# An Exploration of How Clinical Psychologists Make Sense of the Roles of Religion and Spirituality in Their Clinical Work With Adults Who Have Experienced Trauma

Philippa Rose Harbidge

A thesis submitted in partial fulfillment of the requirements of the University of East London for the Professional Doctoral Degree in Clinical Psychology

May 2015

Word count: 32,741

**ABSTRACT**

***Background and Aims***: Spiritual and religious beliefs and practices hold a central role within many individuals' worldviews, how they function socially and in the expression of distress. Within the profession of clinical psychology however spirituality and religion have been referred to as a neglected area. Some psychologists report discomfort in relation to incorporating spirituality and religion into therapeutic practice. However, the salience of spirituality and religion to clients who have experienced trauma is widely reported. The relationship between spirituality, religion and trauma has been explored, in terms of their role within meaning making processes, as a resource for coping and also, for some people, holding the potential for increased distress. This study aimed to explore how clinical psychologists made sense of the roles of spirituality and religion within their practice, working with adults who had experienced trauma.

***Method:*** Semi-structured interviews were carried out with eight clinical psychologists working within two NHS trusts. Participants held a range of preferred therapeutic modalities; cognitive, analytic and systemic. Verbatim interview transcripts were analysed using Thematic Analysis.

***Results***: Four main themes were generated, 'Spirituality and religion: Connectedness and ambivalence'; 'Influencing frameworks'; 'Trauma, spirituality and religion; Important to clients' and 'Contradictions in practice'. A description of these themes and associated sub-themes is presented.

***Conclusions***: Participants reported spirituality and religion to be a difficult topic; Spirituality and religion were acknowledged to hold significance to clients however contradictions were reported between therapeutic intentions and therapeutic actions. Consideration was given to the influence of wider contexts upon actions in practice. Clinical implications and directions for future research are discussed.

**Acknowledgements**

I would firstly like to thank the clinical psychologists who agreed to give up their time to partake in this study and for their invaluable contributions. I would like to thank my mum and dad for their unwavering support and constant encouragement in helping me to complete this project. I would also like to express thanks to Dr Nimisha Patel for providing guidance throughout this project and for many, encouraging, uplifting and much needed telephone calls. I would like to thank my very dear friends for their persistent encouragement and for believing in me. Finally I would like to acknowledge Vera Azarova for whom I am deeply thankful to have known and who has been inspiring, lovely and unforgettable to me. Thank you.

**List of Abbreviations**

APA – American Psychological Association

CBT – Cognitive Behavioural Therapy

DSM – Diagnostic and Statistic Manual of Mental Disorders

PTSD – Post Traumatic Stress Disorder

TA – Thematic Analysis

UK – United Kingdom

US(A) – United States (of America)

NHS – National Health Service

**List of tables**

Table 1: Participant Table

Table 2: Themes and Sub-themes

# Contents


Acknowledgements II

Abstract III

List of Abbreviations IV

List of Tables V

**CHAPTER 1: INTRODUCTION ..... 5**

**Literature Search ..... 6**

Sources and Inclusion/Exclusion Criteria ..... 6

**Defining Spirituality and Religion ..... 7**

Definitions of Spirituality and Religion ..... 8

**Spirituality, Religion and Psychological Well-being ..... 11**

Population Studies of Spirituality and Religion ..... 11

Spirituality, Religion and Physical and Psychological Well-being: General Population Studies ..... 12

**Spirituality, Religion and Ethnicity ..... 13**

Intersectionality of Identities: Ethnicity and Religion ..... 14

Inequality within Service Provision: Institutional Racism ..... 15

Islamophobia ..... 18

**Spirituality, Religion and Psychological Therapy ..... 19**

**Spirituality, Religion and Psychological Well-being Conceptualized by the Profession of Clinical Psychology: A Neglected Area. ..... 21**

Historical Context ..... 21

Guidance from Professional Bodies ..... 22

The Secular-Spiritual Divide within the Profession of Clinical Psychology ..... 24

The Personal and Professional Overlap ..... 25

The Current Status between Clinical Psychology, Spirituality and Religion ..... 27

**Spirituality Religion and Wellbeing: The Case of Trauma ..... 27**

Psychological Trauma ..... 28

Post Traumatic Stress Disorder ..... 28

Broader Conceptualisations of Trauma ..... 29
Trauma: The position of this Study ..... 29
**Trauma and Spirituality and Religion ..... 30**
**The Roles of Spirituality and Religion within Trauma ..... 31**
Spirituality and Religion as a Resource for Coping ..... 31
Spirituality and Religion as Meaning Making ..... 34
Spirituality and Religion: A Potential for Increased Distress ..... 36
**Summary and Rationale for the Study ..... 38**
**Research Aims ..... 40**
**Research Question ..... 40**
**CHAPTER 2: METHODOLOGY AND METHOD ..... 41**
**Epistemological Stance ..... 41**
**Methodology ..... 42**
**Method ..... 43**
**Reflexivity ..... 45**
**Selection and Recruitment of Participants ..... 46**
Sample ..... 46
Sample Size ..... 47
Data Collection and Interview Focus ..... 48
Resources ..... 49
**Ethical Issues ..... 49**
Ethical Approval ..... 49
Consent ..... 49
Confidentiality and Anonymity ..... 49
Further Support ..... 50
**Data Analysis ..... 50**
Transcription ..... 50
The process of Thematic Analysis ..... 51
**Evaluating Qualitative Research ..... 53**
**CHAPTER 3: ANALYSIS ..... 54**
**Summary of Master Themes ..... 54**
**Spirituality and Religion: Connectedness and Ambivalence ..... 56**
A difficult topic ..... 56

Degrees of connectedness ..... 57
Uncertainty and Fluidity ..... 60
**Influencing Frameworks ..... 62**
Personal Experiences ..... 62
Psychological Theory ..... 69
The Wider Context ..... 74
**Trauma and spirituality and religion: Important to clients ..... 77**
Religion 'an anchor' in extreme distress ..... 81
Spirituality and Religion Central to Meaning Making ..... 83
**Contradictions in Practice ..... 86**
Therapeutic Hopes and Intentions ..... 86
Therapeutic Actions in Practice ..... 88
**CHAPTER FOUR: DISCUSSION ..... 93**
**Overview ..... 93**
**Reviewing Research Aims ..... 93**
Aim 1: How clinical psychologists define and understand their own values with regard to spirituality and religion. ..... 93
Theme 1: Spirituality and Religion: Connectedness and Ambivalence 93
Aim 2: How clinical psychologists make sense of the roles of spirituality and religion within their therapeutic work with adults who have experienced trauma. ..... 96
Theme 2: Influencing Frameworks ..... 96
Theme 3: Spirituality, Religion and Trauma: Important to Clients ..... 102
Theme 4: Contradictions in Practice ..... 105
**Further Discussion ..... 106**
**Evaluation of the Research ..... 107**
Sample ..... 107
Interview Schedule ..... 108
Analysis ..... 109
**The Role of the Researcher ..... 110**
First person reflections - Confessions ..... 110
Second person reflections – Positions ..... 111
Third Person Reflections - Theorising ..... 112

Fourth Person Reflections - Crafting....113
**Reviewing the Quality of Qualitative Research....113**
Contribution....113
Credibility....114
**Rigour....114**
Reflexivity....114
Audibility....115
Defensibility....115
**Implications....115**
Theoretical Implications....116
Research Implications....116
Clinical Implications....118
Service Implications....122
**REFERENCES....125**
**APPENDICES....155**
**Appendix 1 – Choosing A Method....155**
**Appendix 2 – Participant Information Sheet....157**
**Appendix 3 – Consent Form....159**
**Appendix 4 – Interview Schedule....160**
**Appendix 5 – University of East London Ethical Approval....162**
**Appendix 6 –Joint Research and Development Office Approval....163**
**Appendix 7 – Worked Extract Example....164**
**Appendix 8 – Coding Manuel....166**
**Appendix 9 – Coded Extract Example....172**
**Appendix 10: Provisional Themes....176**
**Appendix 11 - Thematic Map 1....177**
**Appendix 12 - Thematic Map 2....178**
**Appendix 13 - Thematic Map 3....179**

## CHAPTER 1: INTRODUCTION

This study explores some of the key issues related to spirituality, religion and trauma; focusing on how clinical psychologists make sense of the roles of spirituality and religion within their therapeutic work with adults who have experienced trauma.

Within this introductory section, I establish that spirituality and religion hold central importance within many peoples' lives, influencing both physical and mental wellbeing. On this basis I offer a rationale for why spirituality and religion should be attended to within therapeutic interactions. From here, I argue that spirituality and religion has been an area largely neglected by the profession of clinical psychology. In establishing this claim, I reflect on the history of the relationship between psychology as a discipline and spirituality and religion. I then examine guidance offered by professional bodies related to the incorporation of spirituality and religion within clinical practice. I consider the proposed notion of a spiritual-secular divide whereby the profession of clinical psychology has been suggested to be unrepresentative of the client group it seeks to serve, and I examine how this may facilitate neglect.

Following this I look at psychologists' experiences of incorporating spirituality and religion into therapy, exploring how spirituality and religion have been associated with uncomfortable feelings and reported anxieties surrounding ethical practice and cultural competency. On this basis, I establish firstly, that spirituality and religion is a neglected area within the profession and secondly that psychologists report experiencing discomfort associated with talking about spirituality and religion with clients.

To illustrate this, I focus on the example of trauma, suggesting that spirituality and religion hold particular salience for individuals experiencing extreme distress as a response to trauma. From this basis, I consider literature that explores the roles of spirituality and religion in relation to trauma.

Finally, in accordance with the arguments presented a rationale for the study is outlined.

**Literature Search**

A literature search was conducted in order to review the current extent to which spiritual and religious issues within trauma work are reported and discussed in research. The literature related to this topic focuses on several areas of interest and has been organized into the following:

- Definitions of spirituality and religion;
- Population studies of spirituality and religion;
- Spirituality and religion: A neglected area:
    - The historical relationship between spirituality, religion and psychology;
    - Guidance from professional bodies;
    - A spiritual-secular divide;
    - Psychologists' experiences of talking about spirituality and religion with clients.
- Defining trauma;
- Trauma, spirituality and religion.

Sources and Inclusion/Exclusion Criteria

A number of selected databases were searched (CINAHL, MEDLINE, Psych INFO, Web of Science) using The University of East London's online library search engines of Science Direct and EBSCOHOST. Additionally, 'grey' literature was also accessed (e.g. Google scholar) and the reference sections of identified papers were scanned for further articles. The search terms used were derivatives of: religion, spirituality, clinical psychology, trauma and PTSD. The publication search spanned from 1990 to 2015. The inclusion criteria were: peer reviewed articles for quality appraisal assurances; English language; relevance to the research topic (for

example, focus on clinical psychologists in training, or other qualified therapists). The exclusion criteria employed surrounded: research not deemed to closely relate to the topic (e.g. studies related to children, or the views of non-practitioners) and focus surrounding specialist religious psychotherapy services as opposed to mainstream clinical psychology services.

Research studies were critiqued using standard means (e.g. Coughlan et al., 2007; Ryan et al., 2007). For example, consideration was paid to the believability and robustness of research studies, ethical issues and the recommendations implied by the findings. It is important to note that the literature is rooted within different epistemological and ideological origins, for example some in empirical data and some based on author's own experience. In this regard the literature presented does not fit into coherent categories. Additionally, much of the literature comes from the USA (Aten & Leach, 2009). The USA is different to the UK with respect to religious landscape and the provision of public therapy services; therefore where possible UK literature has been preferred.

**Defining Spirituality and Religion**

It is important to acknowledge the varying ways in which the concepts of spirituality and religion can be defined and how the relationship between these two constructs is understood within psychological literature and research. Historically it has been difficult to clarify and define these two constructs. More recently, authors (e.g. Zinnbauer et al, 1997) have highlighted how there has been a cultural shift in the way in which these terms are understood, with religion being seen as increasingly "narrow and institutional" and spirituality as "personal and subjective". Research carried out to explore this cultural shift indicates that the term 'religion' is used too broadly and that the term 'spiritual' is broad and vague (Rose, 2001; Crossley, 2000). This raises the question of whether terminology employed within research should be adapted to mirror this cultural shift. In the

following section contributions towards definition of the terms spirituality and religion will be considered and from this basis a rationale for how this study will use these terms is offered.

Definitions of Spirituality and Religion

With regard to spirituality, Plante and Thoresen (2012) conceptualize spirituality as;

"*less socially constructed and organized but as more individual, with a focus on the perception of sacredness within life*" (p.23)

Altmaier (2013) expresses this idea quoting, James (1936) who described spirituality as:

"*The feelings, acts and experiences of individual men in their solitude, as far as they apprehend themselves to stand in relation to whatever they may consider the divine*" (p. 32)

However, even definitions of spirituality such as the one above arguably draw on religious language. Sperry and Shafranske (2005) and Nagai (2008) emphasize that the ability to describe and define spirituality constitutes an essential component of spiritual competency for psychologists and that doing so guards against the potential of it being confounded and subsumed by cultural or religious labels. Worthington and Aten (2009) drew on a humanistic perspective in offering a classification of spirituality in terms of religious, humanistic, nature and cosmos spirituality. This enabled spirituality to be defined apart from as well as within a religious context.

With regard to religion, Plante and Thoresen (2012) sought to demarcate religion from spirituality through emphasis on its social construction within groups. They proposed that religion:

"*is a social institution with an organized belief system and rituals that encourage community response*" (p. 24)

Shafranske (1996) attempted to add complexity to the understanding of the term religion through offering a three-fold categorisation of religion in terms of affiliations, beliefs and practices. Watts and Williams (1988) warn that most psychological research has been overly concerned with external practices of religion rather than what they describe as 'religious knowing'. A concept involving:

"*a highly personal process that is both similar to and intertwined with, knowledge of ourselves. Religious and personal insights arise as a result of similar cognitive processes and have many common features*" (p.152)

Despite these contributions however no consensual definition seems to have been adopted for either of these constructs and authors writing within this sphere continue to highlight the overlap between the two. Some scholars have reconciled competing definitions of religion and spirituality by suggesting that they can both be thought of as a personal, affective relationship with the divine that can occur in a religious context (e.g., Hill & Pargament, 2003). Proponents of this position have noted that many lay people consider their spirituality to occur in the context of an organised religion, though some do not. Crawley (1997) suggests that spirituality has become polarized, with either religious or non-religious overtones.

In seeking to engage with the arguable confusion within the literature, though I recognize the inherent limitations of any definition due to the subjective nature of individual experience, I offer definitions to the reader with the aim of providing some level of shared meaning for both concepts (Hill et al., 2000, Worthington & Aten, 2009). The Oxford English Dictionary (2012) defines religion in terms of:

'*The belief in and worship of superhuman controlling power, especially a personal God or gods'*

and spirituality as:

'*Relating to or affecting the human spirit or soul as apposed to material or physical things.' or 'Relating to religion or religious belief*.'

The Oxford definitional terms, although limited, have been given above to offer an opening framework to the reader alongside highlighting that these constructs are not completely interchangeable. In recognition of this, within literature and research they have predominantly been termed together (Masters, 2010; Hage, 2006). Several authors writing within this sphere note a preference for using a composite term for the two rather than separating them (Mulla, 2011; Coyle and Lochner, 2011; Masters, 2010). Hage (2006) suggests that where distinctions have been made in research studies, findings show incongruent meanings amongst participants. From a clinical perspective others have argued that the development of discrete definitions may be unhelpful to clients (Hill & Paragment, 2003; Miller & Thoresen, 2003).

My understanding of the relationship between spirituality and religion would be that spirituality may be one of many ways of searching for meaning around our existence and our inner experiences. This may be sought through religion, which is articulated in a wide variety of ways as religious practices in different social groups, where more 'prescribed' views on the meaning of existence are negotiated. I also believe, however, that spirituality may be expressed through means independent of any religious connotation such as connectedness to people or nature.

In light of their overlap, their frequent coupled use within the literature, the evidence presented and my own preference, the terms spirituality and religion are used together.

## Spirituality, Religion and Psychological Well-being

Within this section literature exploring a potential relationship between spirituality, religion and psychological well-being is considered. Debate surrounding whether spirituality and religion hold positive or negative impacts on wellbeing is outlined.

### Population Studies of Spirituality and Religion

Berger et al. (1999) suggest that most of the world's population adheres to a particular world religion. With reference to the UK, mixed figures regarding religious and spiritual affiliations have been reported. The Office of National Statistics reported that over 65% of the population stated that they hold a religion (ONS, 2011). However this statistic may be inflated due to it deriving from the leading question, "What is your religion?". Data from the 2014 Gallup poll suggests that this may be the case. They report 30% of people within the UK affiliate to a religion (Gallup, 2014). However this was generated from a sample of only 1000 and therefore may lack reliability. The results from the British Social Attitudes Survey (2010) suggest that religiosity can be defined through 'belonging' established through enquiry about affiliation, and 'practicing' established through enquiry of religious meeting or service attendance. They report that around 50% of the UK population affiliate with a religion. Out of this, 18% do not practice through attending meetings or services. However 30 % were reported to both affiliate with a religion and practice their religion through attending meetings or services. With regard to smaller polls considering the importance of religion, YouGov (2014) reported that 29% of people in Britain think that religion is important in their lives. Despite the difficulty in establishing an exact figure, a recurrent finding has been a gradual decline in religious affiliation (Gallup, 2014; ONS, 2011). By contrast however a number of authors have highlighted how spirituality appears to hold increasing significance within the UK, a trend recently termed a 'spirituality revolution' (Tacey, 2004; Woodhead & Heels, 2004). Coyle (2008) suggests that in recent decades, there has been a shift away from religion and towards

spirituality. He suggests that this has been linked to a ‘subjective turn’ in the Western world that is a turn away from external ‘objective’ roles and duties in shaping lives and towards subjective experiences.

Although decline has been observed in recent years, the figures indicate that religion remains important to a significant proportion of the UK’s population. In addition to this, increasing engagement with spiritual ideas and practices suggest an increase in the importance of spirituality for many people. It is therefore suggested that spirituality and religion hold an important role within many people’s lives. This leads to the consideration of what if any impact does spirituality and religion have on health and wellbeing.

## Spirituality, Religion and Physical and Psychological Well-being: General Population Studies

Numerous studies have sought to consider a potential relationship between spirituality, religion and well-being (e.g. Paul, 2005; Plante & Sharma, 2001). Koenig et al (2001) highlight that research within this field has seen extremes between naïve acceptances of all claims that “religion is good” to a “radical scepticism that rejects good scientific evidence”. They suggest that in evaluating research surrounding these positions the role of prejudice, defined, as a “preconceived opinion” must be acknowledged.

Some authors suggest that a negative relationship exists whereby religion and spirituality may have a detrimental impact on well-being (Paul, 2005, Schaefer, 1997). In contrast, other studies report that spirituality and religion were associated with increased well-being. Koenig, McCullough & Larson (2001) looked at the influence of spiritual and religious behaviours and beliefs on both mental and physical health outcomes. They concluded that higher involvement in religious and spiritual beliefs and practices was positively associated with indicators of psychological well-being such as life satisfaction, happiness, positive affect and higher morale.

In seeking to reconcile opposing positions, other contributors have suggested that positive spiritual/religious practices were associated with positive mental health outcomes (e.g. life satisfaction) (McCullough, Larson & Worthington, 1998) and that negative mental health outcomes (e.g increased stress) were associated with negative religious coping styles (Pargament, 1997).

In a review of the literature on the impact of spirituality on mental health, The Mental Health Foundation (2006) acknowledged a modest, but nonetheless positive relationship between spirituality and mental health in relation to a number of areas of mental health problems. In line with this it is suggested that for many people spiritual and religious beliefs and practices hold a positive influence over their well-being.

In recognition of the above, Meador & Koenig (2000) highlight that regardless of whether spirituality and religion hold a negative or positive influence on mental health, repeated findings of a relationship between spirituality, religion and well-being suggest that these areas warrant consideration within clinical settings. The following discussion will consider how spirituality and religion may hold particular salience to some groups of people.

**Spirituality, Religion and Ethnicity**

Research from the Office of National Statistics (ONS) 2011 census religion and ethnicity data reported that 93% of Christians in England and Wales were White. However Muslims were reported to be more ethnically diverse, 68% being from an Asian background. The proportion of Muslims reporting as Black/African/Caribbean/Black British was 10% similar to those identifying with an ‘Other ethnic group’ at 11%. The majority of Hindus and Sikhs were from an Asian ethnic background (96 % and 87% respectively). They report that as with Muslims, Buddhists were also ethnically diverse. The figures above suggest that some, e.g. Muslims, Buddhists and Sikhs

who identify with a religious affiliation are more likely to also identify as belonging to an ethnic minority group. Afuape (2012), alongside others, e.g. Whittacker et al (2005), have highlighted the salience of religious and spiritual beliefs to those within ethnic minority groups, for example refugee populations.

Intersectionality of Identities: Ethnicity and Religion

Given the above, the concept of intersectionality is worthy of consideration. Intersectionality within identity refers to the inherently entangled nature of multiple identities (Crenshaw, 1989). The term was most notably introduced by Kimberlé Crenshaw in her 1989 black feminist critique of anti-discrimination doctrine, feminist theory and anti-racist politics. She emphasised the problematic nature of conceptualising race and gender as being mutually exclusive categories of experience and analysis, proposing that intersections exist between forms or systems of oppression, domination or discrimination.

Subsequently, intersectionality has grown in application to consider the linked nature of additional identity categorisations such as sexual orientation, ethnicity, socioeconomic status and religious affiliation amongst others (e.g., Arredondo et al., 1996; Hays, 2007). Intersectionality explores how identities can overlap creating interdependent systems of discrimination or disadvantage that contribute to systemic injustice and social inequality. In this vein therefore, some individuals who identify as holding an ethnic minority status are also likely to identify with holding a religious affiliation or identity and may experience a multiplicative effect of discrimination across these leading to further oppression and social inequality.

Multiple minority stress (e.g. Bowleg et al, 2003) draws attention to the challenges faced by those who occupy a minority status within more than one identity category. The multiplicative effect of discrimination experienced across identities results in a cumulative stress that is greater than the sum

of its individual parts. For example, Ahluwalia and Alimchandani (2013) explored the experiences of Sikhs within the US after the September 2001 attacks. They highlight that efforts to preserve cultural identity and physical safety within a toxic environment rampant with increased racism and discrimination can result in forced prioritising of affiliation toward faith over other aspects of identity. Thus further amplifying Sikh experiences of multiple minority stress. Within the UK other studies have considered the experiences of Muslims after the July 7th 2005 London Bombing. Abbas (2004) notes how Muslims are increasingly targeted by right-wing groups with more subtle forms of racist prejudice and hatred. The European Monitoring Centre on Racism and Xenophobia published a summary report on Islamophobia in the EU after the 11 September 2001. They reported that although relatively low levels of physical violence were identified in most countries, verbal abuse, harassment and aggression were much more widespread. Muslims, especially Muslim women, asylum seekers and others, including those who look of Muslim or Arab descent were at times targeted for aggression. In light of this the argument for religious and spiritual issues to be considered within therapeutic practice is compounded by the knowledge that those who value religion and spirituality are more likely to experience multiple stress as a result of intersecting identities of ethnicity and religion amongst others, e.g education, class (Abbas, 2004). In line with this the following discussion will consider the potential influence of wider political contexts of institutional racism and Islamophobia.

## Inequality within Service Provision: Institutional Racism

In considering the interaction of identities of an ethnic minority status and religion it is important to consider how discrimination may be experienced through institutional systems such as the NHS. Today racism is fashioned by racial prejudice and underpinned by economic and social factors. Fernando (2010, p.21) posits that when racism is implemented and practised through the institutions of society, often without people involved even being aware that they are being racist, it is called ‘institutional racism’.

Mainstream and mental health services in the UK have a longstanding history of failing the needs of Black and minority ethnic communities. Keating (2002) reports that services have not been able to detect mental health problems across all minority ethnic communities (Bhui, 1997), they have not been effective in engaging members of these groups (Bhugra and Bahl, 1999; Gunaratnam, 1993; McGovern and Hemmings, 1994), and they have not been effective in gaining the confidence of Black communities (Gray, 1999; Hirsch and Powell, 1998). In particular African and Caribbean men often report extremely negative experiences in mental health services, including experiencing institutional racism, being stereotyped, misunderstood and seen in a narrow limited way (e.g. Sandhu, 2007; Morgan et al., 2009). In response to this there has been growing recognition of the importance of redressing inequalities within government proposals for the modernisation of health and social services.

In 2003 the Government commissioned the report ‘Inside Outside’ (NIMHE, 2003) which called for radical changes in the statutory services (the ‘inside’) together with work with Black minority ethnic (BME) communities and the voluntary sector (the ‘outside’). Fernando (2010) notes that, two issues that had never been directly pinpointed in an official report before were highlighted: First, current mental health services being underpinned by models of illness, therapy and care are rooted in narrow western thinking which in other words are ethnocentric; and second, that services have been designed with ‘white people’ alone in mind reflecting attitudes towards ‘others’ that are essentially racist, or at least not designed to address racism.

In 2003 the Department of Health brought out a new policy document entitled Delivering Race Equality: A Framework for Action. The report stated an intention to recognise the problems of mental health care as experienced by black and minority ethnic groups and acknowledged the existence of institutional racism within mental health care systems, stating:

*"We have an obligation to meet this challenge and tackle racism and institutional discrimination within our mental health services." (DOH, P 3).*

As noted above one of the ways in which institutional racism has been maintained is through the mental health system being underpinned by ethnocentric models of illness, therapy and care. Keating (2002) highlights that Universalist assumptions of health and welfare provision, a philosophy that treats everyone the same regardless of their origin or status (Williams, 1993) legitimates non-recognition of the service needs of Black and minority ethnic communities (Atkin, 1996). One area of identified discrimination and inequality in terms of service provision has been a lack of culturally competent and sensitive care for those who identify with a Black or minority ethnic status (Gray, 1999). Nagayama Hall (2001) highlights how many ethnic minority persons want psychology services that are culturally sensitive. He suggests that culturally sensitive therapy involves the tailoring of psychotherapy to specific cultural contexts. Service users within ethnic minority groups have also voiced the importance of spirituality within their lives. For example, Carlin (2009) carried out an evaluation of the Trailblazers project. A multi-agency project that sought to improve assess to talking therapies for black and afro-Caribbean men living in the London borough of Hackney. The evaluation stated how spirituality was of high importance to service users who reported that they wanted to be able to talk about their spirituality and found that the 'Tree of Life' approach (Ncube, 2006) had enabled this to take place.

Therefore with regard to the consideration of spirituality and religion within therapy, Abbas (2004) suggests that although conceptual overlaps exist, the British discourse on racialized minorities has been transformed from "color" in the 1950s and 1960s; to "race" in the 1960s, 1970s, and 1980s; to "ethnicity" in the 1990s; and to "religion" in the present climate. Considering this position therefore, the proceeding discussion explores the context of Islamophobia.

## Islamophobia

Islamophobia has been defined as the fear or dread of Islam or Muslims (Abbas, 2004). In their 1997 publication 'Islamophobia a challenge for us all' The Runnymede Trust, an independent research and social policy agency established the Commission on British Muslims and Islamophobia. The report offered a detailed explanation of Islamophobia, highlighting its consequences for society and offered recommendations for practical action. They define Islamophobia as an outlook or world-view involving an unfounded dread and dislike of Muslims, which results in practices of exclusion and discrimination including exclusion from the economic, social and public life of the nation. The report draws a key distinction between closed views of Islam on the one hand and open views of Islam on the other. Whereby Islamophobia is equated with closed views such as that Islam has no values in common with other cultures, that it is inferior to Western cultures, and is a violent political ideology rather than a religion. The reports argues that this conception of Islamophobia tries to capture its complexity and historical evolution over time however the label has not stood without critique. For example some argue that the use of 'phobia' as a diagnostic terms may avert responsibility taking.

Abbas, (2004) argues that the current portrayal of British Muslims is part of a "new racist discourse." This "new" racism differs from the "old" racism in that it is more subtle but, at the same time, explicit in the direction it has taken. Returning therefore to consideration of the mental health system and the profession of clinical psychology, neglect of religion and spirituality within practice should be considered and understood at least in part by the wider political contexts of institutional racism and Islamophobia. As highlighted by Fernando (2010) it is essential to acknowledge that western psychology may be called scientific or secular psychology however it is only one of many systems of knowledge about the 'mind'. Other contributions may be offered through consideration of spiritual and other meaning making frameworks.

*Spirituality, Religion and Ethnicity: Summary*

In the discussion above, it is acknowledged and emphasised that religion and spirituality can hold particular salience to those within minority ethnic groups, and that these multiple identities connect to experiences of multiple minority stress as a result of intersecting positions of oppression, discrimination and social injustice. This undoubtedly stands as a powerful argument for the consideration of spirituality and religion within therapeutic practice and compounds the need for services to be offered that are culturally sensitive, useful and accessible. It is also cautioned however that religion and spirituality should not be exclusively framed as only holding importance to ethnic minority groups. It is suggested here that doing so can serve to 'other' religion and spirituality constructing them as unique to ethnic minority cultures and in some way exotic. In the case of Islam for example, as highlighted within The Runnymede Trust's report on Islamophobia, closed views were suggested to include that there are no similarities between the religion of Islam and Western religions such as Christianity. Given that at least a moderate proportion of people who identify as white British within the UK also identify as holding a religion and additionally given the 'spirituality revolution' which has been suggested to be taking place within the UK (Tracey, 2004; Woodhead & Heels, 2004), it is argued here that spirituality and religion are expressed in different ways and in different formats across almost all cultures. In light of this religion should not be construed as something applicable and relevant only to those who also identify with holding an ethnic minority status but rather it is suggested here should be considered across all client groups.

**Spirituality, Religion and Psychological Therapy**

As outlined above, many authors have suggested that spirituality and religion should be considered within therapeutic encounters with clients (Hage, 2006; Shafranske, 1996a). Pearce, Rivinoja and Koenig (2008) suggest that spirituality and religion inherently influences clients' narrative frameworks in which they make sense of themselves, others and the world

around them. As sense making is a key part of the psychologists' role, exploration of spiritual and religious beliefs within therapy should take place (Shafranske, 1996a).

