Deciding what Belongs:
How Psychotherapists in Aotearoa New Zealand Attend to Religion and/or Spirituality.

Helen Jane Florence

A thesis submitted to Auckland University of Technology in fulfilment of the requirements for the degree of Doctor of Philosophy (PhD)

2015

Faculty of Health and Environmental Sciences

Table of Contents

Table of Tables

Table of Figures

Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed:

Helen Florence

Dated:

Acknowledgments

I have greatly valued the support of my supervisors, Dr Keith Tudor and Dr Barbara McKenzie-Green, in conducting this study. Your encouragement, collegiality, knowledge, wisdom and patience have been outstanding. Your holding of this process has helped me keep confidence that I would finish the race! You have taught me much; lessons both expected and unexpected. I am profoundly grateful. Thank you too Dr Alayne Hall for your bicultural supervision and your enthusiasm for this research.

Grateful thanks also to all the psychotherapists who participated in this research. I was humbled and inspired by your honesty, courage and the depth of your sharing. I appreciate the trust you have placed in me. Without your risking, this research would not have been possible.

The grounded theory group, of which I was a member for the duration of my doctoral journey, has been an invaluable source of inspiration. In addition to contributing greatly to my knowledge of the methodology, having colleagues who could analyse verbatim excerpts and offer thoughts on my developing theory, has helped shape my work. Your feedback prior to presentations was also invaluable. It was enriching being part of a family at different doctoral "ages" and my journeying together with you all assuaged the loneliness of doctoral work. We were serious and crazy together.

I am also grateful to Richard Charmley. You generously shared your time over lunch on many occasions over a few years, whilst I agonised over my own spiritual process during this study. It was helpful that we shared the same background; I knew that you "got" where I was coming from. I also appreciated our discussions about ethics relating to RS in clinical practice, as you sparked and extended my thinking. I am glad that I have infected you with my love of bromeliads.

Thank you too to my husband John. You accepted and supported my passion, even though it has meant financial constraint. You have good-humouredly (mostly) tolerated my tunnel vision, my vagueness, and the many projects we have had to put on hold as I was occupied with my magnificent obsession. I know that I could not have done this without your ungrudging support.

My (now adult) children, Sarah and Stephen also deserve special mention. Stephen, I don't think that you have known a time when I wasn't studying! Thank you both for accepting that this was important to me.

Thank you too to my dear friends Suzy, Anna, Bron, Joanne and Ruth, and my siblings, Frances, Paul and Andrew. You have listened to my ravings and understood my preoccupation and unavailability. Thank you Ruth for your technical support.

I have also had some funding support which I want to acknowledge. I was a recipient of an education grant from the New Zealand Association of Psychotherapists. Lastly, I wish to thank the Auckland University of Technology for the provision of a fees scholarship, without which I would not have been able to undertake this research.

Approval for this research was granted by Auckland University of Technology's Ethics Committee on 19 March, 2012. No. 12/44

Abstract

Since the founder of psychoanalysis, Sigmund Freud, declared religion to be an illusory refuge for those who could not face the realities of existence, the relationship between psychotherapy and religion and/or spirituality (RS) has been an uneasy one. However, many psychotherapeutic theories, with a range of positions regarding the function of RS in human existence, have evolved since this fraught beginning. The last 30 years has seen an exponential increase in publications concerning RS in psychotherapy. Client need for attention to this matter has been widely demonstrated, and it is now generally accepted that a person's RS perspective is an aspect of their cultural experience and expression. With increasing global migration, cultural variety and complexity has become a societal norm. Although some similar studies have been conducted in other cultural contexts, there has been no enquiry into how psychotherapists are working with RS within psychotherapy in the bicultural context of Aotearoa New Zealand (ANZ).

This knowledge gap provided the rationale for this study which aimed to uncover all that was involved in how psychotherapists in ANZ attended to RS in the therapeutic process. In order to achieve this aim, the methodology of grounded dimensional analysis, a second generation grounded theory, was utilised, since it provided the most fitting approach for a topic of such complexity. Data gathered by purposive and theoretical sampling from 28 psychotherapist participants over 33 interviews were analysed using constant comparative analysis. A substantive theory of deciding what belongs was constructed, comprising three main theoretical categories: engaging, encountering challenge and negotiating challenge actions. Consequential professional and personal outcomes of expanding practice, maintaining the status quo and presenting as legitimate were also derived. Deciding what belongs was an iterative process, with consequences feeding back into the process at engaging, in a continuous cycle.

This study was significant since it found that it was participants, i.e. the psychotherapists themselves, who decided what belonged at all stages of the process of attending to RS in therapeutic engagement. The need for psychotherapist resourcing was demonstrated, resourcing which includes awareness of the impact of therapists own RS perspectives on clinical practice. The iterative nature of the process suggests that, with increased resourcing, the potential exists for more expansive outcomes.

Chapter One: Preparing the Ground

> Spirituality has lurked around the edges of our profession for as long as patients have been encouraged to lie on the couch and free associate. It has often felt as if we've been talking a forbidden language that exists naively, and needily, in black, zipped-up, fantasies. Members of our Association have occasionally dared to talk or write about the "spiritual" but usually in italics and in faint ink. (Younger, 2015, pp. 43-44)

Introduction

Since the founder of psychoanalysis Sigmund Freud, declared religion to be an illusion (Freud, 1927/2010), the relationship between religion and/or spirituality (RS) and psychotherapy has been an uneasy one (Sorenson, 2004). Indeed, this relationship has been named by some as the last taboo (Kung, 1979; Noam & Wolf, 1993). However, because the majority of literature related to this relationship is derived from the USA, and since RS is a cultural construct, I aim in this study, to explore the relationship between RS and psychotherapy in the bicultural context of Aotearoa New Zealand (ANZ).

In this opening chapter, which is divided into four sections, the parameters of the research are introduced. In the first section, my interest in the topic is discussed; the aim and purpose of the study, together with key terms and literature search strategies, are also established; the methodology employed for the study is then introduced. The second section covers the cultural context of the research, and the third considers psychotherapy in ANZ. In the final section, the structure of the thesis is delineated.

My interest in the research

I am a registered psychotherapist and a Christian; my interest in the topic stems from my Christian worldview, my psychotherapy education, clinical work, and experience in the psychotherapy community. The late Gregory Bateson (1904-1980) observed that "the point of the probe is always in the heart of the researcher" (quoted in Bathgate, 2003, p. 278). According to Winnicott (Winnicott, 1949), we research in psychotherapy in an attempt to understand what we have not been able to work out in our own therapy. Both these statements resonate for me.

Chapter One: Preparing the Ground

Religion played an important part in my life as a child growing up in New Zealand in the 1960s, and I attended an Anglican church with my mother and siblings, at a time when church attendance was a societal norm. My father, a lapsed Roman Catholic, never came with us. Although I had an awareness of God, instilled by liturgical ritual, my God was distant and punitive, with exacting standards that I could never reach. My experience of God mirrored that of being a child in my family. In my late teenage years and into my thirties I became very fundamentalist in my Christianity, a position which, in hindsight, I realised compensated for my then lack of identity.

My foray into the counselling world, as a client, began reluctantly in my late 30s. I use the word "reluctantly", because from the somewhat rigid position I held at that time, all problems were spiritual and, therefore, had spiritual solutions. To need psychological help was, from that perspective, a failure of faith. However, sharing a religious belief system with my counsellor gave me a sense of safety, since I had been afraid that my faith in God would be undermined by a secular therapist.

I later embarked on counselling, and subsequently, psychotherapy education. Both of these educations were chosen for their accessibility and the qualifications offered. I no longer held my beliefs with such rigidity, and making meaning of my life in terms of my evolving faith became even more pertinent during my psychotherapy education, given its emphasis on the therapist's own experience in the therapeutic process. Congruence between my beliefs and a psychotherapy worldview seemed essential to me if I was to practise in a manner which honoured the values of both. Yet during my education I was taught nothing about RS from any theoretical perspective. Moreover, I somehow understood that this was not the forum to talk about my beliefs; I had to find my own way.

Wondering about the place of RS in psychotherapy, for my master's dissertation, I conducted a modified systematic literature review, examining the implications of psychoanalytic thinking about God, when working psychoanalytically with Christian clients (Florence, 2009). Among the study's findings were: that there was a dearth of education that addressed RS in therapy; that the therapist's own RS perspective had an impact on the therapeutic relationship; and that there was a noted avoidance of religious material in the therapeutic process. However, the majority of literature that addressed

the topic was from the USA and I became curious how psychotherapists in the bicultural context of ANZ approached this area. In addition, during the course of my education and practice and in the wider psychotherapy community, I have observed a number of situations involving RS matters which fuelled that curiosity.

One of these situations occurred at a placement during my psychotherapy education. I noticed that the weekly group mindfulness practice for clients was taken by a Buddhist monk, identified as such by his wearing of religious robes. Although I was assured that the monk's brief was to focus only on the mental health aspects of mindfulness practice, I questioned what signals clients were receiving. I began to think about "overt" and "covert" messages. My observation of this practice was that some clients had difficulty attending this part of the programme because they felt that it conflicted with their own religious perspective, whilst others were drawn to investigate Buddhism as a result of the mindfulness training.

I also wondered about some things I observed in the psychotherapy community. I recall attending a meeting where a retiring psychotherapist was reflecting on her time in practice. A question from the floor was posed asking if she could talk about how her spirituality had evolved during her years in practice. She blushed and appeared quite discombobulated, commenting that it was a very personal area; and, from (my) memory, she answered the question rather vaguely. I was intrigued by this interaction since this person was usually extremely articulate; moreover, from our own conversations, I was aware that her RS perspective had changed considerably over the years of her practice. It made me think about the context of disclosure and, in particular, about the influence that the psychotherapy community had on her–and anyone else's– reticence to discuss RS.

Another incident occurred at the New Zealand Association of Psychotherapists' (NZAP) Conference in 2012. On this occasion, the chair of a panel discussion chose to begin the meeting with a waiata (song in Māori) which she commented was "evangelical" in content. The conference participants sang the first verse–in Māori–with gusto, the majority of us, I assume, not understanding what we were singing. The second verse, in English, was Christian in its sentiments and the volume in the wharenui (Māori meeting hall), diminished considerably. The volume recovered for singing the

third stanza in Tongan, when again the majority of us appeared not to know what we were singing. Curiously, an examination of the text suggested that all the three verses echoed the same sentiments. The discomfort felt in singing the stanza in English was voiced by one participant at a later gathering, as she cited her difficulty with Christianity. I wondered how this perspective, apparently shared by many, might influence therapeutic interactions.

My own experiences in therapeutic practice have added to my interest. As an identified Christian within the psychotherapy context, I often attract Christian clients, who come with assumptions of "sameness". When exploring the reasons for choosing me as a psychotherapist, these clients often speak about their expectation of feeling safe and understood, echoing the hopes I had when I began my counselling journey. This religious "matching", raises issues of unexplored assumptions: where this match may be helpful, where it may limit, and the usefulness of such identification as a therapist.

My identification as a Christian within the therapy world is in part due to the fact that I am a member of the New Zealand Christian Counsellors' Association (NZCCA), and have held this affiliation for a number of years. This information is easily accessed by potential clients, since it is on the internet. I have been reflecting on the impact of this connection for clients. Whilst it may be helpful for Christian clients who want to see a Christian counsellor, for reasons already stated, I wonder about its helpfulness for other clients. Do I want to be disclosing of my RS position in a profession where clients' imaginings yield important therapeutic information? Moreover, what does my belonging to mean for me?

Aim of the research

The aim of this research is to uncover "What 'all' is involved here" (Schatzman, 1991, p. 310), in psychotherapists' decision-making processes concerning RS in psychotherapy, in ANZ.

The problem, central to the study, is framed in the following questions:

- How do psychotherapists in ANZ attend to RS within the therapeutic process?
- What influences their decision-making processes?

- Are their decisions subject to change, and if so, under what conditions and with what outcomes?

Purpose of the research

This study is being undertaken for the following reasons:

- The last two decades have seen a rise in interest in spirituality in therapeutic contexts, as reflected in the plethora of literature on the topic. Religious or spiritual problems were included for the first time in the fourth edition of *The Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994) as conditions "which may be the focus of clinical attention" (p. 685). Also included was a cultural formulation "that required clinicians to consider cultural idioms of distress, explanations of illness and preferences for care, as well as the role of religion in providing support (Lukoff et al., 2010, p. 424). It is important to find out how this interest and diagnostic criteria are reflected in practice.
- RS perspectives are culturally constructed, yet no research has been conducted into psychotherapy practice in the bicultural context of ANZ on the topic I propose of this study.
- The regulatory authority for psychotherapists, The Psychotherapists' Board of Aotearoa New Zealand (PBANZ or "the Board"), considers RS awareness as part of psychotherapists' cultural competence (PBANZ, 2011a). An exploration of psychotherapists' awareness of RS matters within the therapeutic process is therefore important.
- It is necessary to gain some understanding about how psychotherapists are attending to RS issues, in order that educational needs may be assessed and practice explored.

An explanation of key terms used in this thesis

The key terms–"religion", "spirituality", and "psychotherapy"–used in this research are explained, so that the reader may have some understanding of the domain under consideration. In addition, the term "wairua", an indigenous concept, loosely related to

spirituality, is also explained. In discussing these key terms, it needs to be remembered that these terms are understood variously, depending on context and perspective.

Introduction to the terms "religion" and "spirituality". There is a plethora of literature offering varying definitions of religion and spirituality which suggests that this is a complex field. Bartoli (2007) commented that "definitions of religion and spirituality are almost as numerous as the number of articles published on the subject" (p. 55). Considerable debate also exists as to whether religion and spirituality can or should be differentiated (Oman, 2013). A variety of ways of understanding religion and spirituality, and their commonalities and differences are examined.

Religion*.* The etymological roots of the word "religion" are found in the Latin "religio" meaning "obligation, bond, reverence", and possibly in the Latin "religare" "to bind". Thus, religion involves having a bond, if not being bound or at least connected to a particular tradition that offers a specific worldview, which usually involves the worship of a deity of some kind. Religion represents a particular cultural expression of beliefs, seen in rituals, social practices and a form of community which provides the "how to" of attaining spirituality within a prescribed religion (Bartoli, 2003; Griffith & Griffith, 2002; Miller & Thoresen, 2000). According to Sorenson (2004), religion, with the exception of Buddhism, generally includes a theistic component. Ingersoll (1994) noted that the social identity associated with religious affiliation does not necessarily include a personal spirituality, but that religion is a "'culturally flavoured' framework that helps develop the organismic spiritual potential" (p. 106). Fromm (1950) commented that it is very difficult to think about religion as a general human phenomenon without imposing the angle of a particular religious perspective, and defined religion widely as "any system of thought and action shared by a group which gives the individual a frame of orientation and an object of devotion" (p. 21).

In his seminal work, *The Varieties of Religious Experience*, William James (1842-1910) chose to "ignore the institutional branch [of religion] … to say nothing of the ecclesiastical organisation" (James, 1902/2008, p. 28), and to consider that "religion … shall mean for us the feelings, acts, and experiences of individual men in their solitude, so far as they apprehend themselves to stand in relation to whatever they may consider the divine" (p. 29). James differentiated between what he calls "personal religion" (p.

29) and the institutional or ecclesiastical expression. James's separation of personal expression from institutional adherence reflects what may be considered as spirituality in the world we live in today.

Spirituality. Whereas religion is often associated with outward adherence to prescribed ritual and practices, and is, therefore, more concrete, spirituality is often seen as concerned with an individual's subjective experience of transcendence, as James (1902/2008) sought to convey. The etymological root of the word "spirit", from which spirituality is derived, is found in the Latin *spirare* meaning "breathe" and *spiritus* denoting "breath". Both the Hebrew and Greek words for spirit, *ruach* and *pneuma* respectively, are variously translated as "breath", "wind" and "spirit" (White & Tenney, 1978). Ingersoll (1994) commented that the use of metaphor to denote spirituality captures the inexplicable.

The word "spirituality" has had different connotations over the centuries. Oman (2013) commented that in early English these connotations were positive, spirituality being used to denote a personal relationship with God. However, in the 17-18th centuries the word was used more pejoratively, Oman noted, as being connected with excessive emotionalism, in contrast to the more positive qualities of piety and devotion. The word therefore fell out of favour with mainstream religious traditions. Spirituality began to be used again in the early 20th century to explain the mystical aspect of Christian experience. Further into the century, its increasing respectability was reflected in usage in textbooks and journal titles. Late in the 20th century, Oman said, "The word *spirituality* began to acquire an additional English usage as something that can be explicitly pursued not only within a formal religious tradition, but also *outside* of traditions" (p. 28).

Although spirituality may be expressed as a search for a transcendent being, either found externally or internally, this is not necessarily so, since for some, spirituality is experienced as inner personal growth, or a sense of connection between self, nature and the cosmos (Culbertson, 1998; Hood & Chen, 2013). This broader understanding is echoed by Sperry and Millar (2014) who viewed spirituality as "how individuals find, engage, and transform the sacred in their lives" (p. 1). According to these authors,

spirituality is part of our humanity, implicitly or explicitly reflected in the normal activities of life.

It is evident from these explanations that religion and spirituality may or may not include the other. Emphasising their interdependence, Bolletino (2001) noted that "spirituality is the basis or core of religion; religion is the systemization or codification of spirituality" (p. 93). However, although religion may be a way of expressing spirituality, this is not necessarily so. Spirituality may be derived from religious practices, but again, one does not inevitably follow the other. It is true, too, that each person, as a result of their own cultural histories and life experiences will have their own idiosyncratic ways of viewing religion and spirituality (Bartoli, 2007; Overstreet, 2008; Plante & Sherman, 2001; Stifoss-Hanssen, 1999).

Wairua. The Māori concept, wairua, is often referred to as spirituality; however there is no equivalent word in the English language. Wairua means "two waters" and describes the spirit (Pere, 1997). For Māori, wairua is immersed in every domain of existence and is intrinsic to being Māori; "Māori is wairua and wairua is Māori" (Margaret Morice, personal communication, August 4, 2011). Whilst belief in God is one reflection of wairua, also incorporated in the concept is a relationship with the environment since, in te ao Māori (the Māori world), the land has spiritual significance (Durie, 2003).

The centrality of wairua in Māori health is demonstrated in its incorporation in the two most well-known Māori models of health: Te Whare Tapa Whā (the four-sided house), developed by Dr Mason Durie (b. 1938) in 1982 ((Durie, 1985), and Te Wheke (the octopus), presented by Dr Rangimarie Rose Pere (b. 1937) in 1984 (Pere, 1997). Te Whare Tapa Whā comprises four dimensions: whānau (family), tinana (body), hinengaro (mind) and wairua (spirit). The metaphor of the octopus used in Pere's (1997) model illustrates the interrelatedness of the whole. The eight tentacles include the body, mind and spirit dimensions of Te Whare Tapa Whā, with the addition of: "whanaungatanga (extended family), whatumanawa (emotional), mauri (life principle in people and objects), mana ake (unique identity) hā a koro mā a hui mā (inherited strengths)" (Mark & Lyons 2010, p. 1757). More recently, following research interviews with six tohunga (indigenous healers), Mark and Lyons (2010) proposed a

model called "Te Whetu (The Star), with five interconnected aspects; namely, mind, body, spirit, family, and land" (p. 1756).

Although the above suggests a somewhat homogenous experience and expression of being Māori, the influence of religion brought by the early settler missionaries on Māoridom, noted in the section entitled "Te Tiriti o Waitangi", together with other effects of colonisation, such as physical and psychological diversity (Durie, 2001), means that the indigenous people's experience of cultural identity is very varied. Durie commented that "diversity is the rule and the diverse realities of Māori must be given due consideration" (p. 4).

Explanation of usage of terms religion and spirituality in this research. The complex nature of religion and spirituality, together with the example set by other writers when using these words, were considered when deciding how to represent these terms, in this thesis. I noted that some authors, Baetz, Griffin, Bowen and Marcoux (2004), Barnett and Johnson (2011) and Plante and Sherman (2001), for example, used these words interchangeably, or together, as do Dura-Vila, Hagger, Dein, and Leavey, (2011). Others, such as Saunders, Millar and Bright (2010), used the word spirituality to include religion. Having conducted a survey of the literature concerning the traditional and modern psychological understandings of religion and spirituality, Zinnbauer, Pargament and Scott (1997) concluded that there was a significant overlap between the two terms, and, therefore, advocated an integrative approach to using these terms in writing. I have therefore chosen to use the phrase "religion and/or spirituality", represented by the acronym RS, in this work, except where one or the other is specifically excluded by a participant or in the literature. I have chosen this convention as I considered that either using the two terms interchangeably, or using the word spirituality to include religion, would not reflect the complexity in current understanding. It also needs to be borne in mind that according to a symbolic interactionist perspective, the theoretical perspective underpinning the methodology I have chosen, it is left up to the participants to share their understandings of what these terms mean to them. (Symbolic interactionism is discussed under the section entitled "Choice of methodology")

Chapter One: Preparing the Ground

Psychotherapy. The word "psychotherapy" literally means "healing of the soul" (Symington, 1996, p. 3), as it incorporates the Greek root, "psyche", meaning mind or soul and the Latin for healing, "therapia", which is translated as healing. However, the scope of theoretical diversity under the psychotherapy umbrella, together with "the embeddedness [of psychotherapy] in cultural, linguistic, and historical contexts" (Mitchell & Black, 1995, p. xx), makes it difficult to arrive at a definition which is adequately descriptive and sufficiently comprehensive.

The difficulty of definition is noted by Raimy (1950), who reported that a participant at a conference he attended facetiously suggested that psychotherapy was "an undefined technique applied to unspecific problems with unpredictable outcomes, for which vigorous training is required" (p. 93), and, in the same vein, Barker and Kerr (2001) suggested that "psychotherapy has come to mean … exactly what psychotherapists want it to mean" (p. 1). Bion (1970) commented that psychotherapy is located at an intersection between the medical and the religious, the former characterised by a more authoritative stance of the expert offering help to one suffering from psychological difficulties, with the latter offering collaborative seeking of answers to unanswerable existential questions. Holmes and Lindley (1989) defined psychotherapy as "the systematic use of a relationship between therapist and patient–as opposed to pharmacological or social methods–to produce changes in cognition, feelings and behaviour" (p. 3). Bateman, Brown and Pedder (2000) suggested that psychotherapy is "essentially a conversation which involves listening to and talking with those in trouble with the aim of helping them to understand and resolve their predicament" (xiii). Indeed, psychotherapy is commonly called the "talking cure".

Although the Auckland University of Technology (AUT) (the only tertiary provider of psychotherapy in ANZ) described psychotherapy as a relationship between a therapist and client which involves exploring the dynamics of their relationship as well the issues the client brings to therapy (AUT, 2014), it also noted that the nature, purpose and task of psychotherapy are understood variously depending on particular theoretical orientation. Having said this, however, Bolletino (2001) asserted that the aim of any school of psychotherapy "is the growth and health of the individual as an integrated whole" (p. 95). The varying understandings related to theoretical orientation are discussed under the section entitled "Psychotherapy in ANZ".

Chapter One: Preparing the Ground

Strategies utilised for gathering literature

A number of strategies were used to collect the literature discussed in this thesis. They are as follows:

- Entering the stem terms "religio" "spiritual" and "psychotherap" as well as "counsel" and "psycholog" in the PsycINFO database and viewing abstracts to determine relevance. PsycINFO is an electronic bibliographic database that provides abstracts and citations to the scholarly literature in the behavioural sciences and mental health. The PsycINFO database contains almost 2 million references to psychological literature from the 1800s–present, from journal articles, books, book chapters, technical reports, and dissertations.
- Together with these main search terms, others such as "culture" and "assessment" and "treatment" were added in combinations with the main search terms. Following completion of the findings, terms arising from developed concepts such as "risk" "protect" "repair" were added.
- Sourcing books from AUT's library catalogue, using the above search terms.
- Utilising databases holding dissertations and theses. These databases searched were: ProQuest Dissertation and Theses and Trove databases, in addition to accessing ANZ research on http://nzresearch.org.nz.
- Scanning reference lists in books and journal articles.
- Networking, including presentations of the research at various stages, gleaned further references from interested parties.
- Continuing alerts in publications related to the topic.

Conventions used in this thesis

Māori words Macrons are used on Māori words except where they do not appear in a quoted work.

Explanations of Māori words and discipline-specific words. Brief explanations are added in brackets after the first mention of the word in each chapter. The Glossary, following References, provides more comprehensive explanations.

Use of words to denote clinicians. Throughout this thesis I use the generic term "therapist" interchangeably with "clinician" rather than psychotherapist, since literature

surveyed covers a range of disciplines which incorporate the practice of psychotherapy. However, the term "psychotherapist" is used when referring to the psychotherapy profession in ANZ.

God. In this thesis, when referring to monotheistic religions, the word "God" is capitalised, as are related pronouns, in accordance with the particular religious tradition.

Abbreviations. Abbreviations of organisations and other frequently used terms are employed after their first introduction in each chapter. A full list of these organisations and their abbreviations are found in Appendix A.

Formatting

This thesis was formatted according to the American Psychological Association (APA), 6th edition, (American Psychological Association, 2010). To assist understanding of the theoretical process, where this is delineated in Chapters four to seven, related categories and concepts are depicted in the introductions to these chapters and related paragraph headings, using varying fonts as demonstrated in Table 1. Whilst formatting depicting conceptual dimensions is continued in all data diagrams, it is dispensed with in the general text, for ease of reading.

Table 1: Formatting depicting conceptual dimensions

Theoretical Dimension	Font Style	Example
Overarching theoretical explanation	Times New Roman 12 point bold underline	**deciding what belongs**
Major theoretical category	Times New Roman 12 point bold	**encountering challenge**
Sub-category	Times New Roman 12 point, italic, underline, bold	***conflicting worldviews***
Substantive code	Times New Roman 12 point, italic, bold	***avoiding***

Chapter One: Preparing the Ground

Choice of methodology and rationale

Of crucial importance in any research endeavour is the "fit" of a research topic to choice of methodology. I realised that the issue of religion, spirituality and psychotherapy was complex. As has already been noted, this complexity begins with the variety of ways of understanding religion and spirituality. Psychotherapists too, with their own histories and perspectives on religion and spirituality may have idiosyncratic views. Added to this complexity, was the range of psychotherapies practised, all with differing conceptualisations concerning the place of religion and spirituality in clinical practice. Psychotherapists practise in different contexts, with a variety of client populations. In addition, the bicultural nature of ANZ is an important consideration. These factors suggest that psychotherapists could hold differing perspectives regarding RS in psychotherapy. However, these are only suppositions since no research of this nature has been conducted in this cultural context. In my desire to find out what psychotherapists were doing in such a complex field, I wanted to make sure that everything which had a part to play in their decision-making in the therapeutic process would be taken into account.

In view of the number of factors which could have a part to play in this topic, it was important that I utilised a methodology which looked at processes, spoke to complexity, considered perspectives, and was useful in a field where little was known. For these reasons, grounded theory (Bowers & Schatzman, 2009), with its focus on "What is happening here?" (Giddings & Wood, 2000, p. 6) seemed a good fit. Grounded theory also builds theory as knowledge accrues (Charmaz, 2008) so is well suited to a field that has had little exploration.

Grounded theory has many variants. I chose to use the dimensional analysis variant of grounded theory, grounded dimensional analysis (GDA)–a second generation grounded theory–pioneered by Leonard Schatzman (1921-2008) (Schatzman, 1991), since its more comprehensive enquiry, "What *all* is involved here?" (p. 310) allows for greater complexity, emphasising the dimension of perspective in analysis and delaying in-depth analysis until a large number of dimensions have been amassed (Bowers & Schatzman, 2009). Another reason for my choice of GDA was that its use of the dimensional matrix (Schatzman, 1991), a method of organising data dimensions, made sense to me. In addition to the analytic reasons for my choice, one of my supervisors was fluent in the

use of this methodology. Since there has not been much written about GDA–Bowers and Schatzman (2009) noted that "it is still taught primarily as an oral tradition" (p. 86)–I was fortunate to be able to benefit from this expertise.

Underpinning the GDA methodology, I have chosen the epistemological perspectives of social constructionism and symbolic interactionism. Social constructionist epistemology theorises that truth or meaning is fluid, constructed and changed according to context (Crotty, 1998). A constructionist way of understanding meaning allows for a full exploration of the multiple realities which are seen in psychotherapists' engagement with this topic. Symbolic interactionism suggests that we act towards things depending on the meaning that we infer and that this meaning is derived and changed through interaction (Blumer, 1969). Our interactions are based on the use of symbols; hence the term "symbolic interactionism". From this perspective, the words "religion" and "spirituality" and "psychotherapy" are symbols which are understood variously, and may change over time, depending on psychotherapists' peculiar histories, contexts and cultures. A symbolic interactionist's way of understanding meaning allows for a full exploration of the multiple realities which are seen in psychotherapists' engagement with this topic.

Since, according to symbolic interactionism, meanings and interactions cannot be separated from the contexts in which they occur, it is important to understand the cultural context of ANZ and the history and practice of psychotherapy in this environment.

Cultural composition of Aotearoa New Zealand

The Māori people of ANZ are the nation's indigenous people, known as tangata whenua (people of the land). Immigrants, known as Pākehā, (non-Māori settler of ANZ) began increasing the non-indigenous population in the 18th century. In 1842 the Māori population was said to be estimated at 114,890, yet by 1896 these numbers had declined to an all-time low of 42,113, their numbers decimated by a combination of war, introduced diseases and dispossession (Durie, 2004).

The population of ANZ has continued to increase by immigration (Spoonley & Bedford, 2012). Initially, as Spoonley and Bedford commented, immigrants were mostly British

or Irish, with the exception of those who would best be described as temporary residents, such as Chinese miners. In the latter part of the 20th century, the cultural composition of the nation began to diversify because of some major changes (Spoonley & Bedford). One early change, these authors noted, was the immigration of Pacifika people (people living in the Pacific Islands) who immigrated to join the post-war labour force; a later change occurred in the 1980s as a result of Labour government reforms to immigration policy, which allowed for a greater diversity of immigrants into ANZ.

Te Tiriti o Waitangi The Treaty of Waitangi. Te Tiriti o Waitangi The Treaty of Waitangi, signed in 1840 between the British Crown and Māori chiefs is regarded by many as the founding document of Aotearoa New Zealand (Durie, 2003), forming the basis of a bicultural relationship between Māori and Pākehā (Morice & Woodard, 2011). However, Te Tiriti o Waitangi is not taken into consideration in domestic law, except where its principles are noted in Acts of Parliament (The Treaty in Brief, n.d.)

Te Tiriti o Waitangi comprises three articles common to both English and Māori versions. However, although the Māori version was deemed to be equivalent to the English version, there were significant differences:

First article

In the English text, Māori leaders gave the Queen "all the rights and powers of *sovereignty*" over their land. In the Māori text, Māori leaders gave the Queen "te kawanatanga katoa" or the complete *government* over their land.

Second article

In the English text, Māori leaders and people, collectively and individually, were confirmed and guaranteed 'exclusive and undisturbed possession of their lands and estates, forests, fisheries and other properties'. Māori also agreed to the Crown's exclusive right to purchase their land. Some Māori (and British) later stated that they understood the Crown to have a first option rather than an exclusive right to buy.

In the Māori text, Māori were guaranteed 'te tino rangatiratanga' or the unqualified exercise of their chieftainship over their lands, villages, and all their property and treasures. Māori also agreed to give the Crown the right to buy their land if they wished to sell it. It is not certain if the Māori text clearly conveyed the implications of exclusive Crown purchase.

Third article

Chapter One: Preparing the Ground

> In the Māori text, the Crown gave an assurance that Māori would have the Queen's protection and all rights (tikanga) accorded to British subjects. This is considered a fair translation of the English. (The Treaty in Brief, n.d. p. 3)

The use of the words "kawanatanga" and "tino rangatiratanga" in the Māori version of articles one and two has been a continuing source of tension between the Crown and Māori concerning issues of power (The Treaty in Brief, n.d). Although the Treaty guaranteed Māori tino rangatiratanga (authority and sovereignty) over their people, lands, language and customs, including religious freedom and customary law (Orange, 2013), historically Māori have had to fight to have the Treaty honoured, including the right to be Māori (Durie, 2003). Although recognised as tangata whenua, in a bicultural relationship with Pākehā, this partnership has not been equal, with Māori experiencing the negative impact of colonisation with its resulting social inequities and injustices; consequences which are reflected in psychotherapy, where Western ways have been assumed and imposed (Hall, Morice & Wilson, 2012).

The respect for religious freedom is enshrined in the fourth article of Te Tiriti o Waitangi The Treaty of Waitangi, and included only in the Māori version (Ecumenical Coalition for Justice Aotearoa New Zealand, 2004). When translated, this article provides protection by the Governor of "the several faiths (beliefs) of England, of The Wesleyans, of Rome and also of Māori custom" (Ecumenical Coalition for Justice Aotearoa New Zealand, p. 5). The right to religious freedom was also recorded in the New Zealand *Bill of Rights Act,* 1990 (Vaccarino, Kavan & Gendall, 2011).

Having said this, among the first settlers to come to ANZ were missionaries intent on converting the indigenous people to the Christian faith. Whilst early Māori embraced the Christianity promulgated by these early settlers (Orange, 2013), its connections with colonisation and therefore Pākehā oppression caused many Māori to abandon the religion or adapt it (Gilling, 1998). Syncretistic movements such as Ratana and Ringatu attracted a large Māori following, although as Durie (2004) noted, these movements were rejected as heretical by other churches. Contrary to The Treaty's promise to protect Māori custom, in 1907 the *Tohunga Suppression Act* was passed, outlawing traditional Māori healers, thus opposing the legitimacy of Māori cultural knowledge (Durie, 2004).

Chapter One: Preparing the Ground

Current population statistics. The total population of ANZ counted at the 2013 census was 4,242,048 people (Statistics New Zealand, 2013)[1]. Māori comprised 14.9% of the population. The largest population group at 74% were European, a group which includes people of English, Dutch, British and Australian descent. Those who identified as Asian were the next largest group at 12%, followed by Pacific peoples at 7%. Middle Eastern, Latin American and African residents comprised 1%. In terms of ethnic trends, the Asian ethnic group has almost doubled in size since 2001, and those identifying with the Pacific peoples ethnic group grew by 14.7% over the same period. Since cultural ethnicity and religious affiliation are often closely intertwined (Eshun & Gurung, 2009; Loewenthal, 2007), it follows that shifts in the cultural make-up of ANZ are reflected in religious demographics.

Religious demographics of Aotearoa New Zealand. Although ANZ has no official religion, the country has been greatly influenced by the Christianity introduced by the early European settlers (Vaccarino, et al., 2011). Over the last 40 years, however, religious demographics, as shown in five yearly census statistics, have demonstrated a shift from a predominance of Christianity to a plurality of religions with the increasing religious diversity of immigrants (Hoverd, 2008; Nachowitz, 2007). Statistics from the 2013 census indicated that 48.9% of people who answered the question on religion, identified as Christian (Statistics New Zealand, 2013). This is a decrease from 55.6% in the 2006 census and 60.6% in the 2001 census (Statistics New Zealand, 2013). In the 2013 census, 49.3% of the Māori population identified with at least one religion. The most common religious denominations were Catholic (11.2%), Anglican (10.8%), and Ratana (6.7%) (Statistics New Zealand, 2013).

Whilst adherence to Christianity as a whole is declining, the ethnic make-up of churches is changing due to immigration. Although some denominations are losing followers, the Catholic population has steadily increased (Du Freshne, 2013). Statistics from the latest census (Statistics New Zealand, 2013) found that, for the first time, Catholicism has overtaken the Anglican denomination as the church with the largest number of

[1] Census statistics are gathered every five years. However, the 2011 earthquake, in the city of Christchurch, meant that the census, which should have been conducted that year, was deferred until 2013.

adherents in the country. Citing the growing number of Asian Catholic immigrants as responsible for this change, Du Freshne (2013) also noted the popularity of Catholicism among Pacifika and Māori people.

Immigration can also be credited with the rise in other religions in ANZ. The increase in Hindu temples and Muslim mosques in the community, some occupying space previously held by Christian churches, attests to increasing religious diversity. Individuals identifying as Hindu now number 89,391 (Statistics New Zealand, 2013), up from 18,036 in 1991 (Statistics New Zealand, 2001), an increase of 397%. Between 1991 and 2013 the number of Buddhists increased from 12,762 adherents to 58,440 in 2013, an increase of 358%. As a religion, Islam has shown the most significant growth with the number of Moslems in ANZ having increased to 46,044 in the 2013 census, up from 6,096 in 1991, an increase of 655%.

Despite the increase in religious diversity, Christian traditions are still evident in ANZ. The nation has public holidays for the Christian festivals of Christmas and Easter. It voted in 2007 to retain the Christian prayer in parliament, has a national anthem which acknowledges God's sovereignty over the country, and continues the practice of swearing on the Bible in court (Morris, 2012). In addition, a third of primary and intermediate schools currently offer Christian religious instruction (Nicholas, 2013). However, the ongoing presence of this institution is now debated (Moon, 2014; New Zealand Herald, 2014; Wensley, 2014), reflecting the decline in adherence to Christianity and an increase in religious diversity.

Although the rise in religious diversity of ANZ has been captured using census statistics, Vaccarino et al. (2011) questioned the usefulness of this measure to adequately depict the country's religious landscape, suggesting that the focus in the census on religious adherence only fails to capture the breadth of people's experiences with spirituality. To this end, these authors conducted a quantitative survey with a randomly selected sample of 1,027 people to gauge the religious landscape. However, having themselves questioned the usefulness of census statistics, they acknowledged the limitations of their own data collection instrument, since it could not capture depth and variation in participants' experience.

Nevertheless, whilst being aware of these limitations, the findings do provide a broader picture than census statistics. When asked to state their description of belief in God, 59% of the sample either currently believed in God or had done so at some point in their lives. Moreover, 57% of respondents believed in life after death and 39% believed that horoscopes and star signs can influence the future. Although religious adherence is declining, 45% of participants said that they had "their own way of connecting with God without churches or religious services" (Vaccarino, et al., 2011, p. 91) and 70% expressed satisfaction with their own RS. When questioned about attitudes towards religion, 90% of respondents agreed that "religion helps people gain comfort in times of trouble or sorrow" (p. 92), and 79.2% believed that "there are basic truths in many religions" (p. 92).

Even though census statistics demonstrate a declining trend in adherence to Christianity, a majority of people in ANZ have had some past affiliation. An increase in adherence to other RS traditions is occurring, largely through immigration. In addition, the vast majority of people believe that RS may be supportive in time of trouble. For Māori, the indigenous people of ANZ, wairua is intrinsic to being. It stands to reason, therefore, that for the majority of people seen in psychotherapy in ANZ, RS will, in some way, be part of their narrative. This position will be true, also, for many who practise psychotherapy.

Psychotherapy in Aotearoa New Zealand

Important to the background to this study is the practice of psychotherapy in ANZ, since, according to symbolic interactionism, contextual influences have a bearing on interactions. What is the history and current context of psychotherapy in ANZ? Who can practise as a psychotherapist in ANZ? What are the work contexts of psychotherapists in ANZ? What is the difference in this cultural setting between a psychotherapist and other closely related health professions? What theories of psychotherapy are taught in ANZ and how do these different perspectives understand RS? Given the already stated predominance of Western thinking in psychotherapy in ANZ, how does the profession engage with Māori? All these questions will be considered in this section.

Chapter One: Preparing the Ground

History of psychotherapy in Aotearoa NewZealand. The New Zealand Association of Psychotherapists (NZAP) was formed in 1947 in order to:

> facilitate the provision of competent and accessible psychotherapy services throughout New Zealand by applying high standards of selection for membership, ensuring a high standard of service delivery through supervised practice in accordance with an ethical code, and attending to professional development. (Manchester & Manchester, 1996, pp. 8-9)

The history of psychotherapy in ANZ from 1947-1997 has been chronicled by Manchester and Manchester (1996 [sic]) and from 1997-2006, by Carson, Farrell and Manning (2008).

For a number of years psychotherapy was not a profession in its own right, lacking any identified training or professional qualification (Manchester & Manchester, 1996). Psychotherapists were identified as those who worked "at greater depth than a caseworker, counsellor, or social worker, who established capacity and competence through exposure to appropriate theoretical training and supervised practical experience" (pp. 52-53).

Psychotherapy education. It was not until 1989 that psychotherapy education was offered in the public sector with the Diploma of Psychotherapy training at the then Auckland Institute of Technology (AIT), now Auckland University of Technology (AUT). Psychotherapy education, strongly informed by psychodynamic theory, is now offered as a Master's degree at the same institution. AUT offers the only public psychotherapy education in ANZ (Tudor et al., 2013).

NZAP and Waka Oranga. Recognising the bicultural nature of ANZ, in its *Code of Ethics* (NZAP, 2008), the NZAP has enshrined the principles of Te Tiriti o Waitangi The Treaty of Waitangi. In 2005 the first Māori member was admitted to the NZAP, and in 2009 the Association made two seats available on its governing body exclusively for Waka Oranga (Woodard, 2014). This initiative was the result of the recognition by the NZAP of Waka Oranga as its Treaty partner (Hall, 2009). Waka Oranga is a collective of indigenous practitioners, the majority of whom have psychotherapy qualifications and are members of NZAP as individuals. The name "Waka Oranga" is derived from the Māori word for canoe, "waka" and "oranga" is linked to the word "ora", which, "in

essence, describes state of health and well-being Orange [sic] is about survival, livelihood, welfare and all the necessary determinants required to achieve a health sense of 'ora'"(p. 8) (Hall, Morice & Wilson, 2012).

He Ara Māori. A further acknowledgment of the principles of Te Tiriti o Waitangi occurred with the acceptance, in 2007, of He Ara Māori (the Māori pathway), as a way of recognising and legitimising the cultural practice of Māori practitioners for full membership of the NZAP. This was a significant milestone in the history of psychotherapy in ANZ, since prior to this time, no formal recognition of separate Māori philosophy and practice existed within the Association. He Ara Māori was created by Māori psychotherapists/psychotherapy practitioners, supported by the bicultural group Ngā Ao E Rua (the two worlds), a bicultural group of Māori and Pākehā psychotherapists (Green et al., 2014). However, to date, He Ara Māori has not been accepted as an approved qualification for registration by the PBANZ.

Psychotherapy: A registered health profession. The registration of psychotherapists was pursued over many years by NZAP, as it sought recognition for psychotherapy as a profession (Dillon, 2011), although ostensibly registration was about public safety. This move to registration had been discussed within NZAP since the 1950s (Manchester & Manchester, 1996), and there was a majority agreement to proceed along the path to registration at an Annual General Meeting of the NZAP in February 2000 (Bailey & Tudor, 2011). After intense lobbying, on 15 October, 2007, psychotherapy was included as a registered health profession under the Health Practitioners Competence Assurance Act 2003 (the Act)[2] and the term "psychotherapist" became protected (Tudor, 2011a). Registration with the regulatory authority, the PBANZ became mandated, Tudor noted, for any psychotherapy practitioner who wanted to refer to themselves as a psychotherapist or advertise as such. There are currently 527 registered psychotherapists practising in ANZ. However, as the

[2] *The Health Practitioners' Competence Assurance Act 2003* is about public safety. Its purpose is to protect the health and safety of members of the public by providing mechanisms to ensure the life-long competence of health practitioners. http://www.health.govt.nz/our-work/regulation-health-and-disability-system/health-practitioners-competence-assurance-act/about-health-practitioners-competence-assurance-act

implications of regulation have become apparent after the fact, it is evident that many psychotherapists were unaware of the full consequences of state regulation.

Whilst the purpose of registration has been to "protect the public", there is disagreement within the psychotherapy community within ANZ (Sherrard, 2011; Tudor, 2011b) and abroad (Mowbray, 1997; Postle, 2000) about whether state regulation achieves this aim. Rather, it is asserted, registration "creates a false sense of security" (Tudor, 2011b, p. 146) and that it "restricts and compromises therapeutic practice" (p. 147). Waka Oranga has made a stand against registration, on the basis that "Crown Acts and actions operate to constrict and oppress the growth and practice of indigenous ontologies and subsequent methodologies" (Morice & Woodard, 2011, p. 69). For these, and many other reasons, a number of psychotherapists have chosen not to register and are therefore no longer entitled to use the title "psychotherapist".

Registration and this research. The issue of registration or non-registration is pertinent for this research since my research participants are psychotherapists. At the stage of formulating my research proposal I had to consider what designated a "psychotherapist", since the choice made by some not to register meant that they could no longer call themselves psychotherapists. Since the *Act* has no jurisdiction over academic pursuits, apart from stipulating that participation in any research needs to be confidential, I chose to include in my sample, those psychotherapists who were either registered, and/or members of NZAP or Waka Oranga; in other words, all those who were "registerable". Although Tudor (2011a) noted that prior to registration there were a number of psychotherapy practitioners who were members of other associations, such as the New Zealand Association of Counsellors (NZAC), I felt that ascertaining whether those practitioners belonging to associations other than NZAP could be considered "psychotherapists", was beyond my brief. In these cases I chose the criterion of registration, for the sake of simplicity. In this research, I refer to those clinicians registered and registerable, as psychotherapists.

Registration and psychotherapists' scopes of practice. The scopes of psychotherapists' practice (PBANZ, 2013) expects psychotherapists to be "competent to use various methods of psychotherapy to assist clients in their personal growth, relationship development, psychological life issues and mental health problems, whilst

taking into consideration the bicultural context of Aotearoa New Zealand" (PBANZ, 2013, 1. para. 1). In the practice of psychotherapy, psychotherapists are expected to take client's life contexts into account: social, cultural and spiritual contexts are to be considered (1. para. 3).

Registration and cultural and ethical competencies. The 527 registered psychotherapists are bound to comply with the requirements of the Board in its administration of the Act. As noted in Section 118(i) of the HPCA Act, the Board is responsible for setting standards of clinical and cultural competencies as well as ethical conduct. In line with this authority, the Board developed *Standards of Ethical Conduct* (PBANZ, 2011a) and *Standards of Cultural Competence* (PBANZ, 2011a). The auditing of these competencies will begin in 2016.

Personal therapy. A personal psychotherapy experience (of 120 hours), is one of the conditions of registration for psychotherapists in ANZ–as stipulated in the Psychotherapists' *Scopes of Practice* (PBANZ, 2013). Personal psychotherapy is recommended as part of a psychotherapist's education since self-awareness is crucial in the therapeutic relationship. According to McWilliams (2004), writing from the psychoanalytic tradition, the best preparation for a student to become a psychotherapist is personal psychotherapy. Roth (1987) suggested that personal therapy helps us learn to tolerate anxiety, become aware of our psychological blind spots and to reach resolution, as far as possible, with our own histories. He does, however, add that perfect resolution and awareness are mythical concepts. A psychotherapist's own therapy helps with the realisation of the therapist's true self, along with concomitant emotional capacities (Symington, 1996).

Supervision requirements. Psychotherapists have ongoing clinical supervision, the frequency of which depends on their workload and experience; weekly supervision is required by the NZAP for a period of two years following qualification in order to attain full membership of the organisation. Practitioners are also expected to engage in additional cultural supervision as indicated by client need, with a particular emphasis on bicultural supervision when working with Māori clients. The Board also has certain requirements of supervisors. Full details of supervision requirements are outlined by PBANZ (PBANZ, n.d.) and NZAP (NZAP, 2015).

Chapter One: Preparing the Ground

Work contexts of psychotherapists in Aotearoa New Zealand. Most psychotherapists in ANZ work in private practice although approximately 10-15% of practitioners are employed by District Health Boards (DHBs) (A. Hedley, personal communication, March 26, 2014). An unknown number work in non-government organisations (NGOs) and educational institutions. Unfortunately no statistics are kept either by PBANZ or NZAP concerning psychotherapists' work places.

Although most psychotherapy offered in private practice is funded by the individual client, the Accident Corporation of New Zealand (ACC) subsidises therapy, to those psychotherapists who contract their services, for clients who have suffered a "mental injury[3]", as a result of sexual abuse (as defined by *The Crimes Act* 1961). This funding depends on the submission of assessment and progress reports completed by the therapist. Clients may also qualify for a subsidy for their therapy through Work and Income New Zealand (WINZ). This service is not dependent on reporting, but does require the certification of need by a General Practitioner, and is time-limited.

Psychiatrists, psychologists, psychotherapists and counsellors: What's the difference? Since this research is intentionally limited to psychotherapists as participants, it is important to consider the differences between psychotherapists, psychiatrists, psychologists and counsellors, as all these professions are practised in ANZ. The titles psychiatrist, psychologist and psychotherapist are regulated under the *Health Practitioners Competence Assurance Act* (2003). This means that only practitioners who have met their responsible authority's criteria for registration are entitled to use the respective title. Although counsellors have lobbied the government through their professional organisations for regulation, this has not, as yet, occurred. This means that anyone can call themselves a counsellor.

Psychiatrists, psychologists, psychotherapists and counsellors have different educational pathways and qualifications. Psychiatrists are medical doctors who have specialist qualifications in the area of mental illness and are able to assess, diagnose, prescribe,

---

[3]Defined in the Accident Compensation Act 2001 as 'a clinically significant behavioural or psychological dysfunction'. A mental disorder with a specific diagnosis that requires treatment.

and treat clients, who are generally referred to as patients. Psychologists complete a Master's level qualification and an additional postgraduate diploma in either clinical or counselling psychology. Psychologists' education is orientated more within the medical model, with a focus on psychological assessment, diagnosis and treatment. Neither psychiatrists nor psychologists are required to undertake any personal psychotherapy or counselling as part of their education. Psychotherapists require a Master's level qualification, while counsellors generally complete an undergraduate and/or postgraduate qualification.

The relationship between psychotherapy and counselling has often been debated, including throughout the history of the NZAP. Although the association began its life in 1947 with the name New Zealand Association of Psychotherapists, this was changed in 1974 to the New Zealand Association of Psychotherapists, Counsellors and Behaviour Therapists; in 1981 to The New Zealand Association of Psychotherapists and Counsellors; and, finally, in 1987, reverting to its original name (Manchester & Manchester, 1996). These name changes reflect the process psychotherapy has undergone in this country to develop a discrete professional identity.

Whereas some practitioners assert that psychotherapy and counselling are discrete, others consider that they are processes which exist on a continuum. The words psychotherapy and counselling are used interchangeably by some writers (Baker & Kerr, 2001), which can cause confusion as to the nature of these two activities. Counselling is generally seen as offering more present-focused, short-term interventions to specific problems, with the aim of ameliorating symptoms. Psychotherapy, on the other hand, is often long-term and focused on personality change, addressing issues underlying symptoms, rather than offering strategies for symptom relief. Psychotherapeutic approaches numbered 400 in the 1980s according to Karasu (1986); however, there is a growing trend towards integration of psychotherapies (Norcross & Saltzman, 1990).

Psychotherapy approaches in Aotearoa New Zealand. In ANZ there are 10 psychotherapy approaches in which one can be educated to obtain a psychotherapy qualification (Tudor et al., 2013), eight of which are accepted as "approved qualifications" for registration as a psychotherapist by the PBANZ (PBANZ, 2013);

hakomi and self-psychology are excluded by the PBANZ but accepted by NZAP as recognised modalities. The 10 modalities, in order of their initial introduction to the country, are as follows: psychoanalysis/psychoanalytic psychotherapy in the mid/late 1940s; psychodrama, 1973; transactional analysis, 1974; gestalt therapy, 1977; Jungian analysis/analytic psychology in the early/mid 1980s; psychosynthesis, 1986; self-psychology 1990; bioenergetic analysis, 1992; hakomi, 1993; and psychodynamic psychotherapy, 2006 (Tudor et al., 2013). The omission of existential psychotherapy from educational opportunities in ANZ is curious, given its core focus on matters of being – death, freedom, isolation and meaninglessness (van Deurzen-Smith, 1997); issues of great importance in the area of RS.

Although the emphasis is placed here on the psychotherapeutic modalities taught in this country, since this is the context of the study, it needs to be acknowledged that a number of psychotherapists practising in ANZ have migrated from other countries (Thorpe & Thorpe, 2008), where many have gained their psychotherapy qualifications. This means that the range of modalities utilised by participants in this research may be more diverse that those taught here. However, as has been noted above, there are a large number of theoretical approaches, too many to cover in this thesis, hence the decision to discuss only those taught in ANZ.

Since the nature, purpose and task of psychotherapy differ depending on theoretical perspective, it is important to consider how different theoretical approaches conceptualise RS. As Hirsch (2008) asserted, psychotherapy theories tell us what we are looking for with clients and how to work with them. The psychotherapy modalities taught in ANZ will be considered in this regard, according to the order of their introduction to ANZ, apart from psychoanalysis, psychoanalytic psychotherapy and psychodynamic approaches which are considered together, followed by self-psychology, in view of their close association.

Psychoanalysis/psychoanalytic/psychodynamic approaches. Sigmund Freud (1856-1939), the father of psychoanalysis from which psychoanalytic and psychodynamic approaches are derived, believed that religious ideation was incompatible with psychological maturity. In his seminal work, *The Future of an Illusion*, (Freud, 1927/2010), he asserted that religion arises out of human wishes, and

as such is illusory, bearing no relationship with reality. Freud theorised that the strength of these wishes lay in the:

> terrifying impression of helplessness [which] aroused the need for protection–for protection through love–which was provided by the father; and the recognition that this helplessness lasts throughout life made it necessary to cling to the existence of a father, but this time a more powerful one. (p. 41)

Freud added that "infantilism is destined to be surmounted. Men cannot remain children forever; they must in the end go out into 'hostile life'. We may call this 'education to reality'" (p. 72). Since, in Freud's estimation, the need for religion was infantile, its repudiation was indicative of personal growth and that this need could be "cleared up … by psychoanalytic treatment" (p. 63). Although Freud also commented that "psychoanalysis is a method of research, an impartial instrument" (p. 52), it seems that his views on religion have had a great deal of influence at least on analysts in his lifetime, as Sorenson (2004) noted that after Freud's death, there was a 59% decrease in journal articles pathologising religious affiliation.

The evolution of psychoanalysis from considering humans to be motivated by satisfying impulses in order to discharge tension to seeing people as relationship seeking, a view espoused by the British object relationists in the 1940s, such as William Fairbairn (1889-1964), Donald Winnicott (1896-1971) and Harry Guntrip (1901-1975), made room for the use of God and religious ritual in human development and function. Guntrip is credited with being one of the most ardent advocates of religion within the British object relations school (Beit-Hallahmi, 1992), suggesting that the origins of religion are found in humanity's search for a "good object", a search which extends to the universe (Guntrip, 1961). Whilst acknowledging that some religious expression can be neurotic, Guntrip commented:

> The fullest personal integration and maturing, the profoundest sense of inner strength and meaningfulness in living, includes the religious way of expressing our existence in this world … there has always been "religious experience" as a fact, because it is a natural phenomenon. (Guntrip, 1969, p. 330)

Winnicott (1953/1971) emphasised the importance of transitional experience in a child's development, suggesting that the support of a "transitional object" offering security, such as a blanket or a loved toy, is crucial in increasing independence. This transitional object is created in the child's mind and also found in reality. Winnicott added that this illusory capacity, rather than being antithetical to reality, as Freud theorised, is fundamental to psychological development. Within this transitional experiencing lies our capacity for creativity and religious experience since, according to Winnicott, we never outgrow the capacity for illusion.

Self- psychology. Heinz Kohut (1913-1981), in his theoretical development which became known as "self-psychology", recognised the place of religion in individual self-cohesion (Kohut, 1971), emphasising the needs of early development, rather than inner conflict (Mitchell & Black, 1995). He suggested that healthy development required three selfobject experiences; experiences which occur initially with parents and then parental substitutes, where a relationship with that person is internalised to help develop the self. These essential selfobject experiences are those of twinship, idealisation and mirroring (Strozier, 2003). RS can fulfil these functions. The sense of twinship or belonging is met in religious gatherings of "likeminded" people; idealising is seen in the worship of a perfect God; and mirroring occurs when we experience being valued and accepted by a loving God.

Although the development of psychoanalytic/psychodynamic theory allows space for religious experience, such experience is only acknowledged as useful for psychological function; it says nothing about the real existence of religious objects such as God, nor is there acknowledgment of spirituality, considered by some as intrinsic to being human, unless one counts the creativity found in transitional experience posited by Winnicott (Winnicott, 1953).

Psychodrama. Where psychoanalysis and psychoanalytic/psychodynamic psychotherapy focus attention on internal conflicts, psychodrama has been described as externalising these conflicts so that they can be worked with in a "psycho-drama". Psychodrama is the innovation of Jacob Moreno (1889-1974) who, although born in Romania in the late 1800s, spent most of his life in the United States of America

(Davies, 1976). Psychodrama usually takes place in a group with participants being chosen to take the parts of an individual's "drama".

