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Bringing Spiritually Oriented Psychotherapies Into the Health Care Mainstream: A Call for Worldwide Collaboration

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Bringing Spiritually Oriented Psychotherapies Into the Health Care Mainstream: A Call for Worldwide Collaboration

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The purpose of this article is to describe an overall strategy and specific plans for bringing spiritually oriented treatment approaches into the health care mainstream. We describe *Bridges*, a practice-research network created in 2012 that is devoted to helping practitioners, researchers, educators, and pastoral professionals collaboratively pursue this goal. We describe the achievements of *Bridges* thus far, which include a website for networking, an online psychotherapy research system, several completed studies, and grant funding for future collaborative research studies. We conclude with an invitation to health care professionals around the world to join with us in efforts to mainstream spirituality into clinical practice so that spiritual sources of change and healing are never again neglected in the health care professions.

Keywords: spirituality, religion, psychotherapy, practice, collaboration

For most of the 20th century, mainstream health care professionals ignored the role of spirituality in therapeutic healing. During the past few decades this has dramatically changed as scholars, researchers, and practitioners around the world have made great progress in bringing spirituality into clinical practice (Pargament, 2007; Richards & Bergin, 2005; Sperry & Shafranske, 2005). Important accomplishments in this interdisciplinary effort to bring spiritual perspectives and interventions into mainstream health care include:

1. Longstanding historical and philosophical biases against religion and spirituality were confronted (Bergin, 1980; Griffin, 2000; Jones, 1994; Slife & Williams, 1995). Alternative philosophical and theological perspectives that are more open to spirituality have been articulated (Bergin,

1980; Griffin, 2000; Miller, 2012; Richards & Bergin, 2005; Slife, 2004).

2. Hundreds of research studies have demonstrated the therapeutic potential of religious lifestyles and personal spirituality (e.g., Koenig, McCullough, & Larson, 2001). From an empirical perspective, religion can no longer be dismissed simply as a neurosis to be cured or ignored, but must be acknowledged as a potential resource for healthy living and for treatment and healing.
3. It is now recognized that health care professionals have an ethical obligation to develop competency in religious and spiritual aspects of diversity and treatment (Gonsiorek, Richards, Pargament, & McMinn, 2009; Richards & Bergin, 2014). The ethical guidelines of virtually all health care professions now articulate this ethical imperative (American Psychiatric Association, 2013; American Psychological Association, 2002).
4. Theoretical and clinical literature is now widely available that provides insight into how practitioners can ethically and effectively integrate spiritual perspectives and interventions into health care treatment. Spiritually oriented psychotherapy approaches grounded in the healing practices of both Western and Eastern spiritual tra-

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ditions have been described (Pargament, 2007; Richards & Bergin, 2005; Sperry & Shafranske, 2005). Many spiritual approaches have been integrated with mainstream secular theories, including Jungian, transpersonal, psychodynamic, cognitive-behavioral, rational-emotive-behavior therapy, interpersonal, humanistic, and multicultural approaches (Richards & Bergin, 2004; Sperry & Shafranske, 2005).

5. Many health care practitioners have embraced the importance of religion and spirituality in treatment and incorporate spiritually oriented approaches into their clinical work. Surveys provide evidence that sizable percentages of practitioners—30 to 90% depending on the group surveyed—use spiritual approaches and interventions (Jackson, 2014; Post, Cornish, Wade, & Tucker, 2013; Raphael, 2001; Richards & Potts, 1995; Shafranske, 2000; Wade, Worthington, & Vogel, 2007). Most practitioners integrate spiritual approaches in a treatment tailoring fashion with mainstream secular approaches to psychotherapy (Richards & Bergin, 2004, 2005).
6. Psychotherapy outcome studies provide evidence that spiritually oriented treatment approaches are effective. Seven reviews of the literature on spirituality and psychotherapy have been done during the past 25 years (Anderson et al., 2015; Hook et al., 2010; McCullough, 1999; Smith, Bartz, & Richards, 2007; Worthington, Hook, Davis, & McDaniel, 2011; Worthington, Kurusu, McCollough, & Sanders, 1996; Worthington & Sandage, 2001). The meta-analytic reviews have included as few as five data-based studies (McCullough, 1999), and more recently, as many as 61 studies (Worthington et al., 2011). These reviews have consistently concluded that spiritual approaches 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 approaches. The reviewers have also consistently concluded that there is support for Christian and Muslim forms of cognitive

