, 2014).

We also plan to include the Clinical Outcomes in Routine Evaluation (CORE-10) client outcome measure, which was developed and validated by a team of psychotherapy researchers in the United Kingdom (Barkham, Mellor-Clark, Connell, Evans, Evans, & Margison, 2010). The 10 items in the CORE-10 assess depression, anxiety, functioning (social, close relationships, physical, and general functioning), trauma, and risk. The battery of CORE measures, including the CORE-10, have been used extensively in the UK and other countries with thousands of patients. For our project the CORE-10 enables access to a wealth of normative and comparative data to help us document and better understand the outcomes of spiritually integrated psychotherapies in comparison to other psychotherapy approaches.

All patients at their intake session will also be asked to complete a one-time brief background/demographic questionnaire. Similarly, all therapists will be asked to complete a one-time professional background/demographic questionnaire, which includes questions about what types of training they have received in religious/spiritual competencies, how much training, where they received it, and how long ago. We will require all grant recipients to use the online assessment system, and the CAMOS, CORE-10, and TSC measures, so that we can pool data from multiple investigators, treatment sites, and therapists to answer research questions that can only be addressed through a big data set. Using these common instruments, researchers and practitioners will be able to collect a rich quantitative and qualitative data set concerned with the processes and outcomes of spiritually integrated approaches. The online system will provide a low-cost, efficient, and flexible way of helping researchers and practitioners throughout the world collaborate in collecting spiritual treatment data. Because the CAMOS, CORE-10, and TSC measures are brief and adaptable, they can be supplemented with other measures selected by the individual research teams to meet their unique and specific needs. Thus the researchers can tailor their assessments to fit their unique research questions and treatment sites.

The online assessment system also includes a real-time reporting arrangement giving therapists and clients immediate access to their process and outcome data. Treatment sites and therapists will not be required to use the reporting system, although we anticipate that many of them will choose to do so. For research purposes, we will set up the system so that it automatically tracks and records which therapists use the reports. The system also has data management and statistical analysis capabilities, making it easy for researchers to prepare their data for viewing and analysis. The online system can easily be implemented in clinical settings with a variety of devices, including laptop and desktop computers, iPads, Kindles, and smart phones. The online assessment system does not replace or conflict with other medical record systems that treatment

facilities may already be using. Copies (pdf) of the CAMOS, CORE-10, and TSC items are provided in Appendix 2 of this RFP.

We have tested and refined the online assessment system, including client and therapist measures, in four different mental health/medical treatment facilities. Three doctoral dissertations are currently evaluating the system and its measures with psychotherapy process and outcome research already completed. We have presented our findings at four different professional conferences, and we have published four journal articles discussing it (Lea, Richards, Sanders, McBride, & Allen, 2015; Richards, Sanders, Lea, McBride, & Allen, 2015; Richards, Sanders, McBride, & Lea, 2014; Sanders, Richards, & McBride, 2017; Sanders, Richards, McBride, Lea, Hardman, & Barnes, 2015). We are also currently collecting more normative data on the client and therapist measures as well as two implementation studies to further enhance the use of the online system and measures in psychotherapy treatment facilities. The online system and the CAMOS, CORE-10, and TSC measures are in harmony with the major principles of practice-based evidence, which acknowledge that data collection must have a minimal level of intrusiveness on treatment as usual and that the data collected must be clinically relevant. The system and measures will yield findings that are valid and generalizable to real life treatment settings and will make it possible to link naturally occurring therapeutic processes with treatment outcomes.

IV. Recommended Background Papers

Below are some seminal articles and books relevant to the science of spiritually oriented psychotherapies and practice-based evidence research.

American Psychological Association. (2006). Evidence-based practice in psychology. *American Psychologist, 61,* 271–285.

Barkham, M., Hardy, G. E., & Mellor-Clark, J. (2010). *Developing and delivering practice-based evidence: A guide for the psychological therapies*. West Sussex, England: Wiley-Blackwell. doi:10.1002/9780470687994

Barkham, M., Stiles, W. B., Lambert, M. J., & Mellor-Clark, J. (2010). Building a rigorous and relevant knowledge base for the psychological therapies. In M. Barkham, G. E. Hardy, & J. Mellor-Clark (Eds.), *Developing and delivering practice-based evidence: A guide for the psychological therapies* (pp. 21-61). West Sussex, England: Wiley-Blackwell. doi:10.1002/9780470687994

Castonguay, L., Barkham, M., Lutz, W., & McAleavey, A. (2013). Practice-oriented research: Approaches and applications. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (6th ed., pp. 85-133). New York, NY: Wiley.

Hook, J. N., Worthington, E. L., Jr., Davis, D. E., Jennings, D. J., Gartner, A. L., & Hook, J. P. (2010). Empirically supported religious and spiritual therapies. *Journal of Clinical Psychology, 66,* 46–72.

McMinn, M. R., Chaddock, T. P., Edwards, L. C., Lim, B. R. K. B., & Campbell, C. D. (1998). Psychologists collaborating with clergy. *Professional Psychology: Research and Practice, 29*, 564-570.

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Richards, P. S, Sanders, P. W., Lea, T., McBride, J. A., & Allen, G. E. K. (2015). Bringing spiritually oriented psychotherapies into the health care mainstream: A call for worldwide collaboration. *Spirituality in Clinical Practice, 2*(3), 169-179. DOI: 10.1037/scp0000082

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V. Additional Resources

To learn more about the science and practice of spiritually oriented treatment, please see these resources.

Website

http://education.byu.edu/consortium/bridges

Literature Review

Jackson, R., Richards, P. S., Wheatley, A., Crowton, S., & Rees, M. (2016). Religion and spirituality in psychotherapy: A 20-year review and proposed research agenda. (Unpublished manuscript available on the Bridges website)

Books

Barkham, M., Hardy, G. E., & Mellor-Clark, J. (2010). *Developing and delivering practice-based evidence: A guide for the psychological therapies*. West Sussex, England: Wiley-Blackwell. doi:10.1002/9780470687994

Pargament, K. I. (2007). *Spiritually integrated psychotherapy: Understanding and addressing the sacred*. New York, NY: Guilford Press.

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