> Psychodrama … involves a group of individuals who assemble under the leadership of the therapist or director and enact events of emotional significance in order to achieve resolution of conflicts … which limit their capacity for spontaneous and creative activity, particularly as they affect personal relationships. (Davies, p. 202)

Spontaneity and creativity were seen by Moreno as an expression of God as Creator being formed within a person during genuine interpersonal encounter (Blatner & Blatner, 1988). He encouraged people to grow in their own "god-likeness", as they accept their co-creativity. Moreno shared Martin Buber's (1878-1965) belief that genuine encounter was the basis of change (Tauvona, 2010).

Analytic psychology. Carl Jung (1875-1961), formerly Freud's "ablest … most important pupil … his crown prince" (Palmer, 2009, p. 89), disagreed with Freud over, among other things, the importance of spiritual experience and left his teacher to form his own system, analytic psychology (Scotton, 1996). Unlike Freud, Jung did not see religious belief as neurotic, but considered that the idea of God needed to be studied (Hubback, 1999), commenting that "Everything to do with religion, everything it is and asserts, touches the human soul so closely that psychology least of all can afford to overlook it" (Jung, 1958, p.112). Bolletino (2001) stated that Jung understood religion as "the experience of the "numinous" or Holy" (p. 92), regarding the main focus of his work as considering the spiritual aspects of experience. Having said this, Jung was clear that his observations did not prove God's existence, only "the existence of an archetypal God-image, which to my mind is the most we can assert about God psychologically" (Jung, 1958, p.102).

Psychosynthesis. Jung's analytic psychology and Assagioli's (1888-1974) psychosynthesis have some similarities; an agreement on the spiritual nature of human-kind and a focus on health, rather than pathology, are among them (Assagioli, 1974). A contemporary of Jung's and an early associate of Freud's, Robert Assagioli (1888-1974) formulated a psychological theory, known as psychosynthesis, which explicitly included the transpersonal (Shorrock, 2008). He proposed a psychotherapy which synthesised

personality at a personal and spiritual level, incorporating an understanding of the purpose of spiritual crises in this synthesis (Battista, 1996a). Psychosynthesis is described by Palmer (2010) as a psychospiritual psychology and it is an orientation, Shorrock (2008) noted, that addresses the physical, emotional, psychological and spiritual dimensions of existence. Whilst Assagioli appreciated the need to address internal conflicts, he believed that psychoanalysis neglected the soul, as he considered that spirituality was an essential aspect of the psyche (Bolletino, 2010).

Hakomi. Hakomi, a body-centred, somatic therapy, was developed by Ronald Kurtz (1934-2011) in the 1970s, drawing on multiple sources including gestalt, bioenergetics and the underpinnings of Buddhist and Taoist religious traditions (Johanson, 2011). Hakomi shares the core value of humanistic psychology that, given the proper conditions, a human being will reach their full potential (Bageant, 2012). Hakomi has been a major force in incorporating mindfulness into psychotherapy (Hakomi Institute, n.d), and Bageant (2012) noted that mindfulness is utilised throughout the therapy session as the main therapeutic tool. Hakomi's emphasis on holism, with wellbeing associated with health in the spiritual, mental and physical dimensions of life, including connection to the environment and the cosmos, finds resonance with the Māori worldview (Mark & Lyons, 2010).

Bioenergetics. Like hakomi, bioenergetics is a body-centred sychotherapy. Bioenergetics was originated by Alexander Lowen (1910-2008), who founded the Institute for Bioenergetics Analysis in 1954 (Miller, 2010). Lowen realised that physical exercise had benefits in the lifting of one's mood and believed that loosening muscle constriction could enable previously unconsciously held material to become available for cognitive processing (Miller, 2010). "Bioenergetics Analysis is a movement-based, body-oriented psychotherapy which posits that all trauma is rooted in the musculature of the body" (Miller, p. 197). Miller (2010) noted that Lowen parted company in the 1970s, with close colleague John Pierrakos (1921-2001), with whom he refined bioenergetics, when the latter became increasingly interested in spiritual and transpersonal concerns, whilst Lowen maintained bioenergetics' focus on contact with and through the body.

Chapter One: Preparing the Ground

Transactional analysis. Transactional analysis, a theory of human relating, is based on the work of Eric Berne (1910-1970) and popularised in the 1960s in the well-known book by Berne, entitled *Games People Play* (Berne, 1961). As a theory, transactional analysis is the analysis of relational transactions through what Berne termed "ego states", "scripts", and "games". Although Berne himself paid scant attention to spirituality in his theory (Massey & Dunn, 1999), a number of transactional analysts have utilised Berne's thinking about ego states and scripts to interweave spirituality and work with religious beliefs. James (1981) related the inner core of the self to the/a "Spiritual Self" and proposed that individuals experience themselves as biological, social and spiritual beings. Lawrence (1983) reframed the "redecision" component of transactional analysis to fit the "repentance" language of religious clients. Kandathil and Kandathil (1997) suggested that Berne's concept of autonomy makes room for spirituality. Massey and Dunn (1999) used spiritually-focused genograms to represent intergenerational processes and interconnections, demonstrating the transactional nature of spirituality. More recently, Sherrard (2005) has spoken about a transactional analysis understanding of projection onto God, that is, the ascribing of one's own thoughts and feelings to the deity, commenting that whilst there is no structural analysis of God, we can structurally analyse the projections.

Gestalt. Gestalt therapy was developed by Fritz Perls (1893-1970) and his wife Laura (1905-1990) in the 1940s (Corey, 1996), with a major focus on integration, as a reaction against the prevailing reductionistic conceptualising of people (Gorton, 1987). Growth, awareness and creativity, are additional goals (Williams, 2006). Gestalt therapy is a synthesis of a number of different schools of thought, its name being derived from gestalt psychology, one of these influences. The word "gestalt" means "whole" and gestalt psychology suggests that we perceive things as "wholes" rather than in parts (Wulf, 1998), the whole being "more than the sum of its parts" a maxim coined from this psychology (Gorton, 1987).

Gestalt therapy is particularly present-centred and focuses on the client's awareness in the here-and-now, Yontef and Jacobs (2011) noted, aiming for "self-knowledge, acceptance, and growth by immersion in current existence" (p. 344). Gestalt's focus on awareness in the present moment demonstrates the modality's connection to the religious/spiritual thought of Taoism and Zen Buddhism (Wulf, 1998). Williams (2006)

noted that these spiritual paths were among a number of religious influences experienced by Fritz and Laura Perls. She added that many gestalt therapy trainees and clients comment on the spiritual nature of their experience in gestalt therapy, a point which Williams attributes to these influences.

It is clear that these therapeutic modalities offer widely differing perspectives on RS in human functioning. Since psychotherapists utilise modalities to help conceptualise a person's difficulties and strengths, it stands to reason that clients may have their RS perceptions understood differently, depending on clinician orientation.

Conclusion

In this chapter I have outlined my interest in this research and briefly delineated a rationale for the study. Definitions of religion, spirituality and psychotherapy have been provided to orientate the reader to the field of enquiry. I have introduced the political and cultural setting of the practice of psychotherapy in ANZ and explained the unique bicultural nature of this country. The therapeutic modalities accepted for obtaining a psychotherapy qualification have been outlined. In the following chapter, Chapter two, I explain the place of the literature review within grounded theory methodology as well as discuss literature pertinent to the field of study.

Structure of the thesis

Chapter one, the introduction, has orientated the reader to the research topic; my interest in the subject, the aim and purpose of the research, together with an explanation of key terms, have been outlined. In addition, the rationale for my choice of methodology has been delineated. The scene has been set in terms of the socio-cultural context of ANZ, as well as the culture of psychotherapy practice in ANZ.

Chapter two comprises a critical review of the literature. The place of the literature review in grounded theory is explained. Literature reviewed prior to data collection, providing a broad overview of the topic, is critiqued.

In **chapter three**, I explain in detail the methodology and methods used to carry out the research. Social constructionism, symbolic interactionism and generic grounded theory are described. Grounded dimensional analysis (GDA) is explicated, and the fit of this

methodology to my topic is outlined. The ethical parameters of the study are explained. The research rigour is considered.

Chapter four contains an overview of the GDA generated from data and introduces the major categories together with their sub-categories. The perspectives underpinning participants' actions are explained in detail, together with the conditions under which they form and shift.

In **chapters five to seven** the findings are explicated. **Chapter five** explains the category of engaging, together with its sub-categories. **Chapter six** delineates the category of encountering challenge and its sub-categories. **Chapter seven** explicates the category of negotiating challenge and also explains its sub-categories. Professional and personal outcomes are also explained.

Chapter eight A discussion of the research findings is presented interwoven with the literature searched before and after data collection. The knowledge this work contributes to the field is outlined. The significance of the findings is discussed in terms of psychotherapy education, practice and further research. Strengths and limitations of the study are explicated.

Chapter Two: Literature Review

Introduction

The literature reviewed in this chapter covers literature surveyed prior to undertaking this study. Although some material has been added, this has been to deepen the concepts already considered prior to conducting the study. Literature reviewed after completing the research is interwoven into Chapter eight, the discussion chapter. This distinction has been made because the nature of grounded theory methodology. Deriving theory from the data means that it is important that concepts which are part of the theoretical process elicited during data analysis are developed without the intrusion of existing literature (Henwood & Pidgeon, 2003; Urquart, 2007). This literature review is in three parts. Firstly, the place of literature reviews in grounded theory is discussed; secondly, the literature is reviewed regarding the importance of the inclusion of RS in psychotherapy; and lastly, the complexities of inclusion are considered.

The place of literature reviews in grounded theory

The place and timing of the literature review in grounded theory has long been a source of contention and misunderstanding, according to Birks and Mills (2011) and Charmaz (2014, 2006). Although early grounded theorists (Glaser & Strauss, 1967) advised delaying the literature review until data analysis was completed, to avoid contamination of the research process, this approach is not feasible or useful for a number of reasons. Firstly, any researcher with an interest in a particular field comes to their study with some reading and knowledge (Birks & Mills, 2011), even if generated simply out of interest. Secondly, research proposals require a literature review to provide a rationale for an intended research project (Urquart, 2007). It is clear, therefore, that no researcher embarks on research uninformed as to extant literature. Thirdly, according to Thornberg (2012), the whole idea of research–and, indeed, the doctoral level–is to build on what has gone before, so that knowledge is advanced. Lastly, Strauss and Corbin (1990) noted that analytic questions may be stimulated where data from the current study differ from previous findings in the field.

My interest in investigating RS in psychotherapy was motivated by my Master's dissertation, a modified systematic literature review on the impact of psychoanalytic

thinking about God when working psychoanalytically with Christian clients. This study exposed a dearth of research in Aotearoa New Zealand (ANZ) and I wondered what was happening in the context within which I practised. My extensive reading for this earlier work meant, therefore, that I came to this doctoral project with some prior understanding.

In order to manage the dilemma of both needing to have an understanding of existing literature when embarking on grounded theory research, and not letting that knowledge influence what may be found during the research process, Henwood and Pidgeon (2003) proposed "*theoretical agnosticism*" (p. 138). This term implies being able to hold what is already known with some scepticism, or at least with a degree of questioning, so that one is not wedded to particular ways of thinking. Other researchers (Birks & Mills, 2011; Urquhart, 2007) advised of the need, where possible, to survey the necessary literature broadly, rather than deeply, until after the generation of the grounded theory. Thus, a (more) extensive literature review is conducted once the grounded theory has been generated so that it can be interwoven with the findings.

In summary, the most salient issue regarding the use of literature in grounded theory is that, for theory to be deemed a "grounded" theory, it must be generated from the data. In order to achieve this rigour, a demarcation between literature surveyed prior to the study and that considered once the findings have been established needs to be made. Bearing this in mind, the survey of literature which follows is that made prior to data collection and analysis.

The case for the inclusion of RS in psychotherapy

Interest in the field. Interest in the issue of RS in psychotherapy has increased exponentially in the last thirty years. A search of the PsycINFO Database revealed 330 articles between the years 1985-1994, 811 articles from 1995-2004, and 1,239 articles in the last decade. A number of journals devoted to the topic of RS have emerged, for example: the *Journal of Psychology and Theology*, the *Journal for the Scientific Study of Religion*, the *Journal of Psychology and Judaism*, and the *Journal of Psychology and Christianity*. Latterly, some journals have dedicated issues to this topic and in 2014 a new journal entitled *Spirituality in Clinical Practice* was launched, according to the editor, in response to the expressed need of clients who are turning to psychotherapy

with spiritual needs, a need presumably highlighted by clinicians. The journal's aim is to respond to this need by integrating spiritually-orientated interventions into clinical practice. The diversity of clients' RS perspectives is being noted in publications which seek to familiarise clinicians with the beliefs and practices of a variety of RS worldviews (Dowd & Nielsen, 2006; Lovinger, 1984; Richards & Bergin, 2000; Verhagen, van Praag, Lopez-Ibor Jr, Cox & Moussaoui, 2010). There has also been an increase in research initiatives in the field (Lukoff et al., 2010). However, although research has increased, Worthington and Sandage (2002) noted that the majority of it has been conducted with predominantly Christian samples.

Nonetheless, RS is now widely accepted as important for research; the extent of this change is reflected by the comments of one early researcher in the field. Discussing his proposal for research, conducted in the late 1970s, into the background variables surrounding the experiences and values of psychotherapists in managing religious material, Kochems (1983) commented that the "subject ... is not a common one … I was apprehensive as to how an academic study touching upon religion would be regarded within a university setting" (p. v).

There are a number of interrelated reasons for the increased interest in RS in clinical practice: client need; the inclusion of RS in diagnostic criteria; increased cultural diversity; the ethical expectation of clinicians to be responsive to such diversity; the relationship between RS and wellbeing and, therefore, the clinical significance of attending to clients' RS; and the enhanced therapeutic outcomes which ensue from this attention. These areas are explored in turn.

Client need. One of the most salient reasons for the increased interest of RS in clinical practice is client need. A steady decline in religious affiliation and, therefore, church attendance over the last few decades, as has been noted in Chapter one, along with individuals' spirituality being expressed in wider contexts (Bolletino, 2001; Serline, 2004), means that RS matters, previously the domain of clergy, are increasingly being brought to therapy. According to Stewart and Gale (1994):

> Clients' religious orientations are as important a consideration in clinical work, as race, ethnicity, social class, culture, and gender because the *sina qua non* of all the various religions is their provisions of worldviews, or interpretive lenses, through which believers apprehend and order their experience and reality. (p. 17)

Thorne indicated in 1998, "It is now common for people to present themselves to therapists with concerns that they themselves have categorised as specifically spiritual in nature" (p. x).

For the most part clients want to be able to explore their RS issues in therapy (Knox, Catlin, Casper, & Schlosser, 2005; Peteet, 1994; Post & Wade, 2009) and to have their beliefs treated "respectfully and non-reductively" (Simmonds, 2004, pp. 966-967). In research concerning American clients' perspectives on having RS issues addressed in therapy, Goedde (2000) interviewed six individuals for whom RS was important, who had been in psychotherapy within the last two to three years. Results showed that these participants valued a psychotherapy which integrated their RS concerns with the psychological.

The connection between RS and psychological functioning has been noted in case studies reported by Thomas and Schwarzbaum (2006). In a quantitative research survey involving 74 individuals, Rose, Westefeld and Ansley (2001) found that participants deemed it important to be able to explore spiritual matters, considering that the psychological and the spiritual were interconnected. It is of note that, of this sample, 90% reported a family of origin religious affiliation, whilst only 60% indicated a continuing religious affiliation. Since participants were invited by their therapists to take part in the research, Rose et al. reported this as a limitation of the study, due to selection bias.

The relationship between diverse RS perspectives and desire to have RS matters attended to in therapy is also important. Smith and Simmonds (2006) conducted an on-line survey with a largely Australian sample of 414 research participants to explore "the relationship between help-seeking and adherence to mainstream religion (Christianity, Judaism and Islam), alternative religion (for example, New Age spiritual beliefs and Paganism) and no religion (including agnosticism and atheism)" (p. 331). Nearly three-quarters of respondents believed that their spiritual/religious or non-spiritual/religious belief systems should be considered in professional help-seeking situations, whereas 22% did not have an opinion and only 8% disagreed. No reasons are noted for those who disagreed with the proposition. Differences were noted between the diverse groups as to the nature of help they sought. "The *mainstream* religion group chose

'priest/rabbi/minister/coven/etc.', to a greater extent than *alternative* and *no religion* groups. The *alternative* religion group chose 'other' and 'psychic' to a greater extent than mainstream and no religion groups" (p. 337).

Increasing RS diversity, as a result of immigration, also mentioned in Chapter one, means that clients are presenting in therapy with a wider variety of RS worldviews. Adelowo (2012) conducted narrative enquiry research in ANZ into the immigration experiences of 15 African women. Adelowo noted that RS is intrinsic to a sense of being in African culture. Some of the participants named the importance of RS in managing the stress of immigration, citing the value of the support of their church communities and their faith in a supernatural God. In their work with Tongan and Samoan clients in ANZ, McRobie and Makasiale (2013) commented that "most, if not all [of these clients] have spoken about a spiritual component in their lives" (p. 148), and the importance of utilising their spiritual resources to support trauma processing.

The therapeutic experiences of five (client) participants who were Nichiren Buddhists were explored by Baird (2012) who conducted a qualitative study in ANZ, using thematic analysis. Three participants had been engaged in cognitive-behavioural therapy, the remaining two in psychodynamic psychotherapy. On the whole, the participants reported a welcoming stance by their therapists to their religious tradition and said that the inclusion in their therapeutic process strengthened their Buddhist practice. Only one participant felt that her therapist was somewhat devaluing of her Buddhist practice. In this case the therapist disclosed that they shared the same religious tradition; the participant reported feeling that her therapist compared her own Buddhist practice unfavourably to that of their own. The clients' need to have their RS material explored in psychotherapy is supported by inclusion in *The Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; *DSM–IV*; American Psychological Association (APA), 1994), the most widely accepted taxonomy used by clinicians and researchers for the classification of mental disorders.

Diagnostic mandate. RS was first considered for psychiatric diagnosis in DSM-IV (APA, 1994) in the form of a new "V-code" called "religious or spiritual problem", later carried over to the fifth edition of the DSM (APA, 2013). (The V-code is an

international classification for diagnostic purposes. Further explanation of this code may be found in the Glossary).The V-codes cover:

> Other conditions and problems that may be a focus of clinical attention or that may otherwise affect the diagnosis, course, prognosis, or treatment of a patient's mental disorder … A condition or problem in this chapter may be coded if it is a reason for the current visit or helps to explain the need for a test, procedure, or treatment. Conditions and problems in this chapter may also be included in the medical record as useful information on circumstances that may affect the patient's care, regardless of their relevance to the current visit. (APA, 2013)

The V-code relating to RS is delineated as follows in the *DSM-5*:

> V62.89 (Z65.8) Religious or Spiritual Problem
>
> This category can be used when the focus of clinical attention is a religious or spiritual problem. Examples include distressing experiences that involve loss or questioning of faith, problems associated with conversion to a new faith, or questioning of spiritual values that may not necessarily be related to an organized church or religious institution". (APA, 2013a, Problems Related to Other Psychosocial, Personal, and Environmental Circumstances, para. 1)

The inclusion of religious or spiritual problems in the DSM, was, according to Lukoff et al. (2010) due to: evidence presented citing the extensive literature concerning the prevalence of RS issues in clinical practice; a noted lack of education in this area; and the need for a diagnostic category to underpin research and education in spirituality pertaining to clinical practice.

However, diagnostic inclusion does not necessarily translate to clinical attention. Scott, Garver, Richards and Hathaway (2003) suggested that, since the religiosity[4] of clinicians is notably low, they may omit attention to this area; moreover third-party funders do not usually pay solely for V-Code diagnoses which, therefore, reduces the likelihood of these matters being considered; and since the V-Code is considered separately from the major diagnoses, there may be little incentive to include it in a

[4] "In the *Thesaurus of Psychological Index Terms* (American Psychological Association, 1994b), "religiosity" refers to the degree of religious involvement, devotion to beliefs or adherence to religious observances" (Scott et al., 2003, p. 164).

diagnostic evaluation. Hathaway (2003) added that limiting such an important area of functioning in the lives of many people to a mention of the four lines the V-Code comprises, is somewhat inadequate. Later research, conducted by Hathaway, Scott and Garver (2004), received a negative response to the question posed to clinicians, "Have you ever given a religious or spiritual V-code (V 62.89) to clients as part of their diagnosis?" (p. 99), supporting Scott, Garver, Richards and Hathaway's (2003) earlier hypothesis.

Also included in the DSM-IV was a cultural formulation, updated in the DSM-5 to include a Cultural Formulation Interview (CFI) (APA, 2013b) which requires clinicians to consider the influence of culture, including RS, in a patient's presenting problems, the patient's preference for care and, in addition, the role of RS in providing support. Of particular note in the CFI, is the assessment of "cultural features of the relationship between the individual and the clinician" (APA, 2013b, Cultural Formulation, Outline for Cultural Formulation, para. 5).

However, despite this requirement to consider the influence of culture in a client's presentation, Durie (2001) noted that there has often been a disjunction between theory and practice which has "often led to misdiagnosis and gross mismanagement among ethnic minority groups" (p. 23). In a survey of studies into race and gender bias, Garb (1997) reported that African-American and Hispanic patients were much more likely to attract a diagnosis of schizophrenia than Caucasian patients, even when this diagnosis was not warranted by the degree of psychopathology demonstrated. Nevertheless, increasing diversity of treatment providers may allow for greater understanding of a variety of cultural presentations. For example, the intervention of a Nigerian-born psychiatrist, in a case reported by Dura-Vila, Hagger, Dein and Leavey (2011), permitted a wider cultural understanding of symptoms exhibited by a Nigerian patient, who had previously been diagnosed as psychotic.

Use of diagnostic tools by psychotherapists in Aotearoa New Zealand. The use of diagnostic tools by psychotherapists in ANZ needs mention. In 2013, Manning conducted an informal survey of ANZ psychotherapists' use of the DSM and the Psychodynamic Diagnostic Manual (PDM) (PDM Task Force, 2006). He commented that the utilisation of the *Diagnostic and Statistical Manual* is "virtually mandatory …

in an NZAP case study" (Manning, 2013). He concluded from the survey that although many psychotherapists had some use for the DSM, some also used the PDM. This latter assessment tool has no category for the specific consideration of religion or spirituality; neither is cultural influence in a client's presentation considered. Manning added that:

> Neither [DSM nor PDM] is embraced wholeheartedly, psychotherapists in general preferring to explore what is present in the room, and then perhaps put a name to it from some classification system, always wary of the disruptive and distancing effect of labelling. (p. 40)

Exploring "what is present in the room" takes place from a particular perspective and is discussed under "The complexities of inclusion".

Cultural imperative. Another factor influencing the rise in interest in RS in clinical practice is the "multi-faith, multi-cultural globalised world" (Verhagen, van Praag, Lopez-Ibor Jr., Cox & Moussaoui, 2010, p. xv) in which psychotherapy is now practised. The adaptation of psychotherapy to particular cultural contexts, where RS is important, is increasingly noted (Abernethy, Houston, Mimms & Boyd-Franklin, 2006). Goreng Goreng (2012), an Aboriginal woman, documented her recovery from historical trauma using a combination of psychotherapy and Aboriginal spiritual practices. She commented, "In my experience western treatment is most useful when coupled with a cultural and spiritual recovery based in our own traditions" (p. 209). In Chapter one I have spoken to the increasing mix of cultures which adds to the bicultural foundation of ANZ society. Cultural variety has led to a growing recognition of the need to be responsive to clients' cultural needs within therapy since RS is part of culture (Eshun & Gurung, 2009).

The Victorian anthropologist Edward Tylor (1832-1917) defined culture as "that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society" (Loewenthal, 2007, p. 4). Culture was understood by Rohner (1984) as a set of meanings about living which are shared by a group of people and passed on from one generation to another. These meanings are dynamic, complex and represent a variety of experiences. The United Nations Educational, Scientific and Cultural Organisation (UNESCO) asserted that "[Culture] is that complex whole that includes knowledge, beliefs, arts, morals,

laws, customs, and any other capabilities and habits acquired by [a human] as a member of society" (UNESCO, 2015, p. 1).

In his explication of the philosophy of the Romanian philosopher and novelist, Lucian Blaga (1895-1961), Jones (2006) suggested that religion is, at least in part, a product of culture, since religions are mediated by the contexts in which they arise. Even mystical experience, perhaps the least influenced by cultural mores, cannot escape the times in which it occurs. Jones added:

> Culture is the product of the human attempt to penetrate, to reveal, the mysteries inherent in human existence. Religion is a culturally-mediated attempt to penetrate mystery. Religion does not overcome culture, nor does it escape culture, but religion is a form of culture … "Culture" includes all attempts at revealing mystery; "religion" is culture focused on revealing the ultimate mysteries of existence. (p. 81)

The explicit inclusion of religion in culture is seen in the DSM-5 definition which includes spirituality, noted separately from religion.

> Culture refers to systems of knowledge, concepts, rules, and practices that are learned and transmitted across generations. Culture includes language, religion and spirituality, family structures, life-cycle stages, ceremonial rituals, and customs, as well as moral and legal systems. Cultures are open, dynamic systems that undergo continuous change over time; in the contemporary world, most individuals and groups are exposed to multiple cultures, which they use to fashion their own identities and make sense of experience (APA, 2013b, Cultural Formulation, para. 1).

These understandings of culture acknowledge its complex, multi-faceted nature and the influence of time and context in this complexity. The relationship between culture and psychopathology is part of the complexity of cultural expression.

Considering this relationship, Eshun and Gurung (2009) suggested three ways of understanding the influence of culture on psychopathology. The first, an absolutist perspective, asserts that culture has no bearing on behaviour, meaning that the presentation of mental illness is the same across all cultures. The second view, that of the universalist, suggests that the development and response to a mental illness is influenced by culture, however, "specific behaviors or mental illnesses are common to

all people" (p. 5). Thirdly, the relativist position posits that "all human behaviour (including the expression of mental illness) ought to be interpreted within a cultural context" (p.5).

These positions are also considered by La Roche, Davis and D'Angelo (2015) who have written about the challenges addressing culture poses to evidence-based practices (EBPs). They noted that there are three ways of understanding culture in psychotherapies. (The plural "psychotherapies" is used by La Roche et al. and by Tudor (2012), to indicate the plurality and heterogeneity of psychotherapy). The first approach is the concept of universal psychotherapies which suggests that underneath cultural differences which are superficial, we are all basically, psychologically the same. One of the difficulties with this perspective, these authors noted, is that the assumption of shared characteristics means that approaches developed for one cultural group are seamlessly transferrable to others.

In contrast to the universal psychotherapies approach is the second approach, based on the concept of racial/ethnic psychotherapies, which considers both race and ethnicity essential to the psychotherapeutic process. The purpose of this approach is to ensure the development of psychotherapeutic approaches which are specific to a particular race or ethnic group. Knowledge gleaned from outcome research considering the efficacy of various approaches with people of different races and ethnicities, has led to some culturally adapted treatments as well as providing fuel for the cultural competencies movement (Cabassa & Baumann, 2013). However, La Roche et al. (2015) commented that, "Although meta-analyses findings suggest that ethnicity and race are relevant, we believe that they are insufficient to capture the complex and powerful cultural influences emerging within the psychotherapeutic process" (p. 98).

The third approach to evidence-based psychotherapy, therefore, suggested by La Roche et al. (2015), is a cultural therapies model which takes into account cultural complexity, acknowledging individual variations within race and ethnicity, a wider understanding of all that is involved in culture, including RS, as well as contextual considerations which influence cultural experience and expression. Given that culture clearly includes a person's RS history and expression, it is expected that psychotherapists are mindful of this.

Professional expectations of psychotherapists in Aotearoa New Zealand. The Psychotherapists' Board of Aotearoa New Zealand (PBANZ) has defined culture as the ways that people "define, perceive or see themselves and others, and the world they live in" (PBANZ, 2011a, p. 3). Included in the breadth of culture delineated by the Board are "religion and/or spiritual beliefs" (p. 3). It is expected that psychotherapists demonstrate cultural competence by the following: appropriate attitudes, knowledge and skills, the scope of which are delineated in the *Standards of Cultural Competence* (PBANZ, 2011a).

In addition to the PBANZ's expectations of cultural competence, the New Zealand Association of Psychotherapists (NZAP) has set out its members' responsibility to clients in its *Code of Ethics* (NZAP, 2008). Affiliated clinicians are expected to practise in a non-discriminatory manner, holding the welfare of clients as the psychotherapist's preeminent responsibility. Delineated under the heading, "Responsibilities to Clients", psychotherapists are to meet the following expectations: to

> 146.1 Value client well-being. Psychotherapists shall hold the needs and well-being of clients as a paramount concern and accord priority to the psychotherapeutic aspect of their relationships with clients.
>
> 146.2 Practise non-discrimination. Psychotherapists shall be sensitive to diversity and shall not discriminate on the grounds of colour, creed, ethnicity, gender, sexual orientation, age, disability, social class, religion or political belief.
>
> 146.3 Be responsive to cultural diversity and seek training and guidance to ensure competent and culturally safe practice.
>
> 146.4 Ensure informed consent. Psychotherapists shall seek to ensure that the client is willingly engaging in psychotherapy and has an adequate understanding of the process to be undertaken.

It is evident, both in the PBANZ's *Standards of Cultural Competence* and in the NZAP's *Code of Ethics* that psychotherapists are expected to engage sensitively and competently with clients' RS issues. However, how these expectations are interpreted may be diverse, depending on clinicians' theoretical orientations and style of practice. In addition to profession-specific expectations, public policy also has requirements for the inclusion of clients' RS issues in treatment.

Chapter Two: Literature Review

Public sector policy in Aotearoa New Zealand regarding the inclusion of clients' RS needs in treatment. Clients, called "consumers" in the public sector, who have their mental healthcare needs attended to in the public sector in ANZ, have the right to care inclusive of their RS. Standards of care are delineated in the Health and Disability Services Standards (Standards New Zealand, 2008). Those pertaining specifically to RS are as follows:

> 1.3.2 Consumers receive services that are responsive to their needs, values, and beliefs of the cultural, religious, social and ethnic group with which each consumer identifies.
>
> 1.3.4 Consumers have access to spiritual care of their choice (p. 7).

> Under a section entitled "Guidance" the following is elaborated:
>
> 6.141. (d) Recognising that spirituality is inextricably linked to Māori well-being.
>
> 6.14.4 (e) Validation and observance of the Māori perspective of health which includes cultural, social, spiritual, whanau, environmental, and emotional factors, in addition to physical health (p. 8).

The influence of RS on mental health is an important consideration as psychotherapists meet this territory.

RS and wellbeing. The relationship between RS and wellbeing is complex. The World Health Organisation (WHO) has defined mental health as "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" (WHO, 2014). Since the WHO's definition of wellbeing suggests an equivalence between mental health and wellbeing, these terms are used interchangeably throughout this thesis. RS may be implicated in the difficulties a person is experiencing; it may also help in the overcoming of those difficulties. In other words, RS may be both part of the problem and part of the solution. Much depends on the nature of a person's RS beliefs. There is also some debate about what aspects of RS affiliation and experience is being measured in research in the field.

Chapter Two: Literature Review

The different ways of understanding RS adherence is reflected in the range of measures of RS in quantitative research initiatives which investigate the relationship between RS and mental health. One wonders also whether measuring what at times is a subjective experience, is not something of a contradiction. This difficulty was captured by an editorial on this subject in the *Journal of Psycho-Oncology*, entitled, "Can You Measure a Sunbeam with a Ruler?" (Lederberg & Fitchett, 1999).

An early measure of RS was proposed by Allport and Ross (1967) who, when conducting empirical research into religious prejudice, concluded that religion could be seen as containing polarities–of an intrinsic and extrinsic nature. They commented that "the extrinsically motivated person *uses* his religion, whereas the intrinsically motivated *lives* his" (p. 434). This measure has had a mixed reception. Pargament (2002) supported Allport and Ross's conclusion, commenting:

> Wellbeing has been linked positively to a religion that is internalized, intrinsically motivated and based on a secure relationship with God and negatively to a religion that is imposed, unexamined, and reflective of a tenuous relationship with God and the world. (p. 168)

However, Cohen, Hall, Koenig and Meador (2005) later questioned the applicability of this construct beyond a narrow American Protestant demographic.

More recently, querying the absolute nature of these polarities, Lavric and Flere (2011), conducted a quantitative survey with 400 Catholic, Moslem and Eastern-Orthodox undergraduate students, asking questions which expressed both intrinsic and extrinsic positions. These researchers concluded that even those with what would be considered an intrinsic orientation to their faith, expected external rewards, suggesting that these polarities may not be so absolute; they asserted that a unidimensional view, rather than the polarities suggested by Allport and Ross (1967), better reflected the experiences of their sample.

Hackney (2010) noted three approaches to the empirical quantitative studying of RS and mental health: one which sees religiosity simply as a matter of one's commitment to the practices of a social organisation; another which considers religion as a set of ideological beliefs; and one which measures personal experience of religion. Whilst

bearing in mind the reality of what is measured in empirical research may vary, there is a large amount of literature which has suggested that RS can have both a positive and a negative effect on wellbeing.

RS as supportive of mental health. Many studies have suggested that RS supports mental health (Hackney & Sanders, 2003, Koenig, McCullough & Larson, 2001; Marks, 2005; Plante & Sharman, 2001) since it offers resilience in the face of the adversities of life. An appraisal of research conducted prior to 2000 by Koenig, McCullough and Larson (2001) found that 476 of 724 quantitative studies reported positive associations between RS and wellbeing in areas of depression, anxiety and substance abuse. Spirituality may be a resource for those experiencing mental illness (Tepper, Rogers, Coleman & Malony, 2001). A narrative inquiry by McFadden (2006), investigating the experiences of seven participants who had been diagnosed with a chronic or severe mental illness, found that all participants reported RS as supportive in their recovery. However, whilst participants had mentioned this to their clinicians, only one was encouraged to utilise their RS to support their recovery. McFadden suggested that his findings demonstrated the importance of RS in buffering against suicidality and hopelessness.

Research has demonstrated that many people use RS to cope with life's stressors and crises (Kim & Seidlitz, 2002; Vonarx, 2015). In his seminal work, *Man's Search For Meaning*, Viktor Frankl (1905-1997), a psychiatrist and holocaust survivor, recounting his observations in a concentration camp, observed that those who had a sense of purpose or meaning were more likely to survive, than those who did not (Frankl, 1964). In order to explore the experience of RS on bereavement, Park (2005) conducted a survey of 169 undergraduate students in the USA, who had experienced the death of a significant other in the previous year. Park found that "religion may serve as a meaning system within which the bereaved can reframe their loss, look for more benign interpretations, find coping resources, and, perhaps, identify areas of personal growth" (p. 721).

A particular kind of stress is living through a natural disaster. According to a longitudinal study conducted by Sibley and Bulbulia (2012), religious faith increased amongst those who were affected by a catastrophic earthquake which occurred in

Christchurch, a city in ANZ, on 22 February, 2011. These researchers found that religion became more appealing post-earthquake among those who were exposed to the earthquake, relative to those who were not. Sibley and Bulbulia commented that "This finding offers the first evidence from a large population that religious conversion increases following a natural disaster" (p. 5). They did report, however, that there was also an erosion of faith in those who lived through the disaster, speculating that this may have been, in part, due to existential conflicts. However, the net effect was a significant increase in religious affiliation. It is of note that this study captured religious affiliation denominationally; there was no accounting for the more intangible aspects of spirituality. This notwithstanding, this research supported the notion that people turn to religious faith in times of crisis.

An ethnicity component has also been noted by some researchers in the use of RS for coping. In a study into the use of RS as a stress coping mechanism Chai (2009) conducted a quantitative study, using the World Health Organisation's Quality of Life tool (the WHOQOL) with 515 domestic and 151 international students at a university in ANZ. Chai found that Asian international students used religion as a coping strategy and were significantly more religious than their European counterparts. However, the generalisability of these findings is questionable, as the sample, although large, was limited to one faculty, in one geographical location. A survey of 4,281 ethnically diverse adults in the United Kingdom, investigating the relationship between RS and mental health, conducted by King, Weich, Nazroo, and Blizard (2006), found that immigrants from different ethnicities reported a higher degree of religiousness than participants born in the United Kingdom.

Krägeloh, Henning, Billington and Hawken (2015), again using the WHOQOL, investigated the relationship between quality of life, spirituality, religiousness and personal beliefs of 275 medical students at a Medical School in ANZ. They concluded that for all students, religious or not, existential issues relating to meaning and purpose, hope and optimism were significant in psychological wellbeing. Also utilising the WHOQUOL as a data collection instrument, Krägeloh and Shepherd (2014) researched the quality of life of 399 community-dwelling retirement-aged New Zealanders. They concluded that, among other factors, "religious community membership predicted psychological and social quality of life, although effects were small" (p. 1).

RS as deleterious to mental health. Although RS may be positively associated with mental wellbeing, this is not necessarily so as a number of studies have suggested that some RS beliefs or conflict between behaviour and beliefs, can have a deleterious effect on mental health. Shafranske and Malony (1996) observed that some RS perspectives "can be toxic and impede healthy adjustment" (p. 562). Where behaviour is judged as incompatible with RS beliefs, conflict often ensues. Sorenson, Grindstaff and Turner (1995) found that unmarried mothers with religious affiliation, experienced emotional distress. Musick, Blazer and Hays (2000) reported that elderly Baptists, when using alcohol, felt condemned by the norms of their religion. Conservative religious beliefs are also correlated with higher levels of shame, guilt and internalised homophobia in lesbian, gay and bisexual clients (Sherry, Adelman, Whilde, & Quick, 2010). Boscaglia, Clarke, Jobling and Quinn (2005) reported that anxiety can be exacerbated rather than ameliorated when illness is interpreted as "God's punishment".

In addition to the psychological conflicts experienced when engaging in behaviour at odds with one's RS tradition, or having experiences in life which call into question one's beliefs, there are also some RS beliefs which do not support wellbeing. Bolletino (2001) suggested that the belief that we create our own reality (that the interplay between ourselves and our environments is inconsequential); the banishing of "negative" emotions (where do they go?) and adopting a "serene" composure (searching for meaning involves anxiety and inner tension, inhibit facing reality). She also added that the denial of the body espoused by some RS thinking is unhelpful for integrated living.

Although much research and literature in the area of RS differentiates between what is helpful and unhelpful in terms of wellbeing, in some areas the reality is a "both" "and" synthesis. This is often the case in the field of trauma and psychosis. In order to explore the experience of women childhood sexual abuse (CSA) survivors, recovering in the context of Catholicism, Collins, O'Neill-Arana, Fontes, and Ossege (2014) conducted a qualitative study with eight female participants, who had been raised Catholic and who had had at least two years of psychotherapy. Participants named "a vigilant God, Catholic patriarchy, and the Catholic identity, as both a major influence in suffering and healing" (p. 532). However, this was a small sample of those who were willing to

discuss the issue. The researchers commented that other Catholic CSA survivors may report different experiences.

The place of RS in trauma is significant for several reasons: RS may be implicated in the trauma itself via perpetrator and context; trauma may provoke issues of meaning and existence; RS resilience often supports recovery from trauma; and trauma itself may lead to RS growth. Walker, Courtois and Aten (2015) noted:

> Spirituality and trauma are often inextricably intertwined. Trauma affects the individual and his or her beliefs in the divine and the sacred in ways that may interrupt or sever these beliefs or, simultaneously or alternatively in ways that strengthen them … trauma work is inherently spiritual and must include a focus on the client's belief system. (pp. 3-4)

Ganje-Fling and McCarthy (1996) suggested that childhood sexual abuse tends to arrest spiritual development, causing difficulties in trusting spiritual sources. The devastating and pervasive influence of clergy abuse on the RS of survivors has been reported by McLaughlin (1994) and Rossetti (1995). When a person has been subjected to abuse in childhood, especially if the abuser is a member of clergy, then their experiential relationship with a deity can, without therapeutic intervention, be fused to trauma for the rest of their lives (Frawley-O'Dea, 2015).

In a phenomenological study with eight female participants, Luck (2010) explored the use of spirituality as a means of coping with childhood sexual abuse (CSA). Luck reported that "Participants, in utilising RS resources, described feeling a sense of peace and love, as well as a new sense of self and value of self" (p. 142). Although these findings support comments made by Walker, Courtois and Aten (2015), one of the inclusion criteria for Luck's study's sample was that participants considered spirituality important in CSA recovery. Again investigating the positive relationship between RS and trauma, De Castella and Simmonds (2013) conducted phenomenological research exploring the experiences of RS growth following trauma, with 10 female participants who identified as Christian. These researchers found that the questioning and meaning-making related to the trauma experiences of participants led to a deepening intrinsic spirituality.

Although both Luck's (2010) and de Castella's and Simmonds'(2013) found wholly positive outcomes concerning the use of RS in trauma recovery, Grossman, Sorsoli and

Kia-Keating (2006) reported mixed results. In a qualitative study with 16 male survivors of CSA who were diverse in terms of ethnicity, race and socioeconomic status, Grossman, Sorsoli and Kia-Keating found that about half of the participants made meaning of their experience through spirituality. These researchers reported that "Although only two of the men were actively involved in a religious community, about half of them developed or found spiritual beliefs that seemed to significantly aid in enriching their lives and facilitate their recovery" (p. 439).

Differing outcomes concerning the value of RS in trauma recovery may be related in part at least to researchers' sample groups. Both Luck (2010) and de Castella and Simmonds (2013) chose female participants who either expressed RS affiliation or indicated that they valued RS in their recovery whereas Grosman, Sorsoli and Kia-Keating's (2006) participants were all men, only two of whom had any RS affiliation.

The implication of RS as both part of the problem and part of the solution, is also demonstrated in the area of psychosis. A qualitative study conducted in ANZ by Geekie (2007) investigated the subjective experience of psychosis (first time occurrence), of 15 participants, seen clinically by the author. Geekie noted, "Relationships between psychotic experiences and spiritual matters were often of central importance to participants" (p. 264). Some participants reported believing that spirituality was causal in their psychosis; some mentioned being "possessed" by spiritual beings; others named conflicts between "good" and "evil". Others viewed their psychosis in a spiritual framework–connected to how they made meaning of life, while others described the experience of psychosis as causing them to be out of sync with their spirituality. Geekie also reported that, "Commonly participants found it very difficult to make a clear demarcation between psychosis and spirituality and put forward arguments that it was, in fact, impossible to differentiate these experiences in terms of phenomenology" (p. 266). One participant said that she felt that spiritual matters, although of major concern to people who experience psychosis, were overlooked by mental health services. These findings were supported by Green, Gardner and Kippen (2009), who found, in qualitative research with six participants recovering from mental illness, that RS was important in their recovery, yet also, at times, implicated in their psychological difficulties.

RS as of therapeutic significance. It cannot be disputed that RS is of therapeutic significance. In a world where events and outcomes cannot be controlled and RS beliefs do not allow for human vulnerability, psychological distress ensues, and may become the focus of clinical attention. However, RS may also be a source of resilience in the vicissitudes of life, and therapeutic processes may be advanced by supporting clients' RS resourcing. Important also in the arena, is what psychotherapists take into account when considering the utility of a client's RS beliefs.

Psychotherapists' assessing function of clients' RS. When asked how they determined whether a client's spirituality was a help or a hindrance, 25 psychotherapist respondents in a study conducted by Pharo (1997), said that spirituality was helpful when it supported growth, healing and transformation. Spirituality was a hindrance when it was "restrictive and incredibly punitive [and contributes to] self-destructive and self-defeating [patterns]" (p.63).

These findings were echoed and amplified in later comments made by Pargament (2007), who elegantly described the difference between RS which is helpful to wellbeing and that which is less so, in the following:

> At its best, spirituality is defined by pathways that are broad and deep, responsive to life's situations, nurtured by the larger social context, capable of flexibility and continuity, and oriented toward a sacred destination that is large enough to encompass the full range of human potential and luminous enough to provide the individual with a powerful guiding vision. At its worst, spirituality is dis-integrated, defined by pathways that lack scope and depth, fail to meet the challenges and demands of life events, clash and collide with the surrounding social system, change and shift too easily or not at all, and misdirect the individual in the pursuit of spiritual value. (p. 136)

Enhanced therapeutic outcomes. Whether a client's RS is experienced as supportive, part of the problem, or both, it is clear that therapeutic outcomes are enhanced when RS matters are responded to sensitively within therapy (Worthington & Sandage, 2002). If RS is intrinsic to being human, it stands to reason that in some way it will be present in the therapy room, whether or not it is acknowledged. Pargament (2007) asserted, "When people walk into the therapist's office, they don't leave their spirituality behind in the waiting room" (p. 4). In similar vein, Winton (2013) reflected, "Religion that is not allowed in the door may slip in through the window" (p. 356). As has been noted above,

some people find their RS a source of strength; acknowledging these resources in therapy is strengthening (Griffith & Griffith, 2002; McRobie & Makasiale, 2013; Pargament, 2007; Plante, 2009). Abernethy, et al. (2006) reported an enhanced therapeutic connection when prayer, an aspect of a client family's culture, was utilised in the therapeutic process. Emmons, Cheung and Tehrani (1998) commented that RS is connected with goal content and conflicts for many people and therefore enhances therapeutic outcomes in these areas, when included in therapy.

As well as utilising clients' RS strengths in therapy, therapeutic work is enhanced when the psychological implications of clients' religious "objects" are explored within therapy. Rizzuto (1979) in her seminal work, *The Birth of the Living God*, noted that we all have intrapsychic representations of God which mirror our developmental histories and internal parental images. These representations offers a rich mine of understanding and the potential for facilitating change in an individual's psychological functioning. Tisdale et al. (1997) found that specific targeting of a client's God image during psychotherapy led to shifts to a more adaptive sense of God as well as marked improvement in self-image. Winton (2013) described three insightful vignettes of her therapeutic work, where clients' internal religious objects were thoughtfully explored, with successful therapeutic outcomes.

The literature supports the inclusion of RS in psychotherapy on the grounds that our RS orientations are an integral aspect of cultural expression; as such, RS is an intrinsic part of human existence, being both a source of comfort and a source of distress. Clients are increasingly presenting with RS issues in therapy and expecting these to be attended to, partly because of the reduction in affiliation to church communities which would have afforded RS resourcing. Moreover, a greater variety of RS expression is evidenced in people who have no current or prior affiliation with a RS tradition. In addition, it has been demonstrated that RS has a complex relationship with mental health, and that its inclusion within the therapeutic process leads to enhanced outcomes.

The complexities of inclusion

Although it is evident that RS matters need to be addressed in psychotherapy, and that psychotherapists are trained to be non-judgmental within a therapeutic relationship (which may involve a transpersonal aspect and a therapeutic process which lends itself

to depth exploration), attending to RS issues is not always a straightforward process. To begin with, the history between RS and psychotherapy is fraught–a history which influences the present. Also, there is a range of psychotherapeutic modalities offering different perspectives on the "what" and the "how" of inclusion. This means that assessment and treatment is addressed diversely. Moreover, a psychotherapist's own relationship to their RS and how that influences the therapeutic process needs to be considered, since RS can evoke strong feelings in both therapist and client. However, the skills needed to navigate this field are often lacking, since psychotherapy education in RS is generally inadequate. Lastly, the nature of RS itself adds to the complexities of inclusion. These points are the subject of this section, beginning with RS expression and experience.

RS expression and experience. RS expression and experience often defy language (Hood & Chen, 2013; Rowan, 1990); words such as "ineffable", that which cannot be described in words, and "mystery", or the "unexplainable", are often used in an attempt to explicate this domain. Pesut, Fowler, Taylor, Reimer-Kirkham and Sawatzky (2008) and Spillers (2011) commented on the difficulty of conceptualising RS due to its fluid nature. Spillers reflected that "spirituality is amorphous and messy, with no defined boundaries" (p. 249). In a recent study regarding how spirituality is understood and taught in New Zealand medical schools, by Lambie, Egan, Walker and MacLeod (2015), 15 curriculum coordinators from the Dunedin School of Medicine, were asked what the term "spirituality" meant to them. Six of the interviewees reportedly had difficulty answering the question, "using words such as '*vague*' or '*intangible*'" (p. 55). How to name the unnameable, describe the indescribable, contain the amorphous and boundary that without boundaries, is a challenge for both therapists and clients alike in psychotherapy. In her research, involving 12 psychologist participants, D'Angelo (2013) found that the nature of spirituality itself was an obstacle in a psychotherapist's attention to spirituality in the therapeutic relationship. Many of the participants in her study described the ineffable and elusive nature of spirituality making it difficult for them to put spiritual experience into words.

It is of note that in the space of two years, three psychotherapists in ANZ, Linde Rosenberg, Lauren Sleeman and Kay Ryan, conducted hermeneutic phenomenological research investigating psychotherapists' and counsellors' experiences of "inexplicable

phenomena", "unusual phenomena", and "spiritual experience", respectively. This suggests both interest and a lack of knowledge in the area among psychotherapists in ANZ. Rosenberg (2005) commented that the purpose of her study was to "stimulate thinking about these experiences and bring them into conversation within the psychoanalytic community" (vii). The inexplicable phenomena, explored in Rosenberg's study, included the foreknowledge of events later reported by clients and the "seeing of semi-solid forms, which may be static or moving" (vii). Sleeman (2007) explained the "unusual phenomena", the topic of her study, as "the 'mysteries' of life. They may be called spiritual, mystical, or transpersonal experiences, altered states of consciousness, and experiences of non-dual reality … experiences that are often difficult to define" (p. 2). Ryan's (2007) aim in her research was to explore psychotherapists' spiritual experience and its interface with therapeutic work; she described spiritual experience as having diverse meanings, depending on particular traditions and cultures, however is broadly defined as "a felt sense of the interconnectedness of all things" (p. 8). Spirituality, in her study, was differentiated from religion which was described as "commonly held beliefs and practices that support a connection with spiritual phenomena" (p. 1), the latter being excluded from her study.

Rosenberg (2005) explored the experiences of eight participants. Among other findings, she reported that participants were reluctant to talk about their experiences with inexplicable phenomena within the psychotherapy/counselling community for fear of being pathologised. She also found that Māori participants, who spoke about communicating with ancestors, feared for their professional reputations if speaking to Pākehā about these experiences. Some participants experienced a shaming response when discussing inexplicable phenomena in supervision and subsequently did not talk about it. An aspect of this fear was the concern that their experiences might be deemed psychotic; the boundaries between psychosis and "normal" experience, was unclear. Rosenberg concluded that difficulties having a language to describe what was being experienced, within psychoanalytic theory, meant that participants had problems recognising and using these phenomena for therapeutic ends.

Sleeman (2007) also investigated eight psychotherapists' and counsellors' work with unusual phenomena. Reflecting Rosenberg's (2005) findings, Sleeman found that the majority of participants were unwilling to discuss their work with unusual phenomena

with colleagues, for fear of how they would be regarded professionally; however, they did discuss these phenomena in supervision. They also commented on the dearth of teaching on this area in their psychotherapy education. Sleeman (2007) concluded that her research demonstrated the need for a holistic approach in psychotherapy, one which acknowledges the multifaceted nature of human existence.

Ryan's (2007) Master's thesis explored the spiritual experiences of six psychotherapists and how those experiences influenced their work with clients. Participants reported the following spiritual experiences occurring in their personal lives, and for some, in their client work: a sense of boundary dissolution with feelings of awe and wonder; being protected and guided by something beyond themselves; unexpected and surprising experiences. Ryan noted the importance of openness and space in facilitating spiritual occurrences. She also observed that participants brought spiritual attitudes and practices to their work, that were not taught in their psychotherapy training. One aspect not included in Ryan's study was how participants related to their clients' spiritual perspectives. Important in the discussion of RS expression and experience, is the boundaries between RS and psychosis, an issue noted by Rosenberg's (2005) as an area of difficulty for participants in her study.

Relationship between RS and psychosis. In addition to the difficulties of finding language sufficient to express RS experience, the relationship between RS and psychosis is complex, since the boundary between these experiences is often hard to discern. James (1902/2008) posited that psychotic and spiritual experiences, although largely distinguishable, also shared commonalities. Commenting on this overlap, Clarke (2001) reflected that "Psychosis and spirituality both inhabit the space where reason breaks down, and mystery takes over" (p. 87). According to Lukoff (2012), transpersonal psychologists assert that:

> Some episodes of psychosis are part of a natural developmental process with both spiritual and psychological components. They point out similarities between psychotic symptoms and spiritual experiences (Lukoff, 1988; Perry, 1998) and argue that psychotic experiences are better understood as crises relating to the person's efforts to break out of the standard ego-bounded identity. (p. 67)

Both Lukoff (2000), and Randal (2012), clinicians working in the field of psychosis, spoke of their own experiences of psychosis as "spiritual emergency" which led to

spiritual emergence. Spiritual emergencies were described by Grof and Grof (1989), as "crises of personal transformation" (p. x), the term, a "play on words, suggesting both a crisis and opportunity of rising to a new level of awareness, or "spiritual emergence" (p. x). The concept "spiritual emergency" was advanced by Randal and Argyle (2005), as an explanatory model for some psychoses, because of its normalising possibility. Randal and Argyle commented on the connection and differences between spiritual emergency and psychosis:

> The phenomenology of what might be interpreted as a "spiritual emergency" by the person or by an informed clinician, can be identical to other psychoses–people can present as disoriented, fearful, hallucinated, delusional, affectively dysregulated, and having interpersonal difficulties – thus making differential diagnosis difficult. Anecdotally, the content revolves around spiritual themes, including sequences of psychological death and rebirth, encounters with mythological beings, feelings of oneness and other similar motifs. Many of these states can be extremely distressing and sometimes terrifying. People who see themselves as experiencing "spiritual emergency" are usually open to exploring the experience, and have no conceptual disorganisation. (p. 2)

The overlap between RS and psychosis is often disguised, Clarke (2001) noted, since the profoundly mystical experiences which often occur at the beginning of psychosis, are underreported. This overlap can lead to problems in assessment and diagnosis, or, as Clarke put it, "conceptual quicksand" (p. 88). As well as occupying much of the same space, the fact that the content of psychotic episodes often involves preoccupation with RS (Drinnan & Lavender, 2006; Siddle, Haddock, Tarrier & Faragher, 2002), adds to uncertainty in practice as clinicians attempt to discern "what is what". Dein (2004) suggested that psychosis differed from spiritual experience in the following ways:

> In psychosis:
>
> Experiences are often very personal
> Their details exceed conventional expressions of belief
> In many cases the only distinguishing feature is the intensity of the belief with the patient thinking of nothing else
> Onset of the beliefs and behaviours marks a change in the patient's life, with a deterioration of social skills and personal hygiene
> Episodes often involve special messages from religious figures. (p. 289)

Having made a differentiation in terms of negative effect on general functioning and lack of insight, which Dein (2004) suggested are hallmarks of psychosis as opposed to mystical experience, he added that where mystical experience is not understood and supported by others, this can lead to increased isolation and hinder a person's ability to integrate the experience, a position which Clarke (2001) implied, may lead to psychosis. In order to evaluate what he named as the "grey area between psychotic and spiritual experience", Jackson, (2010, p. 140) conducted a qualitative study involving two groups of people (four in each group). The first group had never received a psychiatric diagnosis but had had extreme spiritual experiences; the other group had received a diagnosis of, and treatment for psychosis but had made "substantial recovery by the time of the study and held a spiritual or paranormal interpretation of key anomalous experiences" (p. 140). Jackson reported no watertight distinctions for separating the two groups. The "benign group" (p. 141), (those who had experienced extreme spiritual experiences, without being diagnosed), were more often able to contextualise their experiences according to their cultural milieu. In addition, their experiences were of relatively short duration and involved more "emotionally positive content" (p. 141). On the other hand, the diagnosed group were more distressed by their experiences which were more persistent. However, Jackson noted, that as well as the distinctions, there were exceptions in both directions. Although only being derived from a small sample, the findings of this study support the overlap and distinction between psychosis and spirituality. Jackson's research also demonstrated that, given the right support, a psychotic experience may be transformative. Acknowledging that psychotic episodes may be transformational, Brett (2010) asserted, means that they are purposeful rather than just psychologically understandable.

Whether an experience is named a spiritual crisis or a psychotic episode may depend on socio-cultural construction (Brett, 2010; Claridge, 2010; Lambrecht & Taitimu, 2012; Mohr & Huguelet, 2004) as was demonstrated by the experience of Jackson's benign group (Jackson, 2010). There have been many instances of phenomena, such as hearing the voices of ancestors, for example, deemed normative in the cultures in which they occur, yet being diagnosed as psychotic. Lambrecht and Taitimu (2012) commented that "when viewed through an indigenous lens, experiences labelled schizophrenic by Western psychiatry have been found to vary from culture to culture, in terms of content, meaning and outcome" (p. iii). In order to explore how Māori understood experiences

diagnosed as "schizophrenic", Taitimu, from the Te Rarawa iwi (tribe), conducted a qualitative study with 57 participants using thematic analysis (Taitimu, 2007). Participants included service users, cultural support workers, kaumata (elders), tohunga (traditional healers), and clinicians, both Pākehā and Māori. Taitimu found that participants' predominant explanation for these experiences were spiritual, and made recommendations for assessment and treatment processes which were culturally informed.

