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Doctoral Degree in Clinical Psychology

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CHAPTER 1: INTRODUCTION

> 'No other human preoccupation challenges psychologists as profoundly as religion. *Whether or not they profess to be religious themselves*... psychologists must take religion into account if they are to understand and help their fellow human beings' (Wulff, 1991, p.3, cited in Richards & Bergin, 2000).

Collicut (2011, p.258) argued that "religion is a profoundly human phenomenon and therefore amenable to study by psychologists". Just as religion is often described as playing a fundamental role in the lives of many individuals, so also is spirituality (Cohen, 2002; Miller, Chan Gardner & Prather, 2013). Increasing numbers of studies continue to highlight the role religion and/or spirituality play in the well-being of many individuals (e.g., Richards & Potts, 1995; Malloy, Lewis & Day, 1999; Leeuwenthal & Lewis, 2011; Nicolas, 2011). It therefore seems a relevant area for applied psychologists to be exploring in order to establish ways in which to adequately work with religious and spiritual issues as presented by clients during therapeutic encounters.

In this chapter, a brief description of my literature search process is provided. This is followed by a literature review on religion, spirituality and psychology. Within the literature review, the issues of definitions, terminology, historical and contemporary context, religion and spirituality in therapy and religious and spiritual competency are addressed. Finally, the research aims and questions of this study are explicated.

1.1 Literature Search Process

The search terms religion, spirituality AND clinical psychology; religion AND psychology; spirituality AND psychology; religion, spirituality AND clinical psychology IN mental health; psychology, religion, spirituality AND competency; and spirituality, competence, clinical psychology were used in database searches. The databases searched included EBSCO Host databases Academic Elite, PsychINFO and

Towards Religious/Spiritual Competence for Applied Psychologists in NHS Settings in the UK

Precious I. Koce

A thesis submitted in partial fulfilment of the requirements of the University of East London for the degree of Doctor of Clinical Psychology

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Abstract

The profession of psychology in the UK is gradually showing signs of renewed interest in the area of religion/spirituality (e.g., Collicut, 2011). The present study aimed to (i) explore applied psychologists' accounts of their practice in the NHS, UK, with clients with religious/spiritual issues; and (ii) from these accounts identify participants' indications of religious/spiritual competencies. Thematic analysis as outlined by Braun and Clarke (2006) was employed and subscribed to a critical realist position. Data was gathered through conducting semi-structured interviews with eight participants employed in the NHS. Following analysis, six super-ordinate themes were presented: [1] broad characteristics attributed to religion/spirituality, [2] personal attributes, [3] knowledge, [4] practice elements, [5] challenges faced when working with and acknowledging the role of religion/spirituality for clients, and [6] developing practice and raising visibility – training and practice.

These themes captured the diverse nature of participants' encounters with issues of religion/spirituality in their clinical work. The complex and diverse roles of religion/spirituality were seen across accounts. Three of the six themes - 'personal attributes', 'knowledge' and 'practice elements' - were instrumental in indicating how participants work with clients' religious/spiritual issues. It appears that in the absence of appropriate training and professional guidance, participants needed to draw on their own personal experience, professional interests and knowledge in order to engage with and meet the needs of clients for whom religion/spirituality is important.

The following broad areas were suggested as participants' indications of religious/spiritual competencies: [1] Recognising the 'broad characteristics attributed to religion/spirituality'; [2] Possessing certain 'personal attributes'; [3] Having 'knowledge'; and [4] Engaging in certain 'practices'. However, further research and substantial refinement is needed before these areas of competencies can be considered viable. Methodological limitations are considered and further research and professional implications are highlighted.

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Finally, I would like to give my utmost gratitude to God, for His grace and strength has sustained me through this programme and especially through the writing of this thesis.

CHAPTER 1: INTRODUCTION

> *"No other human preoccupation challenges psychologists as profoundly as religion. Whether or not they profess to be religious themselves... psychologists must take religion into account if they are to understand and help their fellow human beings*" (Wulff, 1991, p.3).

Collicut (2011, p.250) argued that "religion is a profoundly human phenomenon and therefore amenable to study by psychologists". Just as religion is often described as playing a fundamental role in the lives of many individuals, so also is spirituality (Cohen, 2002; Ivtzan, Chan Gardner & Prashar, 2013). Increasing numbers of studies continue to highlight the role religion and/or spirituality play in the well-being of many individuals (e.g., Richards & Potts, 1995; Maltby, Lewis & Day, 1999; Loewenthal & Lewis, 2011; Nickles, 2011). It therefore seems a relevant area for applied psychologists to be exploring in order to establish ways in which to adequately work with religious and spiritual issues presented by clients during therapeutic encounters.

In this chapter a brief description of my literature search process is provided. This is followed by a literature review on religion, spirituality and psychology. Within the literature review, the issues of definitions, terminology, historical and contemporary context, religion and spirituality in therapy and religious and spiritual competency are addressed. Finally, the research aims and questions of this study are explicated.

1.1 Literature Search Process

The search terms r*eligion, spirituality* AND *clinical psychology; religion* AND *psychology; spirituality* AND *psychology; religion, spirituality* AND *clinical psychology* IN *mental health*; *psychology, religion, spirituality* AND *competency; and spirituality, competence, clinical psychology* were used in database searches.

The databases searched included EBSCO Host databases, Academic Elite, PsycINFO and PsycARTICLES; SAGE Journals; and Google Scholar. In addition, reference sections of identified articles were perused for further related articles.

It is important to highlight that the majority of literature available and thus reviewed on religion, spirituality and psychology and therapeutic practice originated from the United States of America (USA)[1].

1.2 Definitions and Terminology

Multiple and expanding definitions of 'religion' and 'spirituality' have been offered by social science researchers. Clinicians and theologians agree that societal and scholarly definitions of religion and spirituality are changing, and despite extensive theoretical discourse and empirical research, there is still no overarching or agreed-upon definition or standard operationalisation of either

[1] This is not surprising, considering that the USA has a more religious culture in comparison to the United Kingdom (UK) (British Humanist Association, 2013). Within the sphere of psychology, the American Psychological Association (APA) has a specific Division 36 'Psychology of Religion' dedicated to exploring and developing the area of religion and more recently spirituality from a psychological stand point. This division has been established for over 30 years and has promoted a number of APA publications in the area (e.g., Pargament, Exline, & Jones, 2013). In addition, there is a substantial number of USA-based psychology-relevant scholarly journals of religion/spirituality. In contrast, publications in the UK have been relatively few and far between, though the launch of British journal, 'Mental Health, Religion, and Culture' in 1998 and 'Psychology and Religion UK' network in 2006, has galvanized increased interest and publication in the area.

Within the applied (rather than academic) branch of the literature, it may be important to bear in mind other features. (i) The health care system in the USA is markedly different from that in the UK. Clients/patients in the USA pay for their health care but in the UK health care is freely available to all. In addition, clinicians in the USA are more likely to be exposed to and thus familiar with issues of religion and spirituality. With such a difference, it is not unlikely that the clients/patients in the USA will be expecting their clinicians to work in a way that is congruent with their religious and/or spiritual beliefs, and this pressure may make applied psychologists more aware of meeting the expectation. (ii) There is a preponderance of working with clients from Judeo-Christian traditions in this literature and very little focus on other religious traditions. (iii) The empirical literature on applied psychologists and religious and/or spiritual issues is not infrequently drawn from fairly large groups of participants that combine applied psychologists with other practitioners (e.g., medics, social workers, counsellors, etc.) and then uses generic words such as 'clinicians' when discussing the findings.

term (Moore, Kloos & Rasmussen, 2001). Zinnbauer, Pargament and Scott (1999) and Moberg (2001) for example, suggested that religion and spirituality fall on several polarized dimensions: negative-positive, organized-personal, substantive-functional, and so on. Koenig (2008) argued that from a research perspective it is important to clearly define and demarcate the terms religion and spirituality, by looking more closely at what they entail.

1.2.1 Religion

Religion has been recognized as being a central part of human experience and culture for centuries. Traditionally, the term was used to refer to all aspects of the human relationship to the 'divine' or 'transcendent'. However, in recent years, the term has come to be understood as activities, distinctive habits, practices, a way of life, commitments, beliefs and ways of thinking (Nelson, 2009). Hill et al. (2000) describe religion as the adherence to a belief system and a set of practices associated with a tradition and a community in which there is general agreement about what is believed and practiced. According to Schlehofer, Omoto and Adelman (2008), religion represents a set of organized practices established by tradition and conducted in a central place of worship. It holds a substantive focus on its practices, beliefs, and emotions. Based on these definitions, the concept of religion appears to entail both elements of cognition (beliefs) and of behaviour (practices).

1.2.2 Spirituality

Nelson (2009, p.8) described spirituality as a "broad term encompassing multiple domains of meaning that may differ among various cultural, national, and religious groups". Features like 'multiple domains' led Rose (2001) to express that the term spirituality was often used without anyone really knowing what it means or refers to. In an attempt to distinguish between spirituality and religion, Koenig (2008) and Casey (2009) pointed out that spirituality was once seen as central to and part of religiosity, and thus focused on the supernatural (e.g., God or a power transcending oneself). It was also perceived as a feeling of closeness and

connection to the sacred that stimulates a sense of intimacy, engendering feelings that include awe and wonder (Worthington & Aten, 2009). This conceptualization was similar to Zinnbauer et al.'s (1999), who described spirituality as something more personal, consisting of a lived consciousness of relating to a higher power.

However, more recently, there has been a shift in this conceptualization and spirituality has begun to encompass those who are not religious. For example, Gollnick (2004) claims that spirituality carries the connotation of self-reflection on the elements of a person's identity, values and worldview. Spirituality is increasingly being viewed as an individualized, internal and value-based connection to the transcendent, which is at times disconnected from mainstream and organized religious institutions (Sperry & Shafranske, 2005). Within these recent conceptualizations, an individual can self-define as spiritual but not religious, focusing more on personal growth and identity.

1.2.3 The Use of the Terms Religion and Spirituality

Patel and Shikongo (2006) and Ghorbani, Watson and Khan (2007) argued that one of the sources of confusion when it comes to how the terms religion and spirituality are used, was the way the terms were defined in western academia. They noted that the terms were [1] either used interchangeably, [2] treated as distinct concepts or [3] were seen as overlapping concepts. Koenig (2008) also explored and described the ways in which the use of the term spirituality had changed over the years (from a term that traditionally described the deeply religious person to a term that can now include the superficially religious person, the religious seeker, the seeker of well-being and happiness, and the completely secular person) and the implication that this could have on research and clinical settings. Whilst it is essential to identify and agree on a definition of the terms, religion and spirituality, Bartoli (2007) highlights the importance of being aware of each clinician and client's conceptualization of religion and spirituality, as these will be influenced and dependant on their cultural background and life experiences. As a result, she suggests that it is essential to invite clients to

explain/share their understanding of these terms and for clinicians to be aware of their own views on these terms. Considering the diversity which exists between and within different cultures and religious or spiritual beliefs and practices this is an important point to reflect on.

Hill et al. (2000) make the case for a non-polarised conceptualization of religion and spirituality (an example of the concepts being seen as overlapping as mentioned above). They claim that both religion and spirituality encompass two main components; a concept of the sacred (i.e. a perception of some source of ultimate reality or divine being/object) and a search for what is sacred (i.e. the articulation of understanding and maintaining a relationship with one's own personal god). However, religion was described as encompassing two additional components that spirituality does not: a search for the non-sacred (e.g. feelings of safety, hope arising out of a sense of community within a religious group) and a prescription of legitimate means and methods by which to search for the sacred (e.g., religious rituals such as baptism, organized prayers). Similarly, Sperry and Shafranske (2005) posited that these two terms were related and shared qualities which overlapped. Koenig's (2008) view about the degree of religion-spirituality relatedness is that more caution should be taken over defining and/or distinguishing between the terms when conducting research. Nevertheless, he suggests that *as* clinicians, using terms which are inclusive is important for making patients/clients - who have different religious backgrounds or no religion, a wide range of personal beliefs, and come from different cultures - feel welcomed, supported and heard in the health care system. He argues that for clinical work, "a broad, nebulous and diffuse term such as spirituality is ideal" (Koenig, 2008, p.354).

In this present study, I am aware of and acknowledge the importance of ongoing debate about carefully defining and distinguishing between these terms. However, in addressing the research questions for this study, bearing in mind that the findings are intended to address clinical practice, I will conceptualise the terms in a similar manner to Hill et al. (2000) and Sperry and Shafranske (2005) and thus use the term 'religion/spirituality'. This is inclusive enough to capture individuals who are religious and spiritual, religious but not spiritual, and spiritual

but not religious. Individuals who are not religious or identify as being atheist, agnostic, etc., will be referred to as such. Mulla (2011) and Begum (2012) also held and used a similar conceptualisation in their studies.

1.3 Context: Religion/Spirituality and Psychology

In this section I will briefly outline parts of the historical and contemporary context of religion/spirituality and psychology, looking at the relationship between these two areas and how it has developed over several decades. The literature in historical context covers the time period up to 1990 whilst literature in current context covers the time period from 1990 to the present.

1.3.1 Historical Context

Traditionally, psychology as a discipline had historical roots in philosophy and religion/spirituality (Vande Kemp, 1982). However, scholars of psychology have often been divided in their opinions about religion/spirituality. For example, pioneers such as William James, Carl Jung and Abraham Maslow engaged with them and perceived the psychological aspects of human religiousness to be part of their analysis of human potential. James (1902, cited in Haque, 2001) argued that religiousness was an essential aspect of the human psyche, and that religious inspiration, when combined with 'superior intellect', led humankind to its greatest heights of thought and achievement. Similarly, Jung (1928) was of the opinion that people possess 'a natural religious function and that their psychic health and stability depended on the appropriate expression of it' (cited in Fordham, 2004, p.1). Maslow (1970) made the case that spiritual values had naturalistic meaning which did not need supernatural concepts to validate them and thus was not the exclusive possession of organized religion. He claimed that spiritual values were within the jurisdiction of a suitably enlarged science. In other words, spiritual values, which include religious and transcendent experiences, should be the concern of professionals such as psychologists. However, these views were in stark contrast to scholars like Sigmund Freud and B.F. Skinner.

Freud (1927) was of the opinion that religion was best understood as an illusion resulting from wish fulfilment and claimed that psychological growth beyond an infantile stage could only occur with the abandonment of religion. Whilst Skinner (1953) was of the opinion that religious behaviour was no different from other behaviour which occurs because of what he described as techniques for shaping and modifying that behaviour (techniques based on rewards and punishments, also known as reinforcement). He argued that "the religious agency" was a "special form of government under which 'good things', personified as a god, are reinforcing and 'bad things', which result in the threat of hell, is an aversive stimulus", and that both these shape behaviour (cited in Jeeves, 2000, pp.2-3; Haque, 2001).

The influence of these scholars' writing in the area of religion/spirituality has been noted as contributing to the decline and inattention in the area. Bartoli (2007) argued that such writings tended to position religion/spirituality as a form of pathology or characteristic of people from a distant past or place (i.e., outside of the Western sphere). With some psychologists holding views such as these, I imagine that open exploration of religion/spirituality in therapeutic settings, both for clients and clinicians, would have been particularly challenging.

Maslow (1970, p.11) argued that "both science and religion have been too narrowly conceived and too exclusively dichotomized and separated from each other, that they have been seen to be two mutually exclusive worlds". Shafranske and Gorsuch (1984) added to this by suggesting that psychology's desire to detach itself from philosophy and be recognised and respected as an empirical science led to some of the non-obliging attitude of inattention shown towards religion/spirituality. Whilst many early psychologists were interested in or sympathetic toward religion/spirituality, none of the four eventually dominant approaches to psychology (behaviourist, psychodynamic/psychoanalytic, medical (antidepressants and antipsychotics, and cognitive psychological) has been forthcoming towards religion/spirituality (though some might argue that they had been more benign toward spirituality than religion) (Nelson, 2009).

It has also been suggested that the personal beliefs of psychologists are likely to have influenced (and continue to do so) the profession's attitude towards issues of religion/spirituality (Shafranske & Gorsuch, 1984). A number of studies have highlighted that psychologists are generally less religious/spiritual as a group compared to the general population. Some of these studies (e.g. Leuba, 1934; Ragan, Malony & Beit-Hallahmi, 1980; Shafranske & Gorsuch, 1984) showed that psychologists were unrepresentative of religious affiliation patterns in the USA population – most of them described religion as unimportant in their lives, in contrast to the general population (a survey conducted in the UK by Smiley in 2001 also demonstrated similar findings). However, these surveys do not explore psychologists' lack of affiliation and neutralised views of religion/spirituality. It is also unknown what their personal experiences were of religion/spirituality and how these might be influencing their views and attitudes (although Hodge & Bushfield (2006) have theorised their possible intrusion into psychological therapy as 'spiritual counter-transference').

1.3.2 Contemporary Context

Patel and Shikongo (2006) reported that there has been a significant rise of research interest in the role of religion/spirituality in improving the physical and mental health of individuals and communities. They noted that several professions including psychiatry, social work, nursing and (to a noticeably lesser degree) psychology, have begun to address the need to include religious/spiritual issues in their training programmes and professional practice. In addition, the subject of religious/spiritual issues relevant to mental health is becoming increasingly more visible in psychological literature (see table 1.1 below). In recognising the renewed academic interest of the relationship between psychology and religion, Hall, Francis and Callaghan (2011) attributed this change to individuals who were both psychologically and theologically trained. This development may be linked to the increasing awareness of the importance of cultural diversity in the society and thus a need for professional practice that is culturally competent for those it seeks to serve. There has been a growing recognition of just how multicultural, multiracial and multilingual societies such as

the USA and UK are (e.g., Sue, Arredondo & McDavis, 1992; Sue & Sue, 1999; Sue, 2001; Office for National Statistics, 2013). Sue (2001) put forward the idea of multiple levels of personal identity (i.e., individual – uniqueness; group – shared cultural values and beliefs with reference groups; and universal – common features of being human) and argued that a holistic approach to understanding personal identity demands that we recognise all these levels. He claims that ''psychological explanations that acknowledge the importance of group influences such as gender, race, culture, sexual orientation, socioeconomic class, and *religious orientations* lead to more accurate understanding of human psychology'' (Sue, 2001, p.794, *emphasis added*).

The profession of applied psychology is gradually showing more signs of renewed interest in the area of religion/spirituality (Tan, 1996; Bartoli, 2007; Delaney, Miller & Bisono, 2007; Collicut, 2011). Gollnick (2004) noted that, within the last few decades humanistic and transpersonal influences in psychology have broadened clinical practice to include religious/spiritual issues. There have also been a number of studies from the profession, exploring topics such as: the relationship between clients' religion/spirituality and mental and physical health (e.g., Carr, 2000; Seybold & Hill, 2001; Mayers et al., 2007; Loewenthal & Lewis, 2011); clinicians' experience and attitudes towards religion/spirituality (e.g., Abernethy & Lancia, 1998; Baker & Wang, 2004; Delaney et al., 2007); integrating religious/spiritual aspects into therapy (e.g., Tan, 1996; Gollnick, 2004; Barnett & Johnson, 2011; Coyle & Lochner, 2011; Dailey et al., 2011); and religion/spirituality and training (e.g., Aten & Hernandez, 2004; Patel & Shikongo, 2006; Bartoli, 2007).

In addition, within the USA, a series of publications on religion/spirituality and psychology by the American Psychological Association (APA) (2002), APA approval of religiously orientated doctoral programmes, and changes in the APA ethical guidelines all show a change of direction towards the profession's inclusion of religion/spirituality. Applied psychology still has some way to go in the UK before it engages with the role of religion/spirituality in clients' lives to the same extent. Some might want to argue that the UK has been equally as proactive as the USA in its engagement with the topic area. However, these

engagements have predominantly been on an academic level. There has been far less research focusing on the personal and professional (applied/clinical) involvement of psychology and religion/spirituality and the transferring of this knowledge to practice. That is not to say that there is no movement in this direction. For example, in April 2011 the British Psychological Society (BPS) publication, *The Psychologist*, featured a special issue on *psychology, religion and spirituality*. The articles featured were both academically and professionally relevant. Mulla (2011) and Begum (2012) are also recent examples of research with both academic and professional practice relevance in relation to religion/spirituality and psychology. In addition, the BPS publication *Clinical Psychology Forum* recently included two articles in a special issue on *diversity*, on the importance of considering religion/spirituality of clients in therapy (Cooper, 2012; Peden, 2012).

Table 1.1 Literature Publications for Religion/Spirituality and Mental Health

Years of publication	Citations for thesaurus terms "mental health" and "spirit*" (*average per year*)		Citations for thesaurus terms "mental health" and "relig*" (*average per year*)	
1960-1969	66[2]	(6.6)	315	(31.5)
1970-1979	107	(10.7)	505	(50.5)
1980-1989	214	(21.4)	576	(57.6)
1990-1999	958	(95.8)	1284	(128.4)
2000-2009	3617	(361.7)	4159	(415.9)
2010-April 2013	1481	(493.7)	1813	(604.3)

In summary, Aten and Hernandez (2004) and Dein (2004) highlighted that with the population who identify as being religious/spiritual, and expressing an interest in therapy that includes their belief in some way, the likelihood of psychologists working with religious/spiritual issues is high. If this is the case, it is important to consider how equipped applied psychologists are to work with these issues. To answer such a question, more research is needed to explore existing knowledge and practice in this area. It is hoped that through this research study, further

[2] The figures were derived from a search in PsycINFO, with a limiter set to look at citations every decade from the 1960s to April 2013.

clarity can be gained as to how applied psychologists in the UK NHS work with religious/spiritual issues.

1.4 Religion/Spirituality in Therapy

In this section literature on clinicians working with issues of religion/spirituality in therapy is presented and discussed. Important factors for consideration such as issues of concern, assessments and interventions, and training are highlighted.

1.4.1 Working with Issues of Religion/Spirituality in Applied Psychology – Some Concerns

Religion/spirituality can have an impact on some individuals' mental/physical health, which makes it an important area for clinicians to be mindful of during their encounters with these clients. There is a growing literature base showing positive relationships between a person's religious/spiritual involvement and their mental and physical health (e.g., Schnittker, 2001; Coruh, et al., 2005; Cohen, Yoon & Johnstone, 2009; O'Connell & Skevington, 2010). For a significant number of clients, religion/spirituality are essential aspects of their sense of self, worldview, and belief system (Richards & Bergin, 2005; Bartoli, 2007; Barnett & Johnson, 2011). However, the potential for religion/spirituality to adversely affect mental health has also been highlighted by some authors (e.g., Exline, Yali, & Sanderson, 2000; Reeves, Beazley & Adams, 2011). Taking into consideration the potential for both positive and negative relationships, Payne, Bergin, Bielema and Jenkins (1991, p.11) put forward the point that a more useful question to ask was "*how a person is religious (*e.g., intrinsic and extrinsic orientation, level of commitment, and activity level*) rather than whether a person is religious (*i.e., affiliation*)".*

According to Barnett and Johnson (2011), contemporary psychotherapists continue to debate the appropriate lines between psychotherapy and spiritual direction or religious intervention. Whilst it is generally agreed that clinicians

should engage with their client's meaning-making systems and life worlds, clinicians are often wary of colluding with what might be dysfunctional religious/spiritual beliefs and practices (Coyle & Lochner, 2011). This might in part be because some mental health difficulties such as 'delusions' have been noted as being fuelled (not necessarily caused) by religious ideas in some patients. Thus some clinicians may view working with clients' religious ideas as acting on their 'delusional beliefs' which could be detrimental to their health. In addition, the interpretative act of differentiating spiritual experience from 'psychotic delusions' with religious content can be very challenging (Reeves, et al., 2011) and highly contextual, as the meaning attributed to these experiences are likely to vary from culture to culture (O'Grady & Bartz, 2012). Also, religion in particular has been viewed as a source of discrimination and oppression for certain group of people, e.g., women, people who are lesbian, gay or bisexual (das Nair & Thomas, 2012). It has been suggested that when engaging in psychotherapeutic work with a highly religious client, clinicians may experience anxiety-provoking questions about the professional and ethical appropriateness of addressing religious beliefs and practices (Barnett & Johnson, 2011).To meet this, Yarhouse and VanOrman (1999) argued that clinicians are ethically obligated to make efforts to become knowledgeable about different religions and to consult with other professionals about the religions they lack knowledge in. They further add that greater awareness of religion and religious values in clients' lives may drive efforts to provide more accurate assessments and effective interventions.