As explored above spirituality and religion may hold particular salience to some client groups especially those who identify with a Black or Minority ethnic status (Afuape, 2010; Keating, 2002). With regard to the provision of psychological services within the NHS, ethical considerations support the inclusion of spirituality and religion within clinical practice. Mulla (2011) highlights how attention to spirituality and religion within therapy arguably seeks to fulfill The Human Rights Act (1998), through the promotion of equal access to and the quality of care offered by public services. In line with this Sue and Sue (2003) suggested that a culturally competent mental health professional should be aware of their own culturally derived assumptions values and biases, understand the worldviews of clients who are culturally different and use culturally appropriate interventions. Berkel et al (2007) emphasize spirituality and religion as being a part of this, whereby;

"*failure to acknowledge the potential influence of the religious/spiritual beliefs… may be as inappropriate as failure to acknowledge and address the potential influence of race, gender or sexual orientation*" (p.3)

Hackney and Sanders' (2003) review of spirituality, religion and mental health, emphasized that the way therapists engage therapeutically with clients spiritual and religious beliefs, holds impact upon therapeutic outcomes. In accordance with this, some findings suggest that even non-religious clients validate the importance of exploring religious and spiritual frameworks within therapy (Rose et al., 2001). Mayers et al., (2007) reported that when spiritual and/or religious beliefs are thought by clients to be respected and accepted by therapists, this has been linked to increased therapeutic alliance and subsequently better therapeutic outcomes.

**Spirituality, Religion and Psychological Well-being Conceptualized by the Profession of Clinical Psychology: A Neglected Area.**

Despite the much discussed impact of spiritual and religious beliefs and practices on mental well being, and the rationale for their consideration in therapy, religion and spirituality has been labelled as a neglected area within the profession of clinical psychology (Pargament & Saunders, 2007). The following discussion explores this neglect starting with consideration of the history of their relationship.

## Historical Context

Religion, spirituality and psychology have been described by some as holding an unstable history, with tensions emanating from both sides (Begum, 2012). Plante (2007) claims that most of professional and scientific psychology during the past century has avoided the connection between these two areas of enquiry.

Although in the minority, a number of psychology's prominent forefathers such as William James, Carl Jung and Gordon Allport, showed keen interest in the relationship between psychology and religion (e.g., Allport, 1950; James, 1902; Jung, 1938). Jung (1989) encouraged the importance of spiritual experiences, regarding them as an integral part of individualism, and framing them as important maturational processes involving the reuniting of unconscious and conscious aspects of the self in order to achieve wholeness. Furthermore, in the classic 'Varieties of Religious Experiences' William James (1961, p. 434) distinguished between;

"*religion as an individual personal function and religion as an institutional, corporate, or tribal product*".

Despite these contributions, however, the influence of leaders in the field such as Sigmund Freud, B. F Skinner and John Watson, who found little if any value in the study or practice of religion, has left its mark (e.g. Ellis,

1971; freud, 1927/1961; Watson, 1924/1983). In his book “Future of Illusion” Freud stated that religious views: “Are illusions, fulfillments of the oldest, strongest and most urgent wishes of mankind” (1927/1961; p. 30), and later referring to them as “obsessional neuroses” (1927/1961; p. 43). Collins (1977; p. 95) stated:

“*Psychology has never shown much interest in religion…apart from a few classic studies.. The topic of religious behaviour has been largely ignored by psychological writers*”.

As the field progressed and prided itself on being a science, efforts were made to move towards rigorous scientific enquiry within both research and practice. Patel and Shikonga (2006) noted:

“*psychology’s general reluctance to embrace the importance of matters spiritual/religious can be traced to the history of the discipline. As an endeavour to establish itself as a scientific discipline, only rational observable phenomena were accorded the attention they were deemed to deserve*,” (p.94).

Within this vein, the profession of clinical psychology evolved alongside and with substantial influence from the field of psychiatry. Koenig (2008) highlights that prior to the publication of the DSM-IV in 1994, examples of people presented in the DSM were often those of religious persons. Larson et al, (1993) amongst others suggest that negative views towards religion live on within the psychiatric and psychology professions today leading to avoidance within practice (Coyle and Lochner, 2011).

## Guidance from Professional Bodies

A further area of neglect has been that of guidance from professional bodies regarding religion and spirituality and the impact of this on the

training received by psychologists in clinical training and qualified positions (Cooper, 2012).

National agendas within the UK (e.g. Commission for Healthcare, 2007; Mental Health Foundation 2006) offer promotion of spiritual healthcare strategies. More specifically, guidance for working with spiritual and religious beliefs has been offered within National Guidelines for the NHS: 'Religion or Belief' (Department of Health, 2009).

However, contributions to more specific guidelines have most often been issued within the US. The American Psychological Association (APA, 2002; 2003; 2009) has provided guidelines for US psychologists regarding the incorporation of spirituality and religion into psychotherapeutic work with individuals. Despite this, however, authors note a paucity of evidence to support the notion that within clinical practice these issues are being attended to (Hathaway et al., 2004).

In the UK, this specific area of diversity has been neglected in guidance literature from professional bodies for the practice of clinical psychologists. The British Psychological Society (2006; 2008; 2009) and Health Professionals Council (2008) have provided guidance that focus on 'diversity' as an umbrella term yet this has lacked exploration of the unique considerations and differences of its elements. Begum (2012) highlights that a lack of specific guidance for UK clinical psychologists adds to the impression that this particular area of diversity is not prioritized, reifying to the profession the notion of these issues being unimportant. This may lead to a lack of engagement with the roles of spirituality and religion within clinical practice.

## The Secular-Spiritual Divide within the Profession of Clinical Psychology

Further to a lack of guidance, some authors have suggested that the neglect within the profession may be attributed to a mismatch between the religious and spiritual affiliations of the general public and those within the profession, referring to this as the 'secular-spiritual divide' (Mayers et al., 2007; Smiley, 2001).

In defence of this, some authors suggest that a significant proportion of therapists exhibit either personal spiritual or religious spiritual experiences and habits, and that only a minority regard themselves as strictly secular (Smith and Orlinsky, 2004). However, Worthington and Sandage (2002) reported findings suggesting that psychologists do tend to be less conventionally religious.

Allman, Rocha & Elkins (1992) concluded that disparity between the values of clinical psychologists and their clients increases the likelihood of neglect occurring. Berger (1999) highlighted that this disparity between psychologists and clients may reduce the likelihood of psychologists entering into a client's spiritual explanatory framework. In this way, this secular-spiritual divide may affect how professionals make sense of spiritual and religious beliefs, whereby spiritual or religious beliefs and behaviour may be conceptualized by professionals as symptomatic of psychological disorder (Larson, Hohmann & Kessler, 1988; Shafranske & Gorsuch, 1984). In line with this, O'Connor and Vandenberg (2005) reported that the more familiar a therapist was with a particular set of religious beliefs, the less likely they were to perceive them as pathological.

With regard to the impact on clients, Leavey (2004) suggested that clients with spiritual or religious beliefs may experience a dilemma between self censoring these beliefs or risking further pathologisation from mental health staff. West (2000) acknowledged that clients often will not talk about topics to which therapist's are "deaf" to. This is particularly relevant when it is considered that some clients may only be helped effectively if spirituality

and religion are routinely, sensitively and competently addressed (Shafranske, 1996b).

The Personal and Professional Overlap

Other studies have considered a lack of exploration of personal values by psychologists as a contributor to neglect. For example, Cooper (2012) emphasised the need for psychologists to consider their own stance and values with regard to religion and spirituality in order to acknowledge assumptions when working with clients who hold beliefs that are different to their own. Callan and Littlewood (1998) proposed that disharmony between client and therapist's explanatory frameworks can affect treatment satisfaction.

Patel (2003) proposes that psychological approaches seated within positivist ideologies present the perspectives and ideas of psychologists as neutral, rather than being constructed through the lens of their own life experiences and personal values. Afuape (2011, p.46) suggests that those working within the profession of clinical psychology must offer recognition of different types of 'logic'; she emphasizes that there are different ways of connecting to and understanding reality, other than that which is 'rational' and concrete. She also notes that given what seems to be an increasing preoccupation with science and rationality, talking about spirituality can be as difficult for clients, and therapists, as talking about other intimate yet taboo issues, such as sexuality.

In a contribution from the systemic perspective, Burnham (1992) proposed the acronym of social 'GRRAACCEESS' including religion and spirituality to facilitate therapists reflection on identity and experience and how these interact within therapeutic processes. In line with this, Baker and Wang (2004) explored therapists' experiences of the interaction between personal values and professional identity. They suggest that interaction between the two is fluid rather than static, therefore requiring self-reflection and recursive exploration.

Burnham (1993) suggested that this self-reflexivity involves therapists becoming curious about the pre-understandings they hold, what contexts inform them and then, on this basis, change how they act and respond within therapeutic interactions accordingly. However, research considering this process in relation to spirituality and religion suggests that these may be 'social graces' that psychologists find particularly difficult to reflect on and utilize as a resource within their practice. Begum (2012) carried out a study in which she interviewed trainee clinical psychologists about their experiences of religion and spirituality in their clinical practice. She reported that participants seemed to find it difficult to think and talk about the personal aspect of 'personal and professional issues' regarding religion, and to an even greater extent, spirituality. A recommendation from the study surrounded the development of 'tools for thinking' about spirituality and religion. Many authors have highlighted the influence of personal values held by therapists on therapeutic processes and this includes spiritual and religious beliefs (Cooper, 2012; Post & Wade, 2009; Souza, 2002).

In line with the above, some studies have sought to consider psychologists' experiences of talking about spirituality and religion with clients. Worthington et al., (1996) note that the majority of therapists find it uncomfortable to work with religious themes in secular healthcare settings. Other authors have highlighted fears reported by psychologists surrounding ethical practice and cultural competency (Saunders et al., 2010; Hathaway et al., 2004). Psychologists' relationship to the topic of spirituality and religion appears to be marked by discomfort and fear, which some have argued has led to its avoidance within therapy (Pargament, 2007).

## The Current Status between Clinical Psychology, Spirituality and Religion

Despite the argued neglect within the profession, some developments hint of a change in attitude towards spirituality and religion (Delaney et al., 2007). Baker (2011) reports that there has been a substantial increase in literary focus whereby spirituality and religion have become legitimate areas of psychological study (Masters, 2010). Within therapeutic practice there has been an increase in impetus to incorporate spirituality and religion into therapy. Saunder, Miller and Bright (2010) termed this “spiritually conscious care”. Plante (2007) suggested that these developments have arisen as a result of pressure, from the media, clients and professional organisations.

Parallel to this, some therapeutic approaches have incorporated spiritual practices into therapy, such as Mindfulness-based cognitive approaches (Segal et al., 2002). Andersson and Asmundson (2006) suggest that this signifies alignment between psychology and religion. However Coyle and Lochner (2011) highlight that here mindfulness is used as a technique directed towards therapeutic outcomes rather than as a spiritual practice and/or a means of orienting clients to spiritual concerns.

Therefore, though it is acknowledged that some changes appear to be taking place; scepticism regarding the integration of spirituality, religion and psychology appears to remain; and psychologists continue to report discomfort in relation to this topic. The following discussion turns the focus towards the relevance of spirituality and religion in times of psychological distress.

## Spirituality Religion and Wellbeing: The Case of Trauma

In the following section, the literature on trauma as it relates to the relevance of spirituality and religion is considered because it is often argued (e.g. Shaw et al, 2005; Pargament et al, 2003; Herman, 1992;) that spirituality and religion become particularly salient for clients and for

clinicians working with those who have experienced trauma. It is first, however necessary to acknowledge controversies surrounding the conceptualisation of psychological trauma. The following sections outline how this term has been used within psychological literature generally, and how the construct of trauma is employed within this study.

## Psychological Trauma

Furedi (2004) notes that in spite of a rise in both psychiatric discourse and lay parlance, the construct of "psychological trauma" remains largely ill defined within mental health theory and practice. The dual aspects of trauma, in terms of 'trauma as an event' and 'trauma as an effect' result in its definition being both multi-dimensional and also particularly elusive (Eades, 2013). At its core, debate surrounding the concept of trauma has generally emerged from a spectrum of narrow versus broad conceptualisations of trauma. Narrow conceptualisations have attempted to quantify 'trauma as an event' whereas broader definitions have tended to forgo this placing greater emphasis on 'trauma as an effect'.

## Post Traumatic Stress Disorder

In 1980, the American Psychiatric Association (APA) added the construct of 'post traumatic stress disorder' (PTSD) to the third edition of its Diagnostic and Statistical Manual for Mental Disorders (DSM-III; American Psychiatric Association, 1980). Within this framework a traumatic event was conceptualised as a catastrophic stressor that was outside the range of 'usual' human experience; and results in a pattern of "symptoms" such as the persistent and intrusive re-experiencing of the event, through nightmares, flashbacks and sensory hyper-arousal (Roth and Fonagy, 2005).

However, defining trauma through the use of a diagnostic framework rooted within medical discourses has been heavily challenged (Patel, 2003; Summerfield, 2001; Young 1995). Summerfield (2001) emphasizes the role of society and politics in the process of intervention and argues that PTSD

is an entity constructed as much from socio-political ideas as from psychiatric ones. Within this vein the medical anthropologist Young concluded:

"*The disorder is not timeless, nor does it possess an intrinsic unity. Rather, it is glued together by the practices, technologies and narratives with which it is diagnosed, studied, treated and represented and by the various interests, institutions, and moral arguments that mobilized these efforts and resources*." (Young 1995, p.5).

## Broader Conceptualisations of Trauma

Other authors have sought to conceptualise trauma through broader means ranging from a continued focus on external events (with a widening of qualification for traumatic event) (e.g. Herman, 1992) right through to a focus solely on individuals' subjective meaning making processes (e.g. White, 2005). Those in favor of wider conceptualisations of trauma highlight that many people experience traumatic events that are multiple, predictable and cumulative (Afuape, 2011; Summerfield, 1999). Others highlight that clients' reports of the most distressing elements of their experiences often do not meet the criteria for a 'traumatic stressor'. For example Savic (2012) considered the role of spirituality in relation to torture. He reported that experiences of torture where religious practices were defiled, such as being prevented from praying, were considered by some as the most distressing aspects of their experiences. Arguably psychological models contributing to an understanding of trauma have all to a greater or lesser extent centred on individual meaning making in explaining psychological distress as a response to trauma (e.g. Schottenbauer et al., 2008; White, 2005; Brewin, 2011).

## Trauma: The position of this Study

Within this study the term trauma is acknowledged as being understood in different ways, by lay people, professionals and researchers. Weathers & Keane (2007) highlight that this both enriches and complicates the terrain.

Within this study, I use the term ‘trauma’ to refer to emotional distress we can experience as a result of emotionally painful circumstances often linked to forms of oppression, prejudice and/or abuse. In doing so, a broad conceptualisation of trauma is taken up, whereby emphasis is placed upon subjective meaning making. Narrower definitions demarcate trauma through the existence of an objective external event, however broader definitions place emphasis on constructed rather than solely objective ‘realities’.

In addition, I also believe that the outcome of trauma can be both damaging and regenerative or transformative. Papadopoulos (2000, 2001) examined the original Greek meanings of the word ‘trauma’ derived from ‘titrosko’, meaning to pierce. Papadopoulos highlights that ‘titrosko’ in ancient Greek can mean to ‘rub in’ and to ‘rub away’; he writes:

“*People may either be injured psychologically as a result of being exposed to traumatic events (‘rubbed in’) or alternatively, they may experience (in addition to the distress) a sense of renewal when the traumatic experiences erase previous values, routine and lifestyles and introduce new meanings to their lives (‘rub away’).* (Papadopoulos, 2002, p. 28).

The following section makes a case for why spirituality and religion hold particular salience within therapeutic work with people who have experienced trauma.

**Trauma and Spirituality and Religion**

Pargament et al (2006) note that while the psychological, social and physical dimensions of a traumatic experience are well recognised, the spiritual dimension is often overlooked. Yet spirituality and religion can play a critical role in the way traumas are understood, how they are managed and ultimately how they are resolved. It is well established that people draw on spirituality and religion in moments of greatest stress (e.g. Shaw, Joseph & Linley, 2005; Bulman & Wortman, 1977,). For example, Schuster et al.,

2001) reported that following the September 11 terrorist attacks, 90% of a random sample of Americans reportedly coped through turning to religion. Pargament et al (2006) suggest that despite evidence of its salience to people facing major life traumas, psychologists with some exceptions (e.g., Shaw, Joseph & Linley, 2005) have generally overlooked or oversimplified the roles of spirituality and religion during periods of extreme distress resulting from trauma. The following section explores these complexities further.

## The Roles of Spirituality and Religion within Trauma

In a review of the literature on the impact of spirituality on mental health, The Mental Health Foundation (2006) stresses that a wealth of research examining the association between spirituality and trauma does not exist in the UK. They note however that there is an emerging literature from America. Shaw, Joseph & Linley (2005) carried out a review of the literature and found eleven studies that reported links between religion, spirituality and psychological distress as a result of trauma. They emphasize the central role of religious and spiritual beliefs for many clients in the aftermath of trauma with regard to their role as a resource for coping and positive change, meaning making processes, and with some the potential for increased distress. These areas are discussed in further depth below.

### Spirituality and Religion as a Resource for Coping

Many authors have highlighted the potential role of spiritual and religious beliefs and practices as a resource for coping after experiencing trauma. Pargament, Desai & McConnell (2006, p. 123) note that many studies have demonstrated that spirituality is significantly tied to measures of post-traumatic growth and can be a resource for coping after trauma (Cadell, Regehr, & Hemsworth, 2003; Park, Vande Creek et al 1999; Cohen & Murch, 1996).

*Spirituality, Religion and Hope*

Authors writing within this sphere have highlighted the role of religion and spirituality in the facilitation of hope for the future. Weaver et al (2003) note that belief in a God was strongly related to hope for a better future. Kalayjian et al (1996, p. 92) studied Armenian Americans who survived the Ottoman-Turkish genocide during the First World War, many of whom had witnessed death and torture as children. They reported, “Strength, inspired by prayer and faith in the Almighty, was both a source of energy for coping”.

*Rituals and Ceremonies*

One spiritual pathway proposed to hold potential as a resource for coping has been that of the availability of rituals and practices such as meditation, prayer and ceremonies.

With regard to the influence of prayer, Zeidner (1993) found that Jewish teenagers in Israel, who were facing the threat of missile attack during the 1992 Persian Gulf War, used prayer to positively cope with traumatic stress. Other researchers investigated religious coping methods used by individuals who experienced the devastating impact of a major flood. Frequent prayer and worship attendance were associated with better mental health (Smith et al., 2000). Weaver et al (2003) highlight however that it is possible, that individuals with better mental health were more likely to engage in such activities.

Meditation (on a word or phrase with significance – a mantra) has been found to reduce stress in war survivors (Bormann, Smith, Becker et al, 2005). More recently the positive impact of mindfulness-based intervention, originating from Buddhist constructs of mindfulness (Grossman & Van Dan, 2011) has taken to centre stage within many spheres of therapeutic practice (Cloitre & Koenen, 2002; Becker & Zayfert, 2001).

Weaver et al (2003) completed a review of the research on spirituality, religion and trauma. They reviewed studies addressing the therapeutic use of ceremony as a resource to Vietnam veterans experiencing distress as a

result of trauma. They developed ceremonies based on knowledge gained from Western spiritual and Native American rituals. They concluded that the rituals enhanced social bonds within the veteran groups, their families and with staff. Clinicians reported that the ceremonies were highly effective in accessing and managing intense emotions and that this fostered therapeutic work. At discharge, veterans reported that the ceremonies and rituals were of the most valuable of any treatment offered, including group treatment, individual therapy and medications (Johnson et al., 1995; Obenchain & Silver, 1992).

*Community and Social Support*

The Mental Health Foundation (2006) suggest that a potentially powerful source of support for many involved in spiritual or religious activity is the leader, leaders or clergy associated with the spiritual community. Shaw et al (2005) suggest that leaders of religious communities are "front line mental health workers" for many individuals in the United States. They highlight that research within the UK has drawn similar conclusions in recognising that spiritual leaders can provide much support for those using mental health services. In response however, others have cautioned that religious professionals may need training to better understand the nature of mental health and well-being (Foskett, Marriott & Wilson-Rudd, 2004).

The role of social support and belonging within a community context in promoting and maintaining emotional well-being is well established (Almedom, 2005; Beeber & Canuso, 2005; Fudge, Kowalenko & Robinson, 2004; Shields, 2004). In this context, Ren (2012) completed research exploring Chinese communities' responses to the 2008 Sichuan earthquake. She emphasized the significance of spirituality in the process of rebuilding their lives and in turn the conceptualisation of spirituality as a collective rather than individualistic concept. Ren (2012) states:

"*Whoever is affected by a disaster needs ultimately to get back to living, and living itself is the best treatment. To be engaged with life is the spirituality of the survivors of the 2008 Sichuan earthquake*." (p. 989)

In a similar theme, Summerfield (2002) critiques the emphasis placed through medical discourses on the recovery of the individual and through specialist treatment packages. He writes:

"*The question of how people recover from the catastrophe of war is profound, but the lesson of history is straightforward. "Recovery" is not a discrete process: it happens in people's lives rather than in their psychologies. It is practical and unspectacular; and it is grounded in the resumption of the ordinary rhythms of everyday life – the familial, sociocultural, religious and economic activities that make the world intelligible*." (p. 1107)

As highlighted above spirituality and religion may facilitate connection to useful rituals, practices and rhythms of community life, which may in turn facilitate coping and growth after trauma.

A final consideration however, would be how the evidence presented inherently attributes positive outcomes between spirituality, religion and well-being to the existence of mediating factors. Swinton (2001, p. 85) highlights that there is an inherent assumption in the literature that what is at work is a mediating factor, rather than a "direct" spiritual phenomenon, per se. Research considering whether there is a 'non-empirical dimension' that contributes to the association between spirituality, religion and mental health is by its very nature loaded with methodological issues. Nonetheless, there is a framework that mirrors many religious and theological traditions, which assumes that spirituality actually connects an individual with the divine and that it is this connection that mediates any effect of spirituality on mental well-being (Harding, 2001).

## Spirituality and Religion as Meaning Making

Victor Frankl (1962), a holocaust survivor, described the importance of the "will of meaning". He proposed that the primary motive of human beings is

to find meaning and value in their lives, and further, that having a strong sense of meaning and commitment is essential to surviving suffering. Meaning-based theories of trauma posit that the distress following trauma is commensurate with the violation of the person's global beliefs and goals (Park & Folkman, 1997). Park and Ai (2006) described the role of meaning making following trauma as involving "coming to see or understand the situation in a different way and reviewing and reforming ones beliefs and goals in order to regain consistency among them." Parks (2005) suggests that religion and spirituality may offer a framework that can facilitate meaning making. Altmaier (2013) proposes that religion offers answers to important questions that permeate trauma, such as "why have I experienced this event?" and "what relevance does it have for my future?"

Expanding on this, several theorists have suggested that religion may protect against threats to meaning, because most have doctrines that explicitly address the meaning of death and suffering. Religious or spiritual beliefs may help people make sense of trauma in part by providing a framework of available belief systems for incorporating negative events (Pargament & Park, 1995; Park & Cohen, 1993). For example, a religious doctrine may emphasize that the event's meaning is known to or the will of God (e.g., Dull & Skokan, 1995; Chamberlain & Zika, 1992). Davis et al (2000) suggest that specific tenets of faith, such as a belief that a loved one, who is deceased, is in a better place and that the survivor and loved one will someday be reunited may also mitigate an existential crisis.

The majority of psychological approaches that offer frameworks for considering distress as a result of trauma centre around meaning making and the formation of a 'coherent narrative'. Whether 'cognitive restructuring' of attributions after trauma (Resick, et al., 2008) or 'repositioning' within a 'territory of identity' (White, 2005), therapeutic actions almost always involve a sense making process. It is important to note however, that seeking meaning after trauma is not a universal act. Davis et al (2000) highlight that much of the research surrounding spiritual and religious beliefs and their role within meaning making processes is rooted within three assumptions;

that searching for meaning is inevitable, that meaning can be found over time, and, that engaging in meaning making results in adjustment or growth. Davis et al (2000) completed research with parents whose infants had died of sudden infant death syndrome. They concluded that a significant subset of participants "did not search for any meaning and yet appeared relatively well adjusted to their loss".

In summary, the findings from numerous studies suggest that many individuals engage in a search for meaning after trauma. Those who do so may draw on spiritual and or religious frameworks in assisting towards meaning making.

## Spirituality and Religion: A Potential for Increased Distress

On the distress that traumatic experiences can cause Herman (1992) writes:

"*They undermine the belief systems which give meaning to human experience. They violate the victim's faith in a natural or divine order and cast the victim into a state of existential crisis*." (Herman, 1992, p 51)

Davis et al (2000) note that the clinical literature is replete with examples of cases in which experiencing a major loss may lead people to seriously question their religious beliefs. Wilson and Moran (1998) have noted that a major loss can undermine human faith in a loving, caring, and powerful God. These investigators maintain that following a major trauma:

‘‘*God is viewed as absent from a situation which demanded divine concern, divine protection, and divine assistance. The God in whom one once believed no longer deserves faith. Consequently, the spirituality of the traumatized person becomes hardened and numb . . . In these situations, faith becomes impossible; faith oftentimes is broken*" (Wilson & Moran, 1998, p. 173).

Most salient to this discussion is the dissolution of trust as it pertains to the spiritual. Smith (2004) suggests that a spiritual relationship with a higher power is based on the expectation that the higher power will be protective in times of difficulty or danger, the same as a parent is for a child. This basic agreement is breached when the relationship with the higher power does not prevent the traumatic event (Wilson and Moran, 1998). They suggest there can be a strong sense of a contract with the entity one relied on most having been broken.

Very often a traumatic event forces the individual to acknowledge that life is not always fair. Some suggest that this assumption of fairness is a fundamental world-view that trauma fractures (Janoff-Bulman, 1992). People may question the balance of power between good and evil, bringing up additional religious and spiritual issues (Jordan, 1995). Furthermore, trauma may attack and displace a sense of life's meaning and purpose. In this way, it is a central attack on the existential component of spirituality.

Smith (2004) highlights that struggles to understand trauma from a spiritual standpoint may reveal themselves in many forms, including anger, despair, confusion, and guilt. Herman (1992) notes that for those who experience a loss of faith after trauma they may also experience a sense of failure causing additional guilt, and further distress.

Other authors however have sought to bring together experiences of significant distress and comfort through seeing the meaning making processes as transformative, involving a struggle followed by growth. Stanislav & Christina Grof, associated with transpersonal psychology, founded the Spiritual Emergency Network in 1980 (Prevatt & Parke, 1989) (now the Spiritual Crisis Network) and coined the term 'spiritual emergency' whereby spiritual emergence or awakening becomes a crisis or emergency (Grof & Grof, 1989, 1990). Afuape (2011, p.46) suggests that the idea that spiritual emergencies are part of a process of spiritual emergence suggests that despite distress, they can have beneficial transformative effects on individuals who experience them. In line with this, Helgeson, Reynolds and

Tomich (2006) reviewed the process of finding meaning and noted that the search for meaning was associated within increased distress, although establishing new meanings was associated with positive growth.

From the literature reviewed, it is suggested that for many people spirituality and religion are a central part of the human response to trauma. Spirituality and religion can act as a resource towards coping with emotional distress, but importantly can also hold potential for increased distress.

**Summary and Rationale for the Study**

The following arguments have been made to demonstrate a rationale for this study:

- That a significant proportion of the general population in the UK describe themselves as adhering to a particular religion, or attaining to a sense of spirituality within their lives.
- That studies suggest that a relationship exists between spirituality, religion and well-being, which affords consideration within clinical practice.
- That despite this, spirituality and religion have been largely neglected by the profession of clinical psychology.
- That psychologists report discomfort in relation to talking about spirituality and religion.
- That religion and spirituality hold particular importance for clients who have experienced trauma.
- That the relationship between spirituality, religion and trauma is currently known to be complex and not fully understood. Three key areas have been explored regarding - their potential as a coping resource, their role within meaning making, and their potential for increased distress.

In summary, the importance of clinical psychologists' ability to serve the needs of a diverse client group has long been noted. Numerous authors have argued for this neglected area to be developed, especially within the UK, which is seen as lagging behind the USA. Authors writing within this sphere have called for further research exploring how psychologists consider the roles of spirituality and religion within their practice. In doing so, some have highlighted the interplay between personal and professional domains.

The salience of spirituality and religion during times of greatest stress has been well established. Despite this, although psychological, social and physical dimensions are well recognized in working with clients who have experienced trauma, spiritual dimensions are frequently overlooked. The relationship between spirituality, religion and trauma is suggested to be complex and not yet fully understood.

In accordance with the literature presented therefore, this study explores how psychologists' makes sense of the roles of spirituality and religion within their clinical practice.

## Research Aims

This study aims to explore:

1. How clinical psychologists define and understand their own values with regard to religion and spirituality.

2. The role of religion and spirituality within clinical psychologists' therapeutic work with adults who have experienced trauma.

3. To develop understanding of the implications for clinical practice and the profession of clinical psychology in accordance with the above.

## Research Question

The research question is:

"How do clinical psychologists make sense of the roles of religion and spirituality in their clinical practice working with adults who have experienced trauma?"

## CHAPTER 2: METHODOLOGY AND METHOD

This section describes the methodology and method[1] adopted by the study. I begin by outlining the epistemological position of the research and offer a rationale for choosing a qualitative approach. From here I reflect on my role as a researcher and how this may be influential. Next, I describe the procedure of the study, outlining information about the participants, recruitment and data collection. Finally, this section explains how the analysis was conducted and how the results were evaluated.

### Epistemological Stance

Willig (2009) notes that epistemology refers to the theory of knowledge, what is possible to know and the reliability and validity of knowledge. An epistemological stance refers to the extent to which the data produced in research can be seen to reflect reality (Harper, 2012). Research aims to produce knowledge about the world that can be claimed to be valid (Green & Thorogood, 2010, p. 11). It is therefore essential to clarify a researcher's epistemological stance to enable a methodology and method to be chosen that are consistent with this stance (Harper, 2012).

This study adopted a critical realist stance. This is a perspective that lies between realism and relativism. A realist approach proposes that the data derived within the research directly reflects reality and consequently views the world as having knowable truths to explore. Conversely, a relativist approach proposes that truth is constructed and that therefore, there can be numerous interpretations of the same data (Harper, 2012). Taking a critical realist stance, therefore "combines the realist ambition to gain a better understanding of what is 'really' going on in the world with the acknowledgement that the data the researcher gathers may not provide direct access to reality" (Willig, 2009, p.13). Therefore, adopting a critical realist approach should enable emphasis to be placed on what people say

[1] Methodology is defined as the "general approach to studying research topics" (Silverman, 1993,

whilst also acknowledging the social contexts (e.g. culture, religion) from which individuals speak. It also affords consideration of how these contexts may impact upon psychologists and how they make sense of their experiences.