Historical antecedents. The historical relationship between psychotherapy and RS has been uneasy, as has already been noted in Chapter one, since Freud asserted that the need for RS was regressive i.e., a failure to face reality. Black (2000) spoke about the "orthodoxy of atheism that the idealisation of Freud imposed on the first two or three generations of psychoanalysts" (p. 13). Even though psychotherapeutic thinking in terms of RS has evolved considerably since Freud, his influence has "cast a long shadow" (McDargh, 1993, p. 173). Despite theoretical challenge regarding RS since the time of Freud, Simmonds (2004) reflected that reductionist views tended to prevail in psychoanalytic circles. The uneasy relationship between psychotherapy and RS has not been helped by Symington's repeated assertion that psychoanalysis itself is a mature religion, thus appearing to usurp the place of traditional religions (Symington, 1994, 1996, 1999). Priester, Khalili and Luvathingal (2009) noted that the philosophical background of psychology does not allow for "the healthy existence of God" (p. 95). These authors submitted that this creates something of a dilemma; on the one hand this history exists, yet on the other hand there is an expectation that, among other health professionals, psychotherapists are respectful of the worldview of all clients, including those who believe in a deity. This history suggests that assessment of the place RS occupies in a person's life could be seen through the lens of pathology, rather than health.

Noting that there was very little research about spirituality from the perspective of psychoanalysts and psychoanalytic psychotherapists, Simmonds (2004), using a qualitative approach, explored the views of 25 such clinicians concerning how they "experienced, conceptualised and worked with spiritual issues" (p. 951). These participants reported a caution in taking their own RS issues to psychoanalytic therapy, given Freud's assertions that such beliefs were infantile. In response to questioning

about the consequences of clients not being able to discuss their RS concerns in therapy, participants commented that "this dimension will probably be left unexamined, that 'part of the therapy may be aborted,' or patients will simply learn to comply with the analyst's or therapist's wishes or needs" (p. 962).

The nature of psychotherapy and the therapeutic relationship. Psychotherapy itself has been described as a spiritual endeavour, both in terms of the depth of exploration of a person's internal world, and the nature of the therapeutic relationship with its profound interpersonal connection. Whilst Rowan (1993) viewed psychotherapy as a "bridge between psychology and spirituality" (p. 2), suggesting that those in the transpersonal camp have ventured further along the bridge than adherents of other perspectives, Elkins (2005), more inclusively, reflected that "Any psychotherapy that explores the deeper regions of the human psyche will eventually come to the brink of this spiritual realm, whether the client and therapist recognize the place or not" (p. 131). The therapist's self-awareness in this process of attending is crucial, in order that the brink of the spiritual realm, noted by Elkins, may be recognised.

As well as the enterprise of psychotherapy being described as spiritual, the therapeutic relationship itself has been noted for its spiritual qualities. Clarkson (1990) coined the term "transpersonal relationship" (p. 157), to describe the "spiritual or inexplicable dimensions of relationship in psychotherapy" (Clarkson, 1995, p. 18). However, she found this hard to explain in detail because, she said, this quality of relationship is uncommon and language is limited in being able to capture its nature.

Describing the therapist's part in creating a therapeutic relationship with spiritual qualities, D'Angelo (2013) found that "A sacred place was cultivated through the offering of presence" (p. 94), and her co-researchers described this "presence" as a quality of attending to their clients which offered understanding, and a "being with" clients in the depths of their pain. Although psychotherapy and the therapeutic relationship may be described as spiritual, providing fertile ground for a client's growth in this area, the influence of the general goals of psychotherapy also needs to be considered.

Psychotherapy goals. The goals of psychotherapy and RS may both converge and diverge. Although some general observations may be made, the variations in both

psychotherapeutic and RS traditions, need to be remembered. Cooper-White (2008) suggested that integration was both a psychotherapeutic and a theological goal. She also observed that the multiplicity of therapeutic modalities, with their differing aims and objectives, also paralleled the multiplicity reflected in the Christian Godhead, the Trinity. Given that therapeutic modalities number over 400, as noted in Chapter one, and have many differences, the comparison with the Trinity where each member is united in purpose (according to one Christian theologian (Pearlman, 1981)), may be somewhat tenuous. Rowan (1993) commented that both psychotherapy and the techniques of spirituality, such as meditation, are about "daring to open up to what is inside" (p. 2). Holmes (1997) drew a parallel between the Christian assertion that pride is not part of a good life and the narcissism described by psychology as self-involvement and omnipotence; psychotherapy would seek to challenge a narcissistic way of being. Confession is both at the heart of psychotherapy and many RS traditions (Gibson, 2001), although absolution by an authority figure, again common in some RS traditions, is not present, at least consciously, in psychotherapy!

Whilst there may be convergence between psychotherapy goals and those of RS, there may also be divergence. Goals such as autonomy, self-determination and being open to "not knowing", which are valued in Western psychotherapy, may conflict with the values of some RS persuasions and different cultures. The self-actualisation suggested by Maslow (1943) as the pinnacle of human striving, may not be valued by collective cultures. Self-knowledge is considered the key to mental health (Frosh, 2006). Brooke (2001) suggested that psychotherapy challenged religious fundamentalism since it encouraged the integration of aspects of the self which fundamentalist ideology split off. For example, according to Christian fundamentalist thinking, a literal battle exists between the forces of good (God) and evil (Satan); Christian believers are enjoined to resist the attempts of Satan (the enemy) to ensnare them. A psychoanalytic perspective would likely consider such a belief as an externalisation as a disowned aspect of self (Segal, 1988). Hill, Smith and Sandage (2012) commented that fundamentalists, who see the world in absolutist terms, may struggle with psychotherapy which promotes questioning. As can be seen from the above, the lens of the modality through which the client is viewed has an impact on therapeutic interactions.

Chapter Two: Literature Review

Psychotherapists' theoretical orientation and style of practice.

Psychotherapists' theoretical orientations (outlined in detail in Chapter one) influence how RS may be approached within in the therapeutic process (Hoffman & Walach, 2011; Passmore (2003). This means that a client will experience their RS material and presentation viewed and attended to through different lenses. The number of publications outlining treatment of RS from different theoretical orientations attests to this: see, for example, Brodley (2001), reflecting a person-centred approach; Corbett (2013), analytic psychology; and Rizzuto and Shafranske (2013), a psychodynamic perspective. Theoretical orientation also has a bearing on how equipped a clinician is to deal with certain RS presentations. For example, transpersonal approaches are adept at working with what are termed "spiritual emergencies" (Grof & Grof, 1989), facilitating spiritual growth and transformation, with presentations which would be labelled as psychotic, by many other traditions.

Raising RS matters may be a conflict for practitioners whose style of practice is to follow the client's cues regarding the field of investigation. Having said this, it would be unusual for a therapist not to enquire into a client's family background, if this was not mentioned by the client, even if it was just to "notice" this absence aloud. Enquiry into RS may also be impeded, Crossley and Salter (2005) noted, when therapists found this a socially awkward area to discuss; it was difficult to find language to express spirituality; it raised discomfort because it was problematic in therapists own lives and histories; or they did not consider it an area of significance themselves. This raises the issue of a psychotherapist's values.

Psychotherapists' values. According to Fulford (2010), values go beyond professional ethics and include hopes, beliefs, and preferences as well as expectations. Values are the principles by which a person orders their life (Saroglou & Munoz-Garcia, 2008), and are often related to RS worldviews (Yarhouse & Johnson, 2013). What happens when a psychotherapist's values do not concur with those of their client's? A study examining the effects of therapists and patients ideology on clinical judgment was conducted by Gartner, Harmatz, Hohmann, Larson, and Gartner (1990). In this research 363 psychologists were asked to rate two case studies, one of which included the patient's endorsement of an extreme ideological position, whilst the other made no mention of ideology. These researchers reported that all clinicians were more likely to show

preference and empathy for those patients who shared the same ideology as they did. They also found that patients who held an extreme ideology were rated more negatively on clinical dimensions. Gartner et al. concluded that "Clinicians, being human, have personal feelings and judgments about their patients and are influenced by the degree of value congruence between themselves and patients" (p. 104). They suggested that clinicians needed to be sensitive to what they coined as "ideological countertransference" (p. 104). However, homogeneity amongst participants may have had a bearing on these findings, since 96% of this sample were white and 82%, male. One wonders whether a more heterogeneous sample in terms of ethnicity and gender, may have produced different results.

Although Holmes (1997) observed that a technique of psychotherapy is to suspend therapist judgment and so create an atmosphere of acceptance, this ideal may not always translate to practice, especially in the domain of RS (Kochems, 1983; Magaldi-Dopman, 2009). In his forward to Holmes' and Lindley's (1989) book, Hinshelwood made the following assertion about the psychotherapist's values:

> The therapist's values are there, and, like the impact of the observer in Heisenberg's Uncertainty Principle (in which the act of observation at an atomic level inevitably affects what is observed), have to be taken into account; unlike religious dogmas, however, they are not imposed but, rather, can be used to further the therapy. The basis of this is the therapist's capacity for self-awareness and detachment from her own values and responses, and her ability to use them to understand the interaction between herself and the patient. (p. ix)

As Hinchelwood commented, what is salient in the area of values is that psychotherapists are aware of the values they bring to the therapeutic encounter and are able to be self-reflective. Psychotherapists' RS orientations are a significant aspect of these values where self-awareness is crucial.

Psychotherapists' RS orientations. It is widely noted in the literature that a psychotherapist's own RS orientation influences their responses to RS material raised by clients (Brown, 2006; Cannon, 1998; Cohen, 1994; Crossley & Salter, 2005; Daniels & Fitzpatrick, 2013; Forbes, 1995; Frazier & Hansen, 2009; Kochems, 1983; Rossey, 2002; Shafranske & Malony, 1990; Simmonds, 2004; Sullivan, 1997; Turnbow, 2008), and their willingness to engage with RS material in psychotherapy (Walker, Gorsuch, &

Tan, 2004). In an early study of 357 psychiatrists, psychologists, and social workers in Boston, USA, Kochems (1983) concluded that therapists managed the RS material of their clients based on how they personally felt about RS–either positively or negatively. These findings have been repeated in later studies (Baetz, Griffin, Bowen, Marcoux, 2004; Crossley & Salter, 2005; Lestina, 2008).

Although general population statistics indicate that a large proportion of people have some religious persuasion, statistics about the therapist population are varied, depending it would appear, on the therapist's discipline (Bergin & Jensen, 1990), how questions about spiritual beliefs were framed (Bilgrave & Deluty, 2002), and the geographical population from which the sample was taken (Smith & Orlinsky, 2004). Smith and Orlinsky's study surveyed religious and spiritual experiences among 975 psychotherapists in the United States of America, Canada and ANZ. The ANZ demographic comprised 26% of the sample or 251 participants. This study found that of the American sample, 94.2% indicated that they had a religious background; the Canadian sample presented a similar statistic at 92.7%, while the New Zealand sample was slightly lower at 85.5%. However, when asked to report current religious affiliation, 35% of American clinicians reported no affiliation, compared with 43% of Canadians and 61.5% of the ANZ therapists. The fact that, of the New Zealand sample, a large proportion of psychotherapists said that they had a religious history, yet less than 40% indicated a continuing affiliation is of interest, as it could have implications for how they attend to the RS of clients who may hold a religious affiliation that they have eschewed.

Research into the spirituality of psychologists practising in America conducted by Bilgrave and Deluty (2002), which included a broader understanding of spirituality than the study by Smith and Orlinsky (2004), found that 71% of respondents believed in a transcendent realm. In terms of modality, 37% of respondents in Bilgrave and Deluty's study identified with the psychodynamic-psychoanalytic tradition, 26% with a person-centred approach and 6% with an existential orientation. However, a self-selection bias is one limitation in surveying clinicians' responses to issues of RS, so it must be remembered that these percentages apply to respondents, and are not necessarily representative of the general therapeutic population.

RS assessment and treatment. Since RS can affect psychological adjustment, it is important that there be some assessment as to the function it serves in a client's life. Meador and Koenig (2000) suggested that the onus is on the therapist to provide a "window" (p. 550) for a client to talk about RS, by introducing the topic if a client does not do so. At least, by this introduction, a client knows that this domain may be part of therapy (Sieve, 1999). However, even if therapists believe that RS is an important area of enquiry, it does not mean that enquiry is made. In a survey conducted into the behaviour of psychologists concerning their attending to RS within psychotherapy, Frazier and Hansen (2009) found that RS matters were discussed with only 30% of their clients; even though participants believed that RS was an important domain to investigate. However, Frazier and Hansen suggested that RS may not have been among the presenting issues of clients. No data was gathered as to whether it was the client or the therapist who raised the topic for the 30% with whom RS was discussed. Even though these researchers commented that RS may not have been an issue raised by clients, it is important that clinicians make enquiry, in order to assess whether this area is contributing to clients' difficulties and/or providing them with support.

In a further and later study investigating how therapists worked with RS in clinical practice, Jones (2013) conducted phenomenological research, using a semi-structured questionnaire, with 10 participants who met the criterion of addressing RS with their clients. In answering the question, "When and how do clinicians ask about their clients' religious or spiritual beliefs?" (p. 61), eight out of 10 participants reported that they enquired about these beliefs during assessment. One participant addressed RS as it unfolded as part of the client's story; while another waited until the client brought it up. Another participant considered the purpose of assessment was to gain an understanding of the client's values, whilst another commented that by asking, they could "rule in or rule out whether or not spirituality or religion will be an object of clinical concern" (p. 59).

Although clients may want to discuss RS issues in therapy, they do not always raise the issue. Bartoli (2007) and Simmonds, (2004) have suggested that clients often take the lead from their therapists as to what should be addressed in therapy. In questionnaires completed by 30 psychiatric in-patient participants prior to conducting psycho-educational groups into the effects of using RS to raise self-esteem, Lindgren and

Coursey (1995) found that "only half of the individuals who wished to discuss spiritual concerns in therapy had done so" (p. 107). The reasons given for not discussing RS matters included: not believing that the therapist would understand; having a different RS orientation to the therapist and; generally feeling uncomfortable discussing RS in therapy. It is evident that one of the barriers preventing clients' discussion of RS with their therapists is perceived difference in RS views which may cause a client to conclude that they may not be understood.

The relationship between psychotherapists' and their clients' RS perspectives. The interface between therapists' RS and that of their clients is salient since clinicians' views influence their clients. A grounded theory study which explored the religious/spiritual/nonreligious identities of therapists and the interface between these identities and work with clients was conducted in the USA by Magaldi-Dopman, Park-Taylor and Ponterotto (2011). The sample group comprised "16 experienced psychologists who practised from varied theoretical orientations and came from diverse religious/spiritual/nonreligious backgrounds" (p. 286). These researchers found that, when working with clients, the therapists' personal feelings based on their own histories were activated and that this activation led at times to their avoidance of addressing the client's issues. Therapist discomfort with RS may hinder therapeutic conversations (Daniels & Fitzpatrick, 2013; Helmeke & Bischof, 2002).

There is also evidence that clinicians express bias towards religiously dissimilar clients. Research by O'Connor and Vandenberg (2005) into therapists' responses to Catholic, Mormon and Islamic religious beliefs, found that Islamic beliefs were identified as much more pathological than either Catholic or Mormon, irrespective of whether such beliefs were identified as being consistent with the religion's cultural norms. In a later survey of 382 licenced psychologists in the USA, Ruff (2008) investigated how clinicians related to evangelical Christians in terms of empathy and prognosis. Participants were asked to comment on two vignettes of clients with comparable symptoms of Generalised Anxiety Disorder, who differed in terms of religious adherence, career and voluntary activity. Clinicians also completed a measure of their own Christian beliefs, ranging from orthodox to liberal positions. Findings indicated that therapists demonstrated bias in their treatment of clients whose religious beliefs were divergent from their own.

Although some research confirmed therapist bias towards dissimilarity, there are also studies which found that clients' RS perspectives are treated respectfully. Mayers, Leavey, Vallianatou and Barker (2007) conducted a small qualitative research study in a clinical psychology service in the United Kingdom into how clients (a sample of 10 participants) with strong RS beliefs experienced therapy. Nine of these participants were Christian and one was Sunni Muslim. All except one "described their faith or their relationship with God as a consistent source of strength that underpinned coping" (p. 320). The other participant experienced her deity as punitive and therefore unsupportive. All expressed some reticence seeking help from secular services, having "preconceptions about therapy as antagonistic to religious/spiritual beliefs" (p. 324); even so, this did not deter them. However, as a result of this reticence, participants reported being slow to disclose their RS beliefs, and then over time starting "to test the water by introducing their beliefs and observing the reaction of their therapist" (p. 322). The majority, to their surprise, felt that their beliefs, when shared, were treated respectfully. Only one participant said that their RS beliefs were ignored which caused them to be "reluctant to talk further about spiritual beliefs" (p. 322). Most participants spoke about the reciprocal influence of therapy and their RS beliefs: that both their psychological and their spiritual functioning were enhanced as a result of therapy. The therapists' choice of modality was not disclosed in this research article; however, with regard to being able to talk about RS matters, some participants commented on the importance of the quality of the therapeutic relationship. A therapist's comfort with their own RS has also been noted an important condition enabling a clinician to be comfortable with that of their clients' (D'Angelo, 2013).

Therapist/client RS matching. Since bias, when therapist and client hold different RS persuasions, has been attested to in some studies, one could imagine that this may be avoided where clinician and client share a similar RS persuasion. It has been asserted that RS matching leads to greater client satisfaction and better therapeutic outcomes (Norcross, 2002). It is apparent that, where RS matching occurs, a trusting therapeutic relationship may be more easily attained, at least in the initial stage of therapy (Baker, 1998; Lovinger, 1984; Plante, 2009). In their "Cultural Identity Model", Sue and Sue (2003) suggested that cultural matching may be indicated at certain stages of identify formation. Potential clients with strongly held RS views prefer to work with therapists who share the same religious perspective, fearing that their views may not be treated

with understanding in what is, in effect, considered to be secular therapy (Keating & Fretz, 1990; Lovinger, 1984; Worthington, Kurusu, McCullough & Sanders, 1996). However, what constitutes matching may be difficult to determine, since there are considerable variations of belief within individual faith traditions.

There is reason to be cautious about concluding that the matching of the RS beliefs of the therapist with those of a client–even if matching was possible, given variations in belief systems–is always the answer to the problem of bias. Reporting a case where both client and therapist were both clergy members of the same RS tradition, Kehoe and Gotheil (1993) noted that this matching led to therapeutic resistance. They found that: the client was selectively disclosing, fearing that their similarly religious therapist would disapprove of certain of their behaviours; that therapy was experienced as akin to a confessional; and that the dominance of their shared belief system led to a "pseudo" therapeutic alliance, where collaboration was experienced because of beliefs held in common, rather than any relational connection. In the study conducted by Mayers et al. (2007), reported above, participants were divided about the helpfulness of being matched with a religious psychologist. Some found it helpful having a therapist who did not share their religious views as they gained fresh insights. One participant who reported the helpfulness of dissimilarity said that they would be worried that a therapist who shared their beliefs might be offended by some of their views. Others felt that therapists' disclosing their matching RS perspective facilitated discussion about RS matters and enhanced a sense of being understood.

Matching RS orientations could be problematic. Unexplored assumptions, by both client and therapist, together with opportunities for collusion, cause therapeutic difficulties (Abernethy & Lancia, 1998; Cohen, 1994; Cohen, 2003; Genia, 2000; Kehoe & Gutheil, 1993; Plante, 2009; Simmonds, 2004; Sorenson, 1997; Strawn, 2007). Lovinger (1984) reflected that a clinician of a different RS orientation to the client is likely to highlight issues that may be overlooked if both parties to the therapeutic dyad share the same RS perspective, a point later highlighted by Mayers et al. (2007).

Therapist self-disclosure. The discussion of RS matching brings up the subject of therapist self-disclosure in this area. According to Kearns (2011), it is not possible to be in any relationship without revealing something of ourselves: "The question we need to

ask ourselves is how much do we reveal and when and why" (p. 26). Disclosure must occur in some way for a client to be aware whether their therapist shares their RS affiliation. Clients may sometimes ask outright about their therapist's RS perspective, if they wonder whether or not their beliefs will be understood. Therapist disclosure may occur by direct or indirect means. Examples of the latter include therapist advertising, referrals by other practitioners divulging this information, and general community knowledge. McWilliams (2004) commented that from her experience, even therapists whose theoretical orientations tend to parsimony in the area of self-disclosure, would be inclined to make comments which indicate similarity with clients, in order to strengthen therapeutic connection. She gave an example: "A therapist whose politics are similar to those of a patient can smile knowingly when the patient criticises a mutually disliked public figure" (p. 187). She added that in the initial session clients have a right to have answers to questions that are important in their decision-making about whether or not to engage the services of a particular clinician, a point also mentioned by Rubin (2006). Although McWilliams hasn't spoken directly to the issue of disclosure concerning RS, her comments apply broadly to the area of therapist disclosure. Again, speaking to the area of general self-disclosure, Hanson (2005) found that therapeutic connection was enhanced both by self-disclosure and non-disclosure; therapist skill in choosing either position was crucial in clients determining what was helpful. Therapist skill is indicated in Holmes's (1997) suggestion that a balance needed to be found between letting a client know that certain values are shared, to foster a therapeutic relationship, and the reticence needed to allow unconscious material to surface in service of the client's autonomy.

Whatever disclosures are made need to be judicious, and offered only in the best interests of clients, as McWilliams (2004) cautioned "the toothpaste cannot be put back in the tube" (p. 188). It is important not to overwhelm the client with too much self-disclosure and to be aware of the danger of seeing the client's RS experience from within the therapist's own frame (West, 2000). The negative effect of what was perceived as unhelpful disclosure was noted by Baird (2012), who reported that one of the participants in her study, experienced her therapist's disclosure of RS as competitive. RS matters can be the source of strong feelings between therapist and client.

Countertransference. Although transference and countertransference, that is, broadly speaking, the feelings that a client has towards their therapist and the feelings a therapist has towards their client, respectively, have been implicit in much that has been discussed in this section, their importance in the therapeutic process in relation to RS, warrant explicit consideration. Bartoli (2007) argued that a client's comfort in discussing their values is greatly influenced by the therapist's countertransferential responses when this material is raised. Although agreeing that countertransference may be simply understood as the feelings a therapist has towards their client, Clarkson (1995) differentiated between countertransference feelings experienced in reaction to the client's material, and those feelings which were derived from the therapist's own history, using the terms "reactive" and "proactive" respectively to describe these (terms she acknowledged as derived from Lewin's (1963) work). Since this study focuses on the psychotherapist's side of the therapeutic dyad, countertransference, rather than transference will be emphasised predominantly, in this discussion. Having said this, however, mention of transference cannot be avoided, since as Clarkson (1995) pointed out, clients' presentations raise feelings in therapists, and we are talking about dynamic therapeutic relationships.

Rather than encompassing all feelings a therapist has towards their client's RS issues, Griffith (2006) considered that "Religious countertransference refers to an emotional response in the clinician to a patient's religious language, beliefs, practices, rituals, or community that can diminish the effectiveness of treatment" (p. 197). He added that such responses cause a clinician to avoid RS material or engage with it only superficially. Under these conditions, Griffith concluded, a therapist is unlikely to be looking for aspects of a client's RS which may support coping. According to Griffith, these responses may be engendered by a clinician's lack of knowledge–fearing being thought of as incompetent, unpleasant associations to RS, and internalised professional antipathy.

Countertransference and transference are challenging areas because of the following: the historical avoidance of RS in the mental health field; a dearth of therapist education regarding RS issues, which includes a lack of awareness of the influence of a clinician's own RS history and current perspectives; and, perhaps as a consequence, therapist discomfort in discussing RS issues with clients (Abernethy & Lancia, 1998). A case

study where a therapist identified with a client's current restrictive RS thinking was documented by Abernethy and Lancia. These researchers noted that the therapist, although they had intellectually moved away from holding a perspective which matched that of their client, was still subject to its emotional influence; as a consequence, they felt helpless and unable to interact therapeutically with the client's black and white position. Countertransference responses are greatly influenced by therapists' own RS perspectives.

In order to explore the therapist's countertransference to clients' RS material, a case study analysis of one clinician's work with two clients, of similar RS orientation to the clinician, was conducted by Sieve (1999). Sieve concluded that the participant's awareness of her own RS perspective meant that she was inviting of her clients' RS material. However, Sieve also noted that the clinician's hope for the clients' RS growth led to her making directive RS interventions, such as suggesting a place of worship. Sieve observed that countertransference issues concerning God were daunting and required careful attention since material which was ignored could lead to incomplete therapeutic process and, on occasion, premature therapy termination.

Ulanov (2001) commented:

> Whatever our religious affiliation as analysts, ranging from belief to unbelief, from embrace to dismissal…our own countertransference to the infinite object God affects what sort of object we unconsciously offer our patients for their own transference (p. 42).

Irrespective of what RS perspective a clinician holds, whether converging with or diverging from that of their client, what is crucial in therapist-client interactions, is that the therapist is self-aware and reflective about their RS orientation and the interface of their perspective in their client work. A high degree of self-awareness with the capacity to be self-reflective is essential as is the ability to attune to and respectfully engage with, the world of the client. Simmonds (2006) challenged:

> It is informative to our work as clinicians to consider what we each as individuals actually believe, and what we think about contemplating such matters at all … Importantly, what personal feelings as well as thoughts are evoked in us as we allow ourselves to contemplate such questions,

> and how do they impact on our work with patients who are concerned with such matters? (p. 238).

The contemplation which Simmonds advocated needs to be part of the psychotherapist's education.

Psychotherapists' education. Education in RS issues, including fostering therapists' awareness of their own RS perspectives, is lacking in therapist training programmes (Barnett & Johnson, 2011; Bartoli, 2003, 2007; Florence, 2009; Greer, 1995; Lukoff & Turner, 1998; Scott, Garver, Richards & Hathaway, 2003; Shafranske, 1997; Tummala-Narra, 2009). RS should be attended to in the education of psychotherapists, "not as a frill" (van Praag, 2010, p. 246), but as an essential aspect of a human being. Although "Psychotherapists are trained to take a nonjudgmental stance and be aware of their biases [in their therapeutic practice]" (Verbeck et al., 2015, p. 103), it may be difficult for them to be aware of their biases concerning RS if this area is not included in psychotherapy education. Clinician research participants commented that a paucity of education influenced their ability to address their clients' RS concerns (Kahle, 1997; Magaldi-Dopman, et al., 2011; Rossey, 2002). Conducting a survey of five clinicians' accounts of their work with RS issues, Wyatt's (2004) commented that no theoretical rationale was used by these clinicians, just an "implicit knowing" of what to do. One wonders on what such knowing is based. Theoretical competencies need to be translated into teaching clinicians how to practically work with clients' RS matters (Daniels & Fitzpatrick, 2013).

Psychotherapists' education in Aotearoa New Zealand concerning RS. There is a dearth of education in RS within psychotherapy education institutions in New Zealand, with the exception of the teaching of psychosynthesis and analytic psychology, which, as has been explained in Chapter one, have a psycho-spiritual foundation. The Auckland University of Technology's current Master's programme does not include specific education in RS in its psychotherapy programme in its syllabus. This absence suggests that psychotherapists in ANZ, unless they seek post-qualifying education, are largely ill-equipped to respond therapeutically to RS issues in the therapeutic process. Psychotherapy education in ANZ prepares students for the potential of becoming members of the NZAP and/or registered psychotherapists. Given that the PBANZ has clear expectations of its registered practitioners regarding progressive cultural

competence, the absence of inclusion of RS in a psychotherapist's qualifying education is somewhat incongruous.

Conclusion

In this chapter, I have outlined how I approached the literature review in a manner congruent with GDA methodology. I have argued, from the literature, the need for integration of RS into clinical practice for a number of reasons: the RS domain is part of being human and as such, it has an impact on mental health; research evidence has suggested that clients want this aspect of their lives included in their therapy and that such inclusion leads to enhanced therapeutic outcomes; the nature of psychotherapy itself, together with the ethics espoused by the NZAP and the cultural competencies outlined by the PBANZ, all suggest the inclusion of RS in clinical work. Although the case for integration has been outlined, integration is a complex matter. A lack of education in this area means that therapists may lack skills to work with RS in the therapeutic encounter. The nature of RS itself, with difficulties finding words to describe the inexplicable, adds to this complexity.

Although a rationale for inclusion of RS in the psychotherapeutic process is supported by literature, all that is involved in this inclusion and the decision-making processes of psychotherapists in this regard has not been explicated in the literature. The question "How do psychotherapists attend to RS in the therapeutic process?" needs further investigation. These gaps in the literature have provided the motivation for this study, employing a research methodology which speaks to complexity. An in-depth explanation of this methodology, together with the processes used to construct a theoretical explanation which answers the research question, is the topic of the next chapter.

Chapter Three: Methodology and Methods

> "No social study that does not come back to the problems of biography, of history and of their intersections within a society has completed its intellectual journey" (Mills, 1973, p. 6).

Introduction

Central to any research endeavour is the nature of the research methodology used, its philosophical foundations and the fit of methodology to the research question. Crotty (1998) commented on the importance of using a research methodology which is able to satisfy the purposes of the research inquiry. In this chapter I justify my choice of methodology and its underpinnings. Social constructionism and symbolic interactionism, which underpin dimensional analysis, more lately called grounded dimensional analysis (GDA), are explicated. I also explain GDA and why I chose this methodology over other grounded theory variants to explore how psychotherapists in Aoteaora New Zealand (ANZ) attend to religion and/or spirituality (RS) in the therapeutic process. Ethical considerations are elucidated. The methods used to arrive at my research theory and the process of its construction are explained and supported by verbatim excerpts from the study's participants. The quality of the research is also evaluated.

Methodology

In considering the question of methodology, I gave considerable thought to what I really wanted to find out, as this would determine the "how", that is, the most appropriate methodological approach. I knew that I was interested in the area of RS in psychotherapy in ANZ, and more specifically, "What were psychotherapists doing with these issues?" Other questions I thought about were, "What influenced their decision-making processes?" "How did psychotherapists' understanding of the terms, religion and spirituality, impact their decisions?" "What about the impact of the psychotherapists' own RS on their work?" "What about their chosen therapeutic modality, and how that viewed RS?" I envisaged that I would encounter a range of perspectives and I realised that this was going to be a complex enquiry. All these

questions indicated that GDA, underpinned by symbolic interactionism and social constructionism, was the most fitting approach for my research.

Social constructionism. Social constructionist theorists assert that we make meaning through our interactions with each other and with our engagement with our worlds (Crotty, 1998). What can be known, therefore, is not discovered, but constructed. Knowledge is also subject to change, as individuals with different histories and in varying contexts interact over time and under different conditions. Social constructionists would not define the terms "religion" and "spirituality", since such meanings would be constructed and subject to change with different environmental contexts. For this reason, rather than imposing my understanding of these terms on participants, it was left to them to express their own meaning, which was various. Demonstrating the influence of context on appreciating these terms, Nigel, one of the participants in this study, speaking from his Buddhist tradition, said:

> I'm kind of cautious of spirituality without religion because … what I've seen from individual clients that spiritual bypassing (using spirituality to avoid painful issues) often happens in isolation, where there aren't the checks or the guideposts of a tradition. Maybe I'm more likely to take a more questioning or doubting attitude to someone who comes in who is spiritual but not religious.

On the other hand, Isla, working within a therapeutic modality underpinned by spirituality, asserted "I see religion is used by people for all sorts of gross power dynamics". A social constructionist understanding of meaning allows better accommodation of the multiple realities which participants brought to their interactions with RS in the therapeutic process.

Symbolic interactionism. Whilst social constructionists explain what can be known, symbolic interactionists explain the philosophical position which underpins the methodology (Crotty, 1998). Charon noted that this theoretical perspective has its origins in the work of George Herbert Mead (1863-1931) and was expanded by Herbert Blumer (1900-1987), who integrated the thinking of Adam Dewey (1859-1952), William James (1842-1910) and Charles Pierce (1839-1914) among others, into his theoretical understanding. Symbolic interactionists are concerned with process, stating that human beings can best be understood by their interactions, and that these interactions depend largely on the use of symbols, hence the term, "symbolic interactionism" (Charon, 2010, p. 60). Symbolic interactionists assert that the self is

socially constructed; neither self nor society exists without the other–they are "twin-born" (Stryker, 1980). As a "self" defines a situation, so a situation gives rise to individual "selfhood", resulting in what is known as a dialectic circle (Shalin, 1986). This suggests that the decisions psychotherapists make concerning RS in the therapeutic process cannot be understood, or even happen, outside environmental contexts.

Blumer (1969) outlined three widely cited premises which explain how symbolic interactionists understand society and human behaviour. These are:

- Human beings act toward things on the basis of the meaning that the things have for them.
- The meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows.
- These meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things he encounters. (p. 2)

Van Manen (1990) succinctly stated that, "The methodological rule (of symbolic interactionism) is that social reality and society should be understood from the perspective of the actors who interpret their world through and in social interaction" (p. 186). As noted above, the participant Nigel's perspective on religion and spirituality influenced his interaction with these things. Because he was "cautious" around spirituality which did not present in a religious tradition, he said that he would likely be more "questioning" and "doubting" with a client who evidenced a spirituality not attached to religion. Because symbolic interactionism speaks to the complexity of social phenomena (Strauss, 1987), this theoretical perspective is well suited to the explication of the complex interactions which occur in psychotherapists' decision-making concerning RS in the therapeutic process.

Generic grounded theory. Grounded theory is a qualitative research methodology designed to generate theory "'grounded' in observations of human experience and thus provide explanations of phenomena that are grounded in reality" (Giddings & Wood, 2000, p. 14). Grounded theorists seek to answer the question, "What is happening here?" (Giddings & Wood, p. 6). Because theory is generated from the data, it is a useful methodology when little is known about a topic, as is the case with my own

research which is the first study of its kind in the context of the psychotherapy community in ANZ. Grounded theory was first explicated by Barney Glaser (b.1930) and Anselm Strauss (1916-1996), in their book entitled *Discovery of Grounded Theory* (1967). Today, grounded theory is considered internationally as the most commonly used qualitative research methodology (Morse et al., 2009).

Grounded theory has been interpreted variously by Strauss (1987), Strauss and Corbin (1990), Schatzman (1991), Clarke (2003) and Charmaz (2006, 2009, 2014) since its initial explication by Glaser and Strauss (1967). Initially I found such a choice of variants rather daunting and considered the various merits of each permutation with regards to my research topic. Although Glaser and Strauss outlined their research methods, these were not supported by clear ontological and epistemological underpinnings. I found Strauss and Corbin (1990) somewhat prescriptive in their coding strategies which, in my mind, seemed to lack the ability to explain complex processes. Although I toyed with the idea of situational analysis pioneered by Clarke (2003), I found the incorporation of Foucauldian discourse analysis somewhat difficult to grasp. Moreover, I could not find a supervisor who had used this methodology, so I discarded this option. I appreciated the plethora of literature produced by Charmaz (2000, 2006, 2009, 2014) to explicate her methods, as well as her highlighting of reflexivity–the part the researcher plays in the co-construction of meaning (Charmaz,2009). I valued the idea of "dimensions" introduced by Strauss (1987) and further developed by Schatzman (1991) into dimensional analysis.

I eventually chose dimensional analysis over other variants, because it highlighted the salience of perspective and its data gathering processes allow, I believe, the complexity of the phenomena which I am studying, to be fully explored. In addition, one of my supervisors was well-versed in dimensional analysis, having used this methodology in her research. Bowers (1988) commented that there was not much written about dimensional analysis methods and an understanding of the model was more often passed down from supervisor to student.

This paucity of literature means that whilst I am referencing specific texts explaining dimensional analysis in this methodology, I also make reference to other texts expounding grounded theory methods when useful. I describe what dimensional

analysis offers by way of variation, but first explain what is common to all variants of grounded theory.

Methods shared by all variants of grounded theory. There are commonalities shared by all variants. These commonalities are: theoretical sampling, generating theory directly from data, concurrent data collection and coding, having a coding framework and using constant comparative analysis (Charmaz, 2006; Strauss, 1987). Strauss (1987) asserted that these strategies "ensure conceptual development and density" (p. 5). Memoing, although common in qualitative research, requires special mention in grounded theory since it is utilised in theory development (Birks & Mills, 2011; Charmaz, 2006, 2014). Memoing, theoretical sampling and constant comparative analysis are given more explanation under "generic grounded theory"; the coding framework is addressed under "dimensional analysis"; and generating theory from the data and simultaneous data collection and coding is demonstrated under "methods", which will allow more detailed explication.

Memoing. Memos in grounded theory research are "records of thoughts, feelings, insights and ideas in relation to a research project" (Birks & Mills, 2011, p. 40) and are considered essential for quality grounded theory (Birks & Mills, 2011; Bowers 1988; Charmaz, 2006; Lempert, 2007), making connections between the building blocks of data which create theory (Stern, 2007) and igniting conceptualisation (Stern & Porr, 2011). Ongoing memoing is also crucial for reconstructing the theoretical journey (Bowers 1988). I got into the habit of writing memos early in my research journey, beginning a daily diary of my research progress, which then became a springboard for more detailed memos. Memoing became especially useful when I felt somewhat stuck in my process; just writing helped me unblock my stalled thinking. I recorded my thoughts and feelings after an interview, reflections on supervision, even musings I had during the day which seemed relevant to the process. The following is part of a memo written after a participant interview:

> [Her educational environment] made this participant very cautious about mentioning anything to do with spirituality and there was quite a sense of fear engendered when she spoke about it … She found a safe way of holding spirituality with the Māori model of Te Whare Tapa Whā, which gave permission for her to address spirituality, a permission which had not been felt in training … The experience of this context carried over to private practice. What seems

> apparent here is the influence of context on what is given permission. (Memo, 20.4.13)

Writing this memo made me think deeply about the importance of context and permission, both of which were highlighted by subsequent interviews and became important in the developing theory.

Memoing serves different functions as the research progresses. Initially, memos may identify possible dimensions and later, assist with thinking towards greater theory abstraction as illustrated above. Memoing is useful when recording thoughts about how an interview went to enhance reflexivity, as well as decisions about sampling direction as the following demonstrates:

> [He] spoke of how he had chosen a psychoanalytic approach because it reflected his atheistic position. … This interview led me to realise that a clinician may choose a particular modality specifically because it reflects their RS orientation. I felt that interviewing a psychosynthesis trained clinician next would be useful since this modality had an underlying spiritual perspective. My view was supported in discussion with my supervisor. (Memo, 13.8.12)

It can be seen from the above that memoing is crucial to the development of a rigorous grounded theory, as it performs a variety of functions in the construction of a grounded theory. Illustrating this importance, Stern (2007) likened memos to "mortar" (p. 119), holding together the building blocks (data); Birks and Mills (2011) suggested that memos were "the critical lubricant of a grounded theory 'machine'" (p. 40). One of the earliest memos I generated, in advance of commencing the study, for reasons which will be demonstrated, was a summary of what I thought that I might find in the research, commonly known as "presuppositions".

Presuppositions. One way of noting what a researcher already knows about a topic, that is one's *presuppositions,* is to ensure that these are recorded at the beginning of a research project so that they may be compared with analytic findings to check that such findings are grounded in the data. Early in my research journey, prior to project approval, I was interviewed by an experienced grounded theorist concerning my interest in the topic and what I anticipated I would find in my interviews. The interview was recorded and transcribed by myself. This process enabled me to consider the three

lenses I was bringing to the project, that of researcher, psychotherapist and the personal lens of spiritual enquirer. I also realised that I had an expectation that I would encounter a lot of pathologising by participants, rather than an open, embracing stance towards RS. This sensitising helped me interrogate the data more closely when I encountered material which could be interpreted as "pathologising" and to consider in further depth the influence of "discipline-specific" words.

Sampling. Sampling in grounded theory takes two forms depending on the stage of the research. *Initial sampling*, sometimes termed *selective* or *purposive sampling*, enables the study to begin, as it selects participants on the basis of their eligibility to participate (Schatzman & Strauss, 1973), or, as Charmaz (2006) succinctly stated, it is "where you start" (p. 100). I chose my first participant because of her immediate availability and location and the second participant as my first participant (Simone) said "I hope that you'll get a chance to interview X and X because … They'd be fascinating". The next day I received an e-mail from one of these people who contacted me after Simone had rung and suggested she take part. She then became my next participant.

These leads are followed by a second process, *theoretical sampling*, where analysis guides data collection (Charmaz, 2006; Draucker, Martsolf, Ross & Rusk, 2007; Holton, 2007; Stern, 2007; Strauss, 1987). From the in-depth information obtained in these two interviews it became clear that I was able to begin theoretical sampling, even at this early stage. Data already collected from experienced clinicians concerning historical educational conditions indicated that interviewing a relatively new practitioner might yield a different perspective, so this is where I went next. Sampling theoretically advances theory development by clarifying, extending or finding exceptions in the data, of depth, richness and complexity, to ensure that research findings demonstrate "what 'all' is involved here" (Schatzman, 1991, p. 310). The following 26 participants were chosen by the process of theoretical sampling and a memo was kept of the decision-making process around the selection of each participant. Here is an excerpt from this memo:

> The influence of the psychoanalytic approach to therapy with Freud's rejecting position of RS had been noted by the last two participants as influencing how psychotherapists approached RS. I discussed this in supervision and it was agreed that it could be useful to interview … who had a specifically psychoanalytic

> orientation to find out how this affected their attention to RS within therapy. (Memo, 24.7.2012)

Theoretical sampling continues until what is known as *theoretical saturation* is reached (Charmaz, 2006; Henwood & Pidgeon, 1992; Stern, 2007). This is the point, as Holton (2007) noted, at which no further dimensions are able to be extracted from the data. There is some disagreement, however, about whether saturation, which seems such an absolute expression, can ever be reached (Dey, 1999). Instead, Dey preferred the term *theoretical sufficiency*, which is attained, he posited, when current categories are able to accommodate new data without having to be modified or extended. Whatever the preferred term, Morse (1995) suggested that "researchers cease data collection when they have enough data to build a comprehensive and convincing theory" (p. 148). Until theoretical saturation or sufficiency is considered achieved, Birks and Mills (2011) suggested that theoretical sampling continues, stimulated by constant comparisons of the data.

Constant comparative analysis. *Constant comparative analysis* describes analysis where "data is compared with data to find similarities and differences" (Charmaz, 2006). Charmaz explained that these comparisons may be made within the same interview, between interviews and even between early and later interviews with the same participant, should these occur. Data which describe what appear to be similar incidents or processes are also compared. The following is an example of a comparison of similar incidents occurring within the one transcript. I noticed that Simone mentioned two instances of praying with clients but with very different responses from her. Comparing the two incidents, I became aware that these occurred in different contexts with different client groups. A further interview with Simone to deepen the data elicited the concept of "permission giving". Birks and Mills (2011) commented that *induction* of theory, that is generating theory from the data, is achieved by this method of constant comparison. While with most grounded theory variants constant comparative analysis occurs early in the research process, grounded dimensional analysis departs from this convention Bowers (1988) noted, delaying analysis until later in the data gathering process.

Dimensional analysis or grounded dimensional analysis. Dimensional analysis is often spoken of as a grounded theory variant. In some recent publications, in which the researchers have used this methodology, it has been called grounded dimensional analysis (GDA) (Doherty-King & Bowers, 2013; Gilmore-Bylovski & Bowers, 2013; King, Gilmore-Bykovski, Roiland, Polnaszek, Bowers & Kind, 2013), to demonstrate its connection with grounded theory. I am following this initiative. GDA, a grounded theory derivative, is the result of the pioneering work of Leonard Schatzman (1921-2008) in the late 1970s (Schatzman, 1991).

Although procedurally consistent with grounded theory, GDA has its own set of operations (Kools, McCarthy, Durham & Robrecht, 1996). After over three decades of involvement in sociological research, Schatzman became concerned with what he saw as a gap between the teaching of research principles and the application of analytic procedures necessary for the interpretation of data leading to theory building (Kools et al.). While discussing, with a group of nurses, the considerations that they held important in choosing a job, Schatzman demonstrated that academic research is connected to *natural analysis*, that is, the everyday processes we perform in order to solve problems and make decisions (Schatzman, 1991). He realised that such considerations were dimensions of experience and that it was through *dimensionalising*, or delineating these considerations, situations could be constructed, analysed and defined.

Dimensionalising, a procedure used in early analysis, allows for the complexity of a problem to be considered, since dimensional analysis seeks to answer the methodological question "What 'all' is involved here?" (Schatzman, 1991, p. 310). Schatzman suggested that grounded theory's focus on deriving a social process from the data early in the analytic process by logical deduction, meant that researchers were not being true to empirical data and were limiting their understanding of the phenomena being studied (Bowers & Schatzman, 2009). In order to rectify what he considered to be a methodological weakness, Schatzman's dimensional analysis delays comparative analysis until a large number of dimensions have been amassed, waiting until a pattern emerges which suggests the function and relative importance of each dimension (Bowers & Schatzman, 2009). In an article foreshadowing Schatzman's (1991) comprehensive delineation of GDA, Schatzman and Strauss (1973) spoke of this pattern

as a *key linkage* or "story line", highlighting the importance of the researcher finding this in the process of analysis, as it gives them the means for ordering the salience of the dimensions. In researching how psychotherapists make decisions regarding RS in the therapeutic encounter, it is important to have a methodology which addresses the complexity involved in their considerations, not the least of which are the variety of perspectives which are brought to the process.

The issue of perspective was found by Schatzman (1991) to be pivotal in ordering the salience of different aspects of the problem, so "perspective" is central to the dimensional analysis method (Schatzman, 1991). Shibutani (1955) elucidated the nature of perspective as "an ordered view of one's world–what is taken for granted about the attributes of various objects, events, and human nature" (p. 564). Caron and Bowers (2000) commented that GDA assumes that concepts are always subsumed under perspective; which suggests a fluidity of meaning dependent on context. The problem-solving matrix of GDA comprises the following components: "'from' perspective, 'in' context, 'under' conditions, specified actions, 'with' consequences, frame the story in terms of an explanatory logic" (p. 308). The analytic process involved in deciding what place a dimension assumes on the explanatory matrix, is called *designating.* A diagram to demonstrate the process is shown in Figure 1.

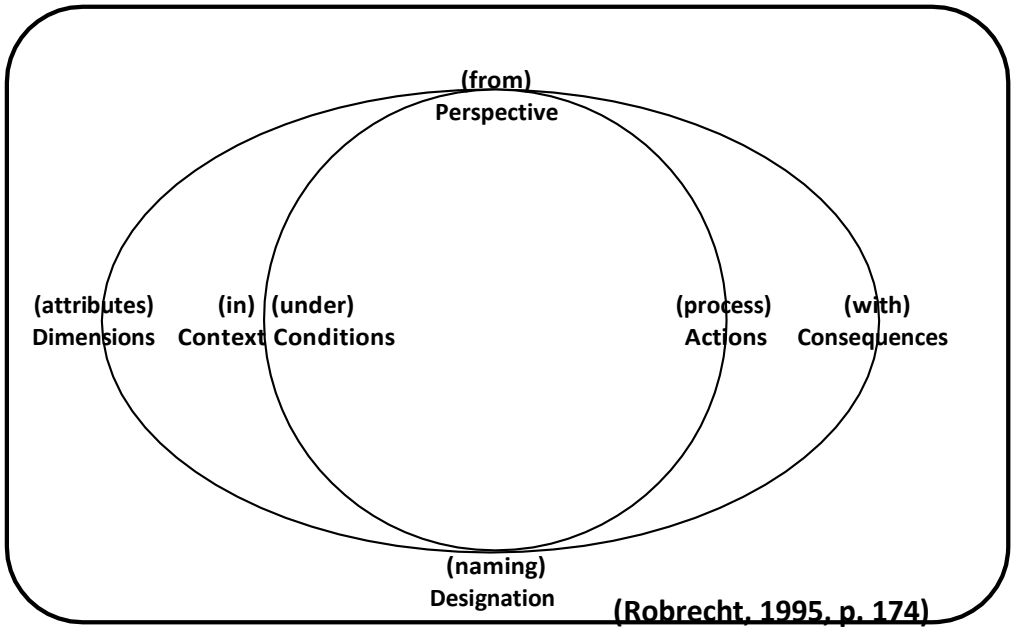


Figure 1: Dimensional Analysis: Explanatory Matrix

"Reference groups" as perspectives. Perspectives have been connected to reference groups by Tamotsu Shibutani (1920-2004). Shibutani (1955) defined a reference group as a group whose perspective is adopted by an individual. Shibutani's description of reference groups is close to Mead's discussion of taking the role of the "generalised other" (Charon, 2010, p. 107). He added that such reference groups occur through the internalisation of norms which are the expectations attributed to some audience for whom one "performs". According to Shibutani, social participation is the means by which group perspectives are internalised. An individual may belong to a number of reference groups such as "membership groups" as well as those of social class, ethnicity and culture (which includes RS) or ethnicity (Charon, 2010). Where a person is faced with choosing between perspectives of competing reference groups, it has been hypothesised that "the norms of the group whose perspective is assumed … depends on one's relationship and personal loyalty to others who share that outlook" (Shibutani, 1955, p. 568).

Understanding an individual's relationship to reference groups is salient in considering what influences a psychotherapist's interactions with RS. As well as reference groups common to everyone such as culture and ethnicity, psychotherapists are members of professional associations, have professional qualifications from particular educational institutions, adhere to various modalities as well as often being required to conform to the expectations of varying work contexts. They are also supervisees, and often psychotherapy clients. Not to be forgotten also, are the RS reference groups both historical and current, or lack thereof, which may have a part to play in forming psychotherapists' perspectives.

Dissonance may occur when the perspective of a reference group, adopted by the psychotherapist, is challenged or when they are confronted with the need to choose between competing reference groups. Shibutani (1955) suggested that in the latter case, a person makes this choice depending on the degree of loyalty they have to others in that reference group, particularly those who are significant. Illustrating this point, Simone talked about her conflict when a client asked her to pray at the beginning of a psychotherapy session, which she described as:

> A test as to how strong is my psychotherapy training? How strictly do I stay with my model as I had been taught where you didn't really include direct references to

> God? I mean it was never told us directly, but implicit in the training as I'd explained to you … it was just not the kind of counselling or psychotherapy that I practise, that includes an overt languaging of anything spiritual, that's not what I'm setting up to do. So it really put me on the spot. And the test in a way was something about my relationship with myself. The test was well, what are you going to do?

Simone reflected on the pull to be loyal to her education and modality reference groups as well as the reference group of being a client herself, all of which held the same perspective. However, the stronger influence was her loyalty to her own values which, she later reflected, encouraged her to be authentic.

How philosophies that underpin GT fit with my personal views of the world. Our environments, from our early family milieu, to our education, our career choices and the groups with which we affiliate, as well as the country with its social and political conditions, and era in which we live, are all responsible for constructing our identities. I agree with the symbolic interactionist premise that we are not just passive repositories of things "done" to us, but that we can and do act on our environments in a mutually constitutive manner. The idea that interactions in our social worlds also depend on inferred meaning, rather than an objective reality, allows me to appreciate perspective. That I, too, can be in relationship with "me" is a reality, since I recognise that I change the way I think, that is, "interact" with myself, depending on environmental conditions.

"Fit" of methodology for topic. Grounded dimensional analysis as a methodology is a good "fit" for researching my topic because of its ability to address complexity, and its usefulness where an area is under-researched. Our social contexts and cultural histories are inextricably connected with the forming and re-forming of our RS perspectives (Rizzuto, 1979), a construction which naturally works with social constructionist underpinnings where variations are observed across perspectives and contexts (Caron & Bowers, 2000). The meanings which research participants attributed to the "objects" of religion and spirituality are important since these perspectives influenced their interactions with clients. Rather than imposing definitions of the terms religion and spirituality, either my own or those of others, participants were asked to explain their own perspective on these words, should it not come up naturally in the interview. The philosophical stance of symbolic interactionism, emphasising inferred meaning, allows

me to consider the topic of religion, spirituality and psychotherapy in its complexity, being mindful of the various social worlds from which these meaning are derived, and the interactions by which such meanings are sustained or changed. As has already been discussed in the Background chapter, the area of RS in psychotherapy in ANZ is under-researched. Birks and Mills (2011) suggested that grounded theory is a good "fit" for research where little is known about the topic. Charmaz (2008) added that this methodology builds theory as knowledge accrues.

In this section, I have explained the GDA methodology being utilised in my research, and my rationale for this choice, remembering that a fit between methodology and research design is crucial to any study. I have also described the philosophies which underpin GDA and its similarities with, and differences from, other grounded theory variants. I now consider what this has looked like in practice by discussing the methods used to apply the methodology.

Methods

In this section the application of the methodology is described. Ethical requirements and procedures are first considered, followed by a description of the positioning of myself as researcher. An introduction to the participants–sampling, recruitment and demographics–follows before data collection, analysis and conceptual development are considered in-depth. Lastly the research process is reviewed to evaluate quality.

Ethical considerations. Approval for this research was given on 19 March, 2012 by the Auckland University of Technology's Ethics Committee (AUTEC) (Appendix B). The purpose of having an ethics approval process is to assess the relative risks and benefits to both researcher and participants, to consider the role of the researcher, and to ensure that the design and practice of the research implements the three principles of Te Tiriti o Waitangi The Treaty of Waitangi (identified as partnership, protection and participation (*Royal Commission on Social Policy,* 1988)) which are discussed throughout this chapter.

A minor amendment to this approval was granted on 16 December, 2013 (Appendix C), allowing either a phone or email interview, at the participant's request, on the occasions that a second interview was conducted. I got somewhat ahead of myself here, since I

had already conducted an e-mail interview with one participant who chose to respond in this manner to my queries about our initial interview. I took this action after being assured of its appropriateness by a colleague. Later supervision, however, alerted me to the fact that I needed an amendment to my ethics approval to do this.

Working with Māori. I began my "partnership pathway" with te ao Māori (the Māori world) in 2009 when I became a member of Ngā Ao e Rua (the two worlds), a bicultural group of Māori and Pākehā psychotherapists (Green et al., 2014). My membership with Ngā ao e Rua enabled me to begin a relationship with Waka Oranga, the national collective of Māori psychotherapists who are the formally recognised Treaty Partner of the New Zealand Association of Psychotherapists (NZAP). Since then I have participated in a hui (meeting) with Waka Oranga and other joint ventures which have helped raise my awareness of Māori worldviews. I also took a beginner's class in te reo Māori (Māori language), to assist with my pronunciation of te reo and to add to my understanding of Māori tikanga (customs).

Together with my primary supervisor, I met the Waka Oranga rōpū (group) kanohi ki te kanohi (face to face) to invite participation in this research. After outlining my research aims and methodology, members agreed to participate in the research. It was through this encounter, and a later comment made by a participant, that I understood the importance of the relationship between myself and the rōpū, in making this decision. Venetia, in our second interview, spoke of the risk in participating:

> But the risk was okay because of the relationship with you. If it had been another person it would have been it would have been an uncalculated risk or an unseemly risk, so because there was already a relationship with Helen, it was kind of like, she's an ethical person, she'll maintain confidentiality … there was an integrity there that allowed that risk to be taken.

I also consulted with Alayne Hall, a bicultural supervisor and a member of Waka Oranga, to ensure that I observed appropriate tikanga (correct procedure) during the research process. However, this left me with a plan in my mind about what I "should" do. I felt somewhat awkward with one participant when, as per my plan, I asked her if she wanted to say some karakia (ritual chant) at the beginning of our interview, in my effort to follow what I assumed was appropriate tikanga. She replied that she had

already done her karakia for the day, however she "obliged". I felt that she did karakia again, just to satisfy me, which felt awkward. This made me aware that I was bringing my assumptions of what was "correct" to the interview. After this reflection I then prefaced my interviews with Māori with "How would you like to begin", rather than imposing my insensitive attempts at cultural sensitivity. Although, as noted above, interviews generally took between 60-90 minutes, I was mindful of nga manu korero (the domain of time) noted by Durie (2007). Durie commented that regardless of time frame or schedule, Māori place a lot of importance on speaking until they feel assured that they have conveyed all they want to.

I considered doing a focus group with Māori participants, even though members of Waka Oranga had agreed to participate individually, since Māori function as a collective. I also attended a hui during the research process where one potential participant suggested I do a focus group as they considered that I would get richer data that way. After discussing this in supervision, however, I decided against this option since the potential pool I would have had to draw from for a focus group was quite small, considering that there were few Māori psychotherapists. In making this decision, I bore in mind confidentiality considerations.

Protection of participants. When potential participants contacted me regarding the research they were emailed a Participant Information Sheet (Appendix D) and a Consent Form (Appendix E) so that they could see what their participation would entail. A minor alteration to my ethics approval later in the data collection process, discussed under the section entitled "Ethical considerations", was noted in information and consent forms which were updated (Appendices F, G). Consent was ongoing as participants were advised that they had the right to withdraw from the study at any stage of the process without this reflecting negatively on them. Participants were also able to stop an interview or recording of an interview at any time. Although this information was included in the Participant Information Sheet, it was reiterated prior to the interviews in most cases. At times, however, I forgot to mention this, and upon reflection, I realise that this failure of emphasis was because of my own professional perspective as a psychotherapist. I reasoned that psychotherapists are well used to self-reflection, as the profession requires it of them, and that this interview was another opportunity for such reflection. My own reflection assisted me to consider the issue

afresh from the participants' perspective and acknowledge that participation could cause embarrassment at a sense of exposure caused when discussing material deemed sensitive. In addition to this, my sensitivity was further assisted by my taking part in a colleague's research, during the course of my own study. I felt surprisingly vulnerable, even though I did not consider it a sensitive topic. My self-reflection, and having the experience of participating in research myself, helped me remember to mention the option of stopping the tape, should a participant wish. Participants were also offered counselling through the Auckland University of Technology (AUT) Health and Wellbeing Clinic, should their participation raise matters for which they wanted support.