1.4.2 Working with Issues of Religion/Spirituality in Applied Psychology – Assessments and Interventions

A growing body of literature examining how various psychotherapeutic domains approach religion/spirituality has developed in recent years (e.g., Tan, 2003; Mayers et al., 2007; Coyle & Lochner, 2011; Cooper, 2012). These works have focused less upon the potential for a negative relationship, and have given consideration to how clinicians can respond constructively to religious/spiritual issues in ways that are respectful, meaningful, and ethical, during therapeutic encounters.

Hodge (2004), Hodge and Bushfield (2006), Dailey et al. (2011) and O'Grady and Bartz (2012) introduced the use of religious/spiritual assessment instruments and techniques in exploring issues of religion/spirituality in psychotherapy/counselling. These include the use of informal assessment tools such as spiritual genograms and/or life maps, timelines, and ecomaps. They suggest that the use of such techniques will assist clinicians in conducting comprehensive and meaningful assessments which pay attention to issues of religion/spirituality as it relates to individual clients. O'Grady and Bartz (2012) also recommended a list of questions which psychotherapists could use during informal assessments to differentiate between spiritually transcendent experience and 'psychopathology'. They maintain that the use of these questions along with comprehensive clinical interviews during assessments is likely to reduce the occurrence of 'misdiagnosis'.

Coyle and Lochner (2011) explored ways in which clinicians could work with clients' religious/spiritual issues in therapeutic practice. They suggested that along with the implementation of standard principles of good clinical practice, certain key areas needed to be given due consideration in order to work in a meaningful manner with clients' religious/spiritual issues. These areas were assessment, responding to problematic religious/spiritual material, and training and supervision. They emphasised that it was important to include clients' religious/spiritual perspectives and experiences in the initial assessment. With regards to responding to problematic religious/spiritual material, it was suggested that clinicians had the option of liaising with and referring clients to relevant religious/spiritual practitioners (e.g., a priest, rabbi or imam), or work with clients to reframe their problematic religious/spiritual material in ways that are helpful and consistent with clients' beliefs. Finally, emphasis was placed on the importance of making training in the area of religion/spirituality available to supervisees and supervisors alike (Coyle & Lochner, 2011).

Though Coyle and Lochner's (2011) provide useful discussion with regards to working with clients' religious/spiritual issues, their commentary and suggestions were based on a review of other articles (which were almost all commentaries

themselves) and a case study, rather than on empirical findings. This current study will aim to explore applied psychologists' accounts of working with issues of religion/spirituality and provide information and recommendations based on the findings.

A similar study conducted by Mulla (2011) explored British clinical psychologists' experience of considering religion/spirituality in therapeutic sessions. She found that clinicians felt that including clients' religious/spiritual beliefs in sessions, formulations and interventions had a positive value in terms of engagement and outcome. Her findings also revealed that there was a need for greater tolerance of and more adequate training in working with people with religious/spiritual beliefs. Mulla's study concluded by recommending further research to continue in-depth investigation of this area.

Cooper (2012) discussed the place of religious/spiritual beliefs of clients in therapy and argued that it was equally important to take these into account as it was any other area of diversity. She pointed out that a number of behaviours and processes such as, clinicians' being aware of their own religious/spiritual beliefs and working with community religious/spiritual leaders, needed to be considered. She argued that in order for clinicians to confidently and competently address issues of religion/spirituality in therapy, the provision of appropriate levels of training and reflective space is needed. Though this seems an obvious need, it is an area that has continuously been identified as lacking. I will discuss this further in the section below.

1.4.3 A recognised Gap in Professional Training Programmes

Shafranske and Gorsuch (1984) suggested that in responding to issues of religion/spirituality, psychologists appeared to be relying on their subjective experience as a guide for understanding the client's phenomenal world. This is unsurprising given the lack of attention and training in the area of religion/spirituality. A number of studies (e.g., Aten & Hernandez, 2004; Cassidy, 2006; Bartoli, 2007; Mulla, 2011) have highlighted that despite the apparent

increased interest in and acceptance of religion/spirituality by many psychologists, it still remains that training in this area is scarce, with very few trainees reporting adequate training and supervision to 'competently' address religion/spirituality in therapy. Hage (2006) argued that trainees lacking knowledge of research on the role of religion/spirituality in mental well-being may inappropriately disregard important aspects of client's religious/spiritual background that could provide therapeutic benefit. She suggests that the failure to integrate aspects of religion/spirituality into psychological training may have significant consequences for the overall well-being of individuals and families.

The BPS, the professional body for psychologists practicing in the UK, has developed a number of generic and specific professional practice guidelines. With regards to issues of diversity, the Code of Ethics and Conduct calls for psychologists to "respect individuals'' cultural and role differences, including their religious status' (BPS, 2009, p.10). Though the practice guidelines for counselling psychologists also refer to religious views, it is only mentioned in the negative context of encouraging counselling psychologists to "*challenge the views of people who pathologise on the basis of such aspects as sexual orientation, disability, class origin or racial identity and religious and spiritual views"* (BPS, 2005, p.7*)*. The guidelines do not inform clinicians of how to address issues of religion/spirituality in their therapeutic work and why it is important to do so. For example, they do not illustrate how 'respecting an individual's religious status' would translate in therapeutic encounters, what an applied psychologist would need to be doing/not doing to demonstrate this respect. This for me raises concerns and perhaps indicates some of the reasons behind the lack of appropriate training in matters concerning religion/spirituality: no agreed curriculum has been put forward.

Bartoli (2007) observed that for some clinicians, this gap in training (and in accrediting by authorities) means that they are left to seek further training and develop relevant competencies on their own. Drawing on the work by Sue and Sue (1990) and Richards and Bergin (2000), she described a number of ways in which clinicians can enhance their competencies in addressing religious/spiritual issues in clinical practice. These include [1] being conscious of one's own views,

perspectives, and biases on religion/spirituality (self-awareness); [2] acquiring information about various religious/spiritual frameworks and how these might impact clinical work (knowledge); and [3] learning specific techniques/therapeutic approaches that are congruent with clients who are religious/spiritual (skills). Greater emphasis was placed on clinicians developing self-awareness, and exercises were suggested to support this endeavour. While all this is clearly useful, it is optional post-qualification continuing professional development, rather than part of a pre-qualification training programme.

1.5 Religious/Spiritual Competency

This section concerns the concept of competency and how it pertains to clinicians' practice in relation to religion/spirituality. Following a definition and brief contextual background, an illustrative account of guidelines from two non-psychology professions about how best to work with clients' religion/spirituality is provided. The section ends with a summary and consideration of the current position of applied psychologists with regards to religious/spiritual competent practice.

1.5.1 Definition and Context

The idea of a 'competency' model is a relatively new concept to psychology. Prior to competency-based models of evaluation, competent practice was ensured by first of all standardising doctoral training in psychology and then evaluating students' progress through a knowledge-based model (Kaslow et al., 2007). Rodolfa et al. (2005, p.348) suggested that competency can be translated to mean that "a professional is qualified, capable, and able to understand and do certain things in an appropriate and effective manner... (*and)* connotes that behaviours are carried out in a manner consistent with standards and guidelines of peer review, ethical principles, and values of the profession, especially those that protect and otherwise benefit the public". In the UK, the professional practice of applied psychologists is underpinned by four key ethical values (respect,

competence, responsibility and integrity) and five core competencies (assessment, formulation, intervention or implementation, evaluation and research, and communication) (BPS, 2008; 2009).

In recent times some professionals have begun exploring and even started developing competencies in the area of religion/spirituality (e.g., Cashwell & Young, 2005; Cashwell & Watts, 2010). Richards and Bergin (1997) characterise a religious/spiritually competent therapeutic stance as an attitude and approach to therapy that is suitable for clients of diverse religious/spiritual affiliations and backgrounds. Hodge and Bushfield (2006) spoke of religious/spiritual competency as a specifically focused manifestation of cultural competency. There is an emphasis on the importance of taking religion/spirituality into account and as a factor in any appreciation of individual difference and cultural diversity. It has also been suggested that training in religious/spiritual diversity is essential for 'true' multicultural competency (Shafranske & Maloney, 1996). Richards and Bergin (2000) added that such training would give clinicians more credibility and trust with religious/spiritual clients, leaders and communities. They further suggested that clinicians had an ethical obligation to obtain competency in religious/spiritual diversity, so that they can work sensitively and respectfully with religiously/spiritually oriented clients.

With changes in attitude, increased research attention, and clinicians becoming increasingly interested in understanding the religious/spiritual orientations of their clients, the need for developing competency/competencies to guide practice in the area of religion/spirituality has become widely acknowledged (e.g., Richards & Bergin, 1997, 2000; Hodge, 2004; Hage, 2006; Bartoli, 2007; Smith & Gordon, 2009). How to achieve this is less clear. Applied psychologists are increasingly called to consider and appreciate the complex (e.g., positive, negative) roles that religion/spirituality play in the lives of their clients (Shafranske, 1996; Sperry & Shafranske, 2005). I believe that having a guideline for religious/spiritual competent practice will not only assist a significant number of applied psychologists in the UK to consider and appreciate the role of religion/spirituality in their clients' lives but will also support them to deliver more efficient interventions in a manner that is consistent with professional guidelines and code

of conduct. However, one would have to be extremely careful so that such a model is not acontextual, not applied mechanistically and does not lose sight of the bigger picture (Dzidic, Breen & Bishop, 2013).

Professions such as social work, counselling and psychotherapy have been forthcoming in developing what are deemed qualities of religious/spiritual competent practice (albeit all emanating from the USA). For example, Richards (2009) offered some preliminary considerations for those who attempt to practice 'spiritually integrated psychotherapy', and others (e.g., Association for Spiritual, Ethical, and Religious Values in Counselling (ASERVIC), 2009; Gonsiorek, 2009; Pargament, 2009; Sperry, 2012; Royal College of Psychiatrists Spiritual and Psychiatry Special Interest Group (SPSIG), 2011, 2013) have also articulated competencies and ethical guidelines. To date, these are the clearest accounts in this topic area, but they all seem to be a mixture of suggestions based on clinical practice and principles agreed by authoritative clinicians in the professions concerned. An illustration is given below from two professions that have attempted to develop accounts of religious/spiritual competent practice. One is an example of comments about dealing with clients' religious and spiritual issues, and guidelines developed from the comments (Hodge & Bushfield, 2006); the other (ASERVIC, 2009) is an example of guidance that is set out more systematically, in the form of standards of practice.

1.5.2 Religious/Spiritual Competency – Guidelines from Social Work

To help social workers understand and implement religious/spiritual competency in their work with clients, Hodge (a prominent US social work academic) and Bushfield (2006, p.106) proposed a definition encompassing three interrelated dimensions. The dimensions were: [1] a growing awareness of one's own value-informed, religious/spiritual world-view and its associated assumptions, limitations and biases; [2] developing empathic understanding of the client's religious/spiritual world-view that is devoid of negative judgement and; [3] an increasing ability to design and implement intervention strategies that are appropriate, relevant, and sensitive to the client's religious/spiritual world view.

They stated that religious/spiritual competency (RSC) can be conceptualised in the form of a continuum, which ranges from religious/spiritually destructive practice at one end to religious/spiritually competent practice at the other. RSC is not a static quality but a set of qualities developed over time. Each of the three dimensions of RSC overlap, inform and build upon one another. Development in one dimension tends to foster progress in the others (Hodge & Bushfield, 2006).

Within the UK, Peter Gilbert, professor of social work and the National Institute of Mental Health's (NIMH) national project lead on spirituality and mental health, echoes Hodge and Bushfield's views that social workers should consider their own religion/spirituality and how it relates to their work. Whilst he recognises that social workers may be resistant to exploring belief because of suspicion of organised religion, he suggests that they should share a 'common ground and humanity' with those people they work with (cited in Mickel, 2009).

1.5.3 Religious/Spiritual Competency – Guidelines from Counselling

The USA counselling profession has been paying attention to incorporating aspects of religion/spirituality in their therapeutic practice. This is largely due to the recognition that religious/spiritual aspects were not being adequately addressed (in some cases not addressed at all) in counsellor training programmes. During a 'summit' on religion/spirituality, leaders of the Association for Spiritual, Ethical, and Religious Values in Counselling (ASERVIC) in 1995 developed a series of religious/spiritual competencies (a process similar to the way in which the 'scientist practitioner' model emerged following the Boulder Conference in 1949 (Raimy, 1950)). These competencies were arranged within four knowledge domains: [1] general knowledge of religious/spiritual phenomena; [2] awareness of one's own religious/spiritual perspective; [3] understanding of client's religious/spiritual perspective; and [4] religious/spiritually related interventions and strategies (Young et al., 2002).

In 2009 these competencies were re-arranged into 14 items of which the first six were cognitive competencies and the last five were clinical competencies which

involve assessment, diagnosis, goal setting and the utilization of religious/spiritually sensitive treatment interventions (Cashwell & Watts, 2010; Sperry, 2012). The competencies were also re-categorised into six domains; [1] culture and worldview, [2] counsellor self-awareness, [3] human and spiritual development, [4] communication, [5] assessment, and [6] diagnosis and treatment (ASERVIC, 2009, (see appendix 15)).

1.5.4 Summary of Accounts of Religious/Spiritual Competency

Several observations of the available religious/spiritual competency accounts seem important. Firstly, as evident in the two illustrations above, literatures on what is relevant to religious/spiritual competency overlap in terms of factors that constitute competent practice – for example, awareness of one's own religious/spiritual world-view; understanding of clients' religious/spiritual perspective; religious/spiritually related interventions and strategies. Secondly, they were developed by professions other than applied psychology. And thirdly, all except one (Royal College of Psychiatrists SPSIG, 2011, 2013) were developed from practice in the USA.

As far as I am aware in the UK and as noted by Sperry (2012) for the USA, the profession of applied psychology currently has no specific consensus on professional competencies for practice in which religion/spiritual perspectives and resources are explicitly integrated. This lack of consensus leaves a 'void' (Sperry, 2012) for applied psychologists whose clients' problems involve this area. While the development of a formal religious/spiritual competency model is beyond the scope of the present research, holding Sperry's comments in mind, an exploration of how applied psychologists in the UK work with issues of religion/spirituality during therapeutic encounters would be a basic step towards such a consensus.

1.6 Résumé, Research Aims and Research Questions

Following a brief synopsis of the literature reviewed above, this section explicates the research aims and research questions of this study.

1.6.1 Résumé

A number of studies have highlighted the importance of religion/spirituality for many individuals (e.g., Cohen, 2002; Coruh et al., 2005; Loewenthal & Lewis, 2011; Nickles, 2011; Ivtzan et al., 2013). Though there has been ongoing debate about defining and distinguishing between the terms 'religion' and 'spirituality' (e.g., Gollnick, 2004; Koenig, 2008; Worthington & Aten, 2009), there is a general agreement that they both encompass a concept of the sacred and a search for what is sacred (e.g., Hill et al., 2000; Sperry & Shafranske, 2005). Historically, scholars of psychology were divided in their opinions about religion/spirituality. Some engaged with them, perceiving them to be part of the analysis of human potential (e.g., James, 1902), whilst others perceived them as being detrimental to human development and thus not worth psychological attention (e.g., Freud, 1927).

Over the last two decades, there has been a significant rise of research interest in the role of religion/spirituality for individuals' well-being and the profession of applied psychology have begun to recognise the need to include religious/spiritual issues in professional practice (Shafranske & Maloney, 1996; Patel & Shikongo, 2006; Collicut, 2011). Some studies have examined and suggested ways in which issues of religion/spirituality can be competently incorporated into therapeutic practice, bearing in mind ethical dilemmas and important factors such as training or the lack of it (e.g., Richards & Bergin, 2000; Hage, 2006; Hodge & Bushfield, 2006; Barnett & Johnson, 2011; Coyle & Lochner, 2011; Cooper, 2012). However, the available approaches to religious/spiritual competencies largely emanate from the USA, from non-psychology professions, and are based upon clinical 'insight' (e.g., Hodge & Bushfield, 2006), joint agreement by noted professionals (e.g., ASERVIC, 1995; 2009), and by generalising from other similar fields such as cultural competency (e.g., Richards & Bergin, 2000; Bartoli, 2007).

1.6.2 Research Aims

In order to develop religious/spiritual competencies that are specific to the clinical practice of applied psychologists in the UK, a different approach to what has been previously adopted is needed. Expressed as a 'grand scheme', this would start by asking applied psychologists and their clients, how religious/spiritual issues have been dealt with in actual clinical practice/therapeutic encounters. This would provide statements leading to the development of competencies that are empirically founded upon the analysis of applied psychologists' accounts of their practice and their clients' accounts of what they judge to be useful. The developed competencies should eventually be reviewed and agreed by the profession as represented by applied psychology within professional bodies such as the BPS and the Health and Care Professions Council (HCPC).

The aims of the present study are more limited: (i) to explore applied psychologists' accounts of their practice in the NHS, UK, with clients with religious/spiritual issues; and (ii) from these accounts identify participants' indications of religious/spiritual competencies. These aims attend to some of the first step described in the approach above but do not cover clients' accounts – the other steps are outside the scope of this study.

1.6.3 Research Questions

1. Generally, what themes may be identified within applied psychologists' talk about how they deal with religious/spiritual issues in client work?

2. Specifically, what may be identified as the participants' indications of religious/spiritual competencies?

CHAPTER 2: METHODOLOGY

This chapter outlines the research methodology of this study. Epistemological position, process of data gathering, and analysis are presented. The chapter ends with research reflexivity and evaluation.

2.1 Qualitative Research

According to Willig (2008) qualitative research tends to be concerned with meaning, quality and texture of experiences. It seeks to engage with data in order to gain new insights into the ways in which participants construct meaning and/or experience their world. The flexibility provided allows participants to respond using their own words, often giving researchers meaningful and rich data material to work with (Willig, 2008). A qualitative methodology was chosen as appropriate for exploring the aims of this research.

2.2 Epistemological Position

The general aim of this research was to explore applied psychologists' accounts of working with clients for whom religion/spirituality is important in the therapeutic encounter, within the NHS. Multiple studies have highlighted the role that religion/spirituality play for individuals, and links are often made between religion/spirituality and (psychological/mental) well-being (e.g., Richards & Potts, 1995; Loewenthal & Lewis, 2011). Though perceived and experienced differently, for many individuals religion/spirituality is a phenomenon that is 'real' (Pimpinella, 2011) and often affects how they relate to themselves and the world. In this research, I am not claiming that the perceptions and experiences reported are 'real' but I will be treating them as representative of something that is 'real'. The ways in which the participants talk about their perceptions and experiences of

working with their clients express one version of that reality, and likewise as a researcher I bring my own view as I interpret them. It is based on these assumptions that I adopt a critical realist position towards this research.

A critical realist approach posits that the world exists and 'is the way it is' but acknowledges that there can be more than one empirically valid way of understanding 'reality'; in other words there are many levels of understood reality. Hence, this approach does not assume that my data is a direct reflection of what is 'going on in the world' but it rather acknowledges that the data is a set of interpretations that will be further interpreted in order to generate an analytic understanding (Willig, 2013, p.16).

Within this position, therefore, my analysis and discussion will be mainly concerned with accounts of how applied psychologists in the NHS report dealing with religious/spiritual issues in therapeutic practice, bearing in mind that these accounts are just a few of the many that may exist.

2.3 Thematic Analysis

Thematic analysis (TA) has been described as a method for identifying and analyzing patterns in content and meaning in qualitative data (Braun &Clarke, 2006; Willig, 2013). Different versions of TA have been proposed within psychology including those of Boyatzis (1998), Tuckett (2005), Braun and Clarke (2006) and Guest, MacQueen and Narney (2012). The flexibility offered by this method means that it can be applied within a range of theoretical and epistemological frameworks. According to Braun and Clarke (2006, 2013) and Clarke and Braun (2013), TA is suited to diverse research interests, can be used to analyse different types of data, and works with large or small data sets. This thesis will employ TA as outlined by Braun and Clarke (2006).

2.3.1 Rationale for Adopting Thematic Analysis Method

There has been much debate as to whether TA is simply a tool to be used across different methods (e.g., Boyatzis, 1998; Ryan & Bernard, 2000). This debate largely stemmed from TA's 'lack' of theoretical concept, described by others as its theoretical 'flexibility'. However, more recently it has been recognised as a qualitative research method in its own right (Willig, 2013) and several accounts exist of how to carry out a clear and rigorous TA (see Braun & Clarke, 2006; Fereday & Muir-Cochrane, 2006). Willig (2013) argues that irrespective of the ascribed theoretical and epistemological 'freedom', TA requires theoretical and epistemological commitment from the researcher, which needs to be identified and presented to the reader by the researcher.

I am aware that other research methods such as interpretative phenomenological analysis (IPA), grounded theory and 'thematic' discourse analysis, which also seek to describe patterns across data (Braun & Clarke, 2006), could have been employed in this study, and would have each shown its own rich light on the research questions. However, considering that the research questions in this study sought to gain insight into an area that has received little research coverage in the UK, as a starting point TA appeared to be well suited for broadly exploring and identifying key themes in this area[3].

According to Willig (2013, p.65) TA "produces knowledge that takes the form of themes, built up from descriptive codes, which capture and make sense of the meanings which characterise the phenomenon under investigation". This knowledge can be generated either inductively or theoretically. An inductive or 'bottom up' approach is data-driven which means that identified themes are strongly linked to the data. It does not try to fit data into pre-existing coding frames or the researcher's analytic preconceptions. On the other hand, theoretical or deductive approaches are driven by the research analyst and their analytic or theoretical interest in the area (Braun & Clarke, 2006). This research adopted an inductive approach towards the data analysis.

[3] The method of grounded theory was initially employed to analyse the entire data set gathered from this study. However, following a review and redefinition of the research questions, the method of thematic analysis was used as more appropriate.

2.4 Data Gathering

Data was gathered by conducting individual semi-structured interviews (appendix 6) with research participants. This method is flexible and permits an in-depth exploration of a particular topic or experience, eliciting each participant's account of his or her experience and has been described as a method of choice for qualitative researchers (Creswell, 1998; Charmaz, 2006).

2.4.1 Ethical Approval

Ethical approval was sought and gained from the University of East London (see appendix 1).

2.4.2 Recruitment

Participants were recruited through a number of ways: initially via an announcement and invitation letter (appendix 2) circulated to British Association of Christians in Psychology members (BACIP, 2013), and to the Head of Psychological Services in the Trust that I was working with at the time; and latterly through word of mouth and 'snowballing'[4].

The inclusion criteria were for participants to be qualified applied psychologists, have an experience of working with clients for whom religion/spirituality was of importance in the therapeutic work they did and to have been employed by the UK NHS. On expression of interest in the research, an information sheet (appendix 3) was sent via email to the participants. A meeting for the interview was then scheduled with the participant.

[4] A plan for recruitment advertising in appropriate publications was set aside in view of the advertising costs incurred.

2.4.3 Participants

Qualitative research tends to use smaller samples than quantitative research but Patton (2002) suggests that there are no rules for sample size in qualitative inquiry. Willig (2013) argues that determining the sample size for TA can be difficult and suggests that this is a decision that should be guided by the research question. For a study undertaken as part of a professional doctorate, Turpin et al. (1997) suggested that eight participants is a sufficient number. Braun and Clarke (2013) provide more guidance on suitable sample size for qualitative research. They suggested a small (6-10 interviews) to moderate (10-20 interviews) sample size when exploring research questions on experience, understandings and perceptions, practices/accounts of practice and influencing factors. Another consideration is the concept of saturation, which refers to the point when additional data fails to generate new information. This concept developed from grounded theory and is a widely used rationale for sample size in qualitative research. Guest, Bunce and Johnson (2006) conducted a study to investigate number of interviews and data saturation and variability. Based on data from a study examining how women talk about sex in two West African countries, sixty in-depth interviews were conducted. Using thematic analysis, they found no new themes after interview number twelve, and that basic elements for meta-themes[5] were present as early as interview number six.