(and rational-emotive) psychotherapy for depression and anxiety. There is also preliminary evidence supporting the probable efficacy of several other types of spiritually oriented psychotherapies (Hook et al., 2010).

Despite the impressive progress that has been made, we believe there are at least two challenges that must be overcome if spiritually oriented psychotherapies are to be more fully integrated into mainstream health care. The first challenge is that despite the growth in the research findings described above, 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 described above must be tempered by the fact that most of the data-based outcome studies have significant methodological weaknesses, including (a) failure to randomly assign clients to treatment conditions, (b) failure to control for therapist effects, (c) small sample sizes, (d) no treatment manual or protocol, (e) no treatment fidelity checks, and (f) nonstandardized outcome measures (Anderson et al., 2015; Smith et al., 2007; Worthington 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. For example, 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? 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, and 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, Presidential Task Force on Evidence-Based Practice, 2006), a more adequate research base is greatly needed. Without a stronger evidence base, there is some danger that spiritual treatment approaches may never be fully integrated into the mainstream health care professions (Richards & Worthington, 2010). This would be a tragedy because it would deprive many religious and spiritually-minded people of access to services that honor the healing resources of their spiritual worldviews and communities.

The second challenge that must be overcome is that training in spiritual aspects of diversity and treatment is not yet adequately included in graduate education or professional continuing education opportunities (Richards & Bergin, 2014). Surveys indicate that there are still relatively few graduate mental health training programs (approximately 10–25%) that systematically address religious and spiritual aspects of diversity and treatment competence (Brawer, Handal, Fabricatore, Roberts, & Wajda-Johnston, 2002; Crook-Lyon, O'Grady, Smith, Jensen, Golightly, & Potkar, 2012; Schulte, Skinner, & Claiborn, 2002). For practitioners, continuing education opportunities in this domain are also relatively scarce. Thus, even though the majority of health care professionals believe spirituality is an important aspect of diversity and treatment (Crook-Lyon et al., 2012; Richards & Bergin, 2014), there remains a gap between professional beliefs and training practices.

One reason for this gap is that most professional accrediting bodies still do not require training in spiritual aspects of diversity and treatment (Richards & Bergin, 2014). There has also been resistance in the multicultural field to including training in spirituality as an aspect of multicultural competency (Crook-Lyon et al., 2012). Finally, because many health care educators are not themselves trained in spiritual aspects of diversity and treatment, they are not qualified to provide training in this domain of practice (Richards & Bergin, 2005). In order for spiritual approaches to be more fully integrated into health care it is essential for spiritual aspects of diversity and treatment to be more fully incorporated into graduate and continuing edu-

cation training. Health care practitioners must have greater opportunities for developing awareness and competency in this domain of treatment.

Undoubtedly, there are additional challenges and barriers that create resistance to including spiritually oriented approaches in mainstream health care practice, including historical, philosophical, cultural, financial, and political ones (Richards & Bergin, 2005, 2014), but it is beyond the scope of this article to explore all of these possibilities. Rather, we wish to focus in the remainder of this article on what we believe is a promising solution to these challenges. We are convinced that greater unity and increased collaboration between professionals who have interests in bringing spirituality more fully into the health care mainstream can overcome the aforementioned challenges and further the progress that has already been made in this domain. Because of advances in technology, it is now possible for us to collaborate on a global scale.

Below we describe an overarching strategy and concrete plan for integrating spiritually oriented treatment approaches into the health care mainstream. Our purpose—our hope—is to bring together an interdisciplinary worldwide group of researchers, practitioners, clergy, and educators who will work together during the next decade to successfully mainstream spirituality into clinical practice. We will describe what we have already accomplished in this effort and our plans for future collaboration.