Confidentiality. Matters of confidentiality have been given careful consideration especially because of the relatively small size of the community of psychotherapists in ANZ and the even smaller number of Māori practitioners. In view of these issues, only limited confidentiality could be promised and prospective participants were advised of this in the Participant Information Sheets (Appendices F, G). Participant characteristics were recorded broadly to provide enough information to describe the sample group, without disclosing too much to compromise anonymity (Appendix H).

Confidentiality issues were raised early in the research process by one potential participant who chose not to participate at that stage because of her concerns about being identified. It became apparent that there was a degree of fear felt by some psychotherapists in discussing this topic. In response to this early concern, in order to add a further layer of anonymity to the process, and with the permission of AUTEC (Appendix C), I arranged for all signed Consent Forms to be held by my second supervisor, Dr Barbara McKenzie-Green, who has no contact with the psychotherapy community. In addition for those who so requested, these forms could be submitted in sealed envelopes.

Although there is a large concentration of psychotherapists living in Auckland, the largest city in ANZ, I chose, where theoretical sampling directed, to interview participants across the country, another measure to increase the potential for anonymity. As a result, psychotherapists from both the North and the South Island, with a mix of major and minor cities, have been included in the sample.

Pseudonyms were assigned to individual participants after the interview was conducted. These pseudonyms were chosen after referring to the PBANZ website and NZAP members' list, to exclude any names of current psychotherapists, in order to avoid potential misattribution. I transcribed all the interviews myself which helped me immerse myself in what participants were conveying; particularly since the transcription process took me so long! Even though this was a laborious process, I was encouraged by Rennie's (2001) comments that transcription by the researcher deepens their understanding of the text as a whole. Tapes were reviewed twice to ensure accuracy.

Identifying material, such as people's names or places of work, was removed from the transcripts which were returned to participants so that they had the right to veto material should they choose. Some chose to make small alterations, such as changing the gender or diagnosis of a client's details, which were then altered on my records. Several participants stated that they did not want specific examples of clients' idiosyncratic presentation to be used as verbatim excerpts but were comfortable for such material to be kept in the transcripts in case they were needed conceptually. One participant asked that he be consulted before any of his verbatim excerpts were used. I kept this agreement with him when presenting material throughout the research process and for the final writing.

Positioning myself as researcher. Analysis is always undertaken with a perspective (Bowers & Schatzman, 2009). It goes without saying, therefore, that I brought my perspective as a psychotherapist to this endeavour. I reflected on this in a number of ways. Prior to undertaking the research, I was interviewed by an experienced grounded theorist colleague, as previously noted. This helped me consider what I expected to find in the research, thus helping me see what I might impose on the data. I also gave much thought to being a researcher/psychotherapist interviewing psychotherapists, and the impact that could have on the interview process. Bowers (1988) commented "Who I am … depends on the 'me' that is called forth by the social context" (p. 37). Although this demarcation sounds clear, in reality, as Bowers noted, it can become a source of confusion when we find ourselves in overlapping contexts where "multiple conflicting selves emerge" (p. 37). That was certainly my experience!

Chapter Three: Methodology and Methods

When I first began interviewing, I did not state my specific role as a researcher, rather than psychotherapist, in the context of the interview. I found that this omission made me less likely to pick up discipline-specific terms. It also meant that at times assumptions about my "knowing" were left unexplored as the following demonstrates:

> In my practice, religion and spirituality, it's not something that I've ever really, except to ask some of those Māori clients at … if they'd like to … pretty much I do it kind of like ACC (laughing). *Sorry, I didn't quite catch that.* Well, how I could language it to ACC, you know. *Right*. (Simone)

In the above excerpt the participant assumed that I know what "ACC" is, and with the "you know", an understanding about how we all write ACC reports. My "right" suggests that I agreed with her assumptions. At times it was also difficult to separate roles when I became engaged in the participant's story and put on my psychotherapist's hat, as the following shows:

> Clients bring us what we want them to talk about…It would be lovely to think that we get what's there, but I don't think that's the case, not in my experience. I don't know. *It feels somewhat sad* yep I am, I am (pause) I guess that's a little bit my ideal of therapy, where it's this totally free space where people bring in themselves in their totality. I mean that's naïve. (Nigel)

I felt sad as Nigel recalled his own experience of having his RS ignored in his own therapy; I empathised.

My tendency to move to a psychotherapist's role, rather than stay firmly in my researcher shoes, was memoed and discussed in supervision, to help me find a way to overcome (or at least be more aware) of the conflict. I was encouraged to be clear about my role as a researcher, not a psychotherapist, at the beginning of the interview and to consider the idea of *marginality* which Bowers (1988) explained as having one foot outside the world of the participant.

With this in mind, at the beginning of the interviews I explained to the participant that although I was also a psychotherapist, for the purpose of the interview, I was wearing a researcher's hat, and therefore asked them to assume that I knew nothing. Prefacing my interviews with these comments helped my awareness of psychotherapy jargon and

therefore being able to ask participants to explain what they meant when they used discipline-specific terminology. The following is an example of this:

> We all have countertransferences, but any area that we are not self-knowing about we can get caught into the countertransference and not maintain an objective psychotherapeutic stance. *So I am just going to ask you what you mean by countertransference.* Well, countertransference for me is anything that arises in me in relation to my being with a client. (Tabitha)

As an exercise in reflexivity, I presented my thinking about being a researcher who is also a clinician at one of our monthly grounded theory group meetings as well as making it the topic of the annual doctoral presentation round at the AUT.

Marginality was tested when I found aspects of interviewees' disclosures, distressing. Throughout the process I saw a spiritual mentor who supported my reflecting on my own spiritual journey; this helped me regain my equilibrium.

Recognition-recall. Given that I was a psychotherapist, interviewing psychotherapists, I have given thought to the phenomenon named by Schatzman (1991) as recognition-recall. Schatzman suggested that a lot of what passes as research is merely a researcher recognising and recalling aspects of their discipline when analysing data. It goes without saying that I brought my own lens as a psychotherapist practitioner, to my viewing of the data; however, I put some strategies in place to, avoid imposing on the data, as far as was possible. Over the time of my study, I exposed a number of de-identified verbatim excerpts to the analytic eyes of my grounded theory group, a group comprising a variety of disciplines, of which I was the only psychotherapist. I also used participants' words wherever possible.

Another strategy which helped mitigate the recognition-recall phenomenon was the later commencement of comparative analysis in GDA compared to other grounded theory variants. The earlier one starts "comparing", it stands to reason that the researcher is going to access much more of their own understandings since they do not have much data to compare. Bowers, Fibich and Jacobson (2009) mentioned the importance of taking time to become "grounded in the data you have", (p. 125) suggesting that the more time a researcher takes over this grounding, the less likely the conjuring of comparisons from one's own experience. Although amassing a large

number of dimensions before beginning comparative analysis caused me to feel somewhat swamped, it did enable me to be more open to where the data might be leading me rather than imposing my own knowledge.

Data collection–The participants. In this section I discuss my recruitment and sampling of participants as well as delineating my data collection methods. Although, as has previously been noted, data collection and analysis are simultaneous processes in grounded theory, I have chosen to cover these processes successively to avoid confusion –both for the reader and the writer! Data was collected over a period of 30 months throughout the research locations. Altogether, 28 participants took part and 33 interviews were conducted.

Recruitment. Participants were recruited by advertisement in the NZAP, New Zealand Association of Counsellors (NZAC) and the New Zealand Association of Christian Counsellors (NZCCA) newsletters(Appendix I), e-mailing all the NZAP regional branch conveners and requesting that my research topic and contact details be advertised at the next available local branch meeting. I also verbally advertised the research at the Auckland branch, which is my local branch, as well as leaving a letter of introduction to the study (Appendix J) on a table, should members be interested in finding out more about the research. E-mails with advertising attached were also sent to the New Zealand Institute for Psychoanalytic Practitioners, the Psychosynthesis Institute, the Gestalt Institute of New Zealand, and the New Zealand Association of Transactional Analysis. Waka Oranga was approached directly, as noted above. As interviewing began, other potential participants contacted me, after having the process recommended to them by participants. Once theoretical sampling ensued, tactical approaches were made–to advance data driven theory development–to potential participants through third parties with whom no power relationship existed.

Participant selection. I chose practising psychotherapists as my research sample. In order to qualify to take part in the research, potential participants needed to be registered with the Psychotherapists' Board of Aotearoa New Zealand (PBANZ) and/or be members of NZAP, or of Waka Oranga.

Data collection instrument–The interview. Interviews were conducted at a place of the participants' choosing. Infrequently, participants chose to come to my place of

work; on these occasions a koha (gift) was given to defray travelling expenses. Most often, however, I saw participants at their place of work which was at times a home office, since a number of psychotherapists work from home. For safety reasons, I was required by AUTEC to notify a third party before and after entering a participant's private residence, a requirement which I generally remembered. My occasional forgetting, I realised upon reflection, had to do with the fact that I internally baulked at this expectation. Since it was not unusual for clients to see psychotherapists at a home office, the thought that I needed to safeguard my own safety by doing the same thing, felt somewhat mistrustful of the professionalism of my participants. At times when travelling out of town, I was invited to stay overnight at the homes of some of my participants. Although I would have enjoyed the collegial discussions which no doubt would have ensued with this arrangement, I was mindful of my role as a researcher and felt the need to maintain this boundary during the research process. Consequently these invitations were regrettably declined.

Data was collected by face to face semi-structured, in-depth interviews of between 60 to 90 minute duration. Charmaz (2014) commented on the fit of interviewing as a data collection instrument for social constructivist grounded theory since both the interviewing and data analysis can progress from being open and broad, to more focused and shaped, as the researcher constructs their grounded theory. Interviews were open-ended and began with an invitation to participants to tell me whatever they wanted to about religion, spirituality and psychotherapy. At times I would ask for more detail and examples to generate specificity and provide context to participants' statements.

Rennie (1996), an experienced grounded theory researcher in the field of psychotherapy, commented that he preferred interviews to be as open-ended as possible, adding that he relied on his interviewing skills to keep a participant on track. Any prepared questions, arising from analysis of previous data, were saved until near the end of the interview, as suggested by Glaser and Strauss (1967), a strategy adopted to avoid any undue shaping of the information elicited. Five participants were interviewed for a second time to add depth to areas which were significant to the developing theory, in order to develop conceptual density (Buckley &Waring, 2013).

The interview process itself became a self-awareness exercise for participants, something which I had not expected. Unconscious material came to light causing some to want to make changes in interactions with specific clients whom they were currently seeing. Some participants chose to take part as an exercise in self-reflection. Brandon, who had named that as his purpose for participating, commented near the end of our interview:

> As we talk I feel a little discomfort in myself about realising that my belief system obviously does make a difference and I probably don't talk about religious spiritual issues as much as in theory I would think that I should, and so that leaves me feeling a little uncomfortable, and thinking I need to think about that and do something with that in my practice.

Betty recognised during the interview that she responded differently to a client's attendance at both Anglican and Spiritualist churches, something that she had not considered prior to this process. She reflected, "I bet I respond more to the Anglican church stories than I do the spiritualist, I bet I do, I can almost hear myself. Mmm. (long pause)". As a result of this realisation, Betty decided to discuss this with her client; she also became more aware of the influence of her own RS history on her interactions with clients.

Harold recounted a movingly vivid dream that he had had the morning before our interview. I became caught up in the transformational nature of the content, and we had the ensuing interchange:

> *That really moves me, excuse me* (looking for tissue as I am crying). Yeah, it was a powerful experience. *Incredible*. Yes, it was one of the most vivid dreams I have ever had … So I think your coming here is part of some sort of integration that is going on for me in terms of sort of the repudiation of … Catholicism, spirituality.

These interviews, where participants had the opportunity to reflect on the topic of RS in psychotherapy, appeared, in some instances at least, to precipitate change in participants' relationship with themselves and their work. I wondered about the rich potential to be realised for the psychotherapy community as a result of ongoing interactions around this topic.

Interviews also elicited moments between me and some participants which were hard to explain. At times, I also left an interview feeling as though I had been in another dimension; again this was hard to put into words. After interviewing Xavier, I recorded the following:

> Holy ground; hard to find the words … That was profound. I feel caught up in another dimension which is hard to describe. God came and we felt His presence. That is the meaning I make from my perspective. I wonder whether other participants have these encounters and how would they describe them. (Memo 4.9.12)

My experience with interviewees led me to wonder about RS experiences in the therapeutic context and what participants had to say about that. Data gathered through theoretical sampling led me to conceptualise "experiencing" as a dimension. This was later designated as a sub-category of the "engaging" category.

Initial sampling. So, I had a pool of potential participants and the question was, "Where to begin?" I started initially with someone who was immediately available and lived close to me. It was convenient. Also, in our initial contact this participant had made some forthright comments about the topic which captured my attention. This form of sampling is known as either *purposive* or *selective sampling* since it is guided by the research purpose, convenience and researcher interest (Bowers, 1988; Strauss, 1987), rather than being driven by data considerations. My second participant was suggested by my first interviewee as being "fascinating", and, serendipitously, after discussing this in supervision, I arrived home from this interview to find an e-mail from this person, volunteering to participate. Data gleaned from the first two participants made me consider where to go next. Since I was a member of the psychotherapy community I had some idea about participants' preferred style of practice. However, these details were also readily available to anyone via a google search. These decisions were recorded in memos. The following is an example of my reflections:

> Discussion in supervision about where to go next. I had interviewed two experienced therapists who had both talked about conditions in terms of educational contexts and the psychotherapy community. I wondered if educational conditions had changed over time. The second participant spoke of her experience of the pejorative attitude of psychoanalytic clinicians towards religion and spirituality. I wondered if this was always the case. I thought I could go either of

> two ways: interview a recent graduate from an educational programme or another experienced clinician, this time with a psychoanalytic orientation. After discussion, I decided to approach a new graduate who had volunteered to participate, since I had already interviewed two experienced clinicians. (Memo 26.6.12)

Theoretical sampling. Once I had interviewed two participants and gleaned a number of dimensions from their data, I began to choose my interviewees by theoretical sampling. Strauss (1987) commented that theoretical sampling basically asks, "Where can I find instances of 'x' or 'y'?" (p. 16). He added that this is a form of sampling where "the researcher, after previous analysis, is seeking samples of population, events, activities guided by his or her emerging (if still primitive) theory" (p. 16). Indeed, at this stage my thinking was quite primitive as I had not yet begun any comparative analysis.

I began this part of the data collection by asking myself what was missing from the data I had already collected. I next chose to interview a participant who came from the psychosynthesis tradition, wondering about the experience of a clinician who was educated in, and practised from, a psycho-spiritual perspective. Further theoretical sampling continued to search for data which was missing, until I gleaned enough data which indicated tentative categories and processes.

Theoretical sampling then focused on developing the categories. However, within this theoretical sampling process, interviews, where participants were being interviewed for the first time, began with the invitation to tell me whatever they wanted to about religion, spirituality and psychotherapy. Although I had prepared questions, arising from my analysis, to pose towards the end of the interview, I was alert to this material being raised spontaneously. When considering the category "Encountering Challenge" for example, I was able to pick up on Noeline's comments about experiencing difficulty with a client whose values were different from hers. Repeating her words, I asked her to elaborate:

> *You spoke about the difficulty in working with someone where your values … maybe hard to hold the unconditional positive regard at times?* (pause). I've got lots of thoughts and at the same time I'm going slightly blank because of course the ideal psychotherapist is always positively regarding and all the time we are making judgment calls about how much to challenge somebody's behaviour.

Theoretical sampling also led me to interview some participants twice to deepen the categories already elicited and to gather data where participants acted differently under different conditions. An example of the latter came when, during comparative analysis, I noticed that Simone demurred when being asked by a client to pray before beginning a psychotherapy session. She was, however, able to engage in karakia with a Māori client in a different context. I asked her about this difference. Simone responded:

> I'm within a context that gives me permission because that is the kaupapa at … with these clients. It's fine. Completely different. I had permission. *You had permission?* I had a whole covering over me in every sense of the word. *What do you mean by covering?* Well, that I am covered, that the client isn't going to go back and say to the psych nurse or the psychiatrist, "hey that weird therapist prayed with me, or inflicted prayer on me".

I began to see that one of the aspects of "Encountering Challenge" was about "permission" and that work context could be an important condition.

Further sampling highlighted what participants did when they encountered challenge. Some participants were re-interviewed to elicit greater details of their actions. For example, Luke, in our first interview, indicated that he had encountered challenge when he said, "the most difficult thing I've done recently is that I've treated a man who is a part of the Jehovah's Witness community". This client was having some experiences which he struggled with in terms of his religious persuasion. Luke said, "I would normalise it but this was not acceptable to him … So I became interested in other things that he did". This data suggested that different strategies may be used, depending on the response of the client. I re-interviewed Luke, via e-mail to elicit more of his decision-making process. This added to the depth of the category as well as implicating Luke's own RS history in his difficulty working with this client.

Participants' perspectives also became the focus of theoretical sampling towards the end of the data collection, as the analysis I had already done suggested that perspectives shifted under some conditions. Harold, whom I interviewed for a second time, confirmed that he shifted perspectives, commenting:

> I've tended to … move between these three perspectives, in terms of seeing psychotherapy as a secular thing but allowing for some stuff to come in but I think that I'm moving towards seeing …I have to allow … the spiritual dimension is very much part of the horizon of what is in the therapeutic frame.

As the foregoing suggests, theoretical sampling was pivotal in data analysis and the formulating of a coherent theoretical explanation of "all that was going on" in participants' decision-making processes concerning how they attended to RS in the therapeutic process. Although a discussion of theoretical sampling decisions of necessity involved a brief foray into analysis, such analysis has not been covered in any chronological or comprehensive manner, a matter which will now be redressed.

Data analysis

Data analysis has two discrete stages in GDA, identified simply by Schatzman (1991) as "early analysis" and "later analysis" (p. 310). Early analysis consists of a process of *dimensionalising* (Schatzman, p. 310), which involves identifying all aspects of the problem being researched. At this stage no value is attributed to the mass of dimensions, to avoid foreclosure of meaning. Later analysis is the integrative phase, where relationships are attributed between dimensions (Caron & Bowers, 2000). Throughout the whole process of analysis, the question I asked myself, as I elicited dimensions, formed categories and constructed a dimensional matrix, was, "what 'all' is involved here" (Schatzman, 1991, p. 310). An overview of the data analysis is shown in Figure 2 (p. 100).

The grounded theory group. Maintaining marginality was a particular challenge when researching my own discipline. Bowers (1988) suggested that belonging to a grounded theory group can assist here as its members can help the researcher by being outside the process. The grounded theory group at AUT, composed of members from a variety of disciplines, became an important part of my research journey. Giddings and Wood (2006) spoke about the history and salience of this particular group in their paper entitled "How to survive (and enjoy) doing a thesis: The experiences of a methodological working group". For me this group provided a place where I could reflect on difficulties I was experiencing in the research process, present ideas, and

utilise the theoretical thinking of those outside of the psychotherapy world, to check my dimensionalising and analytic decisions.

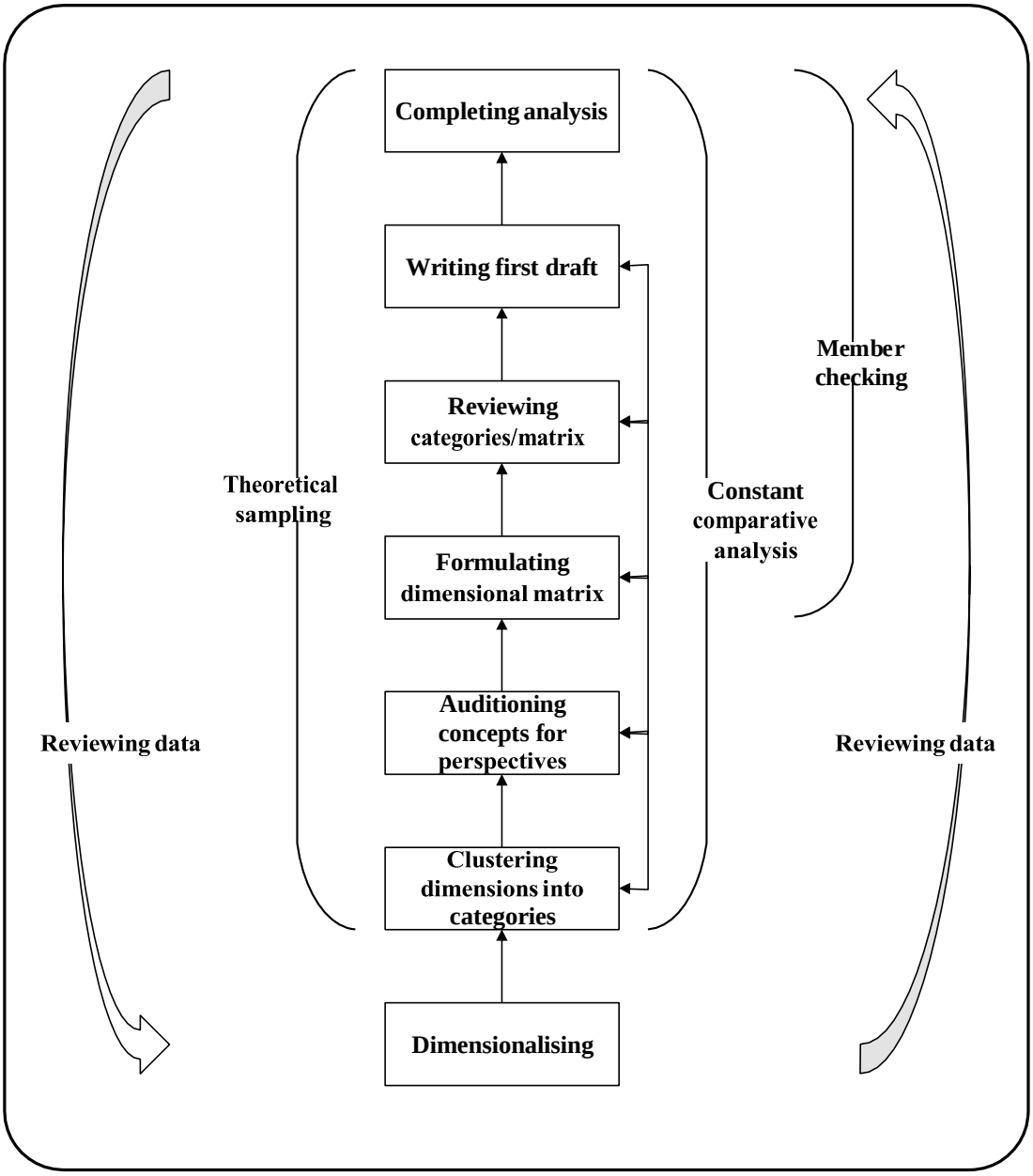


Figure 2: Overview of data analysis

I presented de-identified verbatim excerpts at times for the group's consideration. All material shared was collected, complete with comments, at the end of our analytic sessions, to avoid the potential of compromising the confidentiality of my participants. This assisted in the recognition-recall difficulty which Schatzman (1991) addressed

where a researcher‘s “analysis” is simply a matter of recognising and recalling information familiar to a particular discipline.

Early analysis. I began my analysis by amassing a large quantity of dimensions. I did this by attaching all my transcripts to A3 paper, which left wide margins; on the left for dimensions, and on the right, for my thinking processes. I also completed a memo for each participant, excerpts of which then formed the basis of my thoughts on developing categories. In addition, a face sheet (Schatzman, 1991, p. 310), listing interviewee characteristics, was prepared for each participant, the purpose of which, as noted by Schatzman, was “the identification and assembly of considerations” (p. 310). The strategy of preparing face sheets was further explicated by Browne (2004). I also drew diagrams of data presented by individual participants. Both of these strategies helped me hold data from individual interviews in my mind and also assisted in later conceptualising (Schatzman, 1991). Dimensions gleaned through these strategies were then entered on NVivo, a software programme for data management.

Use of NVivo. NVivo, a software programme for managing research data, was mentioned to me by my grounded theory group members, as a useful tool for storing data. I liked the idea of being able to store my dimensions, as well as have a pathway of connecting them to the verbatim from which they originated. The connection of data to verbatim greatly assisted in the later stages of the research as I began constant comparative analysis.

I attended two NVivo courses facilitated by researchers who used the programme frequently for their own research. I initially felt that this was the answer to data management and even analysis but soon came up against my own technical limitations. It seems that I was not alone. Bazeley (2007) noted that the majority of users of NVivo access only a limited amount of its function; I certainly fell into that category.

Apart from not being particularly technically “savvy”, I struggled with the static representation of dimensions without being able to see relationships and processes at a glance. However, this management system did allow a hierarchy of relationship between data to be recorded. (A page of these dimensions (called “nodes”) in NVivo, is found in Appendix K). I was also concerned that I might lose touch with the complexity of “all that is involved” by computer analysis; Rennie (1996) commented that software

constraints and the restricted field of the video screen may cause the analyst to lose contact with the data to a certain extent. I managed this potential difficulty by the manual coding, noted above.

NVivo was, however, useful for running queries when I started to see patterns in the data, during later analysis. Running a query entailed entering a search word in order to quickly gather all common occurrences, a task that would have taken me hours manually. For example, when I was looking at the concept of "resourcing" in the data, I ran a query search on resourcing and similar words, which helped me think more widely about a range of attributes of resourcing.

Use of diagrams. Another tool for representing the data was diagramming. I found that using diagrams was invaluable during data analysis especially since GDA methodology is about demonstrating process, a difficult task to achieve if one is reliant solely on text. Strauss (1987) commented that diagramming helps "consider relationships between data" (p. 145); Charmaz (2006) added that whilst it is common for qualitative researchers to use diagrams to visually represent their work, "grounded theorists use these strategies in the service of the theoretical development of their analysis" (p. 115). The relative explanatory power of my developing diagrams was indicative of the clarity with which I saw the process. Strauss and Corbin (1998) commented that unless the researcher is able to graphically depict the theoretical process in its entirety, they do not yet have total clarity about what is happening. I found this a useful benchmark, as I drew diagram after diagram each with greater refinement, over the course of the research process. Examples of early and later analysis diagrams, demonstrating this refinement, are found in Appendices L and M.

Later analysis. After conducting about 10 interviews and gathering dimensions, I began constant comparative analysis, comparing data between participant interviews, data within interviews and the dimensions already elicited. Decision-making when constantly comparing data relies on a combination of inductive and abductive thought. Inductive thought is defined as "a type of reasoning that begins with study of a range of individual cases and extrapolates patterns from them to form a conceptual category" (Bryant & Charmaz, 2007, p. 608), whereas abduction is defined as a "type of reasoning that begins by examining data and after scrutiny of these data, entertains all possible

explanations for the observed data, and then forms hypotheses to confirm or disconfirm until the researcher arrives at the most plausible interpretation of the observed data"(Bryant & Charmaz, 2007, p. 603). This explanation of data analysis considers salient analytic decisions which advanced eliciting of the theoretical process in order to answer the question of how psychotherapists attend to RS in the therapeutic process.

During this process, a number of dimensions were renamed as I realised that my early attempts at dimensionalising were more descriptive than analytic. My data analysis began to find a pattern in participants' actions. My supervisors encouraged me to write a "one page thesis" memo at various stages of data analysis, so that I could articulate the evolving analysis of these patterns. An example of this exercise is found in Appendix N. I noticed a change in how participants attended to their clients when some sort of limit was reached and wrote the following memo:

> I am noticing that something happens in the therapeutic interaction when a limit is reached where either the participant does not have the skills, or decides that what the client is asking for or expecting does not belong in the therapeutic engagement. Some sort of gatekeeping occurs, I think. Perhaps this is because of their education or modality prescriptions. Nigel speaks about 'being blinkered,' by his education and work context. The influence of participants' own RS history also seems to be a factor. A participant attended in these contexts by either ignoring, devaluing, not exploring (which is a form of ignoring) the client's RS material, which leads to either the consequence of shaping (the client learns what to bring/ what not to bring)–Nigel talked about learning "what excites the therapist"–the therapy ending prematurely. In the latter case, Brandon noted that one particular participant, when choosing to leave therapy, actually said that they were going to see a therapist who would work with their spiritual material. 'Switching' is a strategy used by Nerida when she judged the client's belief system, rather than continuing to listen and explore what was happening for the client. As a consequence of the switching the client left therapy. What other consequences are there? I need to be alert for all the conditions which make up this limit or boundary. (Memo 6.11.12)

I began to develop a category, initially entitled "Meeting a limit". This is seen in Appendix O, as part of an evolving theory diagram. Discussion with participants helped me reconsider naming this as an "edge". Lucille reflected:

> Limit sounds a bit too firm. It doesn't feel firm. I have never felt it feel that firm. It feels much more mutable really ... It's like new territory. Right*, so this is the known*, yeah *and this is the unknown?* or the less known the unknown, new territory … we all like having maps … I guess that's why I feel a bit like the lone

> ranger because I feel like I go into this without any maps half of the time, and I don't really know what I'm doing.

Lucille's comments led me to consider that the "edge or limit" may have a number of properties. The naming of this category was discussed in supervision, and recorded in the following memo:

> Barb suggested the category of "Meeting uncharted territory" instead of meeting the edge. I have already toyed with this idea. It sounds a useful descriptor but I wondered whether it incorporates everything because there are some things which are deemed "not acceptable". However they are deemed "not acceptable" because of a perspective about what belongs in therapy based on the interactions of modality and education. I need to think about the properties of uncharted territory. When psychotherapists meet RS with which they are not familiar, which is outside of the map provided by their education/ modality, what behaviours do they engage in? What actions do they take? What are the indicators that this is happening? They might seek directions, look for ways through. Get an updated map? It's very frustrating having an outdated map–quite bewildering when you come to something you had not expected to be there. (Memo 26.9.13)

I reviewed all the data indicators around this category and realised that there were three aspects to it, which at this stage were denoted: the unknown, the unacceptable and, out of bounds. Later revisions with further data analysis led to this category being named "encountering challenge" with the sub-categories of "the unknown", "mismatching perspectives" and "out of bounds". Further data analysis and member-checking caused me to later rename mismatching perspectives as "conflicting worldviews" and out of bounds as "perceived beyond scope". The former change recognised that many participants interacted with their clients when their perspectives were mismatched, without encountering challenge. Meeting the condition of "conflict" determined whether or not challenge was encountered. The change from "out of bounds" to "perceived beyond scope", was made as a result of member-checking. Discussion helped me to see that "out of bounds" had a "prohibited" feel. Although that aspect was included in the concept, it did not represent the totality of what the data conveyed; hence the change to something which provided a better explanation of the data.

Bearing in mind the importance of perspective in GDA, I became somewhat "stuck" on trying to decide what perspectives were suggested by the data. I initially thought that the

concept of "values", demonstrated in "authority", "participant's personal values", and "meeting client need" (see Appendix P) were the perspectives which participants brought to their work with clients. After reading Schatzman (1991) I realised that I needed to hold this conceptualising lightly, as he commented that although each dimension has the potential of being elevated to the position of perspective, this may only be "momentarily" (p. 311), and that it might take a lot of analysis for the positions of concepts on the dimensional matrix to be designated. This proved useful advice, since I later came to conceptualise that how participants regarded RS in psychotherapy, comprised perspectives, whilst other dimensions I had previously considered to be perspectives, were conceptualised as conditions.

As I noted earlier in this chapter, my interactions with participants at times caused me to experience what I understood as "something more than the two of us", a different sort of space. I wondered about this sort of experiencing between participants and their clients and became alert to when it happened in the interviews, to see what participants noted, and to ask about their own experiences of RS, or however they understood this phenomenon, in their work. Venetia spoke to this:

> I'm just in a space now … (silence) I think in the silence is a wairua moment. It's a connection in the healing that's happening although we can't contextualize that ... But coming back to your question about what was happening in that silence, I don't know, but something was, and I don't think we have a context for that because I think about a whare (house), I think about a wharenui (main building of the marae which accommodates guests). I think about all the stories that are in that house and when people come into the wharenui, people feel that, they feel their wairua (spirituality) differently. They can feel being held. How do we speak about that? How do we say what that is? I don't know but it is spiritual, it is wairua.

As a result of theoretical sampling I came up with the dimension of "experiencing" which was then elevated to a sub-category in the category of "engaging". As I began to connect categories together, I wondered if this process was a trajectory, that is, is a path or process which develops over time, and for a time, depicted it as such. Strauss (1993) talked about trajectory including "the course of any experienced phenomenon as it evolves over time" (p. 53) and "the actions and interactions contributing to its evolution" (pp. 53-54). He also commented on the presence of phases in a trajectory. Some participants spoke about maps; Harold drew me his map for engaging the

territory; Lucille said that she felt as though, "I go into this without any maps half of the time". To me, that suggested a phase. I creatively came up with the concept of a journey to explain the process. I presented my developing model as such (Appendix Q) at an AUT doctoral conference, on 27 December 2013.

However, with further data analysis, I began to realise that this representation, although sounding "neat", did not have sufficient explanatory power to describe everything that was happening as participants attended to RS in the therapeutic process. For example, not all the data suggested that "new territory" was always charted. Whilst the concept of trajectory suggested progressive development, some participants operated from a particular perspective which did not change. In addition, some participants changed their stance, suggesting something cyclical. Rather than seeing the concepts as a trajectory, I began to conceptualise the data as an iterative process (Appendix R).

My supervisors encouraged me to start writing the first draft of my findings which alerted me to gaps in the developing theory and concepts which needed greater density and explication. Writing the first draft sent me back to the data to refine my findings. As I began to write-up my findings, I had to make decisions about the use of quotes.

Use of quotes. Although the aim of GDA is to construct a process to explain what is happening in the field, it is important that the voices of participants involved in this construction, be heard also, in keeping with constructivist tradition (Bryant & Charmaz, 2007). The use of verbatim excerpts to illustrate the dimensions, sub-categories and categories constructed, also serves to demonstrate rigour, since the reader is able to see some of the data used to make these decisions. Quotes used have been edited for readability, removing words common in conversation such as, "ahhh", and "you know". Square brackets [] have been used where information has been added for clarification; for example, he [the client] said. In addition, where Māori words, or discipline specific words have been used, explanations have been provided in () parentheses. Where verbatim has been truncated, an elipsis … denotes omissions. Italics in quotes indicate researcher comments and questions.

Member-checking. Once I began to assemble my dimensions into a dimensional matrix which had some explanatory power I asked some participants for their comments. At this point my analysis suggested that participants explored client material until they

reached what I called an edge or a limit, when something was deemed unfamiliar, unknown, unacceptable or uncomfortable. I had wondered to myself whether all participants met a limit and sought to check this in my further interviews and member-checking. Without asking this question directly, Ethan, in response to me explaining the process, commented:

> What first strikes me though is that it looks like you are talking about the therapist who is not comfortable or not informed about spirituality ... Are you talking about all therapists?… I suppose I'm asking the question whether every therapist has some kind of difficulty with it … Because I don't think I would fit that. … There is an exception to that; if it is a highly evangelical person who is stuck and doesn't want to move anywhere. I tend to get a bit angry about that.

Ethan answered his own question, and went on to explain his interactions with a "highly evangelical person". I began to feel more confident that all participants did meet a limit of some sort, to some degree, attending to RS in therapy.

Towards the end of the theoretical sampling and the sharing of the conceptual framework, participants became excited in their responses which suggested resonance (Charmaz, 2006). I started to get excited with their enthusiasm! Esther liked the iterative process, saying, "You have covered the formation cycles … and it's true and then we start again". She added:

> And it will be interesting … in terms of teachers and therapists, where do I pitch myself in terms of this diagram? Am I good at accepting challenges and adventuring out as a scout or do I just do a bit of this and that and that but none of that. It's very good for assessment, isn't it? *I guess so*. It's a great assessment plan, *I hadn't thought of it like that*. Even for the client … I mean there are maps in every discipline but this is very useful not too complicated map for me to do my self-reflection, even as an assessment tool.

Esther's comments, together with realising the usefulness of the data diagram which I had conceptualised to explain the process of deciding what belongs, has caused me to consider its future development as a teaching tool (Appendix S).

Member-checking initially provided a lot of data which helped shape and add to the categories being developed. However, after a while I noticed that it became more

confirmatory of the theory derived. This signalled to me that I had reached the end of data collection. By this stage, I had conducted 33 interviews with 28 participants.

Theoretical saturation. The term *theoretical saturation* is often used to indicate that a researcher has reached the point where continued data gathering reveals neither further properties of categories nor adds to the emerging grounded theory (Charmaz, 2014). Morse (1995) commented that "researchers cease data collection when they have enough data to build a comprehensive and convincing theory" (p. 148). I reached a point in my data analysis where further sampling was not eliciting information which caused me to have to reconsider the theoretical process that was being developed. I also had enough data to sufficiently explain the process participants engaged in when attending to RS in the therapeutic process. The terms *theoretical sufficiency* rather than saturation, is preferred by Dey (1999) to describe this point.

Evaluating the quality of the research

After presenting the methodology and methods used to undertake my research on the topic religion, spirituality and psychotherapy, it remains to evaluate the processes I have followed in order to assess the quality of the research. Lincoln and Guba (1985) commented that the purpose of such evaluation is to assist the reader decide whether the findings are trustworthy. The processes inherent in grounded theory: grounding theory in the data, coding, constant comparison and theoretical saturation, Glaser and Strauss (1967) noted, offer a degree of rigour. However, these processes need careful explication for application in a particular research project to be assessed. To this end, I have explained the methods used together with the analytic decisions made, in arriving at a theoretical explanation of all that is going on as participants attend to RS in the therapeutic process. In addition, other criteria are important for judging rigour. The trustworthiness of this research will be addressed using the four criteria explicated by Charmaz (2014), that is: credibility, originality, resonance and usefulness.

The first aspect of trustworthiness to be considered is credibility. One of the considerations here, according to Charmaz (2014), is whether the "research has achieved intimate familiarity with the setting or topic". I believe that my in-depth explication of what participants took into account when arriving at their perspectives concerning the topic provides evidence of this. The theoretical sampling, which caused me to

understand the shifts that participants made in their perspectives and the reasons for this, added to the richness of the research. The connections between category and supporting verbatim excerpts are well made, as is the theoretical explanation of the process.

Originality, Charmaz (2014) noted, covers to what extent the research offers fresh insights, the significance of the work and how it adds to the field. This work is significant as it offers the first theoretical understanding of how psychotherapists attend to RS as they engage with clients in the unique cultural context of ANZ. The challenges which they encountered are well explicated, as are the strategies they engaged in to find their way through these.

Resonance is described in part as occurring when "your grounded theory makes sense to your participants" (Charmaz, 2014, p. 338). The participants, to whom I explained my findings, resonated with the theory that I had arrived at as they could see their own processes mapped out in the findings. It appeared to explain their decision-making processes when attending to RS in their work with clients. However, the research not only explained the micro-encounters participants were engaged in, but also described the variety of contexts which had a bearing on these encounters.

Member-checking, mentioned above, has offered some confirmation of the usefulness of my research findings. Several participants have commented enthusiastically on its applicability as a reflective tool for psychotherapists to increase their self-awareness around RS in the therapeutic engagement. One of the criteria for assessing usefulness, Charmaz (2014) suggested, is whether "the analysis [can] spark further research in other substantive areas" (p. 338). It is my contention that this study will provide a foundation for a range of further studies concerning RS in psychotherapy in ANZ. For example, the research indicates that clients' perspectives need to be considered; there is considerable room for research by Māori psychotherapists, so that their perspectives in this area, as well as their interactions with the psychotherapy profession and other influential contexts, may be fully understood. Raising awareness of the need for psychotherapists to engage in greater self-reflection about the influence of their own RS history and current thinking on the therapeutic process, can only lead to a greater safety for clients as they bring, or not, their own RS views to the therapeutic relationship.

Charmaz (2014) concluded that "when born from reasoned reflections and principled convictions, a grounded theory that conceptualizes and conveys what is meaningful about a substantive area can make a valuable contribution" (p. 338). The renowned sociologist C. Wright Mills (1916-1962) also suggested criteria for evaluating a sociological study, commenting that, "No social study that does not come back to the problems of biography, of history and of their intersections within a society has completed its intellectual journey" (Mills, 1973, p. 6). Based on my evaluation of my work as explicated above, I believe that my research into religion, spirituality and psychotherapy, meets these criteria.

Conclusion

In this chapter, I have explained GDA, the methodology chosen for this study, together with its underpinnings of social constructionism and symbolic interactionism. The reasons why this approach is a "best fit" for this research enquiry have been outlined. In addition, the methods used to construct the theory of "deciding what belongs", have been explicated. These comprised: ethical considerations; my position as researcher; data collection; sampling of participants, as well as data analysis. Finally, the quality of the research has been evaluated. Whilst I have demonstrated the process taken in theory construction, it remains to unveil the final product. An overview of findings follows in the next chapter.

Chapter Four: Overview of Findings

Introduction

In the previous chapter, the methodology and methods used to construct this theory using grounded dimensional analysis (GDA) were explained, and in this chapter, an overview of that completed construction is outlined. Findings are presented using a variety of formatting, as shown in Table 1, in Chapter one (p. 12), to differentiate the theoretical constructs. **Deciding what belongs** is the overarching theoretical process which addresses the research question; "How do psychotherapists attend to RS within the therapeutic process?" This overview includes a brief explanation of the three major categories which comprise the theory elicited from the data, which are: **engaging**, **encountering challenge**, and **negotiating challenge**. The consequences of the process, **personal and professional outcomes,** are also mentioned.

Together with a brief overview of these categories, the perspectives that participants referenced when **deciding what belongs** are explained in depth, since the views that participants took were an important condition in their decision-making. These perspectives were formed by contextual interactions, which are also described. Participants' perspectives shifted under some conditions, a process which is also explained.

Following this introductory chapter, in Chapter five I explain in greater detail the theoretical category of **engaging**, and the sub-categories of ***introducing***, ***differentiating***, ***linking***, ***experiencing***, ***exploring*** and ***teaching***, which elaborate the variety of ways in which participants engaged with RS in the therapeutic process. In Chapter six I describe the challenges that participants encountered which affected engaging, and hence is entitled **encountering challenge**. Sub-categories of this challenge, also delineated, are ***conflicting worldviews***, ***perceived outside scope***, and ***the unknown.*** Finally, in Chapter seven, the strategies participants used to negotiate the challenges they encountered, named **negotiating challenge**, are described. Challenge was negotiated by participants by ***protecting***, ***risking***, ***resourcing***, ***repairing*** *and* ***referring***. The outcomes of this process, **professional and personal outcomes,** comprised the sub-categories: ***expanding practice***, ***maintaining the status quo*** and ***presenting as legitimate***.

ChapterFour: Overview of Findings

The outline of the Findings chapters is depicted in Table 2.

Table 2: Outline of the Findings Chapters

Chapter	Topic
Chapter four	Overarching process: **deciding what belongs**. Overview of findings Perspectives in deciding what belongs
Chapter five	The theoretical category of **engaging** Sub-categories: ***introducing***, ***differentiating***, ***linking***, ***experiencing***, ***teaching***, ***exploring***.
Chapter six	The theoretical category of **encountering challenge**. Sub-categories: ***conflicting worldviews***, ***perceived outside scope***, ***the unknown***.
Chapter seven	The theoretical category of **negotiating challenge**. Sub-categories: ***protecting***, ***risking***, ***resourcing***, ***repairing***, ***referring.*** The theoretical category of **professional and personal outcomes**. Sub-categories: ***expanding practice***, ***maintaining the status quo***, ***presenting as legitimate***

A diagrammatic representation of the process

A diagrammatic representation of the process is found in Figure 3 (p. 113). This diagram depicts the theory of **deciding what belongs** as a circular process, as the process is repeated in an iterative manner. The overarching process, **deciding what belongs** occupies the central hub of the theoretical process, with dashed arrows radiating out to encompass the entire process, since it is the core process which participants utilised in all decisions they made as they considered RS in the therapeutic process. The outcome of the process, **professional and personal outcomes**, feeds back into the continuing process, hence the direction of the large arrows.

The categories of **engaging**, **encountering challenge**, and **negotiating challenge** are shown on arrows to depict the direction of movement within the process. **Client need** is the condition which begins this process and is therefore shown with an arrow entering at **engaging**.

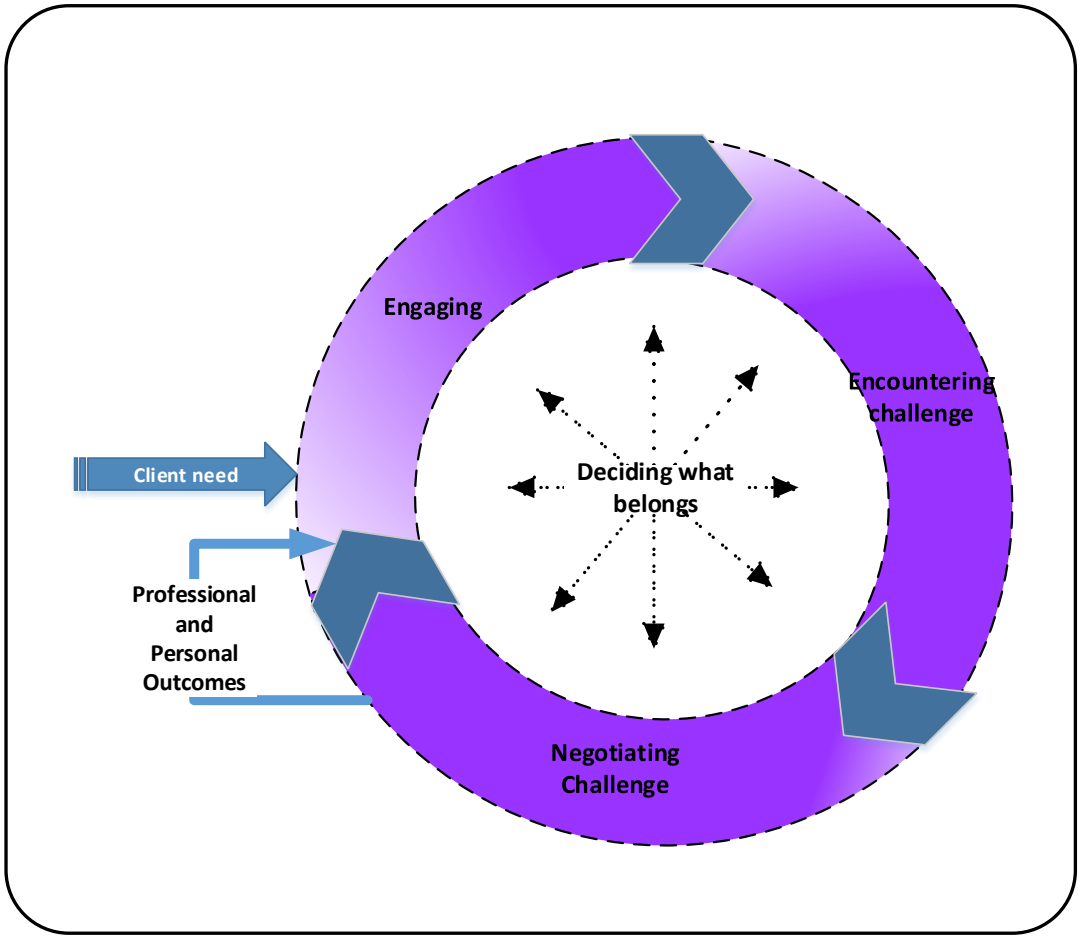


Figure 3: The GDA theory of deciding what belongs

Deciding what belongs

Deciding what belongs, the overarching theoretical explanation which answers the research question, "How do psychotherapists attend to RS in the therapeutic process?" is demonstrated in all participants' actions as they interacted with RS in the therapeutic context. The reality that it was participants who decided what belonged was epitomised by Ada, who commented: "Anything [speaking of RS experience] that comes into therapy, anything that comes into a relationship with a client, I as the therapist have to

allow it in". Deciding what belongs is demonstrated in the three major categories which comprise the theory, briefly overviewed in this chapter and explained in detail the next three chapters. These categories are: engaging, encountering challenge, and negotiating challenge.

Perspectives in deciding what belongs

Deciding what belonged in the therapeutic process was contingent on the perspectives held by participants concerning the relationship between RS and psychotherapy. These perspectives were as follows: psychotherapy is secular; psychotherapy and RS are inextricably connected; and, psychotherapy touches RS episodically. These perspectives were formed through social interaction in a variety of contexts, and shifted across time with further contextual interactions. The various perspectives espoused by participants are explored in detail, supported by verbatim excerpts, followed by an explanation of the contexts which gave rise to the forming and shifting of these perspectives. A diagrammatic representation of these perspectives is found in Figure 4.

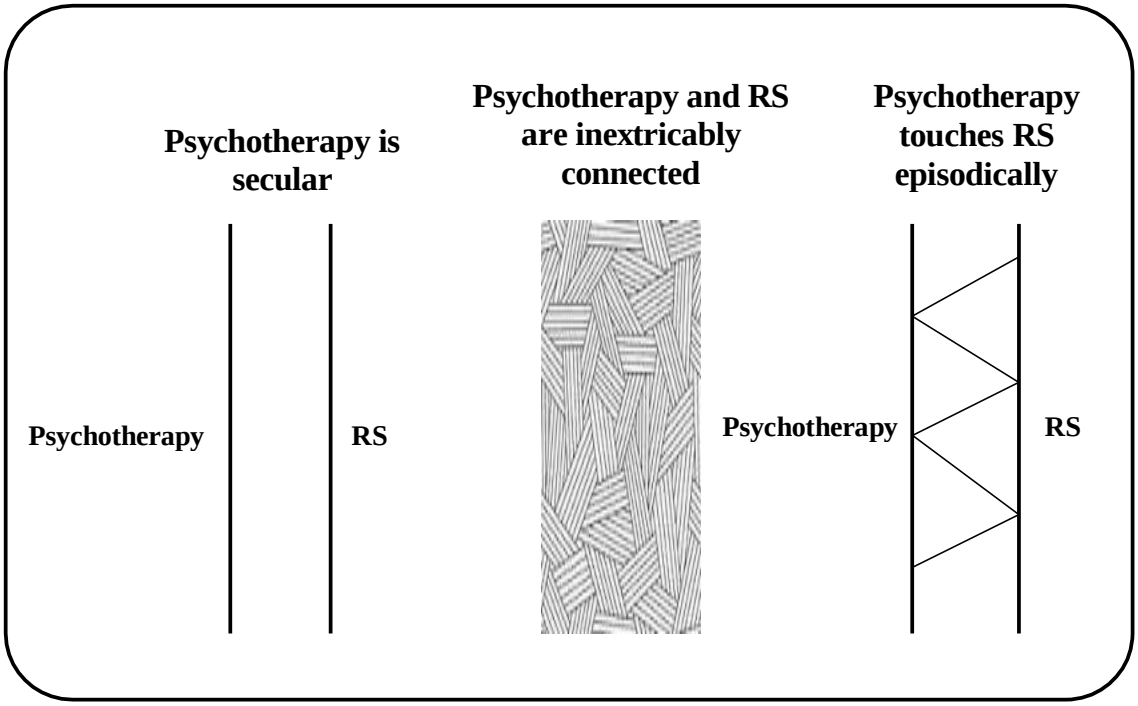


Figure 4: Perspectives in deciding what belongs

Psychotherapy is secular. Participants who held the view that psychotherapy is secular considered that the field of psychotherapeutic enquiry should be limited to the

psychological. Should a client choose to raise RS matters, a participant who held this perspective would consider the psychological meaning of the client's beliefs, which would be the focus of clinical attention. Brandon commented on his chosen therapeutic modality as a "non-spiritual, non-religious type of approach to psychotherapy", which was a good fit for him, since he had eschewed RS himself as a reaction to his upbringing. At the beginning of our interview, as though foundational to everything else that would be said, Tabitha clearly named this perspective:

> I come down in the position of seeing psychotherapy as a secular profession … so that my focus when I am working as a psychotherapist and dealing with religious or spiritual material that people bring is primarily on the psychotherapeutic meaning of that.

Harold also clearly delineated the boundaries between psychotherapy and RS, saying:

> If I think of psychotherapy and spirituality in terms of my practice, I see those as two independent, autonomous spheres of experience … I think of psychotherapy, or dealing with people's emotional and psychological and life issues, as dealing with them within the paradigms of psychotherapy and not wanting to bring spirituality or religion into that.

As Harold spoke about this delineation, he illustrated his comments by drawing a "layer cake". The "cake" had a clearly separate "social-self" as the top layer, separated by "defences" or protections which keep a person away from their "hidden-self". The foundation to the cake was the "deep" self where one's spirituality resided. The layer cake is seen in Figure 5 (p. 116).

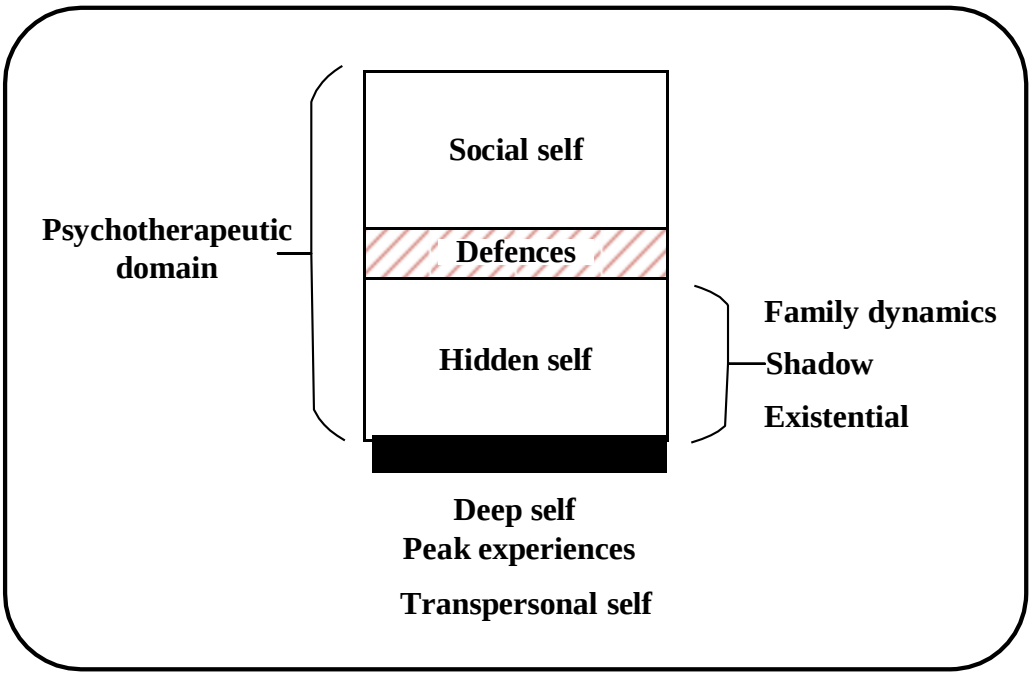


Figure 5: Harold's layer cake

Psychotherapy and RS are inextricably connected. Participants who believed that psychotherapy and RS were inextricably connected suggested that the psychological and spiritual domains of existence could not be separated, since RS was intrinsic to being. Some were incredulous that there was any other way of seeing it. Ethan asserted, "It's [RS] a fundamental strand in a human being … it's a central question". Serena added, "I believe that spirituality is always the basis of life [and] is always key to any psychotherapy intention and encounter". From this perspective, therefore, psychotherapy addresses the whole person, considering a client's RS functioning beyond just the psychological. Hannah commented:

> How could you have a meaningful conversation that didn't include an aspect of that person's spirituality or their spirit or their soul or how they think about themselves in the greater experience of being alive and of this existence? All of that is a spirit conversation, all of that is wairua (spiritual dimension).

The inextricable connection between psychotherapy and RS was framed, by Adam, from a the perspective of a particular RS tradition.

> The concept of a spoiled world is a fundamental perspective and understanding. When a client walks in for the first time, I am meeting somebody who is caught up in that realm of … a wrecked world, a "paradise lost" type world to quote Milton.

Psychotherapy touches RS episodically. Holding the view that psychotherapy touches RS episodically meant that participants with this perspective would rather not attend to it in therapy, but would if it was unavoidable. Simone commented, when investigating a client's resourcing, that she would ask about church, "If there's nothing going on for the person". This reluctant attention was because these participants believed that the primary focus of psychotherapy was psychological enquiry. Some participants who took this stance also acknowledged that spiritual occurrences may happen in psychotherapy, even though the aim was to keep them apart, considering the close relationship between the psychological and the spiritual domains. Harold, who had explained his perspective that psychotherapy was secular, realised that it was not always possible to keep the spiritual away. (Harold said that he was speaking about spirituality which he differentiated from religion, at the beginning of our interview).