However, the concept of saturation is reported as being more appealing to a particular model of qualitative research (experiential, more positivist), where data are collected to provide a 'complete' and 'truthful' picture of the object of study. This is a theoretical position that most qualitative research does not subscribe to (Braun & Clarke, 2013) including that of this research study. Other factors for consideration, as highlighted by Flick (2011), include the time given to complete the research project, finding and keeping in contact with participants and meeting institutional demands of ethics committees. He argued that these factors can often play a more central role than other factors such as methodological and epistemological considerations.

[5] The authors report that their analysis generated four meta-themes but do not reveal what they were.

Whilst a series of eight interviews may be seen as falling on the small side sample wise, it is arguably a reasonable number for the purpose of this research study.

Eight NHS employed Applied Psychologists (seven Clinical and one Counselling Psychologist) were recruited and interviewed. Seven of them were female. The participants worked in a range of settings including: Adult Community Mental Health Team (CMHT), Community Recovery Team and Early Intervention, Clinical Health Team, Adult Mental Health, Paediatric psychology and Acute Inpatient Service. Two of the Clinical Psychologists were consultants and heads of service. The length of NHS employment ranged from 4 months to 21 years. Four participants self-identified as Christian and the other four as a Muslim, 'Spiritual'(not religious), Atheist and as 'sitting on the fence'. Five of the participants reported as White British/Irish/European and three identified as Asian. The participants reported using a variety of psychological models e.g. Schema therapy, CBT, Integrated approach, Systemic/Narrative approach[6]. Three of the participants were recruited through BACIP, one through the information sent to the Head of Service and five through word of mouth and 'snowballing'.

2.4.4 Interview Process

The interview protocol was based on the research questions and was piloted on three colleagues with interest in the research area. Their feedback was incorporated into the final interview protocol (appendix 7). At the beginning of the meeting with participants, a consent form (see appendix 4) to participate in the research was signed and demographic information (appendix 5) was collected before audio-recording the interview. The interviews were conducted at participants' preferred venue which consisted of home visits, participants' place of

[6] Participants were asked about their model of work out of curiosity to see whether there was a breadth in theoretical approaches/models and whether it would be a factor in how they talk about working with religious/spiritual issues. Interestingly, none of the themes identified in the analysis are drawn solely from participants using particular approach/model.

work and one telephone interview. Privacy was ensured for all the interviews by conducting them in a private, quiet room. Interview length ranged from 51 minutes to 117 minutes.

The interviews were later transcribed verbatim (see appendix 9). Transcription focused mainly on the words that were spoken but some subtleties such as pauses, interruptions, and laughter were also included. These subtleties were represented by using signs of the notation system (appendix 8) similar to the Jefferson lite notation system (Jefferson, 2004). However, as highlighted by Willig (2013), it is important to be mindful that all types of transcription carry a form of translation of the spoken word into something else and hence cannot be the mirror image of the interview.

2.5 Data Analysis[7]

The operational guidance for conducting TA as outlined by Braun and Clarke (2006) was utilised in analysing the data from the interviews. I started the process of analysis by repeatedly reading the data and becoming as familiar as I could with it. During this time, I made note of my thoughts, observations that were of interest and ideas of what looked like broad themes as well as ideas for coding. Following that, I began the process of coding the data. To start with, I read through all the transcripts, highlighted and made notes of the ideas that I was developing. I then moved on to coding for the elements that various data segments appeared to represent by making margin notes next to each data segment (see appendix 9 for example of this). As a result, a list of codes related to the elements of the transcripts was generated and collated (appendix 10). The codes along with relevant data extracts were then organised into potential themes.

[7]As a result of the refinement of research questions, the analysis conducted was based on data derived from part 1, 2 and closing remarks of the interview protocol (see appendix 7), as data from the rest of the protocol was no longer appropriate for the redefined research questions.

During this process, overarching/super-ordinate themes and sub-themes were identified (appendix 11). The next phase of the analysis involved reviewing and refining these identified themes; some themes were collapsed to form one theme, some were broken down further and others were simply discarded due to insufficient supporting data (see appendix 12 for thematic table illustrating this process). Finally, the themes were named and defined, allowing for further refinement of the identified themes. This was a recursive process, going back and forth, checking and rechecking developed themes against initial codes and data extracts in order to identify patterns or inconsistencies in the themes that were developing (see appendix 13 for final thematic table).

2.6 Research Reflexivity

As highlighted in my epistemological position above, I am aware that I am not an objective observer and therefore play a fundamental part in the research process, which means that my values will inevitably be reflected in the outcome of the research (Stratton, 1997). With the awareness that I am central to the way in which the data is constructed and construed (Charmaz, 2006), it is important for me to reflect on and make explicit my assumptions about the research topic, my values and life experiences and how they might shape my interpretation of the data (Braun & Clarke, 2006).

I am a 26 year old trainee clinical psychologist of Black African heritage, with a Christian upbringing and of a Christian faith. I am aware that belonging to a faith background will influence the way I understand and interpret participants' data. My personal experiences will shape my reflections and relationship with the data and identified pattern of themes. In addition, identifying as a Christian and being open about this with the participants may impact on how participants perceive me and construct their experiences with me. On the other hand, my personal experiences may allow for a deeper connection with the research process as well as a better understanding/awareness of the concepts referred to when talking

about religion/spirituality. These were issues that I reflected on during supervision meetings and in the writing of this thesis.

2.7 Evaluation

According to Koch (1994) interpretive research requires a trail of evidence throughout the research process in order to demonstrate credibility or trustworthiness. It has been noted that qualitative research is often criticised for the space afforded to subjectivity of the researcher (Madill, Jordan & Shirley, 2000). It is therefore important to evaluate the quality and credibility of qualitative research. Madill et al. (2000) suggest that it is the responsibility of the qualitative researcher to; [1] state their epistemological positions, [2] conduct their research in a manner that is consistent with that position, and [3] present their findings in a way that allows for appropriate evaluation. It has been suggested that different methodological approaches require different criteria for evaluation (e.g., Elliot, Fischer & Rennie, 1999; Yardley, 2000). Elliot et al.'s (1999) guidelines on ensuring good quality and standard in qualitative research were utilised in this study.

The guidelines consist of the following criteria: [1] owning one's perspective, [2] situating the sample, [3] grounding in examples, [4] providing credibility checks, [5] coherence, [6] accomplishing general vs. specific research tasks, and [7] resonating with readers. Each of the criteria was given due consideration and examples are given below of ways in which these were met.

[1] Owning one's perspective

This requires the researcher to disclose their values and assumptions, allowing the readers to interpret for themselves the researchers' analysis and consider alternative interpretations. My theoretical and personal orientation was stated and defined under the headings 'Research Epistemology', 'Research Reflexivity' (in this Chapter) and 'Reflexivity' (in Chapter 4).

[2] Situating the sample[8]

The researcher is required to provide descriptive data of their participants and their life circumstance to assist the reader in assessing the range of persons and situations to which the findings might be relevant. This information is provided under the heading 'Participants' (above).

[4] Providing credibility checks

This requires the researcher to check the credibility of their categories and accounts with others. My supervisor checked some of the transcript data for evidence of identified themes, reaching general agreement with their validity and holding further discussion with me on them (both super-ordinate themes and sub-themes).

[6] Accomplishing general versus specific research tasks

The researcher is required to be clear about the specific research tasks. This has been laid out in Chapter 1 under the heading 'Résumé, Research aims and Research questions', which outlines the rationale for this study, in this chapter regarding operational analytic steps, and below in Chapter 4.

[8] Elliott et al.'s (1999) *situating the sample* criterion is not used in this research as indicating a purely realist concern for 'hard facts' about participants that locates their data as characteristic of a particular group in society. Nevertheless, applied psychologists are a professional group in the UK (for example, accredited by the Health and Care Professions Council as practitioner psychologists), and it was considered appropriate to indicate some self-reported demographic details of the participant group showing breadth of representativeness (e.g., gender, length of post-qualification NHS employment, religious/spiritual affiliation) in addition to specific features that emerged from the data (e.g., at least three had undertaken research in the area of religion/spirituality and applied psychology).

CHAPTER 3: ANALYSIS

Participants' talk about religion/spirituality in relation to their therapeutic work is presented within six themes: broad characteristics attributed to religion/spirituality; personal attributes; knowledge; practice elements; challenges faced when working with and acknowledging the role of religion/spirituality for clients; and developing practice and raising visibility – training and practice. A description of each theme supported with extracts from transcripts is provided below.

3.1 Broad Characteristics Attributed to Religion/Spirituality

This section of the analysis highlights the ways in which participants spoke of and characterised religion/spirituality. Participants spoke of their perceptions of religion/spirituality, made reference to its diverse role and how it relates to clients on an existential level.

3.1.1 Religion/Spirituality as Multi-Factorial, Diverse

Religion/spirituality were spoken of as multi-factorial and diverse, a phenomenon with many strands to it. Three strands seemed important, each adding complexity to participants' presentation of religion/spirituality in their work. The terms religion and spirituality were utilised in various ways, at times used synonymously and at other times distinguished as separate phenomena. Religion/spirituality were also spoken of in terms of their simultaneously positive and negative qualities. The demand religion/spirituality sometimes impose to suspend 'rationality' was also a feature. Based on this description, it could seem that participants talk about religion/spirituality in an imprecise and unclear manner. However, the alternative inference I drew from the way participants spoke, is that the subject matter does not lend itself (easily) to clarity.

3.1.1.1 Religion/spirituality as diverse and intricate phenomena – definition, practices, terminology

The manner in which participants referred to the terms 'religion' and 'spirituality' varied considerably. The terms often appeared to be used interchangeably with the introduction of other terms such as 'faith' and 'belief', also being used interchangeably. With the terms being used in this manner, there seemed an underlying assumption that each term had the same meaning and/or served the same function. In the first example below, the word *faith* could as easily be *belief* or *religion*; in the second, *faith* is used again but the statement reads as well substituting *belief*, *religion*, or *spirituality*; the third specifically equates *faith tradition* and *religion*.

> P1: "I guess that just reinforces to me how, you know people with a strong faith, that it's a part, it's a huge part of their identity" (100-101)

> P2: "Their faith is, can become part of that **[their mental health]** in a good way or a negative way. So I guess its understanding how their faith affects that" (223-224)

> P7: "So people that would not necessarily describe themselves as having any particular faith tradition or religion, in my experience would still present with what I would call quite intense spiritual pain" (22-24)

However, distinctions were also made of the terms, with certain qualities being ascribed to one and not the other. For example, religion was thought of as being doctrine and practice led, whilst spirituality was perceived as more personal and individual led.

> P2[9]: "Something I'm trying to be more **[focused on]** is spirituality in the broadest sense. So I'm increasingly asking people sort of what energises them or what gives them a sense of purpose... Because, so for some people that wouldn't say they're religious or they have a faith, they might feel that sense of peace or sense of *I'm meant to be here* or something like that" (165-168, 186-188)

> P6: "...So hence not the religious side but there's something about the spiritual side that I really value and believe in personally" (199-200)

[9] Some extracts have been edited for readability – see appendix 14 for notation system used for editing extracts.

> P7 **[talking about enquiring about religion/spirituality]**: “Part of that actually I think is to be aware of the difference between spiritual and religious” (19-20)

There was acknowledgement of the various practices and intricacies that exist within any religious/spiritual tradition. For example, participants highlighted variations in practices such as attending worship centres, praying (sometimes at designated days and times), fasting, reading of holy texts, following prescribed doctrines, etc. Participants also spoke of the importance of these practices, and the meaning they may carry.

> P1: “Erm and that also I guess an understanding that just the kind of big headline label Christian, Muslim, atheist, whatever, doesn’t really tell you what that means to the individual” (406-408)

> P6: “Religion and spirituality, they’re so complex and convoluted and messy that for someone, whatever they choose to say in the session or withhold, or you know not be mindful of or be mindful of, it means something” (250-253)

> P8, self-identified as Muslim: “I know for myself that different Muslims do things in different ways” (317-318)

The analysis above illustrates participants’ views of how diverse and intricate the phenomenon of religion/spirituality is and perhaps helps illuminate existing studies and debates on the perception of religion/spirituality.

3.1.1.2 Double face of religion/spirituality; positive and negative qualities

Religion/spirituality were described as having aspects which were desirable and valuable but at the same time containing aspects which were perceived as potentially unhelpful and restrictive.

> P2: “There’s, there’s all sorts of positives erm but there might be negative stuff as well” (203-204)

For example, participants spoke of religion/spirituality as providing an alternative view/understanding of difficulties and thus emotional support in time of need.

> P3: “I mean for many of the people that I’ve seen over the years who’ve got medical conditions, there’s quite a difference between those people who have a sort of a, particularly a Christian faith and those who don’t have a faith. I mean the same thing goes particularly I think for Muslim patients. They can see that their particular health problems, they might be quite a serious thing, perhaps being in God’s hands and that gives them a sort of assurance and a hope that people who haven’t got that kind of faith wouldn’t have” (239-246)

> P4: “**[Religion/spirituality as]** something that really helps people, both in times of crisis, helps people in terms of hope for the future, in terms of you know it being seen as a part of their strengths” (50-53)

Religion/spirituality – especially belonging to a religious/spiritual group – was often described as a helpful resource. Participants spoke of religion/spirituality as being a resource for some clients because it was seen as providing a sense of belonging, a community and offered both emotional and practical support. Participants also said that for these clients religion/spirituality was a way of coping with and getting through difficult circumstances.

> P1: “It’s a huge part of their range of resources, sometimes spiritual practice and their relationship with God is like a really key part of their faith” (103-104)

> P2: “And if they’re part of a faith community or they have a faith then potentially that could be a resource to sort of help them cope with the situation or give understanding” (143-145)

> P4: “And I guess that religion and spirituality is one of people’s main survival and coping [2s] sort of mechanisms. So it comes in to the work a lot” (45-47)

For example, some participants spoke of working with clients who were experiencing difficult situations but remained hopeful and functioning (i.e. going to work, looking after their children as opposed to social withdrawal) largely because of their religious/spiritual belief and the support available within it. These were considered as the ‘positive’ aspects of religion/spirituality.

The participants equally portrayed the ‘negative’ aspects of religion/spirituality, though there was more emphasis on religion as opposed to spirituality.

> P2: “There might be a cult or something that’s quite oppressive or quite rigid or some limiting spirituality, can be quite [2s] unhelpful in terms of mental health. Or

> people misinterpreting things... they might be in a quite healthy faith community but they might be quite obsessive themselves in terms of religiosity" (204-211)
>
> P6: "**[There are]** ways that religion can steer people into being passive, or divide communities and people" (195-197)

Some participants spoke of experiencing the doctrines of certain religious traditions as oppressive and divisive of communities. In this light, religion was described as having the potential to be restrictive and unhelpful to the well-being of clients.

3.1.1.3 Rationality; the explainable and unexplainable

Secular rationality as a basis for understanding when it comes to religion/spirituality was questioned by some of the participants. Religion/spirituality were perceived as an area that has often been viewed through the lens of rationality by clinicians[10]. Rationality in this instance was spoken of as something that can be explained logically, something that has some empirical grounding and is thus ascribed credibility. Rationality was perceived as the profession's default way of viewing and understanding various phenomena, including that of religion/spirituality. However, rationality and its appropriateness in relation to issues of religion/spirituality was questioned by the participants, some in quite a vivid manner.

> P5[11] [Illustrating with a specific example]: "Suddenly as he was saying this to me, I thought hold on a minute, I don't know that **[the archangel]** Michael doesn't visit him,...You know, I don't know that, maybe Michael does visit him [3s]... maybe it happens. Why can't I suspend my rationality?" (575-589)

The same participant elaborated on this and spoke about the notion of evidence; stating that a lack of evidence for a phenomenon does not equate to the non-existence of that phenomenon (e.g. God).

[10] In this chapter, clinician/s refers to applied psychologists.

[11] Though other participants alluded at the issue of rationality, it was a point that was particularly well articulated by P5 as illustrated by the following examples.

> P5: “Suppose I suspend my rationality and listen to him, I don’t have to agree with him, I don’t have to believe him but I don’t have to disbelieve him either, I don’t have to keep trying to convert him to me and then say oh he has insight now... Rational in what sense? Rational is what I understand, just because there’s no explanation for something doesn’t mean it is beyond explanation, you know...God is not absent just because there is no evidence” (591-596, 601-603, 608)

In such an instance, the participant felt that it was important to hold their professional rationality in abeyance.

3.1.2 Existential Connections

Participants spoke of religion/spirituality as being linked to individuals’ sense of personhood/being. Associations were made between a person’s religion/spirituality and the way in which they relate to and understand their self, others and their world.

3.1.2.1 Client religion/spirituality is linked to a sense of identity, meaning making and well-being

The participants spoke of encountering clients for whom their understanding of their life experiences, past and present, was directly linked to their religious/spiritual beliefs. For example, they described some clients as speaking of their difficulties as either being the outcome of not being ‘faithful’ enough in their religious/spiritual practice or as a challenge which will make them stronger in their religious/spiritual practice and result in leading a more purposeful life. The participants also expressed that the way in which a client sees him/herself and identifies with their world was linked to their religious/spiritual beliefs.

> P1: “That **[discussion with clients]** just reinforces to me how, you know people with a strong faith, that it’s a part, it’s a huge part of their identity” (100-101)

> P3: “You can’t really fully understand the person not unless you’re as aware as you can be of what they’re thinking and what their fundamental beliefs are” (192-194)

These clients were described as not only affiliated to a particular religious/spiritual tradition but as presenting themselves as being defined by the doctrines and

practices of a particular denominational stream within the tradition. For these clients, individual decisions and behaviours are often closely governed by their religious/spiritual beliefs. The way in which they interact socially was also perceived as being similarly directed.

> P3: "I've had clients who've been Muslims or Sikh or whatever and it's been the same thing with them, it's been a very important part of the way they view things, they couldn't really separate out their everyday life experience from the spiritual beliefs that they had" (178-182)
>
> P4: "I think because it's [**religion/spirituality**] so much part of her life, you know it's everything important in her life, it's just so much part of her that it would be so hard to, to know her or work with her without knowing that" (135-138)
>
> P6: "[**Religion/spirituality as**] something integral to their kind of way of viewing the world..." (10)

Religion/spirituality were also perceived as being linked to clients' well-being. Clients' well-being was described as being connected to how well they could make sense of their difficulties/challenges within their religious/spiritual belief system. The process of making sense of their difficulties/challenges (in line with their religious/spiritual beliefs) does not necessarily mean that a client's well-being would be better. For some clients, their well-being may further deteriorate, if their perception of their difficulties/challenges is negative e.g. "I deserve what's happened to me, God is punishing me".

3.2 Personal Attributes

Within this theme, personal attributes may be informed and shaped by participants' upbringing, their values, their moral beliefs, their interests and life experiences. They are often illustrated through an individual's behaviour, actions and words. The ways in which participants of this study spoke of their encounters with clients with religious/spiritual issues gave some indication of the personal attributes that facilitated their clinical practice.

3.2.1 Having the Willingness to Explore Area of Religion/Spirituality

When referring to their encounter with religious/spiritual issues, participants spoke of their interest and willingness to explore the area. In describing their willingness to explore issues of religion/spirituality, participants would often make reference to the role of religion/spirituality in clients' lives but also in their lives (for those who identified as religious/spiritual).

> P1: "I did my doctoral research looking at Christians, committed Christians, who were receiving help for psychological problems and what factors were important to them in looking for a psychologist ...I guess that just reinforce to me how, you know people with a strong faith, that it's a part, it's a huge part of their identity" (97-101)

> P2: "And for me it's important part of my life so, and I know it's important for other people that I'm working with" (420-421)

> P6: "... It was my thesis topic in my third year so, you know that's not that long ago, where actually I was thinking about training and religious and spiritual issues... in terms of how trainees might engage with it with their clients and things" (162-165)

They would talk about the significance it holds for many and the sense of duty they have to explore issues of religion/spirituality, using quite strong terms like 'obliged' and 'essential'.

> P3: "Whatever we might think about their beliefs, I think we, you know, we are obliged to at least ask them what those beliefs are and try to understand where they're coming from so we can make sense, in a broader way of how they're functioning and wonder why they're not functioning in some cases" (207-211)

> P7: "And so I've always actually been really interested and seen that as an essential part of the process is to help people find meaning and purpose as to what is going on for them" (18-19)

3.2.2 Having an Open Mind, Being Curious and Avoiding Assumptions

Participants spoke of having an open mind and being curious about religious/spiritual issues. For the participants, having an open mind meant that they were being receptive to clients varying presentations and engaging in a manner that was genuine and non-judgemental.

> P2: “I suppose it’s just keeping an open mind with things and just picking up anything that a client is saying really to [2s] to see whether that’s something that’s useful to talk about with them” (269-271)

Having an open mind was also linked to suspending one’s rationality as a clinician and being curious about presenting matters. Being curious was described by participants as a process that entails (though is not limited to) asking relevant open questions, listening and following up on statements made by clients, proposing formulations in a tentative manner and adopting a non-expert position.

> P7: “Rather than seek to reassure and say **[of]** course there’s nothing you’ve done [laughs] but actually to help well you know I’m wondering what’s behind that question and what you might say to yourself… I suppose again, paying attention and being respectful. Okay so it might not be my faith tradition but it’s theirs and I need to be respectful of that and to understand what that means for that person” (31-33, 369-371)

> P8: “Well I ask, I’m curious to know what they think, what their assumptions about me are, but you know in a kind of careful way… I think I’m guided very much by kind of curiosity and by those models that we have drilled into us but in a way that I kind of [2s] come to an understanding that fits in with spirituality” (122-124, 194-196)

In addition to having an open mind and taking a curious stance, participants spoke of avoiding making assumptions in their practice.

> P1: “You need to just be aware of any assumptions that you might make when encountering someone who [2s] who says that they subscribe to a particular faith” (410-412)

> P8: “So I try to not assume that it **[religion/spirituality]** would have been a positive or comforting experience for them as well… I think not making assumptions generally is important [laughs]… I’m not saying that I’m a perfect psychologist that never makes any assumptions but I think it’s important to notice when you’re making assumptions and to challenge those for yourself and to allow new information to change your idea, your formulation, about the family ” (294-303)

Assumptions were perceived as potentially detrimental to therapeutic relationship and obstructive to gaining meaningful insight into clients’ difficulties. Participants

also spoke of their awareness of how easy it was to make assumptions and added that it was an area that needed constant monitoring.

3.2.3 Being Client-Led – Valuing What is Important to Clients

The participants spoke of the importance of giving value to what was important to clients and being client-led in their practice when it came to understanding their difficulties and identifying ways of intervening.

> P2: "Well it's about the client and whether it's important to the client and if the client sees it as part of their life and it has some role to play, then it's important to talk about it" (161-163)

> P7: "**[would talk about religion/spirituality]** only in the way that is led by the person, so I wouldn't bring it up other than part of the assessment, so I would have an idea of that" (140-141)

Being client-led also involved the act of 'genuine' listening which was illustrated in the way in which participants spoke of their encounters with clients for whom religion/spirituality was important. Genuine listening appeared to be characterised by attentive and interactive hearing.

> P3: "Whereas if you're a bit more open to at least to listen to what their ideas are, you've got a better chance of understanding them and then helping them" (225-227)

> P8: "Erm to listen to what's important for them and what is, what has had an impact in their life, you know. And what informs their current experience... Actually what the person in the room needs is just for you to connect with them and to listen" (338-339, 392-393)

3.2.4 Self-Reflection

The ability to reflect on and understand one's values, beliefs, stance and practice was highlighted by participants. Participants spoke of their values and beliefs and talked about how it could impact on their practice. For example, some participants

were able to reflect on their upbringing, their religious/spiritual experience and described the ways in which it informed/could inform their practice.