Bridges: The Creation of a Practice-Research Network (PRN)

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 with interests in bringing spiritually oriented therapies into the health care mainstream (http://education.byu.edu/consortium/think_tank.html#). Twenty-nine outstanding researchers and practitioners attended the think tank, representing seven academic institutions and 12 mental health treatment sites from around the United States. During the think tank the participants agreed to create a PRN dedicated to bringing spiritually oriented treatment approaches into the health care mainstream. We named the PRN *Bridges*, because its mission is

to build bridges between spiritual and secular approaches to psychotherapy and to help bridge the research-practice gap in the health care 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 first started 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)

We believe that creating a PRN devoted to mainstreaming spirituality into health care practice is a vital step in securing the future relevance, availability, and efficacy of spiritually-oriented treatment approaches. We think a productive PRN is especially important for the advancement of spiritually oriented psychotherapies, which have often escaped the attention of mainstream empirical research agendas and funding. Specific goals we will pursue in *Bridges* include:

1. Seek grants to help fund collaborative research studies and to assist in developing training materials about spiritually oriented treatment approaches.
2. Conduct research studies about spiritually oriented psychotherapy treatment approaches.
3. Publish journal articles about spiritually oriented psychotherapies in mainstream professional and scientific journals.

4. Publish books about spiritually oriented psychotherapy outcome and process research, practice, and training by respected mainstream scholarly publishers.
5. Mentor students in spiritually oriented psychotherapies who will eventually teach and practice in universities, health care facilities, and school settings throughout North America.
6. Provide training opportunities in spiritually oriented psychotherapies for professionals throughout the world so that through them clients and students will have more access to counseling that affirms the values of faith and spirituality in therapeutic change and healing.
7. Seek media coverage about the research findings, publications, and other activities of *Bridges*, including news reports, magazine articles, and film documentaries.

The *Bridges*' Philosophy of Research

Members of *Bridges* believe that the foundation for successfully mainstreaming spiritually oriented treatment approaches is a more adequate evidence base. With this foundation in place, it will be feasible to move forward in credible ways with education and training efforts, and with outreach to accrediting bodies, policymakers, and the general public. Consistent with the APA Task Force report on evidence-based practice in psychology (American Psychological Association, Presidential Task Force on Evidence-Based Practice, 2006), we plan to use a variety of research designs in our efforts to help develop the evidence-base concerning the effectiveness of spiritually oriented psychotherapies. These designs include qualitative research, systematic case studies, single-case experimental designs, practice-based studies in naturalistic treatment settings, process-outcome studies, randomized clinical trials (RCTs), and meta-analyses (American Psychological Association, Presidential Task Force on Evidence-Based Practice, 2006).

At *Bridges*, we value all of these designs, but we believe that practice-based evidence (PBE) designs are especially suited to facilitating collaboration between practitioners and researchers in the *Bridges* PRN. PBE designs are significantly different from the traditional RCT methodology, but in many ways are comple-

mentary (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, it is not necessary to monitor the implementation of treatment to ensure that it meets a certain criteria or protocol.

Another feature of PBE designs is that all clients presenting for treatment are included in the study, which creates heterogeneity with regard to personal characteristics as well as presenting problems. This not only allows for quicker data collection, but also results directly in greater applicability of findings. Ownership by practitioners is an important feature of PBE designs. Practitioners and site managers are the driving force behind the research questions being addressed and they have primary ownership of the data. This is in stark contrast to RCTs where every element of the study is decided by the researchers. Other important aspects of PBE designs include the focus on practice improvement, benchmarking, and large data sets (Barkham et al., 2010).