> I see them [psychotherapy and spirituality] as quite separate, but sometimes reality is not like that. Sometimes (laughing) there are experiences in the therapy room where in a sense like realities which you might label as spiritual or beyond the normal understandings and frame of psychotherapy there are some experiences that erupt into and sort of saturate the experience … In the therapy room we need to keep our spirituality separate, but in fact it comes in in funny sorts of ways ... you don't have to seek God in the therapy room because He or She is already there, but you don't do it explicitly. Sometimes you find it. It's like sometimes there's a thin veil between the psychological and the spiritual and sometimes that veil sort of parts and you are in the presence of something … So … most of the times they are separate but they can also come into relationship where I think in a sense the psychological gets enfolded within the spiritual or into or within some nested within some bigger sense of reality … to make sense of the experience, I think you have to draw on or allow for other ways of explaining reality than the merely psychological.

Contexts forming perspectives

The perspectives held by participants were formed through the interplay of a range of contexts. These contexts were as follows: participants' life experience; RS history and current orientation, including the meaning participants made of the terms "religion"

and/or "spirituality"; psychotherapy education and modality; the psychotherapist's role and the nature of psychotherapy; socio/cultural context including biculturalism; and psychotherapy community. These contexts are explained so that the reader may see their respective valence and their intertwining, in the overall forming of perspectives. The contexts which form perspectives are outlined in Figure 6.

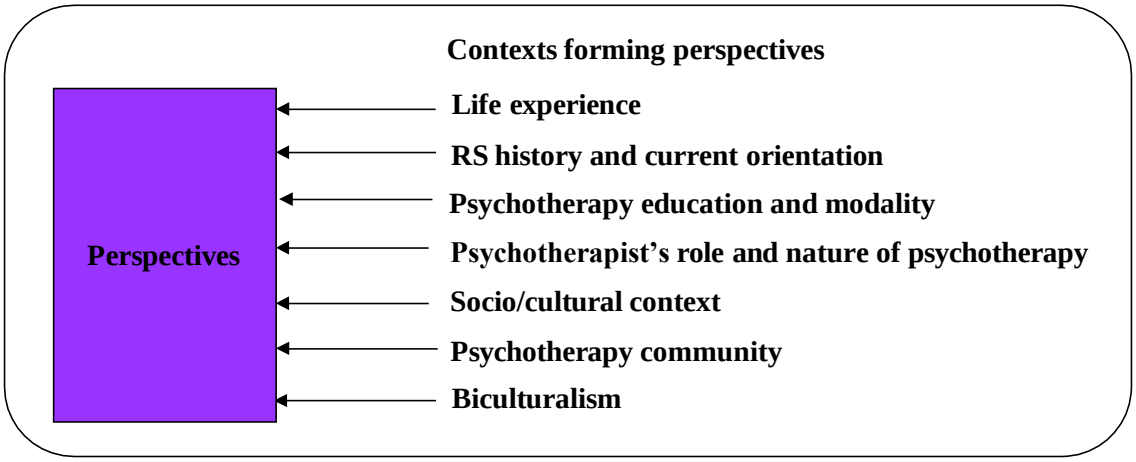


Figure 6: Contexts forming perspectives

Life experience. Participants' life experience was interwoven into their own views of RS in psychotherapy. The importance placed on life experience in forming perspectives was demonstrated in how many participants began their interviews. When asked to say whatever they wanted to about religion, spirituality and psychotherapy, many began with their own life experience, complete with defining moments, providing background to their perspectives.

> All those things do interweave for me right from the beginning … So when I look back at my whole life I can see threads or patterns, so just starting there was bringing some threads together around health, spirituality, religion and being with people … So spirituality and learning about the differences as those were experienced by different cultures was already part of the warp and weft of my experience. (Zara)

RS history and current orientation. Participants' own RS histories and current orientation were intertwined with their understanding of religion and spirituality. Milly

said, "I guess because of my background … I see spirituality … as very much part of being a human being and … spirituality … is very much like the architecture of the building". Adam, from his Christian perspective, said, "My view of my spirituality is that it is centred in relationship with God and that notion of reconciliation or restoring relationship with God". Nigel, speaking from his experience in the Buddhist tradition, asserted that he was much more comfortable with the idea of religion rather than spirituality, saying:

> I'm … cautious of spirituality without religion because … this is what I've seen from individual clients that spiritual bypassing often happens in isolation, where there aren't the checks or the guideposts of a tradition, so maybe I'm more likely to take a more questioning or doubting attitude to someone who comes in who is spiritual but not religious.

Averil clearly connected her Māori culture to her understanding of spirituality.

> I think that everything about being Māori is spiritual. Because in terms of being who we are we have to be connected to Atua (God(s)) or to Ranginui (Sky Father) or to our ancestors who have come before us, The Sky Father, God or whomever, whatever name you give him. And in terms of Māori philosophy, there's a lot up there and that in order to be who we are, we are connected to them. In a spiritual sense we are also connected to Papatuanuku, the Earth Mother, so it is important that connection is at both ends. It is a spiritual connection and outside of that there is the spiritual connection to the environment, to the people around us, to our mountains, our rivers, our whanau (family), all of those relationships and connections. And I do, I see them as all being spiritual, a spiritual connection, because there's this concept called aroaro, which is the sense of, or the feeling of or the nothing something that's not seen, that you can't say, "there it is", but it is something that is felt and the aroaro is that connection to our environment and what I've said.

Some participants differentiated religion from spirituality. Religion and spirituality were seen as quite discrete by Venetia, who described herself as "a very spiritual person. I think of psychotherapy as a spiritual relationship. And what is spiritual? Everything. Everything is related and connected to everything else". However, she had very different thoughts about religion, commenting:

> I think for me religion is imbued with such colonisation … the missionaries coming to Aotearoa New Zealand … they eroded tikanga (customs) really, and a way of life … the intentionality was probably … a good one and yet the result was

> pretty devastating, so that is what I think of, when I think of religion. So I don't think I am anti-religion, but I think I'm quite guarded.

Having highlighted a connection between a participant's RS orientation, history and their understanding of these terms, this connection was not always apparent. Although both Harold and Ada differentiated between religion and spirituality, their reasoning for doing so was about general understandings of the meaning of these words, rather than any stated personal historical influence.

> Spirituality … religions they are really highlighting differences. [Religions] … are … ways of people organising themselves in groups and having support in that. Spirituality, on the other hand is something that I see beyond the different religious traditions that I see as much more of a personal experience of The Divine. (Ada)

Tabitha highlighted the cultural nature of religion and the shaping of religious expression by varying cultural contributors.

> Religion is cultural; it's culture in every bit of it really. The family culture, the culture of the particular racial group, the particular place and religion will have often been through a number of cultural shifts like Christianity [which] arises in the context of Jewish culture, in the Roman world, in the Arabic world … Then there's the shift into European culture and then for New Zealand Catholicism comes through Irish culture, comes through New Zealand as expressed in Pākehā New Zealand culture … So I would see that religion as probably always culturally determined or shaped and just always has to be borne in mind because the therapist has a culture and the client has a culture.

Although some participants clearly separated religion from spirituality, others connected them. Luke commented, "Religion is the collective expression of human social spirituality". Milly reflected, "For some people they [religion and spirituality] are one and the same. And a faith tradition or a faith community is only the accumulated spiritual experiences that have been handed down, at some point any faith tradition".

Both Harold and Brandon made a connection between their own RS histories and desire to keep RS out of psychotherapy.

> I realised I had really repudiated Catholicism. I think part of that is in a sense keeping a major split between psychotherapy and spirituality. Part of that is a repudiation of my past ... Keep it out. (Harold)

Psychotherapy education and modality. Another condition informing participants' perspectives was their psychotherapy education and chosen therapeutic modality. These two aspects are considered together since psychotherapy education is principally taught in modalities. When participants made decisions about a psychotherapy qualifying education, for some the philosophy of the educating body and modality concerning RS was an important consideration; for others, issues of practicality were more salient. Brandon commented that he specifically chose a psychoanalytic psychotherapy education with its fairly "anti-religious, anti-spirituality" view, saying that because of his own rejection of RS, he "very naturally slotted into that". Speaking of her choice of modality, Tessa said:

> I think one of the reasons I chose psychodrama as a training modality is that it does have a strong spiritual component to it … the psychodrama training has an inherent philosophy of God the Creator in each person, … so that's kind of bedded in. It kind of just matches for me.

Isla reflected on her own spiritual journey and the finding of a modality which fitted with her philosophy of life, saying:

> I do feel blessed that I found psychosynthesis … I always had a sense of something greater than the surfaces of life … so different psychotherapeutic processes, psychological exploration in a spiritual context … was pretty formative for me … I have always been held in a modality that has been fundamentally psycho-spiritual. So for me there has never been any conflict in how one brings this experience and reality into congruent practice.

Whilst a deliberate choice concerning education was made by some participants based on RS philosophy, others spoke about availability and needed qualifications. Zara spoke to this practicality, saying that she had been learning psychotherapy through an apprenticeship model and then, "the course in psychotherapy became available … so I joined the course". Xavier commented that a psychoanalytic education became

important for his professional pathway. Both Simone and Averil spoke about working with people and realising that they needed more skills.

> I was working in Māori health … and I could ever only get my clients … to a certain point and I really wanted the skill to be able to move them further and also I really liked my own personal journey which was something that I had been doing myself for over … years and I wanted to continue that, so psychotherapy offered both for me. (Averil)

In addition to participants' choice of education/modality being important in the forming of their perspectives, so too was their experience of how RS was attended to during their education, experiences which often transferred to their own practice. Milly said, "It [RS] was never addressed in my psychotherapy training". Speaking of his education experience, Nigel commented, "I think what I took from all of that was … okay, I get the picture that that doesn't belong here", adding that it was the subtlety of "what was focused on and what was omitted", which caused him to draw his conclusions. Retelling a particular incident relating to RS which happened to a colleague during her education, Simone concluded that, "It was really clear to me that this was a dodgy area". Hannah recalled that "scant attention" was given to opportunities to be "engaged in that training by Māori", commenting that she believed there was still "no specific bicultural paper". Venetia reflected, "If the spaces are not provided for us to have the conversations [about RS] how on earth do we learn to have them with ourselves?

Although some participants were strongly influenced by the lack of attention to RS in their education, this was not always so. Others, having confidence in themselves because of life experience, were able to "hold their own" in an educational programme experienced as not inclusive of, or even hostile to, RS. Esther commented:

> I think because I was a mature student and … [speaking of her background] we study theology and we study spirituality … When I went in [to the psychotherapy programme] it didn't faze me. I just knew I would get this paper and get this three years done and I'll do my own weaving, which I did. … I remember a certain tutor telling me, "Oh well, wait until you've got your piece of paper … and when you go out of psychotherapy training, you can bring in spirituality afterwards, but it will never be in the syllabus". And that was the culture of the time and still is today.

Participants, who were able to choose their education and modality to fit with their beliefs about the importance of RS in human functioning, spoke of the congruence between the two. Ella said, "One of the things that I really like about psychosynthesis was that it helped me to begin languaging my inner experience". Modalities were linked with how some participants viewed the nature of psychotherapy. Ada commented that "every form of psychotherapy has a background dimension, whether claimed or not … some models do it better than others … working with spirituality and inviting a spiritual place".

Psychotherapists' role and the nature of psychotherapy. Also connected with education and chosen modality, is how participants saw their role as psychotherapists. Since this was closely aligned to their understanding of the nature of psychotherapy, these aspects are considered together. Participants had a wide variety of views concerning their role as psychotherapists and nature of psychotherapy. Milly asserted that, "my role as a psychotherapist is to try and understand what it is like to be you", adding that she saw one of the strengths of psychotherapy as not having to "have the answer". Luke commented that a psychotherapist's role was to "listen to the world of others is … a fundamental demand that we have of psychotherapists, so we have to listen to the spiritual world". He added that, "Psychotherapy … is the process of telling one's story over and over again to increase its coherence and its flexibility and its complexity".

Tabitha considered what a psychotherapist's role did not include, saying, "You are not there to influence or change people". Conversely, Nerida saw the importance of influencing, saying, "part of our job as a psychotherapist, a healer of the mind, [is] that we listen for any form of belief pattern that clearly has a destructive or self-defeating outcome". Should she decide that a client's beliefs were of this nature, she would challenge them. Echoing similar sentiments, Noeline also suggested that there was an "ideal" psychotherapist, whom she said was "always positively regarding". She added that psychotherapists were "all the time … making judgment calls about how much to … challenge behaviours which are unhealthy to them or to society".

A number of participants spoke about psychotherapy itself as "sacred" and a "spiritual relationship". Xavier added that it was a "spiritual exercise". He explained:

> Many people think that psychotherapy is like putting a jigsaw puzzle together but it's not; it's the relationship that happens, where the healing happens; moments when something in the relationship is very real, and at the same time beyond words ... I believe that psychotherapy is a spiritual exercise, it seeks to find this transcendental all the time, spiritual or the Divine or whatever at that level. Einstein's idea is that we have problems, we have created problems in our life and those problems can't be solved on this level where they were created … the answer has to come from another level, from the Divine … We need that input from another, higher level for anything to change.

Tessa suggested that psychotherapy aimed to foster self-development:

> The nature of psychotherapy is to enable people to know who they are … to have their fullest potential … to develop their capacity to express their own spontaneity and creativity in the encounter, in being with the other and being with themselves, then they start to develop their own capacity for God to be in themselves in their lives, sort of incarnated.

Ethan's understanding of psychotherapy suggested movement from more commonly held understandings and ways of working, to something with a wider scope:

> I've actually got to the stage where I don't think there is a definition … I mean the traditional thing is that we sit in a room with somebody and I suppose psychotherapy has been mainly about internalising and if you want to go with a traditional view of it then I suppose you then have to start saying, "what does it involve and what it doesn't involve?"But for me I just I think it's just where we are on the verge of exploding the myths really. When I listened to [Māori practitioner] give his presentation … most of the work he did with the client … was by walking along the seashore. And I thought well, that was really interesting … and my guess is that there would have been quite a few people in the wharenui (meeting house) who would have said, "that's not psychotherapy, that's more like support or social work or something like that", and yet … the client was actually doing a lot of internalising and rediscovering.

The boundary between participants taking the role of psychotherapist, and that of an RS teacher, was also noted by some. How far does a psychotherapist go in terms of RS teaching? This seemed difficult to differentiate when both participant and client shared an RS orientation or interest. Making these decisions was considered complex.

> And the question is also, there are certain differences between a spiritual guru or guide or leader or teacher and a psychotherapist. There are also commonalities, and I think that this whole area is really quite a difficult one that needs to be very much reflected on all the time when we practise as psychotherapists. What are the bounds of our paradigm as psychotherapists that we really shouldn't transgress? (Ada)

Differentiating between the role of psychotherapist and RS teacher, Ethan asserted that his role as a psychotherapist was to work holistically. He reflected:

> I'm not sure how I would work with them if it was just about spirituality. I'd probably feel a bit unethical about that because I think a psychotherapist's job is to be holistic. So and I should say that there are a number of times where I have said that I think you should see your church minister about that and come back to me.

Socio-cultural context. Many participants spoke about RS being a "personal area" that wasn't discussed much in what is considered to be a secular society in ANZ. Some suggested that this secularising of society may cause a reticence in both psychotherapists and clients being willing to openly talk about RS in the therapeutic process. Luke mentioned the decline in the centrality of churches in communities, with accompanying falloff in church attendance, "so [apart from a few exceptions] we are no longer … comfortable with religion and with the church … we're embarrassed by it". Whilst Tabitha commented that it was important that psychotherapists reflect on their own RS views, she suggested that since RS was seen by many in our current society as personal, psychotherapists wanted "to feel that they are free to think about it or not to think about it". She added, "I think there is a division that says that this doesn't belong inside psychotherapy".

Although the secularising of society was seen as a condition in psychotherapists' reluctance to discuss RS, interest in spirituality as distinct from religion was also mentioned. Nigel asserted, "We're not that religious [in New Zealand]. [Being] religious doesn't have that much energy here compared to a lot of other cultures. Sure, we've got a fair bit of spirituality". Ada added that as a society we are "awakening more" to spirituality, a fact reflected in increasing attention to spirituality in literature.

Psychotherapy community. The socio-cultural context, with the increasing secularisation of society, has a flow on effect in the psychotherapy community, according to some participants. As mentioned above by Tabitha, psychotherapists might not want to think about their own RS views, thus reflecting the wider social milieu. This reticence, some participants noted, was reflected in the assessment procedures of the New Zealand Association of Psychotherapists (NZAP). Some commented that, in the Advanced Clinical Practice (ACP) assessment, a qualification needed for full membership of the NZAP, (unless one qualifies through registration) there were no questions about RS put to an applicant. Ethan observed that in the assessment panels he was on, unless he "suggested it, nobody was interested in the candidate from a spiritual point of view and the questions were not asked". Tabitha reflected:

> In NZAP we expect people to, if they are doing their Advanced Clinical Practice, we expect them to be able to think about and talk about how they deal with gender issues, how they deal with biculturalism, how they deal with multiculturalism but we don't ask them to talk about how they deal with religion.

Luke suggested that by avoiding questioning applicants for the ACP qualification, "we are obeying an injunction from the wider culture [of New Zealand society], "Don't get into that area", adding that RS was "an unresolved area in our professional field".

The influence of modality on some participants' perception of what they could talk about within the psychotherapy community was also expressed. Anastasia commented that, "The psychotherapeutic community is basically neo-Freudian. I think Freud's bias and his idea that religion is an escape and a defence still colours … their belief systems". Ella voiced the difference she felt between being able to talk about spirituality within her modality, and within the wider psychotherapy context. She said:

> Now as a psychotherapist, it feels … I can have a voice within the psychosynthesis arena because the spiritual dimension is germane to what that's about, but I find that in the wider psychotherapeutic community that might not be especially … acceptable given … the whole Freudian perspective.

The relative lack of discussion about RS is compounded, according to Venetia, by difficulties sharing cultural understandings of wairua.

> I feel comfortable talking the psychotherapeutic way because it is the shared language that we have, but perhaps some of my ideas about mate wairua are really different so that is a really interesting kind of separation in terms of the community too, and probably needs many more discussions and perhaps that's a feeling that I have overall about the community is that we don't talk about the spiritual element very much.

Biculturalism. The influence of biculturalism in NZ society, and, more specifically, within the psychotherapy community and therefore psychotherapy practice, was noted by some participants. Luke commented, "I think that's one of the gifts that we have in this country is the bicultural environment". Hannah added that there was "more bicultural consciousness within the NZAP [than there has been previously]". However, some participants considered the attention paid to Māori culture in society and in psychotherapy as tokenistic. Anastasia asserted, "It's given lip-service as kind of a little ritualistic token thing instead of being taken [seriously]".

Some suggested that biculturalism offered psychotherapists a spirituality that they wanted for themselves. Ada spoke of the richness of spirituality offered on marae (Māori meeting place) commenting that "We are grateful to the Māori people who bring that in for us". Tabitha said:

> Certain things you attend … have karakia (ritual chants). They [psychotherapists] wouldn't actually pray themselves and wouldn't believe in a god, but there is a way of going along with that … that sits alongside a thirst for spirituality in a number of people.

Biculturalism also offered a way of introducing RS into practice, as Simone found, saying, "The only way I can really feel comfortable talking about it [RS] is through the filter of that Māori model [Te Whare Tapa Whā].

However, other participants spoke of an uneasy relationship between biculturalism and psychotherapy, where they considered that RS was foisted on them through biculturalism. Ethan reflected, "I often wonder whether the people who are worried about the bicultural movement in New Zealand psychotherapy are often underneath saying, 'What we are worried about is the spirituality'". Although spirituality per se may be an issue for some, others commented on the melding of Māori spirituality with

colonising religions, often demonstrated in karakia, and the discomfort some Pākehā psychotherapists had with that.

Tessa reflected:

> I was at a conference earlier this year where we had the mihi whakatau (greeting) and the poroporaki (farewell ceremony) and the kaumatua (elder) said a karakia both times which was very traditional Roman Catholic karakia … in te reo (Māori language). So if you understood a little bit of te reo you would pick it up, and so you could see some people in the audience who were bristling a bit … whereas if it had been a prayer that was pre-European, it would have been perhaps more accepted, but I think Māori culture is very infused with Christianity and it hasn't actually examined these things very much to date … so on the marae (meeting place) and other places you talk of the wairua and the spirit the life force and all of that is quite complementary to my own understanding … but I do find in myself a kind of abrupt halting when this other stuff comes in … I don't think that has really grown up or been examined to be culturally in step now.

The increase in numbers of Māori in psychotherapy has had a lot of influence in implementing changes within the psychotherapy profession, as Hannah explained:

> Probably like anything else Māori in psychotherapy and that's Māori who have trained in mainstream psychotherapy … programmes you get … what is referred to as a critical mass in terms of numbers, so you have enough … Māori in the profession of psychotherapy to bring themselves together in a way that allows them to share their ideas and their experiences of being Māori practitioners in the work of psychotherapy.

A few participants commented on what felt like a split between the experience of RS on a marae and the lack of attention to RS within the NZAP's APC assessment criteria.

> But in New Zealand there is a dilemma because of our indigenous population … spirituality is much more in the foreground than in countries in Europe or in the States and so we are kind of in that dilemma. NZAP doesn't have it in the books, the spirituality in the assessment criteria, but when we go on a marae or when we have a powhiri (welcome ceremony), it's there, we all feel it, that's what's calling us, that's what's holding us because we feel that richness. (Ada)

Shifting perspectives

Some participants shifted their perspectives in response to client need and collegial interactions. For example, Brandon, who initially held the perspective that

psychotherapy was secular, commented that over time, he "became a lot less rigid in … response to religious and spiritual issues", so that he now found himself being more attentive to RS in the therapeutic process. The comment "over time", referred to a process which included being confronted by his client about his ignoring of her RS issues. Also included in this process was personal psychotherapy, which enabled Brandon to reflect on the circumstances which led to his historical repudiation of RS; he thought that these processes occurred concurrently, rather than sequentially.

Harold also demonstrated a shifting of his perspective from one of seeing psychotherapy as secular, to touching RS episodically, then to one of greater inclusivity of RS. During a second interview to gather more data on the static or shifting nature of perspectives, Harold said that recent interactions with clients and colleagues had shifted his views. He commented:

> I've tended to … move between these three perspectives, in terms of seeing psychotherapy as a secular thing but allowing for some stuff to come in but I think that I'm moving towards seeing, through the combination of just what happened on the weekend [conversations with colleagues at seminar] but also with some experiences I had yesterday with two clients … I have to allow … [that] the spiritual dimension is very much part of the horizon of what is in the therapeutic frame … It may be me … alternating between these two positions (pointing to spirituality intrinsic to being and touching episodically) but … you could say it's expanded, it's not a great sort of conversion. I mean I'm not into introducing spirituality, but with some clients you need to have that frame …the fundamental thing is being able to hold the reality of the client.

Foregrounding/backgrounding of perspectives

As well as participants shifting perspectives in response to client need and collegial interactions, participants also put their perspectives to the fore, "foregrounding", or pushed them into the background, "backgrounding", in response to different work contexts. The differences between private and public sector practice contexts, in terms of expectations, caused some participants to either bring RS to the fore, or push it into the background. Venetia, who worked both in private practice and in the public sector, commented that she was more able to engage her spirituality in her private work, than in her work in the public sector. She said:

> It is a colonising institution so there is a way of being an indigenous practitioner that I am very wary I think because the structures and the construction of the system is limiting I think in terms of spirituality in terms of culture … anything

> that is outside that biomedical mainstream … and I think there is a history around indigenous people being persecuted for not being rigorously clinical. I am thinking about the *Tohunga Suppression Act* saying Māori spirituality and ways of healing are actually illegitimate. So I think there is a real caution in terms of engaging those issues within the system that is clearly biomedical, clinical, government funded whereas in my private practice I'm under my own system I guess, so it is much easier for people to understand what they are coming in to. It is explicit from the start that … we are a Māori based service where we talk about things like wairua, whanau.

Whilst Venetia pushed her RS inclusive perspective to the background in her public sector work, Simone found her public sector context expected attention to clients' RS. She, however, held the perspective that psychotherapy was secular. Although in her private practice she was very reluctant to engage in prayer with her client, because "that's not what I do as a therapist", she invited and engaged with karakia with clients in her public sector work. In a second interview she explained this difference:

> There's a very specific cultural service at [work place]. I'm having cultural supervision … in that context, they're paying me, they're supervising me … to see these clients. I'm within a context that gives me permission because that is the kaupapa (policy) at [work place] with these clients. It's fine, completely different. I had permission.

Summary of perspectives

Participants attended to RS in the therapeutic process from three perspectives which are: psychotherapy is secular; psychotherapy and RS are inextricably connected; and, psychotherapy touches RS episodically. As has been demonstrated, there were numerous contexts which were woven together to form participants' perspectives perspectives. Life experience, education and modality, the role of the psychotherapist and the nature of psychotherapy, participants' RS history and current orientation, socio-cultural context, psychotherapy community and biculturalism were dimensions which were intertwined, with varying degrees of salience. Participants shifted perspectives in response to client need and collegial interactions; work contexts also influenced participants' referencing these perspectives. Given the complex nature of all that participants took into account in forming and shifting their pespectives, it could be reasonably predicted that interaction with clients' RS would not be homogeneous. These interactions are now delineated as the complex processes of engaging,

encountering challenge and negotiating challenge, are briefly explained together with ensuing professional and personal outcomes. The condition of "client need", which determines participants' engaging, is first considered.

Client need

Participants engaged with RS in the therapeutic process in response to client need. Client need comprised clients' references to RS matters, as well as participants' perception of client need. For example, if participants believed that RS, as a domain of human existence, which needed to be addressed in psychotherapy, even if not raised by a client, this constituted "perceived client need".

Engaging

Engaging explains how participants interacted with RS matters in the therapeutic process. All participants engaged with clients' RS material in some way; however, the strategies used as participants engaged, were dependent on the perspective which they held concerning the relationship between RS and psychotherapy. Strategies which comprised the category of engaging were: introducing, differentiating, linking, exploring, experiencing and teaching. Whether participants introduced RS into the therapeutic process varied according to the perspective they held. Some participants reported always asking clients about RS matters, considering this a central domain of human existence. Other participants responded to clients' initiating RS conversations, but differentiated between RS matters which were part of a client's intrapsychic and interpsychic functioning, and external religious practices. When participants were familiar with RS disciplines, links were made between these disciplines and the practice of psychotherapy. RS matters were explored to increase clients' awareness of their beliefs and the function they served in their lives. RS experiencing was facilitated in the therapeutic process by participants' openness to it. Some participants also taught their clients the importance of RS in their overall functioning. When RS beliefs were held in common, some participants engaged in teaching RS traditions. Engaging with clients' RS material continued until participants encountered a challenge of some sort.

ChapterFour: Overview of Findings

Encountering challenge

Challenges encountered by participants varied in degree and nature, as demonstrated by the sub-categories of conflicting worldviews, the unknown, and challenges where an aspect of the client's RS or presentation was perceived as beyond the scope of the participant's practice. Some participants experienced conflict when their own RS histories and current views were triggered by clients' RS perspectives. Where there was an assumed convergence between the RS of the participant and that of their client, conflicts occurred when these assumptions were not upheld. Conflicts were also encountered when participants did not agree with clients' values. Encountering the unknown was demonstrated in a number of ways. Participants were challenged when encountering RS practices and beliefs which were unfamiliar and when they encountered the limits of their education/modality. Encountering unusual RS experiences was challenging also when they were outside the participant's own experience. Participants also encountered a challenge when some RS activity or expectation was considered by them to be beyond the scope of their practice as a psychotherapist. Conditions which were taken into account when deciding whether or not something was beyond the scope of their practice, were: the philosophy of their workplace; and, what they had experienced during their education, together with the parameters of their modality; all of which influenced how participants perceived their role as a psychotherapist. Once they encountered a challenge, participants worked to negotiate their way through them.

Negotiating challenge

Participants negotiated the challenges they encountered by engaging in strategies of protecting, risking, resourcing, repairing and referring. These strategies were employed individually, and at times, sequentially, depending on the nature of the challenge. Participants protected themselves by hiding, that is, not disclosing how they were engaging with clients; they also pushed clients' RS material away by ignoring it, judging it, and making diagnostic decisions which foreclosed other possibilities. Participants also took risks when responding to client need, by going outside the parameters they perceived had been set for them in their education and modality. As well as protecting and risking, participants also resourced themselves in their work. Resourcing strategies comprised accessing supervision and finding other contexts where

could express themselves freely. They also increased their own awareness through self-reflection and personal psychotherapy. In addition, they ventured outside what they perceived as the psychotherapy frame and incorporated learnings from other disciplines in order to meet client need. Where education was lacking, they taught themselves and asked clients to teach them about their RS traditions, so that they could engage with clients more effectively. Where relationships with clients were disrupted as a result of the challenges participants encountered, attempts were made at repair. Referrals were also made when participants deemed that clients' needs fell outside the scope of their brief. Sometimes referrals meant that participants worked in tandem with therapists who attended to a client's specific cultural needs in conjunction with the psychological aspect of the client work. At other times, clients were referred fully to another clinician, either within or without the psychotherapy discipline, thought to be able to work more effectively with them.

Professional and personal outcomes

A variety of outcomes ensued as participants, deciding what belonged, engaged with clients' RS, encountered challenges and negotiated these. These outcomes comprised: expanding practice; maintaining the status quo; and, presenting as legitimate. Although these outcomes were the results of this process, they also fed back into the cycle at engaging, in a continuing process.

Conclusion

In this chapter I have provided an overview of the theory, "deciding what belongs", to acquaint the reader with the theoretical process which addresses the problem of how psychotherapists attend to RS in the therapeutic process. The perspectives that participants held concerning RS in the therapeutic process, formed by numerous contexts, have been considered in detail in this overview, since they underpinned the decisions participants made at all stages of the process. The theoretical process, begun in response to client need, comprised the major categories of engaging, encountering and negotiating challenges, with a variety of practice outcomes. In the next chapter, the first of these major categories; the concept of engaging, is examined in depth.

Chapter Five: Engaging

Introduction

Having provided, in the previous chapter, an overview of the theory **deciding what belongs**, this chapter examines in depth the first major identified category, the concept of **engaging,** which explains how participants worked with RS in the therapeutic encounter when meeting client need. Participants engaged in a variety of ways with RS, namely by sometimes introducing the topic in different ways to the therapeutic context, and by deciding "what was what" as they sought to distinguish which aspects of a person's RS were supportive of mental wellbeing, and which were not. They also made connections between different disciplines and between the RS and psychological domains of existence. They explored the nature and meaning of a client's RS beliefs and expression, together with sharing and supporting RS experience in the therapeutic encounter. The category **engaging** thus comprises the sub-categories of ***introducing***, ***differentiating***, ***linking***, ***exploring***, ***teaching***, and ***experiencing***, which are explained in turn, together with the accompanying codes that indicate these categories. These explanations are supported by verbatim excerpts.

Engaging

Engaging explains how participants involved themselves with RS in the therapeutic encounter. **Engaging** occurred in the context of participants' perspectives concerning RS in psychotherapy, perspectives which, as has been explained in Chapter four, comprised participants' life experience, their own RS orientation and history, psychotherapy education and modality, the psychotherapist's role and the nature of psychotherapy, socio-cultural context, the influence of the psychotherapy community, and bicultural context. It is evident from participants' reports that whatever occurred within the therapeutic process did so with the facilitation of the participant. **Engaging** was demonstrated as being on the participant's terms, that is, participants decided what belonged. This was illustrated by Ada's comments:

> Anything that comes into therapy, anything that comes into a relationship with a client, I as the therapist have to allow it in and then it can happen with the client.

Chapter Five: Engaging

> What I will not allow in is much more difficult for the client to manifest because subtly they will know that it is not welcome or judged or something, so it ultimately is about what the therapist can embrace.

The perspectives on RS in psychotherapy which were held by participants, and, therefore, brought to the therapeutic encounter, were important, as these influenced the "how", the "when", the "whether" and "to what end" of the engagement. Perspectives, therefore, are interwoven in this chapter. Figure 7 depicts all aspects of engaging.

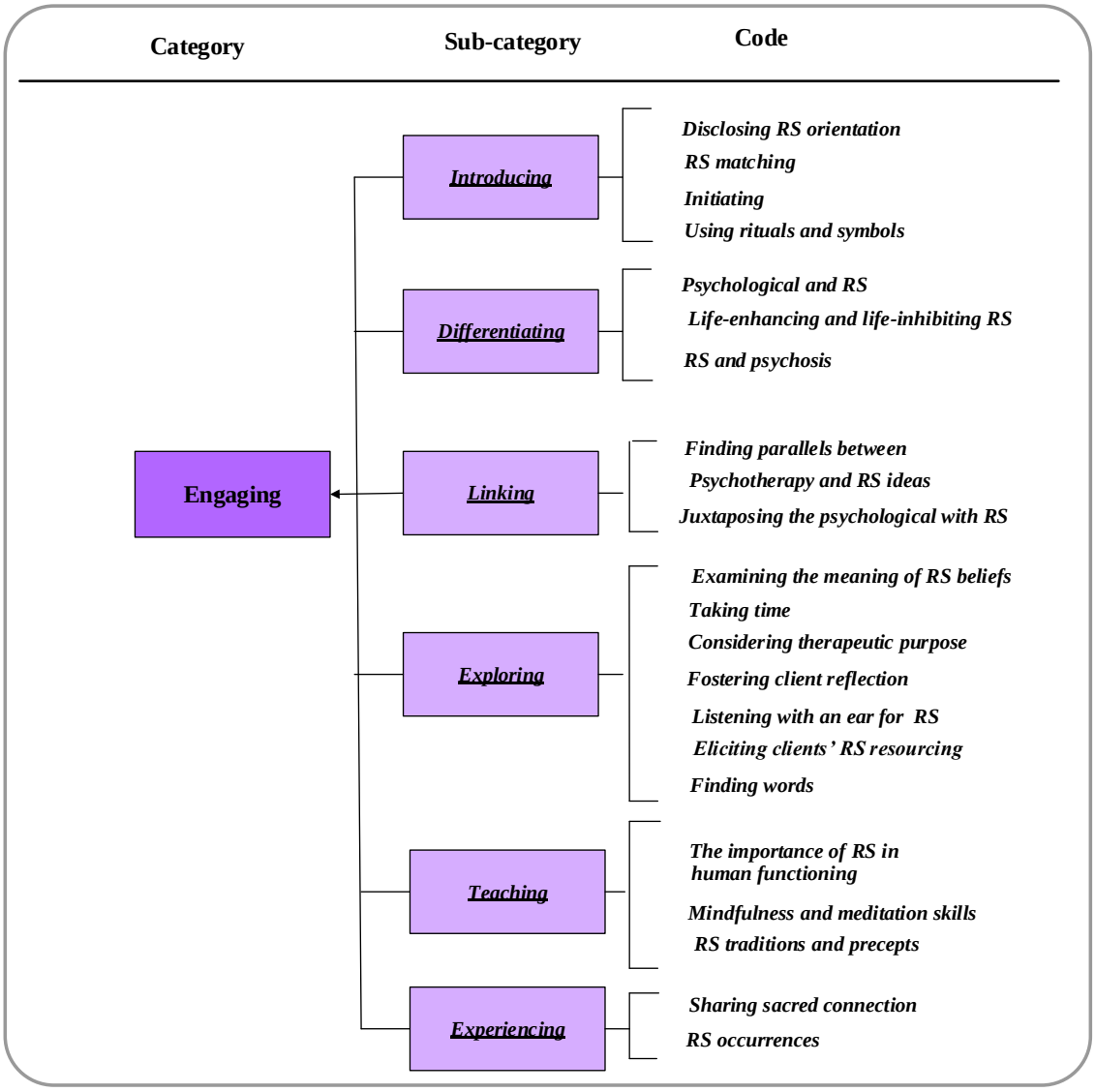


Figure 7: Engaging

Introducing. Whether and how RS matters came into the therapeutic encounter is depicted by the sub-category ***introducing***. Some participants introduced RS as a matter of course since they considered spirituality intrinsic to being. Indeed, some considered such inquiry crucial to obtaining a full picture of the client's presentation. Those who held this perspective were more likely to explore RS as a resource for wellbeing. Having said this, modality and preferred style of practice also influenced whether a participant would introduce RS into a therapeutic conversation. For example, those who held a psychoanalytic view in particular usually tended to wait for clients to introduce the topic. The downside of this approach, noted by both Nigel and Brandon, was that clients, taking their cue from the therapist, may believe that RS matters did not belong in psychotherapy. Introducing may not always have been through overt means. Some participants spoke about what could possibly already be known about them in the community and stated a preference for as little as possible being known, since this allowed for a client's own imaginings about the therapist to be explored. ***Introducing*** was demonstrated in ***disclosing RS orientation***, ***RS matching***, ***initiating***, *and* ***rituals and symbols***, which are discussed in turn.

Disclosing RS orientation. Some participants disclosed their RS perspective to their clients; disclosure took place in several ways. Sometimes this disclosure was inadvertent such as information known about a psychotherapist in the psychotherapy community becoming known to a client. Some participants advertised their RS perspective on websites or by being members of professional bodies with particular RS adherence. At other times, participants disclosed their RS orientation to clients either at the beginning of, or early in the therapeutic relationship, so that clients "knew what they were getting" or to allay anxiety, should assumptions be made.

Some participants advertised their openness to spirituality or affiliation with a particular religion via website introduction, membership with professional bodies or practices which promoted a particular cultural perspective. Both Ursula and Nerida commented on their reasoning, reflecting respectively that "it is much easier for people to understand what they are coming in to" and "the language is already there". Tessa, speaking about a third party's advertising, commented, "that's a very overt statement to the client, even before they walk in the door and people choose … on those grounds

too". Advertising suggested a participant's familiarity with a particular RS orientation, providing a client with information before even meeting the particular psychotherapist.

> We put out there that we are members of the New Zealand Association of Christian Counsellors as well as whatever else we are members of, so that is just part of our promotion. But sometime people come to me from other referrals … and they have no idea that I am a Christian counsellor and I usually ask them at some point if they are particularly looking for a Christian counsellor … that is just part of the mutual getting to know one another process … I'd say many people come to me because I am involved in the Christian world. (Adam)

Although some participants spoke of working in an environment which supported their RS orientation, one participant advertised for Buddhist clients in his private practice, since in his agency work, he was tied to a particular brief, which did not particularly include RS. However, this did raise the question of whose needs were being served.

> I tried an experiment … cos I've just got a little private practice and I thought that wouldn't it be interesting … doing another separate add which advertises … me as a Buddhist therapist … for people who want to work with that. And I thought, they'd be interesting clients for me to work with because then it would feel … they're already interested in or practising Buddhism, so there's all that permission to go there, a shared understanding, having the two has been exciting for me so I thought OK, let's put it out there and see what happens and I got one client engaged through that … I liked it … it's been a big part of my life, both personal experience and just understanding the tradition, I've got quite a bit there, and it was nice feeling like great, I can draw on this. (Nigel)

The positions taken by particular therapeutic modalities concerning RS is also readily accessible to the public via various search engines, so that a client may specifically seek out a practitioner who works in a modality which overtly addresses RS. Ella reported:

> Somebody may have … specifically sought out a psychosynthesis psychotherapist because they want to explore something around the spiritual dimension that there'll be something missing in their lives and … they want to explore in the psychotherapeutic relationship what might be ways in which they can access that.

The data suggested that clients may be aware of a potential psychotherapist's RS perspective from what they find out about a clinician before they choose to engage in therapy, and what may be disclosed by a psychotherapist regarding their RS at some

stage in therapy. These conditions meant that it was possible for RS "matching" to be sought by participants and clients.

RS matching. Some participants spoke about seeking to, or being available to work with clients of a particular RS culture. At other times "matching" occurred without conscious intention. Adam worked predominantly with clients from a Christian culture who, he reported, frequently sought his services as a result of his advertising as working from a Christian perspective. Nigel's advertising as a Buddhist psychotherapist was designed to attract clients who were either Buddhists, or interested in Buddhism. He believed that this matching would give him licence to discuss Buddhism, something he felt constrained about doing in his agency work. Although some clients may choose to have a psychotherapist of similar faith and participants may invite this, a perfect match, even if considered desirable, may be hard to find, since RS is complex and its expression, idiosyncratic. However, some participants reported that having a psychotherapist who matched a client's RS cultural expression may be considered necessary by a client for their own sense of security. In such situations, it was important that a psychotherapist consider the implications of such matching. Tessa reflected:

> I think for some clients they wouldn't feel safe with someone that they perceive not to share their own worldview. But I think the counsellor needs to be very well trained … it's more about the counsellor than the client (laughing). The client ought to go to the person they feel safest with, so that they can actually get going, but the counsellor needs to be very mindful of the of what's being asked of them …It's what they [the client] can manage, particularly if they have quite a suspicious view of the world, that anybody who is not a Christian counsellor, is of the devil. There's a few people out there like that (laughing). You've just got too much interference sitting in the room before you get started …there's a few mountains to climb before, as the therapist, you start to be able to seen as an ordinary person without horns in your head.

Although Noeline agreed that religious matching may bring a degree of security for a client, she wondered how such security fitted with the purpose of psychotherapy.

> Well, it's [religious matching] a bit like a dead end street. You're not going to go any further are you? ... it's secure, there's no through traffic, you are not going to get knocked over. And, you know, there are some lovely cul-de-sacs. (pause) … I think people come at different stages of moral, ethical, intellectual development, … I think psychotherapy is a journey of discovery and expansion … I don't think

> psychotherapy is comfortable, but I think it's about learning to handle, it's about building the person, not about making safe the environment.

Whilst Tabitha commented that religious matching could be "quite helpful", since a degree of familiarity with the client's religion could be useful, she raised the difficulty of variation within religious traditions.

> Sometimes I've supervised people and I think there are in the therapist … assumptions about religion that they are bringing to the work before it even starts and areas where there's not an easy familiarity that there might be say if a Catholic was coming to a Catholic. So I can see that that might be very helpful, but within any religious system there is also quite a degree of variation and I might find it harder to work with an extremely conservative Catholic who is going to be in a very different position from me but close enough that it might get up my nose, than I might find to be working with someone with a very different belief system and I think people will make that choice.

Initiating. Who initiated the conversation regarding RS, and why, was salient in deciding what belonged. Some participants directly raised RS matters with clients while others waited for clients to raise the issue themselves. Asking was a "no-brainer" for some participants who held the perspective that RS is "a fundamental strand in a human being", and "a central question", and, therefore, must be considered in psychotherapy. Adam, who worked predominantly with Christian clients, "might drop in … a question like, "So how do you relate those events to God?" if the client took their faith "very seriously". If that were the case, he would suggest that they put "God at the centre of [the therapeutic work]".

Some participants spoke about the importance of RS resourcing to support a client's therapeutic process. Isla found it hard to believe that psychotherapists would not initiate a conversation around RS since, from her perspective, this information was "useful for you to be thinking about what is going to resource this person when they are not in the therapy room". Some spoke about the valuable material concerning a client's functioning which was gained when asking about RS. Ethan commented, "My experience is that when I ask that question [concerning RS] of a client, so often I will get information that I wasn't going to get any other way".

Chapter Five: Engaging

Participants who deemed RS to be of fundamental importance had formal and informal ways of gaining this information from clients early in the therapeutic process. Ethan commented that he has in his questions in his head and, early in the therapy, will "try and remember to say, 'Have you had any connection with religion or church life or spirituality in your upbringing?'" Nerida had quite a structured way of gleaning this information, saying:

> When I see a client I normally draw a diagram of their genogram within the first or second session. In the first session I at least ask "Where do you come in your family system?" … "What religion or religions was your family?" … I might follow that with a further question, "Do you follow any religious path yourself?"

Being mindful that certain information about their RS perspectives might be known by clients in advance of them coming to therapy, some participants asked clients what was already known about them, particularly regarding their RS affiliation, since they believed that this information would have a bearing on the therapeutic process. Tabitha shared her thoughts about this issue:

> Well, I wouldn't say that they come with a knowledge, they come with a piece of information about me and I would usually try to get that clear at the beginning; where the referral came from, why they chose to come to me as I would with all sorts of matters, but quite often people say "Well, I heard you were … and I thought that might be helpful" or "I heard you were … and that may be unhelpful". Sometimes people … want to come to somebody who is not actually in their religious community, so they've got a certain anonymity and therefore a certain freedom and I think it is always interesting to be able to think about these things. Some people come and they know that, I think unconsciously … that they need to move away from their religion and therefore they might choose to go to somebody right outside of it. Some people, I think unconsciously, want to have an argument with their religious parents and therefore they will choose to come to somebody … inside their religion … the agreed understandings can be very helpful, but can also be quite deceptive.

Other participants recognised that they did not necessarily ask about RS in assessment, not because they did not consider it to be important, but that their preferred style of practice was to follow a client's lead, rather than introduce material. Brandon reflected, "I'm not that systematic about my assessment. I believe more in letting the assessment develop and seeing what comes up for me in the countertransference and following

that". Milly, when asked about how RS conversations come into therapy, said "the patient initiates them". However, she added that how a psychotherapist listens determines what they hear. How participants listened, is discussed more under the sub-category exploring.

Also taken into account in whether RS matters were raised by participants was their own imaginings about what this would be like for the client. Simone said:

> I wouldn't dream … of initiating … I never have, I wouldn't. It would feel really inappropriate and unfair to the client to somehow have to burden them with a whole other bunch of stuff … I say I work conservatively as a psychotherapist, I hardly ever talk about alternative healings, but that the client brings it up, unless it's particularly relevant like massage.

While the participant reported, in the main, an approach she names conservative psychotherapy, this quote suggests that under some conditions there is a movement outside the conservative frame in the mention of massage as therapeutically beneficial.

Even though Luke would ask questions about a client's RS in response to client initiation, he was careful about how he couched the enquiry, based on his own history. He reported:

> I'd say things like, "What supports have you got?" "Have you got any church?", "Are there any groups that you belong to?" It would emerge. I'd be listening for it, but I probably wouldn't say, "Is there a spiritual element in your life?", or something like that. If they said they went to church, I would say, "Is spirituality was important to you then?" It would be a follow-up question. That's because, I think that's personal, because I think it would be OK now, but when I was younger if somebody asked me that question I would have found it alienating. I would have thought "Oh God, I'm in the presence of some spiritual flake, I'm getting out of here". So I've got a bit of an aversion to it still … My own neurotic aversion to churches, based on personal ancient history. So it's something I'm listening for, certainly something I would emphasise.

Tabitha, although listening for RS material, was mindful of the impact naming things might have on the client. She commented:

> I would listen for but not introduce actively, spiritual, religious concepts, but I would listen for if they're there but not necessarily name what I think I am hearing. I am quite cautious about that really. *So that would be a general thing*

> *that you would listen*? But not necessarily introduce, it's too easy to impose things on people. And people are very vulnerable in the therapeutic relationship.

Although some participants chose not to raise RS matters with a client ostensibly for therapeutic reasons, not raising such matters was a dilemma since it brought up the possibility that clients may then consider that such material did not belong in therapy. Nigel spoke about a collusive, "don't ask, don't tell" dynamic which could occur between therapist and client. He observed that clients responded to therapist cues about what belonged in therapy. Brandon reflected:

> I do think that spirituality and religion is a bit like that if you don't bring it up it may be that it's quite key but the person won't mention it because they'll have some idea that it isn't relevant … I try to walk quite a careful line between a sort of a more analytic view of seeing what develops and working with what develops and, from a Laing's point of view that every time you ask a question, you break the frame, although …I think it's necessary to break the frame at times.

In choosing whether or not to initiate conversation about RS, the context in which participants worked, had a bearing. In her group work focused on supporting clients with a particular need, Tessa said that she would raise RS matters "quite deliberately because the group members are facing an existential crisis". Nigel, reflecting on his work context, said:

> There's a sense of the work you do, the territory, you're supposed to be in … What am I doing sitting around talking about God when I'm supposed to be doing 4 sessions of relapse prevention work or motivational interviewing? … Often clients come in here and they have a pretty set idea that it's about the [focus of work] and to sort that out in fairly concrete ways.

Using rituals and symbols. The use of RS rituals and symbols by participants introduced RS into the therapeutic encounter overtly and covertly. A ritual is conceptualised as an established and prescribed pattern of observance, especially seen in religious traditions or in the procedures or actions of a group. A symbol is conceptualised as a thing which represented something. Sometimes rituals and symbols were utilised together. Participants engaged in RS rituals of karakia (ritual chant), prayer, room clearings and the sprinkling of water. Some of these rituals occurred in the

client's presence; at other times they were performed in the therapy room, without clients being present. Sometimes rituals were part of the culture of the work context. Simone, for example, engaged in karakia and prayer in English with her Māori clients in a work environment where this was expected. She commented that she began therapy with clients in this context by asking "if you'd like to start our meeting with a prayer and sometimes it wasn't in Māori and sometimes they'd ask me to close".

Ursula, in her work context which was advertised as having a Māori cultural perspective, used a number of rituals in her work, with and without the presence of clients. She reflected:

> We do karakia, we do blessings, we do clearings … the energy, the space is very important to us … the central part of my healing practice, so it is about clearing my room. *Can you say what you mean by that?* Doing karakia, using things like aura soma [energy shifting ritual using elixirs] between my clients, sprinkling water around, particularly if there has been a hard session with someone, asking the tipuna [ancestors] to leave with that person.

Although some practices were carried out without the presence of clients, they were conducted in the interests of having a supportive space for client work. Ursula recounted the usefulness of this practice from one client's feedback:

> She [the client] said, "This is the first counsellor I've ever been to who has cleared their office" and I thought OK, right. "Can you tell me about that? What do you mean?" "Oh, come on love, you know". And I was like, "No, I really want to kind of engage with this". She was quite a character. "I really want you to tell me what you mean". She goes, "Well, when we arrived there weren't a whole lot of tipuna (ancestors) sitting on the couches. I mean, I've come with mine and so there is room for us".

In choosing whether or not to pray with a client, Adam was thoughtful about the meaning of that ritual to them. What he assessed as the therapeutic need influenced his decisions. He reflected:

> Some people really like you to begin or end usually end at least sessions in prayer and you know sometimes I might want to go along with that and sometimes I might want to resist that and see what happens ... there are Christians who have grown up in a fairly legalistic world and they want to get it right and so with a sense of fear they are walking a tightrope … so I might just go along with that a

> little bit to establish rapport…But I won't necessarily plan to pray every session so that the actual focus is less on the form and more on the substance of what actually happens between us.

Milly, who often supported grieving families following the death of a loved one, spoke about praying in response to one family's request. She had some understanding of the family's RS background and was able to use her own RS understandings as well as her psychotherapy education, to facilitate an intervention which was experienced as supportive. This request was not in the context of an ongoing therapeutic connection, where it could be appropriate to interrogate the meaning of the request. She recounted:

> I went in and was kind of with them in their distress and the brother-in-law said to me "Would you mind praying with us", so I said "Sure". So I started a prayer; I said a prayer of my own creation and then I invited them to say their own prayer. I knew they were practicing Catholics; they didn't know anything about my faith background. And so I invited each of them in turn to pray for the person who had died and that was such a calming experience, but I would never had done that only that they asked and that's where I feel my theology background and my psychotherapy background work really well together in that I can be in both those worlds quite comfortably at this point.

Chloe used to pray with clients at times in therapy in the past, but said she "hadn't actually prayed in the session, for years". Formerly her practice context had a culture of therapists praying with clients. Although she remained in the practice, the culture had changed. She said that when clients raise it now, she says:

> "Well it is up to you", and then it sort of dribbles away … So unconsciously what is happening there, maybe the client feels reassured that it is OK, [they don't need to pray] maybe the client thinks "Oh, that's not appropriate here".

Sometimes symbols were introduced into the therapy room by participants for their own resourcing and/or as part of the tradition of their modality. The placing of symbols in the therapy room, or wearing of symbols, represented something for participants. Some participants, especially psychosynthesis practitioners, often had a candle burning during the therapeutic process. This symbol, together with the ritual of lighting it and blowing it out, served a number of purposes both for participants and also the therapeutic work. Isla reflected:

> The candle is something that I just love because for me it's just a tangible way that I mark the understanding that we live in a multi-dimensional universe. So, *Can you say a bit more about that?* I just like it, at a gut level, there is something for me meaningful [about] that. So I light the candle when I start my practice and I blow it out. It helps me contain, honour [and] draw appropriate boundaries around my practice. It also marks that we enter into a sacred container; we are in a sacred relationship.

Ella added:

> If I am working with clients I will have the candle because for me that's that is a way of aligning … it's sort of like a doorway, to hold what, in psychosynthesis terms, would be the transcendent alongside the immanent and where that sits. And when I am working with clients … I am sitting with their divinity as well as their pathology.

Psychosynthesis practitioners were encouraged to engage in an "aligning" ritual, one of which was the lighting and blowing out of a candle. Isla explained this:

> To have a very discreet gesture that is one that they can make at any time that helps bring them consciously into alignment with what they hold as most encompassing of purpose, meaning and value, however they language that, whether they language that as God, The Divine, spirit, universal life.

However, the use of symbols to represent RS in the therapy room was not the sole domain of psychosynthesis participants. Simone reflected on her covert introduction of her RS into her work space:

> I think my spirituality is something I don't talk about in my work with clients. I bought one of those … Himalayan salt lamps … they're pink when they are lit … and when you look at it it's sort of a soft glow … When I come into my room and I put that on, that for me is a container of some sort for my spirituality … I've got all this awesome jewellery that has a lot of meaning for me … in terms of shamanic, or magic … when I put it on and I don't think about it again, but that makes me feel really good I feel quite grounded and being there with clients and wearing something that's not really super special but if I'm feeling a bit fragile, I might choose something that feels kind of healing or grounding for myself.

Ethan commented that he considered psychotherapists' use of rituals and symbols a "secular … attempt to bring the spiritual into the room … as if people have been looking for something to express their spirituality". Certainly the use of rituals and

symbols served this purpose, according to participants, but their use by participants was reported to also facilitate clients' process beyond just having a psychotherapist who was spiritually resourced.

RS was introduced into the therapeutic process in a number of ways, by advertising; initiating, and the use of rituals and symbols. Overt and covert strategies were employed with the intention of resourcing both participants, as well as the therapeutic relationship. Whether the issue was raised by participants themselves, or in response to client cues, many participants held that RS was important to bring into the therapeutic process. However, context, education and modality both constrained and enabled this introduction. Participants' own thoughts about what raising the matter might mean for clients, sometimes based on their own discomfort, but also therapeutic judgment around client need, influenced introducing. In introducing RS matters, both participant leading and responsiveness to client cues, suggested that it was participants who decided what belonged.

Differentiating. In addition to ***introducing,*** participants also engaged in ***differentiating*** as they sorted out "what was what" when attending to clients' RS matters. Differentiating was conceptualised as finding the difference between two things. This delineation was difficult at times since the "edges" between what was considered psychotic and what might be an idiosyncratic expression of a person's RS, one aspect of differentiating, were not easy to determine. Some participants had theoretically justified ways of making this distinction; others drew on their own experiences and knowledge.

A number of participants spoke about RS beliefs which could inhibit a person's life, as opposed to those which were deemed to enhance living. Again, there were varying ideas about where to draw the line. For participants who held that psychotherapy should concern itself solely with the psychological, there was also the need to separate that from RS concerns. Even then contextual issues and the complexity of RS meant that this was no simple feat. Participants differentiated between the ***psychological and RS,*** between ***life-enhancing and life-inhibiting RS,*** and between ***psychosis and RS.*** These strategies are explained in turn.

Psychological and RS. How participants saw the task of psychotherapy, an aspect of their perspective, caused some participants to draw a clear demarcation between

attending to psychological issues which included what use a client made of their RS internally, rather than its external practice. Xavier, for example, acknowledged that, while clients might feel a spiritual presence in therapy, he saw his role as "trying to open something in the human mind". Tabitha echoed this, saying, "I think psychotherapy is specifically thinking about the way the mind works in very specific ways [it is concerned with] the inner world and with the relational world, whereas religion will perhaps work more with the system of belief".

Ted spoke about trying to differentiate between ideas which were religious and those which were the result of obsessional thinking, cloaked in religion. He reflected:

> I think that the most common thing that comes to my mind is an obsessional presentation that presents as being religious. So somebody comes along with very fixed quite obsessional ideas about the way they are and the way the world is or the way the world should be and the way they should be and the way that they use those ideas to persecute themselves into trying to be like that and therefore end up being thoroughly miserable and often suicidal or unable to take part in anything else in a state which has just taken over their lives which become unmanageable, so I have seen a fair amount of that, and then trying to separate that–what is an obsessional mind state rather than a real religious idea and that's quite fraught, that you need to be careful. It is easy for the therapy to be abandoned quite early on if people think you are criticising their religious ideas rather than actually trying to connect this is a religious idea, now these are obsessional ideas.