> P1: "Well I think because, I suppose it comes from knowing, from having my own faith and it being important, a part of who I am and how I kind of process things, sort of psychologically, emotionally in myself and because in the church kind of community, the Christian community, I know that that's important to a lot of people" (90-93)

> P5: "Yes, so thinking about my own **[religion/spirituality]** because I know, you know it must impact on my work because it's there and it's something that is complex and something that I do think about... Being female, all those things that make us, which has made us sensitised to the injustice, okay" (1072-1074, 1076-1077)

> P7: "...Well my experience as a professional came from my work, I worked in palliative care in cancer services for a number of years as a specialist nurse and it was at that time I became more acutely aware of people's emotional response to illness. And in finding meaning and sense and purpose within that, and that's what really motivated me to change career **[to applied psychology]**" (10-14)

Some participants made links between their interest in the area of religion/spirituality and their religious/spiritual stance in relation to therapeutic work. They spoke about being able to connect more easily with and understand their clients' religious/spiritual stance and practices. For example, some participants used their personal experience and/or familiarity of faith texts and practices (e.g., Bible, Koran, prayers) to explore issues with their clients where relevant.

> P1: "And so she would quote bible verses and I clearly you know understood exactly, you know... I think it would have been obvious that I understood where she was coming from and I related to the verses and I knew them and it was all familiar to me" (58-59 61-62)

> P5: "Another time, I was [2s] with this young girl **[in intensive care unit]**... she's mute... And I'd say hello to her every time, *Salam alaikum*, greeting in Islamic, I didn't know whether she responded at that time. By Monday she's seating on the floor, I went in [2s] Salam alaikum, and she looked at me, so when she looked at me, I was encouraged a little bit and went and sat next to her... And I said to her, shall I read the Koran for you? And she said, indicated yes. So I went and got the little Koran" (157-159, 165-169, 171-172)

> P7: “So I would never say well if you read this part of the bible or that part of the bible what does it say?... But I might say, so you’ve talked about when you read the bible or the Koran, is there anything in there that would give you hope, is there anything in there that would help you with this situation” (86-87, 90-92)

Participants who identified themselves as religious/spiritual spoke of conducting themselves in a manner that was respectful to their clients’ religious/spiritual beliefs and non-imposing of their beliefs, though this was seen as not being without its challenges.

> P6: “In my practice when it does, when I do address those issues, I try and be quite mindful and reflective about how [2s] you know, how someone, what they say and what they do, what they believe in, how it might impact on me personally because of what I bring... And be mindful to not let that get in the way of what I’m trying, you know, the end goal, ...and also try not to, I guess I’m mindful of the opposite, so not to push religious and spiritual conversations on people just because it’s something that I’m interested in” (223-226, 228-232)

> P8: “I think maybe because I’ve grown up kind of in a very diverse experience and kind of met people of all backgrounds… I have always been curious about religion and how you know, how are you the same as me, how are you different from me” (170-171, 174-175)

In addition, some participants spoke of being on a journey of discovering and understanding of their own religious/spiritual position. It was perceived that training and personal therapy in the area of religion/spirituality would be helpful in accomplishing this journey.

> P6: “Actually I have often thought it’s **[religion/spirituality]** something that I should have therapy for myself... Yes, so thinking about my own **[religion/spirituality]** because I know, you know it must impact on my work because it’s there and it’s something that is complex and something that I do think about” (371-372, 381-383)

3.3 Knowledge

As participants spoke of their encounters with clients for whom religion/spirituality were important, they made reference to the types of knowledge perceived to be

needed to work with religious/spiritual issues. Participants highlighted some of the areas where acquisition of knowledge resulted in better practice in relation to religious/spiritual issues. The term knowledge within this theme is given a broader remit than academic information, facts and figures (3.3.2 below). It includes appendages like personal knowledge and awareness of the likely significance religion/spirituality has for clients, and this knowing becomes a role adopted in religious/spiritual matters. Interestingly, although there exist a growing academic religion/spirituality research literature, very little mention was made of this as informing 'on the ground' of clinical work.

3.3.1 Awareness of Religious/Spiritual Issues and Its Significance for Clients and Clinicians

The participants spoke in a manner that illustrated that they had good awareness of religious/spiritual issues and their significance for the clients they were working with (perhaps this was a given in that the research question and inclusion criteria would have attracted participants with some level of awareness).

> P2: "I suppose because I'm quite aware of spirituality and think it's important, I suppose I try and consider it" (130-132)
>
> P3: "And I've had, obviously I've had clients who've been Muslims or Sikh or whatever and it's **[the importance of religion/spirituality]** been the same thing with them… so I need at least to be aware, I think we all do need to be aware of what those beliefs are at least" (178-185)
>
> P6: "I think religious and spiritual values really, you know, they're working towards the same thing, that they're about trying to give someone a positive world view, something to aspire to, something to believe in, something to belong to, all these things are helpful when thinking about people being well" (148-152)

This awareness was often demonstrated in the effort that participants described making in order to engage with their clients and the beliefs they held about their difficulties.

> P7: "I think it's really important to be aware of faith traditions and you know not in any great detail but to be mindful of that and to think about what that might mean

> for the person. So it may be more important that somebody goes off on a pilgrimage rather than taking their medication... so again it is not about me saying to somebody you must take your tablets, but actually looking at how, if at all their faith tradition might influence them in their life choices or choices about health. And I think as practitioners if we don't have any understanding of that, then I'm not sure really [laughs] how we can work holistically" (218-221, 227-232)

> P8: "So kind of managing that **[a Jewish adolescent with diabetes celebrating Purim/sweet festival]** and kind of saying yes it's an important festival but how, how flexible can that be and how can you say, well let's have them at lunch time when you've got an insulin injection. And kind of being aware that that's important but also having somebody else to talk to who isn't connected with that family, just generally can tell me a bit more about kind of the sweets and about how does that work. And so that the family have an opportunity to focus on how it is for them, without having to kind of explain to me, the whole history of everything" (324-330)

Participants spoke in a manner that demonstrated respect for the beliefs of their clients, making connections between clients' beliefs and their sense of being.

3.3.2 Knowledge of Religious/Spiritual Issues, and Skills to Work with Them

This theme relates to being in possession of facts and studies of doctrines and practices of various religious/spiritual beliefs. For some participants, their personal experiences of religion/spirituality as well as their interest in the area meant that they had ready accessibility of information/knowledge. This theme also refers to using one's skills as a clinician to apply the knowledge therapeutically.

> P1: "So knowing the biblical references is been really quite important to our work... for example an understanding of forgiveness from a Christian perspective and how important Jesus is in that ...in other faiths there might be some other really key core things that could be powerful psychologically for somebody who's struggling with anger or anxiety or depression, whatever it might be" (301-302, 487-491)

> P4: "I guess that what it means to me is an ability to understand and appreciate the importance of religion and spirituality in somebody's life. Erm to be able to have helpful conversations with them about it... to be able to help them you know [2s] have the relationships that they want to have with religion and spirituality" (488-494)

> P5: “So I make it my business to understand, the intricacies of their faith... And other than Hindu and Buddhist, Christian, I’ve had to learn Islam because most of my service users are from the Islamic faith” (100-104)

Participants spoke of being able to draw on their knowledge of religious/spiritual issues to guide their practice.

> P1: “And I’ve got probably a bit more [laughs] confidence than some in this area because I’ve done the research ...as part of doing that I read the research that provides I think evidence for the useful faith strategies, coping strategies, religious coping strategies, and also the research that shows a link between committed intrinsic faith and psychological wellbeing” (206-212)

> P8: “I went to a convent school, so I’ve got good extensive knowledge of the bible and you know I have a lot of Hindu friends and Indian friends, so I’ve got a good grasp of kind of Hindu and Sikh practices and faiths” (171-174)

It was said that knowledge could be derived in a number of ways; personal experiences, from friends and colleagues who were versed in the area of religion/spirituality, from academic research and readings and from the clients themselves.

3.3.3 Recognising the Clinician’s Role in the Therapeutic Relationship

This theme describes participants’ understanding of their role as clinicians when working with religious/spiritual issues, awareness of their limitations and awareness of clients’ context.

3.3.3.1The role of clinicians – attitudes and remit

The role of clinicians in relation to working with issues of religion/spirituality was described in a number of ways by the participants. Participants felt that it was in their role to have an attitude that demonstrated openness and respect towards clients’ religious/spiritual beliefs. It was perceived that such attitude would enable clients to feel safer about discussing their religious/spiritual beliefs and how it relates to their difficulties.

> P5: "**[If a client]** has faith in something you have to honour it, it's as simple as that, you know; whether I share it or not, it's irrelevant" (93-94)

> P7: "My role I think is to help them find meaning and purpose and if it's appropriate to help, we might identify strategies from their faith tradition that might actually help" (82-84)

Whilst participants generally felt that it was in their role as clinicians to have an approachable and open attitude, some participants also spoke of the importance of being aware of their remit as clinicians when it comes to issues of religion/spirituality. Remit referred to knowing the extent to which a clinician could go with a client, what was appropriate to say and do, within a therapeutic relationship. Participants did not necessarily make a distinction between their role in working with issues of religion/spirituality and other issues.

> P4: "And you know to think about your own position, I couldn't be positioned as somebody who could [2s] give you know a religious guidance or advice because I just don't have that skill or knowledge" (360-363)

> P6: "And actually that was something that, then I felt it's stepping away from my professional role. So there was a matter of liaising with her local mosque that actually fortunately had a women's section there" (45-47)

3.3.3.2 Awareness of own limitations

Having awareness of own limitations was spoken of in a manner that both described being aware of one's remit (the extent one should go as a professional) and being aware of one's limits as a clinician. Being aware of own limitations was perceived by some participants as an important aspect of their practice. Some participants expressed that there were times when they felt that they had reached their limit when it came to understanding and addressing issues of religion/spirituality, usually because of feelings of not having enough knowledge to do so.

> P3: "I suppose there's always that little bit of [2s] what can I call it [2s] a bit of self criticism I suppose, not knowing what to do sometimes. But I think you get [2s] you get to live with that, I mean I think many of us have learnt particularly again in working with medical patients that [2s] there's often not an answer you can give to people to some of the questions they ask" (349-354)

> P4: “I think it’s really important when you’re doing this work to know your limitations... there’ve been times when you know she’s **[a colleague with whom P4 holds joint sessions with]** you know having a conversation with a client... where it’s so clear and obvious that they really have a shared understanding about an issue that’s a religious issue or a spiritual issue, she’s a Christian as well, [2s] that it’s so way above my head you know that I, I become aware of my own limitations in having those conversation” (357-358, 525-526, 528-532)

Some participants were more accepting when they felt they had reached the limit of their knowledge in the area whilst others found it challenging, reporting feelings of helplessness.

> P6: “But then if it became something on a deeper level, ingrained within the religion where actually either I didn’t have the knowledge or couldn’t have a discussion for whatever this client might bring or if it’s erm I feel like it might be out of my professional remit because we, you know going into different professional area of specialism... Erm or if [3s] you know I’m not equipped then yeah, I might leave it alone then but then I’d try and find other resources which I’ve done plenty of time, so contacting organisations or religious leaders to get the information...” (321-333)

> P7: “I might feel helpless, and sometimes I have to ask myself, am I picking something up from the client? ... Or is my ‘fixing’ bit coming into play, my ‘rescuer’ part?” (312, 315)

> P8: “Erm but I think I’m always aware of not feeling that I don’t know enough and somehow that knowledge will help me, you know being able to quote scripture but actually maybe it’s not about that. Maybe it’s about [2s] you know maybe at times that’s something you hide behind and actually what the person in the room needs is just for you to connect with them and to listen” (389-393)

As a way forward some participants would seek assistance from other sources e.g. faith communities, leaders, and colleagues. Interestingly, except for one, none of the other participants mentioned seeking assistance or support from their supervisors when in this position.

3.3.3.3 Awareness of clients’ context and issues of difference/diversity

Whilst discussing issues of religion/spirituality some participants made reference to the client’s varied contexts. Social and political issues and issues of

difference/diversity such as gender, race, and how these can interplay with religion/spirituality were spoken of.

> P8: "And it's **[new policies on reducing number of interpreters in health care settings]** frustrating because then it means that you can't communicate with someone... I mean I know that they have language line but it's not really helping you to connect with someone... And it's not helping you to understand the kind of broader context for them erm and spirituality is part of that" (474-479)

Some participants made associations between the importance of religious/spiritual issues and the cultural/geographical background of clients.

> P4: "Yes, well in my work at X I work specifically with refugee women, and I would say that religion or spirituality has been an important part of the work with almost everybody" (40-41)

> P7: "A lot of people don't talk about it overtly, erm and it depends on the client group you're working with. I work with a lot of West, East African communities which is a very lived faith tradition" (252-255)

3.4 Practice Elements

The phrase 'practice elements' is used to refer to components of practice clinicians engage in when working with clients for whom religion/spirituality are important. Participants identified a number of such practical 'ingredients'.

3.4.1 Conducting Comprehensive Assessments

Conducting comprehensive assessments which took into account religion/spirituality was an act that participants reported engaging in. Comprehensive assessments were perceived as detailing a wide array of a person's life, areas of difference/diversity in which religion/spirituality were deliberately not omitted.

3.4.1.1 Feeling obliged to ask about religion/spirituality in assessments

Participants reported that it was their obligation to ask about and explore issues of religion/spirituality during an assessment.

> P1: "I always ask people in assessment about their faith, about faith or spirituality or kind of world view and whether they have, ...where are they coming from in that regard" (83-85)

Assessments were perceived as a tool for gathering detailed information about an individual, their life experiences, their values, hopes and aspirations for the future.

> P3: "I think for many years many of us have sort of routinely asked people about the spiritual religious side of their life… you can't really understand someone's psychological functioning unless you understand how they see the world and what sort of beliefs they've got" (162-166)

> P6: "But when I'm assessing it is something I would always cover because but as well I think because I am entrusted in not religion and spirituality specifically but more you know thinking about diversity as the topic and all those different things that come under that" (121-124)

> P7: "And I always ask about people's religious faith tradition as part of the assessment" (62)

Participants were of the opinion that enquiring about religion/spirituality was as equally as important and valid as enquiring about other aspects of a client's life e.g. family history, medical history or sexual orientation.

> P7: "So it's always on the agenda from the outset of therapy for everybody, as in where were you born? You know, what's your family erm interested in upbringing and part of that is were you brought up in any particular faith tradition, how important is that to you? So it gives people an idea that they can talk about it" (74-77)

> P8: "I think when it comes to working with spirituality I don't see it as being particularly different to any other aspect of working as a psychologist" (370-371)

Though some participants reported that they were aware that religion/spirituality would not hold a place of significance for everyone, they still felt that religion/spirituality were areas that should be explored explicitly during

assessments. Some participants felt that in doing so, clients would be encouraged to be open and talk about their religious/spiritual beliefs as opposed to being afraid that their religious/spiritual beliefs might be pathologised or dismissed.

3.4.1.2 Using exploratory tools in assessments

As participants spoke of the importance of conducting comprehensive assessments which take into account clients' religious/spiritual beliefs, they described a number of tools which they often employ to assist with this. Participants spoke of using exploratory tools such as system maps (which were described as an extension of a genogram), genograms (which informs clinicians of clients' roots and connections – family, social, cultural connections), and family trees.

> P4: "I always do a system map with people and I would usually ask them about you know not just people but organisations, institutions, places they go, I would usually ask them if they have a church or a mosque or a whatever, you know" (171-174)

> P7: "I always do a genogram with people...so that really informs me about connections" (158-159)

> P8: "I suppose almost like a genogram you know because where you are isn't where you come from" (89-90)

By employing some of these tools participants felt more able to develop a fuller picture of their clients' stories and identity.

3.4.2 Adaptation of Models and Techniques

Adapting or making psychological models and techniques more flexible was reported by participants as a process in which they engaged when working with clients for whom religion/spirituality is important. It was the perception of some participants that psychological models and techniques in their conventional state were not always best suited to addressing or working with issues of religion/spirituality. For some participants, this meant employing psychological

models that were more exploratory in nature, whilst others tentatively adapted their chosen methods to better address their clients' presenting difficulties.

3.4.2.1 Drawing on religious/spiritual practices, beliefs of the clients in therapeutic work

Some participants spoke of using ideas and concepts from the religious/spiritual beliefs of their client in order to engage them therapeutically. They described encouraging clients to participate in religious/spiritual practices that the clients perceived was helpful in times prior to their current difficulties. These included practices such as praying, attending worship centres, speaking to a clergy, and reading faith books.

> P1: "And as we were doing that **[discussing client's experiences]** and identifying how she viewed herself, we erm [2s] we brought an image, we brought [3s] God in and his perspectives into the thinking... Erm and for one client her, the place where she felt safe and at peace and content was sitting in a particular church and having a particular sense of God close to her and so we use that as a kind of grounding or soothing sort of image" (140-142, 177-180)

> P6: "And then we might talk about so kind of how it **[client's religion/spirituality]** helps them to manage internally but also what they do then, what they might do in terms of practices, to help them manage and cope... connecting it with their value system and you know for example it might be something that we've talked about in terms of motivating them to engage in thinking about their difficulties and how it might connect with their the values, their religion or spiritual beliefs" (13-15, 24-28)

Some participants also described actively using materials (e.g. scriptural materials) from their clients' religious/spiritual beliefs to challenge their clients into engaging in more helpful and functional thinking/behaviours.

> P1: "So we tried to do some exposure and response prevention work on, on that **[client's concept of God]** using sort of bible verses to back up this idea that no this isn't a true concept of God, and that she, she's kind of being able to just kind of shift into accepting that this is a distorted view of God based on ideas that you know ...you know those verses that have kind of supported her idea that this is really the true, God idea" (292-298)

> P2: "And we looked at the bible together as well because that's, that was his, you know understanding and, and because I'm familiar with that as well" (68-72)

These practices were considered necessary in order to engage meaningfully with their clients.

3.4.2.2 Considering the fit of psychological models with clients' religious/spiritual presentations

As mentioned earlier, it was the perception of some participants that most psychological models were not well suited to working with religious/spiritual issues. Participants described considering how well a particular model would fit with a client's presentation and their religious/spiritual beliefs.

> P3: "If you look at all the various psychological models particularly CBT, I mean you can apply that to many people in many situations. But all approaches have their limitation I guess, really when people are coming along and they're hurting spiritually and emotionally, ...it's very hard to I guess find anything in a formal sense you could give to them and say oh this is a particular approach, am going to use this with you because I know it's best evidence, it works with people with your problem. Cause what you're dealing with is by nature a bit vague, a bit sort of shapeless, you know it's very hard to pin down" (407-416)

> P4: "Actually the other thing that I should say that we do here which [2s] we found with adapting therapeutic approaches to the needs of clients is to connect certain things to religious principles or beliefs" (885-887)

Some participants described being careful not to use a model or technique that might trivialise or even pathologise a client's religious/spiritual beliefs.

> P5: "I don't foreground the model at all. I do not, that's why I suppose I find the deconstruction, I don't like the notion of narrative therapy but I use narratives. I think that's my own, narratives, the spoken narrative allows me to enquire into the values, the stories, the themes behind, if you like behind or alongside or with, what makes those narratives the person that is located in that narrative, the values, the experiences" (505-510)

> P8: "I think I'm guided very much by kind of curiosity and by those models that we have drilled into us but in a way that I kind of [2s] come to an understanding that fits in with spirituality. I think maybe because kind of more systemic or narrative approaches allow for that erm but I don't think that other models don't necessarily but maybe they **[systemic/narrative approaches]** lend themselves more to kind of what are the stories around" (194-198)

Some psychological models (e.g. Systemic, Narrative) which are considerate of contextual factors were perceived by some as being more receptive for working with religious/spiritual issues.

3.4.2.3 'Owning' psychological models rather than being owned by them

Following on from the consideration of the fit of psychological models with clients' religious/spiritual presentations, some participants spoke of 'owning' psychological models rather than being owned by them. The process of 'owning' psychological models as described by participants included taking authority over how a model was used, adapting techniques as deemed appropriate, and recognising the limitations of a chosen/prescribed model.

> P5[12]: "So yeah, I mean models I don't allow them to rule me [2s], I rule them ... I will use them, they are models after all [2s] and they're very helpful, they're very useful, ...they help me to put things into package for lesser modules... for **[those that]** just want evidence, so I give them evidence... I really get very cross when evidence becomes the rationale for absolutely no evidence. There is no evidence that CBT makes you better" (624-633)

'Owning' psychological models rather than being owned by them does not necessarily equate to disregarding the place and usefulness of psychological models. The participants rather referred to a process of taking a more critical and evaluative approach towards the employment of the models.

> P5: "So in terms of models, they're helpful and I try and use them in a way that is not Eurocentric... **[in reference to a session with a client]** but what I did was not very different to actually working with his here and now, his cognition, everything had an effect on it, his behaviour, his cognition [2s] but there was another quality to that that was a bit more transcendent I think, and a bit more simpler" (675-676, 715-720)

In contrast, *being owned by* a particular psychological model was connoted by a mechanical adherence to protocol – a form of rigid 'socialisation to the model', applied to the clinician in addition to the client.

[12] Though other participants alluded to this sub-theme, it was most clearly articulated by P5

3.4.3 Process

Process here refers to actions and thinking which inform one's decision-making and practice.

3.4.3.1 Drawing on intuition, instincts and gut feelings

As participants spoke of their encounters with clients for whom religion/spirituality were important and described the ways in which they made decisions about what they were doing, some participants referred to using their intuition and following their instincts and gut feelings.

> P2: "I suppose therapy for me anyways, there's always the model and the structure and I do like the CBT model but there's always my own sort of, I think therapist always however much don't stick to the model, there's always that sort of gut instinct as well" (259-262)

> P3: "There's no easy answer for that, I think most people would say it's just sort of gut instinct... [4s] and it's a difficult one really, I guess again just feeling that it's sort of appropriate, it was actually helping the person and being careful to only do those things that they wanted and they valued" (306-307, 384-386)

Intuition, instincts and gut feelings were perceived by some participants as naturally occurring processes which often assisted them with making helpful decisions with regards to working therapeutically with their clients. These participants considered their intuition, instincts and gut feelings as being reliable enough to follow.

3.4.3.2 Creating opportunity to talk about religion/spirituality with clients and colleagues

Some participants spoke of creating the opportunity to talk about religion/spirituality with clients. Creating an opportunity as described by participants entails having an interest and openness towards talking about the area of religion/spirituality that is visible to both clients and colleagues.

> P4: “But I think having that experience and hearing what people say about it **[religion/spirituality]** has made me more aware of the importance of talking about it in a positive or neutral way” (194-196)

> P8: “Whenever there is an opportunity I would always try to bring it **[religion/spirituality]** to the table... I don’t think that I have control over the moment when it arrives but I think I suppose I do have a bit, have control over allowing the discussion to happen. So if somebody is curious or if somebody makes a comment about it then I will kind of use that as an opportunity to have a wider discussion about what, what they’re understanding, what their assumptions are and what’s important to them” (117-119, 263-267)

Some participants described taking practical steps towards creating opportunities to talk about religion/spirituality. Some of these steps included creating space within initial assessments, picking up on subtle hints made by clients and following them up and organising forums/meetings with colleagues to share knowledge and have discussions around the area. Whilst this was a process that most participants were engaging in, some of them described finding it a challenge to continuously engage in it.

> P2: “I suppose it’s just keeping an open mind with things and just picking up anything that a client is saying really to [2s] to see whether that’s something that’s useful to talk about with them” (269-271)

> P3: “Well, I , I mean generally talking to colleagues, I mean I think most people I’ve spoken to about this sort of thing **[religion/spirituality]** over the years would agree that you need to take that into account” (190-192)

> P6: “So more recently one of the service users that I’m working with, well a patient... he’s developed some friendships with other people on the ward and you know, other guys goes to the Friday prayers... so I was talking through that with him and that was something that he thought, yes I could engage with so kind of encouraging it I guess” (67-74)

While participants spoke about their actions of doing this, they did not describe the sort of cognitive considerations they made/reflected on in taking the decision to encourage or close down the opportunity. However, from earlier accounts it is likely that their knowledge and experiences in the area acted as a guide for their decision.

3.5 Challenges Faced When Working With and Acknowledging the Role of Religion/Spirituality for Clients

As the participants spoke of their encounters with clients for whom religion/spirituality were important, they also described what they perceived as challenges when working with these issues. Power and organisational pressure (3.5.1 below) were described as being most problematic.

3.5.1 Power and Organisational Pressures

Some participants described feeling powerless and experiencing organisational pressures to practice in a manner that they did not always think was suitable or beneficial for their clients. When it came to working with and acknowledging issues of religion/spirituality, participants spoke of feeling that they were operating in a system which was constantly monitoring their actions.

