JPIB Jurnal Psikologi Islam dan Budaya
ISSN online 2615-8183 / print 2615-8191
April 2024, Vol.7, No.1
Page : 23-32

Adaptation of Religious/Spiritually Integrated Practice Assessment Scale-Client Attitude (RSIPAS-CA) in Indonesia

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Abstract / *Abstrak*

Assessment tools are important to helps Indonesian practitioners to understand the preference of clients toward integration of religious/spiritual values in mental health services. Therefore, this study aimed is to adapt the Religious/Spiritually Integrated Practice Assessment Scale - Client Attitude (RSIPAS-CA) by Oxhandler et al. (2018) to Indonesian context as well as describing the responses of participants. Adaptation of this scale was conducted quantitatively, and the process included translations and expert reviews, followed by data collection on 77 participants who had or are currently receiving mental health services. The results showed that the Indonesian version of the RSIPAS-CA with 9 items, had good discriminating power, content validity, reliability, and construct validity. Most participants had a positive view towards the integration of religion/spirituality in the context of mental health services. This questioneer facilitated practitioners to conduct assessments and served as a measuring tool in future studies.

Keywords / *Kata kunci*

Client preferences; Mental health; Religiosity; Spirituality, Scale adaptation; Validity and reliability

Berbagai bukti mengindikasikan perlunya alat asesmen yang membantu praktisi di Indonesia untuk memahami bagaimana klien menyikapi integrasi nilai religiusitas/spiritualitas pada layanan kesehatan mental yang didapatkan, namun alat ukur tersebut belum tersedia pada konteks Indonesia. Tujuan penelitian ini adalah mengadaptasi Religious/Spiritually Integrated Practice Assessment Scale - Client Attitude (RSIPAS-CA) oleh Oxhandler et al. (2018) ke dalam konteks Indonesia serta mendeskripsikan gambaran preferensi partisipan mengenai isu ini. Adaptasi alat ukur ini dilakukan menggunakan metode kuantitatif. Proses adaptasi diawali dengan translasi dan expert review, kemudian dilanjutkan dengan pengambilan data terhadap 77 partisipan yang pernah atau sedang mendapatkan layanan kesehatan mental. Penelitian ini menghasilkan RSIPAS-CA versi Indonesia dengan 9 item yang memiliki daya beda, validitas konten, reliabilitas, dan validitas konstruk yang baik. Mayoritas partisipan berpandangan positif terhadap integrasi agama/spiritualitas dalam konteks pelayanan kesehatan mental. Alat ukur ini dapat digunakan untuk mempermudah praktisi melakukan asesmen atau menjadi alat ukur pada penelitian mendatang.

Preferensi klien; Kesehatan mental; Religiusitas; Spiritualitas; Validitas dan Reliabilitas

DOI:
https://doi.org/10.15575/jpib.v7i1.29083

Article Info
Received: August 15, 2023 **Accepted:** May 7, 2024 **Published:** June 30, 2024

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Introduction

Assessment tools are important to help practitioners in Indonesia understand the preferences of different clients in integrating religious and spiritual values into the mental health services received (Oxhandler et al., 2018). Some clients have high spiritual needs which leads to positive impact when met. Conversely, unmet spiritual needs can result in negative consequences. For instance, a study on cancer patients showed that inadequate spiritual needs incurred higher end-of-life care costs due to more frequent use of Intensive Care Units and higher mortality rates (Balboni et al., 2011). From the perspective of providing mental health services, practitioners' sensitivity and openness to the beliefs of the client strengthen the therapeutic alliance, thereby potentially improving treatment outcomes (Oxhandler et al., 2021). This applies to various fields of mental health services (for example Hairina & Mubarak, 2020; Kiran & Dewi, 2017) and across different religious groups (for instance at Oxhandler et al., 2018).