**Methodology**

The employment of a qualitative approach enables participants' personal and social experiences to be explored (Smith, 2008) as opposed to being measured (Green & Thorogood, 2010). It has also been employed in synchrony with the subject matter, which centres on the generation of new theories rather than testing out existing hypotheses, the chief aim of quantitative approaches (Henwood & Pigeon, 1992). Thompson & Harper (2012) emphasize that this enables an understanding of people's experiences to be generated. A qualitative approach enables the production of rich and descriptive data that is contextually situated and places emphasis on processes and meanings as the subject of interest within a study (Denzin & Lincoln, 2009). To this end a qualitative approach can capture the individual subjective experiences of clinical psychologists considering issues relating to religion and spirituality in their practice. In doing so a qualitative approach can also facilitate the identification of recurring patterns.

As discussed previously, no uniform definitions of spirituality and religion exist and subsequently there are inherent difficulties with conceptualising these for empirical investigation. In response to this, some have argued that quantitative measures in use are limited because they operationalise religion and spirituality in restricting ways (Kapuscinski & Masters, 2010). Authors writing within this sphere have emphasized a need for qualitative approaches to be utilised in order to explore further the complexity of the relationship between spirituality, religion and trauma and how current understandings are applied within clinical practice (Coyle, 2008; Shaw et al, 2005; Weaver et al, 2003).

Taking into consideration the above, alongside the critical realist epistemological stance it was decided to adopt a qualitative methodology.

## Method

Several approaches were considered in selecting a method (see Appendix 1). For this research the most suitable method of analysis was deemed to be thematic analysis (TA) (Braun and Clarke, 2006). TA identifies and analyses patterns of meaning within a data set and aims to organise and describe these in rich detail (Braun & Clarke, 2006).

Thematic analysis is not tied to a particular theoretical outlook and accordingly Joffe (2012) suggests that it can be applied to a range of theories and epistemological approaches. She proposes that thematic analysis is well suited for use with social phenomenology (Farr and Maoscovivi, 1984). Lupton (1999) established that thematic analysis is well matched to theories of weak constructionist tenets like social representations theory (SRT), whereby how people engage with a particular issue is socially constructed although the issues themselves have a material basis. Joffe (2012) construes that this is broadly in keeping with a critical realist position, although holding a less dichotomous view regarding the need to be either realist or social constructionist. In this regard, traumatic experiences are acknowledged to be objective and real however meaning making processes including religious and spiritual belief systems are constructed socially within the context of time, place and culture.

Correspondingly a key feature of social representations theory is that it focuses on the content of people's thoughts and feelings regarding the issue under study without reference to the 'reality' of the issue. Therefore with regard to clinical psychologists sense making of spirituality and religion within their practice, the concern is not towards the accuracy of the representation but rather what meanings clinical psychologists attach to the

meaning making process and the consequences of such meanings for clients, for their own clinical decision making and for wider systems. Braun & Clarke (2006) suggest that from this perspective a TA acknowledges:

"*the ways individuals make meaning of their experience, and, in turn, the ways broader social context impinges on those meanings, while retaining focus on the material and other limits of 'reality'*." (Braun & Clarke, 2006, p. 81).

The identification of themes within TA can be achieved through either a 'bottom up' inductive manner or a 'top down' deductive manner (Braun & Clarke, 2006). An inductive TA seeks to describe and organise the data "without trying to fit it into a pre-existing coding frame" (Braun & Clarke, 2006, p. 83). Conversely a deductive TA involves mapping the data onto pre-established theoretical areas of interest.

Within this study an inductive approach has, primarily been adopted in keeping with the intended exploratory aims and critical realist epistemological stance. However as emphasized by Joffe (2012) when completing new research it is essential to consider the current literature to ensure that research is not simply repeated and that progression is made towards new findings. In consideration of this, despite emphasis upon an inductive approach, both inductive and deductive approaches were adopted.

A further consideration when conducting a TA, is the manifest or latent level at which themes are identified. Themes identified at a manifest level (also known as semantic level) refer to direct observations in the data. Conversely, latent themes at a latent level, refer to ideas and assumptions that may influence the manifest/semantic level (Braun & Clarke, 2006; Boyatzis, 1998). Braun and Clarke (2006) suggest that themes identified at a manifest level are predominately associated with a realist perspective, while themes identified at the latent level are associated with a constructionist perspective. However, Joffe (2012) stresses that TA's often

draw on both types of themes and accordingly within this study both manifest and latent themes were identified. Joffe (2012, p. 210) states that a “dual deductive-inductive and latent-manifest set of themes are used together in high-quality research”. Hence, this study adopted this approach to the TA.

**Reflexivity**

Coyle (2007) notes that within qualitative research the researcher is included as part of the social context and their subsequent influence over interpretation of the data is considered. Unlike quantitative ones, qualitative methods aim to consider this issue through encouraging reflexivity in the research process. Green and Thorogood (2010) postulate that within qualitative research it is impossible to achieve objectivity, because both the research and the researcher are part of a world in which values and subjectivities are inevitable. Therefore, this requires of the researcher transparency in making known their own values, assumptions and prejudices with participants (King, 1996). Runswick-Cole (2011, p. 91) suggest that these can be examined within reflexive processes whereby the researcher considers how “aspects of their lives…. might influence the conduct of the research study” and conversely how the studies outcome may be influenced by their involvement (Nightingale & Cromby, 1999).

I feel that my position as a young, white British, middle class female will have held influence over my understanding of how psychologists make sense of spirituality and religion within their clinical practice. I would describe my personal relationship to spirituality and religion as involving affiliation to Christianity. In my expression of this I am part of a Church of England congregation. On a more personal level I experience aspects of spirituality by which I mean, feeling connected to God, in many different ways, such as through prayer and worship, in my relationships with others and in being in environments of natural beauty. Burnham (2008) offered the concept of ‘visible’ and ‘invisible’, ‘voiced’ and ‘unvoiced’ experiences and

identities in considering difference. It is likely that these identities, in part visible and voiced and in parts invisible and unvoiced may have held influence over what was and what was not discussed in the interviews. My role in the research is considered further within the discussion.

In developing this research project I have also been aware of my position as a Trainee Clinical Psychologist and that this research was being conducted as part of my training. In line with this my interest in this research has been influenced by my previous experiences on placement. Again, this is explored further within the discussion.

## Selection and Recruitment of Participants

### Sample

The sample selected for this study comprised clinical psychologists who had experience of working, by their own definition, with adults who had experienced trauma. Participants were selected from two NHS Trusts in London, where ethical approval had been given, by those Trusts' Research and Development Teams. The participants recruited were working within a range of different services. These were a specialist refugee service, a specialist trauma service and generic adult community psychology services.

The participants held a range of different preferred therapeutic modalities. Four participants worked within a cognitive behavioural model for Trauma. One participant held preference for the systemic approach. Three participants held preference for psychodynamic approaches. One of these participants worked specifically within the Kleinian School of psychotherapy and two other participants held preference for analytic psychotherapy. With regard to religion and spirituality, one participant identified as affiliating with the religion of Buddhism. The other participants reported that they did not affiliate with a religion. However apart from one, most participants reported to hold some connection to a sense of spirituality. Three participants reported that they engaged in spiritual practices such as mindfulness and

meditation. With regard to ethnicity the majority of participants were perceived to be White and one participant Indian Asian. It is acknowledged however that ethnicity overlaps in meaning with both race and culture. Fernando (2010 p.13) cautions that an ethnic status should not be based primarily on physical appearance (race) or social similarity (culture) but rather also encompass a person's subjective feelings regarding how they see themselves as a unique individual.

Sample Size

Eight psychologists were recruited for interview, and this was suggested as an appropriate number with which to conduct a qualitative analysis and to provide a sufficient number of cases for development of meaningful points of similarity and difference between participants (Smith et al., 2009; Turpin et al., 1997).

All of the participants were female; although female psychologists are a majority within the profession, the participants did not match the clinical psychology population. Table 1 denotes participants' interview number, allocated pseudonyms and the length of each interview.

Table 1: Participant Table

| Participant Number | Pseudonym | Duration of Interview (mins) |
|---|---|---|
| 1 | Jo | 46 |
| 2 | Ruby | 35 |
| 3 | Sophie | 43 |
| 4 | Lara | 46 |
| 5 | Ayesha | 50 |
| 6 | Elana | 57 |
| 7 | Zoe | 46 |
| 8 | Susan | 46 |

## Data Collection and Interview Focus

Participants were given a choice about where they would like to be interviewed. All participants opted to be interviewed within their NHS work place and interviews were conducted within private clinical rooms. To ensure the safety of the researcher, guidance was adhered to within the NHS guide for lone workers (NHS Employers, 2010).

Participants were emailed a copy of the participant information sheet (see appendix 2) and consent form prior to the interview (see Appendix 3). Paper copies were also made available to participants prior to the start of the interview.

The interviews were guided by an interview schedule; this consisted of six open ended questions influenced by the research aims (see Appendix 4). After each interview I relayed to participants that should they wish to establish further contact regarding any aspect of the research or the

interview process they could do so. At the time of writing, none of the participants had made contact.

### Resources

The interviews were recorded using a digital voice recorder which was positioned in participants view. Once completed, interviews were transcribed using a computer.

## Ethical Issues

### Ethical Approval

This study gained ethical approval from UEL (see Appendix 5) and also from the local Research and Development Office (see Appendix 6).

### Consent

Participants were given the opportunity to read through the information sheet prior to signing the consent form. They were also given the opportunity to ask questions and discuss their rights (e.g. affirmation that they could withdraw from the study at any point).

### Confidentiality and Anonymity

In conducting this research I acted in accordance with the Data Protection Act (Department of Health, 1998) to ensure confidentiality and anonymity. These aspects were explained to participants within the information sheet and opportunity was given for verbal discussion.

All of the data was collected and transcribed by the researcher. All data was anonymised and participants were allocated a pseudonym and participant number. All identifying details within transcripts were changed (e.g. location names, names of colleagues).

The identifiable data within the consent forms were kept separately in a locked cabinet. All other data including interview recordings, transcripts and the write up of the study were kept on a computer requiring a log-in and in addition to this documents were password protected.

Following examination of the project identifiable data such as the consent forms and recordings of the interviews will be destroyed. The anonymised transcripts will be stored securely for a period of five years.

### Further Support

The topic of spirituality and religion is a sensitive one but no adverse events were anticipated as a consequence of participation in the study. It was highlighted to participants within the information sheet that should they wish to speak or gain further support after the interview they could contact me via my UEL email address.

## Data Analysis

### Transcription

Transcription can be understood to be the first stage in analysis enabling the researcher to become familiar with the data (Wilkinson, 2008). Willig (2009) highlights that there are different methods for interview transcription.

The transcription conventions employed within this study were drawn from what Potter and Heburn (2005) refer to as 'Jefferson Lite' transcription. The interviews were transcribed at a semantic level only, in which focus was placed on what was said rather than the way in which it was said (e.g., emphasis, volume etc.). For the purposes of thoroughness and accuracy the interviews were also listened to again after transcription (Parker, 2005).

## The process of Thematic Analysis

In completing the TA Braun and Clarke (2006) guidelines were observed. They propose that the researcher follow a recursive process through the following steps:

### *Familiarity with the Data*

The process of familiarising myself with the data began during data collection where initial notes were made and expanded during transcription. The data was read through a number of times in an "active way" (Braun & Clarke, 2006, p. 87). This sought to begin the search for meanings and patterns and further notes were made in the transcripts' margins (see appendix 7 for an example).

### *Generating Initial Codes*

The data was coded on a line by line basis, in which features of interest within the data were identified. Boyatiz (1998, p. 63) refer to these as codes and note that they represent "the most basic segment, or element, of raw data or information that can be assessed in a meaningful way".

For the generation of initial codes a list was created within a spreadsheet, and each code was numbered allowing for reuse when arising again within later extracts. As the coding process progressed, after review, some codes were collapsed together. The codes were collated into a coding manual (See appendix 8). The extracts were referenced using the interview number and line number. Some surrounding data was preserved around each extract to ensure that there was no loss of context (see appendix 9 for an example of coded extracts) (Boyatzis, 1998).

### *Search for Themes*

The codes were organised into provisional broader themes (see appendix 10). These were organised visually through printing out the codes, cutting them up and manually aligning them together. Alongside this tree diagrams were drawn to facilitate the organisation of codes. For the development of

themes consideration was given to the relationship between codes, between themes and between different levels of themes (Braun & Clarke, 2006, pp. 89-90).

*Review of Initial Thematic Map*

In reviewing initial thematic maps, Patton (1990) suggests that the themes must be checked for heterogeneity and the codes checked for homogeneity. In considering this, the extracts within each theme were re-read and the themes were reviewed for their distinctiveness. This process led to some themes being merged, split and newly identified (Braun & Clarke, 2006). This process resulted in Thematic Map 1 (see appendix 11). After the production of this map, five main themes were collapsed into four (See Thematic Map 2 appendix 12). The theme of 'Constraining wider contexts' was merged and added to the theme 'Influencing Frameworks'.

In addition to this, the dataset was re-read in order to consider the validity of the candidate themes in relation to the transcripts (Braun & Clarke, 2006). In doing so, the candidate theme of 'Religion and spirituality - A hard topic' was reconfigured and renamed, after further consideration was given to how different codes could be combined. This led to the creation of the theme 'Spirituality and Religion: Connectedness and Ambivalence', which was felt to better represent the data. Some of the themes and sub-themes were also renamed, to try to better reflect the data.

This resulted in four main themes, and thirteen sub-themes, ('Thematic map 2' - appendix 12). Finally, these sub-themes were refined; the sub-theme of 'Identity' was collapsed into the sub-theme 'Degrees of connectedness' and the sub-theme 'Conflicts of faith' was collapsed into the sub-theme 'Meaning making' illustrated within 'Thematic Map 3' (see appendix 13).

*Defining and naming Themes*

For the defining and naming of themes, aspects of the data that each theme and sub-theme captured were identified and consideration was given to

what was interesting about them and why. In defining each theme, thought was given to the story that each theme told. The extent to which each theme related to the research aim was also considered.

### *Producing the Report*

A precise and coherent summary of the data is outlined in the results section. The reader is offered numerous data extracts in order to allow for evaluation of whether the themes and quotes are reflective of the story being told about the data (Braun & Clarke, 2006). For the presentation of data extracts, participants have been referred to using their pseudonym throughout the report.

## Evaluating Qualitative Research

Spencer and Richie (2012) suggest some guiding principles that can be used to evaluate qualitative research. These are: contribution, credibility and rigour. These guidelines were implemented within this study and are considered further within the discussion section.

## CHAPTER THREE: ANALYSIS

This chapter will present themes derived from the data analysis from the eight participant interviews. Using TA, initial codes were grouped into four main themes, each with sub-themes (see Table 2). The analyses are presented as four main themes, titled ‘Spirituality and Religion: Connectedness and Ambivalence’, ‘Influencing Frameworks’, ‘Trauma and Spirituality and Religion: Important to Clients’ and ‘Contradictions in Practice’.

### Summary of Master Themes

The first theme considers how psychologists relate to spirituality and religion with connectedness and ambivalence. The second focuses on what frameworks influenced participants and what contexts they drew on to make sense of spirituality and religion. The third uses the example of trauma to consider how participants made sense of the roles of spirituality and religion within their practice. Finally the fourth theme explores contradictions between therapeutic hopes and intentions and therapeutic actions in practice.

*Table 2: Themes and Sub-themes*

| Main Themes | Sub-themes |
|---|---|
| **Spirituality and Religion: Connectedness and Ambivalence** | • A Difficult Topic<br>• Degrees of connectedness<br>• Uncertainty & Fluidity |
| **Influencing Frameworks** | • Personal Experiences<br>• Psychological theory<br>• Wider contexts |
| **Trauma and Spirituality and Religion: Important to Clients** | • Trauma: Theoretical definition Vs. Subjective experience<br>• Religion: 'an anchor' in Extreme Distress<br>• Central to Meaning Making |
| **Contradictions in Practice** | • Therapeutic Hopes and Intentions<br>• Therapeutic Actions in Practice |

For the presentation of interview extracts, minor changes have been made to improve readability. Where words have been omitted to shorten quotes, a dotted line within brackets (….) is indicated [2]. Where additions to text have been made to offer explanation to the reader, square brackets [text] are

[2] Some repetitions of 'filler' words within extracts have been removed for reader clarity (e.g. words such as 'like', and hesitations such as 'umm…').

indicated. Pauses have been represented by dotted lines - .. to represent a brief pause and … to represent an extended pause. Identifying information has been removed or changed to protect the anonymity of participants. The letter **I:** has been used to indicate the interviewer's speech and **P:** to indicate the participants' speech.

## Spirituality and Religion: Connectedness and Ambivalence

This first main theme, considers how psychologists relate to spirituality and religion in both personal and professional contexts. In opening, this theme has been constructed to offer context in which to situate the proceeding themes. Taking a wide lens it seeks to consider how participants related to the topic of spirituality and religion. This will be considered in relation to three sub-themes of; 'A difficult topic', 'Degrees of connectedness' and 'Fluidity and uncertainty'.

### A difficult topic

A notable aspect of how participants related to spirituality and religion surrounded their acknowledgment that it was a difficult topic to think and talk about.

> *"Oh gosh that's a hard question for five o'clock."* (Jo)

> "Help! Frightening questions!! haha (laughter)." (Susan)

One participant articulated awareness in the moment of her experience of talking about spirituality and religion across both personal and professional domains. In the extract below she considers her worries about sounding foolish, feeling a sense of shame and the potential for something private or socially unsanctioned to be exposed.

> "Well I think increasingly … um oh I'm worried about sounding so foolish, its interesting isn't it, I think there's something around shame with this area which is very interesting um shame and exposure" (Susan)

Similarly in the extract below Ayesha also constructs spirituality and religion as something private and potentially embarrassing or uncomfortable to talk about, in comparing talk about religion to talk about sex.

> "I think it's the spirituality or the spiritual side of religion that kind of, I don't know is it like asking people about their sex lives it feels too weird" (Ayesha)

In the extract below, Lara describes how spirituality and religion are talked about within a work context.

> *"I think that people approach it with a mix of humor where that's appropriate, to talk about it quite lightly, where people are quite open and tolerant of others views*" (Lara)

Of interest, is the words "humor" and talking "quite lightly" perhaps alluding to how on some level these topics may be experienced as heavy and potentially charged, thus, needing to counter balanced through humor and light talk.

Degrees of connectedness

Participants also spoke of how they conceptualized the terms spirituality and religion. Participants often began by considering religion in relation to formal categories.

> *"religion is a sort of … I suppose my understanding would be that it is sort of more of a category of something"* (Zoe)

> "*you know, like Islam, Judaism or Christianity or Buddhism*" (Jo)

Further exploration often led to the construction of religion as externally agreed practices and beliefs within an organized context.

> "*religion being slightly more about the practices and collective agreement on er you know doctrine*" (Sophie)

> "*where there's er, common frames of reference and common kind of beliefs between people*" (Ruby)

In the construction of religion as organizing and externally agreed a number of participants also expressed apprehension or fear regarding what organized religion can do.

> *"I think it's interesting the way in which religion in particular polarizes and organizes people and I think I'm a bit afraid of that"* (Susan)

> *"I think it can be quite unhelpful when you're just kind of in some religions where it means that things stop being questioned"* (Sophie)

Many participants constructed their definition of spirituality in contrast to their understanding of religion. In this way most participants constructed spirituality as being experienced internally and being personalized to each individual.

"*the first thing that came to my mind when you said that was about spirituality being a little bit more of an inner experience" (Sophie)*

"*Spirituality to me is more a personal thing of how you understand maybe what's happening in your world and maybe religion is more something that you are a part of with other people I guess*" (Ayesha)

Religion appeared to be understood in terms of externally agreed practices and beliefs, holding an organizing function, and in this way participants seemed to depict religion as restrictive. In line with this participants appeared to relate to religion with varying degrees of ambivalence, articulated in the extracts below.

"*Um I think I think I would still describe myself in the boxes on you fill on the sort of HR forms as a Christian um but I probably don't subscribe to quite a lot of the traditional Bible values I guess*" (Zoe)

*"I think most psychologists would view religion as oppression, or traditional religion as no choice for women, no choice for gay people you know conservative with a small c and lets face it we're all lefty in our social beliefs anyway we just sort of think its archaic and we don't want anything to do with it"* (Ayesha)

Correspondingly, defining spirituality, as internal, individual and personalized, participants appeared to distinguish spirituality as being more permissive than religion. In line with this participants appeared to find spirituality easier to relate to.

*"Spirituality seems a much more benign concept than religion, erm and I suppose that's because it seems much more under the control and decisions of an individual."* (Ayesha)

> *"I think that it's [spirituality] more of a kind of sense of one's individuality or kind of meaning making which might not subscribe to a set of rules"* (Zoe)

In the extract below Zoe characterises spirituality as not involving subscription to a set of rules, she later went on to consider how she resonates with spirituality more strongly than religion.

> "*how females are portrayed in religion I probably find quite difficult and they don't really align with my belief systems, um and I guess spirituality, I probably subscribe more strongly*"

Uncertainty and Fluidity

Throughout participants accounts there was a sense in which spirituality and religion were related to with uncertainty with participants frequently constructing their views in fluctuating ways. Participants appeared to be cautious and often constructed accounts which oscillated between contrasting positions. This was seen across the interviews in many different formats however here for the illustration of this theme participant's relationship to conceptualising spirituality and religion and participant's personal relationships to spirituality will be considered.

With regard to defining the concepts of spirituality and religion, participants' discussion frequently portrayed contradictions. Most participants initially constructed these terms as separate and distinguishable. However as discussion progressed they were also constructed as intertwined and overlapping.

> "*I think to be religious you have to have a spirituality where you have to, to be inclined to, to feel the need for the acknowledgement of, of something that transcends one or humankind in some way or in nature or in … in the shape of a God or something you worship"* (Elana)

"*spirituality might be related to religion or it might not be*" (Sophie)

Some participants spoke in similarly uncertain ways in describing how they relate personally to spirituality and religion. In the first extract below Jo describes a number of differing positions regarding her relationship to spirituality and religion, as she considers how working with clients who have experienced torture has challenged her "faith".

> *"I didn't really have faith anyway, so I'd kind of like to believe that there's something benign out there kind of protecting us in some way from something, but it definitely challenges it, so its not very important to me, no.*" (Jo)

> "*I think spirituality is more fundamental to me, um well I don't know, that's rubbish because there sort of recursively connected aren't they because I think religion is the way that you act into some of those um beliefs*" (Susan)

Participants also spoke of how different people relate to spirituality and religion in very different ways.

> "*to kind of think about it in terms of what it tells you about you know, you know that people can have the same religion but a very different relationship to it*" (Sophie)

> "*Um so when you ask in which way religion is important in the work it will be patient by patient."* (Elana)

Fluidity in relation to these areas was also evident within participants talk around the intertwined nature of spirituality, religion and culture. Some participants spoke of a distinct separation between religious beliefs and cultural practices.

> "*what the actual religious stance might be on something, which might be quite different to the cultural stance on something*" (Lara)

> "*because it's I think … it's a different culture and may be it's more cultural issues than religious*" (Zoe)

However other participants spoke of the overlapping and inseparable nature of the two concepts, of spirituality and religion and culture.

> "*me tryna understand what their faith and their cultural background meant to each of them but also their differences in how they each related to these things which were in very different ways*" (Ruby)

> "*You know you could say those things are religious you could say there cultural*" (Ayesha)

**Influencing Frameworks**

The second master theme, 'Influencing Frameworks' explores what psychologists drew on as they sought to consider the roles of spirituality and religion within their practice. This theme is explored through three subordinate themes, of 'Personal experiences', 'Psychological theory' and 'Wider contexts'. In essence this theme considers how participants appeared to be influenced by and to draw upon frameworks surrounding their own personal identity and values, theoretical frameworks offered by the profession of clinical psychology, and wider contexts, such as culture and politics.

Personal Experiences

This subtheme considers how participants drew on personal experiences as a framework for making sense of spirituality and religion, within both personal and professional domains. Participants spoke of their experiences

of religion within their upbringings, their personal beliefs, ideas and principles from religion that they have found valuable, and experiences of drawing on spirituality and religion in times of personal distress.

*Personal experiences: Upbringing*

In conceptualizing and defining spirituality and religion a number of participants drew on their upbringing and their experiences of religion growing up.

> *"I mean I was brought up loosely Christian in a um a kind of social Christian really" (Susan)*

> *"so I grew up, I was raised as a church of England Christian so I went to a C of E school erm and I went to church, my grandparents also all went to church um and I went with my mum, my dad didn't go" (Lara)*

Participants who spoke about growing up within a religious tradition most often demarcated their experiences of religious practices, such as attending church, from their beliefs or personal relationship to religion.

> *"I'm not religious at all, although I suppose I have been brought up a Muslim but a very light touch one at that (…) I notice that when I feel really anxious or really nervous the first thing that you do is that I spit out bits of the Koran, out of habit its not really something I believe in, but I think there's something about your childhood and religion that is quite powerful and um, your just sort of indoctrinated or brainwashed with it" (Ayesha)*

> *"so I went to Sunday school and all that kind of stuff, erm I think when I was younger I just believed what I was told" (Lara)*

Most participants spoke of their early experiences of religion involving a divide between beliefs and practices. Whereby although they engaged in

religious practices, such as attending church, they did not hold religious beliefs.

Some spoke of religion in terms of a set of rules or principles to follow, and appeared to find it harder to engage with non-material aspects of religion e.g. a connection to the divine. In making sense of spirituality and religion within their practice, it was inferred that at times, participants appeared to draw on an understanding of religion as a set of rules, similar to how they experienced religion within their upbringing, in seeking to make sense of clients' experiences of spirituality and religion.

This appeared in different formats through the interviews however a frequent occurrence surrounded how participants made sense of the roles of religion in relation to clients' safety and the completion of risk assessments. In the extract below Ayesha identifies the role of religion in enabling clients to keep going. She attributes this to the rule that it is "forbidden in Islam".

> *"I'd say it's the biggest protective factor for people killing themselves, I mean I don't know what these people, if you had a different client group whether you'd end up with people with much higher rates of suicide, cause obviously its forbidden in Islam as it is in most religions"* (Ayesha)

A number of participants spoke of how enquiry about clients' religious beliefs arose within the context of assessing risk.

> "*it's always handy to put on a risk assessment form that their religious factors will protect them from killing themselves, um so I think it's sort of seen much, viewed much more like that rather than being held centrally to a client's experience*" (Zoe)

> "*so there's really not much keeping them safe and that can be the only thing that keeps them safe and then I think, thank God! Literally (laughs) you know, that that is the case because it would be very hard to find anything else um and that's true for quite a lot I think of our clients*" (Lara)

A striking feature within the extracts above surrounded how participants emphasized that religion was the key thing that was keeping clients alive; however further exploration was not reported beyond the completion of risk assessment procedures. It is inferred here that the conceptualization of religion in terms of offering a set of rules for living, rather than attention to spiritual elements involving a connection to the divine, may have constrained exploration of what elements of clients' relationship to spirituality and religion were keeping them going, and how this could potentially offer resources to the work.

*Personal experiences: 'Useful ideas' and Practices.*

A number of participants drew on their own experiences of finding ideas or practices within different religions to be of value to them.

In their own relationship to religion some participants spoke of fluidity in exploration, in terms of taking up useful ideas and practices without subscribing to all ideas offered or to group membership.

> *"what I practice at home probably more subscribes to kind of more Buddhist kind of yoga um beliefs of mindfulness, although I don't practice it in the kind of taste the raisin format that um, just sort of letting go and kind of seeing the bigger picture and actually not getting hung up on the small things which feels much more of a spiritual origin rather than a religious one" (Zoe)*

> "*another really useful idea which was to do with some parable from the bible but basically not hiding your talents or abilities other wise you'll loose them um so not about not being modest but to kind of help other people*" *(Lara)*

One participant drew on her own personal experience of engaging in spiritual practices in seeking to makes sense of her client's spiritual practices.

> *"so she had talked about her faith as quite a helpful grounding thing, so she'd been memorizing verses from the Koran almost as a way of, as a way of you know, I've started doing some mindful meditation as a way of feeling quite grounded and that kind of stillness of quite a structured space, making a space for something in particular um and that felt to her to be not just about the erm, making the time and the kind of calm of the activity, but about reconnecting with God really" (Sophie)*

In the extract above, Sophie connects her client's experiences of memorizing the Koran to her own experiences of engaging in mindfulness meditation. She also however recognizes a difference whereby her client attributes the feeling of being grounded to connection with God rather than purely an outcome of the activity itself. Drawing on her own experiences appears to have enabled her to both connect with her client through shared understanding alongside acknowledge a difference in their attribution of the purpose of the task.

At other times however, when religious issues arose within therapy in which clients experienced distress as a result of conflicts of faith, participants seemed to draw on their own ways of relating to spirituality and religion in making sense of client's experiences. This appeared to involve drawing on their relationship to religion that surrounded appreciation of useful ideas and practices but not subscription to group membership. It could be inferred that participants found it difficult to engage with client's dilemmas surrounding

beliefs which conflicted with their experiences but which were held collectively within their religious community. In this way religious beliefs were conceptualized by participants as being held under the autonomy of an individual rather than being held collectively and agreed within a religious group. In this way their therapeutic actions surrounded focus on the pros and cons of taking up or laying down a belief in accordance with its usefulness.

> "*what being a Muslim and then being an ex-Muslim had meant to the girl I was working with and you know what doors it opens and what doors it closes if you decide on that identity*" (Sophie)

> "*I would normally be quite pragmatic really and just explore the dilemma with them really, I mean I don't know what is or isn't true […] but more sort of explain or help them see what their dilemma is that they face and um you know what might happen if they jump one way what might happen if they jump the other*"

It is inferred that participants found it difficult to understand the collective aspect of clients' beliefs, and participants appeared to draw on rational frameworks of pros and cons in seeking to talk with clients about dilemmas of faith.

### *Personal experiences: Personal values*

In considering their experiences of talking with clients about spirituality and religion, a number of participants considered how their personal values influenced their experiences of talking with clients about spirituality and religion. Participants spoke of feeling de-skilled in talking about spirituality and religion with clients and attributed this to their own personal relationship to the topic.

> "*I think its something I feel is slightly outside of my experience cause I don't um, I'm not religious so I think its probably something I feel slightly cautious about*" (Sophie)

> "*I suppose difficult because I can't, I don't orientate with the religion, but I'm sort of talking about um kind of his own religious beliefs*" (Zoe)

In considering a time when spirituality and religion were talked about and utilized within therapeutic work, in the extract below Susan attributes the incorporation of a client's spiritual and religious beliefs into therapy to have been facilitated by her comfort in working within that belief framework due to it correlating with her upbringing.