> P2: "See I suppose within the NHS, you have to be quite careful, even though [2s] the client's comfortable and you're comfortable but still how it might be perceived outside the room" (731-734)

> P5: "In between the line a lot of things are going on, we are all surviving ...who says it, that the inconsistency with which we practice evidence base, yeah, that is what is being helpful... That is why I just remain inconsistent. If you live in times like this [3s] I wonder if your only way to carry on...is to just get on with it quietly and not make a big hoo-ha and feed the beast[13] every now [laughs] and then" (694-696, 724-727)

> P8: "But I think in as much as you try to be critical of the models that you have, you're kind of with, you are within a wider system and you can sometimes find kind of powerlessness of it" (539-542)

While developing religious/spiritual sensitive methods of working, at least one participant found it easier to do this in a private practice setting rather than within the NHS.

[13] The "beast" in this context refers to those in position of power within organisational settings such as the NHS.

> P1: “So [laughs] cause one of the reasons I moved into private practice was so that people who wanted to work with their faith in therapy could kind of find someone who would do that. So I started, since I’ve been in private practice I’ve seen more people for whom faith is important and I’ve worked with in the therapy... I do feel a bit more freedom if I’m honest in the private practice area” (49-52, 238)

3.5.1.1 The neglect of religion/spirituality in doctoral training and NHS settings – implication for practice

Participants were of the view that religion/spirituality was an area that received little or no (practical) attention from the profession. Some participants reported feeling that doctoral training courses did not create enough space for issues of religion/spirituality to be explored and discussed by trainees.

> P1: “And so I think its really quite bad that that’s not been part of the core training” (95-96)

> P1: “But I think its kind of interesting...that I haven’t generally seen people with really strong faith in the NHS... You know, because I think that well, my guess will be ...that they’ll probably steer away from the NHS, that they’ll want to see somebody who is of their faith, ...that would be my guess, that people with a really sort of strong active faith wouldn’t end up in the NHS” (348-359)

> P6: “We did have a couple of sessions when I trained about religious and spiritual things but I wish there was a bit more of it cause it’s something quite meaty and I would have liked to get my teeth into it more” (358-360)

> P7: “I think we don’t talk about that in work, I don’t think we have to but... it must inform your practice in some way. And I think the danger is if we don’t pay attention to it, then it’s more likely to inform your practice in a negative way” (440-441, 446-447)

Similarly, participants spoke of experiencing the NHS and professional bodies as being ‘tokenistic’ in its past effort to acknowledge and work with issues of religion/spirituality.

> P1: “I found it quite interesting in my training that in the realm of teaching on difference, and ‘isms’, you know we looked at ageism, racism, sexual orientationism...and it was, you know of course we had to look at what our prejudices and biases might be, unconscious and be aware of those. But faith, religion, that didn’t come into it and yet, in my experience everyone knows you’re

> not meant to be racist or sexist or [2s] prejudice against people with different sexual orientations" (419-428)
>
> P2: "Because I think a lot of people avoid it which is why it's not on courses, well there's a token usually, usually a token lecture on courses... And so, there's things about culture and sexuality and but in terms of religion [2s] I find that, I suppose that there is a bit of a prejudice for people and I suppose that's been backed up by psychological [2s] understanding, Freud and people like him who have said things that, like religion is a crutch or is a defence mechanism, it's unhelpful" (343-345, 360-364)

For some of the participants, this was perceived as being partly responsible for the ambiguous feelings and attitudes which some clinicians hold towards issues of religion/spirituality.

3.5.1.2 Working within evidence based practice (EBP) as reducing effective therapeutic outcome?

Working outside evidence based practice was described as exercising flexibility in the way in which one practices. Participants spoke of the idea of EBP being derived from empirical findings and some argued that these empirical findings were often lacking in contextual factors and thus felt that what was being classified as EBP may not translate as such for some of the clients they work with.

> P6: "**[Existing guidelines]** are neither here nor there because the core of it is about these models and evidence base and all that we know about, you know, who the evidence is on and how relative that might be to some of the clients that we work with" (622-625)

For this reason some participants spoke of working outside what was perceived as EBP and instead doing what they felt was more suitable based on their experiences and encounters with clients for whom religion/spirituality was important. Participant 5 spoke very passionately about this.

> P5: "I really get very cross when evidence becomes the rationale for absolutely no evidence. There is no evidence that CBT makes you better [2s], there's no evidence for schizophrenia ... I don't have to be evidence and not evidence, what evidence I have I give you, what I don't have I give you something else, look. So I

> don't have a war against evidence, all I'm saying is that it's not enough [2s] ...So because you are telling me evidence and what is empirical, what is present but there are things that we don't know, because we don't know it doesn't mean that knowledge is impossible" (635-637, 753-756, 785-788)

Some participants gave the impression that their decision to work outside EBP was one of the ways in which they could stay with what was important for the clients and also challenge organisational norms of working (an idea congruent to that of 'suspending rationality' – section 3.1.1.3).

3.5.1.3 Working with clients' religious/spiritual issues as a specific example of psychology's tension with the medical model

Some participants described experiencing tension operationalized at the level of local organisation and policy, but attributed at the level of societal discourse between religious/spiritual discourse and medical discourse. Participants reported that some of their clients had a tendency of talking about religion/spirituality and medical/psychological interventions as two concepts at the extreme ends of a spectrum. Religion/spirituality were considered to be vastly different from medical/psychological interventions and clients often felt that they had to align with the one and shun the other.

> P8: "There are times [2s] when it feels very dichotomous, that it's either the faith or spirituality or it's this model of care, and people see it very much as two different things" (43-45)

Participants reported that this tension was more visibly present for clients for whom religion/spirituality was important, and seeking/being referred for medical/psychological interventions left them with feelings of disloyalty to their respective religious/spiritual beliefs. Some of this tension was reported as coming from clients' experience of their religious/spiritual beliefs being pathologised.

> P4: "Some of the work I've done here a lot with African and Caribbean men who had diagnosis like schizophrenia and things like that. And one of the things that they talk about a lot and very critically about is how their religion and spirituality is pathologised in mental health services, seen as delusional or psychotic or and you know err bad influence of something that makes them you know not want to engage with services" (178-187)

3.5.2 Disclosure Issues

Disclosure in this context refers to disclosing one's religious/spiritual stance as a clinician to a client. Participants spoke about the issue of disclosure differently. Some participants described having no issues disclosing their religious/spiritual stance to clients but explained that they would only do so if they felt it would enhance the therapeutic relationship.

> P3: "But I'm just saying that if it feels appropriate to share my beliefs ...if they ask for what my beliefs are, what I think about the situation, I'm happy to self disclose if it feels appropriate to do that, if I think it might help them to get a better understanding of you know, why they feel the way they do and how they can better cope with the way they feel" (294-299)

Some participants felt that disclosing their stance made the therapeutic relationship more transparent and allowed clients to decide on the level of detail they wanted to share/disclose about their religious/spiritual beliefs.

> P4: "I mean one thing I should say is I do you know I'm quite open with my clients that I'm not religious because I think it's important for them to know that. But I would, you know happily tell that I've been brought up as a Catholic so I know these things... Again I think it's quite important to be transparent with the clients if they're having those discussions with you so that, you know, they know where to place you and where to place them self in relation to you" (279-282, 367-370)

For some participants the choice of whether or not to disclose was not present for them. This was because these participants bore certain identifiers which disclosed their religious/spiritual stance, sometimes before they had formally met with their clients. Some of these identifiers included participant's names or their clothing (e.g. wearing a hijab).

> P8: "I think being Muslim does, being Muslim and wearing a scarf really, allows me to, I think faith and spirituality as a discussion enters the room no matter who I'm meeting with... because it's kind of disclosed as soon as I walk in the room... so I think being kind of a very obvious and observable Muslim has made it easier to talk about issues of difference generally, but spirituality I think particularly" (108-110, 114-115, 143-146)

Whilst for some other participants, disclosing their religious/spiritual stance was seen an inappropriate as that was an aspect of their private life which they did not think appropriate to share with clients.

> P6: “I’m really I don’t know if I’d say fiercely but I am quite protective of my own personal beliefs and I think there’s something about training and working in this profession that makes people feel threatened to actually be you know just themselves... I mean my beliefs are my own, you know, they’re not for sharing and I don’t think I need to. But I respect people that do when there is a community sense and it is good for people, great, but not for me” (562-565, 568-571)

> P7: “I don’t share my faith tradition with clients, as I don’t share my sexual history [laughs] or my personal history with clients” (87-88)

It can be inferred that whatever participants views were on disclosing, it was something that they had given careful thought to.

3.6. Developing Practice and Raising Visibility – Training and Practice

Following a discussion of their experience of working with clients for whom religion/spirituality was important, participants highlighted some points which they felt would assist clinicians to develop in the area. There was a collective view that more visibility was needed in the area and participants spoke of this in terms of implications for training and professional practice.

3.6.1 Taking a Proactive Interest in the Area of Religion/Spirituality

The participants all spoke of the need for clinicians to take a more proactive interest in matters pertaining to religion/spirituality. Taking a proactive interest includes giving the area of religion/spirituality the same level of professional attention that is given to other areas of difference/diversity. It also involves explicitly engaging in practices that will make the area more visible in the profession (e.g. creating substantial space to address issues of religion/spirituality

in training curriculum, conducting comprehensive assessments, incorporating clients' religious/spiritual beliefs in formulations).

> P1: "Just that, you know these, all these things get put more on the agenda ...I think actually the awareness, awareness of the literature in this area and having that tool to all clinical courses, what the research findings are showing about **[religion/spirituality]**" (641-646)
>
> P2: "I think it's just having it on the map really, it's just having that awareness and that curiosity and I suppose incorporating it into formulations" (844-845)
>
> P4: "I think first of all just being able to discuss it, you know, just being able to talk about these things in staff you know CPD and staff meetings and things like that. Being able to talk about the issues in general" (836-839)

Taking a proactive interest was seen as taking steps towards addressing the religious/spiritual area of difference/diversity that is often either neglected or pathologised when raised.

> P7: "I think putting it on the agenda is really important... In terms of spirituality and maybe that's more of a divide practice but again it's just finding people out there, people to come and talk from different faiths... About illness beliefs or religious rituals and beliefs and understanding, you know having people from different faith communities as part of that coming to talk about those things" (553-561)
>
> P8: "Yeah I think we need to be having more conversations about religion and spirituality about all difference, and we need to be more accessible to the people from different backgrounds and it needs to be, we need to make it safer for people to talk... but yeah just finding ways of making it safe for us as professionals to talk to each other" (616-619, 630-631)

Taking a proactive interest in religion/spirituality does not necessarily require a clinician or trainee to also have personal interest (positive or negative) in the area of religion/spirituality.

3.6.2 Creating Scope for Discussion of Own Religious/Spiritual Stance in Training Programmes

Training programmes were described as potentially the most effective place to introduce and explore issues of religion/spirituality. As mentioned above (section

3.5.1.1) participants felt that the issue of religion/spirituality received inadequate coverage on training programmes and identified the need for development in this area. They suggested that training programmes create a platform that allows for the exploration, discussion and reflection of own religious/spiritual stance during training.

> P5: “I think in the training we need to hold, we need to have proper reflection and thinking time about our own values and beliefs... Pay attention to the personal, this whole distinction between the personal and professional, yeah, it needs to be properly tackled and through a group medium” (1217-1218, 1222-1224)

Some participants felt that trainees would be better empowered to work with issues of religion/spirituality if they have exposure to critical thinking and discussion of such issues with peers in an open and safe environment.

> P1: “I think kind of [2s] having that **[reflection]** a bit more out on the table, in training and having some competency about [2s] yeah, just unpacking upon own prejudices and standing back and being a bit more aware of the literature and research on it all, would seem pretty important” (446-449)

Whilst the development of practice and increased visibility in this area was perceived by all the participants as important, they all spoke at a fairly general level about this need.

CHAPTER 4: DISCUSSION

This chapter will review the findings of the present study, how they contribute to the literature, consider methodological limitations, research and professional practice implications. It will also offer recommendations for future research and training, and discuss researcher reflexivity.

4.1 Review of Findings

The super-ordinate themes generated were: Broad characteristics attributed to religion/spirituality; Personal attributes; Knowledge; Practice elements; Challenges faced when working with and acknowledging the role of religion/spirituality for clients; and Developing practice and raising visibility – training and practice. These themes captured the diverse nature of participants' encounters with issues of religion/spirituality in their clinical work, highlighting their conceptualisation of religion/spirituality as a phenomenon, their actual practices and the factors that influence these and their views of how to further develop practice in the area of religion/spirituality. Detailed below is a brief summary of each super-ordinate theme.

The theme 'Broad characteristics attributed to religion/spirituality' put across participants' perceptions of religion/spirituality. It illustrated the varied use of the terms 'religion' and 'spirituality' and delved into the different meanings they were perceived to hold for individuals. Though there was a general view that religion/spirituality played important and crucial roles in the lives of many, there was also an acknowledgement that it could equally be detrimental to the lives of many other.

The theme 'Personal attributes' details influences that facilitate working with religion/spirituality; influences such as upbringing, values, moral beliefs, interests and life experiences were examined, and how when translated into action via behaviour or spoken words, they impact upon clinical work. The sub-themes

‘having the willingness to explore area of religion/spirituality’ and ‘having an open mind, being curious and avoiding assumptions’ are some examples of behaviours impacting upon clinical work. The sub-theme ‘self-reflection’ also illustrates the importance participants placed on understanding their own position and experience of religion/spirituality, as they felt that it was something that could impact - negatively or positively - on their practice.

The theme ‘Knowledge’ created a picture of the types of knowledge perceived by participants as necessary to possess when working with religious/spiritual issues. Within this theme, the term knowledge is given a broader remit, so that it is not limited to academic knowledge but also spreads over to personal knowledge and awareness. If and when necessary, participants would draw on the various sources of knowledge available to them during clinical encounters, ensuring that they engage with their clients in a manner that is therapeutically useful but also congruent with clients’ beliefs. For some participants, this meant being aware of the interaction between clients’ context, issues of difference and their presenting difficulties. In this sense, the acquisition of religion/spirituality-oriented knowledge, and knowledge of the clinical skills needed to work in the area, are linked to good practice.

The theme ‘Practice elements’ portrayed in more concrete terms the actual practices that participants engage in when working with religious/spiritual issues. The sub-themes ‘conducting comprehensive assessments‘, ‘adaptation of models and techniques’ and ‘process’ detailed the practices participants engaged in and how they did so. It also captured the extent that some of the participants were willing to go with regards to working in a way that not only acknowledge the religious/spiritual beliefs of their clients but also respected and validated it during clinical encounters. For some participants, this meant creating and looking out for opportunities to talk about religion/spirituality with clients and in some instances colleagues.

The theme ‘Challenges faced when working with and acknowledging the role of religion/spirituality for clients’ conveyed the struggle and perhaps frustration that participants’ often felt as they addressed issues of religion/spirituality in a

profession and organisational setting (NHS) that was considered as conservative in their approach towards religion/spirituality – conservative in the sense that the participants felt and experienced a gap in doctoral training programmes and the NHS setting when it came to acknowledging and working with issues of religion/spirituality. Strict and/or rigid adherence to medical models and notions of evidence based practice were described as potentially perpetuating the existing gap in the area. The participants also spoke of a different type of challenge, a challenge more personal to them, which was that of deciding whether or not to disclose their own religious/spiritual position.

The theme 'Developing practice and raising visibility in the area of religion/spirituality – training and practice' brought together ideas which participants considered to be useful for applied psychologists to engage in if the profession is to progress beyond its current state. Participants expressed that if more applied psychologists were to show a proactive interest and create avenues for discussing religious/spiritual issues, as it pertains to them and their clients, visibility in the area will be heightened. In addition, practice would be more responsive to the religious/spiritual needs of clients.

4.2 Discussion of the Findings

The present study aimed to explore applied psychologists' accounts of their practice in the NHS, UK, with clients with religious/spiritual issues and from these accounts identify participants' indications of religious/spiritual competencies. The aims were to be addressed by asking the following research questions: (i) generally, what themes may be identified within applied psychologists' talk about how they deal with religious/spiritual issues in client work? (ii) specifically, what may be identified as the participants' indications of religious/spiritual competencies? This section will address the research questions and discuss them in the context of existing literature.

4.2.1 Findings in the Light of Research Question One

The findings suggest a comprehensive picture of the ways in which applied psychologists dealt with religious/spiritual issues in their client work. The participants initially began their accounts with what might be described as the background to the reason they worked in the ways they did with clients in this area - encompassed in the first theme 'Broad characteristics attributed to religion/spirituality'. The complex and diverse roles of religion/spirituality were seen across accounts. The observed and implied significance of religion/spirituality for some clients was also evident. These appeared to account for the participants' decision to engage with issues of religion/spirituality in client work. The diverse and complex role of religion/spirituality is well documented (e.g., Payne et al., 1991; Zinnbauer, Pargament & Scott, 1999; Hill et al., 2000; Moberg, 2001; Rose, 2001; Gollnick, 2004; Sperry & Shafranske, 2005; Bartoli, 2007; Ghorbani et al., 2007; Koenig, 2008; Nelson, 2009; and Collicut, 2011). A number of studies have also explored the significance that religion/spirituality holds for some people, highlighting a mixture of positive and negative impact on mental health and well-being (e.g., Exline et al., 2000; Schnittker, 2001; Coruh et al., 2005; Richards & Bergin, 2005; Cohen et al., 2009; O'Connell & Skevington, 2010; Barnett & Johnson, 2011; Loewenthal & Lewis, 2011; and Reeves et al., 2011). However, fewer studies have formally explored applied psychologists' decision about and/or process of engagement or non-engagement with issues of religion/spirituality in client work (e.g., Delaney et al., 2007; Baker & Wang, 2004; Mulla, 2011; Begum, 2012). The participants' accounts provide some insight into this area.

Three of the six themes identified from participants' accounts were instrumental in indicating how participants deal with clients' religious/spiritual issues - 'personal attributes', 'knowledge' and 'practice elements'. Proportionally more of the discussion will examine these three themes. Of the others, the first has been discussed in the paragraph above, and the last two will be covered below (4.2.3).

4.2.1.1 Personal attributes

Encompassed within the theme 'personal attributes' were sub-themes to do with having willingness to explore the area of religion/spirituality; having an open mind, being curious and avoiding assumptions; being client-led; and the ability to self-reflect. Post and Wade (2009) reported that when working with religious/spiritual issues, an explicit statement or discussion communicating openness to exploring religion/spirituality with the client is essential for effective intervention. Richards and Bergin (2000) and Slattery and Park (2012) similarly argued that all psychotherapists should be open to working with clients' religious/spiritual beliefs if they are to sensitively and holistically treat their clients effectively. The participants expressed similar views, describing acts of being receptive to and engaging with clients' religious/spiritual issues without judgement or assumptions – as Participant 8 put it, "*I'm guided very much by ...curiosity ...but in a way that I kind of [2s] come to an understanding that fits in with spirituality*". The act of 'careful listening' was another attribute which the participants spoke about within client work. Whilst careful listening might appear an obvious act to engage in as qualified clinicians (it is after all an essential skill for the 'therapy' professions), it might prove difficult for some clinicians who are either ambivalent towards or feel unskilled to work with religious/spiritual issues. Slattery and Park (2012) equally emphasise the importance of listening carefully to clients' religious/spiritual beliefs, suggesting that these beliefs are likely to affect their presenting issues.

Reflecting on their own values, religious/spiritual experiences and stance, and their potential impact on client work was another aspect that all the participants referred to in detail. For some participants, self-reflection necessitated little effort either because of their interest in or/and the active role that religion/spirituality play in their own lives. Self-reflection in this case appeared to serve a dual function, that of facilitating openness to issues of religion/spirituality and that of examining one's intention, attitude and practice as a professional. Similarly, Slattery and Park (2012) argued that psychotherapists' state of awareness concerning issues of religion/spirituality in their own lives (achieved through evaluating their personal and professional stance about religious/spiritual experiences) and their openness to facilitate discussion about these issues during therapeutic process were important factors in clinical work. O'Grady and Bartz

(2012) put it more bluntly by insisting psychotherapists examine the role that religious/spiritual experience plays in their own lives and in the psychotherapy they provide. This is consistent with Grimm's (1994) argument that therapists are responsible for becoming more aware of their personal values, attitudes and emotional responses to religious/spiritual issues. Whilst this also cohered with participants' views and practices, they generally felt that this was an area that was being neglected in doctoral training programs and some service organisations. This meant that they had to take personal responsibility for engaging in self-reflection in relation to issues of religion/spirituality. Some participants expressed that training schedules needed to assist trainees and clinicians to become aware of their values, attitudes and responses to religious/spiritual issues in order to practise more efficiently. This is in line with the connection Cassidy (2006) makes between training programmes addressing the issue of religion/spirituality more directly, and therapists being more responsive and aware of religious/spiritual issues. She added that such awareness is important because a therapist's personal beliefs and attitudes could interfere with the treatment of clients in various ways. For example, she explains that negative feelings and biases about religiosity/spirituality may lead to therapists covertly or overtly discouraging a client's religious/spiritual preferences (Hodge and Bushfield (2006) add that unless those negative views are worked through, the therapist may experience 'religious/spiritual counter-transference' when working with religious/spiritual clients.). Likewise, therapists with positive views of religion/spirituality run the risk of allowing such values to interfere with therapy, by overlooking client's unique spiritual outlook due to assumptions of commonality between own and clients' values – while therapists who hold 'neutral' or unconcerned views about religion/spirituality may ignore or see clients' religious/spiritual issues as unimportant during therapeutic encounters (Cassidy, 2006).

Overall, the participants spoke in a manner that indicated that the personal attributes above optimised their ability to work with issues of religion/spirituality. That is not to say that the list of personal attributes identified within participants' account is exhaustive. And, as applied psychologists, personal attributes such as being open minded, curious and being able to reflect on own values and stance

are not necessarily unique to clinicians working with religious/spiritual issues. For example, clinicians who align with systemic approach/models or use systemic ideas in their practice will be very familiar with these attributes, as they are concepts which the approach also endorses (e.g., Cecchin, 1987; Tomm, 1987; Anderson & Goolishian, 1992; Fredman, 2007). Some of the similarities between systemic approaches and the present data at this point, may be: (1) the idea of 'neutrality'-openness to viewpoints; (2) curiosity and questioning; and (3) a non-assuming stance.

4.2.1.2 Knowledge

Knowledge and the array of ways in which it can be acquired was another theme that clearly depicted the ways in which participants approached working with religious/spiritual issues. Participants indicated that a degree of knowledge in the area of religion/spirituality was needed in order to engage effectively with issues arising from the area. This is consistent with Richards and Bergin's (2000) and Slattery and Park's (2012) argument that in order to recognise the importance of religion/spirituality in clients' lives and how clients are perceiving life events, psychotherapists need to have an understanding of religious/spiritual beliefs. They were of the opinion that having such an understanding would provide psychotherapists with guidance of how to effectively intervene with clients with religious/spiritual issues. In addition, 'multicultural' literature stresses the importance of acknowledging the various influences that shape an individual when providing services (e.g., Sue, Arredondo, & McDavis, 1992; Sue & Sue, 1999; Sue, 2001; Fernando & Keating, 2008), which can only be achieved by gaining knowledge of the individual and their various influences (e.g., race, culture, gender, religious/spiritual orientations).

The participants made reference to the different ways in which they had come to acquire knowledge of religious/spiritual issues: academic and professional interest in the area, often combined with their personal experiences ('personal knowledge') and awareness of the significance religion/spirituality holds for many individuals (gained through feedback from clients, colleagues, and wider social network). Richards and Bergin (2000) particularly advise engaging in scholarly

readings, and in continuing education – workshops and courses ('academic knowledge'), increased supervision and consultation. These activities were also emphasised by Cassidy (2006).