In PBE designs it is essential to engage in routine outcome measurement (ROM) to monitor the progress of patients. ROM simply means that practitioners and researchers collect quantitative and/or qualitative measurements of patient processes and outcomes during the course of treatment. ROM can help establish the effectiveness of treatment, document progress, and serve as an aid in decision making for therapists (Barkham et al., 2010). The paradigm of practice-based research also provides a foundation for implementing additional research designs, if desired, within the practice-based framework, including qualitative research, systematic case studies, process studies, and even RCT's (Barkham et al., 2010).

By participating in the *Bridges* PRN and collaborating on practice-based evidence studies, psychotherapists in clinical settings can evaluate their own practices and contribute to the establishment of a database on the outcomes of spiritual psychotherapies. *Bridges* makes this feasible by connecting practicing clinicians with scholars in academic and research settings. Both clinicians and scholars will benefit from

such collaboration and the database on spiritual psychotherapies will rapidly grow.

PBE designs can provide a rich source of quantitative and qualitative data about the processes and outcomes of spiritually oriented treatment approaches. During the past three years, we have launched, in collaboration with our colleagues in *Bridges*, PBE research studies in Utah, Idaho, and Hawaii. The two articles that follow in this special section of *Spirituality in Clinical Practice* describe some of the findings from this collaboration and illustrate the richness of the data that such methodologies and collaboration can produce.

***Bridges'* Theory of Change**

In order to succeed at bringing spiritually oriented psychotherapies more fully into the health care mainstream, we believe that the *Bridges* PRN must impact multiple stakeholders. Figure 1 illustrates our theory of change and how various stakeholders can work synergistically to bring spiritually oriented psychotherapies into the health care mainstream. *Bridges* will include collaboration between researchers, practitioners, health care educators, and pastoral professionals. Through this team approach, *Bridges* will have increased ability to directly influence these four crucial stakeholder groups.

The foundation of changing the practice of health care begins with high quality research. There is currently a strong movement toward accountability and evidence-based practice in the medical and mental health fields (American Psychological Association, Presidential Task Force on Evidence-Based Practice, 2006). Mainstreaming spiritually oriented treatment approaches must begin with a strong evidence-base because this will 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 also 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 will be more relevant to their work. Members of *Bridges* will publish their findings in both research and practice-focused journals and books.

We also believe it is crucial to influence mental health educators. By including graduate