Each person has different preferences regarding religious or spiritual-based

psychological services, proving the essentiality of assessment tools. Oxhandler et al. (2021) stated that demographic characteristics of clients who are more inclined to integrate religious and spiritual values into the care process include females, racially and ethnically diverse populations, and older adults. Additionally, individuals with a high level of religiosity prefer to integrate beliefs into the services received. Based on the beliefs of clients, traditions also influence preferences in this regard. For example, Catholics tend to seek secular counseling more than Baptists and Mennonites. It is important to acknowledge that individuals who frequently engage in spiritual practices (e.g., prayer and meditation) have higher expectations and preferences for integrating beliefs into mental health services. The similarity of beliefs between client and therapist also plays a role, despite studies presenting varying results. Based on this observation, there are distinct characteristics among clients with high religious or spiritual needs. However, a screening tool can facilitate the process of identifying these needs, depending on the numerous variables to be considered.

The urgency of the assessment tool becomes increasingly significant, particularly in the context of Indonesia. It is believed that providing services in line with the belief systems and psychological approaches of the clients, is more appropriate (Hairina & Mubarak, 2020). However, in countries with high levels of religiosity such as Indonesia, religion may serve as a social identity for some individuals (El Hafiz & Aditya, 2021; Ninin et al., 2018). Therefore, a client might refuse mental health services that incorporate religious elements into the treatment.

No assessment tool was specifically designed to evaluate the attitudes of clients toward the integration of religious and spiritual values in mental health services in Indonesia. In the United States, Oxhandler et al. (2018) developed a tool named the Religious-Spiritually Integrated Practice Assessment Scale - Client Attitude (RSIPAS-CA). It is aimed at measuring preferences and attitudes towards the integration of beliefs in mental health services (Oxhandler, n.d.). This tool allows practitioners to understand preferences for integrating religion and spirituality into the treatment process. The RSIPAS-CA helps determine preferences regarding who should initiate conversations about topics, the clients openness to discussing beliefs, and willingness to work with professionals of different beliefs. The tool also provides a broader understanding of how clients use religiosity and spirituality during difficult times and the perceived impact on psychological treatment outcomes.

The RSIPAS-CA is being in use within the population of the United States (as ween in Oxhandler et al., 2018, 2021) and has not been adapted for other populations. This tool is used to measure client attitudes towards the integration of religious/spiritual beliefs, supported by strong psychometric evidence, primarily due to the large sample size. The psychometric evidence for the first version of RSIPAS-CA was obtained from 245 participants (Oxhandler et al., 2018). Meanwhile, the evidence from the second version was derived from 989 participants (Oxhandler et al., 2021). The tool is unique due to the identical design of its items with those in the attitude dimension of the Religious/Spiritually Integrated Practice Assessment Scale (RSIPAS). Attitudes of mental health practitioners regarding the integration of religious/spiritual values in practice were assessed by RSIPAS (Oxhandler & Parrish, 2016). The adoption of 2 scales with similar items, measuring client and practitioner attitudes respectively prompt future study to compare these perspectives on the same issue equitably (Oxhandler et al., 2018). It is important to acknowledge that the RSIPAS has been widely adapted in various contexts, such as in Iran (Shamsi et al., 2022), France (Gauthier et al., 2023), and Kuwait (Al-Ma'seb, 2019).

This study aims to adapt the RSIPAS-CA for context and use by Indonesians, specifically within a sample of mental health clients subjected to psychological treatment. The adaptation includes investigating the reliability, validity, and discriminative power of the measurement tool. Additionally, the secondary objective of this study is to describe the responses of participants regarding attitudes toward the integration of religion and spirituality in mental health services. This description can enrich previous study outcomes, signifying the need for further understanding of the impact of religious and spiritual values in the context of counseling (Harahap et al., 2023).

Method

The study adopted a quantitative method to obtain objective psychometric evidence by comparing data scores against cut-off criteria for reliability, validity, and item discriminative power. This method facilitated the description of responses regarding attitudes toward the integration of religion and spirituality in mental health services.