Consistent with Yarhouse and VanOrman's (1999) suggestion that clinicians were ethically obligated to make efforts to become knowledgeable about a variety of religions, some participants expressed that it was their responsibility to acquire and/or develop a broad knowledge of religious/spiritual issues – such as Participant 5: "*I make it my business to understand, the intricacies of their faith... I've had to learn Islam because most of my service users are from the Islamic faith*". For some participants this process involved using their initiative and drawing on formal and informal resources such as Google, attending and giving workshops, consulting with friends, colleagues and religious/spiritual organisations and leaders. However, some participants were of the opinion that whilst it is important to have awareness and knowledge of religious/spiritual issues, it is not compulsory to have 'complete' knowledge in the area ('complete' knowledge in the sense of knowing all that there is to know about religious/spiritual issues). The topic area of religion/spirituality was considered to be too vast and complex to come to a full understanding of it: for this reason, having some level of knowledge and awareness of it was considered to be enough, at least to generate and engage in discussion.

Participants also spoke of being aware of their remit and limitations as clinicians. Reference was made to the importance of knowing and being able to recognise the extent one could go as a professional, when one felt that the presenting issue was outside of their expertise and when to seek assistance from others e.g., clergy persons in faith communities and colleagues. Similarly Mulla (2011) found that clinical psychologists engaged in a process of trying to understand their own role, where it begins and ends in relation to working with religious/spiritual issues. A part of this process meant considering the role of clergy and the support that they can offer. Public criteria setting out the limits of professional skill in dealing with clients' religious/spiritual issues are not available, and when participants sensed themselves reaching this boundary, some reported feeling helpless – possibly because referring on to clergy attributes expertise to them (Fallot (2007)

has discussed this in terms of a dilemma experienced by mental health professionals). Other participants adopted a notion of shared expertise, and onward referral was experienced more comfortably. Further research and/or training are needed regarding recognising and managing the limits of skill in religious/spiritual issues.

It would appear that having some knowledge and awareness in the area creates a sense of confidence and prepares participants to engage with the work in a manner that is respectful and meaningful to their clients. Participants indicate that this has the effect of strengthening therapeutic relationships and generating ideas for interventions that are congruent with clients' religious/spiritual beliefs (provided that they are founded on beliefs which aid rather than damage psychological well-being). Post and Wade (2009) also present findings that clients reported stronger therapeutic alliance when they felt the therapist accepted and respected their beliefs. However, the power differential that can exist between therapist and clients needs to held in mind, so that clients' voices and versions of 'reality' are not dominated by the therapist (Anderson and Goolishian, 1992; Murray-Swank and Murray-Swank, 2012).

In sum, it might appear that the participants' reported need for knowledge in this area is stating the obvious. But an alternative view is that the data may emphasise this because despite its obviousness, in practice participants had keenly felt the need for such knowledge, or encountered applied psychologist colleagues who did not possess such knowledge. It may be that many applied psychologists are aware that they ought to/should have knowledge in the area but far fewer actually engage in acquiring it.

4.2.1.3 Practice elements

The participants highlighted in concrete terms some of the practices they employed when working with religious/spiritual issues. All the participants described engaging in a process of conducting assessments that is comprehensive and allows for the inclusion and exploration of clients' religious/spiritual beliefs. Some participants explored their clients' beliefs almost

as a matter of course; others did so in a more considered way, as an area which could offer insight into clients' difficulties; whichever, generally there was an indication that the participants considered it good practice to do so. This is consistent with a number of writers (e.g., Richards & Bergin, 1997; Hodge, 2004; Hodge & Bushfield, 2006; Post & Wade, 2009; Dailey et al., 2011; O'Grady & Bartz, 2012). Tan (1996) suggests that at the outset of therapy, clinicians should ask more questions in order to gain further information about clients' religious/spiritual experiences, values and beliefs. Coyle and Lochner (2011) add that doing so carefully can also convey to clients that their religious/spiritual views are acceptable aspects of their lives which can be discussed during therapy. A number of authors (e.g., Pargament, 2007; Aten & Leach, 2009; Plante, 2009; Slattery & Park, 2012) have recommended assessment tools and open-ended questions which can be used in exploring religious/spiritual constructs during the assessment process. Similarly, the participants made reference to methods and/or tools which they used in exploring clients' religious/spiritual beliefs. These included system maps, genograms, and family trees. However, Coyle and Lochner (2011) note that these suggestions of proactively including religion/spirituality in assessment do not accord with what they had informally gathered about their clinical colleagues' actual practice. In addition, though this study's participants did not make reference to this, conducting comprehensive assessments with individual clients in this manner will likely mean an increase in time devoted for such activities which the structure and pressure of most NHS services do not permit.

The adaptation of psychological models and techniques was also described by participants. The participants indicated that some level of adaptation was needed in order to acknowledge the role of clients' religious/spiritual views in the therapeutic process. They spoke of considering the fit between a psychological model and a client's presentation and some appeared to consciously choose models which they felt would not trivialise or pathologise clients' beliefs, models such as systemic and narrative approaches. Some participants spoke of using concepts from clients' religious/spiritual beliefs during therapy, actively using materials such as scripture verses, and encouraging clients to participate in religious/spiritual activities that they perceived to be helpful (e.g., praying, reading

faith books) – as illustrated by Participant 2: "*we looked at the bible together ...because that's, that was his, you know, understanding*". This finding is in line with a number of authors (e.g., Tan, 1996; Aten & Worthington, 2009; Coyle & Lochner, 2011; Slattery and Park, 2012; Sperry, 2012) who suggest that skilful translation of the ideas and techniques of secular psychotherapy into clients' own religious/spiritual language can help psychotherapists: (i) understand and engage clients in treatment; (ii) make treatment more powerful and effective, and (iii) reduce religiously/spiritually-based fears that may be barriers to change.

Other participants described a process of taking 'ownership' over the psychological models they employed, directing them in ways they felt were more useful rather than simply following them rigidly - Participant 5: "*So yeah, I mean models I don't allow them to rule me [2s], I rule them ... I will use them, they are models after all*". This process (owning a model) does not necessarily equate to disregarding the place and usefulness of psychological models but rather referred to taking a more critical and evaluative approach towards the employment of the models. None of the participants spoke in 'gung ho' manner, but clearly indicated that adaptations of psychological models were carefully considered and kept within professional boundaries. Although the notion of evidence-based practice (EBP) was one that some of the participants considered during this process, the extent to which the adaptations compromise EBP must be contentious, and a subject for further research.

Some Participants also spoke of a process of drawing on their intuition, instincts and gut feelings when making decisions about how to work with clients religious/spiritual issues. Formal literature making connections between intuition/instincts/gut feelings and religion/spirituality are not easily found. Although not as part of clinical practice with religion/spiritual issues, Jung made intuition a major part of his theory of personality; interestingly, his specific consideration of religion/spirituality (Jung, 1938) makes no link with intuition. In addition, while Tovey and Baker (*in press*) explore the role of intuition in clinical practice and found that using intuition was an active issue for their participants, no link specifically with working with religious/spiritual issues was made by the psychologists interviewed. It is a subject for further research.

4.2.1.4 Summary

It appears that in the absence of appropriate training and professional guidance, participants needed to draw on their own personal experience, professional interests and knowledge in order to engage with and meet the needs of clients for whom religion/spirituality is important. Together the themes 'personal attitude', 'knowledge' and 'practice elements' presented participants' accounts of their ways of working with these issues, which concur with and extend the findings of previous studies.

4.2.2 Findings in the Light of Research Question Two

This study also sought to identify participants' indications of religious/spiritual competencies. Based on participants' accounts, and careful consideration and deliberation of analytic themes, discussed within supervision, the following broad areas are suggested as a first attempt to assemble such competencies, drawn from data collected in a UK NHS applied psychology setting (terminology in quotes is drawn from the analysis): [1] *Recognising the 'b*road characteristics attributed to religion/spirituality'; [2] Possessing certain 'personal attributes'; [3] Having 'knowledge'; and [4] Engaging in certain 'practices'. Each of these areas encompass specific statements which detail how to work in a competent manner with clients' religious/spiritual issues (please see appendix 16 for a list of statements[14]). The four areas identified should not be considered as distinct aspects – it seems more consistent with the data to understand them as being interconnected.

[14] I am aware that the idea of suggesting a list of statements which could be considered for the development of competencies for working with religious/spiritual issues might be viewed by some as inconsistent with a critical realist stance. However, the identification of such a list and eventual development of competencies would parallel other aspects of applied psychologists' practice which is often measured by clinical activity. In addition, in no way do I propose that the developed competencies are fixed or all encompassing, but rather propose them as a first step in the many steps needed to think about ways of working more effectively with religious/spiritual issues. Nevertheless, the tension that this causes in maintaining my epistemological stance is touched on below.

The identified areas are generally in line with studies which have sought to address good practice/competency as it relates to client religion/spirituality within professions other than applied psychology, and in the USA (e.g., Cashwell & Young, 2005; Young, Wiggins-Frame, & Cashwell, 2007; ASERVIC, 2009; Richards, 2009; Cashwell & Watts, 2010). Richards and Bergin's (1997, 2000) recommendation of what they deemed essential attitudes and skills for acquiring greater competency in religious/spiritual diversity (see appendix 17) highlighted items which are very similar to those identified by the participants of this study. The identified areas are also consistent with Hodge (2004) and Hodge and Bushfield's (2006) conceptualisation of religious/spiritual competency, which is summarised as 'awareness of one's own value-informed, spiritual world and associated biases'; 'understanding of the client's spiritual worldview'; and 'ability to design and implement intervention strategies that are appropriate' (see appendix 18 for a summary of each quality).

Both Richards and Bergin (1997, 2000) and Hodge and Bushfield (2006) write about areas that are not dissimilar to those of the present study; but they write in terms of acquiring/developing increased competency over time. Clearly, the statements of Appendix 16 could be viewed as aspects of competency that can be developed over time. However, although they require substantial refinement, I think of the present statements as standards-to-be-achieved, the eventual idea perhaps of having ratings which would indicate the extent to which any one of them has been achieved. If, with suitable further refinement, such a set of competencies was viable, it could provide the elements for training and assessment in dealing with clients' religious/spiritual issues that previous authors (and the present participants – see below) have pointed out, is missing, whether at pre-qualification or post-qualification level. This said, I would be the first to admit that this scenario is 'visionary'.

Apart from the 'developmental' aspect noted above, there were some differences noted between the current findings and the existing literature. The participants explicitly made reference to the importance of conducting comprehensive assessments and taking the opportunity to talk about religious/spiritual issues

with colleagues. While these are all points of difference, they extend rather than disagree with previous studies. As noted in Chapter 1, the existing literature largely emanates from the USA, which is more accepting of religious/spiritual inclusive services (within other professions as well as in applied psychology) (e.g., Richard & Bergin, 1997, 2000; APA, 2002), therefore it could be that these factors do not appear so worthy of specific comment.

4.2.3 Other Issues for Consideration

The fifth and sixth analytic themes may be thought of as slightly less directly focusing upon the research questions, and more upon a broader professional context. The fifth super-ordinate theme of this study portrays some of the challenges that the participants faced when working with and acknowledging the role of religion/spirituality during therapeutic encounters. Participants alluded to power and organisational pressures, and some called into question the appropriateness of evidence based practice as a standard for work involving clients' religious/spiritual issues. Studies by Baker and Wang (2004) and Foskett, Marriot and Wilson-Rudd (2004) reported similar findings, where staff members described being at odds with their institutions and feeling frustrated by their bureaucracy when working with religious/spiritual issues. The participants of this study also spoke rather passionately about the neglect of religious/spiritual issues in doctoral training programmes and expressed that this contributed to the neglect of these issues during therapeutic encounters. This reflects a number of previous studies (e.g., Aten & Hernandez, 2004; Bartoli, 2007; Mulla, 2011; Cooper, 2012). More strongly, Hage (2006) argued that the failure to integrate aspects of religion/spirituality into psychological training may have significant consequences for the overall well-being of individuals and families.

Finally, the sixth super-ordinate theme highlights recommendations participants considered important for developing practice and raising visibility in the area of religion/spirituality. All of them expressed a need for the profession in the UK to take a more proactive interest in the area of religion/spirituality, and advocated for doctoral training programmes to create scope for the exploration of religious/spiritual issues.

Both of these, the challenges and the recommendations, were clearly important matters to participants, and may be important and possibly linked areas for further study of dealing with clients' religious/spiritual issues in a wider social context. But within the focus of the participants' own clinical practice, the way the analytic findings from themes five and six provided responses to the study's research questions was felt to be less relevant than the content of the first four super-ordinate themes.

4.3 Methodological Limitations of the Present Study

No study is free of methodological limitations and three particularly struck me as worthy of mention.

4.3.1 Homogeneity

Participants were recruited and consented to participation on the basis of their personal, professional and/or research interest in the area of client religion/spirituality. In addition, my pursuit of the research topic would have disclosed my interest in the area. This 'double interest' influenced the way in which the participants spoke of their encounter with religious/spiritual issues in their therapeutic work. Whilst I felt that, as planned, it enhanced participants' willingness to talk openly, the possibility should be acknowledged that our shared interest may have induced some collusion, or dampened my attempts to be curious. A certain sort of social desirability (King & Bruner, 1999) may have played a part in the accounts participants provided, and my responses to them, especially for those who identified with a religious/spiritual position.

4.3.2 The Issue of Diversity-Intersectionality

This research was designed from the outset to focus upon participants' encounter with religious/spiritual issues in their therapeutic work. Nothing was built into the

study's conceptualisation of religion/spirituality that accounted for its intersectionality with other areas/issues of diversity in clients. Diamond and Gillis (2006) and Crenshaw (2008) argue that human identity is shaped by an interplay of forces influencing how individuals experience themselves and the world around them and that these forces (e.g., age, race, ability, gender, religion/spirituality, etc.) intersect and cannot be divided into discrete entities of identity.

On reflection, I am aware that my asking participants to talk about one aspect of their clients' identities and not following up on issues of intersectionality when alluded to in the data might have come across as over-simplifying. Therefore this study tended towards one-dimensionality. Although not excusing this limitation, it is true that the majority of the literature highlighted in chapter one also ignores this aspect of complexity. It is possible that I decided to focus upon this issue in isolation because I feel that religious/spiritual research in this profession in the UK is still at a rudimentary stage. Nevertheless, the identified limitation has an implication for further thinking, along the lines of das Nair and Thomas (2012), whose work[15] did not come to my attention until the very end of writing up the present study.

4.3.3. Epistemological Tension

In addressing my research aims and questions, particularly that of identifying indications of religious/spiritual competencies, I am aware of the tension that this creates of maintaining a critical realist position. Though my general aim and research question of exploring participants' account of their practice is coherent with my position as a critical realist, I realise that the more specific aim and question of identifying a competencies list (from the analysis of the participants'

[15] In their chapter on religion, das Nair and Thomas (2012) explored the intersectionality between people who were religious/spiritual and also lesbian, gay, or bisexual (LBG). Religion/spirituality was perceived as being an important 'resource for the construction of meaningful LGB lives' (p.108). However, this was thought to be only possible for people who have successfully negotiated the contradictions between their religious beliefs and their sexual practices, alongside some acknowledgement/approval of their religious communities. das Nair and Thomas (2012) present some guidelines for good clinical practice when thinking about how religion/spirituality and sexuality interact.

accounts), which can guide applied psychologists (and act as criteria which their practice can be judged against) fall into a realist epistemological stance. Whether unavoidable or avoidable, this was a methodological flaw, and any further study of the development of a list of competencies will have to take it into account - possibly by adopting from the outset, a scientific realist stance for such a study.

4.4 Research Implications of Study

Three lines of research are tentatively outlined, concerning assessment processes, the adjustment of psychological models, and the development of competencies.

Conducting comprehensive assessments which explore clients' religious/spiritual stance was consistently emphasised by the participants in this study, which would likely mean an expansion of assessments. However, the present study leaves unanswered the question of how to harmonise the importance of such expanded assessments with the importance of psychologists' time management within the NHS.

Participants spoke of needing to make adaptation to psychological models in order to intervene in manner that is congruent with clients' religious/spiritual beliefs and values. The notion of evidence-based practice (EBP) was one that some of the participants considered during this process, however the extent to which the adaptations might compromise EBP is a subject for further research. Drawing on intuition/instincts/gut feelings was another process that was spoken of; similarly further research is warranted to explore the link between intuition/instincts/gut feelings and working with spiritual/religious issues.

A part of the aim of the present study was to identify indications of competencies needed to work competently with religious/spiritual issues, which could potentially lead to the development of religious/spiritual competencies that are empirically founded upon applied psychologists' accounts of their practice and their clients' account of what they judge to be useful. Some statements have been suggested

based on an applied psychologists' account and future research is needed to examine how transferable the account of this study's participants may be, were it to be developed towards a general 'applied psychology account'. And still further research is needed to present a service user account of clients themselves.

4.5 Professional Practice Implications

Two areas of professional implication are highlighted: pre-qualification training issues, and the maintenance (or development) of open attitudes towards dealing with client religious/spiritual issues. The first seems easier to specify, and has been articulated previously by several others, as well as the present study's participants. The second focuses upon assessment possibilities, less easy to be specific about, but flowing clearly from what participants said.

Firstly, similar to other studies (e.g., Hill et al., 2000; Patel & Shikongo, 2006; Bartoli, 2007), the participants in this study all spoke of feeling that religion/spirituality was a neglected area in the profession of psychology. The area of pre-qualification training was highlighted as a key area where religious/spiritual issues were being neglected. As a result, the present study's implications for professional practice are largely based around responding to this.

- Issues of diversity such as gender, sexuality, race, etc., often receive substantial coverage, both pre and post qualification, for obvious reasons; likewise religion/spirituality should receive similar or equal coverage. Relevant research and literature materials should be provided or signposted, especially during training.

- In addition, trainees and clinicians are often encouraged to reflect on issues of diversity as it relates to them. Reflecting on own religious/spiritual position, assumptions, and prejudices should also be encouraged and normalised. Provisions should be made to facilitate these reflections so

that it is done in a respectful and safe manner (both within teaching programmes and placements).

- As a way of diversifying teaching on religion/spirituality and sharing knowledge, speakers with personal and/or research interest and clergies from the community can be invited to lead or facilitate teaching sessions.

Secondly, further implication for professional practice includes recognising the importance of and the actual exploration of issues of religion/spirituality, alongside other issues during the assessment phase. This does not necessarily call for a specific religious/spiritual assessment (alongside existing generic assessments) to be conducted with each and every client, as there will be clients for whom these issues hold no relevance. Rather, an attitude of openness and respect for issues of religion/spirituality, how it intersects with other identities of the client, should be adopted. In addition, findings from this study indicate that some psychological models lend themselves better to openness and curiosity i.e. systemic and narrative approach. It might be worth considering the use of such models when working with religious/spiritual issues.

One of the aims of this study was to identify indications (based on applied psychologists' account) of competencies needed to work with religious/spiritual issues. Though further research is needed before the identified statements can be considered for use of developing religious/spiritual competencies, the findings of this study can be used in holding discussions (both in training programmes and organisational settings) about practices that may be useful to consider when working with religious/spiritual issues.

4.6 Reflexivity

The area and topic of religion/spirituality has always been a point of interest to me. Being a young Black African female with a Christian upbringing, religion/spirituality was and still is presented as a way of life, both for me but also

within my cultural community. The profession of psychology and practice of providing psychological support has also always been an area of interest to me. Although I was somewhat aware of the disharmonious relationship between religion/spirituality and psychology, I was nonetheless determined to pursue a career in psychology whilst staying committed to my religious/spiritual convictions. This is because, for me, religion/spirituality and psychology serve similar purposes - support and empower individuals with their sense of self and well-being.

On commencing training as a clinical psychologist it was no surprise to find that there was very little, if any, scope for the consideration of religious/spiritual issues, how it pertains to an individual as a trainee but also how it pertains to the clients the profession seeks to serve. However, this situation became more problematic and anxiety provoking when I first encountered clients for whom religion/spirituality was important and felt confused and uncertain in terms of how to approach and work with these issues. It was for this reason that I embarked on a study exploring how applied psychologists address issues of religion/spirituality during therapy and from these accounts suggest statements indicative of religious/spiritual competencies, which could be carried over for future research.

The actual process of conducting and writing this study was one that I found exciting, encouraging but also challenging. There were moments during the analysis (both initial and re-analysis) phase when like the participants, I felt strong feelings in two directions. There was resentment towards the profession of psychology and the service organisation it works in. These feelings often shifted and turned to admiration of the participants' efforts and open practice towards issues of religion/spirituality. However, in another direction I was aware of my desire to remain curious and explorative throughout the research process. Whilst this was managed to a significant degree, I know that my life experiences, interests and knowledge will still inevitably influence my perception and thus interpretations and understanding of the phenomena under study (Charmaz (2006, p.131) presents a similar idea when referring to constructivist grounded theorists).

Through this research process, I became even more aware of how sensitive the topic of religion/spirituality was for the profession of psychology. I use the term sensitive here to mean an area that is ‘sore’ and may arouse myriad emotions and reactions (e.g. from anger, scepticism, to fear and confusion). I also have a better understanding of just how important the issue of religion/spirituality is, not just personally but professionally. At the same time, I’ve been able to reflect on how I have tended to focus on the positive aspects of religion/spirituality and thus not fully appreciated the negative aspects and how detrimental they can be for individuals. Together, this has made me more determined to find ways of working ethically, perceptively and professionally with these issues.

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APPENDICES

Appendix 1 Ethics Registration Letter

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

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Appendix 2. Letter of Invitation

An invitation for participation in thesis research in Clinical Psychology

I am writing to invite participants to take part in my thesis study entitled "**Towards Spiritual and Religious Competencies for Clinical Psychologists in NHS settings in the UK**". I am looking for clinical psychologists working in Britain, in the NHS, who encounter and feel that issues of religion and spirituality are relevant to their clinical work.

Participation involves an interview which will be recorded and transcribed. The interview is expected to last a total of 60 to 90 minutes ad will be held at the University of East London or a suitable location within greater London. If you would like to take part or have any questions, please email me.

The study has ethical approval from the University of East London Research Ethics Committee. Many thanks for your time.

Precious Legemah

Email address: u1037631@uel.ac.uk

Appendix 3. Participant Information Sheet

UNIVERSITY OF EAST LONDON

School of Psychology
Stratford Campus
Water Lane
London E15 4LZ

The Principal Investigator(s)
Precious Legemah
Contact Details: u1037631@uel.ac.uk

Consent to Participate in a Research Study

The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate in a research study. The study is being conducted as part of my Doctorate in Clinical Psychology at the University of East London.

Project Title

TOWARDS SPIRITUAL AND RELIGIOUS COMPETENCIES FOR CLINICAL PSYCHOLOGISTS IN NHS SETTINGS IN THE UK

Project Description

Spirituality and religion are important aspects of human diversity, these concerns are important to our clients. Whilst there have been studies addressing this area in relation to health and well-being, there is little or no account by the profession

of clinical psychology working in the NHS, UK. This research will explore the issue of spiritual and religious competency in the practice of clinical psychologists working in the NHS, UK.

Participants will be interviewed exploring their experience and views of how they address spiritual and religious issues which arise during therapy. The interviews will also explore what guides participants in the process of addressing such issues with a client. The interview will also explore participants' views of existing accounts of the characteristics of religious and spiritual competent practice.

There are no known hazards or risk resulting from participation in this research. In the unlikely event of this research raising feelings of discomfort or distress, participant can make this known to the researcher and the interview session will be suspended, allowing for participants to seek support in the way they deem most appropriate (e.g. taking time out, further discussion of the matter with researcher or seeking support from peers/supervisor).

Appendix 4. Consent Form

UNIVERSITY OF EAST LONDON

Consent to participate in a research study

SPIRITUALITY AND RELIGIOUS COMPETENCIES: A MODEL OF FOR CLINICAL PSYCHOLOGIST IN NHS SETTINGS IN THE UK

I have the read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher(s) involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw, the researcher reserves the right to use my anonymous data in the write-up of the study and in any further analysis that may be conducted by the researcher.

Participant’s Name (BLOCK CAPITALS)

…….

Participant’s Signature

……..

Researcher’s Name (BLOCK CAPITALS)

PRECIOUS LEGEMAH……..

Researcher’s Signature

……

Date: ……..…….