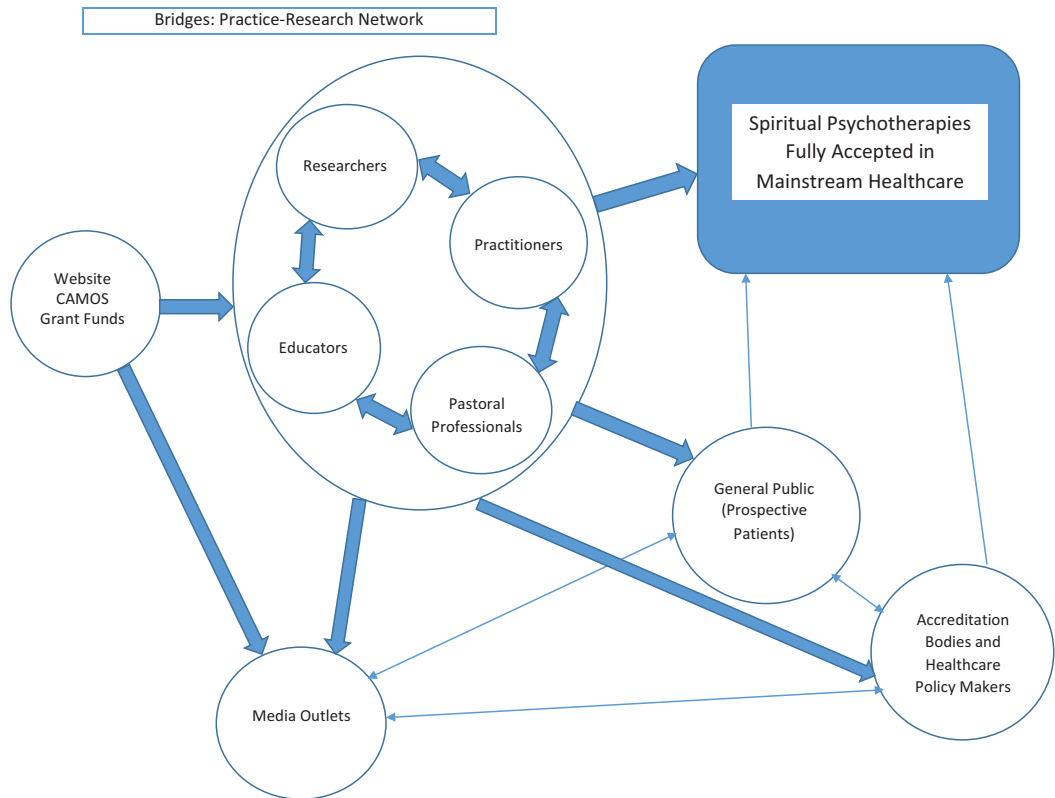


Figure 1. Theory of change. See the online article for the color version of this figure.

educators as members of *Bridges*, we will be more capable of designing studies and developing products based on research that will impact education and training (e.g., textbooks, articles targeting mental health educators and supervisors, workshops, and other continuing education materials). By influencing health care educators, we will ensure that future generations of practitioners receiving training about spiritual aspects of diversity and treatment so that these are never again neglected in the health care professions.

We also believe it is crucial to inform and collaborate with pastoral professionals. Clergy, chaplains, and pastoral counselors are front-line mental health workers in the sense that many people struggling with psychological and relationship problems first go to them for help (McMinn et al., 1998). Pastoral professionals prefer to work with and refer to mental health professionals who are competent and sensitive to religious and spiritual aspects of diversity and

treatment (Richards & Bergin, 2014). By including pastoral professionals and clergy in the collaborative teams within *Bridges*, we will be more capable of designing studies and developing products based on research that is relevant for, and that will serve as resources for, pastoral professionals and members of religious communities.

We also believe it is crucial to use all forms of available media outlets to inform and influence the general public about the availability and effectiveness of spiritual treatment approaches. By helping the general public understand that spiritually sensitive and effective approaches to mental health care treatment are available, we believe this will help increase the public demand for such services. Informing the general public about the work and findings of the *Bridges* PRN is crucial and will give us powerful leverage to change professional attitudes and practice, which are oftentimes resistant to change. There are many forms of media

that can be used to educate and inform the general public, including print, TV and Internet news outlets, film documentaries, social media, websites, and online video offerings. Members of *Bridges* will work with media specialists to publicize our research findings, events, and products.

We believe that it is also essential to influence professional accreditation bodies and other health care policymakers. As the evidence base supporting the effectiveness of spiritual approaches grows this will give researchers, practitioners, educators, and pastoral professionals credibility and leverage to influence leaders in the health care field and in government. Members of *Bridges* will leverage the evidence base from our collaborative research to help convince accrediting bodies and licensing boards in the mental health professions to adopt training and licensure requirements in religious and spiritual aspects of diversity.

In conclusion, bringing spiritually oriented treatment approaches more fully into the health care mainstream will require planning and effort by multiple stakeholders during the next decade. We are convinced that the *Bridges* PRN can serve as a catalyst to make this happen.

Resources for Collaboration in *Bridges*

Since forming *Bridges*, we have worked to create ways for practitioners and researchers with interests in spiritually oriented treatment approaches to connect and collaborate with one another. Collaborative research on spiritually oriented psychotherapies is more feasible today than it has ever been. Computerized and web based outcome assessment systems and data analysis packages make data collection and analysis easier than it has ever been. Computerized assessment systems are helpful because they enable clients to conveniently complete the measures on the computer, which can simplify and speed up scoring, data analysis, and report writing. Clients' test scores can be available for research purposes and can also be provided in a timely fashion to clinicians for treatment planning and client feedback. Because of advances in technology, it is now literally possible for practitioners and researchers throughout the world to collaborate with each other on research in clinical settings.