Adapted Measuring Tools

Analysis conducted by Oxhandler et al. (2018) showed that the RSIPAS-CA is considered a unidimensional measurement tool that comprises 10 items. Item 9 stated "*I would be open to discussing my religious/spiritual beliefs in therapy*. However, item 6 which reads, "*I am open to working with a therapist who has a different belief system than I do*" did not meet the reliability or validity criteria and was excluded from the final model. Despite this, item 6 was included by Oxhandler in subsequent studies based on a follow-up survey conducted in 2020 (Oxhandler, n.d.). Each item was responded to using a *Likert scale* with five options, namely 1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, and 5 = Strongly Agree.

Adaptation of RSIPAS-CA considered the differences between the contexts of Indonesia and the United States. In America, religiosity and spirituality were perceived as distinct terms by the public (Zinnbauer et al., 1997). Meanwhile, in Indonesia, the meanings tend not to be distinctly defined (El Hafiz & Aditya, 2021). According to official documents in the country, there is no specific definition of religion. The 6 major religions generally practiced by the population were Islam, Christianity, Catholicism, Hinduism, Buddhism, and Confucianism. Other religions and beliefs included the Indigenous belief systems that were recognized under the constitution (Viri & Febriany, 2020). These definitional differences were considered in the adaptation process of the measurement tool. Based on the explanation provided to expert reviewers and notes in the data collection questionnaire, the term "religion/spirituality" in this context equally represents thoughts, experiences, and behaviors acquired from the search for God (definition derived from Oxhandler et al., 2018).

Procedure and Participants

The measurement tool was adapted by following the procedures outlined by the World Health Organization (WHO, 2016). Firstly, *forward translation* was conducted by a translator external to the team (TOEFL ITP 557) and the study analyst (the first researcher, TOEFL ITP 617). Both were Master of Professional Psychology students proficient in English. Furthermore, the results were synthesized by the initial translators (also the second *forward translator*), and another Master of Professional Psychology student proficient in English (TOEFL ITP 593). Secondly, an *expert review* was conducted by 2 lecturers and a psychologist, following the procedures of Polit & Beck (2006). The results of the review were also synthesized by the translators. Thirdly, back *translation* was performed by a student majoring in Communication Science and proficient in English (TOEIC 855). The concluding results were obtained by comparing the original *items*, the items resulting from the synthesis of *forward translation* and *expert review*, as well as the items from the back translation. Finally, the remaining items were included in an online questionnaire for pilot testing.

Data collection was conducted using convenience sampling, where an online questionnaire was distributed through a Google Form link. As a result, participants who met the inclusion criteria were allowed to fill out the questionnaire. The participants were Indonesian citizens (WNI) over the age of 18, adherents of a legally recognized religions or other beliefs, and have been previously or currently being subjected to psychological treatment (mental health) with mental health professionals, such as psychologists, psychiatrists, counselors, social workers, and others (e.g., psychotherapists, mental health nurses, etc.). These were referenced from the National Narcotics Board Regulation (*Peraturan Perundang-undangan*, 2020) and the Republic of Indonesia Law Number 18 of 2014 Regarding Mental Health (UUD, 2014).

The online questionnaire link was distributed in October-November 2022 and January-February 2023 until a sample size of 77 was reached. The sample size met the minimum requirement considering the relatively simple nature of the model (with only 10 indicators or items). This was in line with the guidelines from Boomsma et al. (cited in Kyriazos, 2018), that a CFA model with 6-12 indicators can be specified with N = 50. The *rule of thumb*, where the sample size should be larger than the variable size with a ratio of 5:1, was also proved (Kyriazos, 2018; Tanaka, 1987).