> "*and I suppose I felt comfortable because Christianity is like my upbringing*" (Susan)

### *Personal experiences: Spirituality and religion a resource when distressed*

In the extract below, one participant spoke of times of personal suffering and distress, when they had found spirituality and or religion of value to them.

> *"I don't know whether you know this but I had breast cancer a couple of years ago, (…) and I found it immensely helpful then to have those ideas although I couldn't meditate at all, (laughs) but I was living some of the principles really" (Susan)*

In a later extract Susan offered an in depth account of how she worked with a client exploring resourceful aspects of the clients religious beliefs. This was notable, as it appeared to be one of the only case examples offered where spirituality and religion were incorporated into the work as a resource. It could be inferred that, Susan's personal experience of using religious practices during times of distress may have facilitated her exploration of their usefulness with a client in practice.

> "*so we've talked a lot about that quote and what that means to her and about um Jesus suffering in the wilderness and his challenges from satan in the wilderness and his feeling of being forsaken so I think um I suppose I wanted to enter into her discourse*" (Susan)

Another participant spoke of her experience of prayer and meditation during a difficult period in her life and considered how it has enabled her to understand why religion is important to clients.

> *"but there was something about feeling alone and having been bought up as being part of something bigger that was comforting and I suppose that's the closest that I've ever, not even touching on what these people have been through, the closest I ever felt from being really far from home (…) but there was something kind of emotionally very alone in that place and just having something to do, it felt like you were doing something about your lot and you weren't just staring at the wall but you were gaining some strength or something from it, and I suppose maybe that understanding kind of helps me, even though I'm slightly loathe to admit it actually because I don't believe and I'm all rationalist" (Ayesha)*

## Psychological theory as a framework for making sense of religion and spirituality

Participants spoke about the influence of theoretical ideas and frameworks that they drew on to make sense of spirituality and religion in their clinical practice. Some participants drew on theoretical frameworks that constructed God in symbolic terms in order to make sense of spirituality and religion in their clinical practice. A number of participants drew on theoretical frameworks that made sense of religion in functional terms, whereby religion was constructed as filling deficit or loss. Alongside this participants spoke of how some theoretical frameworks they drew on offered little to

make sense of spirituality and religion and this required drawing on wider frameworks.

*Psychological Frameworks: God as symbolic*

Drawing on psychological frameworks participants spoke about their clients' relationship to religion or a God in symbolic terms. Participants from varying preferred models made sense of spirituality and religion through constructing religion or belief in a God as symbolic of internal psychological processes often described using theoretical language. In trying to make sense of client's relationship to religion, participants talked about God as an internal object, and spirituality and religion as 'belief systems'.

In the extracts below participants drew on their understanding of a psychoanalytic framework to make sense of clients' relationships to religion. They spoke of making sense of religious beliefs through consideration of them as symbolic or representative of an internal object.

> *"I think religion was apparent in the way, in terms of her, the voices that she heard, so for instance there were some voices that she kind of though of as being a bit like angels, that were very kind of helpful to her and would kind of provide advice and a kind of reassuring voice, erm a bit like a sort of good object" (Ruby)*

> *"when I am thinking about it with people in a more psychoanalytic framework I am thinking about what it means, what its about, is it sort of about a kind of God that can be quite punitive which could be a way of understanding an internal object that can be quite punitive or is it about feeling safer in the world and feeling held and contained which again could be, I might be understanding in terms of an internal object"* (Sophie)

The extract below conveys how Sophie goes on to consider how drawing on this psychological framework positions her client's religion as symbolic rather than a different way of conceptualising reality.

*"which is not to dismiss the reality of their religious belief but to kind of think about it in terms of what it tells you about, you know that people can have the same religion but a very different kind of relationship with God, um so it could be another way of understanding what relating is about for them" (Sophie)*

Other participants drew on frameworks offered by different theoretical models, such as CBT. Whereby religion and spirituality were made sense of as belief systems, and it is inferred, were spoken of in an objective 'mode' of talking.

*"as a therapist I'm quite like a cognitive therapist so I think a lot about belief systems so I would just see religion as a belief system" (Lara)*

*"so yeah their religious or spiritual beliefs has just been part of their belief system that forms as they grow up really" (Jo)*

In the extracts below, of interest is how spirituality and religion are connected to "magical" thinking or solutions, inferred here to signify an unreal, childish or under developed way of thinking. It could be argued that the construction of a religious worldview as under developed or irrational implies comparison to a secular, rational and superior western worldview. It could be inferred that presumed superiority of western worldviews may lead to religious worldviews being talked about in ways that infer a primitive or unsophisticated status.

"*there's probably a way in which religion can be a way of not really er getting to grips with the reality of a situation, so sort of taking flight towards religion or erm it being a bit of a magical solution to things"* (Ruby)

> *"I guess that there's a way in which it might kind of feed into sort of as I was saying before a tendency towards more magical thinking or kind of omnipotence (I: um) erm, I don't know"* (Ruby)

*Psychological Frameworks: Spirituality and Religion Filling Deficit*

Participants also spoke about theoretical frameworks that influenced them, whereby religion was constructed as holding functions within internal processes, and in particular processes which sought to regulate or account for deficit. Within these accounts participants emphasized how people relate to religion and spirituality in different ways. However the theoretical frameworks participants drew on in majority considered religion and spirituality in terms of accounting for distress or dysfunction.

One participant drew on psychodynamic theory and spoke of the possible function of religion in easing a persecutory super-ego.

> *"Analytically I wonder if there's something about God and the super-ego, I guess, and that sort of people being drawn towards something where erm something else, a kind of organization takes over that super ego function for them, so that their not kind of, I don't know erm, as a way of perhaps easing up that sort of dynamic inside themselves erm, sort of particularly where you know, there might be a superego which is particularly kind of persecutory" (Ruby)*

In the extract below, Elana also drew on psychodynamic theory rooted within the Kleinian school, constructing religion as holding a function in the separation of good from bad. It is inferred here that religion is constructed as being connected to deficit or underdevelopment, whereby good and bad experiences are separated through religion rather than integrated; indicative of a mature or developed psyche.

*“I don't think that in itself religion is good or bad but I think it, because of the stories that are told in religion the stories always have the good and the bad and always have someone who conquers something and so because of the stories being how they are I think it lends itself to being the refuge for people who function in this very split kind of way” (Elana)*

### *Insufficient theoretical frameworks*

Other participant’s described how in practice they experienced times when theory did not offer them a useful framework for making sense of spirituality and religion within their clinical practice.

In the extract below Zoe describes drawing on other theoretical frameworks or wider frameworks to make sense of religion and spirituality in her practice. These included ideas from a systemic perspective and politics.

> “*it probably did go quite off piste from the cognitive model really .. not sure .. not sure it's a good question, not quite sure how it does fit, how it would fit with a cognitive correlation … It's kind of the outer onion layers that CBT ignores.* ***I:*** *So how else did you make sense of um his experiences? …* ***P:*** *we should talk more I suppose about kind of cultural meaning and also probably a little bit weaving in some systemic thinking but um - thinking about kind of family meanings but also kind of thinking about much more political meaning as well”* (Zoe)

Similarly, in the extract below, Sophie describes how she drew on different theoretical frameworks outside of her preferred model as a resource in working with a client who held religious beliefs that were different to her own.

> *"I guess the model that feels its most explicitly addressed that probably is the systemic training that I've had which you know talks about the graces*[3] *and all the ways you can be different to someone and very explicitly makes you go through those and challenge um preconceptions about them"* (Sophie)

The wider context

This sub theme considers how psychologists drew on wider contexts that held influence over how they made sense of spirituality and religion within their practice.

*Organizational Constraints: The NHS*

When considering why spirituality and religion were largely absent within their practice a number of participants considered the effect of the economic climate and subsequent financial pressures the NHS faces, and drew on these as contributing factors.

> "*There's a lot of pressure now about payment by results and getting things done quickly within a certain amount of sessions um, … possibly like that like talking about religion is .. is not seen as doing the kind of nitty gritty bits of reliving*" (Zoe)

Other participants also talked about the time pressures that placed constraints on their work with clients.

[3] 'SOCIAL GGRRAAACCEEESSS' See Burnham (1992)

> "*I wonder if part of the reason why it doesn't get talked about in more detail is that some of my work with adults has been in services where therapy has been quite time limited and so it feels like your not really working with the whole person your trying to just focus on a particular thing" (Ruby)*

*Organisational Constraints: The medical model.*

Participants also talked about spirituality and religion in connection to working within an organization founded within the medical model. In the extract below Zoe explicitly linked working in a medical framework to its absence within her practice. Perhaps inferring the conflict between the ideologies of science and religion.

> "*Um.. but I suppose why is it not we have explicit resources in the NHS but its a medical model isn't it? I guess, why would there be? Religion doesn't really come into symptoms and diagnoses*" (Zoe)

Other participants did not explicitly connect the NHS as a medical system to holding influence over how they made sense of working with spirituality and religion in their practice. However participants frequently drew on diagnostic terminology to make sense of clients' spiritual and religious beliefs and experiences. In this way the medical framework central to the NHS it is inferred became a framework that they drew on to talk about religion and spirituality in their practice.

> *"I'm not saying that you wouldn't factor it in if it was clearly a problem, so if you were working with people with schizophrenia who have kind of delusional beliefs that are religiously based then of course it would be part of your formulation"* (Ayesha)

In the extract above Ayesha notes that if religious beliefs were "clearly a problem" then they would be accounted for in the formulation. In this sense spirituality and religion were incorporated into practice when they could be

made sense of through a medical framework of understanding, in this case as connected to delusions.

Some Participants talked about their fears that engaging with religious beliefs may lead them to feel disconnected from 'reality'. Perhaps this linked to ideas about the role of a psychologist, holding responsibility to implement evidence-based interventions rooted within objective evidence.

> *"I found it quite difficult um and I think it was partly to do with my ignorance and my lack of experience with those kinds of belief systems that I was worried about going off into, I was worried about losing touch with reality, whose reality? My reality, so I found that difficult"*

The context of a medical system it is suggested placed constraints on psychologists through the promotion of reality defined through objective means.

*The Cultural and Political Context: Religion as Dangerous*

A number of participants also spoke about the wider political and cultural context within the UK. Some participants drew connections between religion and extremism and terrorism. Religion was conceptualised by participants as dangerous and something to be wary of.

> "*Well I'm terribly aware of the sort of awful you know polarizations that are happening with ISIS and the radicalization of young people and you know I think there is this kind of connect between religion and being primitive*" (Susan)

In the extract above Susan describes her understanding of some of the wider contexts of radicalization and ISIS she associates with religion, reflecting upon a connection she sees between "religion" and being "primitive". Her use of the word "primitive" perhaps begins to touch upon connections between religion and race or ethnicity, linking back to theories

of human development where races and people groups have been held to exist at different stages of evolution. In this way it could be inferred that the construction of religion as primitive may be indicative of a secular western view of racial and cultural superiority.

In the extract below, Elana draws on the political context of terrorism. She suggests that religion itself is not good or bad but that some extremist religious frameworks justify pathology or criminal actions.

> *"People get stuck and then they don't develop themselves and they can become fanatics as we can see in our day is very clear, where its evolving er in France; it can become the refuge for pathology so and then you can kill and then you feel God and that's OK so its not bad but very good because you're doing something very special killing yourself, exploding yourself" (Elana)*

In the extract below Zoe infers how the cultural context surrounding religion may hold influence over her own conversations with clients where talking about spirituality and religion was acknowledged to have been rare.

> "*I think the word sort of 'Muslim' has different connotations now and it's, you know, it's linked with ideas about terrorism and religion and Islam. Um.. I haven't really thought about it before but I wonder if that somehow kind of plays a role in not bringing it up, as this sort of idea of not encouraging extremist beliefs by talking about it. It's probably similar to hearing voices, you don't engage with the voices, you talk about it on a symptom level in terms of whether they're present or not rather than what's being said or not said*" (Zoe)

**Trauma and spirituality and religion: Important to clients**

The third main theme considers how psychologists make sense of the roles of spirituality and religion in their clinical work with adults who have

experienced trauma. It represents how participants spoke of spirituality and religion holding an important role in relation to trauma. This theme will be explored in relation to three sub-themes of 'Trauma: Theoretical definitions Vs. Subjective experience', 'Religion: 'an anchor' in extreme distress' and finally 'Spirituality and religion central to meaning making'.

*Trauma: Theoretical definitions versus subjective experiences*

This sub-theme considers the different ways in which trauma can be conceptualized and particularly the differences between theoretical definitions of trauma for example those offered through diagnostic classification and clients' accounts.

Participants talked about how trauma was difficult to define.

> "*pheow, um things that come to mind when you said that, lets just start there again*" (Sophie)

> "*I'm not really saying what I mean by trauma*" (Susan)

Participants contributed a wide range of definitions for trauma which ranged from trauma conceptualized as external and obvious often denoted as meeting the diagnostic criteria for PTSD, to trauma as subjective to the person and intricately linked to their hopes, values and expectations.

In the extracts below Ayesha and Jo construct trauma as relating to experiencing an external physical event. In Jo's account coherent with diagnostic frameworks.

> *"I guess I would define it as that, you know in the formal sense, have you been sexually assaulted? Have you been, someone tried to kill you, so fear, helplessness, horror are the kind of ones"* (Ayesha)

> *"Trauma, um, er, trauma to me is, well say a traumatic event is an event in which someone you know, is in, in genuine fear for their life or the life of someone else or there's a threat of serious harm to someone else or themselves, erm, so probably rather like the DSM criteria"* (Jo)

Other participants frequently moved between positions in which trauma was conceptualized as external and obvious and internal and subjective. In the extract below Lara contributes these two polarized positions in offering her understanding of trauma; Perhaps to reconcile the limitation in theoretical definitions and her clinical experience regarding clients' subjective reports of how they define trauma.

> *"I think I define trauma in two ways […] small 't' and big 'T' so small 't' trauma could be anything that you subjectively find kind of generally traumatic erm and then the big 'T' trauma would be basically something that meets the DSM criteria for a trauma within the context of PTSD*" (Lara)

The majority of participant's spoke about trauma in terms of the impact that experience(s) had on clients.

> "*I guess its some kind of combination of what impact the thing has had"* (Sophie)

> "*My definition would obviously be quite subjective in terms of how someone um what someone perceived the impact of it to have been"* (Zoe)

In constructing trauma through impact on the client, participants also sought to offer a rich description of each client's context. In the extract below Susan offers an explanation of the cultural context regarding the separation of a son from his family in constructing the experience as traumatic. In this

sense trauma was defined in terms of an interruption to or dislocation from an expected or hoped for future.

> "*for this family, this Muslim family um the loss of their son was um enormous in particular because in their culture the son would never leave home, the son would bring his wife into the house um and you could see that the home office was seeing it that he was an adult so he didn't need to be with his family so there was a kind of you know an issue about different view of family*" (Susan)

Other participants' spoke of how the theoretical definitions or their own understandings of what constitutes trauma can conflict with clients' reports of what experiences they found to be most traumatic.

> "*I know in terms of what people subjectively regard as traumatic or not so, some people find like even though they've been through lots of horrible events might find the most traumatic thing is because they don't get leave to remain here even though that might not fall into that DSM definition so neatly*"

> "*the things people say are the worst bit of their trauma often surprises me um sort of having a dog lick their face or something, um you know at the point before their meant to pray, you know when they've previously been hung from a ceiling lamp*" (Zoe)

In the extract above Zoe highlights the role of religion in one client's experience of torture. Emphasis is placed on how theoretical frameworks and clients' subjective experiences of trauma can often contradict.

Religion ‘an anchor’ in extreme distress

Participants spoke about how they attributed religion to be a resource to clients who have experienced trauma. Religion seemed to fulfill a steadying and stabilizing role, offering for some people a supportive community, and acting as a source of hope and strength to clients.

*Spirituality and Religion as Steadying Stabilizing*

A number of participants referred to religion holding a steadying or stabilizing role within client’s lives. This idea was emphasized as particularly valuable to clients experiencing trauma in light of trauma being defined in terms of the impact on the person, where hoped or expected pathways are ‘disconnected’ or ‘shaken up’. In line with this, steadying referred to how religion was a constant and unchanging connection to hold onto.

> “*I suppose you’ve lost everything, your country, your family, your job, it may be one thing that you can hang onto wherever you are is your religion*” (Ayesha)

> “*You might go every Sunday you know there’s something quite structured about it and you know I think that can be very helpful for people” (Ruby)*

Some participant’s referred to religious quotes that they spoke of clients finding helpful. Participants described these in the quotes below, as “holding” and “grounding” indicating religion to hold an anchoring, or stabilizing role for clients.

> “*One of the phrases that she’s had which has been one the most holding and helpful things for her is a quote from going on a quiet day with erm a church*” (Susan)

> *“so she had talked about her faith as quite a helpful grounding thing, so she’d been memorizing verses from the Koran” (Sophie)*

*Religion as protective: A community*

A number of participants discussed how religion offered clients a community, which can be resourceful to them. This connected to clients finding a place of belonging, social relationships and practical resources.

In the extract below Ayesha describes how within her service context working with refuges, religion may offer an vital place of belonging and a family; of particular value to clients who have been disconnected from friends family and country through conflict.

> "*I think for our clients, maybe aloneness is quite an important issue it gives you something that is not just about belonging to a country, because the whole thing about Islam is that it goes beyond borders of countries its about everyone in the religion is your brother or your sister, so maybe that's, it gives you something to belong to when you've not got anything else" (Ayesha)*

In majority participants' personal relationships to religion were largely ambivalent towards and fearful of group membership. However interestingly here, in making sense of the role of religion within clients' lives, group membership that is articulated positively as holding a steadying role.

Other participants spoke about how connection to a spiritual or religious community gave opportunity to develop friendships, again enabling clients to feel connected and supported.

> "*she was able to develop friendships which after twenty years of living in isolation in her house so it was a major thing for her so I think religion was what saved her"* (Elana)

"*who were around for her, were people who she had a whats-app group with, where they were trying to kind of support each other with er, religious things but sort of in the service of also feeling a bit more supported and a bit more connected" (Sophie)*

*Spirituality and Religion: A source of strength and hope*

Participants also spoke of how spirituality and religion could act as a source of strength and hope to clients.

*"keeping something hopeful in them" (Ruby)*

*"then possibly some goodness or hope in the world, allows you to keep going and to try and, to have some trust in people, some where, it gives you a much broader sense of faith in humanity as well as in God" (Ayesha)*

## Spirituality and Religion Central to Meaning Making

In considering the roles of spirituality and religion in their clinical work, participants spoke of the central role they play in clients' meaning making of what they have experienced and their attributions of why events had happened. Discussion centered on how clients made sense of their experiences in very different ways. In this way spirituality and religion were spoken of as both an integral and helpful framework in which to make sense of traumatic experiences and a source of conflict when traumatic experiences stood in conflict with held beliefs, causing considerable distress.

Participants spoke of case examples where clients had drawn on religion and spirituality as a core framework for making sense of the traumatic experiences they had endured.

*“I sort of talk about how they make sense and what’s happened to them in terms of their religious and spiritual beliefs with just about everybody I see here” (Jo)*

*“the meaning of religion is so tied up with her traumas as well” (Zoe*

Participants spoke of how many clients seemed to enter into a process of trying to understand why the things they experienced had happened to them.

“*this terrible thing has happened to me and not that person, there is someone in charge I must have done something either in this life or in a previous life that has resulted in this happening to me so yeah I think it probably is, slightly more important in trauma than in others*.” (Jo)

A notable aspect of participants talk about meaning making surrounded the emphasis on the individuality in which each person constructs meaning. Participants described how spirituality and religion became present in their conversations with clients often through detailed description of their client’s experience and context. In the extract below Susan explains how she understands her client to have made sense of religion in relation to her experiences of being sexually abused by her stepfather. She repeatedly uses the phrase ‘for her’ perhaps emphasizing the individual nature of meaning making to each person.

*“um for her it was he used to abuse her when her mother was at church and for her it, the abuse and Christianity it fused together and she saw um her abuse as kind of akin to erm to the abuse that Trinidad had or its Jamaica had experienced through slavery and that Christianity had been bought by um the white colonial presence, and she was really struggling with this and we talked a lot about what spirituality might mean to her” (Susan)*

In line with this, attributions of 'why' although similar in content were experienced differently by different clients. In the extract below, Jo describes talking through what she describes as a "crisis of faith", with a client regarding the will of God, which was causing the client distress.

> *"who was obviously having a bit of a crisis of faith really and he was sort of saying well, I didn't know that all of this torture and murder was going on and that the people in charge of our country are apparently religious people who are you know following the will of their God and if their doing this, what he's saying is, if they're doing this, then either our God is a bad God or its just all rubbish and you could see how much fear that was giving him, that actually it might all have been rubbish and you know, you know it's a bit of a lose lose really*" (Jo)

In contrast to this, one participant described how a client she worked with found the idea of a traumatic event being the will of God comforting and helpful in alleviating a feeling of intense guilt.

> "*They basically feel quite guilty about it so erm the when, other family members say to them kind of it was God's will and they'll kind of be able to believe that for a bit, then that actually helps to alleviate some of that distress*" (Lara)

Participants also spoke of dilemmas or conflicts of faith that arose after traumatic experiences which lead to clients' experiencing increased distress.

*“she was in a huge dilemma because if she were to say actually that’s not true all the bad things that have happened are a punishment from God then all that I’ve been taught my whole life at school and in my society is actually not true, and so she was caught between either accepting that and feeling somehow to blame for everything that had happened to her or not accepting that and feeling that all that she had learnt hither to, is wrong, so almost an impossible situation*” (Jo)

“*one of the real sticking points was that if he’d stayed then her death would have been in the hands of Allah, his god, um I guess it would have been something he didn’t have control over and it would have been just what was right*” (Zoe)

**Contradictions in Practice**

This theme focuses on the incongruity that seemed to be described by participants between their therapeutic hopes and intentions and their reported actions within clinical practice.

Therapeutic Hopes and Intentions

In considering the roles of spirituality and religion within their practice, participants frequently begun by speaking about their therapeutic hopes and intentions. These surrounded being curious about clients’ experiences and beliefs, including spirituality and religion.

“*What I try to do in theory is to be curious about someone else’s beliefs and to try to find out about them*” (Sophie)

For some participants this involved considering and reflecting on differences between therapist and client.

> "*Well I suppose that I would always hope to have erm you know a lively attention to difference, both how a client or a family is different from me, but also how they experience living in (location name), in this century with these sorts of tensions and experiences, in terms of racism, radicalization you know all those, um kind of issues very present in peoples lives*" (Susan)

> "*the work is always about trying to work out the ways in which you differ and kind of what that means for the patient" (Sophie)*

Participants also spoke of their intentions towards working appreciatively or through consideration of spirituality and religion as a resource.

In the extract below, Susan outlines her therapeutic hopes to bring spirituality and religion into the therapeutic domain and consider how understanding how clients' relationships to spirituality and religion may be utilized within therapeutic work.

> *"I suppose I think there is such a wealth um through exploring spirituality and religion in terms of peoples sense of themselves, I think that um one of the things that I learnt from (educational institution name) and (person name) was working in an appreciative way, so I want to be looking all the time about peoples' resources their resilience, you know what they've got from their cultural hereditary, their sexuality their spirituality you know how all the different graces enable them to be who they want to be, or stop them and how and what might need to happen in order for them to um live the life that they would hope to be living"* (Susan)

Participants spoke of how they hoped to connect with and understand their clients. They spoke of how spirituality and religion held a central role in terms of understanding how clients made sense of who they were, and the world around them.

"*And that if you believe in God that's also how you understand who you are in relation to your God*" (Sophie)

*"I do think that it is an important thing in understanding someone and how they see the world"* (Ruby)

Therapeutic Actions in Practice

In spite of participant's hopes and intentions for their practice, discussion often portrayed discontinuity between therapeutic intentions and how they described their experiences of religion and spirituality within their clinical practice.

In exploration of examples within clinical practice where spirituality and religion had been a salient feature of the work, a number of participants reflected on how they felt that it was hard to think of any examples when they had spoken with clients about spirituality and religion.

"*I think its sort of notable in its absence (…) when I heard about your study and I thought about it, I wasn't quite sure why that is*" (Ruby)

"*so I was trying to remember times when people had talked about their religion because I wouldn't really bring it up*" (Sophie)

Other participants explicitly reflected on the absence of spirituality and religion within their clinical work whilst contrasting this with acknowledgement of their importance to clients.

"*its kind of surprisingly almost embarrassingly like quite um a kind of unfamiliar topic of conversation within this setting, um like how much religion plays such a central role in our clients lives and communities and families*" (Zoe)

A number of participants considered spirituality and religion in relation to other differences they experience between themselves and clients. In doing so they reflected on how spirituality and religion was by comparison a neglected area.

> "*for instance if somebody never mentioned their family then I would ask them about it, but if somebody never mentioned their religious beliefs I realize that I wouldn't necessarily ask them about it.*" (Sophie)

> *"it sort of makes you think actually its quite bad that we don't factor it in, in the way that we do other things, because actually its part of diversity, as much as kind of race is or ethnicity or culture or sexuality and all the things we're told to factor in, gender, but actually we sort of bumble it to one side" (Ayesha)*

In seeking to make sense of this, a notable area of discussion surrounded how participants did not enquire about spirituality and religion, which participants spoke of arising only when clients brought it up.

> "*I was following her, not ahead of her, I wasn't going to introduce any questions about anything about her body and religion, I simply followed her interest, her curiosity about herself*" (Elana)

> "*I wouldn't really necessarily bring it up with people unless they bring it up first*" (Jo)

In the first quote above, it could be inferred that Elana draws on her theoretical position of working analytically to justify her actions in not bringing up religion; Allowing her to present a clear and direct account of her actions. However in the second extract, interestingly Jo uses the words 'really' and 'necessarily' indicating uncertainty perhaps regarding what appropriate therapeutic actions may be.

In reflection on this disparity, a number of participants considered how other areas of exploration seemed to dominate their minds within their therapeutic work and this led to their not enquiring about spirituality and religion.

> "*In my own mind somehow I am more caught up with other things*" (Ruby)

> "*it just feels like there's so much else about thinking about yourself or the world or other people, but somehow you don't factor it [spirituality religion] in unless people bring it up*" (Ayesha)

Participants seemed to reflect openly on their practice and often explicitly stated how spirituality and religion were neglected. However they also appeared to express awareness of conflict between how they felt they should practice and what they actually did in practice. In the extract below Ayesha acknowledges her experience of talking about religion as "wishy washy". It is inferred that this may highlight a mismatch between her values and the values of some clients. Her open expression of this perhaps indicates the power and supremacy of secular discourses within the profession that appear to enable religion, important often to those who identify with non-western cultures, to be constructed as holding less value and importance. In this case able to be openly dismissed. Reflection however on her comments as "awful" perhaps indicates some awareness of this.

> *"I think its possibly because it feels, sometimes I think it feels a bit wishy washy that's awful, I realize how awful it is because its erm please tell me that other people have said this"* (Ayesha)

> *"I feel like religion in particular isn't actually something that comes up very often in my work in sessions with people, which when I first heard about your study really made me think about that, how little it comes up"* (Sophie)

Participants also spoke of their experiences of what it was like for them to talk with clients about beliefs and practices that were different from their own. Participants spoke of how talking with clients about spirituality and religion could be difficult. This connected to uncomfortable feelings they experienced such as cautiousness and fear in relation to both the unknown quality of the content and the content itself, which conflicted at times with their own values and worldviews.

> "*I think that there's always a fear when your kind of talking about something that is different to what you know about so that your either going to put your foot in it, or that you should know*" (Ruby)

> "*So that was a very challenging piece of work for me because I had to try my very best to own my feelings but not do anything about it in the presence, I could have my feelings about that man and her but this is not what helps. This is how I understand the meaning it has for her, so it was very hard work*." (Elana)

In the extract above the ending phrase, it was "very hard work", appears to testify to how talking with clients about values and beliefs that were very different to those held by participants could be emotionally costly, in terms of processing uncomfortable feelings that arose. Other participants' accounts also alluded to the emotional aspects of working with clients who held very different beliefs to their own.

> "*there was a family I saw here actually where the mother, it was very interesting, she had a lot of aboriginal beliefs but again I found it quite difficult*" (Susan).

> "*there's something about working out whether what your feeling is counter transference or whether it's your own anxiety and trying to disentangle that*" (Sophie)

In this section, four main themes were presented, around which participants' accounts were clustered: Spirituality and Religion: Connectedness and Ambivalence, Influencing Frameworks, Trauma and spirituality and religion: Important to clients, and Contradictions in Practice. Each theme was presented with subordinate themes, together with verbatim extracts from the transcripts and my analytic commentary. The following section will discuss further the analyses and outline links to the existing literature.

# CHAPTER FOUR: DISCUSSION

## Overview

In this chapter, the main themes from the analysis will be developed further and explored in relation to both the research questions and existing relevant literature. Following this, the study's limitations and the role of the researcher will be considered. Finally, the implications of the findings will be outlined.

## Reviewing Research Aims

The principal aim of this study was to explore how clinical psychologists made sense of the roles of spirituality and religion within their therapeutic work with adults who have experienced trauma. In the following section, the four main themes from the analysis will be viewed in the context of existing literature and possible links between them will be explored.

### Aim 1: How clinical psychologists define and understand their own values with regard to spirituality and religion.

The first aim of the study was to examine how clinical psychologists define and understand their own values with regard to spirituality and religion. This first research aim was predominately addressed through theme 1 of 'Spirituality and Religion: Connectedness and Ambivalence'.

### Theme 1: Spirituality and Religion: Connectedness and Ambivalence

This theme sought to represent how participants appeared to relate to spirituality and religion, as a difficult topic, with varying degrees of connectedness and with deep uncertainty.

Participants appeared to conceptualize religion as restrictive and spirituality as more permissive. In accordance with this participants' related to religion with varying degrees of ambivalence and reported spirituality to be easier to affiliate with. The conceptualization of spirituality and religion in these ways

stands in line with a suggested cultural shift in the way in which these two terms are understood (Zinnbauer et al., 1997, Hill & Pargament, 2003). However, although some participants began by conceptualizing spirituality and religion as separate and clearly distinguishable, further discussion portrayed contradictions in which spirituality and religion were discussed in both overlapping and fluid ways. This finding stands in agreement with literature reporting that attempts to develop discrete categories in defining religion and spirituality have been largely unhelpful (Hill & Pargament, 2003: Miller & Thoresen, 2003).