We have created a *Bridges* website that enables members to share and collaborate on research and training projects (<http://education.byu.edu/consortium/bridges>). A second, improved version of this website is currently under development and will be available before the end of 2015. We also created a LinkedIn group to ease communication among members of *Bridges*. We purchased a WebEx account, an online videoconferencing service, and have used it to connect practitioners and researchers from around the country for conversations and presentations. We created an online psychotherapy research system—called the Clinically Adaptive Multidimensional Outcome System (CAMOS)—for conducting practice-based process and outcome research. We also sought and obtained grant monies to help support collaborative efforts in scholarship and clinical training for spiritually oriented psychotherapies. We will say more about the CAMOS and the *Bridges* funding opportunities below.

CAMOS Online Psychotherapy Research System. The CAMOS is an Internet-based system for assessing the processes and outcomes of psychotherapy (Richards, Sanders, McBride, & Lea, 2014). The CAMOS was designed not only to assess traditional outcome variables, but also to monitor clients' spiritual concerns. The CAMOS seeks to satisfy the demands of evidence-based practice and to maintain the benefits of routine outcome monitoring, while also taking into account the assessment needs of psychotherapists. In order to do so, it blends together several types of assessment: global, population-specific, and individualized.

The CAMOS system includes two research measures. First, a Clinically Adaptive Client Outcome Measure (CA-COM) that has 42 intake items for assessing clients' most salient concerns on six clinically relevant dimensions, including therapy expectations, relationship distress, psychological distress, physical health distress, spiritual distress, and work/school distress. The global nature of the core dimensions allows for the analysis and comparison of aggregate data and helps psychotherapists know when clients are not responding to therapy. After the initial intake session, the CA-COM does *not* require clients to complete all items each session—only those items that are part of short-form versions of the CA-COM that have been developed for routine outcome monitoring pur-

poses, as well as items selected by therapists and clients that are most relevant to the client's concerns.

The CAMOS also includes a Clinically Adaptive Therapist Session Checklist (CA-TSC) that enables therapists to document what clinical issues they explored and what interventions they used during each session. Feedback from therapists who have used the CA-TSC has confirmed that it takes therapists only one to two minutes to complete and that they find it helpful for quickly recording the major focus and approaches they used during each therapy session.

The CAMOS's unique approach is called "clinically adaptive assessment" and involves making a small subset of items required for all administrations, while allowing other items to be optional. These optional items can then be added or removed from the CAMOS at the discretion of the treatment site or individual therapist. Required items are standardized in ways that are similar to traditional ROM systems, and allow for aggregation and comparability, thus maintaining the major features of these systems. The optional items can either be chosen from an existing pool of items or can be written by the treatment site and/or therapist.

Treatment facilities and psychotherapists can tailor the CA-COM and CA-TSC to their site and even to specific clients by choosing from an existing item pool or writing their own unique items relevant to individual clients. This adaptability increases the relevance of the CA-COM and CA-TSC for clients and psychotherapists and fosters a more collaborative approach to the implementation of the outcome assessment system. Like other ROM systems, the CAMOS reporting system provides real-time feedback to clinicians that aids in treatment planning and outcome monitoring for individual clients. Both clients and therapists can use a handheld device (e.g., Kindle Fire, iPad) to complete the measures. The CAMOS automatically downloads the data after patients complete the measures for report generating and data analysis. Therapists receive summaries of the assessment results for each of their clients to help in treatment planning.

The CAMOS enables *Bridges* members to standardize the measures they use during collaborative research projects, but because of its flexibility it also permits research teams to ad-

dress questions that are unique to their interests and context. It provides a low-cost, efficient, and flexible way for researchers and practitioners throughout the world to collect their own data and to collaborate in developing a large aggregate data set about the outcomes and processes of spiritually oriented treatment approaches. The CAMOS is in harmony with the major principles of practice-based evidence; that is, data collection must have a minimal level of intrusiveness on treatment as usual and that the data collected must be clinically relevant. It can yield findings that are more valid and generalizable to real life treatment settings, and make it possible to link naturally occurring therapeutic processes with treatment outcomes. Its adaptability allows for even greater collaboration with clinicians than existing measurement systems, because it can allow for treatment sites to tailor the measure to specific research questions they may have. With the CAMOS as their measurement system, researchers and practitioners can use various research designs that are helpful for developing an evidence base, including practice-based, process-outcome, discovery-oriented, systematic case studies, qualitative, and experimental designs (American Psychological Association, Presidential Task Force on Evidence-Based Practice, 2006).