Data Analysis

The evidence for content validity was obtained from the *expert review* assessment by calculating the *content validity index* (CVI) following the guidelines of Polit & Beck (2006). The minimum acceptable value for the item-level CVI (I-CVI) was 1.00 for an item to be considered valid. Meanwhile, the minimum value for the scale-level CVI (S-CVI) was .83 for 3 *experts* to declare the entire measurement tool as valid.

The data obtained from the pilot test were analyzed using *Jeffreys's Amazing Statistics*

Program (JASP) version .16.4.0. This analysis includes (1) item quality evaluation through item-test correlation analysis with a good magnitude typically ranging from at least .20, .30, or .40 (Zijlmans et al., 2018), (2) reliability testing using *Cronbach's alpha*, with a minimum $\alpha = .80$ (Agbo, 2010), and (3) construct validity testing conducted through *confirmatory factor analysis* with *goodness-of-fit indices such as chi-square*, X2/df, *comparative fit index* (CFI), *root mean square error of approximation* (RMSEA) at 90% *confidence interval*, as well as *Tucker-Lewis index* (TLI; Hu & Bentler, 1999; Kline, 2023). Additionally, all translated items were descriptively analyzed to describe client attitudes.

Results

Participant Characteristics

Table 1 shows the characteristics of the study participants. Based on demographic data, the participants had an average age of 24.5 (*SD* = 4.4) and were predominantly female (90.9%), of Sundanese ethnicity (41.6%), adherents of Islam (88.3%), and from the island of Java (87.0%). The majority filled out the questionnaire because of previous mental health services received (77.9%), while the rest completed it while being subjected to treatment. The most common service providers were psychologists, psychiatrists, and counselors, and the issues addressed were primarily anxiety, stress, and *mood* disorders. In terms of religiosity and spirituality, 97.4% believed in God or a 'Higher Power' and tend to be considered religious (M = 2.83 out of a minimum score of 1 and a maximum score of 4, SD = .64). The topic of religion/spirituality was more frequently addressed in the treatment received by the participants and was discussed earlier by mental health professionals (29.9%) compared to clients (24.7%). Meanwhile, this topic was not discussed with other participants, making 28.6% happy compared to a proportion of 16.9% who expected the discussion.

Content Validity

An *expert review* process was conducted to obtain content validity evidence from the translation of the measurement tool into Indonesian, as detailed in table 2. Subsequently, an S-CVI of .97 was obtained, with 9 out of 10 items receiving an I-CVI of 1. These items were rated between scales 3 and 4 which representsomewhat relevant and relevant, respectively. Only item 6 showed an I-CVI of .67 because an *expert* rated it as "sufficiently relevant" (scale 2). According to the expert, "*This item could be sufficiently irrelevant because individuals who feel the need for spiritually-based healthcare services demand someone with the same spiritual belief, at a level capable of fulfilling the needs of clients*."

According to Polit & Beck (2006), the measurement tool and almost all items are suitable to proceed. Despite item 6 not being included in the analysis, it was analyzed based on the procedures of Oxhandler et al. (2018) who experienced the same issue. Table 3 presents the final items from the translation process and *expert review*.

Table 1
Participant Characteristics (N = 77)

Characteristics	n	%
Demographic data		
Age (M = 24.5, SD = 4.4)		
Gender		
Female	70	90.9%
Male	7	9.1%
Ethnic group		
Sunda	32	41.6%
Java	24	33.8%
Others	19	24.7%
Religion		
Islam	68	88.3%
Christian	6	7.8%
CatholicCatholic	3	3.9%
Place of Origin		
West Java	42	54.5%
Central Java	8	10.4%
DKI Jakarta	6	7.8%
Banten	5	6.5%
East Java	4	5.2%
Yogyakarta	2	2.6%
Outside Java (Nusa Tenggara, Riau, Jambi, North Sulawesi)	10	13.0%
Characteristics surrounding the psychological treatment		
Status		
Have had service	60	77.9%
Currently undergoing service	17	22.1%
Mental health workers providing services*		
Psychologist	40	-
Psychiatrist	24	-
Counselor	8	-
Others (social worker, psychotherapist, spiritual counselor)	6	-