Appendix 5. Demographic Information Sheet

Demographic information

1. Number of years employed by the NHS as a Clinical Psychologist:
2. Type of service working in e.g., CMHT, CAMHS, LD Service, Older Adults:
3. Current post/position:
4. Gender:
5. Religious/spiritual status:
6. Main model/approach of working:

Appendix 6. Interview Protocol

Part 1: Current experiences and views

1. Can you tell me your experience of working with clients for whom religion and spirituality was of great importance in the work/intervention you did with them?
2. Was there anything guiding your practice? How did you come to the decisions you made in regards to the intervention you adopted or did not adopt?
    - What guiding ideas do you have regarding the point at which(/the trigger for) spiritual and religious concerns should be (to be especially) focused upon, in
        - Assessment
        - Intervention
    - Do any examples come to mind, of times when you decided to, and when you decided *not* to, make a deliberate focus upon such issues?

Part 2: Competency

1. What does the term ‘competency’ mean to you?
2. What in your opinion makes a ‘competent’ clinician (i.e. clinical psychologist)?
3. Is there anything that makes you feel incompetent, with regards to this client group? How would you like to behave?

Part 3: Awareness of guidelines related to spirituality and religious practice

1. Are you aware of any guidelines, documents, which directs you on how to work with clients for whom spirituality and religion is of great importance?
2. What are your views on these guidelines? Are they useful, not useful, neutral?

Part 4: Views and responses to existing accounts of spiritual and religious competent practice lists

1. Having seen these list/guidelines put together by various authors from different professional backgrounds, what are your views on them?
    - Are there various aspects of it that are being met or not met?
    - ? Relevance? What's missing? What is important to know?

- As a clinical psychologist, what things might you say or do differently? What type of questions might you ask?

Appendix 7. Revised Interview Protocol

**** added item***

What ideas did you have about what my research might be about after reading my invitation letter?

Part 1: Current experiences and views

1. Can you tell me your experience of working with clients for whom spirituality and religion was of great importance in the work/intervention you did with them?

2. Was there anything guiding your practice? How did you come to the decisions you made in regards to the intervention you adopted or did not adopt?
    - What guiding ideas do you have regarding the point at which(/the trigger for) spiritual and religious concerns should be (to be especially) focused upon, in
        - Assessment
        - Intervention
    - Do any examples come to mind, of times when you decided to, and when you decided not to, make a deliberate focus upon such issues?

* Having awareness (follow line through with participants – what does having awareness entail with regards to religion and spirituality?)

* Going with what one is 'feeling' – what does this look like? what situation is this likely to occur in, why?

Part 2: Competency

1. What does the term 'competency' mean to you?
2. What in your opinion makes a 'competent' clinician (i.e. clinical psychologist, social worker)?
3. Is there anything that makes you feel incompetent, with regards to this client group? How would you like to behave?

Part 3: Awareness of guidelines related to spirituality and religious practice

1. Are you aware of any guidelines, documents, which directs you on how to work with clients for whom spirituality and religion is of great importance?
2. What are your views on these guidelines? Are they useful, not useful, neutral?

Part 4: Views and responses to existing accounts of spiritual and religious competent practice lists

1. Having seen these list/guidelines put together by various authors from different professional backgrounds, what are your views on them? - *rate self/practice*
    - Are there various aspects of it that you practice or don't practice?
    - ? Relevance? What's missing? What is important to know?

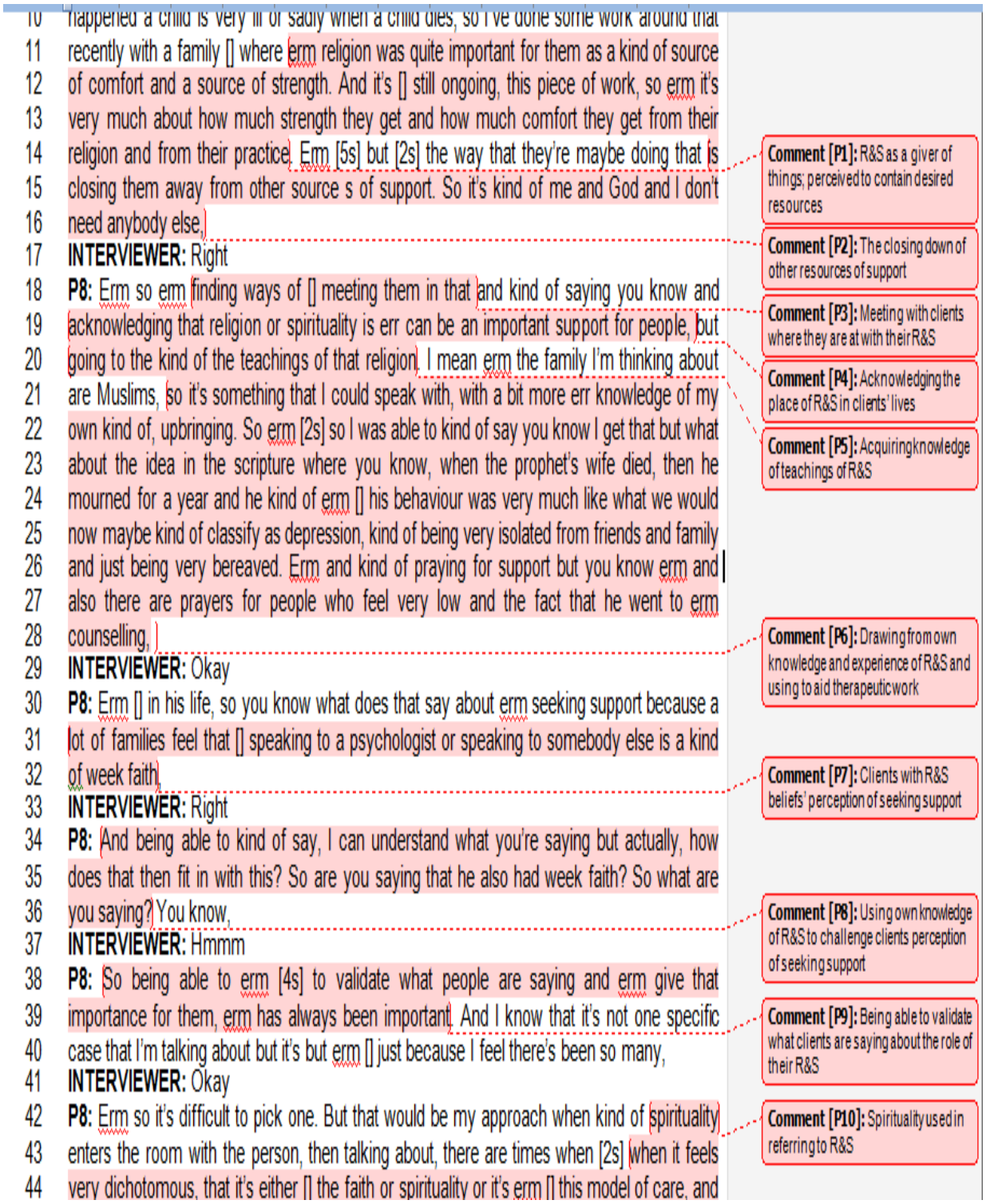
- As a clinical psychologist, what things might you do (or say) differently? What type of questions might you ask?

Closing remarks?

Appendix 8. Transcription Notation System

Notation	
P	Participant e.g., P1= Participant 1
[]	A pause
[2s], [3s], [4s]	Number of seconds of pause
[laughs]	Quiet laughter/snigger
[LAUGHS]	Loud laughter
Words in CAPS	Emphasis on words e.g. word dragged, word projected louder than other words
Words in italics	Interviewer not sure of uttered word
_	Word not clear/undetectable
(/)	Word unfinished/incomplete
...	Sentence interrupted, intrusion either by interviewer or by participant
“”	Quotes
[sighs]	Sighs
Words in bold	Actions being carried out by participant or interviewer
X	Name of a person, place, organisation, country
[and]	Words added by researcher to complete or give context to sentence

Appendix 9. Example of Transcript – with Coding (P8)



happened a child is very ill or sadly when a child dies, so I've done some work around that
recently with a family [] where erm religion was quite important for them as a kind of source
of comfort and a source of strength. And it's [] still ongoing, this piece of work, so erm it's
very much about how much strength they get and how much comfort they get from their
religion and from their practice. Erm [5s] but [2s] the way that they're maybe doing that is
closing them away from other source s of support. So it's kind of me and God and I don't
need anybody else,
INTERVIEWER: Right
P8: Erm so erm finding ways of [] meeting them in that and kind of saying you know and
acknowledging that religion or spirituality is err can be an important support for people, but
going to the kind of the teachings of that religion. I mean erm the family I'm thinking about
are Muslims, so it's something that I could speak with, with a bit more err knowledge of my
own kind of, upbringing. So erm [2s] so I was able to kind of say you know I get that but what
about the idea in the scripture where you know, when the prophet's wife died, then he
mourned for a year and he kind of erm [] his behaviour was very much like what we would
now maybe kind of classify as depression, kind of being very isolated from friends and family
and just being very bereaved. Erm and kind of praying for support but you know erm and
also there are prayers for people who feel very low and the fact that he went to erm
counselling,
INTERVIEWER: Okay
P8: Erm [] in his life, so you know what does that say about erm seeking support because a
lot of families feel that [] speaking to a psychologist or speaking to somebody else is a kind
of week faith,
INTERVIEWER: Right
P8: And being able to kind of say, I can understand what you're saying but actually, how
does that then fit in with this? So are you saying that he also had week faith? So what are
you saying? You know,
INTERVIEWER: Hmmm
P8: So being able to erm [4s] to validate what people are saying and erm give that
importance for them, erm has always been important. And I know that it's not one specific
case that I'm talking about but it's but erm [] just because I feel there's been so many,
INTERVIEWER: Okay
P8: Erm so it's difficult to pick one. But that would be my approach when kind of spirituality
enters the room with the person, then talking about, there are times when [2s] when it feels
very dichotomous, that it's either [] the faith or spirituality or it's erm [] this model of care, and

Comment [P1]: R&S as a giver of things; perceived to contain desired resources

Comment [P2]: The closing down of other resources of support

Comment [P3]: Meeting with clients where they are at with their R&S

Comment [P4]: Acknowledging the place of R&S in clients' lives

Comment [P5]: Acquiring knowledge of teachings of R&S

Comment [P6]: Drawing from own knowledge and experience of R&S and using to aid therapeutic work

Comment [P7]: Clients with R&S beliefs' perception of seeking support

Comment [P8]: Using own knowledge of R&S to challenge clients perception of seeking support

Comment [P9]: Being able to validate what clients are saying about the role of their R&S

Comment [P10]: Spirituality used in referring to R&S

be believing and to practice and to have that but at the same time to experience distress and upset and worry because that's what life is about,

INTERVIEWER: Hmmm

P8: And actually that you can find [] sources of support and stories of support from within [] the faith,

INTERVIEWER: Right

P8: Whichever faith that might be or whichever faith position or spirituality you might come from. Erm [3s] so I think that's what I mean with that

INTERVIEWER: Okay

P8: Erm I'm trying to think of a specific piece of work that was very much about [3s] around faith or spirituality and I can't think of one. Erm [2s] I can kind of think of snatches where you know for example like I'm saying with this family where a child dies, where [] where it's okay to be upset,

INTERVIEWER: Hmmm

P8: You know and it and [3s] but actually it kind of [] fits in to part of your [] your formulation in a way. Erm [] that you know, because there's feelings of guilt and feelings of kind of I could have done something better, I could have been more, I could have [] you know being, and so, for example once I was working with a woman who said to me well I don't do this and this and this, do you think [] does that make me a bad Muslim?

INTERVIEWER: Right

P8: Do you think I'm a bad Muslim? [] And [] I kind of heard that as being her asking if she was, you know, it depends what she means by it but what does it mean to be a good Muslim, what does it mean to be a bad Muslim? And erm [] and how central to her identity is it to be a Muslim? So is she in essence asking am I a bad person and so then is that kind of what she's feeling. So without kind of answering yes or no,

INTERVIEWER: Hmmm

P8: But erm [] finding out what that means for her, erm and [] what impact faith has on her life because, and I'm talking very much about the people who found spirituality as being something that is really positive in their lives, but of course there people for whom it's been a negative,

INTERVIEWER: Hmmm

P8: Thing too. Erm [3s] for whatever reason erm [2s] so it's always important to find out from people what they mean by [] what their experience has been with the erm [] with their kind of

Comment [P14]: Perception that one can have R&S beliefs and also experience distress – both can co-exist

Comment [P15]: The potential resourcefulness of R&S

Comment [P16]: Instances/scenarios where R&S may arise as a source

Comment [P17]: Using formulations

Comment [P18]: Clients associated feelings of loss

Comment [P19]: Formulating client's question around R&S

Comment [P20]: Exploring the role/meaning of R&S for a client

Comment [P21]: Dual role of R&S – positive & negative

disclosed as soon as I walk in the room,

INTERVIEWER: Hmmm

P8: Erm that I always [3s] whenever there is an opportunity I would always try to bring it to the table and kind of say you know what does it mean for you that somebody is [] err [] you know there are some very multiple differences around us. And I kind of, I put it on the table,

INTERVIEWER: Your [] erm, you bring yourself in in terms of what it feels like for the client that ...,

P8: Well I ask, I'm curious to know what they think, what their assumptions about me are,

INTERVIEWER: Okay, right

P8: Erm but you know in a kind of careful way, I'm trying to remember [] in a way that fits with the conversation that we're having, you know. So for example one client erm that I was working with had just had a termination but she was finding it difficult to [2s] to speak about it, understandably,

INTERVIEWER: Hmmm

P8: Erm because well you know I don't want to assume how it felt for her but erm [] but we were talking about talking and how there are certain things that make it difficult to talk about these things and certain things might make it easier,

INTERVIEWER: Hmmm

P8: What might make it easier and what are the things that stand, that you feel get in the way of that, and what would be different. Erm and just kind of being curious and saying oh I wonder whether there is something about our relationship, about the way [] that we are together, the way that I am with you that makes it difficult to speak about it, and kind of, so not saying [] in very bold terms you know look I'm a Muslim, are you making assumptions that I'm judging you in some way, you know not saying something as blatant as that,

INTERVIEWER: Hmmm

P8: But working it and allowing the opportunity for that conversation to happen

INTERVIEWER: Hmmm

P8: Erm [3s] is something that I've kind of spent training and then [] qualification [laughs] doing. Erm so I think, yeah I think being kind of a very obvious and observable Muslim [] erm has made it easier to talk about issues of difference generally,

INTERVIEWER: Okay

P8: Erm but spirituality I think particularly, and I think also with people who aren't Muslim because they say well you know you're not of my faith but I can see that you do have a faith,

INTERVIEWER: Hmmm

P8: And you do have spiritual practices so you know what it's like for me because I have to do this or because you know. So whatever their experience, their particular experience that they're struggling with, I've had that [] said to me a lot of the times in sessions.

INTERVIEWER: Okay. Erm so sort of thinking about if you weren't a Muslim and you just

Comment [P25]: R&S as something that is disclosed – by appearance

Comment [P26]: Ceasing opportunity to raise issue of R&S

Comment [P27]: R&S referred to as difference/s

Comment [P28]: Being curious about clients assumptions about clinician

Comment [P29]: Using curiosity to elicit clients assumption of clinician who is R&S

Comment [P30]: Harnessing the skill of curiously asking questions and creating opportunity for conversation around R&S

Comment [P31]: Being an observable Muslim linked to ease of talking of talking about issues of difference – R&S

Comment [P32]: A sense of commonality of clinician's R&S and that of the clients

Comment [P33]: A sense of

Appendix 10. List of Codes and Initial themes

Codes

1	Feeling comfortable addressing R/S
2	Conducting assessments
3	Positive impact of R/S
4	Negative impact of R/S
5	Awareness of people's emotional response to illness – work in palliative care
6	'Careful listening'
7	Essential to help people find meaning and purpose in their experiences
8	Perceptions of illness – punishment vs. Unfortunate
9	Rejection by faith background
10	Holding R/S in conscience to guide practice
11	Being informed by experience – personal and professional
12	Being informed by interest in the area
13	Being informed by training
14	Being informed and influenced by multiple factors
15	Meaning and purpose linked to R/S beliefs
16	R/S linked to past and present experiences
17	Using formulations
18	Issues of diversity, difference
19	Certain groups lean more towards R/S
20	Tension faced by clients with R/S seeking psychological assistance
21	Being interested in what people give value to
22	Avoiding tendency to focus on medical explanations
23	Psychology as atheistic
24	Having an obligation to ask about R/S
25	Changes in practice in the last two decades
26	Networking with faith groups
27	R/S influence on life choices
28	Being aware of faith traditions
29	Meaning of faith traditions for clients
30	Working with R/S not different from working in other areas as a psychologist
31	Having a base of bits of knowledge
32	Practical knowledge
33	Having someone to talk to in order to get knowledge
34	Taking the weight of explanation off of clients
35	Having self-awareness
36	Having the willingness to work with R/S
37	Awareness of people's context
38	Openness about own R/S
39	Empathising with client's situations
40	Using strategies from client's R/S traditions – prayers, texts
41	Assessing adequacy of intervention
42	Going with feelings about the situation
43	Peer supervision
44	Asking questions
45	Checking client's beliefs

46	The place of understanding
47	Clinician's attitude - hindrance
48	Being open – keeping an open mind
49	Making an effort
50	Clients with faith - clients without faith
51	R/S linked to assurance, hope
52	R/S way of making sense of difficulties
53	Disclosing own beliefs
54	Self disclosure useful
55	Self disclosure not useful
56	Avoiding self disclosure
57	Using intuition to guide practice
58	Connecting R/S with own identity
59	Going with gut feelings
60	Being led by what clients value
61	Awareness of own limitations
62	Not knowing what to do
63	Working in private sectors
64	Notion of rationality – explainable vs. unexplainable
65	Issues of power on organisational level - pressures
66	Need for evidence – evidence based practice
67	Feeling of R/S issues being neglected by training courses
68	Having research interest in R/S
69	Distinguishing levels of faith
70	R/S as a range of resources
71	Reflection on nature of work
72	Working systemically
73	Having an identified psychological technique
74	Exploring beliefs and content of belief
75	Validating beliefs
76	Using resources identified by clients
77	R/S as coping strategies
78	Linking practice to research
79	More freedom in private practice compared to NHS
80	Interconnection of R/S issues and well-being
81	Adapting psychological intervention to work with R/S issues
82	Importance of having knowledge of faith texts
83	Variation in work with clients with R/S issues
84	Lack of choice in NHS for clients with R/S issues
85	Issue of exclusion of clients with active faith
86	Having the skills and knowledge to work with R/S issues
87	Understanding complexity of each faith tradition
88	Having awareness of own assumptions about R/S
89	Recognising when issues of R/S are brought into session
90	Distinguishing between spirituality and religion
91	Use of assessment tools, techniques – genograms
92	Need for flexibility
93	Avoiding assumptions – not making assumptions
94	Respecting, honouring R/S beliefs of clients
95	Creating opportunity to talk about R/S – with clients, colleagues

96	Role as a clinician
97	Identifying where expertise lie
98	Clients' fear of their R/S beliefs being stigmatised by services
99	Importance of good therapeutic relationship
100	Learning about different faith traditions
101	Multiple sources of gaining knowledge
102	using faith languages/words of clients
103	Practicing with 'inconsistency'
104	Making an effort, reaching out
105	Enquiring and being curious about individuals and their R/S beliefs
106	Deconstructing psychological models
107	Appropriating the use of psychological models
108	Creating space for prior knowledge
109	Working against the system to meet clients' needs
110	Evaluating the concept of evidence based practice
111	Being mindful of meeting service organisation targets, deadlines
112	The act of 'being'
113	Being mindful of own practice
114	Having awareness of impact of own R/S beliefs on practice
115	R/S and psychology as linked and overlapping
116	Not pushing/forcing topic of R/S with clients
117	A need for specialist in area of R/S
11	Seeking more training in area of R/S

Initial Themes

N	Themes	Corresponding data (participant and line number)
1	Finding meaning and purpose in life – past and present experiences	P3: L264-268; 281-287 P7: L190; 1204
2	R/S is linked to people's sense of identity; well-being; the world	P1: L101; 243-245; 319-328 P2: L162-163 P3: L165-168; 172; 181; 235; 249; 270 P4: L135-138 P5: L464 P6: L9-11; 14-15 P7: L33-35; 119-120; 228-234; 369-371 P8: L19-20; 78
3	R/S a resource, a way of coping with life difficulties	P1: L103-104 P2: L141-145 P3: L261; 278 P4: L45-46; 50-53 P5: L447-461 P7: L223-225 P8: L11-12; 59-60
4	Drawing on R/S behaviours, practices, beliefs of the clients in therapeutic work	P1: L121-123; 140-142; 170-173; 178-184; 192-196; 266-269; 270-278; 292-298 P2: L68; 72; 91-99 P3: L101-108 P5: L58; 61-64; 109-110; 163-169; 191-212; 382-384; 449-450 P6: L8; 14-15; 21-22; 26; 30-36; 59-64 P7: L83; 90-93; 141-142; 148-149; 401-402 P8: L20; 206-213; 217-221
5	Considering the fit of psychological models with clients' R/S presentation	P1: L136-138 P2: L47; 52-54; 75-77; 102-104; 109; 259-261 P3: L404-419; 422-427 P4: L108; 113-114; 144; 157-159; 403-404; 413-416; 886-887;959-960 P5: L449-455; 479-484; 503-507; 511-520; 592-599; 614-619; 638-639; 648-650 P7: L101; 108-110 P8: L194-196; 130-131
6	Incorporating R/S in psychological formulations	P1: L264-266 P2: L618-619; 621-624; 634-643; 845-853 P3: L760-761; 870-873 P8: L70
7	Awareness of the role of R/S for clients and clinicians	P1: L402-404 P2: L130-131; 140-141; 270 P3: L178-186 P4: L195-196 P5: L439; 444-445 P6: L148-152; 171-172 P7: L12; 22-28; 218; 251; 495 P8: L31-32; 44-57; 177-178; 203-204; 242
8	The role of clinicians – attitudes and remit	P1: L470; 788 P2: L191-194

		P4: L184-186; 290; 389; 397-400; 786 P5: L91-96; 467-472; 497-498; 1176; 1184; 1211-1212 P6: L45-46; 114-117; 120-121 P7: L19; 63-70; 82; 131
9	Double face of R/S – positive and negative	P2: L198-211 P3: L239-246; 260-262 P4: L50-54; 220 P6: L195-197 P7: L157
10	The act of disclosing – as a client and as a clinician	P1: L55; 61-70 P3: L294-299; 311-319; 592-594 P4: L279-282 P5: L135-140; 345-346 P6: L562-576 P7: L86-88 P8: L108-115; 143-151; 252-254
11	Drawing on intuition, instincts and gut feelings	P1: L57-59 P2: L259-262 P3: L95; 113; 124; 294; 307; 322-323; 384-385; 405; 699
12	Having an obligation to ask about R/S in assessments	P1: L83-85; 96; 105-107; 110-113; 411-412 P2: L132; 147; 201-204; 216; 231-238 P3: L162; 208-211 P4: L195-197 P5: L401-405; 408-413; 488-494 P6: L121-127; 504-517 P7: L62 P8: L82-89; 92-94; 289-292
13	Using exploratory tool such as genogram in assessments	P4: L171-174; 206-212 P7: L158; 212 P8: L89
14	The role of clinicians' personal experiences and knowledge in relation to R/S	P1: L90-93 P2: L264-267 P3: L292-293 P5: L541-545; 773-776; 780; 863-865; 1010-1012 P6: L173-186; 201-202; 240-241 P7: L161-162; 186-189 P8: L20-30; 34-36; 183-187
15	The neglect of R/S in doctoral training and NHS settings	P1: L95-96; P2: L343-345 P4: L624 P5: L716-717; 1056-1061; 1072-1074 P6: L358-360 P7: L440-441; 446-447
16	Having the willingness to explore area of R/S	P1: L97-101; 207 P2: L416-420; 426-429 P3: L207-211, 215 P5: L121; 142; 408; 419-421; 424-428; 719-721; 1067-1071; 1090 P6: L113-114; 162-169; 348; 707-711 P7: L18; 37-38; 257-260; 369; 586 P8: L174-175; 249