Life-enhancing and life-inhibiting RS. Many participants spoke about deciding whether a client's RS view was helpful or unhelpful, positive or negative and perhaps more descriptively, life-enhancing or life-inhibiting. The question of what constituted mental wellbeing was considered in participants' decision-making. Esther commented that RS could be used "negatively, because of adverse histories, or … as a potential for resilience and their [the client's] health". Tessa spoke about deciding whether a client's RS thinking was "life-giving" was a "benchmark". Considering this she would ask herself the question, "Is this enhancing who they are in the world or is this a restrictive and difficult thing that is shaping them in a particular way that is denying them?" Nerida added, "I listen to them [clients] talking where it seems to me that religious beliefs are unhealthy, abusive, self-destructive". How participants proceeded when they decided that a client's expression of RS was life-inhibiting is discussed in Chapter seven.

Chapter Five: Engaging

When differentiating between beliefs which were life-inhibiting or those which were life-enhancing, participants considered the adaptability of a client's RS beliefs in the face of a life crisis. Participants reported that clients often presented in therapy when the disparity between difficult life events and their beliefs, created conflict. Adam spoke of the difficulties encountered when working with some Christian clients who might hold the view "that God's job is supposed to be making life comfortable for me", and God doesn't do that very well for most of us, there are some very large gaps (laughing) that we have to deal with, so that creates crisis". Nerida commented:

> The one that really bothers me is when they [the client] have a very punitive understanding of God pursuing them for their sins like this guy or a very simplistic understanding that if you are a good boy or a good girl then God will look after you and nothing bad will happen, then something bad has happened and their faith has collapsed …when they have suffered major grief for example, "how could God let this happen to me?"

The misuse that could be made of specific RS traditions, in terms of avoiding the realities of life was mentioned by some participants.

> There's a shadow to transpersonal psychology too, because some spiritual people are doing spiritual bypass, or are not relational. *So what's spiritual bypass?* It's an idea that you do spiritual practice to get out of living your life, basically, because you can go into these fabulous altered states … and act very arrogant and holier than thou because you can do these altered states. ... So, there's an idea of spiritual narcissism in Transpersonal, that some people actually use it just to feed their egos but do not use it for transformational purposes. (Anastasia)

> I am just thinking that the few Buddhists that I have seen who have got into difficulty; it appears that their way of appropriating Buddhism in a particular way, of not feeling things. So it's similar in a way, putting meditation or meditative practice in order to not feel difficult thoughts just to let things pass through or any other kind of mantra that may be about not allowing difficulty to accrue yeah, in that way it feels similar to what people do particularly with Catholicism but it is a very different presentation. It feels like a very different presentation. It doesn't feel as obsessional. It feels more like a denial. Sort of less about right, it feels less persecutory and more denial based. (Ted)

Psychosis and RS. The relationship between psychosis and RS was also mentioned by participants. Brandon, reflecting with a supervisee about their client's

experience, asked the question, "Was it a psychotic experience or a spiritual experience?" Tabitha commented that she had, "one ear out to see whether this [a client's RS issue] is defensive or delusional". Some participants noted that the delusional might masquerade as RS ideas and it was important to differentiate "what was what". In their deliberations, participants considered the degree to which a client was in touch with reality and the potential purpose of their experiences. It seemed evident that this was familiar territory for some participants who were experienced to consider different possibilities and support clients in processing these issues themselves. Others, however, were not as well equipped and labelling something as psychotic or delusional was a strategy used when encountering this challenge. This is discussed in Chapter seven.

> You need to understand different spiritual traditions and windows of meaning making … that help you have a discussion, that helps you clarify, "Is someone going off into a psychotic state?" or "Is somebody going into an altered state of consciousness that is in the service of life enhancing meaning making?" (Isla)

> Anybody can touch the collective unconscious. I mean you can do it in psychosis, you can do it in dreams, but so what, unless you are guided by a meaningful way in the world to serve, and so the basic difference between someone who is psychotic or mystic, is the mystic is humbled and uses it for service whereas the psychotic identifies with it and gets overwhelmed and can't actually use it properly. (Anastasia)

> I have a client who I think is a little on the edge … I hesitate to use the word psychotic but there's a magical quality in some of the belief systems which she has and … she was talking about something … and I thought, that feels a bit loose, a bit disconnected from reality … I think some might say it is part of her spiritual life. (Brandon)

Participants' judgments concerning the nature of their client's experience had a lot of bearing on what they facilitated.

> I don't think he had a mental illness. … I mean if the psychiatrist got hold of him they might say [he had a mental illness] but he was having some sort of experience that belonged to another realm. (Harold)

> Somebody might bring … a belief that God is communicating, a person believing that God is communicating with him through the numbers and the names on the buses and who is acting in a very agitated way. It's delusional and the person needs to be treated within the mental health system, it's psychotic delusional and I'm very careful about that. (Tabitha)

The potential of diagnosing cultural expression as mental illness was also considered by some participants.

> [It] would be a really common for Māori, especially in the past. I mean all the Māori people with visions or talking about their ancestors would be diagnosed with paranoid schizophrenia and locked up real quick and probably still are, actually. (Simone)

The challenge of not knowing what participants were dealing with and how they negotiated this difficulty, is considered in Chapters Six and Seven, Encountering challenge, and Negotiating challenge.

Although not an easy task, participants differentiated between the psychological and RS, and also assessed whether a client's RS expression was life-enhancing or life-inhibiting, within the realms of "normal" RS experience, or psychotic. These decisions had a bearing on how participants worked with their clients. As well as differentiating, some participants worked to make connections between the RS and psychological domains of existence.

Linking. ***Linking*** explains the strategy of making connections between the psychological and RS. Sometimes this was seeing similar ideas in each domain, whilst using different language to express the ideas. Participants who made these connections were demonstrating their perspective that psychotherapy and RS are inextricably connected. Having experience in both psychotherapy and theological disciplines or RS traditions assisted participants to make these connections. Some participants also made connections between a client's relationship with God and their relationship with parents. Although these particular connections may have drawn attention to similarities, they may also have had a conflating effect, collapsing RS into the psychological. ***Linking*** was demonstrated when participants were ***finding parallels between psychotherapy and RS ideas*** and ***juxtaposing the psychological with RS***.

Chapter Five: Engaging

Finding parallels between psychotherapy and RS ideas. Linking was an important activity for some participants since it allowed them to practise psychotherapy in a way which was congruent with their RS perspective. Zara, speaking of linking her psychotherapy practice with another discipline, said, "It certainly helped me immensely". Nigel asserted that making these connections helped "integrates something for me". Adam commented:

> A Christian understanding of what salvation is all about, is reacquiring our ability to engage in relationships with God, self, others and the environment, in a way that's fully consistent with respect and recognising the reality of the other and making room for that properly, our values and as far as I can see, that fits in beautifully with say healthy object-relations therapy.

Being familiar with psychotherapy and RS traditions made it possible for participants to comment on the parallels between them. Tabitha spoke about the "many … parallels and connections" that she saw between spiritual notion[s] and psychotherapeutic notions[s]". Milly commented:

> I think all sorts of disciplines are saying the same thing just using different language, and this book [referring to a book she had mentioned] is talking about things in a psychotherapeutic way which I can also recognise out of my … religious background as the same ideas, the same concepts that would be expressed differently in a religious spiritual tradition than what they would be in a psychotherapeutic tradition but I can see that they are talking about the same thing.
>
> The course [course she attended from an RS tradition] is based on listening contemplatively, and the more I learned what it was to listen contemplatively, I decided that it was almost if not identical with listening as a psychotherapist in that broad way; listening for the images … the unspoken languages, the resonances, the energies, the sort of openness, without that memory or desire sort of thing, so you weren't imposing, so contemplatively listening … it certainly helped me immensely to find the crossovers between psychotherapy and [discipline, omitted to preserve confidentiality]. (Zara)

Some participants noted that their own experience of RS assisted them in being a psychotherapist, since similar qualities were important in each discipline. Both Tabitha and Nigel reflected on the value of his RS tradition linking with his psychotherapy work.

Chapter Five: Engaging

> A lot of the training I would have had in religion is very applicable to psychotherapy. You do what you can do and you value that, but you don't over value it, which would sit quite comfortably alongside Freud's notion that you come in with a neutrality, an evenly hovering attention, and you see what you see. You are not there to influence or change people. I think the training I had in self-discipline, in genuinely thinking for the good of the other, those kind of virtues are very helpful in the practice of this work because you do have to be quite strong in the work. And the spiritual notion that the human being is on a journey of growth throughout their entire life, sits well with this psychotherapeutic notion that people come into this work for a period to engage in a period of growth and that that will go on after psychotherapy finishes. There are many more parallels and connections that I would see. (Tabitha)

> In my daily practice of Buddhism and meditation … there's a continued sense of little pieces click into place here or there of how they can meet up for me. Things like experiencing on a retreat of getting viscerally how the freedom of free associating in a session and the challenge of that, is the same as the practice of non-discrimination and not getting hooked in discriminating consciousness which is a practice within mediation, a practice I do, and so getting on a not just intellectual level how it's the same thing, that can be pretty powerful and I guess it integrates something for me, in that that I don't need to be explicitly addressing spirituality or religion in the room sometimes, sometimes it's just something about the quality of attention or awareness, I think to me, can be spiritual without having to have a particular label or belief system attached. (Nigel)

Noticing links between psychotherapy and RS in terms of outcomes was also mentioned. Adam commented that the Christian goal of reconciliation was served by a psychotherapeutic process which "helps people reflect on what is true". Whilst Tabitha reflected that both disciplines may share similar values in terms of outcome, she noted the specific skills of psychotherapy in achieving these outcomes:

> I think it's about what we are trying to do and I think we do work in psychotherapy in very specific ways; that's our skill, that's our gift that we can work with people around the human mind, which includes the human body. Some of the things that we might arrive at might be rather similar. A person who goes through a psychotherapeutic experience may arrive at a more complex way of being able to accept life; a greater self-acceptance, ability to tolerate paradox, ability to accept others without judgment. All of those would be psychotherapeutic values and also religious values. So in that area there's a lot of overlap but in the specific techniques of doing the work I think psychotherapy has specific areas.

Although some participants spoke of experiences which they felt could not be explained solely by the meaning-making psychotherapeutic theories afforded, they might, as a general practice, keep the psychological and RS separate in their work. This

demonstrated the perspective of psychotherapy meeting RS episodically. Harold recounted a dream which had a profound effect on him.

> So I really love the psychotherapeutic literature and I love philosophy and I love theology and so I love reading them as separate lines but occasionally I have experiences that want them together. See that dream I had. It's like goodness, "Where does that come from?"… Does it just come from … a sense my Freudian unconscious or does it come from some archetypal … In a strange way it feels like because the name that was there "The Lion of God" , it feels like God came and put his arm around me in a human form, it's a strange phenomenon and how do you understand that. I mean I can only understand that through the lens of my personal experience and my own meaning systems.

Juxtaposing the psychological with RS. Putting the psychological alongside RS when working with clients was another aspect of linking discussed by participants. The relationship between psychological development and spiritual maturity was noted by some participants who suggested that a developmental level in one domain is usually reflected by a similar level of development in the other. However, Tabitha commented that, although this was the most usual pattern, there were times when a person could exhibit RS maturity that was not reflected in their psychological development. Considering the juxtaposing of the psychological with RS meant that addressing RS matters could improve psychological functioning and vice versa. Zara, who was skilled in integrating a spiritual discipline into her psychotherapy work, commented on the importance of considering which lens would work more effectively for the client, saying, "There are different ways of achieving the same end". Some participants reported that when clients resolved psychological difficulties these changes were mirrored in changes in their RS functioning.

> If we look at stages of spiritual growth or the stages of personal growth … if you think of descriptions of spiritual maturity, they are not dissimilar from descriptions of psychological maturity … a person may be very spiritually immature, religiously immature, very immature religious beliefs that are at the level of the 11 year old or whatever or the adolescent … if a person talks about their belief, I will be thoughtful about what level of maturity it might reflect … where a person … hasn't made certain psychological developments, it's very hard to make similar developments in the spiritual world and a person may and we actually see this sometimes, as a person makes psychological growth their idea of God may change or their idea of what the meaning of life is may change ... I think they may go along side by side … growth in one is matched by the growth in the other. (Tabitha)

Chapter Five: Engaging

A corollary of juxtaposing psychological development with RS maturity was participants making connections between a client's family history and their relationship with God. Ada commented that she would possibly make this link with a client, suggesting, "It sounds to me as if maybe how you think about God as if He is a bit like your father would have been. What do you think?" Nerida, reflecting on her client's religious difficulties says, "His own father was an absolute tyrant so God very readily slips into being an absolute tyrant". Noeline made observations between a client's relationship with their parents and God, in order to raise their awareness about these parallels:

> I'd be primarily trying to work with the parental part of that but also reflecting "so … it was very difficult for you to get your father, your parents to take notice of you, to take your view point into consideration. I know this is alive with you and the church. I wouldn't make it more explicit but I would draw the parallel … I notice how angry you are about what is happening at the church. Is this how it was for you with your father?

Participants specifically mentioned the psychological and RS growing together as they noted shifts in both domains in their client work.

> You see people becoming more religiously tolerant and people coming to see you know that perhaps God isn't really this nasty punishing grandfather that I grew up with but actually someone who can love me … so it all kind of can grow along together. (Tabitha)

> Like for instance she used to have quite a high expectation of herself, too high, a little bit perfectionistic of what she thought she needed to measure up to in God's eyes, but that's shifted hugely, hugely, so her self-acceptance … She has grown immensely and of God, as understanding and not judging. (Zara)

Some participants spoke about working in an integrative way with the psychological and RS. Ethan likened his way of working to a tukutuku panel [distinctive Māori weaving] "Spirituality is not followed through as a separate thing; it would always be tied into all the other factors that are there". Milly reflected, "At some level, it's all spiritual work really. In my own life and in the lives of the people I work with I don't make a distinction, I don't separate it out".

Chapter Five: Engaging

Engaging in linking occurred when participants had some understanding and experience of RS traditions and theology as well as psychotherapeutic thought. Making connections between these domains was reported as enabling participants to integrate something within them which increased their therapeutic confidence. Juxtaposing clients psychological and RS functioning meant that integrative interventions could promote concomitant growth. However, the danger of equating these domains could lead to the conflation of RS into the psychological. It was a challenge to hold both.

Exploring. In addition to ***introducing***, ***differentiating*** and ***linking***, participants also explored clients' RS material. ***Exploring*** consisted of investigating the meaning of client's RS adherence and expression, exploring beliefs and looking for aspects of RS which could resource a client's therapeutic journey. It took time to understand the function of RS in a client's life and required listening in a way which elicited RS matters as well as supporting clients to find words to describe their experience. These strategies were named as ***examining the meaning of RS beliefs, taking time, considering therapeutic purpose***, ***fostering client reflection, listening with an ear for RS, eliciting clients' RS resourcing*** and ***finding words.***

Examining the meaning of RS beliefs. Rather than taking clients' RS beliefs at face value, many participants spoke about examining the meaning underneath these beliefs to understand their function, or as Brandon put it, "trying to understand how it works in your life". Tabitha and Ted commented that clients could sometimes use RS beliefs to protect them from something they wanted, often unknowingly, to avoid. Tabitha spoke about the questions she asked herself, when with the client, to assess the function of the client's beliefs:

> Sometimes religion can be used defensively. A person will not want to look at themselves or will want to protect certain ways of being and may use religion to do that and so I'm thoughtful about that. … "What's the context?" "What's the person's life as I understand it?" What's going on at the moment?" "Is there a sense that we are going deeper and going forward or a sense that we are striking a brick wall and the person is going sideways and there is something they are not wanting to talk about?" and we get to a certain point in the therapy and all of a sudden they start talking about religious matters and I think, "How did that happen?" "Why did that come up at this time?" And I am thinking of a specific person who would do that quite a lot and that would be particularly when this person felt experiences of shame.

Chapter Five: Engaging

With the examining of meaning was the encouragement to clients, posed by some participants, to think about RS "givens" and what lies beneath them. Ted reflected:

> The most common thing I remember is people say things like "God wants me to do this" or "God expects me to behave like this". "It's selfish to behave otherwise", and to start to get people to think about how much that controls other feeling states. To get to the feelings underneath that that are in conflict but don't really get to come out much because you slap it with that "God makes … etc., etc".

Some participants commented that it was not their place to judge the content of a client's beliefs, but to consider meaning.

> I'm not there to say, "Do you think that's sensible?" or, "Do you think that is real or whatever", I'm there to think, "Why is this person doing this?" "What does it mean to them?" "What is inside them that they are seeking in this?" "Why is it that they are bringing this to me at this point?" (Tabitha)

Another way that participants examined meaning was to "unpack God" by asking clients to say what they meant when they used the word "God". Nerida stated, "It is really important what they think God is, or is like", saying, "I ask them what … they believe about God". Zara recalled her work with one client:

> The young woman for instance, she used the word 'God' a lot and we had to unpack "What is this 'God'?" What sort of a God is that?" and "Where did she really get that from?" and "Did that really relate to her actual experience of life or was it imposed by dad?" Had she swallowed that whole?

Dreams were also considered by some participants as a way of examining RS meaning. Nerida commented that dreams, "often speak from a spiritual perspective. I think they are created from the spiritual perspective". She added:

> There are times when dreams actually present metaphors or insights or glimpses of reality … I find them a profound source of insight for people who are genuinely seeking where they are going in their life and often their dreams will tell them and once they begin to listen to their dreams they recognise hey there is some sort of wisdom going on inside there, I need to listen to it.

Although examining clients' RS beliefs was important to increase self-understanding, this examination needed to be attended to carefully, since, as Ted noted:

> It is easy for the therapy to be abandoned quite early on if people think you are criticising their religious ideas rather than actually trying to connect: this is a religious idea, now these are obsessional ideas.

Taking time. The process of exploring clients' RS involves complexity and participants spoke about taking time to understand the meaning of a client's RS. Taking time meant not coming to premature conclusions and carefully weighing up the information gained from the client about their RS.

> So I have no idea what it means if someone tells me they are religious. I often feel that I have to spend many hours with them before I know anything about what that means about them at all. And I have met a few atheists who tell me that they have no truck with it at all and it's not true … I find it very difficult to really get to know what people are actually doing with their minds, whether or not … they are drawing on something else and making use of it or not. (Ted)

In addition to this, having an understanding of the protective nature of some beliefs helped participants explore carefully. When Lucille believed that her client's RS perspective was restrictive, it was important that she stay with "where the client was at". She commented, "[I] just gently have to wait until her capacity was such that she could see beyond … I had to learn just to wait".

Considering therapeutic purpose. Some participants explored client's RS material holding in mind their perceived purpose of psychotherapy. This means that participants were taking into account their own understanding of what constituted "a good life", or "good mental health", in their exploration of a client's RS perspective. In this regard, client goals were not mentioned. These psychotherapeutic goals varied according to the participant's theoretical persuasion.

> I am thinking of someone …who … sees himself trying to be in the light. I find it very difficult when people talk about being in the light … where people, through their religious/spiritual beliefs feel they are on the path of the light and they demand that that is their right and that is what they are all they are all about, they project all their dark, they, somebody else has to be dark, somebody else has to be bad. If I'm going to be all good then you've got to be all bad … and of course my understanding of psychotherapy is that everything [is] both good and bad and light and dark and that the whole freedom through psychotherapy is about acknowledging, integrating one's shadow… it's a defence against what is too difficult to. *And when you are aware of that, when you are working with someone,*

> *how do you work with that? …* Well it depends very much on the person. I mean when this addict tried to draw me into his … "I can feel that you are part of the light too", then I might say "And I can be part of the dark as well", so in that I might quite forthrightly state that I can be both, so refuse to be sucked in. (Noeline)

Fostering client reflection. Supporting client reflection is an aspect of exploring which was often raised by participants. Important in this was the provision of an open, supportive environment. Isla commented, "We create a lot of space for people to reflect on what has purpose, meaning and value for [them]". Chloe spoke about reflecting what the client was saying, which encouraged exploration. Tabitha added, "In my work I try to listen with care and respect and without judgment to whatever spiritual or religious things that people express", and continued:

> I do what a psychotherapist does and I stay with the conversation really. It's not about changing their experiences or making their experience something that it isn't , it's about trying to understand what it might be like for them to be in that place … It's about me helping you to explore your ideas and your opinions and your beliefs and how they work for you and how they don't work for you.

The importance of not imposing their own views on clients was noted by some. Milly said, "It's about 'being with' the patient in what they bring". Zara commented that she was "exceptionally rigorous around never imposing my views and my understandings [on clients]". This aim facilitated participants being self-aware around their own perspectives. This awareness enabled some participants to offer different ideas without imposing.

> So how do I hold my beliefs and ideas and be in relationship with that person's beliefs and ideas and be respectful and possibly broadening and widening also about different ideas and different possibilities … The way we can offer comfort, expansion and respect and honouring also. (Ursula)

Participants reflected that issues of meaning and existence often became the focus of therapeutic exploration, especially when clients were trying to make sense of a life crisis. Nerida noted that crises often ensued when a person's view of how things should

be, did not reflect reality, resulting in a collapse of faith as the client questioned, "How could God let this happen to me?"

> Existential issues come up a lot. "Who am I?" "What's it going to be like after death?" "What's it going to be like?" "I've kept all the rules; I've done all the right things; How come I've got cancer?" So a lot of existential work in this environment, so it is about exploring and helping people make sense of and to understand what they bring to the particular situation they find themselves in. (Milly)

Some participants suggested interest in RS such as exploring issues of meaning and existence was more salient at different life stages or circumstances; ageing and facing life-limiting illnesses, for example. However, Milly disagreed, saying:

> Some people are very open and aware of the spiritual dimension of life and be they in their 20s, 30s, 40s. Some people aren't aware at all that it's important. They don't give it any attention so I don't think you can generalise.

Listening with an ear for RS. How participants listened was an important consideration in what they heard. As Milly said, "The ears have a lot to do with it". Luke, speaking about RS matters when assessing, commented, "I'd be listening for it". Tessa reflected that "There might be something that comes out of the language that intimates to me that …it's sort of a framework that's in their life that they might not be fully conscious of". Those who held that RS was intrinsic to being would be more likely to listen with an ear for the spiritual. How participants listened then influenced their ongoing conversations.

> I think … my psychotherapeutic training … has given me an ability to listen in a particular way. … [the] thing I hear quite frequently is "I don't know what I have done to deserve this". Now to me that is a question about the spiritual realm … the person has the sense that someone somewhere out there is punishing them. And so … I will respond to that with something like, "It sounds like you feel as if you are being punished and I wonder who is doing the punishing?" And so, depending on the person, that can take us in all sorts of directions and because of the way I've been trained I think I hear that statement in a particular way that maybe someone with different training would hear differently. (Milly)

Milly also reflected on the importance of the therapist's awareness around their own RS

in influencing the listening.

Eliciting clients' RS resourcing. Acknowledging the resourcing clients found in their RS connections was an important aspect of therapeutic work for many participants. Understanding that some clients found their RS beliefs and rituals soothing and comforting was noted. This included acknowledging resources which might shore up a fragile sense of self. Noeline spoke about being careful to support a client's involvement with Islam, commenting that it was her "life raft" and supported her functioning at this stage in her life. Speaking of another client's use of their RS, Noeline reflected:

> In terms of his own ideas … I didn't challenge because I thought this actually could be a bit of a parachute that helps to keep him out of the addiction. "Support the defences" is the jargon, and certainly where somebody has a long way to fall, there's that image of the parachute. Where they have a long way to fall you don't puncture their parachute. My way is to help him to touch in to it, to be able to be with that sadness himself so that eventually he might take off the parachute.

Eliciting RS resources to support clients through crises was a strategy engaged in by some participants. Ursula noted that "faith and hope", central aspects of RS, were part of a client's healing. Tessa commented that she would encourage clients to, "really think about what their spiritual beliefs are, and what's going to hold [them] through this [crisis]". Milly said that "One question I often ask people is, 'What gets you up in the morning when life is so tough?' and that generally takes you into the spiritual domain". For Simone, however, who held the perspective that psychotherapy touched on RS episodically, enquiring about RS resourcing was a last resort:

> I guess where it might come up in my practice … it's like a resource, so if someone's a mess … and I want to find some self-soothing things that they're doing, "Do you breathe, do you play music?" What can you do when you're getting really distressed and panicking?" Have a hot shower?", "Oohh do you go to church?" I don't usually ask that but if there's nothing going on for the person.

Eliciting resources also included drawing attention to presences, which were felt in the room by the therapist, so that they could be utilised by a client. Simone recounted an incident with one client, which followed a mindfulness exercise:

> I've noticed an enormous sort of peace: I've noticed energetically an enormous peace comes over her and I ask her about that and she says "I feel that there is someone watching over me", so we work with that. "What could that be?" "What might that be?" "Would you like to work with that a little more to discover a little bit more about how that could be a resource for you?" So we will gently work with that so with her it's like a mother.

Simone also spoke of naming her impressions of presence with a client, with the aim of resourcing:

> I get a sense that there are other people in the room with you or that you might have maybe someone who really loves you seems to be quite close to you … often it's more like accessing resources for people, so they can talk about their tipuna, their ancestors, their history, their aunt or their uncle. It's become something I quite easily do now. I don't make a big thing out of it usually it's something that's come up once or twice rather than an ongoing kind of thing but it's a positive resource for that client.

Finding words. Another aspect of exploring was helping clients find words to express their RS beliefs and experiences. Important in this endeavour, some participants noted, was using the clients' language, since people framed their experiences according to their RS traditions. Lucille reflected, "I frame it using their language. I don't impose mine, if that's not theirs, that's not theirs".

When clients were having difficulty finding words, finding words which resonated, supported their articulating experience. Nerida, reflecting on dreamwork, noted:

> I often have people say, "I don't know how to put it into words", and I try a few words and sometimes they resonate. … We have to find verbal language in order to communicate our dreams. We are beginning to interpret using the language we have. So depending what religion we've been brought up in, we will have different ways of naming that and yet I think that underlying there is common human experience in all of it.

Having the facility to join clients in their expression of RS was helped by some familiarity with RS traditions.

In exploring clients' RS issues, participants acknowledged that this was complex and took time to understand how someone used their RS. RS served both protective and

resourcing functions; however, even protective measures were seen as an attempt at resourcing. Participants noted that finding words to describe RS experience could be challenging for clients, and assisted these descriptions by offering their own understanding, whilst being careful to check resonances. Using clients' own words, wherever possible, was preferred, because of the risk of participants imposing their own knowledge. The usefulness of having some knowledge of RS traditions was experienced as helpful, however, as this increased participants' confidence in being able to support clients' RS expression.

Teaching. Another strategy participants used to engaging with RS in the therapeutic process, was that of ***teaching***. Some participants who believed that RS was an essential aspect of humanity educated their clients in this regard; some others who held to particular RS traditions sometimes taught their clients about these traditions and some taught mindfulness and meditation skills. Although teaching could also be considered under "introducing", since by utilising this strategy participants brought RS into the therapeutic process, it has been given a sub-category of its own since it comprises a number of indicators. Strategies used in the ***teaching*** sub-category were teaching: ***the importance of RS in human functioning***; teaching ***mindfulness and meditation skills*** and teaching ***RS traditions and precepts***.

The importance of RS in human functioning. Some participants who held that RS was intrinsic to being human would talk about this with their clients so that they could appreciate the need to attend to all aspects of their being. Some used particular models for this, such as one Māori model of health, Te Whare Tapa Whā. For one participant this was a strategy utilised to discuss RS with non-Māori clients in the absence of any other tools. When assessing a client's functioning, Noeline commented that psychotherapists have a "responsibility" to educate clients about all domains of their existence.

> At some point I will use a model which is simply a circle divided into quarters. And it's body, mind, heart, soul. And I would use this model, talking about a healthy life being where you tend to your body's needs, where you tend to your mind … where you tend to your social and emotional needs and where you tend to your need to be in touch with something which goes beyond all that.

Likewise Ursula introduced the relationship between different aspects of human functioning with her Māori clients.

> Often those spiritual discussions in psychotherapy are really left field. "So what does spirituality or wairua have to do with my alcoholism or my depression or with grief and loss?" … "Why are we talking about spirituality?" But I guess I see it again as that central aspect.

Mindfulness and meditation skills. A number of participants mentioned teaching mindfulness and mediation techniques to clients in private practice and in public sector settings. Some mentioned that it was quite easy to move from what they named as secular mindfulness to incorporating an RS aspect. Some participants considered that RS was part of mindfulness but separated from its practice to it by some practitioners. Tabitha reflected:

> Theories of ... mindfulness … for … a number of psychotherapists connects into … Buddhist meditation practices. … There can be a secular mindfulness and there can be a religious mindfulness and there … can be an openness between those. Perhaps that's given some psychotherapists permission to think in a more spiritual way. *I am wondering what you see as the, you talk about the secular mindfulness and the spiritual?* Well there are people who … would approach it as a religious practice and other people who would learn it as a mental health practice. So you can come into it from either way. And either one they might influence each other … I mean people can learn mindfulness … in the mental health system as quite a secular thing but it can quite easily also open into a religious kind of mindfulness.

Nigel, who identified as Buddhist had this to say:

> With some clients I work with mindfulness and awareness. I'm not using spiritual or religious language, but certainly that's influenced by my background within Buddhism, so I bring that in and that feels fine.

RS traditions and precepts. Teaching clients aspects of RS traditions was both an overt and embedded strategy engaged in by some participants. Client interest was noted as leading Nigel to teach various precepts of his Buddhist tradition to a client to whom he had been teaching mindfulness and meditation practices. Because of her interest in exploring "what [Buddhism was] as a spirituality …. [he] didn't feel like [he] was overstepping a boundary". Adam, who worked with Christian clients, often engaged in

discussing RS precepts with his clients, both overtly and covertly. An example of covert teaching was including his theological perspective in praying with a client:

> In the content of my praying I will always pray about the broader issues that help give security you know, address God as our loving Heavenly Father who has reached out to us in Christ who accepts us fully and completely and who invites us to come to Him with an open heart. I will pray about things like that in their presence, and then move to some of their specific concerns and perhaps current distress.

Teaching was a strategy engaged in by some participants when they responded to clients' interest in an RS area with which they were familiar. Some also considered that it was their role to educate clients about what they understood it meant to be human. The teaching of mindfulness and meditation, depending on the RS perspective of the participant and interest of the client, could cross over into the teaching of RS traditions.

Experiencing. ***Experiencing*** is a sub-category which denotes actual RS experiences which occurred during the therapeutic encounter. These experiences consisted of having a sense of connection with a client which was described as spiritual, visions experienced by participants in relation to a client as well as spiritual happenings which overwhelmed the therapeutic encounter. Some participants observed that spiritual experiences occurred more often with Māori clients who were connected to their culture. Harold commented, "This other realm, other world for enculturated Māori people, it is a reality". Experiencing was expressed in ***sharing sacred connection*** and ***spiritual occurrences.***

Sharing sacred connection. Participants spoke about moments in the therapeutic encounter where something expansive happened between themselves and their clients. These moments were described as "sacred", "profound", "a bit ephemeral", "more than" and "hard to put into words". Many participants, trying to describe these experiences, also commented about what they thought was happening. Nerida reflected that she had "the experience of a kind of a stillness [and thought] "wow, breathe gently, something very precious is happening". Tessa said that, "there are times … when there is the sacred, and there is the capacity of more than the sum of the parts in the room … there is transcendence. I think there is a move out of something into something that is greater".

Although these connections appeared to "just happen", they were often facilitated by the nature of psychotherapy itself and preceded by therapeutic responses which facilitated a greater depth of connection. Lucille said "I think there is something … almost meditative, about … really being available and listening, that opens that… lovingness that I've talked about, that's a kind of, not an interpersonal thing, but a bigger … transpersonal". Harold recounted a profound moment with a client with whom he had been working for several years:

> She [the client] just looked at me one day and said, "You don't know me". And it was like a profound existential statement and I just found my narcissistic psychotherapeutic ego just (making exploding noise) disappear, and I just felt completely empty and it was like the ground opened up and I had nowhere to go. I didn't know her. She was right and all my presumptions and all my narcissistic therapeutic ego just collapsed … I let myself experience my emptying and I said to her, "You're right, I don't know you", and there was just this space opened up and there was a stillness that just emerged, then a connection just happened, and it was like we both knew each other profoundly. I would call it sort of a God moment, if you like, but it was a moment of … a deeper awareness of both self in a true sense, myself, and I presume she was having a similar sort of reaction and we both just smiled. I leaned over and shook her hand and said, "I'm very pleased to meet you", and she did the same. … There was something more than each of us … and in a sense held us both in some sort of stillness. It was like a deep loving knowing came into being. It didn't feel psychological.

The psychotherapy relationship itself was seen to be a spiritual connection and transformative by some participants, reflecting the perspective that RS and psychotherapy are inextricably connected. Milly commented that, since, from her perspective, "spirituality is … about connectedness … where two people can connect and be with each other in an open non-judgmental kind of way, that's spirituality. It's a spiritual encounter when you meet the other". Nigel said that he didn't "need to be explicitly addressing spirituality or religion in the room sometimes, sometimes it's just something about the quality of attention or awareness [which] … can be spiritual".

Spiritual occurrences. Some participants spoke of spiritual occurrences in the therapeutic encounter, which, although occurring in connection between therapist and client, had a sense of occurring out of the blue. However, these moments needed the facilitation of participants as they engaged with clients, to occur and be sustained. As Lucille commented, there is "something about that unique [therapeutic] relationship, in

a therapeutic environment that really lends itself to it". The co-creation of such moments was highlighted by Lucille who reflected on an encounter she had with one of her clients.

> All of a sudden … the room we were in became lighter and lighter and lighter like somebody's headlights were coming into the room, and I wasn't quite sure what was happening in the moment and he was sort of looking at me like, "what the hell is going on?" and we didn't speak, we just sort of sat there and his eyes started welling up with tears and he cried, and the room was incredibly light and there was this overwhelming sense of love in the room and we just didn't speak. We didn't speak for quite a long time and I knew not to say anything. This was his moment, something had happened. … I think we both summonsed that up. I don't think it was me at all. I think … there was some moment between the two of us that expanded.

Although speaking of an experience which was facilitated by the therapeutic relationship, Lucille noted that the client's "take on it was that it was God, and I just sort of nodded and I felt quite emotional too. It was extremely powerful". Participants' ability to "be with" whatever was happening in these occurrences had a facilitating effect. However participants constructed these experiences, even if they had any frameworks to make sense of them, they reported that they supported the client's meaning-making, rather than imposing their own theories, in order that nothing add or take away from the client's experience.

Validating a client's experience had the potential to enlarge and potentiate what was occurring. Harold commented that supporting and validating his client's process helped him "come into his own power". Serena reflected on interventions that she used to facilitate this process:

> If the client has a sensation that they can identify as a spiritual presence then I as a therapist would always, can invite and facilitate, staying with that experience, expanding it if appropriate, so I can encourage them to trust their perception and receive what might be being offered. … I think that, if they experimentally describe a little of their experience and then they'll wait to see if I am going to open our encounter to more of that, that's one way. So opening it would be by, how would you do that? By getting them to describe more of their experience or what it is they can hear or feel or see, tell me more, you know is it someone you know? Is it familiar?

The experience of RS in therapy was not always felt to be from positive forces. Harold recounted an experience with a client where "we were sort of in the presence of horror and evil". He reflected:

> It's not possible to make sense of that stuff psychologically … it undoes you, it leaves you breathless or it's something beyond understanding and so I think that's another sort of experience where in a way you have to reach for something bigger if you are to make meaning of it.

Participants' openness to RS experience within themselves was deemed to be important in facilitating RS experience for clients. Harold commented on what he felt supported RS experiences:

> Coming into the present moment, yes, brings the spirituality more to the fore. Coming into getting out of the stories in our heads brings spirituality more to the fore. Essentially spirituality needs the gaps between the thoughts to be able to enter and we create gaps between the thoughts, not through the psychotherapeutic techniques because they are word based, largely, but through holding space … to allow in certain energies and the therapist being open to their own spirituality, because that opens the space for the client's spirituality to come forth.

Whether consisting of a depth of relating between participants and their clients, or RS occurrences which seemed to just happen, participants' willingness to engage at this level, creating space and being open to RS occurrences, was essential; through these actions, they decided that these experiences belonged in the therapeutic process. However, these encounters were mentioned by only some participants, from which it could be inferred that only some were able to, or wanted to, create the necessary conditions for such occurrences.

Conclusion

Participants' perspectives on RS in psychotherapy influenced their decisions about what belonged in terms of engaging with a client's RS material in the therapeutic process. Although waiting for clients' to raise the matter, rather than initiate discussion regarding RS, was preferred by some, it was acknowledged that this may convey to clients that such issues were not the domain of psychotherapy. In their assessment of therapeutic objectives, participants considered whether clients' RS was conducive to mental wellbeing, or was contributing to their difficulties, although it did not appear that these

objectives were always communicated to clients. Making connections between the psychotherapy and RS domains, possible for those participants who had some understanding of RS disciplines, helped in their internal integration and therefore confidence in practice. Exploring RS matters was addressed using a variety of strategies aimed to increase clients' awareness of the use they made of their RS beliefs; resources were elicited and unhelpful beliefs examined. In addition to introducing, differentiating, linking and exploring, some participants taught their clients the importance of RS in human functioning; some even taught clients the precepts of specific RS traditions. Participants also engaged in RS experiencing in the therapeutic encounter, whether the therapeutic relationship itself was experienced as "sacred" or RS occurrences appeared to come into therapy unbidden, some participants reported that these encounters were enriching for themselves and also appeared to be so for clients. Engaging with clients' RS continued, using these strategies, until participants encountered challenges of some kind. This is the topic of the next chapter.

Chapter Six: Encountering Challenge

Introduction

In the previous chapter, the strategies participants used to engage with clients RS, in the therapeutic process, were outlined. This chapter explains the category **encountering challenge** in the theory of **deciding what belongs**. A challenge is conceptualised as an obstacle of some kind where something is questioned. Participants' comments such as "put me in a very odd position", "dangerous", "a minefield", "not wanting to engage", suggested that they were encountering something which they perceived as an obstacle. The concept conveyed by the word "encountering" is that of meeting something difficult to deal with, sometimes unexpectedly.

Encountering challenge

Encountering challenge occurred when participants met issues in the therapeutic encounter which were beyond what they considered their "brief" in terms of the psychotherapist's role; the expectations of the work context; what they had been taught in their education and chosen modality; and their knowledge. Some participants were also challenged when their RS views conflicted with those of their clients. These challenges are denoted respectively by the sub-categories: ***perceived outside scope***, ***the unknown,*** and ***conflicting worldviews***. **Encountering challenge** caused participants to act in a variety of ways as they negotiated the particular challenge with which they were faced. These sub-categories are explained in turn, with accompanying codes, and illustrated with verbatim excerpts.

One of the questions I asked myself during the data collection was, "Does every participant encounter challenges, and if so, how, when, and to what degree?" and "Do these challenges change over time?" As has already been noted in Chapter four, when participants met therapeutic territory, they did so from a variety of work contexts, bringing with them a range of life experiences, differing educational environments and theoretical orientations, as well as varying cultural backgrounds, including RS worldviews. These perspectives influenced how they "saw" the territory. As a result, participants were equipped with differing degrees of knowledge, perceived permission, and "fit" with the client's perspective. Figure 8 (p. 170) depicts all that is involved in the category named encountering challenge.

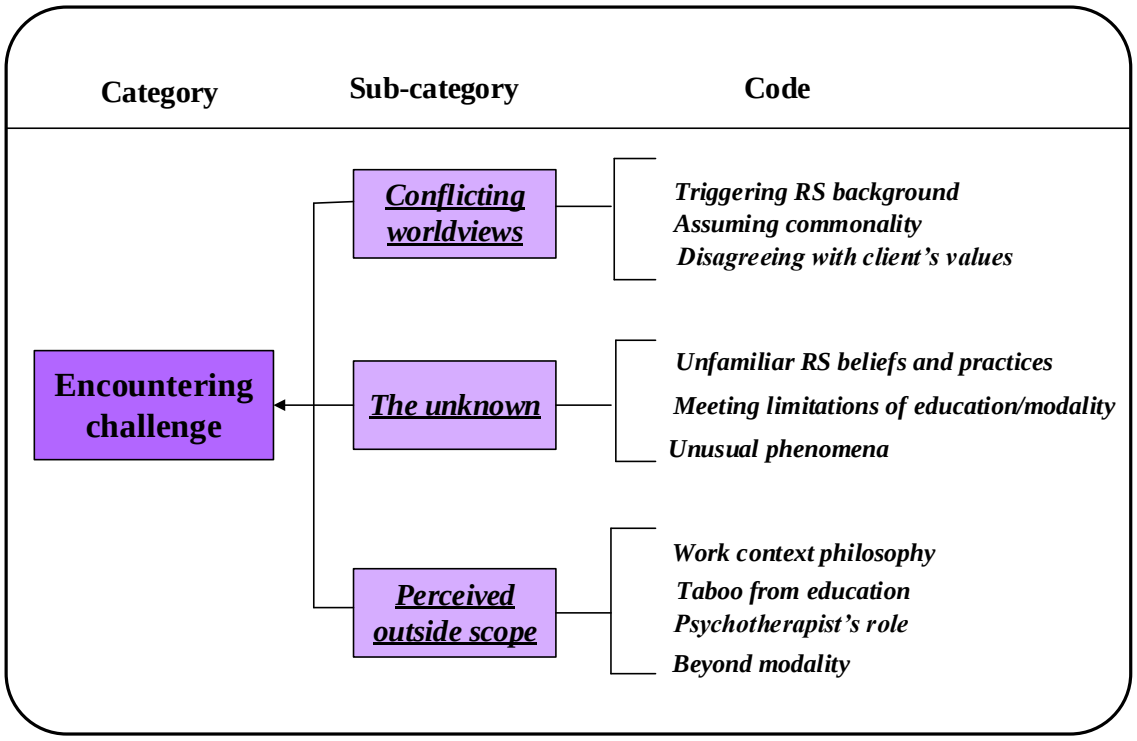


Figure 8: Encountering Challenge

Conflicting worldviews. When participants' RS perspectives did not match those of their clients, many participants indicated that was challenging. Words which indicated these challenges were "triggered", "scary", "difficult", and "a major problem", "that would get to me", "turned off", and "struggle". ***Conflicting worldviews*** were encountered when a client's RS material evoked difficult memories about the participant's own RS history; where perspectives were assumed to be held in common without clarification; and, when the values of the psychotherapist and client conflicted. These challenges are named as ***triggering RS background***, ***assuming commonality*** and ***disagreeing with client values***.

Triggering RS background. Conflicting worldviews were often encountered when RS material presented by the client triggered something from the participant's RS history and current orientation. Some participants found it difficult when they encountered clients who espoused RS positions that they had moved away from themselves. Milly commented that, from her observation, psychotherapists tended to

have "more receptivity to Buddhism than Christianity" because "a lot of people have had early experiences of a punitive judgmental, guilt-laden experience of religion, spirituality". Ethan, speaking about his reaction to the "highly evangelical person", said "it triggered all my value systems and all my stuff about the church generally". Luke spoke of his strong feelings in response to a client's RS perspective, being aware "of not wanting to engage with his spiritual world, of finding it distasteful, even disgusting". He linked his visceral response to childhood memories. Brandon also reflected, "Because of my history I had rejected spiritual religious belief systems". Then, when he was working with a client "with quite a heightened sense of spirituality", it became a "major problem for our therapy". He commented that "She began to get really angry with my disqualification of her spiritual system". As with Luke and Brandon, a number of participants made direct reference to their personal histories which led to participants' triggering when they and their client had conflicting worldviews. Chloe demonstrated the longevity of such beliefs even though one has intellectually moved away from them, saying:

> I've got a client who is a spiritualist and I have not invited her to explore that … and she has said a few things that I haven't picked up … it's an old conviction or teaching … that there's something scary or spiritually not ok about … Satanic practices and the spiritualism would go with that … I am a bit afraid … still.

The client Chloe referred to visited Anglican and Spiritualist churches alternately, and coming from an Anglican tradition herself, Chloe invited exploration of the client's material related to her Anglican affiliation, but not that relating to her Spiritualist affiliation. Nigel also noted a "preference" for one RS tradition over another in his engagement with clients. Even though he had been raised in a Christian tradition which wasn't "poisonous", he now held a Buddhist perspective. Although he was able to acknowledge the "strength and values" of a Christian tradition, at a "surface" level, this was different to the more in depth engagement he reported to have with clients from Eastern traditions.

As a Māori woman whose people have suffered spiritually because of colonisation, Venetia commented about the conflict she experienced when she encountered a Christian client.

> If somebody has a very strong belief in God and for myself I go, well, actually Christianity has really been both positive and very negative particularly for Māori women especially in terms of their relationship with their body our menstruation … a whole range of things and how do I work that through? How do I still be in context with a person that I have worked in depth with over a whole period of time and have all these underlying contextual difficulties with I guess.

Assuming commonality. Conflicting worldviews were also in evidence where commonality was assumed. This conflict was unexpected and difficult if the participant had firm beliefs about how a RS tradition should be expressed. Adam, a participant with a Christian belief system, spoke of working with a Christian man, active in his Christian community, who was engaged in activities which Adam considered did not "fit within Christian moral categories". On reflection, Adam commented that he:

> Sort of jumped to probably the false conclusion that because of his [the client's] association with some … Christian teachers … that he would have shared some of their views and of course in time that became clear that wasn't true and he actually reacted … I think because of some things I assumed … it would have probably helped had we spent more time exploring what his assumptions were about his Christianity.

The multiplicity of cultural make-up also contributed to assumptions of commonality. Difficulties occurred when one aspect of a client's culture, held in common with a participant, became the lens through which the participant saw the client, when another aspect of the client's culture was more salient for the client. Averil explained this:

> I have an idea about what being Māori is and think that all Māori should be more Māori because I think that that would be really helpful. So I don't force that on my clients meaning "you must do this", but I think it really influences my practice. And I speak in Māori. I use Māori terms which means that if you don't resonate with that I wonder if there would be a missing in that. *Is there any practice issue, or work with a client which comes to mind when you think about that?* There was one client … she was Māori, and her and I could not get on. She would speak in religious terms. She would quote … Bible passages and I had no idea what she was talking about so we ended up transferring her to another therapist there who was very Christian really … her and I … we just missed each other.

Disagreeing with client values. Conflicting worldviews were also encountered when participants disagreed with their client's values where there were issues of human rights and beliefs about what constituted a good life. Some participants found it difficult when they considered that their client's RS perspective was inhibiting their lives. Lucille felt "quite confronted" by her client's:

> fairly strict Catholic background as she could see that she [the client] … had lots of potential spiritually … that was my personal, professional observation, but she had confined herself within Catholicism, and I found that quite challenging because I didn't want to challenge her faith, but in a way it was hampering her.

Ada reflected:

> I welcome any person's religious beliefs, however, even there are limitations …but it becomes more difficult when the person believes in a God that I see as life-defying or strict, or where I have a sense that the client projects their own critical parent onto the god figure that they believe in … and so the difficulty arises at this place where the client says, "God wouldn't want me to", or "God wouldn't allow me to do that".

Noeline mentioned the difficulty of keeping what she called "positive regard", which she saw was an important psychotherapeutic value, when she differed markedly from her client in terms of values. She said:

> Somebody else I worked with actually, who was …in a fundamentalist Christian church, and I worked with for a few sessions in terms of couples work, and it was not a successful relationship … that would be one person that was really hard for me to keep positive regard for … I did my best but behind it was my suspicion about people with very black and white attitude and a bit of sexism … when a client brings attitudes and behaviours which are contrary to our own values, that can be quite difficult … in the end they left.

Participants found it challenging when their perspectives conflicted with those of their clients. At times they were unaware of their own internal conflicts related to RS until these surfaced in an interaction with a client; they were unable to monitor their responses. It was a trap to assume homogeneity of RS tradition, or indeed to assume that a client shared the participant's perspective regarding the salience of ethnicity over RS values. Participants were also challenged when their values were at irreconcilable odds

with those of their clients, making it difficult to work to support client goals. To recap: conflicting worldviews, a sub-category of encountering challenge, occurred when: there was a triggering of the participant's RS history; when there was an assumption of commonality between a participant's and their client's RS perspective; and when there was a disagreement with client values. Another sub-category of encountering challenge is when participants met RS material or presentation which they considered to be unknown.

The unknown. Encountering something in relation to RS beliefs and expression which was unknown to participants was experienced as challenging. At times, what was unknown defied knowing, as in ***unusual phenomena.*** At other times, participants were perplexed by RS beliefs and practices which were outside their experience, denoted as ***unfamiliar RS beliefs and practices***. Although encountering ***the unknown*** revealed a paucity of knowledge, this may have been contributed to by the bounds of participants' modalities which, when education was in only one modality, also comprised the limits of their education. This has been named as ***meeting limitations of education/modality***. These aspects of the unknown are explained respectively.

Unusual phenomena. Unusual phenomena are episodic, sometimes dramatic and unusual in nature. They do not easily fit the category of engaging with spirituality in psychotherapy. Nor do they fit easily within the sub-category of spiritual experiencing. Nevertheless, unusual phenomena do occur in the psychotherapeutic encounter usually 'in the moment' requiring, as reported here, careful response from the participant. Some participants spoke about occurrences which occurred with clients which were beyond their psychotherapeutic understanding, hard at times to put into words and leaving them at a loss as to what to do. Harold said, "There are experiences in the therapy room … like realities which you might label as spiritual or beyond the normal understandings and frame of psychotherapy there are some experiences that erupt into and sort of saturate the experience". He offered one such example from his own practice which has not been included since it could be identifying.

Participants who were not Māori spoke about unusual phenomena which occurred with Māori clients where they were at a loss to know what was happening. Simone reflected, "Both of us, us Pākehā therapists had had what one might call unusual experiences, or

things that happen in the room with a Māori person that we weren't quite sure what it was". Harold recalled:

> And I've had experiences with Māori clients where … I remember one kuia I worked with where the energies in the room–I saw her face changing in such a way … it felt like all her ancestors for about three or 400 years were manifesting in her face as she went back as she just went down because I do … therapy because of in terms of the Te Whare Tapa Whā model in terms of tinana (body) I find Māori, some Māori people as they access their body they are also accessing deep wairua deep history and with this kuia I mean this stuff was Whew! It was in the room. … I just felt this panoply of ancestors just came into the room … And I didn't know what was happening. She was just sitting there and going mmm mmm mmm mmm her face was changing … and then she said "Oh the people have said it's OK, those people up there have said it is OK" and she resolved what she came for. … So it was an amazing experience.

Nerida spoke of the unusual experiences she had had with other clients' dream material.

> There are also, within the framework of dreaming, a lot of examples of clairvoyance and pre-cognition, prophetic dreaming, spiritual visitations, near death experiences, all of those, they're all powerful, potentially mind boggling if you didn't know anything about them but I am used to them now.

Unfamiliar RS beliefs and practices. Meeting unfamiliar RS beliefs and practices was experienced as challenging. Some participants said that they struggled with the unfamiliarity of different religious traditions such as working with Moslem clients. Nerida, reflecting on difficulties she encountered with one client, said that she, "really struggled to understand where he was coming from, especially when he talked about demonic deliverance". Ella spoke about her struggle with a client's family's unfamiliar Hindu practices, saying that "This young Hindu client who … describes practices from her Hindu side, sort of exorcisms, which she describes as witchcraft, which her mother's side of the family perform … I sort of struggle with that". In her engagement with indigenous clients, Simone found that she lacked knowledge of Māori cultural beliefs. She reflected, "It's a really big thing when you have a client who says … I've got a mental illness because there's a curse on me … with the Māori clients … as a Pākehā. I knew there was a lot I didn't know".

Tabitha commented on her work with supervisees who made assumptions in their work with Catholic clients, assumptions of which she was aware, because of her own understanding of Catholicism. She reflected:

> Sometimes I've supervised people and I think … there are assumptions about religion that they are bringing to the work before it even starts and areas where there's not an easy familiarity that there might be say if a Catholic was coming to a Catholic.

Meeting limitations of education/modality. Meeting the limitations of their education and/ or modality was mentioned by a number of participants. They spoke about not knowing what to do in relation to a client's RS presentation or material suggesting that neither their education, nor their theoretical approach had prepared them sufficiently. Chloe, recounting an incident with a potential client when she was unsure whether or not aspects of her RS presentation were psychotic, said, "Thinking about it I feel a bit helpless and unskilled". Some mentioned the lack of particular psychotherapy education around RS matters, given that these issues came up with their clients. Ted commented on the number of religious clients who were coming to him for psychotherapy and that, "It still felt quite difficult to have anything like a full understanding or way of exploring those things with them and not having any religious training". Ethan reflected:

> In professional trainings there usually isn't any focus on religion and spirituality. So … you are not required to do papers, for example, in the world religions, which I think would be a huge start, and in New Zealand we could include Māori spirituality and religions in that.

The limitations of psychotherapy language, at least of some modalities, when it came to expressing spirituality, was mentioned by Zara, who reflected, "I … felt that somehow the language that I had for working with some of that was lacking. I'd learnt this psychotherapeutic language and way of thinking and somehow that wasn't quite enough". Others spoke about the limitations of their particular modality. Nigel stated that psychodynamic psychotherapy and spirituality always felt like a "tricky kind of split". Xavier also commented on the limitations of the psychoanalytic approach:

Chapter Six: Encountering Challenge

> I have felt like being a kind of smuggler between different domains, not staying only in the rigid psychoanalytical frame but bringing thoughts and ideas to my work from other disciplines I have learnt. … For example, ideas of spirituality.

What was unknown was also at times, "unknowable", given the nature of RS, which suggests that the unknown will always be a challenge in this arena. Unfamiliarity with RS expression was also an indication of a participant's own perspective, with all the contexts they comprised. In addition, the unknown also demonstrated a lack of understanding. As well as encountering the unknown, another aspect of challenge encountered by participants was when RS material was perceived to be beyond the bounds of permission.

Perceived outside scope. The concept of not having permission has been encapsulated in the sub-category ***perceived outside scope*****.** It is important to distinguish between use of the term "scope" as it is used by the Psychotherapists' Board of Aotearoa New Zealand (PBANZ) to define the parameters of psychotherapists' practice (PBANZ, 2013) and the use of the word in the context of this research. In this context, the scope and range of practice is specific to the particular participants, and denotes the activities that they have permitted themselves, according to the influence of the variety of contexts with which they have interacted and with which they continue to have interactions. Participants spoke about meeting something in the therapeutic encounter with which they believed that they did not have "permission" to engage. Simone used her hands to demonstrate the quotation marks around the word when using the word "permission". She named RS in psychotherapy a "minefield" and a "dodgy area". Venetia commented that it was a "dangerous area". There are four ways that participants encountered the challenge ***perceived outside scope***. These were when a client's need was thought to conflict with ***work context philosophy***; when a participant perceived that a client's need was outside the ***psychotherapist role****;* when participants recalled a ***taboo from education;*** and when client need was deemed to be outside the bounds of the participant's modality, that is, ***beyond modality***.

Work context philosophy. A participant's work context philosophy was one aspect of what was deemed to be outside the scope of their practice. As has been noted in Chapter one, although the majority of psychotherapists in Aotearoa New Zealand (ANZ)

work in private practice, a number are also employed in non-government organisations (NGOs) and District Health Boards (DHBs), where they are contracted to meet employment expectations. Those who work in private practice may also be contracted to the Accident Compensation Corporation (ACC) where client work is monitored through written reports and assessments by an external practitioner. Nigel, commenting on the work practice philosophy of his employer, said, "What am I doing sitting around talking about God when I'm supposed to be doing four sessions of relapse prevention work or motivational interviewing?" He also commented that clients in that work context have come to address a particular issue, so in a way, the work context also fashions the expectation of clients. There was no provision for assessing a client's RS needs in Nigel's work context. Simone said, "I would sit with a lot of uncomfortableness about doing anything outside of fairly conservative parameters with an ACC client". Venetia spoke about a work context which she believed paid lip service to the spiritual needs of indigenous people:

> It is a colonising institution so there is a way of being an indigenous practitioner that I am very wary I think because the structures and the construction of the system is limiting … in terms of spirituality in terms of culture, in terms of anything that is outside that biomedical mainstream paradigm and I think there is a history around indigenous people being persecuted for not being rigorously clinical. I am thinking about the *Tohunga Suppression Act* saying well actually Māori spirituality and ways of healing are actually illegitimate. So I think there is a real caution in terms of engaging those issues within the system that is clearly biomedical, clinical, government funded.

Psychotherapist's role. What participants considered to be their role as a psychotherapist was often mentioned when deciding whether an RS issue was perceived as outside the scope of their practice. Considering whether a client's RS needs would be better addressed by a teacher or minister from the client's religious tradition was deemed important. Nigel asserted, "There are definitely times in therapy where I think to myself, okay, this is far enough for me to go here because I'm not a spiritual or religious teacher, that's not my role". The limit for Nigel was about not usurping the authority of a RS leader. This perspective was shared by Ethan, who considered that it was not his role to address a client's RS needs in isolation since he believed that "a psychotherapist's job is to be holistic".