Characteristics	n	%
Dominant mental health issues		
Worry	26	33.8%
Stress	15	19.5%
Depression	15	19.2%
Bipolar	9	11.7%
Others	12	16.8%
Characteristics surrounding aspects of religiosity/spirituality		
Are your religious/spiritual beliefs discussed in health services? What mental/psychological treatment are you undergoing?		
Yes, it is discussed first by a mental health professional	23	29.9%
No, I'm glad they didn't bring it up	22	28.6%
Yes, I discussed it first	19	24.4%
No, but I hope they address it	13	16.9%
To what extent do you consider yourself a religious person? (M = 2.83, SD = .64)		
Very religious	9	11.7%
Religious	47	61.0%
A little religious	20	28.0%
Not religious at all	1	1.3%
Do you believe in God or a 'Higher Power"?		
Yes	75	97.4%
No	2	2.6%

[a] Participants are allowed to choose more than 1 answer option; [b] "other" include family problems, *self-esteem*, *bereavement*, *loneliness*, insomnia, and a *quarter-life crisis.*

Table 2

Tabulation of I-CVI Calculations from Three Experts

Item Relevance Rating by **Expert (1-4)**			**Item Relevance (0-1)**			**I-CVI**
E1	**E2**	**E3**	**E1**	**E2**	**E3**	
4	4	4	1	1	1	1
4	3	4	1	1	1	1
4	3	4	1	1	1	1
3	4	4	1	1	1	1
4	4	4	1	1	1	1
3	2	4	1	0	1	0.67
4	4	4	1	1	1	1
3	4	4	1	1	1	1
3	4	4	1	1	1	1
4	4	4	1	1	1	1

Table 3

Final Item Translation Results and Expert Validation

	Item
1	*Penting bagi seorang tenaga kesehatan mental untuk mengetahui cara mendiskusikan agama/spiritualitas klien dalam penanganan psikologis.*
2	*Seorang tenaga kesehatan mental harus menjadi pihak yang memulai bertanya mengenai agama/spiritualitas klien, bukan menjadi pihak yang menunggu klien untuk mengemukakannya.*
3	*Klien harus menjadi pihak yang memulai membahas mengenai agama/spiritualitasnya, bukan menjadi pihak yang menunggu tenaga kesehatan mental untuk mengangkat bahasan tersebut.*
4	*Mendiskusikan keagamaan/spiritual saya selama proses penanganan psikologis membantu meningkatkan kondisi saya secara positif.*
5	*Tenaga kesehatan mental yang meluangkan waktu untuk memahami keyakinan agama/spiritual kliennya menunjukkan kepedulian yang lebih besar terhadap kesejahteraan klien daripada mereka yang tidak melakukannya.*
6	*Saya terbuka untuk menjalani penanganan psikologis bersama tenaga kesehatan mental yang menganut sistem kepercayaan yang berbeda dengan saya.*
7	*Tenaga kesehatan mental yang baik peka terhadap keyakinan agama/spiritual kliennya.*
8	*Saya terbuka untuk dirujuk berkonsultasi dengan tokoh agama jika tenaga kesehatan mental yang menangani saya berpikir hal tersebut akan membantu.*
9	*Saya akan terbuka untuk mendiskusikan keyakinan agama/spiritual saya dalam penanganan psikologis.*
10	*Keyakinan agama/spiritual merupakan hal penting bagi saya saat menghadapi masa-masa sulit*

Item Quality or Differential Power Analysis

A total of 9 items showed good discrimination as signified by *item-rest correlation* values (r > .20) (Zijlmans et al., 2018). Only item 6 has a correlation value close to 0 (r = .009), hence it was deleted. Table 4 presents the *item-rest correlation* after item 6 is removed. Among all items, item 3 had the lowest correlation magnitude.