In considering their relationship to spirituality and religion, participants reported finding spirituality and religion to be a difficult topic. Talking about spirituality and religion was connected to feelings of discomfort, embarrassment, and shame. Participants frequently offered accounts that were contradictory in nature, generating fluidity in content often between opposing positions. This was interpreted to represent deep uncertainty in relation to the topic.

Overall, the inference that participants found spirituality and religion to be difficult to talk about and that they related to this topic with great uncertainty, stands in line with the findings of other studies carried out with professionals from a range of therapeutic backgrounds, for example Crossley & Salter's (2005) study with clinical psychologists and Begum's (2012) study with trainee clinical psychologists, amongst others; (e.g. Gravell, 2007; Stamogiannou, 2007; Hay, 2006; Suarez, 2005).

Braun and Clarke (2006) suggest asking the question 'What are the assumptions underlying this theme?' One assumption is undoubtedly that people should be able to clearly articulate and express their views about spirituality and religion. Some authors writing within this sphere, (e.g. Coyle, 2008) have suggested that spirituality and religion are by definition ineffable and it is this aspect of the subject material which accounts for why participants frequently have such trouble articulating their views. In this regard therefore, the difficulty participants had in articulating their views,

rather than being attributed to their relationship to the topic, may be attributed to the nature of the topic itself. However, this does not explain the range in participant's expression, and why some participants were more able to express their views clearly than others. Coyle (2008) noting Suarez's (2005) study on the views and experiences of integrating spirituality into psychotherapy, highlights that some participants were able to articulate their experiences and thoughts surrounding spirituality and religion in powerful and eloquent ways. Accordingly, though I acknowledge that the non-material nature of the topic certainly poses a challenge to participants, it is suggested here that other analytic conclusions could be drawn from the way in which participants talked about their personal relationships to spirituality and religion.

Firstly it could be inferred, that the uncertainty reported, mirrors participant's own feelings of uncertainty in relation to the concepts of spirituality and religion, which may be attributed to a lack of personal exploration or reflection on this subject. This stands in line with suggestions made by other authors, regarding the need for psychologist's to engage in personal reflection upon how they relate to this topic. For example Begum (2012) suggested that 'tools for thinking' should be developed within the profession to facilitate personal reflection with the aim of increasing comfort and self-awareness.

Another consideration may be the influence of wider contexts on how participants make sense of their own relationships to spirituality and religion (Cronen and Pearce, 1985). It could be argued that the uncertainty participant's spoke with, may be reflective of wider social discourses of fear connected to the current cultural and political context within the UK. This notion will be explored further within the next section, through consideration of the second theme, which explores frameworks that appear to hold influence over how participants make sense of spirituality and religion. Discussion of this theme, will seek to consider what conditions are likely to have given rise to this first theme, of spirituality and religion being a difficult topic.

## Aim 2: How clinical psychologists make sense of the roles of spirituality and religion within their therapeutic work with adults who have experienced trauma.

This second research aim is addressed through themes, two, three and four. Theme two explores frameworks that appeared to influence and inform how psychologists made sense of their own and their client's relationships to spirituality and religion. Theme three considers the example of trauma, and represents how participants ascribed importance to the roles of spirituality and religion in the lives of many clients who had experienced trauma. In addition however, theme four considers 'Contradictions in practice', whereby participants hopes and intentions for working with spirituality and religion appeared to contradict with their reported actions in practice. Analytic interpretations will be offered regarding why this may be and reflection will be offered surrounding relationships between the four master themes.

## Theme 2: Influencing Frameworks

The second theme 'Influencing Frameworks' considers what participants drew on to make sense of spirituality and religion within their practice. The theme highlights how participants appeared to draw on, their own personal experiences, psychological theory and wider contexts, such as the workplace context of the NHS and wider political and cultural influences to make sense of spirituality and religion within their practice. Due to the complexity of this theme, discussion will be addressed at the sub-theme level.

### *Personal experience*

The sub theme of personal experience sought to consider how participants appeared to make sense of client's experiences of spirituality and religion through drawing on their own experiences. At times this appeared to

facilitate entering into clients conceptual frameworks, for example some participants spoke of how drawing on spirituality and religion during times of personal suffering, aided their understanding of its importance to clients. At other times however drawing on personal experiences as a framework appeared to make it difficult for participants to engage with some client's dilemmas, where there were conflicts between the worldviews held by participants and by clients.

Historically, a Rogerian view of therapy emphasised the notion of 'value free' therapy, in which personal and professional selves were separated. However this sub-theme suggests that at times participants drew on their personal understandings of spirituality and religion in order to make sense of their roles within their therapeutic work. Bergin, Payne and Richards (1996) suggest:

"*a value-free or value-neutral approach to psychotherapy has become untenable, and is being supplanted by a more open and more complete value-informed perspective*," (p.297).

This theme supports the notion that personal values cannot be isolated from professional practice. With regard to the literature, other studies have gained comparable conclusions in suggesting that personal and professional identities are inherently connected, and that personal values can be both used as a resource within therapeutic work but can also act as a hindrance to understanding and working in attunement with client's world views (Frazier and Hansen, 2009; Bidwell, 2009; Smiley, 2001a; Baker and Wang, 1992).

### *Psychological theory*

The sub-theme of 'Psychological theory' sought to capture how participants were influenced by and drew on psychological theory as a framework to make sense of spirituality and religion within their practice.

Participants spoke of making sense of spirituality and religion through constructing religion or belief in God as symbolic of internal processes. Some participants also drew on analytic theory, which offered frameworks that conceptualized religion in functional terms, involving regulation or accounting of deficit. In this way theoretical frameworks available to participants tended to make sense of spiritual or religious beliefs in negative or pathologising, rather than resourceful ways. This finding stands in line with similar findings reported within the literature (Pargament & Park, 1995, King-Spooner, 2001).

The above finding suggests that the theoretical frameworks available to participants were constraining and offered little resourceful guidance as to how participants could make sense of spirituality and religion within their practice. One exception to this, however seemed to be the systemic approach, which one participant drew on in conceptualising spirituality and religion in a resourceful way.

All of the participants however, were qualified clinical psychologists and therefore held access through their clinical training to many different theoretical frameworks on which they could draw. It could therefore be questioned as to why participants chose to draw on particular frameworks to make sense of spirituality and religion within their practice. Some authors have studied relations between psychotherapeutic orientation and worldview or religious orientation (Shafranke & Gorsuch, 1984; and Bilgrave & Deluty, 1998). Bilgrave & Deluty (2002) sought to consider whether religious beliefs and political ideologies could be used to predict psychotherapeutic orientation, within clinical and counseling psychologists in the US. They concluded that religious beliefs were related to therapeutic orientation for example, those with Christian beliefs tended to endorse cognitive behavioral orientations whereas Eastern and mystical beliefs were more strongly related to humanistic and existentially oriented psychologists. On this basis it could be argued that participants may draw on psychological frameworks that align with their own personal values with regard to spirituality and religion.

Developing this further, Social Conditioning Theory would posit that participants speaking within their professional roles as clinical psychologists may experience pressure to contribute answers in keeping with what they know to be approved of by the professional group to which they belong (Bandura 1977). It could be inferred that participants drew on psychological theory as an acceptable way of voicing their own worldviews surrounding spirituality and religion. This may be congruent with a 'value free' attitude considered within theme one, which may still exist within the profession. The pressure to adhere to socially sanctioned professional discourses, could be inferred to be apparent in the tensions some participant's acknowledged such as, "*please tell me others have said this*…" (Ayesha).

Finally, of further consideration was the acknowledgement by participants that psychological theory, as they understood it, offered insufficient guidance for making sense of spirituality and religion within their practice. A consideration also noted by others within the literature in relation to the wider profession (e.g. Coyle & Lochner, 2011) and with regard to specific models such as CBT (e.g. Andersson & Asmundson, 2006).

In summary this sub-theme represents how participants drew on psychological theory to make sense of the roles of spirituality and religion within their practice. Theoretical frameworks tended to conceptualize spiritual and religious beliefs in negative or pathologising ways, or neglect them altogether. From this it could be concluded that participants were constrained by the theoretical frameworks available to them. However, a second interpretation could be that participants drew on models that aligned with their own personal values. In this way theoretical frameworks were used as a professionally acceptable way of voicing personal views.

### *Wider Contexts*

Further frameworks which participants drew on in making sense of religion and spirituality linked to wider organizational, economic and political

contexts. Drawing on these wider frameworks predominately took place as participants reflected on their experiences of talking about spirituality and religion with clients and for some, reflection on its absence within their clinical work.

One way of understanding the influence of these wider contexts upon how participants made sense of the roles of spirituality and religion within their practice, could be through consideration of Coordinated Management of Meaning (CMM) (Cronen and Pearce, 1985). This is a framework which considers how wider societal forces shape individual perceptions. This model draws on Foucault's notion of power, whereby an individual's actions cannot be considered totally autonomous and therefore exercises of power are merely power's 'ultimate destinations' (Foucault, 1980, p. 96) as they originate in social discourses. Afuape (2011), suggests that this can be a useful framework to consider how wider social forces shape individual perceptions and how the individual as an agent then proceeds to shape the world.

Participants reflected upon the influence of the NHS context in terms of its positioning as a medical system. This stands in line with research suggesting that the majority of therapists find it uncomfortable to work with religious themes in a secular healthcare setting (Worthington, Kurusu, McCullough and Sandage, 1996)

With regard to further contextual influences, numerous authors within the media have highlighted NHS culture to be dominated by a need to be 'politically correct' (Beckford & Gammell, 2009; Harrison, 2013). Proponents of this position, often those within equality and diversity departments, emphasise the importance of using language that does not discriminate against any one group. However critics of this position have argued that political correctness can be taken so far that it serves to stifle, through fear, people's ability to talk about difference.

Drawing on the CMM model therefore, it could be inferred that these contexts, which consider social discourses such as medical discourses which privilege objective truth, and discourses surrounding what you can and cannot say, may hold vital influence over each participant's individual practice, leading participants to experience pressure to avoid talking about spirituality and religion. With regard to levels of context, this model suggests that the greater the weight of the contextual force, the more a person can feel obliged to respond in a certain way. In this way, rather than focusing on the autonomy of individual therapists, consideration is given to the wider forces, which may be constraining participants practice.

Similarly, with regard to the wider political context surrounding international conflict and the influence of religious extremism, Coyle (2008) emphasizes that the sweeping interest in spirituality reported within the UK has occurred alongside the development of a cultural fear, panic and dread about the religion of Islam also termed 'Islamophobia'. Thus, it could be argued that participants did not engage in conversations with clients about spirituality and religion due to the contextual force of fear associated with organized religion which in turn constrained their practice.

Participant's reflections on these wider contexts frequently occurred right at the end of interviews, although in part due to the interview schedule, many contributions were made in response to the offer of any final reflections. The CMM model also suggests that people continually reconstruct themselves in relationship to others (Afuape, 2011, p. 91). Perhaps therefore, this indicated that, through gaining reassurance throughout the interview, participants became able to share their views on issues of a more sensitive nature. Coyle (2008) suggests that in a context where participants may have been uncertain about the interviewer's stance on topics their initial accounts may have been hesitant to avoid committing themselves to a position from which they may have wanted to retreat, had they been met with any sign of disapproval from the interviewer. Thus, once the safety of the interview context was ascertained, or at the end of interviews, when participants could imminently leave, they may have felt more comfortable in

speaking about their experiences and positions regarding issues of a sensitive nature. This implies that participants may experience tensions between ideas about the topic of spirituality and religion that they think can be shared and ideas that may be deemed less safe to share.

In summary, this sub-theme highlights the influence of wider contexts upon the communication actions of participants within therapeutic encounters. In considering higher level contexts, this sub-theme inevitably links to other themes. For example, theme one, considered how participants appeared to relate to spirituality and religion with great uncertainty and feelings of discomfort and fear. Consideration of wider contextual influences, participants drew on to make sense of spirituality and religion within their practice, offers meaning to why participants may relate to the topic with fear and uncertainty. Later, attention will be given to how the influence of wider contexts may be used to contextualize theme four, 'Contradictions within clinical practice'.

### Theme 3: Spirituality, Religion and Trauma: Important to Clients

This theme sought to highlight how participants perceived spirituality and religion to be important to many clients, who had experienced trauma. Participants emphasised the role of spirituality and religion in terms of the subjective way in which clients conceptualised the most distressing aspects of their experiences; these subjective conceptualisations often conflicted with diagnostic frameworks. The notion that distress, as a response to trauma is dependent upon individual meaning making, is well documented within the literature (Park and Folkman, 1997; Park and Ali). The observation that violation of spiritual and religious practices, as a form of torture, as a feature of client's attributions of distress, does not seem to have been explored within the literature. However, Savic (2012) interviewed men who had sought asylum in the UK after experiencing torture within their country of origin. A finding of the study described how client's reports of the most traumatic or distressing elements of their experiences did not align

with diagnostic definitions of external threat to life, but included aspects such as violation of religious customs.

Spirituality and religion were also understood by participants to hold a central role as a resource for clients experiencing distress, providing them with a stabilizing function. This stands in line with literature reporting similar findings (e.g. Weaver et al., 2003). Participants also spoke of how spirituality and religion offered clients connection to others through community and friendship. This was conceptualized as vitally important in relation to trauma, whereby many people were described as experiencing a sense of aloneness and separation from previously held connections, to people, places and values. The notion that religion can offer social support and the sense of belonging to a community and that this can aid coping has been widely reported in previous studies (Almedom, 2005; Beeber & Canuso, 2005; Fudge, Kowalenko & Robinson, 2004; Shields, 2004).

In the majority of interviews, the participant's personal relationships towards religion were largely ambivalent towards and fearful of the organizing aspect of religion involving group membership. Interestingly however, when reflecting on the meaning of spirituality and religion for clients, this group membership was conceptualized as having a positive and resourceful function. It could be inferred, that reflecting on client's experiences, especially those that took place predominately outside of therapy, omitted the complication of participant's personal ambivalence towards religion, facilitating greater reflection on the potential benefit of group membership.

Participants also conceptualised spirituality and religion as a source of hope and strength to clients. This suggestion stands in line with other studies that have reported similar findings (Weaver et al, 2003; Kalayjian et al., 1996).

Finally participants described how spirituality and religion held a central role within meaning making processes. From a psychological perspective, Paloutzian (2005) describes meaning systems as a structure that makes sense of the world through the integration of ideas, feelings, behavior and

motives and ‘ultimate concerns’. Consistent with this, participants spoke of how spirituality and religion were drawn on by clients particularly in situations where ‘why’ questions were raised. In this way spirituality and religion held the potential to facilitate meaning making, through offering frameworks which make sense of suffering. Parallel findings, where religious frameworks have facilitated clients meaning making of suffering are widely reported within the literature (Altmier, 2013; Pargament & Park, 1995; Park & Cohen, 1993).

Participants also spoke of how clients faced crises of religious faith, where previously held beliefs and understandings were questioned. This supports existing literature that considers how experiencing major loss may lead people to seriously question their religious beliefs (Herman, 1992; Wilson and Moran, 1998; Smith 2004).

For further research, it may be important to consider how although the role of meaning making appeared to be very important to participants within this study, however, a universal quest for meaning dominant in theistic religions such as Christianity or Islam, may not hold a place in all religions. For example Fontana (2003) highlights that within Hinduism meaning making is not privileged as a human need but rather is simply a part of ‘being’ and ‘doing’ within everyday life. Further research may consider whether the finding of its centrality of importance can be applied universally.

Overall this theme sought to represent how participants made sense of the roles of spirituality and religion in relation to client’s experiences of trauma. Firstly, this involved their influence over what aspects of their experiences clients found most distressing. Secondly, in terms of their role as a resource to clients in offering stability, community and hope and finally their central role in understanding how clients made sense of their experiences.

Theme four ‘Contradictions in Practice’ considers disparity between participants’ therapeutic intentions towards working with spirituality and religion and participants’ reported actions. Theme three, ‘Trauma,

spirituality and religion; important to clients' could be conceptualised as informing participants' therapeutic intentions. In this way, their understanding of the roles of spirituality religion within trauma could be understood in terms of offering a platform on which participants took up the position of intending and hoping to work with spirituality and religion within their practice. Theme four however, discussed below, will consider contradictions between how participants theorize about the roles of spirituality and religion and what they reported within their practice.

## Theme 4: Contradictions in Practice

Theme four sought to represent the contradictions evident within participant's accounts. Although participants spoke of their hopes and intentions to work with spirituality and religion and readily theorized regarding their roles (explored within theme three), they also spoke of spirituality and religion being largely absent within their clinical practice.

The sub theme 'Therapeutic intentions' encapsulated participants' hopes to practice in an appreciative way, working with difference and including spirituality and religion within their practice when relevant. However, when reflecting on case examples, participants frequently revealed the absence of spirituality and religion within their practice. Participants' reported that they did not enquire about spirituality and religion unless clients brought it up. This mirrors the findings of other relevant studies, for example, Crossley & Salter's (2005) study with clinical psychologists. They found that some practitioners reported waiting for clients to raise spiritual issues on the assumption that if these were significant, the client would mention them without prompting.

When spirituality and religion had been a salient feature of therapeutic work, participants reported an array of uncomfortable feelings of fear, frustration and discomfort. Some of these fears related to competency within unknown

territories, a finding also represented within the literature (e.g. Saunders et al, 2010; Begum, 2012). Other participants attributed these feelings to a conflict between their own values and the worldview or the values of clients. This experience of discomfort could be explained in terms of consideration of a zone of tolerance that therapists may have to working with differences, described by Worthington (1988), whereby participants may be less effective in building relationships with clients experienced as different from themselves.

Therapists' experience of discomfort with regard to talking about spirituality and religion may offer an explanation as to why there was a disparity between their therapeutic intentions and what they reported happened in practice. Psychodynamic theorists suggest that uncomfortable feelings may be avoided, at the level of both the individual and within wider systems, especially those under stress (Menzies Lynth, 1960). This finding may provide one way of understanding the disparity between intention and practice; whereby the difficult feelings participants experienced in previous therapeutic interactions may have led them to avoid addressing these areas within their current practice.

**Further Discussion**

Consideration should be given to what conditions are likely to have given rise to the theme of 'Contradictions in Practice'. In considering this it is important to consider potential relationships between all of the four themes.

The above contribution considers neglect due to discomfort participants experienced, on an individual level. This may link to theme one, whereby participants' own relationships to spirituality and religion were inferred to involve deep uncertainty, and with regard to religion varying degrees of ambivalence. It therefore could be argued that discomfort on a personal level may be seen to parallel discomfort or difficulty talking about spirituality and religion within therapeutic interactions.

However, theme two considers how wider contexts hold influence over both how participants may relate to spirituality and religion on a personal level and within their professional practice. Using the CMM model it could be inferred that these frameworks each offer layers of context linked to fear or uncertainty surrounding spirituality and religion, each of which influence actions within both personal domains as represented within theme one, and within professional spheres of clinical practice represented within theme four. In line with this, therefore the contradiction expressed within theme four, may stand as a testament to the weight of the contextual forces participants experienced constraining their practice. Later, actions which psychologists may take to offer resistance against contextual pressures to not talk with clients about spirituality and religion are considered within the implications section.

## Evaluation of the Research

Within the section below some of the limitations of the study are considered.

### Sample

Participants' demographics varied in terms of their age, ethnicity and number of years qualified. The sample was heterogeneous with regard to psychologists' preferred therapeutic modality, and service context.

The proportion of self-reported spiritual and religious identities, were similar to a study of the wider clinical psychology population with regard to non-religiousness (Smiley, 2001) but also with regard to increased interest in less formal and more personalized spiritualties and spirituality based practices as observed within the wider UK population (Tracey, 2004; Worthington & Sandage, 2002). One participant affiliated with the religion of Buddhism, however representation from other religions such as Islam, Hinduism, and Christianity were neglected. In addition to this there was no

representation of males. It is acknowledged that a more systematic approach, such as recruitment from within additional NHS sites and seeking out targeted representation, may have enabled a richer data sample to be drawn.

In addition to this the composition of the sample could be considered a limitation, in terms of the two NHS trusts that were recruited from. One of the findings of the study surrounded how participants drew on the frameworks of psychological theory, and the wider context including organizational influences in making sense of spirituality and religion within their practice. In this regard it is therefore difficult to infer the findings from this study to the wider profession of clinical psychology, since the sample was drawn from within two NHS trusts and 4 different services.

However participants were recruited from a range of different service backgrounds, for example a specialist trauma service rooted within a specific therapeutic modality as well as generic services. Lavigne and Faier-Routman (1992) suggest that recruiting from multiple sites may mitigate the issue of bias arising as a result of the characteristics of local services.

Although the sample size was small, in light of the qualitative nature of this study, generalizability could be conceptualized in terms of individuals standing as bearers of a shared culture and in this sense may therefore offer insights into a broader socio-cultural and historical context.

### Interview Schedule

Within the interview schedule the terms spirituality and religion were presented together throughout the interview. A practice other authors writing within this sphere have favored due to there argued inter-twined meaning (e.g. Coyle & Lochner, 2011). Some participants did refer to spirituality within their discussion however participants tended towards talking about religion more often. The separation of enquiry surrounding

spirituality and religion within the interview schedule may have promoted greater attention to be given to the topic of spirituality through actively demonstrating the importance of spirituality as a topic of consideration. In addition to this Coyle (2008) highlights that participants may feel embarrassed or wary of feeling judged in sharing their ideas in relation to spirituality and religion and therefore good rapport within interviews is essential. In response to this the interview schedule was carefully constructed to facilitate and enable participants to share their views. The use of open ended questions intended to convey to participants that I was interested in hearing what they thought might be important regarding the research topic.

## Analysis

Analysis of the results was undertaken using a critical realist TA influenced by social constructionist ideas. This considered psychologists relationship to spirituality and religion, and how they make sense of their roles within therapeutic practice. In light of TA being a method which is not directly aligned with any epistemological stance, the analysis could have been conducted within a purely social constructionist stance to consider how the ways in which psychologists make sense of spirituality and religion are socially produced (Braun & Clarke, 2006).

Another method could have employed the use of discourse analysis to enable exploration of how psychologists construct their experiences in relation to spirituality and religion within their practice and the impact this may have. Alternatively interpretative phenomenological analysis may have been used. This may have enabled deeper exploration of psychologist's subjective experiences of spirituality and religion within their practice. The focus of different methods is discussed further in appendix 1.

A further important consideration surrounds how TA can be understood to organize data in agreement with how the researcher and his/her research

questions connect with it (Joffe & Yardley, 2004). This will be considered further below.

**The Role of the Researcher**

Patton (1990) emphasizes the role of the researcher in the way in which qualitative research is conducted and reported. Parker (2005, p. 25) suggests that reflexivity is a way of:

"*attending to the institutional location of historical and personal aspects of the research relationship*."

In offering a framework for researchers to consider the process of reflexivity, Parker (2005) suggests engagement in three stages: confessions, positions, theorizing and crafting. With the intention of engaging with these ideas throughout the data collection process a reflective journal was kept (Andrews, 1996). Example extracts can be seen within appendix 7.

<u>First person reflections - Confessions</u>

It is also inevitable that my own worldview and personal relationship to spirituality and religion have held influence over the development of the research and the generation of themes. My relationship to the religion of Christianity has been influenced by my upbringing within a family who attended a Church of England Parish. In my early years these were practices I participated in alongside my family members. At aged 13 I was confirmed but in my mid teenage years I found religion to be of little relevance to my life. In my later teenage years however whilst attending a Christian youth festival I had an experience which led to me understand the Christian faith in a more personalized way, in which I would describe my faith as becoming relational and involving entering into a relationship with God rather than believing that a God exists. From this point I have viewed my affiliation to this religion as being enriching to my life. I have also

experienced challenging times when my beliefs and hopes about how things should be and experiences have seemed to be in conflict.

I would also identify myself as having an interest in social constructionist ideas, and correspondingly therapies such as narrative and systemic practice. Inevitably this will have influenced the epistemological stance from which the research was undertaken. Arguably this may be seen in the development of the themes surrounding personal experiences and the wider context. Whereby personal and professional identities were conceptualized as intertwined and the influence of wider systems was considered.

I also feel that my position as a white, middle class female may have been influential. In light of the lack of diversity within the profession of clinical psychology there were similarities between participants and myself. As considered earlier, the topic of spirituality and religion is a sensitive one and I wonder whether this perhaps facilitated openness in some areas and inhibited it within others.

Second person reflections – Positions

In offering the reader insight into the context in which this project developed, I previously worked in a Community Mental Health team and an adult inpatient ward based within an ethnically diverse borough of London. During this time I worked with clients experiencing extreme distress and found that many of them similar to myself, held spiritual and religious beliefs that permeated how they made sense of their experiences of the world, themselves, and others around them. In my own practice working with a client who held very different beliefs to my own, however I also experienced first hand how complex and unfamiliar territories can be avoided. Reflection on this experience led to further interest in the interplay between personal and professional identities and the wider contexts that overshadow and inform them. This context has inevitably influenced the way in which I have approached this research.

Additionally, I also feel that my position as a Trainee Clinical Psychologist may have been influential. The interview questions I asked requested detailed accounts of participant's practice. I felt acutely aware that this held the potential to be experienced as exposing. Although acting within the role of researcher my overlapping role as a trainee psychologist also meant that I held significantly less power than all of the interviewees to varying degrees. I wonder whether at times this power dynamic may have led me to not probe or offer prompts in areas that perhaps felt challenging, in light of my awareness of the sensitive nature of the material under discussion. Perhaps this was also however influenced by my status as a University of East London (UEL) trainee. I felt aware that participants might be influenced by potential ideas that they may hold about my values, especially with regard to participant's awareness of the association between the UEL clinical psychology course and taking a critical approach. One participant for example explicitly named my UEL status within the interview;

*"I feel like I went to UEL now! What am I talking about dominant narrative (laughter)"* (Ayesha)

I think this also may highlight how in spite of my reduced power with regard to my role as a trainee there is also perhaps an inherent desire to contribute ideas which fit with those of the interviewer. My UEL status perhaps stood to indicate to participants what some of these values may be (Landsberger, 1958).

Third Person Reflections - Theorising

Parker (2005) suggests that interactions between the researcher and interviewees hold an essential and valuable role within the research and that reflection on these interactions is important. Coyle (2008) highlights that the topics of spirituality and religion can be difficult for participants to talk about and therefore building a good therapeutic rapport where a

facilitative and supportive stance is communicated, is important. I felt that I was able to establish a good rapport with each of the participants, and this appeared to be exemplified across the duration of interviews where participants appeared to share increasingly openly, their experiences and reflections upon them. At the end of the interviews a number of participants expressed thanks and noted that they had found the interview useful. For example, Ayesha thanked me for the interview and relayed that "*it was very interesting*" and Susan relayed that she was pleased to have been asked to take part.

### Fourth Person Reflections - Crafting

Compiling this report has enabled me to reflect on my relationship to issues related to difference, not only, spirituality and religion but also other social 'graces' that may be further from my attention (Burnham, 1992). In completing interviews with participants, I was acutely aware of a potential for participants to feel exposed or judged. However, in spite of this potential I felt that participants were open to questioning their own experiences and relationships to this topic. Going forward I hope to be able to approach my own practice, with an equivalent level of curiosity, humility and openness.

## Reviewing the Quality of Qualitative Research

Willig (2009) highlights that numerous contributions have been made in accordance to methodological preference, regarding the assessment of the quality of qualitative research. Further to this, Spencer and Richie (2012) outline three guiding principles that can be applied to all qualitative research, inclusive of the critical realist TA adopted for this study.

### Contribution

With the intention of enabling the reader to reflect on the contribution of this study, the findings of this study have been summarized and evaluated with reflection on how these may relate to the current research literature.

Additionally consideration of limitations of the study has taken place and implications of the findings will be discussed further below.

### Credibility

The issue of credibility was addressed through a thorough transcription process in line with what Potter and Heburn (2005) refer to as 'Jefferson lite' transcription. This was implemented to ensure that the accuracy of each interview was represented in the same way. Additionally, multiple extracts have been used to illustrate arguments made.

The process of triangulation has been suggested by some as useful in assessing the credibility of a study through the extension of integrity of, or the inferences drawn from the data (Spencer & Richie, 2012, p. 231). However in accordance with the adoption of a critical realist approach and the social constructionist influence upon this, within this study further parties were not drawn upon to analyse the data and offer inter-rater reliability. An initial credibility check was carried out whereby my supervisor read a number of transcripts and checked some of the transcript data for evidence of related themes. Further triangulation could have been carried out through participant validation (Henwood & Pidgeon, 1992). This was not completed due to the time restraints of the study and the time restraints of the participant's involved.

## Rigour

In the following section the rigour of this study will be considered in relation to Spencer & Richie's (2012) framework which proposed the consideration of reflexivity, audibility and defensibility.

### Reflexivity

Some have suggested that it is possible for researchers to stand aside from their personal values when undertaking research (e.g. Seale, 1999). Other

however suggest that this is a challenge within qualitative research (Spencer & Richie (2012). In light of this in approaching the data and conducting TA analysis, I sought to check for possibilities that I may be imposing my own conceptions and expectations on the data. This was achieved through frequently returning to the original transcripts. This required flexibility during the analysis of each interview whereby I tried to recognize any new and distinctive perspectives contributed that needed incorporation within emerging themes. Reflexivity has also been attended to within both the method and discussion sections.

### Audibility

Spencer and Richie (2012) advocate for a clear documentation of the research process with regard to how and why decisions were made. In achieving this aim, the process of completion for the TA has been outlined in the method section with attention given to how and why decisions were made.

### Defensibility

A critical aspect of rigorous research also involves the outline of a clear rationale for the choice of sample and method (Spencer & Richer, 2012). This has been offered in both the introduction and method. Additionally critical attention has been given to the epistemological stance taken and ethical issues involved in the research within the method section.

## Implications

Within this section the third research aim, to develop understanding of the implications for clinical practice and the profession of clinical psychology will be addressed. Attention will be paid to the theoretical, research, clinical and service implications of this study.

## Theoretical Implications

The findings of this study suggest that the broader theoretical frameworks available to psychologists either failed to acknowledge spirituality and religion or conceptualized spirituality and religion in negative or pathologising ways.