Some participants talked about responding to spiritual promptings or, in the case of Māori participants, communication from the ancestors which supported their therapeutic work. Lucille, reflecting on one event when she responded to a client as a result of spiritual prompting questioned, "Where is that doing that in the psychotherapeutic kind of profile?" Venetia observed:

> Working in a wairua way, you have to be willing to step outside the psychotherapy room and square and that can be, with the advent of complaints and things like that, quite scary, because I guess there's a safety in terms of the frame, the therapeutic framework, so when we go outside of that there's a whole lot of possibilities that open up for healing and also for I guess complaint or dissatisfaction, I get a really strong feeling … my tīpuna (ancestors) saying "come on you need to kind of move with this".

Taboo from education. Some participants said that RS was not discussed during their education which left them with the impression that RS did not belong in psychotherapy. Venetia commented that, "There's never been, as far as I am aware, any of those conversations [about RS in therapy] within the training". Both Simone and Nigel spoke about specific incidents within their education, pertaining to RS issues, from which they received negative messages which influenced their practice. Nigel, reflecting on his lack of attention to clients' RS issues in his own work as a psychotherapist, commented, "I'm internalising something or acting out something of how that feels like it doesn't belong in the therapy world", as he spoke of the influence of his education on his practice. When faced with a direct request for prayer from a client, Simone says that this put her "on the spot" because of her experience in her formative education. She said:

> It did feel like some sort of test in a way, a test as to how strong is my psychotherapy training? How strictly do I stay with my model as I had been taught where you didn't really include direct references to God? I mean it was never told us directly, but implicit in the training … it was just not the kind of counselling or psychotherapy that I practice, that includes an overt languaging of anything spiritual. So it kind of really put me on the spot.

A psychotherapist's own personal psychotherapy–which is a requirement in education/training and for psychotherapist registration, as has been noted in Chapter one–is also educational, as psychotherapists learn a lot about how to conduct

psychotherapy, by being a client themselves. Simone said, "My own experience of being counselled, I've never had anybody introduce a spiritual dimension in the counselling I've had". Nigel reflected on how he learnt from "what was focused on and what was omitted", not only in his education but also in his personal psychotherapy. I asked him to expand on his comments. He reflected:

> I think that … my therapist was, and is much more excited by talking about family stuff and history and that sort of thing than stuff to do with my religious or spiritual experience, so I guess, just shaping, behavioural shaping all the time … I'd bring up the conversation that would … go somewhere. [He had a conversation with his therapist about this and recalled her response] which was something like her acknowledging that was probably the case … And in a way I find that a pity and in another way … I guess that's not where she's working so much so I'll bring the stuff that works to therapy and I'll take the more spiritual, religious stuff elsewhere.

From his experiences in his education and personal therapy, Nigel said, "maybe it's just the … blinkers which get put on without even realizing it, or which I don't always question the way I so often focus on the intrapsychic or the interpersonal".

Beyond modality. Participants' choice of psychotherapeutic modality also helped them decide what belonged concerning the client's RS material. This is distinguished from ***meeting limitations of education/modality***, as an aspect of ***the unknown***. The emphasis in ***beyond modality*** is on what is included or excluded within a modality, whereas the emphasis on ***meeting limitations of education/modality*** is on what has not been taught. Some participants were clear that attending to the intrapsychic and the interpersonal was their brief, and a client would be referred to an appropriate person for RS needs beyond that. Tabitha, who held the perspective that psychotherapy attended to the psychological, made this differentiation:

> I don't see my task in psychotherapy to promulgate religion, to help people specifically religiously, that if somebody comes and they are concerned about a struggle around belief that seems to be about the belief mostly and not about their inner practice of it, I would probably refer them to a spiritual director. I would at least discuss that with them … sometimes a person will come asking for a Christian counsellor and their prime aim is not to look at themselves and understand themselves but they are specifically wanting to work out something religious, in a religious framework and I will refer them if that is the case.

Chapter Six: Encountering Challenge

The limitations of psychotherapy generally, in being able to adequately incorporate the concept of wairua and other indigenous concepts were articulated by Venetia:

> In terms of psychotherapy if we look at it in an English way, it is within a room, in the now, with you and me. But if we are looking at it from an indigenous or a spiritual concept we are not only in this room but we are connected to everything right here and everything through time and space so anything is possible when you talk about wairua … that's enormous, that's the potentiality of everything, that's the mauri or the life essence of everything affecting everything else and the ecological systems. Why history is so important is that again, some first nations brothers and sisters talk about that we actually have embedded in our souls colonisation, and so we have to go back there in that time and space to heal it, in the here and now. So, I don't think those concepts are within psychotherapy, I don't even think we have those conversations but they are spiritual conversations and they are essential to healing our people I think.

Because of these limitations, Venetia was mindful of not having educational back-up to justify her interventions when working with Māori clients.

> So if … I think there's an issue of wairua here and somebody takes offence to that and if I end up with a complaint, how do I justify that conversation because I can't kind of go back to my clinical training and say "well … this module about spirituality, religion and wairua?"

Participants' perception of what was beyond the scope of their practice was influenced by what they had witnessed and experienced themselves in their education, which included their personal therapy. In addition, the RS needs of clients caused participants to be uncertain of where their role as a psychotherapist ended. The philosophical underpinnings of therapeutic modalities also indicated boundaries of practice concerning RS. Participants also commented that certain work contexts also had philosophies which suggested limits concerning engaging with clients' RS.

Interweaving challenges

The challenges that participants encountered were not always met discretely; at times an overlap of challenges was demonstrated. This overlap of challenge is evidence of the complexity of participants' engagement with RS in the therapeutic process. Examples of these overlaps are outlined.

Chapter Six: Encountering Challenge

When Chloe met a potential client who was "staunchly Christian", although was familiar with this RS tradition, Chloe found aspects of the client's beliefs and practices "bizarre". She was concerned about how she would "deal with it", saying that she did not know what to do, saying "It felt a bit psychotic". Chloe demonstrated that she had encountered something that was unfamiliar to her personally and also outside the bounds of her education/modality. Simone commented about the dilemma she faced when being asked to pray with a client, a request which was, in her experience, outside the psychotherapist's role and an education taboo, the latter two indicative of something which was perceived as outside the scope of her practice, even though the ritual of prayer was personally familiar. She said:

> It's not like it's a Muslim … or Catholic or somebody with a very specific religion that I don't necessarily 100% go along with. I wasn't being asked to go outside a zone that wasn't relevant to me or socially acceptable to me.

Averil also demonstrated this overlapping of challenge, when, as a Māori psychotherapist working with a Māori client, she assumed a commonality between them, whereas in fact she and her client had conflicting worldviews . She commented that she did not understand the client, that they spoke a different language and therefore "missed each other". This suggested that she was also encountering what was unknown to her in unfamiliar RS beliefs and practices.

Conclusion

In this chapter, the variety of challenges that participants encountered when working with RS in the therapeutic process have been discussed. Challenges were encountered when the worldviews of participants and clients conflicted; when an aspect of RS was determined to be outside the scope of the psychotherapist's practice; and when participants' knowledge was limited concerning the RS beliefs, practices and the presentation of their clients. The challenges presented left participants with decisions to be made about how to proceed. How they negotiated these challenges, is the focus of the next chapter.

Chapter Seven: Negotiating Challenge

Introduction

When participants encountered the challenges regarding RS, explained in the previous chapter, i.e., where their worldviews conflicted with those of their clients; when they met something which was unknown in terms of presentation or experience; or when they encountered RS material and expectations considered outside their scope of practice, they then negotiated a way through these challenges. Strategies employed in this negotiation comprised ***protecting***, ***risking***, ***resourcing***, ***repairing*** and ***referring***; each strategy demonstrated in a variety of actions. Figure 9 shows all that is involved in this process.

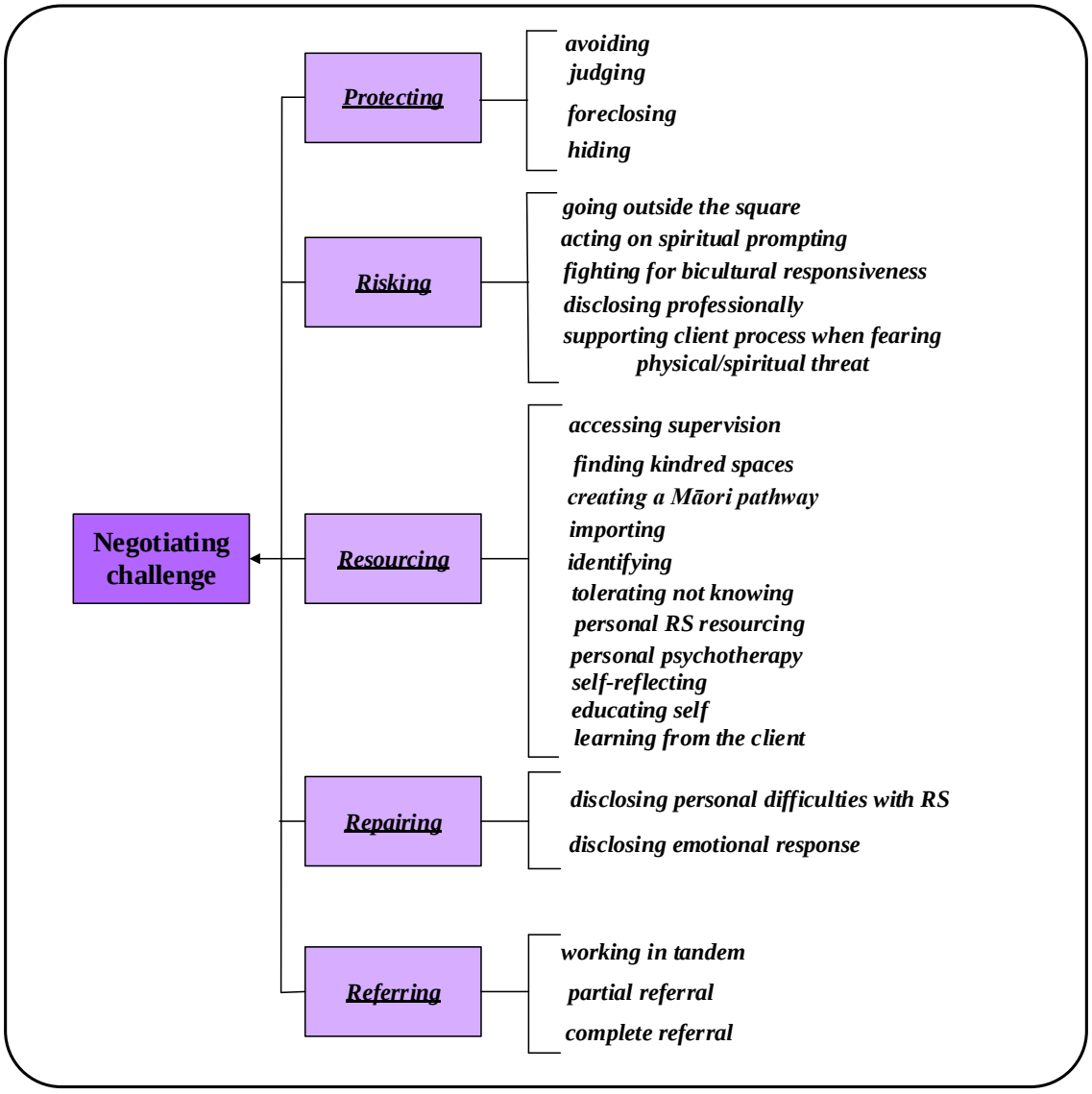


Figure 9: Negotiating challenge

Chapter Seven: Negotiating Challenge

Negotiating challenge

Like navigating, negotiating infers finding a way both through and around obstacles, and also attempting to reach an agreement on something through discussion; both meanings are intended in the term **negotiating challenge**. As participants negotiated challenges, the strategies chosen were connected to the nature of the challenge. It was more likely that a participant would act to protect themselves or take risks, should they experience something as beyond the scope of their practice, or should the client's RS beliefs conflict with their own worldview. For example, Averil engaged in some RS interventions with clients which she described as "risky" because she perceived them as "outside the frame". However, when the challenge encountered consisted simply of a lack of knowledge, participants were more likely to utilise a resourcing strategy, since there was no perception of internal or external threat. Ted spoke about doing a lot of reading since he had a number of clients who would talk to him about "religious ideas", and he "hadn't had any religious training at all". Negotiating was indicated by participants' comments such as, "not wanting to engage" (Luke), and "tricky juggling" (Venetia).

Protecting. Participants protected themselves when they perceived that the challenge they encountered represented a threat; protecting is conceptualised as actions taken by participants to keep themselves from being harmed or threatened. These threats comprised challenges to their own way of seeing things as well as challenges to their professional standing. When taking protective action, participants engaged in ***avoiding***, ***judging***, ***foreclosing*** and ***hiding***.

Avoiding. Some participants reported ***avoiding*** their client's RS material by not responding to what the client was talking about. Simone stated, "I would choose maybe to ignore something because I just don't want to go there". She emphasised her point by repeating, "I just don't want to go there". Brandon added, "I think that if she talked about something related to her psychic ability, I would probably just listen … probably not respond at all". Chloe spoke about avoiding selectively, realising in hindsight that she was welcoming of a client's RS material when it related to the Anglican church, an RS tradition with which she was personally comfortable, yet avoiding engaging with the client's spiritualist leanings, with which she was not comfortable, saying, "I have not

invited her to explore that [client's spiritualism] and actually … she has said a few things that I haven't picked up". She also spoke of being "Turned off by [a potential client's'] spiritual stuff and did not make a follow-up phone call to pursue the client's engagement in therapy. When speaking about his lack of attending to RS in his work, Nigel commented on the "blinkers" (attributed to education and work practice philosophy) which caused him to focus on certain aspects of the client's presentation.

> I don't always question the way I so often focus on the intra-psychic or the interpersonal and focus my clients on the more obvious forms of that without even realising and I'm sure part of that [is that] the big majority of my practice has been working in agencies, and there's a sense of the work you do, the territory, you're supposed to be in.

Avoiding was a strategy used not just with RS material raised by the client, but also with unusual occurrences in the therapeutic process, which, Simone, commenting on her avoidance, said, "I didn't really know how to handle it". She explained:

> Both of us Pākehā therapists had had what one might call unusual experiences, or things that happen in the room with a Māori person that we weren't quite sure what it was. It wasn't necessarily negative but we would never talk about it to the client or not necessarily talk about it in our … clinical supervision … my friend that I was supervising with, said, "Why don't you say anything?" I said, "Well, I feel really stupid. I don't know whether I'm imagining this or if the client's going to think I'm really weird or if my supervisor's going to think that I'm losing the plot".

Participants avoided engaging with RS material and unusual occurrences as they chose not to facilitate discussion around the issues. The nature of the challenges they were negotiating was also clear. They took this action when they lacked knowledge and when they experienced some conflict within themselves, regarding the client's views.

Judging. In addition to avoiding, some participants spoke about overtly judging the client's perspective as they pushed away the client's worldview. Participants engaged in judging when they challenged, devalued, discounted or pathologised the client's position, thereby protecting and privileging their own worldview. Adam, speaking from his perspective as a Christian, commented about a difficult interaction he had with a client who was also a Christian. He judged the client according to his understanding of how Christians should behave.

> [He] was in some bizarre sexual practices. I am calling them bizarre sexual practices, S and M. Yet, this man is in a high position in the Christian community. Now to me, there is something incongruous about that that does not fit within Christian moral categories, and his wife would agree with me.

Ethan spoke strongly about favouring his belief system over that of his client's, asserting:

> I say no to the highly evangelical person. I say "You are with the wrong kind of therapist" … I would say, "This is my belief system". "This is the way I will work with you". "If you want to keep telling me that everything is controlled by God and all that we do in this room is controlled by God then you need to see someone else because that's not me".

Brandon commented that in addition to not responding to his client when she spoke about psychic material, he would sometimes, "devalue what she was saying". Ella also spoke about judging her client's perspective.

> With this young Hindu client who described … practices from her Hindu side, sort of exorcisms, which she described as witchcraft, which her mother's side of the family perform … I sort of struggle with that … I notice I have a tendency … to make some judgments around that.

Judging also included challenging the client's RS values when participants felt that they were life-inhibiting. Nerida commented that she would challenge what she considered abusive or self-destructive. For Ada, an aspect of that challenging was sharing her understanding of God.

> I gently challenge this, and coming from an intersubjective paradigm I have permission to make "I" statements and to say things like "oh, I hear this is how you think about God. I'd like to share with you my how I see God" and so just basically holding my perception of a much more benign God than some clients may have with their understanding of God.

One of Adam's clients believed that God would reverse a sex change operation, since he (the client) realised, in hindsight, that this decision was a mistake, a mistake which, in his mind, God should have prevented him from making. Adam recounted:

> He wasn't open to reflection and eventually I took the view that well, from my understanding of how God works, I have no confidence that God plans to reverse that surgery miraculously, and he got quite angry with me … and he dropped out of therapy.

Attempting to normalise behaviour that participants, from their particular RS perspective, deemed inappropriate, was another aspect of challenging. Luke spoke about one client who had come to psychotherapy because he was troubled by having sexual thoughts about women other than his wife. Luke commented that he "would normalise it, but this was not acceptable to him [the client]".

Participants judged what they did not understand, what they did not agree with, what they considered to be detrimental to a client's wellbeing, and what they sometimes found personally threatening.

Foreclosing. Participants also engaged in foreclosing, a strategy which limited the participant's understanding to a "this is that" conceptualising of a client's presentation. This strategy assisted participants in distancing from material which was either not understood or at odds with the participant's perspective. Foreclosing conveyed a shutting out of something, thereby limiting possibilities. Ella, commenting on her client's childhood experience of her dead grandmother visiting her, said, "She thought that was absolutely normal to have her grandmother visit her but that she found it terrifying … and I had pathologised it to some extent and thought it was slightly psychotic". Luke talked about foreclosing as a "diagnostic defence", as he struggled with a client's religious view.

> In this case there was a distinct concreteness about his conceptual world to which I responded with a kind of "diagnostic defence" I thought, "This is Aspergers'"or "This is limited intellect", or "This is a learning difficulty"– which alienated me comfortably enough from his spirituality … I am, in retrospect, aware of not wanting to engage with his spiritual world, of finding it distasteful, even disgusting. That there was something akin to Aspergers' syndrome, I do not doubt, but that is not the point. The diagnosis served me and made me capable of staying in the room with the dangerously fundamentalist religion that the client brought with him. So at times I missed his humanity, of which there was abundant evidence.

It is evident that participants foreclosed as a protecting strategy so that they did not have to open up their thinking when something was, as Luke said, "distasteful", or outside the bounds of their knowledge.

Hiding. Hiding was a common protective strategy chosen by some participants. This strategy was engaged in when participants were afraid of how they would be seen if they spoke about an action they had taken within the therapeutic relationship, either to colleagues in the psychotherapy community, including peers and supervision, or to employers. Averil said that she would not talk about her belief in, and use of clairvoyance, with her supervisor, since he was Pākehā and "very psychodynamically focused". Some commented that I was the only person they had talked to about some of the matters they were disclosing, since they feared negative professional appraisal. Simone commented, "we don't talk about spirituality in psychotherapy very often at all … I don't talk about the stuff I'm just talking to you about, and the only time I've discussed stuff like this is within … cultural supervision". At the beginning of our interview, Ella disclosed:

> I noticed I was a little bit anxious about you coming … I realise that I don't actually get to articulate it very often, so on one hand I was … excited about the opportunity to articulate it and I'm not sure what will come out (laughing nervously) and the other side a little bit anxious around that, that I do expose myself at some level. I notice I'm thinking, "Oh will she think I'm mad or will she think I'm really 'out there' or shouldn't be practising psychotherapy or something" (laughing nervously).

Averil experienced her Māori cultural worldview as accepted; however, was reticent about her RS tradition. As noted under "avoiding", Simone did not mention the unusual occurrences which happened with a Māori client because she thought her supervisor would consider her crazy. Lucille, commenting on unusual occurrences in the therapy room, said, "I thought it was happening [in psychotherapists' work] more than it was being spoken about", thus suggesting that clinicians were hiding this issue. Hiding RS material in clinical supervision, when considering the need to be considered a "legitimate practitioner", was mentioned by some participants. Venetia reflected:

> If you think about the *Code of Ethics*, you think about complaints' procedures … to be a legitimate practitioner where that [religion/spirituality] is included as a

> normal part of clinical supervision is a really different experience … feeling like you have to protect some of yourself, having to keep something a little bit hidden.

Averil commented on practising differently in one context than she did in another, as she feared professional judgment. She explained that she sat "on the margins between the non-orthodox therapy and my orthodox training … There is a part of me that just wants to hide and pretend that I am an orthodox psychotherapist, which I am as well". She continued:

> Sometimes when I do these things like that [mentioning spiritual interventions] I wouldn't do those things in a group. See that's why I'm probably different in a group where there are more eyes than what I am in the one on one ... It's my own personal stuff about being judged. Being told I am wrong or being made to feel wrong. But because my clients do well no one questions me. As long as it looks like it's working, no one really knows what each other is doing inside those rooms.

Sometimes hiding was partial. Venetia spoke about her work in a context which operated from a different paradigm to hers.

> I think practising cautiously … I might … make sure I see a whanau long-term before I start introducing some of those conversations. It might be about acknowledging the wairua, spirituality, but not necessarily delving into that area or saying "you know in the hospital context it is difficult to talk about some of those things"…it's a colonising system … They still have key performance outcomes that are very mainstream. So it means I am a round peg in square hole. And somehow I have to adjust my practice to remain safe within that system and also, it's a kind of balancing act and also remaining true to indigenous practice with the families that I see.

Hiding was a strategy participants utilised when they perceived that their RS perspective was outside the brief of their work context, when they engaged in RS interventions with clients that they thought would not be accepted by supervisors, or when they feared spiritual occurrences which they encountered with a client would cause other psychotherapists to question their sanity. Through interactions with different environments, a participant learned what was advisable to hide, how much to hide, and when it was expedient to take this action.

Chapter Seven: Negotiating Challenge

Participants protected themselves when encountering challenges by pushing the clients' RS material away, sometimes consciously and sometimes unconsciously. Of particular difficulty was material which brought up unresolved RS matters in themselves. They also protected their position in the psychotherapy community and on occasion, with employers by hiding the manner of their engagement with clients' RS when they perceived that it was outside the scope of their practice. This implies that they also took risks in their engaging.

Risking. In addition to participants engaging in protecting strategies as a way of negotiating challenges, some also took risks. ***Risking*** is conceptualised as participants exposing themselves to potentially negative personal and professional consequences. ***Risking*** was demonstrated when participants acted outside perceived psychotherapy "norms"; intervening with clients in response to spiritual guidance, rather than understood psychotherapeutic practice; fighting for cultural recognition in an environment perceived as non-accepting; sharing information regarding RS in the professional environment and not knowing how this would be received; and supporting a client therapeutically when fearing for personal safety. These strategies are named respectively as: ***going outside the square; acting on spiritual prompting; fighting for bicultural responsiveness; disclosing professionally; and supporting client process when fearing physical/spiritual threat.***

Going outside the square. Some participants spoke about the "scariness" of risking; going outside what they believed was permitted psychotherapy practice, as they responded to client needs in the area of RS beyond the limits of their education. However, they did this because they valued the therapeutic relationship that they had with their clients. Simone reflected:

> I even feel uncomfortable talking about that [referring to praying with a client, at client's request] because it still feels like going outside the parameters of what you know "legally" [making quotation marks with her fingers] It's really strange. *Can you say a bit more about the uncomfortable feeling you are having*. Well, that I know I am anonymous in this but I have done something really "out there". To do it and now to talk about it and now it's part of your research; it feels big.

Venetia commented on her risking, working in a "wairua way" when she did not have a sense that that was permitted within the "clinical frame". She spoke about her cultural

history, citing the *Tohunga Suppression Act1907*, an Act which outlawed Māori healers, and the impact that has had on her.

> Working in a wairua way, you have to be willing to step outside the psychotherapy room and square and that can be, with the advent of complaints … quite scary …if it is not within this … clinical frame there's always the possibility of the door opening for somebody saying, "You've offended me", or "That was unsafe practice", and you can't back yourself up … So if ... I think there's an issue of wairua here and somebody takes offence to that and if I end up with a complaint, how do I justify that conversation because I can't kind of go back to my clinical training?

In contrast to Venetia, Averil's going outside the square concerned her RS tradition rather than her Māori culture. She said, "It's not my culture I think that feels risky, it's my spirituality that feels risky".

Acting on spiritual prompting. Acting on promptings which were described by some participants as "more than themselves", and not consciously understood, was deemed to be risking because they were not sure where or whether these responses fitted within psychotherapy. Even though participants trusted these leadings, they had difficulty understanding them themselves, and therefore a challenge to explain according to psychotherapeutic theory. Averil reflected,

> My intuition I believe is connected straight to Atua [superordinate beings, ancestors] and they tell me things or show me things and I really trust that and so and working with a client if I hear them say, "this would be good", then I offer it to the client.

Lucille explained her responses after she had responded to spiritual prompting:

> I sat afterwards and thought, "God, right, I'm not sure what happened there. It might have been God, again, I don't know and you know where is doing that in the psychotherapeutic kind of profile?" I think what happens is something else that is created, that I really don't fully understand, I don't, but I trust it. And I sometimes when I am back in the everyday state of consciousness, I think "oh my crikey, what happened there?" "I hope that's all right". I feel a bit like the Lone Ranger because I feel like I go into this without any maps half of the time, and I don't really know what I'm doing … I kind of trust but it is scary when I'm in the everyday reflecting and thinking oohh God.

It is easy to see why participants may also engage in the protecting strategy of hiding when they go outside the square and act on spiritual prompting.

Fighting for bicultural responsiveness. Some participants took risks in fighting for bicultural responsiveness in the profession. The risk was to their own wellbeing and reputation as their fight was often not supported. There was a risk in advocating from a marginalised position when it was professionally and personally challenging. Hannah expressed her difficulty.

> I am compelled to seek ways that would be more useful, meaningful, effective in response to that degree of suffering for Māori … I don't have a choice about that. And it stretches me to it stretches me to limits that I never expected I would ever be stretched. I have suffered this development probably much as anybody, but mostly with myself because I have felt that I have had to really expand my own ways of thinking and being and they have been incredibly challenging. They've been a challenge every step of the way so while I say publicly it's a noble cause … it's difficult because you're all the time having to uphold something and defend it against what turns out to be a mass of ignorance and challenge.

At times, fighting for bicultural responsiveness involved some "tricky juggling". Functioning in a work context with a philosophy different from her own, when working with Māori, was described as tricky juggling by Venetia, who had to satisfy the expectations of her employer, yet advocate for the cultural needs of her patients.

> I became a mediator … explaining, "This is where the whanau [family] are coming from, this is what their needs are in terms of wairua,[spirit] in being with their baby and going through the process of tangi,[rites for the dead] having whanau at the hospital for withdrawal of care, in terms of karakia,[ritual chant] what needs to happen. … the whanau are coming from out of town so where are they going to stay? And the clinical ward saying, well, we are a 50 bed unit, this is only one family, we can't have all these people. … So there were all these dilemmas in which I became the negotiator because I had the emotional and the wairua side of the whanau, I guess I had that relationship with them which is incredibly tricky because when the unit was saying, "No we can't do that", that meant I had to go back to the whanau and say, "These are the constraints of the hospital system, I am really sorry. I understand where you are coming from. They will move on this but not on that".

Disclosing professionally. Disclosing professionally was seen as risky, some participants asserted, since they feared that disclosure of their experiences and

perspectives could have a negative impact on their professional reputation. This disclosure may consist of verbally sharing with colleagues or supervisors, or even writing about experiences. Lucille, speaking about some writing she had done, commented, "I felt like I could have been professionally jeopardising myself in some way". Lucille also spoke about recounting an incident of acting on spiritual prompting to her supervisor, whom she had chosen specifically because of his perspective on RS, saying that "I think if I had a … psychoanalytic supervisor … it would be a bit challenging". Venetia spoke of a measured disclosing in clinical supervision, sharing a little, waiting to see what response she would get, and then either sharing more or returning to a protecting stance. She reported:

> Feeling like you have to protect some of yourself, having to keep something a little bit hidden or not quite say the full extent or maybe you do a little bit and risk and then it's kind of like "oh gosh, that wasn't the resourcing that I wanted or that wasn't the response", because the supervisor is feeling freaked out or out of their depth.

Both Ada and Brandon spoke about disclosing their own RS position when encountering conflicting worldviews with their clients. Brandon, when challenged by his client that he was avoiding talking about the RS material she was raising, agreed with her, saying, "At a certain point I disclosed to her that I felt that she was right and that because of my history I had rejected spiritual religious belief systems".

Supporting client process when fearing physical/spiritual threat. Fearing threat because of exposure to spiritual forces encountered when engaging with client work was commented on by some participants. For participants who believed in the reality of the spiritual world, this was a real consideration. Simone spoke about needing cultural supervision, not for her clients so much, but for her own safety, "I need to feel safe I'm dealing with people who are coming with so much … like the whole thing about the tipuna … the ancestors, there's some really icky stuff that's out there". Harold told of an incident with a client where he feared for his life, an experience he saw as both a physical and spiritual threat:

> What happened in that second was, oh my God, I could die. If this flips very suddenly, I'm dead. There's no way I could protect myself from this guy's maniacal evil rage. I can't explain it more than that apart from the fact that I let

> myself feel the edge of terror. I was still in reality as it were, I wasn't freaking out or I wasn't splitting, but I felt an edge of what it would be like to be in a sense come face to face with the devil or the demon.

A number of participants took risks in engaging with clients' RS material and presentation, in order to meet client need. Risking was often accompanied by hiding in the absence of perceived resourcing. Participants were more likely to take risks when they considered an intervention might be outside the bounds of psychotherapeutic practice; limited knowledge was also a condition of risking. Although risking was connected with protecting, it also led to resourcing in a number of situations.

Resourcing. Many participants spoke about different resourcing strategies they used when encountering challenges regarding RS in their therapeutic work. Resourcing comprised actions that participants took within and outside of the psychotherapy community to enhance their work. It also included personal resourcing. ***Resourcing*** was demonstrated in ***accessing supervision, finding kindred spaces, creating a Māori pathway, importing, identifying, tolerating not knowing, personal RS resourcing, personal psychotherapy, self-reflecting, educating self*** and ***learning from the client.***

Accessing supervision. Discussing RS matters in clinical supervision was a strategy utilised by participants when they perceived that their supervisors were open to such discussion, and when they believed that their interactions with clients warranted supervisory input. Lucille commented on having supervisors sympathetic to including RS and wondering how it would be if she did not have that supervisory support.

Both Ella and Tabitha mentioned the importance of supervisory input when working with a client of a religiously dissimilar background. Ella said that discussing her Hindu client's RS practices in her supervision, helped her see these practices "in a cultural context", which helped her realise "that sometimes we have to actually hold the lens very wide". Tabitha highlighted the need for clinicians to understand the influence of a client's RS perspective in their presentation, and the importance of supervision specific to the client's RS tradition:

> Somebody might report a client as having, say it's a Catholic client and the supervisee doesn't have a background in religion at all, they might report certain things that the client has said that they don't necessarily understand the context of

> what they might mean. I [with an understanding of Catholicism] would sometimes try to say, "Well I think when this person is saying this, this is the background that they are coming from, and it might be what it means in terms of that background", as … feeding into the therapist's understanding, … as I might find when I go to a perhaps cultural supervisor, a Māori supervisor if I am working with a Māori client, they might well fill me in on things that are background that my client doesn't need to explain, or thinks they don't need to explain but it's helpful for me to know and I think the same thing can be true religiously.

Some participants, who were also supervisors, reported that they were chosen by supervisees because of their openness to RS matters. Nerida reflected, "A very large part of my practice now is supervision, and many people choose me because I include a spiritual viewpoint". Anastasia added, "A lot of people come to me because I'm known to be open [to RS] and knowledgeable". Esther, also a supervisor, said that she would coach a Hindu supervisee, for example, to think about their RS values in relation to their counselling training. She said:

> I will ask them, "How can you and I work together so that you are at home in what you value … and use that valuable part of you in the work that you have studied in the western context. Let's put our heads together and weave something new for you". … Because if they can do it for themselves then they might have some idea how to weave it for the other. So it is like, coaching them into weaving cross-disciplinary.

In addition to clinical supervision, participants also spoke about resourcing through "cultural" supervision, which was generally understood as "bicultural" supervision, that is, supervision with a Māori clinician concerning their work with Māori. Both Simone and Venetia spoke about the importance of bicultural supervision in their practice. Simone added that bicultural supervision enabled her to talk more freely in her clinical supervision about issues with Māori clients:

> [talking about spiritual occurrence in the room with a Māori client] in the process of going to this cultural supervision, it kind of gave me permission to, to talk about it, and to talk about it in my other supervision too **…** And sort of within that supervision, we contextualised things in a way that I'm incredibly comfortable now to say all kinds of stuff to a client that I never did before …until I did that cultural supervision, I did not have a context to really language stuff like that.

She added that cultural supervision was essential for personal safety when venturing into the spiritual domain:

> You have to be covered, you have to have that support or you are not safe. I think to venture into the spiritual domain without guidance and without protection, without people to talk to, you're crazy. You are crazy to do it by yourself because it's just too complicated. You are out of your depth if you don't have … that background or understanding … I have people to talk to that I am confident that if I don't know I will find out.

Accessing supervision also took the form of peer support. Simone spoke about the importance of her peer group, intentionally formed as an experiment in cultural supervision. Venetia said, "Spirituality is easier to talk about with my indigenous colleagues than it is with my tauiwi [non-Māori] colleagues".

Finding kindred spaces. Having colleagues to talk to, and educational opportunities where there is a resonance with their way of being was mentioned by Xavier, Esther, Simone, Tabitha, Milly, Venetia and Hannah. Xavier commented that he had been "lucky having many good people around, which was helpful". Esther said that she was part of a community which discussed the relationship between psychotherapeutic and RS ideas. Simone spoke about a group of which she was a part where "spirituality within psychotherapy and psychology" was discussed. Tabitha mentioned feeling valued by Māori for her spirituality, adding, "There are not many places where you experience that". Milly reflected on working with clients around issues of meaning, life and death and feeling somewhat uncertain about whether she was really practising psychotherapy, since it was not how she had been trained. She then went to a conference and found her "home":

> [The speaker] did several keynote addresses on existential psychotherapy … and I just thought "That's my home" so while I had been doing what I do and wondering whether it was or it wasn't [psychotherapy] … it totally confirmed to me in the fact that what I do is, but it is no longer that important to me really. I think what I do is therapeutic because people tell me all the time how helpful it is to sit with me.

Venetia reflected on the importance of having a kindred space in developing knowledge:

Chapter Seven: Negotiating Challenge

> I get lots of supervision from my Māori colleagues and that's a kind of kindred space where we can talk and I think that the kuia (female elder) and kaumatua (male elder), that I have also, are really influential in my understanding about things and my development … had a conversation with a South American psychotherapist who had come over and there was some really shared understandings and then I had a conversation last year with a First Nations' woman and a similar sort of wairua connection with the land.

Hannah referred to kindred space as a place for creating a groundswell:

> You get to what is referred to as a "critical mass" in terms of numbers, so you have enough of you, that is, Māori in the profession of psychotherapy, to bring themselves together in a way that allows them to share their ideas and their experiences of being Māori practitioners in the work of psychotherapy.

Creating a Māori pathway. Achieving a critical mass and having a groundswell, were actions which fostered the creating of a Māori pathway (to NZAP membership), since, as has been noted in Chapter one, no formal recognition of separate Māori philosophy and practice existed within the NZAP. Important in this creation were the kindred spaces of Ngā Ao E Rua to support this initiative, and the gathering of a Māori collective. Hannah reported that "We were able to grow over the years in what I have called a uniquely Māori practice or a uniquely Māori way of understanding ourselves in this work". Venetia reflected on the process of the creation of the Māori pathway:

> So for them [Nga Ao E Rua] to say … "We support a Māori Pathway". I don't think that we would have gone through that process otherwise. If we hadn't have had that groundswell of support from Nga Ao E Rua saying, "This is a good idea, we can help you, we can bridge some processes, we have people on Council who can take that and talk", it wouldn't have happened.

Importing. Importing was a resourcing strategy used by participants when they perceived that what they practised as psychotherapy was limited in what it offered clients. Some participants spoke about importing from other disciplines and modalities to enlarge their work with RS. Xavier referred to himself as being "a kind of smuggler between different domains, not staying only in the rigid psychoanalytical frame but bringing thoughts and ideas to my work from other disciplines I have learnt … ideas of

spirituality". The concept of smuggling suggests the importing of contraband, perhaps considered "beyond scope". Serena incorporated a spiritual discipline into her work, which has enabled her to work at greater depth with a client's RS. Referring to the particular discipline, she said:

> It is soul-based and works very much with feelings and intuition and training people to perceive spiritually so they can perceive, I can't see people's ancestors who are spiritual presences but I can sometimes feel them, and certainly where there is an openness on the part of the therapist, clients can often identify presences or sensations of spiritual beings that they may or may not be able to name. I find it is much more common than I would have thought. *When you say, When there's an openness on the part of the therapist, then the clients are more able to?* to allow that experience I think. *I am just curious about what happens in that interaction.* If the client has a sensation that they can identify as a spiritual presence then I as a therapist … can invite and facilitate, staying with that experience, expanding it if appropriate, so I can encourage them to trust their perception and receive what might be being offered.

Zara commented that she found psychodynamic language limited when exploring the RS domain which her clients were bringing, so she incorporated teaching from another discipline to aid exploration.

> While I included … spirituality in my work and I saw it in people and people brought those issues, I also felt that somehow the language that I had for working with some of that was lacking. I'd learnt this psychotherapeutic language and way of thinking and somehow that wasn't quite enough.

Simone imported a Māori model of health, Te Whare Tapa Whā, into her private practice as a way of introducing RS to her work with non-Māori clients. She had been taught this model in another work context where clients were predominantly Māori. She reflected:

> The only way I can really feel comfortable talking about … [RS] is through the filter of that Māori model [Te Whare Tapa Whā] and I'm really clear that that's given me permission … it's given me a framework that, with my clients in my private practice this whole concept of wairua which is like that energy, that spiritual energy. See I use that a lot … it's given me permission to talk about that kind of stuff.

Identifying. Finding some degree of commonality, or identifying with the client was noted by some participants as a strategy for negotiating the challenge of conflicting worldviews. Chloe reported having moved away from her Christian upbringing which "was black and white". However her familiarity with that perspective means that when she encountered clients who held such beliefs "I totally know what they are on about, I totally "get it". Harold commented on the "mental gymnastics" he engaged in to "try and find some consonance or some congruity between [a client's] belief system and my belief system. I had to go a long way back and down to find that congruence". I asked Luke what he did when faced with very different worldviews between himself and his client, since, from what he reported, he was able to find a way to work therapeutically with him, even though the client's perspective triggered his own RS history. He offered the following:

> I had a supervisor once who, in response to a problem where I simply (as I thought) did not like a client or their worldview, suggested that my job was to find something about the client that I could identify with, otherwise I should consider referring on. This client challenged me thus: My own longing for God, for a saviour, is usually well buried. Here was a man for whom these things were an everyday part of life.

Tolerating not knowing. Although the importance of finding some commonality with the client's worldview was noted as important for therapeutic connection, some participants spoke about the challenge of "not knowing". Ted reflected on the dilemma faced by psychotherapists between "needing to know" and living with "not knowing" in therapeutic work:

> I can only say that the task is to move towards the unknown, to be interested in it. But I don't know if that at any one time, getting to know the unknown is a kind of colonisation of it, so moving towards something or to start to try and understand something is always trying to make the other into something we know about. I certainly recognise that in myself and I also recognise a resistance too about trying to not make the other known. There's always a conflict there. When you try to represent things you turn them into something that is known and at the same time the task is to not do that. To let them remain other.

Personal RS resourcing. The importance of a psychotherapist's own RS resourcing was noted by some participants. Milly reflected that "it's territory that I'm at

ease in", suggesting that it was familiarity with one's own spiritual "pathway" which enabled a clinician to be comfortable with being in the territory with their clients, however that presented. Some participants utilised their own RS resources in order to manage the demands of therapeutic work. Sometimes these resources were RS practices which were drawn on within the therapeutic process. Xavier, for example, commented that there were times when it is not clear what was happening in therapy and he would ask for divine help. He explained, "So if you were a patient and we were talking and I didn't understand … what was going on … I [would] ask, "God help us, God help us". *Openly?* No, I don't say it loud, only inside". Noeline also reflected on her use of visualisation and meditation for "staying open even in the face of a client's closedness … to keep open myself". Nigel recognised that his Buddhist meditative practice of "non-discrimination and not getting hooked in discriminating consciousness" enabled him to have a "quality of attention or awareness" within the therapeutic process.

In addition to RS strategies engaged within the therapeutic process to resource themselves, a number of participants had RS practices which they engaged in outside of the session with a client, which supported their practice. Tabitha commented on the need for spiritual resourcing to manage the nature of psychotherapeutic work.

> I do need my own spiritual strength and context to kind of hold me through the work when it is really difficult and I find that probably sometimes I go through a kind of anguish with some clients that in the end can be very productive but at the time can be awful. So … my own spiritual context does manage to hold me in doing some … some difficult work.

Personal psychotherapy. One participant spoke about the influence of their personal psychotherapy in changing how they engaged with RS in the therapeutic encounter. Brandon spoke of moving from a position of rejecting RS to a greater openness, in his therapy with a therapist who was "very spiritual and very Christian". He commented on what enabled this shift:

> What immediately comes to mind is that my therapy is the fundamental area … I certainly felt very free to explore my spirituality, religious beliefs in my therapy and felt that it was a very open environment to do that … I think in exploring my … history I think over time … I don't think he ever made the interpretation that I rejected Christianity as a sort of a defence against my anger with my parents. I think that was something I came to myself.

Self-reflecting. In addition to having personal psychotherapy which increased self-awareness, participants also spoke about self-reflecting, as they negotiated challenges. Working with clients' RS belief systems meant that it was important that psychotherapists reflected on their own, according to Tabitha, who said "it's very helpful to have reflected on your own position, where it comes from, how you got to believe, your own religious upbringing or lack of it … to be self-aware around that". Brandon reflected on the influence of his RS history and how that was affecting his interactions with his client's RS position. Luke did a lot of self-reflecting when he thought about how to engage therapeutically with a client whose worldview clashed markedly with his own. He concluded:

> The people you have the most difficulty with … you are looking at your own shadow. I understand shadow in this context as that which others can see about us but to which we are blind, with perhaps elements which are invisible to both.

He began to consider what it was in him that he was avoiding.

Included in self-reflecting was the aspect of internally monitoring responses to challenging material, a strategy noted by several participants. Tabitha commented:

> When I start to feel my own religious thoughts getting triggered off in the room … then I need to be able to manage that internally in a way that frees me to … do the psychotherapeutic work with the client and my thoughts may be psychotherapeutically relevant or they may be something that I just need to hold so that I can hear what is going on. *Can you say your understanding of "hold?"* Not act on, come back to and think about later but not act on in the moment.

Educating self. Ted observed that having a large number of religious people referred to him necessitated him reading widely to help him understand the nature of the issues with which they were struggling.

> I ended up with a whole lot of religious people referred to me. I don't even know how or why that happened but it did so I've seen quite a few, over the years … So I think that … forced a bit more study and contemplation about it.

When recognising that they lacked knowledge–knowledge about themselves,

knowledge regarding the RS material or presentation of their clients, and knowledge which limited their practices–participants engaged in a number of resourcing strategies to ameliorate this. At times resourcing then led to participants being able to repair difficulties that had arisen in the therapeutic relationship because of therapeutic failure. Some also asked the client to teach them about their RS.

Learning from the client. Another avenue for gaining knowledge, utilised by some participants, was that of learning from the client. Luke asked his Jehovah's Witness client about his RS practices so that he could better support the client's process. Sometimes learning took the form of inquiring, at others it felt imperative, to avoid a breakdown in the therapy. This imperative was described by Simone as an unavoidable client request which was "right in my face"; Brandon's client taught him that he needed to consider his lack of responsiveness to the client's RS material, so Brandon reported that he "bloody well had to". Learning from the client, Harold realised that he needed to be able to shift his perspective on RS in therapy, in order to facilitate client process. This led to him being profoundly influenced by clients' processes. He reflected:

> It means being open to what the client is bringing no matter what the dimension of that and not excluding their much more subtle, more spiritual or mythic or archetypal I'm not a Jungian. It's like being open to having one's own horizon opened to what's within the horizon of the other person, being deeply available to be affected and influenced by that, allowing one's own psyche as it were to be impacted by their deep psychic reality.

Simone recognised that in the client's asking her to pray to open the session, something happened for her. She experienced a personal challenge, "a test", regarding what was more important to her, personal authenticity or adhering to what she perceived as the educational taboo. Moreover, she reflected, the client "gave me a gift by asking that", since "she was allowing me to connect with that energy". However, the influence of her education then returned to the foreground, as neither of the meaning of the request, nor the experience of praying, were discussed with the client.

Participants, resourcing themselves, utilised a range of strategies. It was evident that all participants needed to resource themselves in some way in order to work therapeutically with the RS material either raised by clients or experienced in the therapeutic endeavour. Although perhaps obvious, it needs to be noted that resources needed to be

perceived as being available in order for them to be used. For some participants, resourcing themselves enabled them to attempt to repair therapeutic breaches which had occurred between themselves and their clients.

Repairing. When some participants were aware that they had not responded therapeutically to clients' RS material and that this had damaged the therapeutic relationship, they attempted to repair the connection between themselves and their client. ***Repairing*** is conceptualised as taking action to restore the therapeutic relationship. ***Repairing*** was demonstrated by ***disclosing personal difficulties with RS*** to their clients or ***disclosing emotional responses***.

Disclosing personal difficulties with RS. Brandon, whose client confronted him because of his lack of responsiveness to his RS material, disclosed his own difficulties with RS which related to his history, in order to reduce the tension between himself and his client. However, this repairing, although in the short term helped their relationship, was not sufficient to cause the client to stay with the therapy. Reflecting on their therapeutic difficulties in relation to the client's RS material, he remarked "I don't know if the client talked of leaving because of that, but the therapy did have a fairly conflicted ending and I would say that would be an aspect of it".

Disclosing emotional response. Ella recognised that after she had pathologised her client's RS narrative, the client had not mentioned the material again. She reflected on the need to revisit this with her client, saying that she intended:

> going back the next week bringing that into the space again and being able to say "I noticed I was a bit surprised and perhaps overreacted when you brought that up and I realise that there are many many ways of making meaning". So I have a bit of reparative work to do around that.

Although participants worked to repair breaches in disrupted therapeutic connection, they needed to be aware that a breach had occurred in order to take this action.

Referring. When the client's RS needs were considered to be outside of the participant's scope of practice and/or beyond their knowledge, they were sometimes referred to other clinicians or RS leaders, an action intended to meet the client's best interests. ***Referring*** comprised a continuum of actions: from a participant working on

the psychological aspects of a client's difficulties, whilst having another team member attend to RS needs; referring the client to an RS professional outside of the therapeutic context, so that their RS needs could be attended to in conjunction with therapy; or a complete referral to an RS professional or other clinician, thus ending the therapy relationship. These strategies were named as: ***working in tandem, partial referral*** and ***complete referral***, which are considered in turn.

Working in tandem. Working in tandem was only possible when a clinician worked within a team, usually within the public sector, where responsibility for a client's treatment was held amongst a group, rather than by an individual clinician. In addition, in order to refer, there needed to be someone within the team who was able to attend to the client's cultural needs. In referring her client to another clinical team member, Simone recognised the limits of her knowledge and also had a sense of the scope of her practice. She reported:

> They [the cultural team] did a lot of work around [the cultural aspect of a patient's condition] … So I never had to say, "Yes you are", or "No you're not [cursed]", but work with that alongside it all. I could just be the psychotherapist, I didn't have to do anything else, but be the psychotherapist. That was really awesome. And being where the client is …he says, "I'm cursed. That's what my mental illness is, it's a curse". [the cultural team could attend to that]. So I could say, "Well … we could look at some of the stuff that's happening for you right now".

Partial referral. Referrals were also made as an adjunct to therapy, when a participant considered the client's needs would be best met by a RS professional. When participants used this strategy, they had some knowledge of the client's RS needs and how these would be met by the professional involved. The referral in these instances did not involve consultation with the intended referral source, rather an encouragement to the client to consult them. Ethan, suggesting that clients worked with their minister over a particular issue and then return to work him, commented:

> I am thinking particularly about Roman Catholics and Anglicans there, where they believe quite strongly in the priestly forgiveness of things that they have done so when I sense that I think it's important to have that if they want to go and do that. … I would get them to use their own church minister, if possible, but if they are not comfortable with that then yes, there are other people I can refer them to.

Nigel suggested that his client consult a RS professional when he realised that it was important that he not usurp the authority a professional in the RS tradition would have.

> That was a point where I encouraged her to go, to connect with a Buddhist or spiritual teacher I guess claiming the authority of the tradition what would that have meant? (pause) I guess it would have meant bringing in some of the more challenging aspects of meditation awareness practice, or of the kind of Buddhist ways of seeing the world …I didn't want to introduce anything to do with koans [spiritual questions] for instance … where the understanding of koan is a dramatic shift in a state of consciousness, so they are kind of powerful tools and I was … with that client in that moment I felt the impulse to draw on some of the more powerful tools out of my excitement, and I was like, … that's the role of a teacher.

Complete referral. Some participants referred clients to other colleagues or RS professionals, rather than see them themselves, if it was considered that the client's needs were beyond the scope of their practice or their knowledge. The influence of the participant's education/modality was a condition in this referral. Tabitha, commented that sometimes a client would come to therapy when their "prime aim is not to … understand themselves but they are specifically wanting to work out something religious, in a religious framework and I will refer them if that is the case". Ethan said that he would not work with a client who just wanted RS matters attended to, commenting, "I'd probably feel a bit unethical about that because I just think a psychotherapist's job is to be holistic". In these cases, like Tabitha, he would refer. Both Ethan and Tabitha spoke of having a referral network for such instances. Ada noted that "we don't have to do everything", commenting that where a client's goals, reflecting their values, were at odds with her own values, she would refer a client to another therapist, and had done so.

One participant, Janene, who assumed a cultural matching with her client, in terms of ethnicity, realised that the RS aspect of this client's culture was the language with which she was more familiar; hence she arranged a referral to a clinician who shared the client's RS perspective. She reported:

> I speak in Māori. I use Māori terms … There was one client, … she was Māori, and her and I could not get on … She would quote the Bible … and I had no idea what she was talking about so we ended up transferring her to another therapist

> there who was very Christian really. He likes to speak in biblical terms ... She did really well with him, but her and I … we just missed each other.

Referring was a strategy engaged in by some participants when they deemed that their particular RS needs would best be met by another clinician or RS professional. In order to refer in these circumstances, participants needed to have appropriate referral networks and opportunities. Some had these already set up in advance of such eventualities.

Shifting between strategies of protecting, risking, resourcing, repairing and referring. As some participants negotiated the challenges of conflicting worldviews, when an aspect of a client's RS was unknown, or perceived to be beyond the scope of their practice, they moved between the strategies of protecting, risking, resourcing, repairing and referring. Participants, who protected themselves by hiding, also took risks. Oscillating between protecting and risking occurred when resourcing was not apparently available. Venetia, for instance, spoke about a fluidity of movement, from protecting to risking, then attempting resourcing, and back to protecting, when she didn't get what she needed.

> [In supervision] feeling like you have to protect some of yourself, having to keep something a little bit hidden or not quite say the full extent or maybe you do a little bit and risk and then it's kind of like, "Oh gosh, that wasn't the resourcing that I wanted or that wasn't the response" [that I hoped for], because the supervisor is feeling freaked out or out of their depth.

Both Brandon and Simone initially protected themselves when faced with challenges where, in Brandon's case, his perspective did not match that of the client's, and in Simone's, where she considered the client's request beyond what she perceived her education permitted. Brandon self-reflected after he was challenged by his client over his avoidance of her RS material. He realised that the therapy was in danger of ending; his actions were in response to therapeutic need. Simone had initially refused her client's request (protecting), but later acquiesced, following self-reflection (resourcing). She explained her thinking:

> How authentic is that, that I enjoy her opening our session and praying and maybe closing it, then she invites me or asks me to do the same thing. ... I felt that it wasn't authentic for me to say, "Well I don't do that kind of thing".

Implied in Simone's response, is her repairing of a probable breach in the therapeutic connection, had she continued to refuse the client's request. Resourcing often preceded repairing. Simone's self-reflecting enabled her to respond positively to her client's request. However, it could be considered that she then reverted to protecting, since the meaning of the client's asking her to pray, was not explored.

Referring may, on occasion, have followed protecting, should a participant not consider that attending to the RS matters raised by their client was a part of their brief. However, one could argue, as was explicated by Tabitha, that referring was supporting the best needs of the client, when a clinician has a clear sense of what they will, or will not attend to regarding RS in psychotherapy.

Professional and personal outcomes

Negotiating the challenges participants encountered when attending to RS in the therapeutic process led to a range of **professional and personal outcomes**, which fed back into the actions of engaging, encountering and negotiating challenge, in an iterative process. These outcomes were: ***expanding practice*** which comprised ***increased confidence***, ***enhanced therapeutic connection***, ***personal transformation***, ***broadened theoretical understanding*** and ***integrated client outcomes***. ***Maintaining the status quo*** also occurred, and was demonstrated by participants in ***being blinkered*** and in ***perpetuating conditions***. In addition, ***presenting as legitimate***, a further consequence of this overarching process of deciding what belongs, was seen in ***avoiding punitive outcomes*** and ***being accepted in the profession***. These outcomes are depicted in Figure 10 (p. 208).

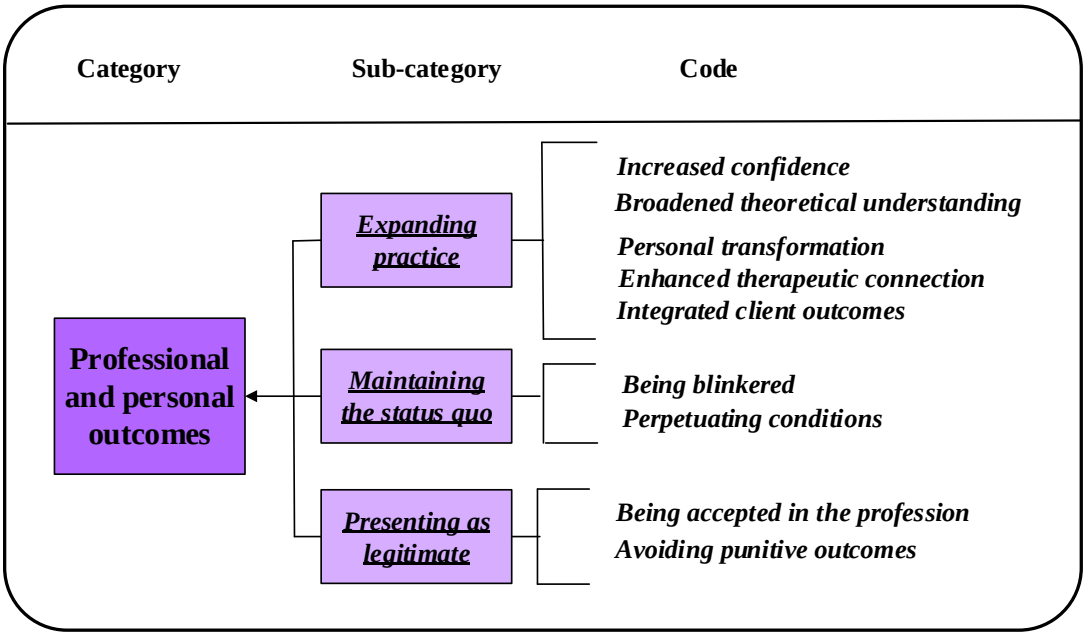


Figure 10: Professional and personal outcomes

Expanding practice. When participants negotiated challenges by taking risks**,** resourcing and repairing, the outcome was ***expanding practice***. ***Expanding practice*** comprised a broadening and deepening, both professionally and personally. Participants experienced: an ***increased confidence*** in their ability to meet client need, together with ***broadened theoretical understanding,*** as they acquired new knowledge. Some experienced ***personal transformation*** as they allowed themselves to be influenced by challenges to their own RS understandings. ***Enhanced therapeutic connection,*** also ensued as participants' increased flexibility led to enriched relationships with their clients. Some participants also reported ***integrated client outcomes,*** as their integrative practises enabled clients to grow both psychologically and spiritually.