Table 4

Item-Rest Correlation of 9 Items Declared to Have Good Differential Power

No Item	*Item-rest correlation*
1	0.580
2	0.558
3	0.265
4	0.717
5	0.687
7	0.676
8	0.570
9	0.767
10	0.713

Table 5
Factor Loading of 9 Valid Items

No Item	*Factor loading*	*Std. Error*	*95% Confidence Interval* *Lower*	*Upper*
1	.624	.045	.536	.713
2	.661	.043	.576	.746
3	.271	.042	.188	.354
4	.829	.039	.753	.905
5	.822	.039	.745	.900
7	.792	.039	.717	.868
8	.742	.040	.662	.821
9	.851	.038	.777	.926
10	.843	.041	.762	.923

Description: all items are significant ($p < .001$)

Table 6
Summary of Goodness of Fit Analysis Results (N = 77)

Fit indices	*Statistic*	*Cut-off*	**Interpretation**
Chi-square (X^2)	28.294	-	-
df	27	-	-
X^2/df	1.048	$\leq 3^a$	Good fit
p-value	.396	$\geq .05^b$	Good fit
CFI	.999	$\geq .95^b$	Good fit
RMSEA	.025	$\leq .05^a$	Good fit
RMSEA 90% CI lower bound	.000	-	-
RMSEA 90% CI upper bound	.094	-	-
TLI	.999	$\geq .90^b$	Good fit

Description: [a]Kline (2023), [b]Hu & Bentler (1999)

Reliability

Following the removal of item 6, the remaining 9 items were considered to have good reliability according to Kline (2023) with sebesar $\alpha = .867$, 95% CI [.834, .894].

Construct Validity

The results of the CFA analysis on the 9 items showed positive and significant *factor loadings* (p < .05; Table 5). Item 3 had a *factor loading* below the minimum threshold from Hoe (2008; λ >.30) but was not deleted from the final model due to its significant *p-value* ($\lambda = .271$, p < .001). In line with the previous analysis, item 6 also had a *factor loading* that did not meet the criteria ($\lambda = .014$, $p = .753$).

All *fit indices* of the model with 9 items met the *cutoff* proposed by Kline (2023) and Hu & Bentler (1999), hence, were not modified, as presented in table 6.

Based on the CFA results, the final proposed model included 9 final items, as shown in Figure 1. It was important to acknowledge that 8 had high *factor loadings* (Hair et al., 2019).

Description of Participant Responses

In addition to the reliability and validity analysis of the results of the Indonesian version of the RSIPAS-CA adaptation, a descriptive analysis was conducted on the 10 original items, as shown in table 7.

The majority of participants feel religious/spiritual beliefs were important in facing difficult times (87.0% referring to item 10 in table 7). This item also had the highest mean and the second lowest standard deviation ($M = 4.44$, $SD = .87$), suggesting that the response was uniformly agreed upon by participants.

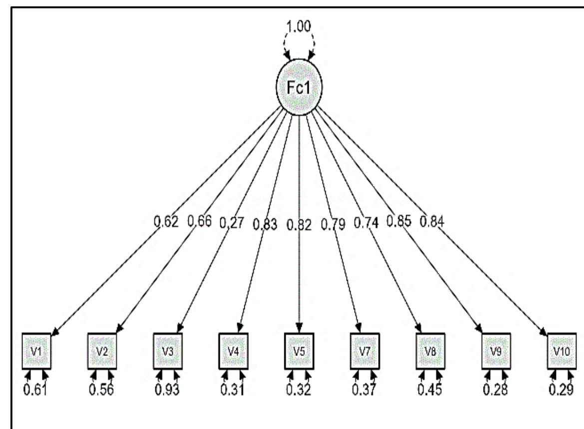

Figure 1. The Indonesian version of the final RSIPAS-CA model

Table 7
Descriptive Analysis of Participant Responses (N = 77)