Findings to date provide support for the reliability, validity, and clinical adaptability and usefulness of the CAMOS system and measures (McBride, 2015; Richards et al., 2014; Sanders, 2015). The long form (42 items) of the CA-COM can be used during initial intake sessions to obtain a broad, multidimensional assessment. We also developed a 25-item short form of the CA-COM for use in routine outcome monitoring that assesses five dimensions: psychological distress, spiritual distress, relationship distress, physical health distress, and therapy progress (Sanders, 2015). An ultrabrief version of the CAMOS is available, which consists of the seven psychological distress items. The psychological distress subscale correlates .81 with the Outcome Questionnaire, a widely used psychotherapy outcome measure of psychological distress.

Templeton Foundation grant and funding opportunities. In 2013, we were awarded a sizable internal grant from Brigham Young University to begin a research program on spir-

itually oriented treatment approaches. To date, we have used that funding to conduct practice-based evidence research studies in four different treatment settings. We report some of the findings from this research in the two articles that follow.

In 2014, we were awarded a planning grant from the John Templeton Foundation to prepare for a project titled, "Bringing Spiritually Oriented Psychotherapies into the Healthcare Mainstream: An International Grant Competition." This project aims to answer the 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?" If approved, the project will fund primarily PBE research designs that engage in the routine monitoring of treatment processes and outcomes of spiritually oriented treatment approaches as they naturally occur in actual mental health treatment sites. It will not fund large-scale RCTs of spiritually oriented treatment approaches. Rather, we will use a ground-up approach that investigates and describes what practitioners actually do in their practices.

With this emphasis, 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, with what clinical issues and client populations they are used, and how effective they are. Accomplishing this goal will require active collaboration between a multidisciplinary team of interested parties. Grant recipients will automatically be included in the *Bridges* PRN from which they will be able to give and receive support, collaboration, and feedback. One of the major strengths of *Bridges* is that members will use the CAMOS online measurement system to create a large shared dataset about spiritually oriented psychotherapies.

The audience we seek to influence through the project is mainstream health care professionals, including physicians, psychiatrists, psychologists, and psychotherapists. The project will open multiple lines of inquiry about the effectiveness of different types of spiritual approaches with specific patient populations and disorders. We believe the project will accelerate quality research and provide a strong evidence-

base for mainstreaming spiritually oriented treatment approaches.

Invitation to Participate in Worldwide Collaboration

We invite practitioners, researchers, graduate educators, and pastoral professionals and clergy to join us in this important worldwide collaborative effort to bring spiritually oriented psychotherapies into the health care mainstream. We are convinced that the time is ripe for this achievement. Our success will help ensure that religious and spiritual people throughout the world have greater access to health care services that are respectful of and draw upon the healing resources of their faith communities and personal spirituality.

We plan during the next five years, in collaboration with members of *Bridges*, to launch many additional studies about spiritually oriented treatment approaches at mental health and medical facilities at a variety of locations throughout the world. Our goal is to develop an evidence base that gives spiritually oriented treatment approaches a place of equality and influence in the health care professions.

It is our hope that within the next decade health care professionals will widely recognize that spiritual approaches are essential ingredients of best practice in psychological and medical care. We hope that practitioners will become even more sensitive and competent in their work with spiritually minded patients. We hope that patients will have greater access to treatment approaches that are effective and honor their faith and spiritual communities. We hope that health care educators and supervisors will provide future generations of practitioners with training that ensures that spiritual sources of change and healing are never again neglected in the health care professions.

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