The findings of this study highlight how individuals can relate to spirituality and religion in very different ways. While some people may engage in religious practices without resonance to collective belief frameworks, for others spirituality and religion appear to constitute their core beliefs and offer an exclusive framework for making sense of themselves, others and the world around them. With regard to trauma, religion and spirituality appear to hold the potential to act as both a resource and a potential source of increased distress in highly idiosyncratic ways. In light of this it seems unrealistic, or impossible even to expect a theoretical model to explain such a wide-ranging continuum. However the importance of spirituality and religion to many clients was evident within participants' reports. This study supports the need for paying greater attention to the role of spirituality and religion within theoretical models that seek to conceptualise trauma. Some examples already exist and may be developed for an adult client group. For example, Walker, Reese and Troskie (2010) constructed a model for trauma focused CBT for children and adolescents which does promote attention to spiritual beliefs. In addition to this, Ncube's (2006) 'Tree of Life Project', offers a narrative approach allowing for the incorporation of spiritual and religious stories into therapeutic conversations.

## Research Implications

The relevance of spiritual and religious beliefs in the context of trauma is well established within the literature and has been identified across a wide range of experiences e.g. child sexual abuse, combat experiences, road traffic accidents and bereavement. Participants' reports of the importance of

spirituality and religion to clients who have experienced trauma support this finding.

However, in light of the mismatch between participants' therapeutic hopes and intentions and their actions within clinical practice, further research may seek to explore these contradictions further and consider contexts that may influence this, for example personal values, organizational culture and political influences. Future research could also be undertaken using different participant groups. It would be interesting to explore how psychologists who work explicitly with client's religion and spirituality practice. How they make sense of religious and spiritual material with clients and how they navigate problematic material, for example when clients experience distress in connection to conflicts of faith. This may contribute towards the generation of further guidance and training for psychologists. In addition to this future research could also be undertaken from a client perspective with consideration given to different groups, such as those who identify as belonging to an ethnic minority group or refugee populations.

With regard to qualitative methods, Coyle (2008) highlights that quantitative analysis has continued to dominate the psychology of religion. The employment of qualitative methodologies is recommended and may enable marginalized questions that address non-material and non-practical aspects of spirituality to be considered. The employment of different qualitative methods may facilitate further in-depth analysis. For example the use of Discourse Analysis would allow for examination of what participants do with language and the performance qualities of discourse, enabling consideration of how 'reality' is constructed through language.

In addition to this, Coyle (2008) highlights that participants' difficulty in articulating their views about spirituality and religion may relate to the subject material by its very nature being in part "ineffable". Thus, future research considering the roles of spirituality and religion within practice could employ creative methodologies to explore possibilities for accessing

non-material, religious and spiritual experiences and analyzing them in ways that are psychologically useful and non-reductionist. In doing this, although holding considerable research challenges, further research may consider methods of data generation that are non-verbal (e.g. Braun & Anderson, 1998). For example researchers may invite participants to convey religious/spiritual experiences or concepts through creative means such as drawing or painting (Coyle, 2008).

## Clinical Implications

This study raises awareness of the need for enquiry surrounding spirituality and religion within therapeutic conversations. Coyle and Lochner (2011) emphasise the importance of psychologists offering an invitation for clients to talk about their spirituality within therapeutic conversations. They caution that the assumption reported within this study amongst others (e.g. Crossley & Salter, 2000) that clients will raise spiritual issues if they are significant to them, may not always be justified. Griffith and Griffith (2002) support this notion suggesting that useful questions for enquiry around spirituality may be; what has sustained you? From what sources do you draw strength? Where do you find peace? Future implications surround training for psychologists where ideas can be generated and encouragement is given to reflect upon when and how to sensitively invite discussion of religious and spiritual experiences within therapeutic conversations.

### *Talking with Clients about Spirituality and Religion*

Within this study it was inferred that at times participants struggled to consider clients' relationship to God and spoke most frequently of beliefs or practices. In their book, Encountering the Sacred in Psychotherapy, Griffith and Griffith (2002) offer perspectives and guidance for considering clients' spirituality within therapy. They warn against centring solely on the concept of beliefs and highlight that this is a western preference not universal to all

religions. Rather they propose numerous genres for expressing spiritual experience, such as metaphors, stories, dialogues, rituals, ceremonies, practices and community. They highlight that beliefs most often denote rights, privileges and entitlements both for the self and others that constitute the 'politics of daily life' (Shotter, 1993, a). As such, they suggest that beliefs more easily become topics of debate and commonly are the medium for political action and the exercise of power. In contrast however they give preference to enquiry about clients metaphors, dialogues and stories. In doing so they advocate for a stance of 'radical listening' whereby attention is given to listening first to what the storyteller thinks about the story he or she is telling rather than considering the validity of a belief.

In line with this therefore, foundationally one implication for training psychologists would be expansion in considering the ways or genres in which spirituality might be experienced and expressed. In this way more avenues may be available to verbally express and articulate spiritual and religious experiences. Doing so may also serve to facilitate psychologists' reflection on their own relationship to spirituality alongside also opening up ways for considering clients' spirituality.

Further to this, Griffith and Griffith (2002) consider spirituality to mean connectedness to God or a spiritual being and suggest that this connectedness holds unique characteristics. For example, a relationship to God may be the only relationship where there are no secrets; it may provide a continuous source of meaning and it may prove to be the only relationship that can be counted on to always be present and available. In accordance with the uniqueness of relationship with the divine, they propose that spirituality can act as a rich resource to therapeutic work.
Participants within this study spoke of psychological theory offering little guidance as to incorporating religion and spirituality into therapy. In addition to this, it was inferred that the theories suggested by participants in making sense of religion and spirituality tended to conceptualise them in pathologising rather than resourceful ways. In response to this, training should seek to equip psychologists to work resourcefully with the strengths

and resilience's that clients' religious and spiritual experiences offer them. A starting point for working resourcefully with peoples' spirituality may be to welcome the voice and perspectives of peoples' God into therapeutic conversations. Within the family therapy tradition it has long been understood that impasses in relationships sometimes can be resolved by adding a new voice to an old conversation that has evolved around the problem. Griffith and Griffith (2002) suggest that new possibilities can sometimes appear when the voice of a person's God is added to the conversation of therapy. Through definition of spirituality as connectedness to God, they suggest that relating in one area can change relating in others.

*Spirituality Expressed Through Community*

The sub-theme religion 'an anchor in distress' represented the role of religion in offering a community, a place of belonging, friendships and practical support. A further implication would be where appropriate for psychologists to include communities within individual work. For example through inviting significant members of the community to meetings with clients. Griffith and Griffith (2002) suggest that clinical work with communities centres on five sets of questions;

1. What constitutes community for the client?
2. What are the expectations of the community?
3. What access does he or she have to the community?
4. What is provided by this community for its' members?
5. What is the role of a guest? How does a clinician enter the community as a respectful and respected guest?

Some of the participants within this study were working with refugee populations where clients frequently identify with both holding an ethnic minority status and affiliating with a religious tradition. Keating (2002) emphasises that rootedness in community seems to lessen the impact of racism and discrimination and inadequate service provision within the lives of Black and ethnic minority clients. In the light of this, the implications of this study suggest that working with communities rather than individuals

may be a central feature of culturally competent and sensitive care. Below, further discussion of service level implications considers the potential for using a community psychology approach to working with local communities.

*Problematic material*

The theme contradictions in practice sought to represent disparity between psychologists' hopes and intentions within practice, whereby religion and spirituality were reported to occur rarely within therapeutic interactions. The sub-theme of meaning making which highlighted the potential for conflicts of faith also stands as a reminder that as much as spirituality and religion can offer resources to therapeutic work they may also raise dilemmas for therapists. Griffith and Griffith (2002) note;

*"how to honour a personal narrative is confusing when the stories, beliefs and traditions that are the core of a person's spiritual life are ones that seem intrinsically destructive. In such situations, a commitment to honour the wisdom of the person's lived experience and ones ethical accountability as a professional can seem mutually exclusive."* Griffith and Griffith (2002, p. 230).

One response, when clients experience distress in connection to religious or spiritual experiences may be consideration of referring the dilemma for a religious specialist such as a chaplain, priest, rabbi or pastor to resolve. Griffith and Griffith (2002) note that sometimes a religious professional can convince a person that destructive beliefs are misinterpretations of the scriptures or doctrines of their religious tradition. The conclusions of this study support the notion of working jointly with members of a person's religious community. Doing so it is suggested may prevent dilemmas related to spirituality and religion from being neglected and enable connection between client and therapist to be sustained whilst widening the circle of perspectives around a problem (McMinn et al., 1998).

Alongside the acknowledgement that the dilemmas raised by destructive uses of spirituality or religion are often too complex for any set of guidelines

to provide clear solutions to, Griffith and Griffith (2002) do offer some ideas for addressing problematic material. They advocate for forming ‘dialogue’ by which they mean a space where attempts are made to level power and all voices can be heard. In establishing this they propose that therapists must focus on the emotional postures they bring to conversations (Fredman, 2007). They propose that attention should be given to the quality of the conversation and the relationship with the person. In creating this kind of space they suggest that questions should be asked of oneself as a therapist and about the other. Given the consideration of wider contexts of influence, such as institutional racism and Islamophobia, one implication of this study would be raising awareness of how these contexts may influence the emotional postures that psychologists bring to conversations about religion. It is suggested here that psychologists must reflect upon emotional postures related to fear and prejudice. The promotion of personal engagement and reflection regarding psychologists’ own relationships to spirituality and religion is a suggestion also widely reported within the literature (Begum, 2012, Souza, 2002). This could take place through training, or within the context of supervision. Aten and Hernandez (2004) highlight that this aim must be accompanied by training for supervisors so that psychologists can feel comfortable and confident in exploring religious and spiritual issues within supervision.

### Service Implications

At the broadest level, this study raises awareness to how cultural and political contexts may hold influence over communication actions within practice. Consideration should be given to how uncomfortable feelings can be held on both individual and collective levels, leading to neglect or avoidance, in this case of different world views and ways of understanding reality (Menzie Lynth, 1960).

This study raises awareness of a disparity between the importance of religion and spirituality to clients who have experienced trauma, the values of participants and the level to which they were equipped through service models, training and theory to engage in and facilitate conversations that utilise spirituality and religion in resourceful ways.

At a service level, one implication suggested here is the need for services to be commissioned, developed and structured in ways that seek to address wider social inequalities. Therefore rather than developing services which impose individualised professionally defined models of health and wellbeing reflecting western constructions of health upon diverse client groups, services should be developed in response to an understanding of what service users and local communities want and need. This could be achieved through asking clients, especially those within minority groups such as refugee populations, and local communities to define their own mental health needs and strengths. Within already existing services taking steps towards this could be achieved through service user involvement and feedback, not only from individual clients but also from local community groups for example, churches, or Mosques. Examples of this exist such as collaboration with a local church pastor reported within Morgan et al's (2009) review of the 'Trailblazers Project' - a project aimed at improving access to Black and Afro-Caribbean men in Hackney.

With regard to new initiatives, Webster and Robertson (2007) suggest that a community psychology approach offers the chance to provide mental health services which are more congruent with community's' own constructions of mental health and wellbeing. They suggest that service planning should be proactive and community-based and that practice should focus on the strengthening of community resources for future prevention within everyday contexts.

In addition to this, Keating (2002) reviewed models of service provision in relation to mental health services for Black and minority ethnic communities. He analysed contributions from different service models, of black-led

initiatives, ethno-specific agencies, multi-cultural agencies and multi-agency partnerships. He concluded that all models made vital contributions to meeting the needs of Black and minority ethnic groups, however Multi-partnership models which bring together local communities, the voluntary sector and the NHS were recommended as a positive way forward. The implications of this study support this notion and suggest that partnerships with local communities and the voluntary sector may facilitate learning on the part of psychology services about how to serve the needs of those for whom religion and spirituality holds importance.

Some examples of multi-agency partnerships working within a community psychology approach already exist, such as the Hackney BME Access Project (Morgan et al., 2009). This project focused on African, Caribbean, Turkish, Kurdish, Orthodox, Jewish and Vietnamese communities and identified barriers to accessing services such as stigma, lack of awareness, accessibility of services and concerns regarding talking therapies such as fear of loss of religiosity. The project was guided by principles of 'cultural humility' - a term used to describe a process that encourages humility on behalf of professionals in how they bring into check power imbalances and maintain mutually respectful partnerships with communities (Tervalon and Murray-Garcia, 1998).

In line with the above, service implications advocate for increased flexibility to enable therapists to hold influence over the number of sessions offered, whether others such as community members can be invited to meetings and whether collaboration with local religious leaders, if necessary is facilitated.

## REFERENCES


Abbas, T. (2004). After 9/11: British South Asian Muslims, Islamophobia, multiculturalism, and the state. *American Journal of Islamic Social Sciences*, *21*(3), 26-38.

Afuape, T. (2012). *Power, resistance and liberation in therapy with survivors of trauma: To have our hearts broken*. Routledge.

Ahluwalia, M.K., Alimchandani, A. (2013) A call to integrate religious communities into practice: the case of Sikhs. *The Counseling Psychologist*. 41(6) 931-956.

Allman, L. S., de la Rocha, O., & Elkins, D. N. (1992). Psychotherapists‟ attitudes toward clients reporting mystical experiences. *Psychotherapy: Theory, Research, Practice, Training*, 29(4), 564-569.

Allport , G. W. (1950). *The individual and his religion: A psychological interpretation*. New York: Macmillan.

Almedom, A. M., Tesfamichael, B., Mohammed, Z. S., Muller, J., Mascie-Taylor, N., & Alemu, Z. (2005). “Hope” makes sense in Eritrean sense of coherence, but “loser” does not. *Journal of Loss and Trauma*, *10*(5), 433-451.

Altmaier, E. M. (2013). Through a glass darkly: Personal reflections on the role of meaning in response to trauma. *Counselling Psychology Quarterly*, *26*(1), 106-113.

American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders* (4th Edition). Washington, DC: American Psychiatric Association.

American Psychological Association. (2002). *Ethical principles of psychologists and codes of conduct*. Washington, DC: APA.

American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice and organizational change for psychologists. *American Psychologist*, 58, 377-402.

American Psychological Association Commission on Accreditation. (2009). *Guidelines and principles for accreditation of programs in professional psychology*. Washington, DC: APA.

Andersson, G., Asmundson, J. G. (2006). Editorial: CBT and Religion. *Cognitive Behaviour Therapy*, 35(1), 1-2.

Andrews, J. (1996). Using a reflexive diary in social constructionist research into clinical practice. *Journal of Psychiatric and Mental Health Nursing*, 3, 267-268.

Arredondo, P., Toporek, R., Brown, S., Jones, J., Locke, D., Sanchez, J., & Stadler, H. (1996). Operationalisation of multicultural counselling competencies. *Journal of Multicultural Counseling and Development*, 24(1), 42-78.

Aten, J. D., & Hernandez, B.C. (2004). Addressing religion in clinical supervision: A model. *Psychotherapy Theory, Research, Practice, Training*, 41(2), 153-160.

Atkin, K. (1996) 'An opportunity for change: voluntary sector provision in a mixed economy of care', in W.I.U. Ahmed and K. Atkin (eds) *Race' and Community Care*, Buckingham: Open University Press.

Baker, M., & Wang, M. (2004). Examining connections between values and practice in religiously committed UK clinical psychologists. *Journal of Psychology and Theology*, *32*(2), 126.

Baker, M. (2011). *Religious and spiritual issues in clinical psychology*. Lecture notes. UK: University of East London.

Bandura, A. (1977). Self-efficacy: toward a unifying theory of behavioral change. *Psychological review*, 84(2), 191.

Becker, C. B., & Zayfert, C. (2001). Integrating DBT-based techniques and concepts to facilitate exposure treatment for PTSD. *Cognitive and Behavioral Practice*, 8, 107-122.

Beckford, M., & Gammell, C. (2009). *NHS staff face sack if they discuss religion. Reported in the Daily Telegraph, 5th December, 2009*.

Beeber, L. S., & Canuso, R. (2005). Strengthening Social Support for the Low‐Income Mother: Five Critical Questions and a Guide for Intervention. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, *34*(6), 769-776.

Begum, N. (2012) *Trainee clinical psychologists talking about religion and spirituality in their work*. Professional doctorate thesis, University of East London.

Berger, P. L., Sacks, J., Martin, D., Weiming, T., Weigel, G., Davie, G., & An-Naim, A. A. (Eds.). (1999). *The desecularization of the world: Resurgent religion and world politics*. Washington, DC: Ethics and Public Policy Center.

Bergin, A. E., Payne, I., & Richards, P. (1996). Values in psychotherapy. In E. Shafranske (Ed.), *Religion and the clinical practice of psychology* (pp. 297-325). Washington, DC: APA.

Berkel, L. A., Constantine, M. G., & Olson, E. A. (2007). Supervisor multicultural competence: Addressing religious and spiritual issues with counseling students in supervision. *The Clinical Supervisior*, 26(1-2), 3-15.

Bernal, M. E., & Padilla, A. M. (1982). Status of minority curricula and training in clinical psychology. *American Psychologist*, *37*(7), 780.

Bhugra, D. and Bahl, V. (1999) *Ethnicity: An Agenda for Mental Health*, London: Gaskell.

Bhui, K. (1997) 'London's ethnic minorities and the provision of mental health services', in S. Johnson, R. Ramsay, G. Thornicroft, L. Brooks, P. Lelliot, E. Peck, H. Smith, D. Chrisholm, B. Audini, M. Knapp and D. Goldberg (eds) *London's Mental Health*, London: Kings Fund.

Bilgrave, D. P., & Deluty, R. H. (1998). Religious beliefs and therapeutic orientations of clinical and counseling psychologists. *Journal for the Scientific Study of Religion*, 329-349.

Bilgrave, D. P., & Deluty, R. H. (2002). Religious beliefs and political ideologies as predictors of psychotherapeutic orientations of clinical and counseling psychologists. Psychotherapy: *Theory, Research, Practice, Training*, 39(3), 245.

Bormann, J. E., Smith, T. L., Becker, S., Gershwin, M., Pada, L., Grudzinski, A. H., & Nurmi, E. A. (2005). Efficacy of Frequent Mantram Repetition on Stress, Quality of Life, and Spiritual Well-Being in Veterans A Pilot Study. *Journal of Holistic Nursing*, *23*(4), 395-414.

Bowleg, L., Huang, J., Brooks, K., Black, A., & Burkholder, G. (2003). Triple jeopardy and beyond: Multiple minority stress and resilience among Black lesbians. *Journal of Lesbian Studies*, 7(4), 87-108.

Boyatzis, R.E. (1998). *Transforming qualitative information: Thematic analysis and code development*. London: Sage.

Braud, W. & Anderson, T. (1998). Editors: *Transpersonal research methods for the social sciences: honoring human experience*. Thousand Oaks, CA: Sage.

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77-101.

Brewin, C., (2011). The Nature and Significance of Memory Disturbance in Post Traumatic Stress Disorder. *Annual Review of Clinical Psychology*, 7, 203-227.

British Psychological Society. (2006). *Core competencies - clinical psychology - A guide*. Leicester: BPS.

British Psychological Society. (2008). *Generic Professional Practice Guidelines*. 2nd Edition. Leicester: BPS.

British Psychological Society. (2009). *Code of ethics and conduct*. Leicester: BPS.

British Social Attitudes. (2010) National Centre for Social Research. *British Social Attitudes Survey*. London

Bulman, R. J., & Wortman, C.B. (1977). Attributions of blame and coping in the “real world”: Severe victims react to their lot. *Journal of Personality and Social Psychology*, 35, 351-363.

Burnham, J. (1992) Approach–method–technique: making distinctions and creating connections. *Human Systems*, 3: 3–27.

Burnham, J. (1993) Systemic supervision: the evolution of reflexivity in the context of the supervisory relationship. *Human Systems*, 4: 349–381.

Burnham, J. (2005) Relational reflexivity: a tool for socially constructing therapeutic relationships. In C. Flaskas, B. Mason and A. Perlesz (eds), *The Space Between: Experience, Context, and Process in the Therapeutic Relationships*. London: Karnac.

Burnham. J., Palmab, D.A., Whitehouse, L. (2008) Learning as a context for differences and differences as a context for learning. *Journal of Family Therapy*. 30: 529–542.

Byrne, A., Warren, A., Joof, B., Johnson, D., Casimir, C., Hinds, C., Mittee, S., Jeremy, J., Afilaka, A. and Griffiths, S. (2011). 'A powerful piece of work': African and Caribbean men talking about the tree of life. *Context*, 117, 40 - 45.

Cadell, S., Regehr, C., & Hemsworth, D. (2003). Factors contributing to posttraumatic growth: A proposed structural equation model. *American Journal of Orthopsychiatry*, 73(3), 279-287.

Callan, A. & Littlewood, R. (1998). Patient satisfaction: Ethnic origin or explanatory model? *International Journal of Social Psychiatry*, 44, 1-11.

Carlin, M. (2009). *Trailblazers: An introduction to talking therapies for African and Caribbean men with mental health problems: An evaluation report*. Mellow. East London NHS Foundation Trust.

Cloitre, M., Koenen, K. C., Cohen, L. R., & Han, H. (2002). Skills training in affective and interpersonal regulation followed by exposure: A phase-based treatment for PTSD related to childhood abuse. *Journal of Consulting and Clinical Psychology*, 70, 1067-1074.

Collins, G. R. (1977). *The rebuilding of psychology: An integration of psychology and Christianity*. Wheaton, IL: Tyndale House.

Commission for Healthcare Audit and Inspection (2007). *Caring for dignity. A national report on dignity in care for older people while in hospital*. London: Healthcare Commission.

Cooper, C. (2012). The place of religious and spiritual beliefs in therapy. Clinical Psychology Forum, 230, 20-24. Coughlan, M., Cronin, P., & Ryan, F. (2007). Step-by-step guide to critiquing research, Part 1: quantitative research. *British Journal of Nursing* 16(11,) 658-663.

Coyle, A. (2007). *Analysing qualitative data in psychology*. London: Sage.

Coyle. A. (2008). Qualitative methods and 'the (partly) ineffable' in psychological research on religion and spirituality. *Qualitative Research in Psychology*, 5(1), 56-67.

Coyle, J., & Lochner, J. (2011). Religion, spirituality and therapeutic practice. *The Psychologist*, 24(4), 264-266.

Crawley, N. (1997). Towards defining spirituality. An exploration of the concept of spirituality. *International Journal of Palliative Nursing*, 3, 31-37.

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *U. Chi. Legal F.*, 139.

Cronen, V. E. & Pearce, W. B. (1985). Towards an explanation of how the Milan method works: An invitation to a systemic epistemology and the evolution of family systems. In D. Campbell and R. Draper (Eds.), *Applications of systemic family therapy: The Milan approach. London*, UK: Grune and Stratton.

Crossley, J. (2000). *Clinical psychologists' understanding of how spirituality is addressed within therapy*. Unpublished Doctoral Thesis, University of Leicester, UK.

Davis, G. Camille, B., Wortman, D, R., Lehman., Cohen, R., Silver, C. (2000). Searching for meaning in loss: Are clinical assumptions correct?. *Death studies*, 24(6), 497-540.

Davis, G., Wortman, C., Lehman, D. R., Cohen, R., Silver, C. (2000). Searching for meaning in loss: Are clinical assumptions correct?. *Death studies*, *24*(6), 497-540.

Delaney, H., Miller, W., & Bisono, A. (2007). Religiosity and spirituality among psychologists: A survey of clinician members of the American Psychological Association. *Professional Psychology: Research & Practice*, 38, (5), 538-546.

Denzin, N. K., & Lincoln, Y. S. (2009). *Qualitative research*. Yogyakarta: PustakaPelajar.

Department of Health (1998). *Data Protection Act 1998*. London: Stationery

Department of Health (2003) *Delivering Race Equality: A Framework for Action* (London: Department of Health).

Department of Health (2005) *Delivering race equality in mental health care: an action plan for reform inside and outside services and the Government's response to the independent inquiry into the death of David Bennett*. (London: Department of Health).

Department of Health. (2009). *Religion or belief: A practical guide for the NHS*. DoH.

Dull, V. T., & Skokan, L. A. (1995). A cognitive model of religion's influence on health. *Journal of Social Issues*, 51(2), 49-64.

Eades, H. (2013). *An exploration of the ways in which Ethiopian refugee people living in the UK understand extreme adversity*. Professional doctorate thesis, University of East London.

Ellis, A. (1971). *The Case against Religion: A Psychotherapist's View*. New York: Institute for Rational Living.

European Monitoring Centre on Racism and Xenophobia (2002) *Summary Report on Islamophobia in the EU after 11 September 2001*. EMCU.

Farr, R.M. & Moscovici, S. (2004). *Social representations*. Cambridge: Cambridge University Press.

Fernando, F. (2010). *Mental Health Race and Culture* (3rd ed). Hampshire: Palgrave Macmillan

Follette, V., Palm, K. M., & Pearson, A. N. (2006). Mindfulness and trauma: Implications for treatment. *Journal of rational-emotive and cognitive-behavior therapy*, *24*(1), 45-61.

Fontana, A. & Rosenheck, R. (2004). Trauma, change in strength of religious faith, and mental health service use among veterans treated for PTSD. *The Journal of Nervous and Mental Disease*, 192, 579-584.

Foskett, J., Marriott, J., & Wilson-Rudd, F. (2004). Mental health, religion and spirituality: Attitudes, experience and expertise among mental health professionals and religious leaders in Somerset. *Mental Health, Religion & Culture*, *7*(1), 5-22.

Foucault, M. (1980). *Power/Knowledge: Selected interviews and other writings 1971-1977*. New York, NY: Harvester Wheatsheaf.

Frankl, V. E. (1962). *Mans search for meaning*. Boston: Beacon Press. (Original Work Published 1948).

Frazier, R. E., & Hansen, N. D. (2009). Religious/spiritual psychotherapy behaviours: Do we do what we believe to be important? Professional Psychology: *Research and Practice*, 40, 81-87.

Fredman, G. (2007). Preparing Our Selves for the Therapeutic Relationship Revisiting 'Hypothesizing Revisited'. *Human Systems: The Journal of Systemic Consultation & Management*. Vol. 18 pp. 44-59.

Freud. S. (1961). The Future of an Illusion, In J. Strachey (Ed.) *Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol. 21*. London: Hogarth Press. (Original work published 1927).

Fudge, E., Falkov, A., Kowalenko, N., & Robinson, P. (2004). Parenting is a mental health issue. *Australasian Psychiatry*, *12*(2), 166-171.

Furedi, F., (2004). *Therapy culture: cultivating vulnerability in an uncertain age. Routledge*: London.

Galen, L. W., & Kloet, J. (2011a). Mental well-being in the religious and the non-religious: Evidence for a curvilinear relationship. *Mental Health, Religion & Culture*, 14, 673–689.

Gallup Jr, G. H. (2014). *The Gallup poll: Public opinion 2014*. Wilmington, DE: Scholarly resources.

Gravell, L. (2007): *A portfolio of academic, therapeutic practice and research work including an investigation into the spiritual and psychological development of a former alcoholic*. Unpublished Practitioner Doctorate (PsychD – Psychotherapeutic and Counselling Psychology) portfolio: University of Surrey.

Gray. P. (1999). 'Voluntary organisations' perspective on mental health needs', in Bhugra, D. and Bahl, V. (eds) *Ethnicity: An Agenda for Mental Health*. London: Gaskell.

Green, J. & Thorogood, N. (2010). *Qualitative Methods for Health Research* (2nd Ed.). London: Sage Publications Ltd.

Griffith, J. L., & Griffith, M. E. (2002). *Encountering the sacred in psychotherapy: How to talk with people about their spiritual lives*. New York: Guilford Press.

Grof, S,, & C. Grof. (1989). *Spiritual emergency: When personal transformation becomes a crisis*. Los Angeles, CA: Jeremy P Tarcher.

Grossman, P., & Van Dam, N. T. (2011). Mindfulness, by any other name: trials and tribulations of sati in western psychology and science. *Contemporary Buddhism*, *12*(01), 219-239.

Gunaratnam, Y. (1993) 'Breaking the silence: Asian Carers in Britain', in Bornat, J., Peteira, C., Pilgram, D. and Williams, F. (eds) *Community Care: A Reader*, London: Macmillan/Open University Press.

Hackney, C. H., & Sanders, G. S. (2003). Religiosity and mental health: A meta-analysis of recent studies. *Journal for the Scientific Study of Religion*, 42, 43–55.

Hage, S. M. (2006). A closer look at the role of spirituality in psychology training programs. *Professional Psychology: Research and Practice*, 37(3), 303-310.

Hall, G. C. N. (2001). Psychotherapy research with ethnic minorities: empirical, ethical, and conceptual issues. *Journal of consulting and clinical psychology*, *69*(3), 502.

Harding, O. G. (2001) The healing power of intercessory prayer: *West Indian Medical Journal*, 50 (4), 269-272.

Harper, D. (2012). Choosing a qualitative research method. In D. Harper & A.R. Thompson (Ed.), *Qualitative Research Methods in Mental Health and Psychotherapy: A Guide for Students and Practitioners* (83-98). West Sussex: John Wiley & Sons Ltd.

Harrison, I. (2013). *NHS ban the terms 'elderly' and 'family doctors'. Reported in the Sunday Post*, 29th September, 2013.

Hathaway, W. L., Scott, S. Y., & Garver, S. A. (2004). Assessing religious/spiritual functioning: A neglected domain in clinical practice? *Professional Psychology: Research and Practice*, 35, 97-104.

Hay, D. (2006): *Something there: the biology of the human spirit*. London: Darton, Longman & Todd.

Hays, P. (2007). *Addressing cultural complexities in practice: Assessment, diagnosis, and therapy* (2nd ed). Washington, DC: American Psychological Association.

Health Professions Council. (2008). *Standards of conduct, performance and ethics*. HPC publication code 20071105bPOLPUB/2008. London: HPC.

Helgeson, V. S., Reynolds, K. A., & Tomich, P. L. (2006). A meta-analytic review of benefit finding and growth. *Journal of consulting and clinical psychology*, *74*(5), 797.

Henwood, K. L., & Pidgeon, N. F. (1992). Qualitative research and psychological theorizing. *British journal of psychology*, 83(1), 97-111.

Herman, J. L. (1997). *Trauma and Recovery: The Aftermath of Violence - From Domestic Abuse to Political Terror*. New York: Basic Books.

Hill, P. C., & Pargament, K. I. (2003). Advances in the conceptualization and measurement of religion and spirituality: Implications for physical and mental health research. *American Psychologist*, 58, 64-74.

Hill, P. C., Pargament, K. I., Hood, R. W., McCullough, M. E., Swyers, J. P., Larson, D. B., & Zinnbauer, B. J. (2000). Conceptualizing religion and spirituality: Points of commonality, points of departure. *Journal for the Theory of Social Behaviour*, 30, 51-77. 103.