Item	Response Frequency (*n*, %) STS/ TS	N	S/S	*Mean*	SD
1	6 (7.8%)	10 (13.0%)	61 (79.2%)	4.21	1.03
2	21 (27.3%)	30 (39.0%)	26 (33.8%)	3.16	1.05
3	15 (19.5%)	26 (33.8%)	36 (46.8%)	3.36	1.06
4	6 (7.8%)	12 (15.6%)	59 (76.6%)	3.97	.96
5	6 (7.8%)	14 (18.2%)	57 (74.0%)	3.99	.95
6*	29 (37.7%)	9 (11.7%)	39 (50.6%)	3.19	1.39
7	2 (2.6%)	13 (16.9%)	62 (80.5%)	4.13	.83
8	15 (19.5%)	9 (11.7%)	53 (68.8%)	3.82	1.26
9	3 (3.9%)	8 (10.4%)	66 (85.7%)	4.25	.89
10	3 (3.9%)	7 (9.1%)	67 (87.0%)	4.44	.87

Description: STS = Strongly Disagree (scale 1), TS = Disagree (scale 2), N = Neutral (scale 3), S = Agree (scale 4), SS = Strongly Agree (scale 5)
*= Item 6 deleted in the final model

In the context of mental health services, most participants feel open to discussing religious/spiritual beliefs (item 9, 85.7%, *M* = 4.25, *SD* = .89). The discussion was expected to have a positive impact on their condition (item 4, 76.6%, *M* = 3.97, *SD* = .96). Majority of participants believe that a mental health professional should be knowledgeable about how to discuss these beliefs in psychological treatment (item 1, 79.2%, *M* = 4.21, *SD* = 1.03). Additionally, sensitivity to the beliefs of clients (item 7, 80.5%, *M* = 4.13, *SD* = .83) and efforts put in place to understand these beliefs (item 5, 74.0%, *M* = 4.11, *SD* = .95) are indicators of the caring nature of the professional. Participants agreed that clients should initiate discussions about religious/spiritual beliefs (item 3, 46.8%, *M* = 3.16, *SD* = 1.06), compared to mental health professionals (item 2, 33.8%, *M* = 3.16, *SD* = 1.05).

Participants varied opinions regarding referral to religious leaders (item 8, *SD* = 1.26), with the majority being in favor of the decision (68.8%, *M* = 3.97). There is also significant variability in opinions regarding the openness of clients to psychological treatment by mental health professionals with different beliefs. While a majority agreed (50.6%), a substantial number of participants disagreed (37.7%, *M* = 3.19, SD = 1.39). The final 9 items had a total mean score of *M* = 35.32 (*SD* = 6.25), with scores ranging from a minimum of 9 to a maximum of 45.

Discussions

The study primarily aimed to describe the item quality, reliability, and validity of the adapted version of the RSIPAS-CA instrument within the Indonesian context. The 9 adapted items were discovered to have good evidence of content validity, item quality, reliability, and construct validity. However, these items can be used to show the preferences of clients regarding the integration of religiousness and spirituality values in the mental health services received. The results were in line with those of Oxhandler et al. (2018) which identified an item as unreliable and invalid. Based on the construct validity test, the instrument was interpreted collectively by considering each item.

When reviewing client preferences per item, details from items 2 and 3, signify whether the practitioner or the client should initiate discussion. Item 2 had a higher item discrimination and *factor loading* compared to item 3 which featured a higher average response. Additionally, the item discrimination and *factor loading* of item 3 were relatively lower compared to other items. The results showed that clients in Indonesia believed they should initiate the conversation. However, this opinion is not strongly indicative of preference regarding the integration of their beliefs in the services received. Clients who preferred being asked first about the issue show a relatively strong preference. The opinion of the majority of participants to initiate the topic about preferences was related to their characteristics of being female with a relatively high level of religiosity. According to (Schaffner & Dixon, 2003), individuals with these characteristics tend to show a stronger preference for religious interventions.