17	R/S as diverse and intricate phenomena – definition, practices	P1: L100-101; 348-359; 406-407; 449 P2: L165-172; 174-178; 183-189 P3: L240-244 P5: L398-401 P6: L188-193; 201-203; 250-254; 408-410; 412-421; 199 P7: L20; 252-255 P8: L317-320
18	Creating and ceasing opportunity to talk about R/S with clients and colleagues	P2: L64-65; 82-84; 104; 118-123; 163; 140-141; 270 P3: L101; 142-147; 190 P4: L195-197 P5: L146; 150; 167-187; 944; 1093-1096 P6: L12-13; 24-25; 72-74; 93-95; 278-280; 349-354 P7: L77; 156-157 P8: L117-119; 130-131; 140; 264-267; 269-276
19	Having an open mind, being curious and avoiding assumptions	P2: L269-271 P3: L225; 552-554; 567 P5: L149; 550-560 P7: L29; 31-32; 102-105; 131-132; 147; 166; 316-317; 369-371 P8: L122-126; 129; 134-138; 194; 215-217; 243; 246-247; 294-298; 300-306
20	Rationality – the explainable and unexplainable	P5: L561-571; 573-576; 584-583
21	Being client led – valuing what's important to client	P1: L338-339 P2: L161-163 P3: L97-98 P4: L135; 797 P5: L657-670; 674-677; 683-690; 730-738; 754-766; 782-787 P6: L79-80; 89-90; 134-138; 145-148 P7: L140; 152 P8: L18; 336
22	Acquiring knowledge about different R/S values, practices	P1: L301-302 P5: L98-99; 101; 389-393; 422-432 P8: L20
23	Self reflection – reflective practices	P1: L412-418; 436-441 P2: L73; 114-116; 134-136 P5: L143; 320-323; 377-380; 428; 434; 813; 1083-1085 P6: L130-131; 215-221; 223-232; 243-244; 372-394; 420-431; 433-436
24	Organisational pressures and issue of power	P1: L28; 49-52; 238-244; 361 P5: L601-619; 633; 652-656; 693; 708-711; 740-743; 768-770; 807-809;883-892; 957-990; 1004-1008; 1034-1037 P6: L103-105
25	Working outside EBP as important for effective therapeutic outcome	P5: L667-677; 683-690; 730-738; 754-766; 782-787
26	Influence of multiple factors on practice in relation to R/S	P1: L206-212 P5: L1127, 1130-1131

		P7: L159, 161, 265-268 P8: L170-174
27	Tension between R/S and medical discourse	P3: L201-205 P4: L166 P7: L241-242 P8: L43-46
28	Owning psychological models rather than being owned by them	P5: L89, 626-635, 648-649
29	Knowledge of R/S issues and skills to work with them	P1: L383-386; 391-396; 402-407; 447-448; 630-634; 642-645 P2: L283-285; 288; 291; 809-810; 845 P4: L488-494 P5: L79; 88-89; 96-104, 349-353; 1131-1134; 1136 P6: L462-463; 521-523 P7: L218 P8: L312-315; 317-320; 326-328;
30	Awareness of R/S issues and its significance for clients	P1: L100-104, 406-408 P2: L143-145 P3: L178-182, 192-194 P4: L135-138 P6: L250-256 P8: L317-320
31	Being aware of and avoiding making assumptions	P1: L410-412 P3: L552-554, 567-568 P8: L294-303
32	Possessing genuine listening skills	P3: L225-227, 353-355, 858-861 P4: L194-197 P6: L246-247 P7: L111-112, 280-284, 320-323 P8: L338-339, 392-394, 605-607, 635-636
33	Conducting assessments and talking about R/S	P1: L83-85 P3: L162-166 P6: L121-124 P7: L62-65, 74-77 P8: L370-371
34	Understanding and reflection of own position and experience of R/S	P1: L97-101, 412-418, 436-441 P2: L353-357 P5: L157-172, 1072-1074, 1075-1077 P7: L10-14, 124-129
35	Knowledge of therapeutic models and how to adapt these accordingly	P1: L136-138 P2: L47; 52-54; 75-77; 102-104; 109; 259-261 P3: L404-419; 422-427 P4: L108; 113-114; 144; 157-159; 403-404; 413-416; 886-887;959-960 P5: L449-455; 479-484; 503-507; 511-520; 592-599; 614-619; 638-639; 648-650 P7: L101; 108-110 P8: L194-196; 130-131
36	Being aware of own limitations – feelings of incompetence	P1: L526-535 P4: L357-358, 525-526, 528-532 P6: L321-326, 328-333 P7: L312, 315

37	Awareness of clients' context and issue of difference/diversity	P4: L41-46 P5: L641-650 P7: L252-255 P8: L474-479
38	Making R/S more visible - having more conversations	P2: L824-827, 835-844 P6: L642-648 P7: L553, 586, 604-605 P8: L616-619, 630-631
39	Taking a proactive interest in the area of R/S	P1: L641-646 P2: L844-845 P4: L836-839 P7: L553-561 P8: L616-619, 630-631
40	Creating scope for discussion of own R/S stance in training programmes	P1: L446-449 P4: L623-629 P5: L1217-1218, 1222-1224
41	Establishing a collaborative relationship with faith communities	P3: L490-495, 689-694 P4: L660-675 P6: L330-332 P7: L226-229

Appendix 11. Super-ordinate Themes and Sub-themes

- R&S = Religion/Spirituality
- EBP = Evidence Based Practice

Super-ordinate themes	Sub-themes
1. Perception of role of R&S for clients	1. Finding meaning and purpose in life – past and present experiences
	2. R&S is linked to people's sense of identity; well-being; their world
	3. R&S a resource, a way of coping with life difficulties
2. Clinicians' perception of R&S	9. Double face of R&S – positive and negative
	17. R&S as diverse and intricate phenomena – definition, practices
	20. Rationality – the explainable and unexplainable
3. Perception of place of R&S in psychology	15. The neglect of R&S in doctoral training and NHS settings
4. Personal characteristics that enable clinicians to work with R&S issues	7. Awareness of the role of R&S for clients and clinicians
	16. Having the willingness to explore area of R&S
	19. Having an open mind, being curious and avoiding assumptions
	23. Self reflection – reflective practices
	30. Awareness of R&S issues and its significance for clients
	32. Possess genuine listening skills
	34. Understanding and reflection of own position and experience of R&S
5. Knowledge needed to enable clinicians to work with R&S issues	8. The role of clinicians – attitudes and remit
	14. The role of clinicians' personal experiences and knowledge in relation to R&S
	26. The influence of multiple factors on practice in relation to R&S
	29. Knowledge of R&S issues and skills to work with them
	36. Awareness of own limitations – feelings of incompetence
	37. Awareness of clients' context and issue of difference/diversity
6. Practical elements of working with clients for whom R&S is important	4. Drawing on R&S practices, beliefs of the clients in therapeutic work
	5. Considering the fit of psychological models with clients' R&S presentation
	6. Incorporating R&S in psychological formulations
	11. Drawing on intuition, instincts and gut feelings
	12. Feeling obliged to ask about R&S in assessments
	13. Using exploratory tools such as genogram in assessments
	18. Creating and ceasing opportunity to talk about R&S with clients and colleagues
	21. Being client led – valuing what's important to client

	22. Acquiring knowledge about different R&S values, practices
	28. Owning psychological models rather than being owned by them
	31. Being aware of and avoiding making assumptions
	32. Possess genuine listening skills
	33. Conducting assessments and talking about R&S
	35. Knowledge of therapeutic models and how to adapt these accordingly
7. Challenges faced when working with and acknowledging role of R&S for clients	10. The act of disclosing – as a client and as a clinician
	15. The neglect of R&S in doctoral training and NHS settings – implication for practice
	24. Organisational pressures and issue of power
	25. Working outside EBP as important for effective therapeutic outcome
	27. Tension between R&S and medical discourse
8. Developing area of R&S – training and practice	38. Making R&S more visible - having more conversations
	39. Taking a proactive interest in the area of R&S
	40. Creating scope for discussion of own R&S stance in training programmes
	41. Establishing a collaborative relationship with faith communities

Appendix 12. Thematic Tables – Reviewing and Refining Themes

Thematic Table 2.

Super-ordinate themes	Sub-ordinate themes
1. Perceptions of R&S	1. Finding meaning and purpose in life – past and present experiences
	2. R&S is linked to people's sense of identity; well-being; their world
	3. R&S a resource, a way of coping with life difficulties
	9.Double face of R&S – positive and negative
	15. The neglect of R&S in doctoral training and NHS settings
	17. R&S as diverse and intricate phenomena – definition, practices
	20. Rationality – the explainable and unexplainable
2. Personal characteristics that enable clinicians to work with R&S issues	7/30. Awareness of R&S issues and its significance for clients and clinicians
	16. Having the willingness to explore area of R&S
	19. Having an open mind, being curious and avoiding assumptions
	23. Self reflection – reflective practices
	32. Possess genuine listening skills
	34. Understanding and reflecting on own position and experience of R&S
3. Knowledge needed to enable clinicians to work with R&S issues	8. The role of clinicians – attitudes and remit
	14. The role of clinicians' personal experiences and knowledge in relation to R&S
	26. The influence of multiple factors on practice in relation to R&S
	29. Knowledge of R&S issues and skills to work with them
	36. Awareness of own limitations – feelings of incompetence
	37. Awareness of clients' context and issue of difference/diversity
4. Practical elements of working with clients for whom R&S is important	4. Drawing on R&S practices, beliefs of the clients in therapeutic work
	5. Considering the fit of psychological models with clients' R&S presentation
	6. Incorporating R&S in psychological formulations
	11. Drawing on intuition, instincts and gut feelings
	12/33. Feeling obliged to ask about R&S in assessments
	13. Using exploratory tools such as genogram in assessments
	18. Creating and ceasing opportunity to talk about R&S with clients and colleagues
	21. Being client led – valuing what's important to client
	22. Acquiring knowledge about different R&S values, practices
	28. Owning psychological models rather than being owned by them
	31. Being aware of and avoiding making assumptions
	32. Possess genuine listening skills
	35. Knowledge of therapeutic models and how to adapt these

	accordingly
5. Challenges faced when working with and acknowledging role of R&S for clients	10. The act of disclosing – as a client and as a clinician
	15. The neglect of R&S in doctoral training and NHS settings – implication for practice
	24. Organisational pressures and issue of power
	25. Working outside EBP as important for effective therapeutic outcome
	27. Tension between R&S and medical discourse
6. Developing area of R&S – training and practice	38. Making R&S more visible - having more conversations
	39. Taking a proactive interest in the area of R&S
	40. Creating scope for discussion of own R&S stance in training programmes
	41. Establishing a collaborative relationship with faith communities

Thematic Table 3.

Super-ordinate themes	Sub-ordinates themes	Themes
1. Perceptions of R&S	***R&S and sense of personhood/being***	1. Finding meaning and purpose in life – past and present experiences
		2. R&S is linked to people's sense of identity; well-being; their world
		3. R&S a resource, a way of coping with life difficulties
	R&S as a diverse phenomenon	17. R&S as diverse and intricate phenomena – definition, practices
		9.Double face of R&S – positive and negative
		20. Rationality – the explainable and unexplainable
	15. The neglect of R&S in doctoral training and NHS settings	
2. Personal characteristics that enable clinicians to work with R&S	***7/30. Awareness of R&S issues and its significance for clients and clinicians***	
	16. Having the willingness to explore area of R&S	
	19. Having an open mind, being curious and avoiding assumptions	
	23/34. Self reflection – reflective practices, understanding and reflecting on own position and experience of R&S	
	32. Possess genuine listening skills	
3. Knowledge needed to enable clinicians to work with R&S issues	***The role of clinicians***	8. The role of clinicians – attitudes and remit
		14/26. The influence of clinicians' personal experiences and knowledge in relation to R&S
		36. Awareness of own limitations – feelings of incompetence
		37. Awareness of clients' context and issue of difference/diversity
	29. Knowledge of R&S issues and skills to work with them	

4. Practical elements of working with clients for whom R&S is important	***Conducting comprehensive assessments***	12/33. Feeling obliged to ask about R&S in assessments
		13. Using exploratory tools such as genogram in assessments
		21. Being client led – valuing what's important to client
	35. Adapting psychological models/interventions	4. Drawing on R&S practices, beliefs of the clients in therapeutic work
		5/35. Considering the fit of psychological models with clients' R&S presentation
		28. Owning psychological models rather than being owned by them
	22. Acquiring knowledge about different R&S values, practices	31. Being aware of and avoiding making assumptions
	11. Drawing on intuition, instincts and gut feelings	
	18. Creating and ceasing opportunity to talk about R&S with clients and colleagues	
	32. Possess genuine listening skills	
5. Challenges faced when working with and/or acknowledging role of R&S for clients	***24. Organisational pressures and issue of power***	15. The neglect of R&S in doctoral training and NHS settings – implication for practice
		25. Working outside EBP as important for effective therapeutic outcome
		27. Tension between R&S and medical discourse
	10. The act of disclosing – as a client and as a clinician	
6. Developing area of R&S – training and practice	***38. Making R&S more visible - having more conversations***	39. Taking a proactive interest in the area of R&S
		40. Creating scope for discussion of own R&S stance in training programmes
		41. Establishing a collaborative relationship with faith communities

Appendix 13. Final Thematic Table

Super-ordinate Themes	Sub-themes	Themes
1. Broad characteristics attributed to Religion/ Spirituality (R/S)	R/S as Multi-factorial, diverse	*R/S as diverse and intricate phenomena – definition, practices, terminology*
		Double face of R/S; positive and negative qualities
		Rationality; the explainable and unexplainable
	Existential connections	*Client* religion/spirituality *is linked to a sense of identity, meaning making and well-being*
2. Personal attributes	Having the willingness to explore area of religion/spirituality	
	Having an open mind, being curious and avoiding assumptions	
	Being client-led – valuing what is important to client	
	Self-reflection	
3. Knowledge	Awareness of R/S issues and its significance for clients and clinicians	
	Knowledge of R/S issues, and skills to work with them	
	Recognising the clinician's role in the therapeutic relationship	*The role of clinicians – attitudes and remit*
		Awareness of own limitations
		Awareness of clients' context and issues of difference/diversity
4. Practice elements	Conducting comprehensive assessments	*Feeling obliged to ask about R/S in assessments (theme 12, 33)*
		Using exploratory tools such as genogram in assessments
	Adaptation of models and techniques	*Drawing on religious/spiritual practices, beliefs of the clients in therapeutic work*
		Considering the fit of psychological models with clients' religious/spiritual presentations
		'Owning' psychological

		models rather than being owned by them
	4.3 Process	*Drawing on intuition, instincts and gut feelings*
		Creating opportunity to talk about religion/spirituality with clients and colleagues
5. Challenges faced when working with and acknowledging the role of R/S for clients	Power and organisational pressures	*The neglect of religion/spirituality in doctoral training and NHS settings – implication for practice*
		Working within evidence based practice (EBP) as reducing effective therapeutic outcome?
		Working with clients' religious/spiritual issues as a specific example of psychology's tension with the medical model
	Disclosure issues	
6. Developing practice and raising visibility – training and practice	Taking a proactive interest in the area of religion/spirituality	
	Creating scope for discussion of own religious/spiritual stance in training programmes	

Appendix 14. Notation System Used for Editing Extracts

Notation	
P	Participant, e.g., P1 = Participant 1
[2s], [3s], [4s]	number of seconds of pause
...	original sentence has been broken before completion
[and]	words added by researcher to complete or give context to sentence
[laughs]	laughter
Words in italics	text spoken by participant referring to a thought or a clients' thought/spoken word
[sighs]	sighs
X	name of a person, place, organisation, country
(200-213)	line/s number from original transcript

Example of an extract edited for readability

Original extract from transcript	**Edited extract**
P2: Er, [] and I think it, its [] I suppose I'm [] something I'm [] trying to be more of is spirituality in the broadest sense. So erm [] I, I, I'm increasing asking people sort of what energises them or what gives them a sense of purpose or what [], ...(165-168) because erm [2s] yeah, so for some people that wouldn't say they're religious or they have a FAITH, they might feel [] erm that sense of peace or sense of [] erm *I'm meant to be here* or something like that.(186-188)	P2: "Something I'm trying to be more **[focused on]** is spirituality in the broadest sense. So I'm increasingly asking people sort of what energises them or what gives them a sense of purpose... Because, so for some people that wouldn't say they're religious or they have a faith, they might feel that sense of peace or sense of *I'm meant to be here* or something like that" (165-168, 186-188)

Appendix 15. Association for Spiritual, Ethical, and Religious Values in Counselling (ASERVIC) – Competencies for Addressing Spiritual and Religious Issues in Counselling

(1) Culture and Worldview

1. The professional counselor can describe the similarities and differences between spirituality and religion, including the basic beliefs of various spiritual systems, major world religions, agnosticism, and atheism.

2. The professional counseling recognizes that the client's beliefs (or absence of beliefs) about spirituality and/or religion are central to his or her worldview and can influence psychosocial functioning.

(2) Counselor Self-Awareness

3. The professional counselor actively explores his or her own attitudes, beliefs, and values about spirituality and/or religion.

4. The professional counselor continuously evaluates the influence of his or her own spiritual and/or religious beliefs and values on the client and the counseling process.

5. The professional counselor can identify the limits of his or her understanding of the client's spiritual and/or religious perspective and is acquainted with religious and spiritual resources and leaders who can be avenues for consultation and to whom the counselor can refer.

(3) Human and Spiritual Development

6. The professional counselor can describe and apply various models of spiritual and/or religious development and their relationship to human development.

(4) Communication

7. The professional counselor responds to client communications about spirituality and/or religion with acceptance and sensitivity.

8. The professional counselor uses spiritual and/or religious concepts that are consistent with the client's spiritual and/or religious perspectives and are acceptable to the client.

9. The professional counselor can recognize spiritual and/or religious themes in client communication and is able to address these with the client when they are therapeutically relevant.

(5) Assessment

10. During the intake and assessment processes, the professional counselor strives to understand a client's spiritual and/or religious perspective by gathering information from the client and/or other sources.

(6) Diagnosis and Treatment

11. When making a diagnosis, the professional counselor recognizes that the client's spiritual and/or religious perspectives can a) enhance well-being; b) contribute to client problems; and/or c) exacerbate symptoms

12. The professional counselor sets goals with the client that are consistent with the client's spiritual and/or religious perspectives.

13. The professional counselor is able to a) modify therapeutic techniques to include a client's spiritual and/or religious perspectives, and b) utilize spiritual and/or religious practices as techniques when appropriate and acceptable to a client's viewpoint.

14. The professional counselor can therapeutically apply theory and current research supporting the inclusion of a client's spiritual and/or religious perspectives and practices.

Appendix 16. Participants' Indications of Religious/Spiritual Competencies

The following areas have been identified as indicative of best practice/ competency:

1. [*Recognising****] Broad characteristics attributed to religion/spirituality***

- Religion/spirituality as multi-factorial, diverse
  - Double face of religion/spirituality; positive and negative qualities
  - Religion/spirituality as a resource, a way of coping with life's difficulties
- Existential connections
  - Client religion/spirituality is linked to a sense of identity, finding meaning and well-being

2. Personal attributes

- Having the willingness to explore area of religion/spirituality
- Having an open mind, being curious and avoiding assumptions
- Being client led – valuing what's important to client
- Self-reflection – being able to reflect on own religious/spiritual stance, views, experiences, etc.

3. Knowledge

- Awareness of religious/spiritual issues and its significance for clients and clinicians
- Knowledge of religious/spiritual issues, and skills to work with them
- Recognising the clinician's role in the therapeutic relationship
  - The role of clinicians – attitudes and remit;
  - Awareness of own limitations
  - Awareness of clients' context and issues of difference/diversity

4. Practice elements

- Conducting comprehensive assessments
- Adaptation of psychological models and techniques
- Creating opportunity to talk about religion/spirituality with clients and colleagues

Appendix 17. Richards and Bergin's (1997, 2000) Recommendation for Religious/Spiritual Competency

A summary of some of the essential attitudes and skills of Spiritual Competent therapist:

1. Spiritually competent therapists are aware of own religious and spiritual heritage, worldview assumptions, and values and are sensitive to how their own spiritual issues, values, and biases could affect their work with clients from different religious and spiritual traditions.

2. Spiritually competent therapists seek to understand, respect, and appreciate religious and spiritual traditions, worldviews, and values that are different from their own.

3. Spiritually competent therapists are capable of communicating interest, understanding, and respect to clients who have religious and spiritual worldviews, beliefs, and values that are different from the therapist.

4. Spiritually competent therapists seek to understand how a client's religious and spiritual worldviews and values affect the client's sense of identity, lifestyle, and emotional and interpersonal functioning, but they are sensitive to how their own religious and spiritual values and beliefs could bias their judgement.

5. Spiritually competent therapists are sensitive to circumstances (e.g., personal biases, value conflicts, lack of knowledge of the client's religious tradition) that could dictate referral of a religious client to a member of his or her own religious tradition.

6. Spiritually competent therapists have or seek specific knowledge and information about the religious beliefs and traditions of the religious and spiritual clients with whom they work.

7. Spiritually competent therapists avoid making assumptions about the beliefs and values of religious and spiritual clients on the basis of religious affiliation alone, but they seek to gain an in-depth understanding of each client's unique spiritual worldviews, beliefs, and values.

8. Spiritually competent therapists understand how to handle sensitively value and belief conflicts that arise during therapy and do so in a manner that preserves the client's autonomy and self-esteem.

9. Spiritually competent therapists make efforts to establish respectful, trusting relationships with members and leaders in their clients' religious community and

seek to draw on these sources of social support to benefit their clients when appropriate.

10. Spiritually competent therapists seek to understand the religious and spiritual resources in their clients' lives and encourage their clients to use these resources to assist them in their efforts to cope, heal, and change.

11. Spiritually competent therapists seek to use religious and spiritual interventions that are in harmony with their clients' religious and spiritual beliefs when it appears that such interventions could help their clients to cope, heal and change.

Appendix 18. Hodge (2004) and Hodge and Bushfield's (2006) Conceptualisation of Religious/Spiritual Competency

A summary of Hodge (2004) and Hodge and Bushfield's (2006) three dimensional definition of spiritual competence

Dimension 1. Develop a growing awareness of one's own value-informed, spiritual worldview and its associated assumptions, limitations, and biases

This entails an examination of the preconceived notions, values, and assumptions about the nature of reality that are embedded in the practitioner's worldview, regardless of whether or not the world view is explicitly acknowledged as spiritual or not. Part of the self-examination process entails an exploration of personal prejudices, stereotypes, and negative attitudes. The pain associated with identifying, acknowledging, and owning negative beliefs and attitudes often fosters resistance, both conscious and unconscious. However, developing cognizance of one's own values is important for a number of reasons. For example, to avoid imposing one's personal values in therapeutic settings implicitly, one must be aware of what those values are and the cultural heritage in which they are embedded.

Dimension 2. Developing an empathic understanding of the client's spiritual worldview that is devoid of negative judgement

Practitioners do not necessarily have to share the worldviews of their clients, it is necessary however, to develop respect and appreciation for clients' worldviews, to see them as legitimate alternatives to their own or culturally dominant worldviews. As is the case with other cultural worldviews, clients' spiritual worldviews can affect attitudes and practices in a number of areas of significance to practitioners, including child care, communication norms, family relations, gender interactions, understandings of metaphysical, etc. Consequently, it is important to develop specific knowledge about various spiritual populations, particularly those encountered on a regular basis. When learning about various

worldviews, practitioners should be alert for personal issues that may hinder their ability to develop empathic, strengths-based understanding of the belief system. Some personal issues may foster a tendency to perceive various worldviews in a negative light and unless these are identified and resolved, practitioners may experience spiritual counter-transference when encountering devout theists and their narratives.

Dimension 3. The ability to design and implement intervention strategies that are appropriate, relevant, and sensitive to the client's spiritual worldview

Social workers should strive to work within the parameters of clients' spiritual worldviews. Intervention strategies should make sense and resonate with the internal logic of the client's worldview. This approach preserves client autonomy, enhances the likelihood that interventions will be effective, and helps mitigate the possibility that harm will be perpetuated upon the client. Attempts to change clients' theologies, either overtly or covertly, will likely attenuate any existing distrust and possibly end the clinical relationship. Conversely, developing interventions that are consistent with clients' theological beliefs helps build trust, as well as exhibits respect for the central social work value of autonomy.