Hirsch, M. and Powell, D. (1998). 'Non-governmental organisations and the welfare of minority ethnic communities in Britain and Germany', in Williams, C., Soydan, H. and Johnson, M.R.D. (eds) *Social Work and Minorities: European Perspectives*, London: Routledge.

James, W. (1902). *The varieties of religious experience*. Cambridge, MA: Harvard University Press.

James, W. (1936). *The varieties of religious experience*. New York: Modern Library. (Original work published 1902).

James, W. (1961). *The Varieties of Religious Experience*. New York: Collier. (Original work published 1902).

Janoff-Bulman, R. (2010). *Shattered assumptions*. Simon and Schuster.

Joffe, H. (2012). Thematic Analysis. In D. Harper & A.R. Thompson (Ed.), *Qualitative Research Methods in Mental Health and Psychotherapy: A Guide for Students and Practitioners* (83-98). West Sussex: John Wiley & Sons Ltd.

Joffe, H. & Yardley, L. (2004). Content and thematic analysis. In D. Marks & L. Yardley (Eds.) *Research methods for clinical and health psychology* (pp. 56-68). London: Sage.

Johnson, D. R., Feldman, S. C., Lubin, H., & Southwick, S. M. (1995). The therapeutic use of ritual and ceremony in the treatment of post-traumatic stress disorder. *Journal of Traumatic Stress*, *8*(2), 283-298.

Jordan, M. R. (1995). A spiritual perspective on trauma and treatment. *National Center for Post-Traumatic Stress Disorder Clinical Quarterly*, *5*, 9-10.

Jung, C. G. (1938). *Psychology and religion*. New Haven, CT: Yale University Press.

Jung, C. G. (1989). *Psychology and Religion: West and East* (2nd ed., R. F. C. Hull, Trans.). Princeton, NJ: Princeton University Press. (Origernal work published 1938).

Kalayjian, A. S., Shahinian, S. P., Gergerian, E. L., & Saraydarian, L. (1996). Coping with Ottoman Turkish genocide: An exploration of the experience of Armenian survivors. *Journal of traumatic stress*, *9*(1), 87-97.

Keating, F. (2002). Black-Led Initiatives in Mental Health: An Overview. *Research Policy and Planning*. Vol. 20 no.2.

King-Spooner, S. (2001). The place of spirituality in psychotherapy. In S. King-Spooner & C. Newnes (Eds.) *Spirituality and psychotherapy*. Ross-on-wye: PCCS Books.

King, E. (1996). The use of self in qualitative research. In J. T. Richardson (Ed.). *Handbook of qualitative research methods* (pp 175-188). Leicester: The British Psychological Society.

Koenig, H. G. (2008). Religion and mental health: what should psychiatrists do?. *Psychiatric Bulletin*, 32(6), 201-203.

Koenig, H. G., McCullough, M. E., & Larson, D. B. (2001). Religion and health. New York: Oxford University Press. Kurtz, E. (1999). The historical context. In W. R. Miller (Ed.), *Integrating spirituality into treatment: Resources for practitioners* (pp. 19-46). Washington, DC: APA.

Landsberger, H. A. (1958). *Hawthorne Revisited: Management and the Worker, Its Critics, and Developments in Human Relations in Industry*. Michigan: Cornell University.

Larson, D. B., Hohmann, A. A., Kessler, L. G., Meador, K. G., Boyd, J. H., & McSherry, E. (1988). The couch and the cloth: the need for linkage. *Psychiatric Services*, 39(10), 1064-1069.

Larson, D. B., Thielman, S. B., Greenwold, M. A., (1993) Religious content in the DSM–III–R glossary of technical terms. *American Journal of Psychiatry*, 150, 1884– 1885.

Lavigne, J. V. Faier-Routman, J. (1992). Psychological adjustment to paediatric physical disorders: a meta-analytic review. *Journal of Paediatric Psychology*, 17, 133-157.

Lupton, D. (1999). *Risk*. London and New York: Routledge.

Martinez, S., & Baker, M. (2000). 'Psychodynamic and Religious? 'Religiously committed psychodynamic counsellors, in training and practice. *Counselling Psychology Quarterly*, *13*(3), 259-264.

Masters, K. S., & Kapuscinski, A. N. (2010). The current status of measures of spirituality: A critical review of scale development. *Psychology of Religion and Spirituality*, 2(4), 191-205. 104.

Mayers, C., Leavey, G., Vallianatou, C., & Barker, C. (2007). How clients with religious or spiritual beliefs experience psychological help-seeking and therapy: A qualitative study. *Clinical Psychology and Psychotherapy*, 14, 317-327.

McCullough, M. E., Larson, D. B., & Worthington, E. L. (1998). Mental health. In D. B. Larson, J. P. Swyers, & M. E. McCullough (Eds.), *Scientific research on spirituality and health: A consensus report* (pp. 55–67). Rockville, MD: National Institute for Healthcare Research.

McFadden, S. H. (1995). Religion and Well‐Being in Aging Persons in an Aging Society. *Journal of Social Issues*, *51*(2), 161-175.

McGovern, D. and Hemmings. P.A. (1994) ‘A follow up of second generation Afro-Caribbeans and white British with a first admission diagnosis of schizophrenia: Attitudes to mental illness and psychiatric services of patients and relatives’, *Social Science and Medicine*, 38: 117-127.

McMinn, M. R., Chaddock, T. P., Edwards, L. C., Lim, B. R., & Campbell, C. D. (1998). Psychologists collaborating with clergy. *Professional Psychology: Research and Practice*, *29*(6), 564.

Meador K.G. & Koenig H.G. (2000). Spirituality and religion in psychiatric practice: Parameters and implications. *Psychiatric Annals*. 30:549–555.

Mental Health Foundation (2006). *The impact of spirituality on mental health: A review of the literature*. London: Mental Health Foundation.

Menzies-Lyth, I. (1960). Social Systems as a Defence Against Anxiety. *Human Relations*, 13: 95-121.

Miller, W., & Thoresen, C. E. (2003). Spirituality, religion, and health: An emerging research field. *American Psychologist*, 58(1), 24-35.

Morgan, R., Khan, A., McFarlane, F., Thomas, L. & Ram du Sautoy, S. (2009). Access to talking therapies: The views and experiences of people from Black and minority ethnic communities in secondary care in East London. *Clinical Psychology Forum 196,* 37-40.

Mulla, A. (2011). *How British NHS Clinical Psychologists talk about their experiences of considering spirituality in therapeutic sessions*. Unpublished Doctoral Thesis, University of East London, UK.

Nagai, C. (2008). Clinicians "self-assessment of cultural and spiritual competency: Working with Asians and Asian Americans. *Community Mental Health Journal*, 44, 303-309.

National Office of Statistics (NOS) (2001). *Full Story: What does the Census tell us about religion in 2011?* England and Wales

Ncube, N. (2006). The Tree of Life Project: Using narrative ideas in work with vulnerable children in Southern Africa. *The International Journal of Narrative Therapy and Community Work, 1,* 3-16.

NHS Employers (2010). *Improving Safety for Lone Workers: A Guide for Lone Workers*. London: NHS Employers. Retrieved from: http://www.nhsemployers.org/SiteCollectionDocuments/Improving%20safety%20for%20lone%20workers%20%20workers%20guide%20FINAL.pdf (11January 2013).

Nightingale, D. & Cromby, J. (Eds.) (1999). *Social Constructionist Psychology: A Critical Analysis of Theory and Practice*. Buckingham: Open University Press.

NIMHE (National Institute for Mental Health in England) (2003) *Inside Outside Improving Mental Health Services for Black and Minority Ethnic Communities in England* (London: Department of Health).

Obenchain, J. V. and Silver, S. M. (1992), Symbolic recognition: Ceremony in a treatment of post-traumatic stress disorder. *Journal of Traumatic Stress*, 5: 37–43.

ONS. (2013). Census (2011): *Ethnicity and religion in England and Wales*. London: Office National Statistics.

Oxford Dictionaries Online. (2012). Oxford University Press. Accessed online 14/03/2012 at oxforddictionaries.com/definition/

Paloutzian, R. (2005). Religious conversation and spiritual transformation: A meaning-system analysis. In R. Paloutzian & C. Park (Eds.) *Handbook of the psychology of religion and spirituality*. New York: Guildford.

Papadpoulos, R. K. (2000). A matter of shades: Trauma and psychosocial work in Kosovo. In. N. Losi (ed.), *Psychosocial and trauma response in war-torn societies; the case of Kosovo*. Geneva, Switzerland: International organisation for migration.

Papadpoulos, R. K. (2001). Refuges, therapists and trauma: Systemic reflections. *Context*, 54 (April), 5-8.

Papadpoulos, R. K. (Ed.) (2002). *Therapeutic care for refugees: No Place like home*. London, UK: Karnac Books.

Pargament, K. I. (1997). *The Psychology of Religion and Coping: Theory, Research, Practice*. The Guildford Press.

Pargament, K. I., & Park, C. L. (1995). Merely a defense? The variety of religious means and ends. *Journal of Social Issues*, *51*(2), 13-32.

Pargament, K. I., & Saunders, S. M. (2007). Introduction to the special issue on spirituality and psychotherapy. *Journal of Clinical Psychology*, 63, 903-907.

Pargament, K. I., Desai, K.M., McConnell, K.M. (2006). Spirituality: A pathway to post traumatic growth or decline? In Calhoun, L.G., Tedeschi, R.G (Eds.), *Handbook of Post Traumatic Growth*. New York, USA: Lawrence Erlbaum Associates.

Park, C. L. (2005). Religion as a Meaning-Making Framework in Coping with Life Stress. *Journal of Social Issues*, *61*(4), 707-729.

Park, C. L., & Ai, A. L. (2006). Meaning making and growth: New directions for research on survivors of trauma. *Journal of Loss and Trauma*, *11*(5), 389-407.

Park, C. L., & Cohen, L. H. (1993). Religious and nonreligious coping with the death of a friend. *Cognitive Therapy and Research*, *17*(6), 561-577.

Park, C. L., & Folkman, S. (1997). Meaning in the context of stress and coping. *Review of general psychology*, *1*(2), 115.

Park, C. L., Cohen, L. H., & Murch, R. L. (1996). Assessment and prediction of stress‐related growth. *Journal of personality*, 64(1), 71-105.

Parker, I. (2005). *Qualitative Psychology: Introducing radical research*. Maidenhead: Open University Press.

Patel, C., & Shikongo, A., (2006). Handling spirituality/religion professional training: Experiences of a sample of Muslim psychology students. *Journal of Religion and Health*, 45, (1), 93-112.

Patel, N. (2003). Clinical psychology: reinforcing inequalities or facilitating empowerment?. *The International Journal of Human Rights*, 7(1), 16-39.

Patton, M. Q. (1990). *Qualitative Evaluation and Research Methods* (2nd Ed). Newbury Park, California: Sage Publications Ltd.

Patton, M.Q. (1990). *Qualitative Evaluation and Research Methods* (2nd Ed.). Newbury Park, California: Sage Publications Ltd.

Paul, G. S. (2005). Cross-national correlations of quantifiable societal health with popular religiosity and secularism in the prosperous democracies. *Journal of Religion and Society*, 7(1), 1-17.

Pearce, M. J., Rivinoja, C.M., Koenig, H. G. (2008). Spirituality and health: Empirically based reflections on recovery. In M. Galanter, *Recent developments in alcoholism*. (pp.187-208). New York, NY. Springer.

Plante, T. G. (2007). Integrating spirituality and psychotherapy: Ethical issues and principles to consider. *Journal of Clinical Psychology*, 63(9), 891-902.

Plante, T. G., & Sherma, N. K. (2001). Religious faith and mental health outcomes. In T. G. Plante & A. C. Sherman (Eds.). *Faith and health: Psychological perspectives* (pp. 240-261). New York: Guildford Press.

Plante, T., & Thoresen, C. E. (2012). *Spirituality, religion and psychological counseling*. Oxford University Press handbook of psychology and spirituality, 388-409.

Post, B. C., & Wade, N. G. (2009). Religion and spirituality in psychotherapy: a practice‐friendly review of research. *Journal of clinical psychology*, 65(2), 131-146.

Potter, J. & Hepburn, A. (2005). Qualitative interviews in psychology: problems and possibilities. *Qualitative Research in Psychology*, 2, 38-55.

Prevatt, J. &Park, R. (1989). The Spiritual Emergence Network (SEN). In S. Grof & C. Grof (Eds.), *Spiritual emergency: When personal transformation becomes a crisis*. Los Angeles, CA: Jeremy P Tarcher.

Ren, Z. (2012). Spirituality and community in times of crisis: Encountering spirituality in indigenous trauma therapy. *Pastoral Psychology*, *61*(5-6), 975-991.

Resick, P. A., Galovski, T. E., Uhlmansiek, M. O. B., Scher, C. D., Clum, G. A., & Young-Xu, Y. (2008). A randomized clinical trial to dismantle components of cognitive processing therapy for posttraumatic stress disorder in female victims of interpersonal violence. *Journal of consulting and clinical psychology*, 76(2), 243.

Richards, P. S., & Bergin, A. E. (1997). *A spiritual strategy for counseling and psychotherapy*. Washington, DC: American Psychological Association.

Rose, E. M., Westefeld, J. S., & Ansley, T. N. (2001). Spiritual issues in counseling: Client's beliefs and preferences. *Journal of Counselling Psychology*, 48, 61-71.

Rose, S. (2001). Is the term "spirituality" a word that everyone uses but nobody knows what anyone means by it? *Journal of Contemporary Religion,* (16), 193-207.

Roth, A. and Fonagy, P., (2005). *What Works for Whom? A Critical Review of Psychotherapy Research*. New York: Guilford Press.

Runnymede Trust, *Islamophobia: A Challenge for Us All* (London: Runnymede Trust, 1997); Tahir Abbas, ed., *Muslim Britain: Communities under Pressure* (London: Zed, 2004).

Runswich-Cole, K. (2011). Interviewing. In P. Banister, G. Bunn, E. Burman, J. Daniels, P. Duckett, D. Goodley, R. Lawthom, I. Parker, K. Runswick-Cole, J. Sixsmith, S. Smailes, C. Tindall & P. Whelan (2nd Ed.), *Qualitative Methods in Psychology: A Research Guide* (88-99). Buckingham: Open University Press.

Russell, S. R., & Yarhouse, M. A. (2006). Training in religion/spirituality within APA-accredited psychology predoctoral internships. *Professional psychology: Research and practice*, *37*(4), 430-436.

Ryan, F., Coughlan, M., & Cronin, P. (2007). Step-by-step guide to critiquing research, Part 2: qualitative research. *British Journal of Nursing* 16 (12), 738-744.

Sandhu, S. (2007). *Alternative Pathways Project Report: Action towards alternatives.* London: East London Foundation NHS Trust.

Saunders, S. M., Miller, M. L., & Bright, M. M. (2010). Spiritually conscious psychological care. *Professional Psychology: Research and Practice*, 41(5), 355-362.

Savic, B. (2010). *An exploration of the meaning and relevance of spiritual beliefs amongst survivors of torture*. Professional doctorate thesis, University of East London.

Schaefer, W. E. (1997). Religiosity, spirituality, and personal distress among college students. *Journal of College Student Development* 38, 633–44.

Schottenbauer, M., Glass, C., Arnkoff, D. and Gray, S., (2008). Contributions of Psychodynamic Approaches to Treatment of PTSD and Trauma: A Review of the Empirical Treatment and Psychopathology Literature. *Psychiatry*, 7(1), 13-34.

Schuster, M. A., Stein, B. D., Jaycox, L.H., Collins, R.L., Marshall, G.N., Elliot, M. N. et al. (2001). A national survey of stress reactions after the September 11, 2001, terrorist attacks. *New England Journal of Medicine*, 345, 1507-1512.

Seale, C. (1999). *The Quality of Qualitative Research*. London: Sage Publications Ltd.

Segal, Z. V., Williams, J. M. G. & Teasdale, J.D. (2002). *Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse*. New York: Guildford Press.

Shafranske, E. P. (1996a). Introduction: Foundation for the consideration of religion in the clinical practice of psychology. In E. P. Shafranske (Ed.), *Religion and the clinical practice of psychology* (pp. 1-17). Washington, DC: American Psychological Association.

Shafranske, E. P. (1996b). Religious beliefs, affiliations, and practices of clinical psychologists. In E. P. Shafranske (Ed.), *Religion and the clinical practice of psychology* (pp. 149–162). Washington, DC: American Psychological Association.

Shafranske, E. P., & Gorsuch, R. L. (1984). Factors associated with perceptions of spirituality and psychotherapy. *Journal of Transpersonal Psychology*, 16, 231-241.

Shafranske, E. P. & Malony, H. N. (1990). Clinical psychologists' religious and spiritual orientations and their practice of psychotherapy. *Psychotherapy*, 27, 72-78.

Shaw, A., Joseph, S., & Linley, P. A. (2005). Religion, spirituality, and posttraumatic growth: A systematic review. *Mental Health, Religion & Culture*, 8(1), 1-11.

Shields, M. (2004). Stress, health and the benefit of social support. *Health reports*, *15*(1), 9-38.

Shotter, J. (1993a). *Conversational Realities: Constructing Life Through Language*. Thousand Oaks, CA: Sage.

Silverman, D. (1993). *Interpreting Qualitative Data: Methods for Analysing Talk, Text and Interaction*. London: Sage Publications Ltd.

Smiley, T. (2001). *Clinical psychology and religion: A survey of the attitudes and practices of clinical psychologists in South East England*. (Unpublished Doctoral Thesis), University of Surrey: Surrey, UK.

Smith, B.W., Pargament, K.I., Brant, C. & Oliver, J.M. (2000). Noah revisited: Religiouscoping by church members and the impact of the 1993 Midwest flood. *The Journal of Community Psychology*, 28(2), 169–186.

Smith, D. P., & Orlinsky, D. E. (2004). Religious and spiritual experience among psychotherapists. *Psychotherapy: Theory, Research, Practice, Training*, 41, 144-151.

Smith, J.A. (2008). Introduction. In A.J. Smith (2nd Ed.), *Qualitative Psychology: A Practical Guide to Research Methods* (1-3). London: Sage Publications Ltd.

Smith, S. (2004). Exploring the Interaction of Trauma and Spirituality. *Traumatology*, *10*(4), 231-243.

Souza, K. Z. (2002). Spirituality in counseling: What do counseling students think about it? *Counseling and Values*, 46, 213-217.

Spencer, L. & Ritchie, J. (2012). In Pursuit of Quality. In D. Harper & A.R. Thompson (Ed.), *Qualitative Research Methods in Mental Health and Psychotherapy: A Guide for Students and Practitioners* (227-242). West Sussex: John Wiley & Sons Ltd.

Sperry, L., & Shafranske, E. P. (Eds.). (2005). *Spirituality oriented psychotherapy*. Washington, DC: APA.

Stamogiannou, I. (2007): *A portfolio of academic, therapeutic practice and research work including an exploration of psychotherapists' and client's experiences of addressing spirituality in cognitive-behavioural therapy*. Unpublished Practitioner Doctorate (PsychD) – Psychotherapeutic and Counselling Psychology) portfolio: University of Surrey.

Suarez, V. (2005): *A portfolio of academic, therapeutic practice and research work including an investigation of psychotherapists' and client's accounts of the integration of spirituality into psychotherapeutic practice*. Unpublished Practitioner Doctorate (PsychD) – Psychotherapeutic and Counselling Psychology) portfolio: University of Surrey.

Sue, D. W., & Sue, D. (2003). *Counseling the culturally diverse: Theory and practice*: New York, NY: Wiley.

Summerfield, D. (2002). Effects of war: moral knowledge, revenge, reconciliation, and medicalised concepts of "recovery". *BMJ: British Medical Journal*.

Summerfield, D., (2001). Asylum-seekers, refugees and mental health services in the UK. *Psychiatric Bulletin*, 25, 161-163.

Summerfield, D., Gorst-Unsworth, C., Bracken, P. J., Tonge, V., Forrest, D. M. & Gillian, H. (1991). Detention in the UK of tortured refugees, [letter]. *Lancet*, 338, 58.

Swinton, J. (2001). *Spirituality and mental health care: rediscovering a 'forgotten' dimension*. Jessica Kingsley Publishers.

Tacey, D. (2004). *The spirituality revolution: the emergence of contemporary spirituality*. Hove: Brunner-Routledge.

Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. *Journal of health care for the poor and underserved*, *9*(2), 117-125.

The Runnymede Trust (1997). Islamophobia: A challenge for us all. London.

Thomas, P., Bracken, P., Cutler, P., Hayward, R., May, R., & Yasmeen, S. (2005). Challenging the globalisation of biomedical psychiatry. *Journal of Public Mental Health*, 4(3), 23-32.

Thompson, A.R. & Harper, D. (2012). Choosing a qualitative research method. In D. Harper & A.R. Thompson (Ed.), *Qualitative Research Methods in Mental Health and Psychotherapy: A Guide for Students and Practitioners* (83-98). West Sussex: John Wiley & Sons Ltd.

VandeCreek, L., Pargament, K. I., Belavich, T., Cowell, B., & Friedel, L. (1999). The unique benefits of religious support during cardiac bypass surgery. *Journal of Pastoral care*, 53, 19-19.

Walker, D. F., Gorsuch, R. L., & Tan, S. Y. (2005). Therapists' use of religious and spiritual interventions in Christian counseling: A preliminary report. *Counseling and Values*, *49*(2), 107-119.

Walker, D. F., Gorsuch, R. L., Tan, S. Y., & Otis, K. E. (2008). Use of religious and spiritual interventions by trainees in APA-accredited Christian clinical psychology programs. *Mental Health, Religion and Culture*, *11*(6), 623-633.

Walker, D. F., Reese, J. B., Hughes, J. P., & Troskie, M. J. (2010). Addressing religious and spiritual issues in trauma-focused cognitive behavior therapy for children and adolescents. *Professional psychology: Research and practice*, 41(2), 174.

Watson, J. B. (1983). *Psychology from the standpoint of a behaviorist*. Dover, NH: Pinter. (Original work published 1924).

Watts, F.N. & Williams, M. (1988). *The Psychology of Religious Knowing.* Cambridge: Cambridge University Press.

Weathers, F. W., & Keane, T. M. (2007). The Criterion A problem revisited: Controversies and challenges in defining and measuring psychological trauma. *Journal of traumatic stress*, 20(2), 107-121.

Weathers, F. W., & Keane, T. M. (2007). The Criterion A problem revisited: Controversies and challenges in defining and measuring psychological trauma. *Journal of traumatic stress*, 20(2), 107-121.

Weaver, A. J., Flannelly, L. T., Garbarino, J., Figley, C. R., & Flannelly, K. J. (2003). A systematic review of research on religion and spirituality in the Journal of Traumatic Stress: 1990–1999. *Mental Health, Religion & Culture*, *6*(3), 215-228.

Webster, A., & Robertson, M. (2007). Can community psychology meet the needs of refugees?. *Psychologist*, *20*(3), 156-158.

West, W. (2000). *Psychotherapy and spirituality: Crossing the line between therapy and religion*. London, UK: Sage.

White, M. (2005). Children, trauma and subordinate storyline development. *International Journal of Narrative Therapy & Community Work*, 10,(3-4).

Whittaker, S., Hardy, G., Lewis, K., & Buchan, L. (2005). An exploration of psychological well-being with young Somali refugee and asylum-seeker women. *Clinical Child Psychology and Psychiatry*, *10*(2), 177-196.

Wilkson, S. (2008). Focus groups. In J.A. Smith (2nd Ed.) *Qualitative Research: A Practical Guide to Research Methods* (186-206). London: Sage Publications Ltd.

Williams, F. (1993) 'Gender, 'Race' And Class in British Welfare Policy', in Cochrane, A. and Clarke, J. (eds) (1993) *Comparing Welfare States: Britain in International Context*, London: Sage Publications Ltd.

Willig, C. (2009). *Introducing Qualitative Research in Psychology* (2nd Ed.) Berkshire, England: Open University Press.

Wilson, J. P., & Moran, T. A. (1998). Psychological trauma: Posttraumatic stress disorder and spirituality. *Journal of Psychology and Theology*.

Woodhead, L. & Heels, P. (2004). *The spiritual revolution: why religion is giving way to spirituality*. Oxford: Blackwell.

Worthing, E. L., & Sandage, S. J. (2002). Religion and spirituality. In J. C. Norcross (Ed.), *Psychotherapy relationships that work* (pp. 383-399). Oxford: Oxford University Press.

Worthington Jr, E. L. (1988). Understanding the values of religious clients: A model and its application to counseling. *Journal of Counseling Psychology*, 35, 166-174.

Worthington Jr, E. L., & Aten. J. D. (2009). Psychotherapy with religious and spiritual clients: An introduction. *Journal of Clinical Psychology,* 65(2), 123-130.

Worthington, E., Kurusu, T., McCullough, M., & Sandage, S. (1996). Empirical research on religion and psychotherapeutic processes and outcomes: A 10-year review and research prospectus. *Psychological Bulletin*, 119, 448-87.

YouGov Poll. (2014). YouGovPlc. Accessed online 19/08/2015 at www.YouGov.co.uk.

Young, A. (1995). *The harmony of illusions: Inventing Post-traumatic Stress Disorder*. Princeton, NJ: Princeton University Press.

Zeidner, M., & Ben-Zur, H. (1994). Individual differences in anxiety, coping, and post-traumatic stress in the aftermath of the Persian Gulf War. *Personality and Individual Differences*, 16(3), 459-476.

Zika, S., & Chamberlain, K. (1992). On the relation between meaning in life and psychological well‐being. *British Journal of Psychology*, *83*(1), 133-145.

Zinnbauer, B. J., Pargament, K. I., & Scott, A. (1999). The emerging meanings of religiousness and spirituality. *Journal of Personality*, 67(6), 889-919.

Zinnbauer, B. J., Pargament, K.I., Cole, B., Rye, M. S., Butter, E. M., Belavich, T.G., Hipp, K. M., Scott, A. B., & Kadar, J, L. (1997). Religion and spirituality: Unfuzzying the fuzzy. *Journal for the Scientific Study of Religion*, 36(4), 549-564.

## APPENDICES

### Appendix 1 – Choosing A Method

In consideration of what method to adopt, several approaches were considered. These were, interpretative phenomenological analysis, discourse analysis, grounded theory and thematic analysis. Below I offer information regarding each analysis considered alongside a rationale for why it was or was not chosen.

*Interpretative Phenomenological Analysis (IPA)*

IPA was considered as a viable method to adopt for this study. Smith & Osborn (2008) note that IPA considers the lived experiences of participants. Further to this the primary aim of IPA is to;

"*explore in detail how participants are making sense of their personal and social world*" (Smith & Osborn, 2008, p53).

Willig (2009) highlights that in addition to the above, the role of the researcher is acknowledged and the relationship between the researcher and participant is considered. Although this study sought to consider how psychologists made sense of the roles of spirituality and religion within their practice, including their subjective experiences, the study also sought to consider broader factors that may hold influence over this. In addition to this, IPA requires a homogenous group and given that participants were recruited from different services, and held different preferred therapeutic models, this method was not adopted.

*Discourse Analysis (DA)*

Willig (2009) notes that DA considers the role of language in the construction of reality. In line with this DA focuses on;

"*what people do with language and it emphasizes the performance qualities of discourse*" (Willig, 2009,p.95)

As an example, it may explore the function and consequences of making reference to certain things such as ‘religious coping’ or ‘low mood’. Potter & Hepburn (2005) suggest that DA is most appropriate for the study of naturally occurring text and conversation. Therefore with regard to this study DA was not deemed appropriate.

*Grounded Theory (GT)*

Green and Thorogood (2010) suggest that the primary purpose of GT is to produce new theories that are grounded within empirical data. It can however also be used for exploratory research questions. However Willig (2009) contends that doing so, results in engagement in a descriptive rather than an explanatory exercise, which does not produce new theories. On this basis, she suggests that GT should be assigned to the study of social psychological processes. In line with this, GT was therefore excluded as a viable method for this study.

*Thematic Analysis (TA)*

For a rationale of why TA was employed please the Method section.

**Appendix 2 – Participant Information Sheet**

**INFORMATION SHEET ABOUT A STUDY EXPLORING HOW CLINICAL PSYCHOLOGISTS MAKE SENSE OF THE ROLES OF RELIGION AND SPIRITUALITY WITHIN THEIR CLINICAL PRACTICE WORKING WITH ADULTS WHO HAVE EXPERIENCED TRAUMA**

Dear Sir/Madame,

My name is Philippa Harbidge. I am a Clinical Psychology Trainee studying at the University of East London. Below are some answers to questions that you might have about the study to help you decide whether you wish to take part.

**What is the research about?**

The aim of this research is to develop a better understanding of how psychologists make sense of the roles of religious and spiritual beliefs within their clinical work with adults who have experienced trauma. I am interested in how psychologist's work with and make sense of different cultural frameworks and belief systems within their practice. It is hoped that information gathered during the course of the study can contribute to our understanding of how clinical psychologist's can help people who have experienced trauma. It is hoped that the findings of this research will be useful to health professionals and may serve to direct training within this area.

**What is required of you if you decide to take part?**

If you agree to take part, you will be invited to share your experiences of religion and spirituality within your clinical practice working with adult clients who have experienced trauma. The interview will be audio recorded and may last from 60 to 90 minutes. The interview will take place either in your place of work within a private space or at the University of East London research suite. You are allowed to withdraw from the study at any time, if

you change your mind, even in the middle of the interview the information you have provided will be destroyed and not used.

**What will happen to the information I provide?**

The information you provide for the purposes of the study will be kept confidential. Names and identifying features will be altered in transcripts, thesis extracts and any resulting publications, to protect anonymity. Contributions may be identifiable by readers from within your team/organisation (both professionals and service-users) however this will be minimised by careful selection of quotations. Consent forms and transcripts will be kept in a locked environment. I will transcribe the interviews. Only supervisors, my examiners, and myself will have access to transcripts. Transcripts will be kept for 3 years after the completion of the study.

**What will happen to the results of the research study?**

The results obtained from this research will be incorporated into a doctoral thesis that will be submitted to the University of East London. The thesis may be published in an academic journal in the future.

**What happens afterwards?**

I will be available to discuss any concerns or questions you have throughout and after the interview session.