A strong determinant of clients attitudes towards the integration of religious values in mental health services is the openness to mental health professionals initiating the discussion on the preference issue. This is related to the high level of religiosity among the participants. In populations with these characteristics, there is often a negative assessment of demanding mental health assistance (Hashmi et al., 2020). Specifically, when the issue is related to conflicts concerning religion, feelings of guilt, shame, and fear of stigma can discourage individuals from discussing their problems (Currier et al., 2018).

The removal of item 6 signifies that clients willing to receive psychological treatment with mental health professionals who hold different belief systems do not necessarily show specific preferences regarding the integration of religious and spiritual values. This can be explained by the variation in response distribution and the magnitude of standard deviation for the item, as presented in table 7, suggesting diverse opinions among participants. Furthermore, the characteristics of the participants who completed the questionnaire are diverse. Some believe in the existence of God and are considered religious. In practice, various factors influence the choice of religious, spiritual, or secular treatment. These include level of spiritual belief, gender, correlation between the beliefs and values of clients as well as those of the counselor, type of therapy, and openness to spiritual issues (Harris et al., 2016).

This study also aims to determine the responses of participants towards their attitudes and preferences regarding the integration of religious and spiritual values in mental health treatment. The majority showed positive attitudes toward the integration of religion/spirituality into

mental health services. The average preference scores obtained in Indonesia are slightly higher compared to the United States, which is also a countries with the highest number of religious adherents in the world, despite its secular value (Oxhandler et al., 2018; Pew Research Center, 2012). Specifically, the results in the Indonesian context signify high regard for religious/spiritual values as resources during difficult times. This differs from the observations of Oxhandler et al. (2018) where views were more varied. The results are consistent with previous studies evaluating the role of religiosity in positively affecting the resilience of tsunami survivors (Sarbini et al., 2021; Muzdalipah et al., 2018).

Some distinct characteristics of clients in Indonesia were identified. Practitioners need to understand how to discuss this issue in their treatment. The practitioners should also be sensitive to the beliefs of participants and show a willingness to openly conduct discussions. This uniqueness can be explained by the predominantly religious characteristics of the participants (Schaffner & Dixon, 2003) concerned about avoiding negative stigma at the point of expression (Hashmi et al., 2020),

The study limitations include the *sampling* method which affects the interpretation of the results. This is because the sample was obtained by openly distributing questionnaires on the internet to anyone who met the inclusion criteria, hence *self-selection* bias was not controlled. The procedure differs from Oxhandler et al. (2018) who controlled the bias by combining the questionnaire with others in a market survey. In terms of the number of participants, this study also had a smaller sample (Oxhandler et al., 2018, 2021). Additionally, the characteristics of the participants need to be considered. For example, the participants in this study were predominantly female and Muslim, which affected the choice of services intended to receive (Harris et al., 2016). The issue was observed from the perspective of clients, while the perspective of practitioners was understood from another measurement tool, named the RSIPAS, designed in tandem with the RSIPAS-CA (Oxhandler, 2019). Practitioners view on the issue become important because some sources stated their high reluctance toward discussion (for example, Oxhandler et al., 2015).

The factors influencing the preferences of participants to express their needs first and what factors influence the choice of religious, spiritual, or secular treatment in Indonesia, should be investigated in the future. Additionally, further studies could also present practitioners' preferences regarding this issue, for example, by first adapting the RSIPAS measurement tool (Oxhandler, 2019).

Conclusion

In conclusion, this study produced an Indonesian version of the RSIPAS-CA measurement tool with 9 valid and reliable items that showed good discriminative power. Additionally, an overview of the attitudes of practitioners presented a positive view toward the integration of religion/spirituality within mental health services, particularly regarding the potential of religiosity and spirituality as resources in facing challenges. The adapted measurement tool was utilized to facilitate assessment processes in the field and served as an instrument in future studies.

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