**Who can I contact if I have any questions now?**

If you have any further questions, you can contact:

Philippa Harbidge (Trainee Clinical Psychologist at the University of East London) u1235016@uel.ac.uk

Dr Nimisha Patel (Clinical Psychologist/Academic Tutor at the University of East London) nimisha_evaluation@hotmail.co.uk

**Thank you**

## Appendix 3 – Consent Form

Participant Identification Number:

### CONSENT FORM

**An exploration of how clinical psychologists make sense of the roles of religion and spirituality in their clinical practice working with adults who have experienced trauma.** Name of Researchers: Philippa Rose Harbidge & Nimisha Patel

1. I confirm that I have read the information sheet for the above study and I have been given a copy of the information to keep. ☐
2. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
3. I understand what is being proposed and the procedures in which I will be involved have been explained to me. ☐
4. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. Should I choose to withdraw from the study, any data I have provided will be withdrawn from the study and not used in the final analysis. ☐
5. I agree to the interview being audio recorded. ☐
6. I understand that my involvement in this study and the particular data from this research will remain confidential. Only the researcher(s) involved in the study will have access to Identifying data. ☐
7. I agree to take part in the above study. ☐

| | | |
|---|---|---|
| Name of Participant | Date | Signature |
| Person taking consent | Date | Signature |

**Appendix 4 – Interview Schedule**

**An exploration of how psychologists make sense of the role of religion and spirituality within their clinical practice working with adults who have experienced trauma.**

**Introduction**

- Recap aims of interview
- Re-visit consent to record, right to withdraw and confidentiality.
- Opportunity to ask questions.

**Audio Test**

Could you tell me your name, and where you are working at the moment?

1. Can you tell me what you understand by the terms spirituality and religion?

2. How do you think spirituality and religion are relevant to you personally and/or professionally?

3. How have spirituality and/or religion been salient in your clinical work, with clients who have experienced trauma?
   *Prompt if necessary: How would you define trauma? How do your clients understand trauma and issues of R/S in relation to their experiences of trauma?*

4. Can you describe clinical situations where spirituality and/or religion became relevant or highlighted for you or your clients?
   *Prompt if necessary - When, how/ in what way? If not, why – perhaps issues of R/S not important or raised by client/ by yourself?*

5. In your clinical practice, how do you make sense of the roles of spirituality and/or religion in people's difficulties in relation to trauma experiences?
   *Prompt if necessary - How did you decide when and how to address spiritual and/or religious issues or not? What resources did you draw on to make sense of the roles of spirituality and religion in these example(s)?*

6. How have you made sense of religious or spiritual beliefs, which you have felt to be very different or very similar to your own?
   *Prompt if necessary - What thoughts and feelings did you experience? What was the influence of the psychological model/your approach on this process?*

**Closing**

- Review consent again. Ask if there is any information that they are concerned about having given during the interview, check out how the participant is feeling, and whether any additional support is needed, explain how and when research findings will be made available, thank participant for agreeing to participate and for their time.

## Appendix 5 – University of East London Ethical Approval

SCHOOL OF PSYCHOLOGY
Dean: Professor Mark N. O. Davies, PhD, CPsychol, CBiol.

UEL
University of East London
www.uel.ac.uk

**School of Psychology**

**Professional Doctorate Programmes**

To Whom It May Concern:

This is to confirm that the Professional Doctorate candidate named in the attached ethics approval is conducting research as part of the requirements of the Professional Doctorate programme on which he/she is enrolled.

The Research Ethics Committee of the School of Psychology, University of East London, has approved this candidate's research ethics application and he/she is therefore covered by the University's indemnity insurance policy while conducting the research. This policy should normally cover for any untoward event. The University does not offer 'no fault' cover, so in the event of an untoward occurrence leading to a claim against the institution, the claimant would be obliged to bring an action against the University and seek compensation through the courts.

As the candidate is a student of the University of East London, the University will act as the sponsor of his/her research. UEL will also fund expenses arising from the research, such as photocopying and postage.

Yours faithfully,

Dr. Mark Finn

Chair of the School of Psychology Ethics Sub-Committee

Stratford Campus, Water Lane, Stratford, London E15 4LZ
tel: +44 (0)20 8223 4966 fax: +44 (0)20 8223 4937
e-mail: mno.davies@uel.ac.uk web: www.uel.ac.uk/psychology

## Appendix 6 – Ethical Approval from the Joint Research and Development Office

[redacted] NHS
Research Support Service
[redacted]

30 September 2014

Philippa Rose Harbidge
[redacted]

Dear Philippa Rose Harbidge

I am pleased to confirm that the following study has now received R&D approval, and you may now start your research in **the trust(s) identified below**:

**Study Title:** An exploration of how clinical psychologists make sense of the roles of religious and spiritual beliefs within their therapeutic work with adults who have experienced trauma
**R&D reference:** 157053
**REC reference:** N/A

This NHS Permission is based on the REC favourable opinion given on N/A and the most recent amendment submitted to REC on N/A

| Name of the trust | Name of current PI/LC | Date of permission issue(d) |
|---|---|---|
| [redacted] | [redacted] | 30 September 2014 |
| [redacted] | [redacted] | 30 September 2014 |

**If any information on this document is altered after the date of issue, this document will be deemed INVALID**

| Specific Conditions of Permission (if applicable) |
|---|
| |

**If any information on this document is altered after the date of issue, this document will be deemed INVALID**

Yours sincerely,

[redacted]
Research Operations Manager

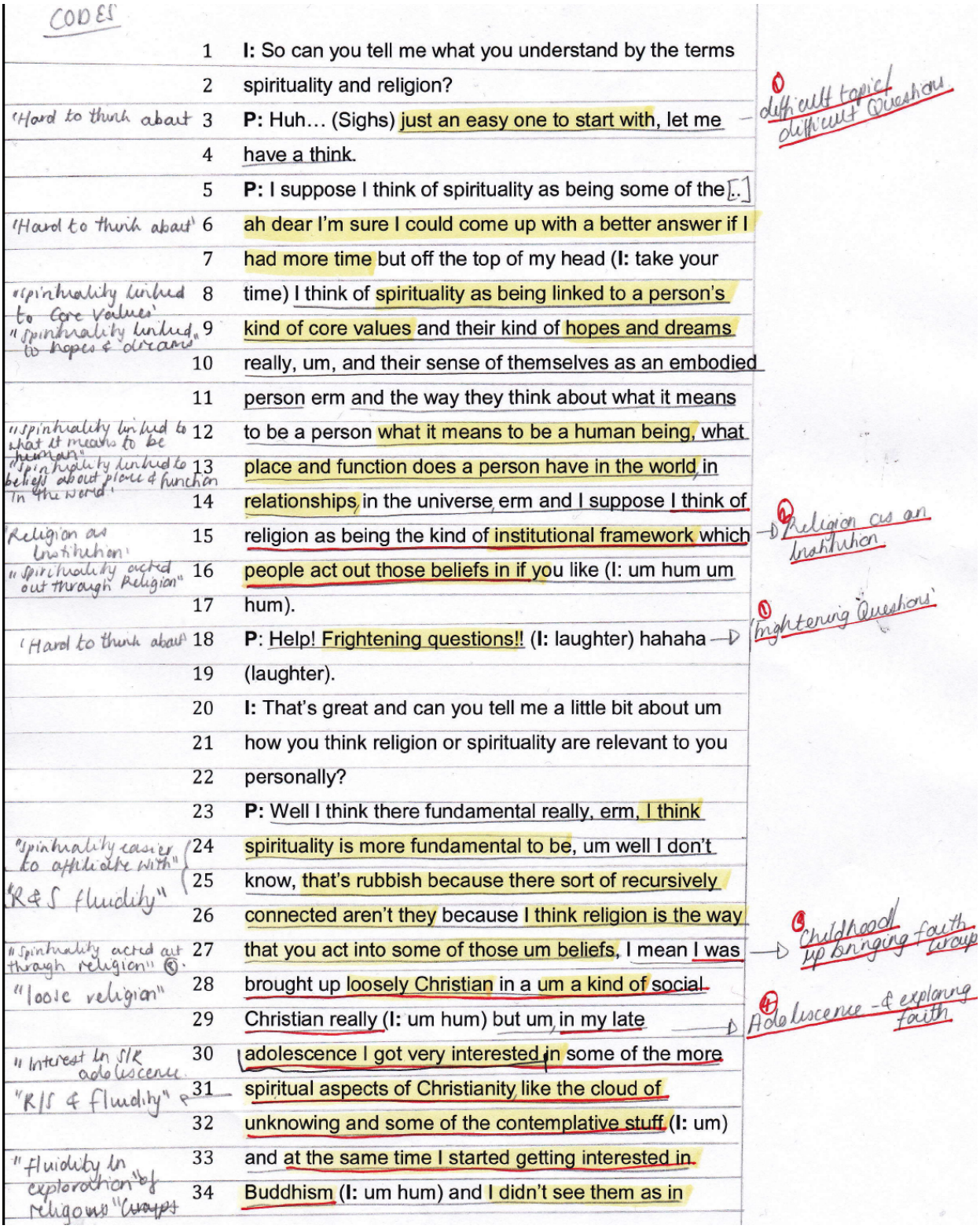
Cc: Principle Investigator(s)/Local Collaborator(s), Sponsor Contact

[redacted] NHS
Research Support Service
[redacted]

May I take this opportunity to remind you that during the course of your research you will be expected to ensure the following:

- **Patient contact:** only trained or supervised researchers who hold the appropriate Trust/NHS contract (honorary or full) with each Trust are allowed contact with that Trust's patients. If any researcher on the study does not hold a contract please contact the R&D office as soon as possible.
- **Informed consent:** original signed consent forms must be kept on file. A copy of the consent form must also be placed in the patient's notes. Research projects are subject to random audit by a member of the R&D office who will ask to see all original signed consent forms.
- **Data protection:** measures must be taken to ensure that patient data is kept confidential in accordance with the Data Protection Act 1998
- **Health & safety:** all local health & safety regulations where the research is being conducted must be adhered to.
- **Serious Adverse events:** adverse events or suspected misconduct should be reported to the R&D office and the Research Ethics Committee.
- **Project update:** you will be sent a project update form at regular intervals. Please complete the form and return it to the R&D office.
- **Publications:** it is essential that you inform the R&D office about any publications which result from your research.
- **Ethics:** R&D approval is based on the conditions set out in the favourable opinion letter from the Research Ethics Committee. If during the lifetime of your research project, you wish to make a revision or amendment to your original submission, please contact both the Research Ethics Committee and R&D Office as soon as possible.
- **Monthly / Annually Progress report:** you are required to provide us and the Research Ethics Committee with a progress report and end of project report as part of the research governance guidance.
- **Recruitment data:** if your study is a portfolio study, you are required to upload the recruitment data on a monthly basis in the website: http://www.crn.nihr.ac.uk/can-help/funders-academics/nihrcrn-portfolio/recruitment-data/
- **Amendments:** if your study requires an amendment, you will need to contact the Research Ethics Committee. Once they have responded, and confirmed what kind of amendment it will be defined as, please contact the R&D office and we will arrange R&D approval for the amendment. If your study is Portfolio Adopted, amendments must be submitted for R&D review via the NIHR CRN (CSP), please refer to the Amendments Guidance for Researchers: http://www.crn.nihr.ac.uk/can-help/funders-academics/gaining-nhs-permissions/amendments/
- **Audits:** each year, noclor select 10% of the studies from each service we have approved to be audited. You will be contacted by the R&D office if your study is selected for audit. A member of the governance team will request you complete an audit monitoring form before arranging a meeting to discuss your study.

## Appendix 7 – Worked Extract Example



## Appendix 8 – Coding Manuel

1. Abandoning religion
2. Affiliation to a spiritual/religious group
3. Affiliation to being non-religious
4. Ambivalence about being organised
5. Anti-religion: connected to experiencing torture/extremist regimes
6. Asking about spirituality/religion (difficult)
7. Being a materialist (spirituality as immaterial/ supernatural)
8. Being careful in talk about religion/spirituality
9. Being rigorous in practice
10. Belief Frameworks
11. Client's experience: Talking about spirituality/religion different to therapist (difficult)
12. Clients difficulties
13. Clients meaning making define trauma
14. Clients meaning making of trauma
15. Clients talking about struggles with faith with non-religious therapist (difficult)
16. Clinical Psychology current times: A new realism
17. Colleagues relationship to religion and spirituality
18. Context cultural climate
19. Cumulative trauma
20. Debates around defining trauma
21. Demarcating personal and professional stories
22. Desire for congruence between personal and professional self
23. Difference between therapist and client(s)
24. Difference between therapist and clients (felt to be navigated successfully)
25. Difference hindering exploration
26. Difficult attributed to ignorance
27. Difficulty attributed to lack of experience
28. Difficulty talking about examples of working with R/S in practice
29. Economic climate

30. Emergence of interest: adolescence
31. Example offered but spiritual/religious aspects unclear
32. Expert discourses (negative impact on R/S in work)
33. Exploration process leading to depth
34. Exposure/ embarrassment talking about religion/spirituality
35. Facilitating exploration of spirituality
36. Faith important to client
37. Faith used in therapeutic work (positive)
38. Fear of offence
39. Fear of what religion does (negative)
40. Fluidity between religion and spirituality
41. Fluidity in achieving congruence between personal and professional selves
42. Fluidity in exploration
43. Getting other perspectives
44. Hard to explore
45. Hard to talk about spirituality/religion with clients
46. Hard to think of clinical examples
47. Helpful/holding quote/phrase
48. Hesitancy to demarcate trauma
49. Important not to get too evangelical
50. Lack of congruence between personal and professional self dissatisfying
51. Lack of exploration by therapist: suggests lack of interest
52. Legitimacy
53. Living some of the principles/ Useful Ideas
54. Loose religion
55. Making sense of R/S difficult to think about
56. Meaning of trauma connected to religion & culture.
57. Mismatch diagnosis vs. clients definitions of what has been traumatic
58. Navigating conversations: Feelings in the room (discomfort)
59. Navigating difference between therapist and clients (difficult)
60. Need to be grounded in reality

61. No enquiry spiritualty/religion
62. Not making any assumptions
63. Persecution from extremist regimes: Clients views negative
64. Personal and professional values connected
65. Personal experience of religion/spirituality as a resource in difficult times
66. Personal values coherent with client values: comfort
67. Personal/professional interface and organizational culture
68. Pressure to divide the personal/professional self
69. Psychoanalytic model: What clients bring
70. PTSD (negative)
71. Reflection on lack of enquiry through comparison to other areas
72. Reflection: Further exploration
73. Relating to religion/spirituality in different ways
74. Religion and spirituality absent
75. Religion arising through exploration of social networks
76. Religion as a cultural way of life Vs. Religion as beliefs about relating to God
77. Religion as a means to organize and divide
78. Religion as core to self
79. Religion as dangerous/abusive
80. Religion as devout
81. Religion as institution
82. Religion as primitive
83. Religion as steadying/stabilizing
84. Religion protective: a community
85. Religion, culture, ethnicity: overlap
86. Religion: protective (risk/harming self)
87. Religion/Spirituality a difficult topic
88. Religion/Spirituality and organizational context (negative)
89. Religion/Spirituality and organizational context (positive)
90. Religion/Spirituality hard to think about
91. Religion/Spirituality important to understand clients
92. Religious affiliation as private

93. Religious beliefs and experience of religious community connected (negative)
94. Resistance to being labeled as new age/alternative
95. Resourceful aspects of religion/spirituality
96. Resources from ‘social graces’
97. Satisfaction in congruence personal and professional identities
98. Self re-assurance in relation to ‘not knowing”
99. Separation beliefs and practice
100. Sharing religious affiliation with colleagues
101. Spiritual beliefs acted out through religion
102. Spiritual discourse is shy
103. Spirituality and religion personally important
104. Spirituality as connection to past generations Spirituality as transcendence
105. Spirituality easier to affiliate with
106. Spirituality experienced through nature
107. Spirituality expressed through congruence with psychological ideas/approaches
108. Spirituality linked to beliefs about place and function in world
109. Spirituality linked to core values
110. Spirituality linked to hopes and dreams
111. Spirituality linked to meaning of being a human being
112. Spirituality linked to relationships/ connectedness
113. Spirituality: as experiences outside of ordinary experience
114. Spirituality: personalized versions
115. Spirituality/ religion connected to ethics
116. Spirituality/religion absent
117. Strong religious ideas and reality
118. Struggle congruence between personal and professional selves
119. Talking about clients meaning making
120. Talking about clients understanding of trauma
121. Talking about religion/spirituality - Shame
122. Talking about religion/spirituality - Sounding foolish
123. Talking about spirituality/religion overlap: talking about ‘meaning’

124. Talking about spirituality/religion with clients
125. Theoretical meaning making: God constructed as symbolic not real.
126. Therapeutic approach: ‘being neutral’
127. Therapeutic intention: working with religious beliefs
128. Therapeutic work: applying rational paradigm
129. Therapist cautiousness with spirituality/religion due to non-religious affiliation
130. Therapist preconceptions: clients religious status/experience
131. Therapists theoretical meaning making: Religion as a ‘belief system’
132. Trauma – an overused term
133. Trauma a westernized concept: (no translation)
134. Trauma and effect on spiritual/religious beliefs: different for different people.
135. Trauma and therapeutic techniques
136. Trauma as common
137. Trauma as disconnection
138. Trauma as impact on the person
139. Trauma defined through diagnosis/symptoms
140. Trauma difficult to define
141. Trauma leading to strengthening of religious faith
142. Trauma specific services and treatments (negative)
143. Trauma specific services and treatments (positive)
144. Trauma: beliefs Will of God (helpful)
145. Trauma: beliefs Will of God (unhelpful)
146. Trauma: PTSD
147. Unclear: How to and when to name Spirituality/religion
148. Understanding clients’ identity
149. Understanding clients’ reality
150. Unknown territories: worrying
151. Using religion/spirituality as a resource: helped by others
152. Why questions – spiritual and philosophical
153. Working appreciatively

154. Working with different beliefs to own: difficult

**Appendix 9 – Coded Extract Example**

| Number | Initial Code | Participant Number and Line Number |
|---|---|---|
| 116. | Spirituality and Religion Absent | **“**So I think the only times I’ve ever had to really think oh, huh we’re going to really have to really kind of have a very hard look at your religious beliefs have been cases where, there must have been two or three cases I’ve seen in twenty years where they blame themselves for a rape for example or a murder someone close to them has been murdered or something like that and they blame themselves because of a religious understanding” 1: 216-233 |
| | | “I think its sort of notable in its absence, I think you know when I heard about your study and I thought about it I wasn’t quite sure why that is, I think um, I think you know when I go about doing an assessment with somebody I’m interested in finding out about what ever it is that they bring about themselves and I wouldn’t necessarily enquire about religion and spirituality although thinking about it now I don’t know why I wouldn’t” 2:89-94. |
| | | “but I suppose I’m not sure if this is quite what your asking here but I feel like religion in particular isn’t actually something that comes up very often in my work in sessions with people which when I first heard about your study really made me think about that, how little it comes up” 3: 60-65<br><br>“so I was, I was trying to remember times when |

| | | |
|---|---|---|
| | | people had talked about their religion because I wouldn't really bring it up, I mean partly because I mostly work in a psychodynamic way where you wouldn't, I would follow what somebody else says, I mean there are things for instance if somebody never mentioned their family then I would ask them about it but if somebody never mentioned their religious belief I realize that I wouldn't necessarily ask them about it, I would just assume that it wasn't something um they felt that they wanted to bring, but I suppose its very possible that somebody might have a religious belief that they felt I wouldn't be interested in" 3: 75-86. |
| | | "keeps people safe, stops them harming themselves or committing suicide um, ad that I think that's the way that it comes up with most clients In terms of in the therapy it doesn't come up a massive a huge amount to be honest in terms of the nitty gritty content of the work" 4: 155-160<br><br>"I guess I don't actually ask about spiritual beliefs um directly as a specific question religion we do ask because its on our assessment form and its on all the NHS stuff so you kind of they need to know and I know its something that you know, I've worked in various places and its been like you actually have to record this because its one of those figures that's actually looked at um but I guess that's a way that it might come up its just a label more than anything else I guess it isn't something I'm not looking for it unless its risk in which case I'm hoping its there" 4: 329-339. |

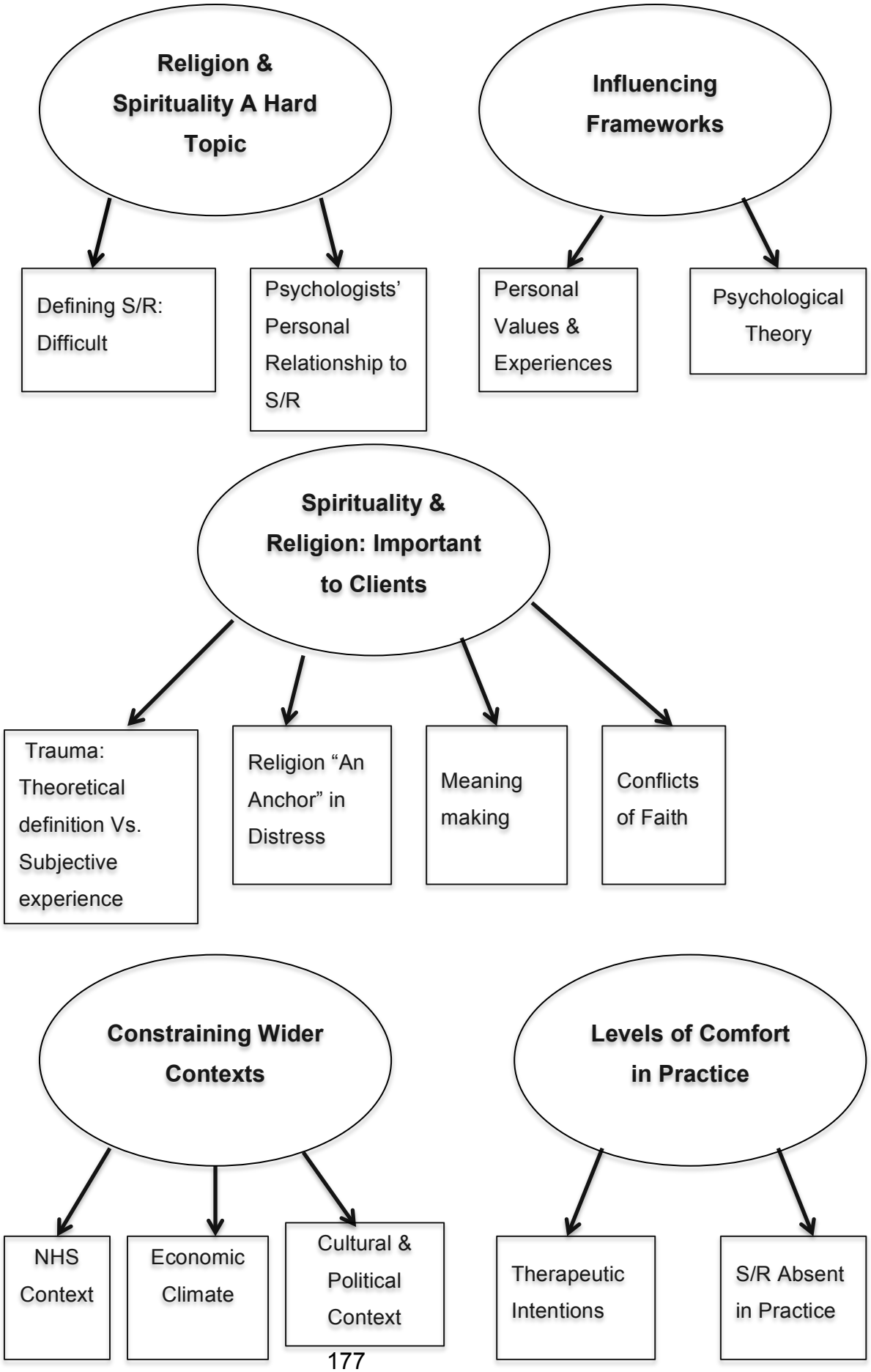
| | | |
|---|---|---|
| | | "it isn't something that I'd specifically check out with everyone and I think spirituality I kind of neglect maybe because… I don't really know what it is I don't know I guess with spirituality I kind of group maybe wrongly, because it depends how you define spirituality because I think sometimes erm I don't know maybe I've got some bias around thinking, you know magical thinking and erm and not thinking there's as much potential use" 4: 352-360 |
| | | "I mean I really must be honest I'm quite bad about thinking about spirituality and religion only I realize now as we're talking about it, its only as a protective factor that you really think about it, are they going to kill themselves or not, no, great er you know thank God, you know that there's something they're hanging onto or it's a political thing but it doesn't often, I suppose I don't readily use it, I mean I have to say I don't think I factor in religion and spirituality that much, unless a client really brings it, because I sort of don't factor it into my own life that much" 5: 234-244.<br><br>"I think its possibly because it feels, sometimes I think it feels a bit wishy washy that's awful, I realize how awful it is because its erm please tell me that other people have said this, er I suppose yeah I think back to my training and we had an afternoon on spirituality and the first thing I thought is er can I bunk off this its just so.. what's the point erm I'm not saying that you wouldn't factor it in if it was clearly a problem, so if you were working with people with |

| | | |
|---|---|---|
| | | schizophrenia who have kind of delusional beliefs that are religiously based then of course it would be part of your formulation erm but I kind of just thought, I guess it gets lost somewhere in what feel more concrete beliefs, but I wonder whether that's because we're scientists and you know and we kind of, we don't do that and it feels a bit flimsy erm but of course what's happening there is you're bringing what you think is important into your therapeutic relationship and that's not good because you wouldn't do it in any other sphere but you would do it with religion and spirituality you'll just think, well, I don't know it isn't something that seems to come up here" 4: 513-533.<br><br>"It's been really interesting to have a think about what I think about it - it's it's kind of surprisingly almost embarrassingly like quite um kind of unfamiliar topic of conversation within this setting. um given like how much religion plays such a central role in our client's lives and communities and families" 5: 565-570 |
| | | "I think its interesting because at (name of educational institution) I would have gone much more strongly into peoples um religious beliefs than I do here and I think I need to think about that for myself, um because I don't think we pay enough attention to them." 8: 505-510. |

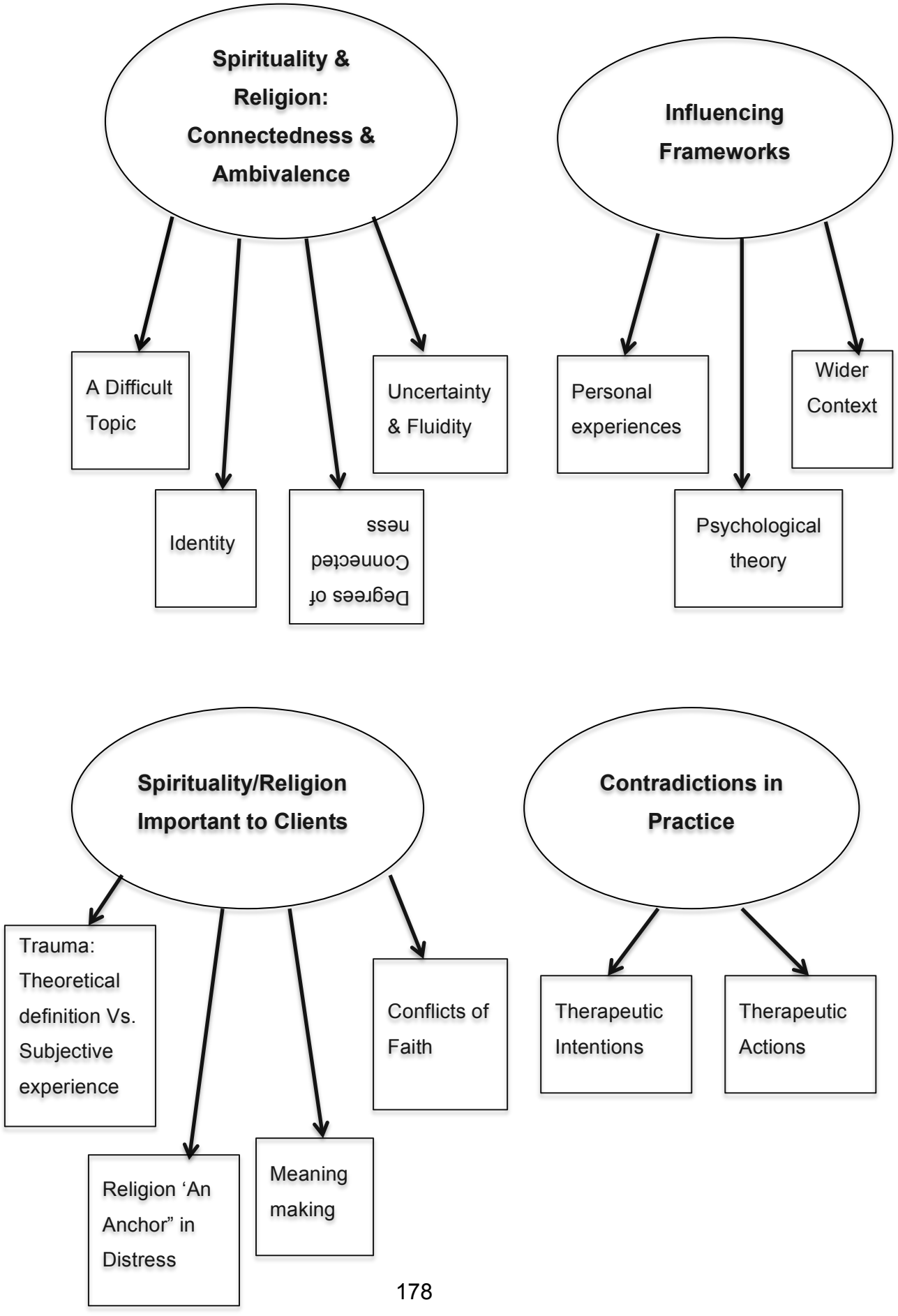
## Appendix 10: Provisional Themes

1. Personal relationships to spirituality & religion
2. Spirituality & religion: Hard to define
3. Experience of talking about spirituality & religion
4. Personal & professional values connected
5. Conceptualising trauma
6. Trauma: Spirituality & Religion - Important
7. Trauma: Spirituality & Religion – Helpful
8. Trauma: Spirituality & Religion - Unhelpful
9. No enquiry about spirituality & religion
10. Spirituality & Religion: Psychological Theory
11. Spirituality & Religion: Absent
12. Therapeutic intensions
13. Experience of talking about spirituality and religion with clients
14. Working with beliefs different to own: Difficult
15. Wider context constraining: Economic
16. Wider context: Cultural/Political (ISIS, radicalisation)
17. Wider context: NHS
18. Wider context: Organisational Values

**Appendix 11 - Thematic Map 1**



**Appendix 12 - Thematic Map 2**



**Appendix 13 - Thematic Map 3**