Increased confidence. Some participants spoke of having an increased confidence in themselves as practitioners, as a result of adding to their knowledge and being confirmed in ways of working which embraced RS. They increased their knowledge in a range of ways: interweaving learnings from another discipline; modality; reading; experiencing supervisory support; personal therapy; and by introducing He ara Māori pathway, which legitimated Māori practitioners working in culturally inclusive ways. Lucille mentioned that supervision "validated her perceptions". Milly spoke

about discovering a modality which "really confirmed my growth and confidence". Tabitha reflected on supervisory support which enabled her integrate her own RS way of life into her thinking as a psychotherapist. She reported that "it was a great relief to me that I could kind of be more whole in the profession, that I could think about that. It just felt good, it felt affirming". Simone asserted that her bicultural supervision enabled her to "have confidence" in herself in naming her experience of unusual occurrences which happened when she worked with Māori clients. She added "I'm happy to do all kinds of things now because I have people to talk to that I am confident that if I don't know I will find out". Serena noted that her education in a particular RS perspective has given her "much more skill and depth and confidence in going deeper, deeper, deeper with feelings, that the person's experiencing". She found that being able to include this in her work was "wonderfully liberating". Zara, who had also interwoven her understandings from an RS discipline into her work, commented that "the course gave me more confidence to help the person explore [their RS thinking] … a greater freedom to engage at that level".

Broadened theoretical understanding. Closely connected to increased confidence, and often contributing to it, is the outcome of broadened theoretical understanding. When participants were able to explain their thinking and interventions with reference to theory, this was experienced as expansive. Zara, reflecting on the integration of another discipline into her work, said "it's like I have the freedom within my mind to conceive in a whole variety of ways, what I'm experiencing with the client". Lucille spoke about embracing a paradigm in which RS experiences "make more sense". Ted commented:

> My early experience of psychoanalysis that they weren't particularly interested in religion or spirituality. I mean there was no teaching about it really from the analytic point of view. It wasn't for me until discovering people like Marion Milner and particularly for me, Bion. [Speaking about a course he attended] they talked about Bion and "O" [and the] the Cloud of Unknowing. So they did a very good job of linking up some of Bion's writing about "O" and similar passages in the Cloud of Unknowing. That was the first time that I had seen any real theology and psychoanalysis together and that really worked, that started to make some connections.

Personal transformation. In addition to theoretical expansion, some participants spoke of changing themselves as they engaged with clients' RS at an experiential level and reflected on RS in a wide variety of contexts, including dreams and personal

reflection. Brandon said, "I've moved quite a way to being quite open about spirituality … thinking about it and talking about it". Milly reflected:

> I think that if you have not dealt with [the influence of one's own RS history] in your own therapy you are not going to be able to work with people in theirs and while it wasn't part of my training it was very much a part of my own therapy, a lot of blood sweat tears and anguish, coming to terms with all that and what it all meant to me and while it was tough at the time it was really enriching and rewarding and I don't feel I have any particular hang-ups. It's made me a more well-rounded therapist I think.

When discussing the concept of expanding practice with Harold, whilst member-checking, he commented:

> I think … there can be some possibility of some sort of transformation … the experiences can be such that it actually more than expands your horizon, it actually enables you to have … some sort of personal transformation process through immersion in these in some of these areas.

Enhanced therapeutic connection. Enhanced therapeutic connection ensued when participants took risks in responding to client need. A corollary of growing knowledge was seen in enhanced therapeutic connection. Venetia risked stepping outside of the therapy room with her client to facilitate deeper connection. Lucille's capacity to facilitate a spiritual experience in the therapy session with her client led to something deepening between them. Harold's willingness to venture into frightening territory to support his client's process reaped rewards in their relationship. In addition, to deepened therapeutic connection as a result of risk-taking, connection was deepened when participants increased their knowledge and, therefore, confidence and when they experienced some kind of personal transformation. Brandon recognised that his increasing openness to RS in the therapeutic process meant that he could "talk with [clients] more meaningfully about [RS], being able to "try with them to understand whatever the issues are and to explore it". Lucille reported an experience with a client where:

> There was this overwhelming sense of love in the room and we just didn't speak. We didn't speak for quite a long time and I knew not to say anything … it makes me feel a bit goose bumpy talking about it. There's not many people you can share this stuff with … his take on it was that it was God, and I just sort of nodded

and I felt quite emotional too. It was extremely powerful.

Integrated client outcomes. Some participants reported that clients demonstrated growth in both the psychological and spiritual aspects of their beings, when these were integrated in their therapeutic work. Serena explained a client's process of psychological and spiritual growth following abuse, saying of the client:

> Only by gradually loosening that up could she gradually entertain the idea that God would not see her in those condemning terms … And she's gone on to explore and claim a much much bigger sense of spirituality, God, in herself.

Zara made a direct connection between the integration of an RS discipline into her psychotherapeutic work and her client's integrated growth.

> She's made huge psychological growth; she's made huge spiritual growth. Her theology is so completely different, and so you know, those issues are all resolving through psychotherapy with her but my … training and my experience in that has just made it much … richer I believe I've been able to offer her the best of both worlds in her psychotherapy.

Maintaining the status quo. ***Maintaining the status quo*** was an outcome when participants continued with the direction they adopted during their education. Limiting exposure to conditions which could challenge perspectives, for example by working with a relatively homogeneous client group, maintained the status quo. Sometimes conditions were limiting in themselves, such as a lack of educational opportunities and collegial discussions which could engender change. However, maintaining the status quo did not necessarily reflect a limited view regarding RS, since some participants were educated in modalities which had psycho-spiritual foundations. Tessa reflected, "it doesn't seem to be different to my own practice right from the beginning … It doesn't necessarily expand being more than what I have already got". Maintaining the status quo was not always within participants' awareness. ***Maintaining the status quo*** was seen in ***being blinkered*** and ***perpetuating conditions.***

Chapter Seven: Negotiating Challenge

Being blinkered. Being blinkered is conceptualised as having one's vision directed towards a particular focus which limits taking other things into account. Tabitha spoke about clinicians making assumptions about certain RS groups. If those assumptions are not queried, with the possibility of redirecting their gaze, the status quo is maintained. Milly suggested that if we are "asleep in our own lives about something or don't deem it important then we're not going to hear it when somebody else brings it up". Whilst this is mixing metaphors, the same sentiment is conveyed. Nigel reflected:

> It's just … the blinkers which get put on without even realizing it, or which I don't always question the way I so often focus on the intrapsychic or the interpersonal and focus my clients on the more obvious forms of that without even realising and I'm sure part of that, the big majority of my practice has been working in agencies, and there's a sense of the work you do, the territory, you're supposed to be in and maybe that's been another set of blinkers.

Perpetuating conditions. Some participants' practices indicated that they continued to hold views which they had gained in their education, thus ***perpetuating conditions***, since their contexts did not interrupt this trajectory. This perpetuating was seen in phrases such as "it continues to feel a tricky kind of split", as Nigel reflected on his current position, gained during his education. The lack of inclusion of any enquiry about a clinician's RS in the NZAP's Advanced Clinical Practice (ACP) assessment is evidence of maintaining the status quo since it implies that RS is not part of the domain of enquiry. Ada commented:

> The whole of NZAP is very psychoanalytically-biased, as is AUT [the Department of Psychotherapy and Counselling at Auckland University of Technology], but because there is such an overlap in personalities it's the same, and then it just keeps recreating itself and becomes stronger.

Presenting as legitimate. For some participants, ***presenting as legitimate*** was an important outcome in their work. Some feared negative responses from colleagues and professional bodies and protecting their professional reputation was valued. Anastasia spoke of a "culture of fear" within the psychotherapy community. This meant that some encounters with RS were hidden, or selectively shared with likeminded colleagues, in contexts where they felt professionally safe. The nature of RS itself was seen by some as somewhat illegitimate. Averil said, I don't think spirituality is legitimacy [sic]".

Chapter Seven: Negotiating Challenge

Presenting as legitimate was demonstrated in ***being accepted in the profession*** and ***avoiding punitive outcomes***.

Being accepted in the profession. Being accepted in the profession–watching one's professional standing and being connected to the right people to ensure progress in the profession–was mentioned by some participants. Anastasia commented, "you want to be on the right side of those people you feel are the gateway to your professional life, and "you have to be a certain way to get through the gate". For some, this meant that important conversations were either not engaged in, or avoided. Ada reflected:

> Even psychotherapists' difficulty talking about certain phenomena because they fear that they will be judged by their community … to belong … to a community and to be valued is so strong, that there is so much censoring that happens publically and then also some that happens privately with the client … what is said publically is much less than what happens in the therapeutic space, I believe, but still there is that censoring.

For others being part of the psychotherapy community meant carefully choosing language which they thought would meet with acceptance. Venetia reflected:

> I feel comfortable talking the psychotherapeutic way because it is the shared language that we have, but perhaps some of my ideas about mate wairua are really different, so that is a really interesting kind of separation in terms of the community too and probably needs many more discussions … perhaps that's a feeling that I have overall about the community is that we don't talk about the spiritual element very much.

In addition to participants themselves needing to safeguard their community acceptance, Anastasia commented on the need for psychotherapy, as a profession, to ensure that it was seen as legitimate.

> It's hard enough to get psychotherapy accepted in the first place, you know, for a conservative population, people are already a little suspicious, they don't want it to get a bad name, or to get contaminated by any little kind of a charge, and of course with modern culture being so excessively rational and scientific, anything that sounds like spirituality, sounds unscientific [causes] excessive concern about being legitimate and having a professional standing in the modern world.

Chapter Seven: Negotiating Challenge

Although some participants were reticent about sharing Māori concepts within the psychotherapeutic community because of a lack of shared knowledge, others used Māori models of health which included RS, in the absence of other sources. Simone was clear about how this legitimised discussion about RS. She said:

> It's given me a framework … with my clients in my private practice this whole concept of wairua which is like that energy, that spiritual energy. See I use that a lot … And it opens up a non-religious way … it's given me permission to talk about that kind of stuff.

Avoiding punitive outcomes. Some participants managed their attending to RS in a way which avoided punitive outcomes. Having permission was important and fearing consequences of not having permission meant that some participants hid their practises, or "engaged reluctantly". The importance of permission was noted by Simone who spoke about her need to be "covered". She elaborated that when she knew that she had permission to work in a certain manner that "the client isn't going to go back and say to the psych nurse or the psychiatrist, 'hey that weird therapist prayed with me, or inflicted prayer on me,'" since she was working within the "kaupapa" (policy) of her work context.

Simone also recalled an episode which occurred in her education when one of her colleagues had to re-sit an assessment because she prayed with a client. She was then enjoined by her supervisor to remove RS material from her assessment.

> [The supervisor said] … "You've got to take that out", and I said, "What do you mean?" and she said "Look it's got that spiritual, religious edge and it's not going to serve you". I said, "Oh no, it really is important". She said, "Look … I want you to get through, it's probably not useful for you".

Simone said that she omitted the "questionable" material because she had spent a long time studying for her qualification and wanted to pass. Even though this event occurred at the beginning of her psychotherapy career, the need to be seen as legitimate has continued to influence her practice.

With all these potential outcomes, however, it needs to be remembered that since the process of deciding what belongs is iterative, that given the necessary conditions,

participants could change the strategies which they chose, with differing outcomes. Simone, for example, was able to find a context–bicultural supervision–where "we contextualized things in a way that I'm incredibly comfortable now to say all kinds of stuff to a client that I never did before". Both Brandon and Harold, whilst initially intent on maintaining the status quo, expanded their practice by becoming more responsive to clients' RS need.

Conclusion

In this chapter, I have demonstrated the processes with which participants engaged, with ensuing outcomes, as they negotiated the challenges they encountered in relation to RS in the therapeutic process. The key to supportive therapeutic engagement and outcomes was that participants were able to resource themselves when they encountered challenges. In the absence of resourcing, participants took risks and protected themselves, which, should these strategies be used extensively and/ or on an ongoing basis, is detrimental, not only to the clients with whom they work, but also to themselves as psychotherapists and to the psychotherapy profession in ANZ. Maintaining the status quo and presenting as legitimate do little to advance the psychotherapy profession. It is possible, however, as has been demonstrated, for practice to expand as clinicians extend their knowledge, experience professional and personal transformation and enhanced connections with clients. The findings explained in this and the three preceding chapters raise a number of issues for discussion. The Discussion chapter, which follows, reflects on the findings, literature searched following the findings, together with material already raised in the previous chapters.

Chapter Eight: Discussion

Introduction

This research aimed to uncover a theoretical explanation of all that is involved in psychotherapists' decision-making processes concerning religion and/or spirituality (RS) in the psychotherapeutic process. Questions considered in this study, as noted in Chapter one were: How do psychotherapists in Aotearoa New Zealand (ANZ) attend to RS within the therapeutic process? What influences their decision-making processes? Are their decisions subject to change, and if so, under what conditions and with what outcomes? Utilising grounded dimensional analysis (GDA) methodology, an overarching process of "deciding what belongs", was derived from data, which explained participants' decision-making processes. In summary, my research found that:

- Participants decided what belonged in the therapeutic encounter from three perspectives: psychotherapy is secular; psychotherapy and RS are inextricably connected; and psychotherapy touches RS episodically. These perspectives were formed through interaction with a variety of contexts and sometimes shifted over time in response to further contextual interactions. It is from these perspectives that participants engaged with clients' RS, encountered and negotiated challenges.
- The process of engaging comprised: introducing; differentiating; linking; exploring; teaching; and experiencing. During the process of engaging, participants encountered several challenges.
- Challenges occurred when participants and clients held conflicting worldviews; where clients' needs were perceived to be outside the scope of the participants' practice; and lastly, where participants encountered RS material and/or experiences which were unknown to them.
- Participants negotiated these challenges by: protecting themselves; taking risks; resourcing themselves; repairing the therapeutic relationship; and referring clients.
- The outcomes of these actions were various; participants either: expanded their practice; maintained the status quo; or presented as legitimate.

Chapter Eight: Discussion

These findings were explained in Chapters four to seven; in this chapter they are discussed in conjunction with the literature, including where they are supported by and diverge from extant works, and where they advance the field. In order to provide comprehensive coverage of these complex findings, this discussion largely follows the outline indicated by the summary of the research, as noted above. Firstly the overarching process of deciding what belongs is discussed, together with the perspectives from which participants approached the field. Then, the strategies of engaging, encountering challenge and negotiating challenge are considered, and the professional and personal outcomes of the theoretical process discussed. The limitations of the research are outlined and implications for education, practice and further research are considered. In conclusion, I offer some personal reflections.

Deciding what belongs

This study has found that "deciding what belongs" best explained how participants attended to RS in the therapeutic process. Deciding what belongs was influenced by participants' perspectives on RS, which were formed through a combination of their own life experience, RS history and orientation, education and modality; their understanding of the role and nature of psychotherapy; socio-cultural context, including biculturalism, and the context of the psychotherapy community. These contextual influences evidenced in my research findings suggest that deciding what belongs has most likely occurred long before the psychotherapist–client encounter which means that many interactions regarding RS in clinical practice may occur outside psychotherapists' awareness, should these contextual influences not be consciously explored. The concept of deciding what belongs, as a description with sufficient explanatory power to encompass the actions of psychotherapist participants, in relation to RS in the therapeutic encounter, contributes new knowledge to the field.

Research studies have found a range of conditions which have a bearing on therapists deciding what belonged in the therapeutic process, in relation to their clients' RS. Magaldi-Dopman, Park-Taylor and Ponteroto (2011) reported the influence of therapists' theoretical orientation in their interactions with clients' RS, whilst Baetz, Griffin, Bowen and Marcoux, (2004) found that it was clinicians' own RS beliefs, rather than practice guidelines, which "predicted inquiry into their patients' spirituality" (p. 265). Baetz et al. stated that the "practice guidelines for psychiatric evaluation of adults

[of the American Psychiatric Association (APA)] include consideration of spiritual and religious issues as part of standard practice" (p. 270).

Although findings from both Magaldi-Dopman et al.'s (2011) and Baetz et al.'s (2004) research implied the concept of therapists' perspective in their decisions, the forming of perspectives and the numerous strands of which they comprise, as conceptualised in my research, contributes new knowledge to the field. This is an important finding, since it demonstrates the complexity involved in clinicians' decision-making processes regarding RS in the therapeutic process. Baetz et al.'s reporting the subsuming of practice guidelines in favour of clinicians' own RS perspectives, a finding supported in this research raises the question of the relationship between psychotherapists' perspectives and professional expectations.

The relationship between psychotherapists' perspectives and professional expectations. As noted in Chapter one, psychotherapists in ANZ are expected, both by the New Zealand Association of Psychotherapists (NZAP), as well as the registering body, the Psychotherapists' Board of Aotearoa New Zealand (PBANZ), to engage competently and respectfully with clients' RS values, being aware of their own cultural values, and not imposing them on others.

Even though the PBANZ has clear expectations of psychotherapists' cultural competence, and its Standards were published in 2011, i.e., prior to my data collection, it is curious that no participants made reference to these standards in their decision-making processes. One reason for this may be the ambivalent relationship that many psychotherapists have towards the regulatory body. Additionally, there is no formal accountability to these Standards until the auditing of psychotherapists which commences in 2016. Moreover, not all professionals who practise psychotherapy are registered psychotherapists; therefore, not all psychotherapy practitioners are subject to the Board's requirements. However, having said this, a recent informal survey suggested that 90% of NZAP members are now registered (Robertson, 2015).

Whilst participants made no reference to the PBANZ, some noted the lack of attention paid to psychotherapists' RS in the NZAP assessment processes for Advanced Practising Certificate (APC), an anomaly which intimates a degree of incongruence within the organisation. Although culture is mentioned in the assessment, it is

considered under "Biculturalism", "Multiculturalism" and "Gender" (NZAP, 2014, pp. 15-16). In terms of culture, one could reasonably infer that what is being considered by the NZAP is the ethnicity aspect of culture, rather than the broader understanding advanced in this research. There is no mention of RS. The exclusion of RS in considerations of culture has been noted by Hage, Hopson, Siegel, Payton and DeFanti (2006) and Jones (2013). As well as being absent from the written criteria, Ethan, a participant in this study, observed that the inclusion of RS in the oral interview associated with the APC qualification, rested on interviewer interest. He said, "It's always fascinated me that the [interviewing] panels I was on anyway, unless I suggested it, nobody was interested in the candidate from a spiritual point of view and the questions were not asked". Thus deciding what belongs regarding RS in psychotherapy, may be communicated to psychotherapists in assessment processes within NZAP.

The influence of education in deciding what belongs. Although demonstrating competence in RS is not solely predicated upon formal educational opportunities, since an individual's own "informal" experiences are influential, the salience of formal education in this area cannot be underestimated. My findings demonstrated a definite connection between participants' actions in therapy, in deciding what belonged, and their educational experiences. For many participants, RS was given scant attention during their qualifying education; a lack which they noted influenced their work.

These findings are supported widely in overseas literature. In a US study of staff and pre-doctoral interns, Hicks (2003) found participants reported they received less training and felt less competent attending to RS issues than issues of gender, ethnic diversity and sexual orientation. In order to explore the attention to culture and diversity education in psychotherapy, Cilitira and Foster (2012) conducted a mixed-methods study. During interviews, the 24 participants, from diverse backgrounds, were asked about the impact of their ethnicity on their education and how sexual orientation, gender, social class and religion might influence training experience. One major finding was that psychoanalytic trainings tended to focus on intra-psychic exploration, rather than external issues. Participants also reported feeling silenced in matters of diversity. It seems that RS education, or lack thereof, is related to the preferred modality taught in educational institutions; findings confirmed by my research.

In addition to neglect of RS in academic education programmes, and focus on RS being influenced by modality, some participants in Magaldi-Dopman et al's (2011) study reported they experienced hostility during their education when discussing and exploring their religious/spiritual/non-religious identities. These researchers wondered of their participants, "Did they repeat the unspoken message that they received in their programs to their clients–"keep it at home?" (p. 296). My research indicated that this taboo mentioned by some participants influenced their hesitancy to welcome clients' RS matters in the therapeutic process.

Even though researchers have reported a dearth of education for clinicians in the area of RS, there is some evidence, at least in the USA, that this is changing. A survey of psychologist education programmes conducted by Brawer, Handal, Fabricatore, Roberts and Wajda-Johnston (2002) found that while was no systematic coverage of RS in education programmes, most psychology training programmes addressed RS in some way. A follow-up investigation undertaken by Schafer, Handal, Brawer and Ubinger (2011), however, reported that more programmes had at least some coverage, although systematic attention was still lacking. These findings are hopeful for the inclusion of RS in psychotherapy education in ANZ. In addition, research in ANZ in the health sector suggests changing thinking regarding the inclusion of RS in curriculum.

Although there has been no research of education providers in the counselling, psychology and psychotherapy field in ANZ, regarding RS, a recent survey was conducted in this country by Lambie (2015), eliciting the perspectives of medical education providers about the provision of RS education to medical students. Findings revealed 75% of participants agreed that RS education should be included in the curriculum. However, there was no consensus as to "how" this should occur. Nevertheless, there was general agreement of the need to revisit curriculum. One participant reflected that "the teaching of spirituality should not become another box to tick" (p. 55), a warning which, in my opinion, needs to be heeded in any proposed inclusion of RS in psychotherapy education programmes in ANZ. Moreover, lecturer receptivity to any inclusion is an important condition, since 25% of the curriculum providers, surveyed by Lambie, did not believe that spirituality should be included in the curriculum. In addition the methods of inclusion, suggested by some participants, such as tutorials and mentoring, required a high degree of lecturers' personal

involvement. In this study, work contexts were also reported as influencing the inclusion of RS in therapy, a finding also reflected in my research.

The influence of psychotherapists' work contexts in deciding what belongs. My research found that some participants' interactions with their work contexts meant that they either "foregrounded" or "backgrounded" their own perspectives regarding RS, or attended cautiously, and in a limited way to clients' RS needs in some contexts.

A backgrounding of perspectives in order to ensure job security was demonstrated in a qualitative study exploring the beliefs and attitudes towards RS in practice, of 20 psychiatrists in the UK, conducted by Dura-Vila, Hagger, Dein and Leavey (2011). This participant sample comprised equal numbers of UK-born and immigrant psychiatrists. A salient finding of this research was the difference between the immigrant psychiatrists whose practice in their countries of origin was to include RS, whereas the practice of the UK-born psychiatrists was one of exclusion. Immigrant participants held to their RS perspectives regarding the importance of including the RS dimension in their work, yet put their views to the background to meet the expectations of their secular work context. However, one Nigerian clinician spoke of providing consultation reluctantly concerning the RS presentation of an African patient, thus supporting the "cautious" foregrounding, also demonstrated in my research.

Findings from my study also suggested that time constraints, the work "task", and philosophy of the work place all influenced participants decisions in addressing clients' RS matters. This finding was supported by research conducted within public mental health services in ANZ by Ihimaera (2004). Ihimarea's study explored the facilitation of taha wairua (the spiritual dimension) for Māori service users, and reported that although Māori cultural practices were being implemented to a degree, greater incorporation was hindered by such factors as: a lack of resources; lack of time; practitioners being expected to perform both cultural and clinical roles often without additional resources; a lack of appropriate cultural spaces; racism; and the dominance of Western practice methods. Later research in the USA by Coyle and Lochner (2011) also reported that limited time and the need to adhere to specific ways of working in different organisations may inhibit clinicians' ability to address clients' RS needs.

Differences in therapists' attention to RS depending on context, was noted by Morrison, Clutter, Pritchett, and Demmitt (2009), in another USA study. These researchers found that clients seen in a Christian counselling agency were much more likely to have their RS matters attended to than those seen in a secular agency. In the former, clinicians were largely responsible for the introduction of RS, whilst clients seen in the latter setting reported that they were most often responsible for its inclusion. This study does not say what influenced clients in their choosing a religious or secular setting for counselling, so that the influence of client expectation in these findings, although perhaps implied, is not explicit.

From the perspective of clients who held RS beliefs, Castell (2013) explored the raising of RS matters in public and private contexts, using a self-report survey–a survey which involved 725 individuals, in the USA, UK and ANZ. Clients in this study reported that their RS material was attended to more often when seen by clinicians in the private sector, as distinct from the public sector. Focusing on results from the 454 participants in the ANZ sample, Castell reported that a total of 37% discussed RS and felt that it was considered in their therapy. However, this decreased to 34% in the public sector and increased to 42% in the private sector. A total of 45% discussed RS and were satisfied with how their RS beliefs were considered, decreasing to 39% in the public sector and increasing to 55% in the private sector.

As has been noted in Chapter two, clients who have their mental healthcare needs attended to in the public sector in ANZ have the right to care that is inclusive of their RS needs. However, my research has found that, for the most part, participants experienced public sector contexts as constraining. One exception to this was Simone's report that her public sector context–which made specific provision for the cultural needs of its Māori patients–was where she "grew … spirituality". Although attention to clients'RS may be legislated, it would appear that a particular organisation's philosophy also has an influence on what is attended to, as Nigel spoke about being "blinkered" by his work task.

Although this study reported that participants were more likely to attend to clients' RS issues in private practice than in the public sector, my study also found that clinicians working predominantly in private practice shifted, in the course of their

work, from positions which favoured an exclusion of RS from the therapeutic encounter, to one of inclusivity, in response to client need and collegial interactions. Although one could assume, with the plethora of literature now focused on addressing RS needs in clinical practice, that over time clinicians' positions may change, I could find no research which demonstrated this shifting; hence, this is a contribution of new knowledge to the field.

In summary, deciding what belongs in relation to RS in the therapeutic encounter, has been demonstrated as being the choice of participants in my study; a finding supported by a number of research outcomes. There are a range of contexts which have shaped, and continue to shape perspectives. Even though constrained or enabled by work contexts, participants were the ones engaged in the therapeutic encounter.

Engagement with RS in the therapeutic process

My research findings have demonstrated that how, and to what end participants engaged with RS matters therapeutically, depended on their perspective regarding RS in psychotherapy, mediated on some occasions by work context requirements. Of particular salience in terms of perspective were participants' own RS history and orientation, together with their modality/education. These findings concur with research findings by Baetz, Griffin, Bowen and Marcoux (2004), Crossley and Salter (2005) and Lestinga (2008), which supported the importance of clinicians' own RS in attending to RS in clinical work, and Magaldi-Dopman et al. (2011), who highlighted the salience of therapists' modality in addition to RS orientation, in attending to this domain.

Who raises the topic? Practices around introducing RS in the therapeutic milieu reflected the perspectives which participants brought to the work. Those who held the perspective that RS is inextricably connected with psychological functioning would often introduce the topic in some way, yet their practice style and modality also influenced this introduction. A number of participants left it up to clients to initiate conversations about RS, should they so choose, sometimes reflecting their own ambivalence about its belonging, yet also at times reflecting a practising style preference. Castell's (2013) research found that, "Client's Expectations [sic] of whether their religious/spiritual beliefs would be addressed were … significantly related to whether the topic was raised [by the therapist] in therapy" (p. 174). Castell's findings

reflected Ljungberg's (2006) assertion that it is important that the therapist raise the issue of RS, thereby indicating to the client that it belongs.

Reticence in raising RS with clients, even if participants deemed this an important aspect of existence, was supported by findings from a quantitative study investigating the inclusion of RS in clinical assessing by psychologists in the USA (Hathaway, Scott, & Garver, 2004). These researchers reported that although the majority of participants considered RS to be at the minimum "slightly" important domain of human functioning, this did not always translate to inclusion of RS in assessment and treatment. However, Hathaway et al. did note that clinicians who more explicitly addressed this area were more likely to understand its importance in human functioning.

Another reason for reticence in raising RS matters, noted by a few participants in my research, was a desire not to "impose" on clients. Imposing is a strong word which invites a pressured compliance. Would a clinician consider that they were imposing if they asked about a client's family or living situation? What is spoken or unspoken influences our clients, as Casement (2002) stated, "Patients note not only what we have said but also what we have not said … monitoring what this could indicate of our interest/our priorities/our sensitivities" (p. 27). Not initiating conversation regarding RS out of deference to the client needs closer consideration about what all is involved in such a decision. Trautmann (2003) reflected:

> Many therapists know and value the spiritual dimension of life, but some will wait for it to emerge from the client and may not initiate the discussion directly themselves, leaving the impression that it is not part of the process. By the same token, some clients will not bring it up unless the therapist does, thus leaving the impression that it is not part of their lives. Other therapists will not deal with it at all. (p. 32)

Conducting grounded theory research with 14 psychotherapy clients that involved participants reviewing an immediately preceding therapy session, Rennie (1994) concluded that clients acted deferentially towards their therapists by saying what they thought therapists want to hear, and pretended compliance. However, the research design for Rennie's study involved the therapist nominating client participants for the study may have chosen those who were compliant. Winton (2013) asserted, "If a client senses or imagines that a therapist has a particular response to religious content,

whether this is felt to be avoidance, resistance, particular interest or approval, this will be registered" (p. 347).

This registering of a therapist's response by clients was noted in a hermeneutical-phenomenological study exploring three religious clients' experiences in therapy conducted in the USA by Ahern (2011). Ahern reported that one of the participants in his research felt "misunderstood and negatively judged by her therapist ... [however] she did not feel able or willing to completely reject, avoid or dismiss her therapist's perception" (p. 47). This judgment related to her and her partner's decision to abstain from sex until marriage, a decision in line with their RS tradition. Ahern added that this participant "receded from full engagement in the therapy, passively acceding to her therapist's interpretation of her reality" (p. 89).

Some therapist participants in Simmonds' (2004) study concluded that clients could simply learn to comply with therapists' needs. Simmonds wondered, "What part does the psychoanalyst or psychotherapist play in the intersubjective field in either facilitating or discouraging bringing an important domain of human experience" (p. 962). Findings from my research suggest that they may play a large part in this dynamic, to the extent of deciding what belongs.

Even though the scope of this present study did not cover clients' reports of their experiences of the treatment of their RS material by their therapists, a few participants reflected on their experiences as clients; both welcoming and unsupportive. Whilst one participant was able to process his repudiation of RS, with his therapist, whom he identified as Christian, another said that RS was never raised by herself or her therapist. Yet another reported that he stopped taking RS matters to therapy as his therapist did not pick up on them. This finding echoes findings by Simmonds' (2004) in her research involving psychoanalytic clinicians. Speaking of their own therapy, one participant reported that "spiritual matters were given 'pretty short shrift' with the effect that 'there were some experiences I wouldn't take there or learned not to take there'" (p. 962). It is evident that clinicians communicate their values to clients whether or not they are aware of it (Giglio, 1993; Hawkins & Bullock, 1995; Meehl, 1959). Some of these values are derived from clinicians' education/modality.

Chapter Eight: Discussion

How education/modality influences engagement. My research findings demonstrated that how RS was attended to by participants was strongly influenced by the clinician's education/modality. This finding is supported by Brown, (2006); Brown, Elkonin & Naicker (2013) and Magaldi-Dopman et al. (2011); the latter reporting that:

> Psychodynamic or psychoanalytically trained psychologists placed a strong emphasis on how the discussion of spirituality and religion affected the therapeutic relationship, exploration of spirituality and religion, acceptance, and tolerance. These psychologists used language from within their theoretical orientation to describe clients' spirituality or religion, including discussing God as an object from object relations theory, God as the super-ego, religious transference, and religious projection. (p. 298)

The continuing influence of education, and in particular the example set by educators, was one of the findings in this research; this example was perpetuated in practice. This finding concurred with the experience of a Māori psychotherapist in ANZ, who reflected on her experiences during her psychotherapy education (Winter, 2013), commenting, "The freedom of my knowing was greatly reduced. I did not listen to my intuition as much … my sense of wairua seemed to be partially disconnected, as if I was in limbo or missing a part of myself" (p. 170). This was only redressed after Winter qualified, when she joined a wānanga (place of indigenous learning) and was taught by a tohunga (expert healer). She explained that through this later process she was able to become a "psychotherapist connected to wairua" (p. 171). It could be logically assumed that, prior to this post-qualifying education Winter's disconnection from wairua influenced her practice.

Rather than psychotherapy education having an inhibitory influence on RS expression, Ella, a participant in my research, made what appeared to be a seamless transition between her psycho-spiritual education and the inclusion of RS in her practice. Therapists like Ella, educated in transpersonal approaches, are trained to incorporate spiritual experiencing into the psychotherapeutic process and tend to elicit clients' RS strengths (Vaughan, Wittine, & Walsh, 1996). However, having said this, this participant judged an aspect of a client's RS tradition with which she was unfamiliar, which suggests that even education in a psycho-spiritual modality cannot wholly mitigate clinicians' conflicts with RS differences.

Chapter Eight: Discussion

A number of participants in this study spoke of exploring client's RS resources in terms of accessing the support of a divine figure, as well as a RS community. This finding concurred with literature which emphasised the need to look for the positive aspects of a client's faith for support (Gonsiorek, Richards, Pargament, McMinn, 2009; Pargament, 2007; Plante, 2009).

It is evident that the education/modality through which a clinician views a client's RS has a bearing on what they see, hear, and, therefore, how they respond to the RS material that the client brings. As Milly, a participant in this study reflected, "The way I listen to [the client] takes the conversation in a particular direction".

Assessing function of RS. Part of a psychotherapist's task is to assess a client's functioning, coming to some understanding of what may be causing conflict and what strengths a client has to support recovery. As has already been mentioned in the preceding chapter, clients' RS perspectives may be part of the problem and/or part of the solution. A finding in this research was that participants made decisions about whether clients' RS presentations were life-enhancing or life-inhibiting based on a number of conditions; their own values, experience, theoretical perspectives and cultural norms.

Clinicians' tasks in attempting to differentiate between healthy and unhealthy RS is fraught, Zinnbauer (2013) asserted, because RS is now included under the umbrella of cultural diversity which increases complexity. Vandenberghe, Prado, and de Camargo (2012), suggested that the challenge of respecting clients' RS perspectives, whilst also considering that some expressions of RS are problematic, is akin to "cultural competence tightrope walking" (p. 83). Gonsiorek, et al. (2009) asked whether it is ever ethical to target a client's RS perspective for change, even if, from the therapist's perspective, they are causing the client distress. Zinnbauer (2013) summarised this challenge, saying:

> In fact, to even suggest that another's worldviews, sacred beliefs or traditions are "healthy" or "unhealthy" is akin to wading into a social, political, and cultural minefield. One misstep and an explosion of criticism and controversy is triggered. "Who gets to make those judgments?"; "From what perspective?"; "In what context?" "With what groups or individuals?"; and "With what consequences?" (p. 71)

Chapter Eight: Discussion

Zinnebauer has raised some important questions. I have argued, in Chapter two, that RS is an aspect of culture. Does this mean that all nuances of cultural expression are accepted without demur?

In order to help assess the health or otherwise of cultural beliefs and practices, two forms of differentiation–an–emic, and an etic perspective–have been noted by Lett (1990, 1996). The former relies on the opinions of cultural or spiritual insiders to determine the relative health of a belief, whilst the latter is determined by objective means, where more generalised, cross-cultural understandings of healthy functioning and wellbeing are evaluated. Zinnbauer (2013) suggested that a combination of the two approaches was useful in evaluating healthy spirituality, commenting that a total reliance on the insider's group perspective (the emic model), would mean that values of extremist groups, although destructive by an etic standard, could be considered culturally normative. An etic approach is complementary, Zinnbauer asserted, since it revealed "relationships among various spiritual beliefs, attitudes, behaviour, and health outcomes" (p. 78).

Although Zinnbauer's (2013) proposition has merit in theory, its practical application is not so clear-cut. Apart from the fact that, from a symbolic interactionist perspective, the "objective" does not exist, even outsiders have perspectives which are constructed according to the groups with which they interact. For example, Paul Pruyser (1916-1987) using a psychoanalytic lens (one could argue from an etic perspective), suggested three indicators of healthy religious faith: holding on to the capacity to think for oneself, rather than surrender intellect to a religious tradition which prohibits questioning; the ability to tolerate reality rather than flee into pleasurable fantasies; and the ability to hold onto personal freedom (Malony & Spilka, 1991).

The foregoing suggests that although different ways of understanding RS health provide some useful guidelines, these need to be considered cautiously. It is important in assessing RS functioning to take into account the client's experience of distress, rather than what may be attributed by an outsider who has their own perspective. Murray-Swank and Murray-Swank (2013) seem to have addressed this in their definition, considering an RS problem to be "a problem involving aspects of religious or spiritual

belief, experience, or practice as indicated by an individual's distress or impairment in functioning" (p. 423). Having said this, one needs to ask what criteria are being used to determine "impairment in functioning". It is unrealistic, therefore, to expect that a clinician put their perspective aside; however, awareness of what that perspective is, and how it has been arrived at, is essential.

Weighing up the function a person's RS serves in their life is important, since, as has been said, this is a very complex relationship; assessing takes time, a reality noted by some participants in this study. It is important that clinicians, whilst respecting an individual's cultural expression, do not jettison intellectual reasoning, and collude with an individual's suffering by not challenging RS perspectives that do not support adaptive living. Having said this, however, if emic and etic perspectives are considered, where does the therapist's theoretical lens fit?

Although much can be gleaned about the health or otherwise of a client's RS views from understanding the particular use a client makes of their RS beliefs, there may be times when more information is needed. It may be helpful to consult with RS leaders who can provide information about cultural norms within a particular tradition.

Consultation with and referral to RS leaders. Consultation of, and referral to clergy and RS leaders by clinicians, is considered important (Giglio, 1993; Johnson, Ridley, & Nielsen, 2000; Zenkert, Brabender & Slater, 2014). Consultation may be helpful during treatment, where a client's RS views are atypical of their particular tradition (Johnson, Ridley & Nielsen, 2000). However, since RS traditions embrace wide variations, may be held idiosyncratically, and therapist knowledge may be limited, what is atypical may be difficult to determine. Nevertheless, it is useful for psychotherapists to develop community connections for consultation and referral.

Referral may be useful where a client is already connected to a faith tradition that occupies an important place in their lives. However, there are exceptions to this. Speaking about clients who have experienced sexual trauma, Brown (2008) asserted, "Clients may not trust clergy, may not have a relationship with a member of the clergy who they find credible on these matters, or may not practise an organized religion despite still believing in God" (p. 236).

Although some literature supports referral, Brown (2008) disagreed with referring clients to RS leaders, suggesting that it was the clinician's task to support the client finding their own authority in relation to the divine, rather than reinforcing the need for an external authority, which is implied by referral. This is an interesting point, and one which highlights a potential difference between the aims of both disciplines, at least from certain theoretical perspectives. This dilemma aside, one wonders whether the hypothetical client would be "on board" with the "clinician's task", in this instance. Ethan, one of the participants in my research, acknowledged the cultural importance that a church minister had "particularly with the Pacific Islanders he is right up there in terms of authority" and he would refer clients to their priest especially around areas of forgiveness to alleviate guilt. Whilst acknowledging client preference, he also said:

> What I will say to the client is that you are actually going to, from my perspective, is what we would call a father figure to let you know what the next step should be and you need to ask yourself is whether what he says is what you want, but I do understand that you will probably take his direction.

Whilst acknowledging client preference, this participant's words suggested a rather reluctant referral, which illustrates the tension between the two disciplines and may in part explain a lack of consultation by clinicians.

Although client referral was mentioned, no participants spoke about consulting with RS leaders themselves, possibly also indicating the fraught relationship between these professions. This finding is supported by Hathaway, Scott and Garver (2004) who reported that over 80% of clinicians in their research, reported rarely or never consulting or collaborating with RS professionals in client treatment, although the reasons for this were not elaborated. One of the participants in my research, who identified as Christian, said that he doubted the capacity of some religious leaders to offer appropriate support. For this reason he tended not to refer clients to RS leaders, offering Christian clients support in the Christian tradition, himself. Plante (2007) cautioned against this practice, warning that sharing a similar faith perspective as their client, this does not make the therapist an expert in the tradition. The issue of consultation and referral raises the issue of the boundaries of psychotherapeutic practice, which is discussed later.

Bicultural supervision. Although consultation with RS leaders was not mentioned by participants when working with clients from different or even similar RS traditions, some participants mentioned consultation with Māori for what they named as "cultural supervision". This may be because consultation with Māori around bicultural issues is widely expected and available within the psychotherapy community and public sector work contexts, in line with Te Tiriti o Waitangi The Treaty of Waitangi expectations, whereas the relationship between psychotherapy and RS disciplines is not established. Possibly reflective of this, the NZAP member's annual supervision agreement (NZAP, 2015), requires psychotherapists to discuss the use of bicultural supervision with their supervisors; there is no mention of other forms of cultural consultation.

Whilst it is heartening to see that NZAP expects its members to have bicultural supervision when appropriate, it appears that this emphasis may cause a de-emphasis on other aspects of cultural supervision or consultation, as suggested by a conflation of bicultural with cultural by participants in this research.

RS beliefs held in common? Some participants demonstrated they were more able to invite discussion and explore beliefs with clients, when these beliefs were held in common. Where interests coincided there appeared to be benefit to both participant and client. Castell (2013) also found that the likelihood of discussing RS beliefs with a clinician was substantially higher when practitioners held similar RS beliefs to their clients.

However, "sharing" beliefs was seen to lead to unexplored assumptions by some participants in my study. Adam who assumed that both he and a Christian client held similar perspectives on sexual expression because of their shared religious tradition, judged his client's choices. This led to an irretrievable breakdown in the therapeutic relationship. One participant in Carney's (2007) study reported making assumptions about a client's RS because of some of the client's views, without enquiring further, only to discover that they shared "the same" religious tradition. This alerted her to the wide variety of belief, even ostensibly within the same RS worldview. Zinnbauer and Pargament (2000) warned about the potential for missing differences due to assumptions of commonality. Given the wide variation in beliefs within particular religious traditions, it is debatable that beliefs can be entirely shared (Priester, Khalili &

Luvanthingal, 2009). This means that careful enquiry needs to be made into pertinent aspects of clients' RS traditions, whether or not they are similar to those of the therapist.

Whilst it is important not to assume homogeneity within an RS tradition, my findings demonstrated it is equally important not to make assumptions about the salience of one aspect of a client's culture over another. Janene, a Māori participant, reported that her Māori client identified strongly with her RS tradition (a tradition neither shared nor understood by the participant) rather than with her Māori ethnicity. Jim and Pistrang (2007) cautioned, "It is … important to realise that clients will vary in the degree to which they adhere to the values and norms of their indigenous culture" (p. 461), a reality noted by Durie (2001) concerning Māori identity.

Therapist self-disclosure. One finding in this research was that some participants disclosed their RS perspective to their clients, either through advertising, or within the therapeutic process, either at the beginning of therapy to establish rapport, or during therapy to negotiate some relational difficulty. This finding is supported by the literature. It has been suggested that disclosure can help to establish therapeutic connection in the initial stages of therapy (Brown, 2006; Gonsiorek, et al., 2009; Hawkins & Bullock, 1995), and deepen rapport at other times (Stricker, 2003). Denney, Aten and Gringrich (2009) suggested that self-disclosure may be important for fundamentalist clients who may need to know that their RS beliefs will be respected.

One clinician participant in a study conducted in the USA by Williams and Levitt (2007) mentioned having difficulty working with clients with rigid Christian fundamentalist belief systems. He managed this challenge by disclosing his difficulty with such belief systems to the clients concerned and left the decision up to them regarding whether they continued to work with him. Disclosures such as these, even if considered desirable, are only possible if a clinician has a high degree of personal awareness.

Whatever choices therapists make regarding self-disclosure of their RS positions, it is important that these decisions are made with well considered therapeutic rationale (Stricker, 2003). The purpose and timing of the disclosure, together with the needs of the client are important to bear in mind (Denny, Aten & Gringrich, 2009).

Chapter Eight: Discussion

Whether or not clinicians choose to disclose their RS position, clients may come to therapy with significant knowledge, real or imagined, about their proposed therapist. This matter was raised by a few participants in this study. Given the size of ANZ, especially the small populations of some cities, together with information available via the internet, psychotherapists, in ANZ, need to be alert to what may already be known about them, and how this may influence the client's choice of them as a therapist. Winton (2013) commented:

> I practice psychotherapy in a small city in New Zealand. I am also a Dominican Sister. Many of my clients will know this. Some will approach me with this in mind. Knowledge of my other vocation not only means that clients can bring religion into the consulting room but that some expect to find it already there waiting for them. (p. 346)

As Winton's (2013) example suggested, disclosure may be something of a moot point when knowledge is easily obtained.

Whilst Yarhouse and Johnson (2013) agreed that if clients are aware of the therapist's framework in advance of engaging in therapy, they are better informed regarding choice of a clinician to help them achieve their goals, however they caution that such disclosure may influence the client's future actions. Nevertheless, therapist disclosure of their RS position may be an important consideration in relation to informed consent (Josephson, Peteet & Tasman, 2010).

Informed consent: What is the client entitled to know? Since this research demonstrated that conflicting RS views challenge therapeutic connection, it is understandable that clients, who want their RS beliefs to be treated considerately, may require information about the therapist's RS perspective before they engage in therapy.

Psychotherapists are required to ensure that clients consent to therapy. The NZAP *Code of Ethics*, Section 1.4 stated that "Psychotherapists shall seek to ensure that the client is willingly engaging in psychotherapy and has an adequate understanding of the process to be undertaken" (NZAP, 2008). Section 6.1 of the PBANZ *Standards of Ethical Conduct* (PBANZ, 2011b), whilst reflecting these requirements, added that informed consent is an ongoing process. It seems apparent that what clients are consenting to is process rather than outcome, and that this consent needs revisiting throughout the

therapeutic engagement. Although the need for, and expectation of informed consent seems clear, "informing" and "consenting" are not as clear where RS is concerned.

Crucial to informing and consenting is the psychotherapist's knowledge and self-awareness of RS matters, both in terms of their professional practice and their own relationship with RS, and how these may influence the therapeutic process. Clients also have the right to know how a proposed psychotherapist's modality may position RS, since different psychotherapeutic approaches engage with RS diversely. Article 3.2 of the PBANZ *Standards of Ethical Conduct* enjoined the psychotherapist to "Be aware that each modality has a cultural context which may differ from that of the client" (PBANZ, 2011b). Although a few participants in this study discussed this with clients during the engaging process, this was not common practice. How many psychotherapists would know how their chosen modality approached RS if this knowledge was not included in their education, an exclusion which may have given the message that this was not important?

Connecting disciplines. Although some psychotherapists may not be aware of how their modality considers RS, some participants in this study made connections between psychotherapeutic theory and RS theology. Some posited that both domains were saying the same things, shared similar goals, and had some techniques in common. Those who made these connections and conclusions mostly had RS backgrounds and/or held the perspective that psychotherapy and RS were inextricably connected. This strategy appeared to be useful for their meaning-making.

Tillich (1970) suggested that it was not possible to compartmentalise the fields of psychotherapy and theology, since the root of both was existentialism; the need to find meaning in existence. For this reason, he proposed that "The relationship is not one of existing alongside each other; it is a relationship of mutual interpenetration" (p. 114). Interpenetration suggests an intentional connecting and influencing.

Suggesting a commonality of goals, Litjmaer (2009) noted that both psychotherapy and RS share the search for authenticity, whereas Johnson and Sandage (1999) saw the goals of both domains as that of enhancing personal wellbeing, going as far as intimating that psychotherapy could be seen as a religious enterprise as both endeavours focus on "restoration, salvation and healing of the soul" (p. 6). Drawing

both the Christian and psychoanalytic traditions together, Hoffman (2011) reported that "the process of psychotherapeutic transformation is an analogue to ancient redemptive narratives" (p. 17).

In a hermeneutic study of literature, Damon (2010) drew a number of parallels between the chakra system, a theory from the Hindu religious tradition, and Maslow's hierarchy of needs, a psychological perspective. She concluded that all psychotherapeutic modalities support a person's growth, which could be understood as a spiritual endeavour.

Although finding commonality can assist with meaning-making, it also brings with it the possibility of conflation, where RS is collapsed into the psychological. Some participants made connections between a client's experience of God and their internalised parent figures, which could be considered reductionistic. In an approach which recognised commonality yet appeared to avoid conflation, Strength (1998) expanded Davanloo's interpretive triangles, which connected the client's experience between the therapy relationship, current social relating and past parental figures, to include a client's relationship with God, thus changing the figure to a square. It is a difficult, although not impossible, task to be able to hold the nuances of commonality together, as well as acknowledging difference.

It is evident that more conversations need to be had between the disciplines of theology, spirituality and psychotherapy. Both McWilliams (2000) and Sorenson (2004) have suggested that psychotherapy education needs to incorporate other disciplines– especially the theological, to widen understanding. In addition to making connections which draw these arenas together theoretically, RS experiencing within therapy was noted by many participants.

Spiritual experiencing: By chance or psychotherapist facilitation? This research found that spiritual experiences occurred within the therapeutic process with some participants. For these experiences to occur, some participants spoke about the need for therapist to be open to them, open to their own spirituality and even to create the necessary conditions for such occurrences, thus suggesting that it was participants who decided what belonged in the therapeutic process. This finding is supported by Ryan

(2007) in her research, as she spoke to the importance of therapist openness and space being important conditions in the facilitation of spiritual experiencing.

The influence of therapists' themselves in spiritual experiencing in therapy was also supported in a phenomenological study conducted in the USA by Carney (2007). Carney explored the spiritual experiences in therapy of nine female therapists: social workers, counsellors and psychologists who believed spirituality (separate from religion in this study) was important to attend to in counselling. Some participants in Carney's study spoke about a sense of surrendering to something bigger than themselves in therapy. Carney reported that one participant said, "There's a bigger process than me at work here and I just need to follow it … and when I can surrender like that I really think powerful things happen" (p. 77). The belief that they were guided by a spiritual power meant, for some therapists, that they experienced themselves as a conduit of that power, with one participant commenting, "I feel that some of the things that I am saying, I'm saying because … a higher power or God … is channelling that through me" (p. 79).

Although some participants in my study spoke about receiving and acting on spiritual prompting in therapy with their clients, whether or how to report this was a dilemma for some. This may be indicative of the tension between disciplines, with some commenting about the need to frame their "sources" in familiar language. Saying that one was using their "countertransference" sounds acceptable, whereas reporting that "God told me" may be cause for alarm. It was evident that these tensions impeded open, honest disclosure and transparency.

Spiritual experience was also equated with deep therapeutic connection, by some participants in my study. This finding was supported by Magaldi-Dopman et al. (2011) who reported that some participants, including one who identified as an atheist, described that within the discussion of RS material in psychotherapy:

> There was a spiritual connection formed, a feeling of the transcendent, or a 'religious moment' where they felt the presence of something larger than themselves. The therapeutic relationship, then, has the power to mirror a transcendent relationship. (p. 299)

In summary, it is evident that how participants' engaged with RS in the therapeutic process was determined by their own perspectives on what belongs, and how what is allowed in, is attended to. It is clearly not a "level-playing field" for a client who may have no idea that their RS material could be seen so diversely. Irrespective of the therapist's stance, however, Bartoli (2007) argued that what is crucial in the therapeutic encounter is the psychotherapist's conscious and unconscious ability to convey respect for, and curiosity about a client's beliefs, together with the awareness of what, within them, may militate against a stance of openness towards the client. When these conditions were not met, the findings in this research demonstrated that challenges ensued.

Psychotherapists face distinctive challenges when engaging with RS

In the study reported in this thesis, the process of engaging therapeutically with clients was disrupted when participants' and clients' worldviews (values) conflicted, where participants encountered something which was deemed beyond the scope of their practice, or when they met something within the RS realm which was unknown to them. Challenges encountered by clinicians, when working with clients' RS material, are widely noted in the literature (Aten, 2011; Crossley & Salter, 2005; Daniels & Fitzpatrick, 2013; Frazier & Hansen, 2009). Summarising challenges faced by clinicians in the area of RS, Bond (2011) commented, "The therapist … faces distinctive challenges to listening beyond his or her own life experience. These challenges are substantial when the listening is across major obvious differences in experience, such as life stages, gender, ethnicity, culture, or religion" (p. 155).

The difficulty of value conflicts. One of the challenges experienced by participants in my study was that of conflicting values with their clients. At times these conflicts involved their own unprocessed RS material, causing reactivity and disrupting the therapeutic process. In the area of RS, according to the literature, value conflicts are common (Aten, Mangis &Campbell, 2010; Brown, Elkonin, & Naicker (2013); research by Vandenberghe et al. (2012) has demonstrated that clinicians have difficulty prioritising client goals, rather than their own, in instances of value conflicts. Yarhouse and Johnson (2013) noted, "The interface between psychology, religion, and spirituality presents a special concern for value conflicts" (p. 42).

Chapter Eight: Discussion

One pertinent finding was the struggle some participants had with clients who held fundamentalist perspectives. This finding is supported by research conducted by Carlson, 1997; Magaldi-Dopman et al. 2011; and Williams and Levitt, 2007. In their work educating psychologists, Aten, Mangis and Campbell (2010) found:

> Religious fundamentalist clients often 'push their buttons', particularly if they have any history of conflict with authoritarianism. Some therapists experience this phenomenon as a result of their own negative experiences with religious fundamentalism, while others lack understanding or exposure to religious fundamentalism. (p. 516)

These authors advocated therapist self-awareness regarding potential bias against fundamentalism, so that they can work ethically with these clients. Raising clinician awareness is important since conflicting RS values were not always within the conscious awareness of participants in this study, sometimes being realised in interactions with myself as researcher, and at times highlighted by clients. Lannert (1991) noted the damage that can be done in the therapeutic relationship when psychotherapists visited their own unresolved RS issues on their clients. He commented:

> Therapists may have a negative attitude towards religion in general or to a specific sect or denomination, due to personal experience and/or observation. This may inhibit their open response to the client's perceptual world in which religion or non-sectarian spirituality may be important. (p. 72)

Lannert (1991) also reflected that therapists may be limited in their own RS expression, having been brought up with RS orientations they have now cognitively outgrown, yet may not have explored a more mature RS perspective. Research conducted by Magaldi-Dopman, et al. (2011) found that therapists' RS identities were "activated" by the RS of their clients which inhibited their attending to clients' RS matters. Also concurring with findings in my thesis, these researchers reported that participants' theoretical orientations affected how they worked with RS in therapy and could be used to distance themselves from clients' RS. Research conducted by Brown (2006), found that some participants recalled incidents with their clients' RS which caused their own painful histories with RS to be activated. In particular, this led to one participant over-

identifying with her client, and another needing to refer a client since the client espoused religious beliefs which she had eschewed.

Whilst it is apparent that conflicting values are a source of clinical difficulty, as evidenced in my research, and supported by the literature, this finding appears to be incongruent with a psychotherapy profession which emphasises therapist self-awareness. In addition to personal awareness regarding RS, psychotherapists also need to demonstrate a capacity to bear with the unknown.

What cannot be known and what needs to be known. This study found that what participants did not know about a client's RS presentation, presented challenges. There were two aspects to "not knowing" demonstrated: firstly that of unfamiliarity with RS beliefs systems; and secondly, the "unknowable" nature of some spiritual experience. The finding of unfamiliarity is supported by research by Wilde (2008) and Brown, Elonin and Naicker (2013). A qualitative descriptive study involving 15 psychologists, conducted in South Africa by Brown, et al. (2013) investigated the facilitating and inhibiting factors surrounding the inclusion of RS in clinical practice. Only one participant in the research sample had no RS affiliation; the rest were Christian. Participants identified a lack of knowledge and education regarding RS as inhibiting. In addition, they commented that their own discomfort with RS meant that they were not comfortable discussing this area with clients.

Even though the findings in my study demonstrated the need for more knowledge in this complex field, it was also evident that much RS experiencing defies apprehension or explanation, a finding supported by Rosenberg (2005), Ryan (2005) and Sleeman (2007), whose research in this area was conducted within ANZ. This seems especially pertinent in the bicultural context of this country, since instances of unusual phenomena often involved indigenous clients. This suggests the importance of psychotherapists developing a capacity for tolerating uncertainty and not knowing–a capacity deemed essential in the field of psychotherapy (Long, 2001).

Ted, a participant in this study, commented that the challenge was to "be with" the not knowing and to resist "colonising" it. It seems, however, that the area of RS, where "not knowing" is sorely required, presents the most challenge. How does this fit with the expectations of PBANZ and registered practitioners? The nature of spiritual territory

means that there is much that cannot be known. Although it is possible to become knowledgeable the beliefs of various RS traditions, the experience of RS, with its sometimes ineffable character, means that capturing or colonising it is neither possible nor desirable. Taylor (2010) advocates the need to develop a "negative capability". He explained:

> It seems safe to say that Keats' Negative Capability also refers to an open attitude of mind, rather than to a closed, pre-determined or judgemental position … negative capability seems to be defined by an internal stage of *forbearing* to conclude prematurely, and also by a respect for the object which is being considered". (p. 404)

The need to develop a respectful stance as a necessary aspect of developing an open attitude, as suggested by Taylor (2010), may be fostered by therapists' own RS experiences. Some clinician participants in Simmonds' (2004) study suggested that it was their own spiritual practice which helped them develop the therapeutic capacity of not knowing. There is a difference, however, between not knowing and ignorance. The former embraces the ability to tolerate ambiguity; the latter implies a lack of information.

The boundaries of psychotherapeutic practice. My research demonstrated that how participants decided the boundaries of psychotherapeutic practice regarding RS was determined by their own perspectives, of which their own RS, education and therapeutic modality as well as the psychotherapy community, were particularly salient. Given that some participants made connections in their thinking and practice between the psychotherapeutic and RS disciplines, it is evident that there are overlaps which can cause difficulties for therapists in knowing where their role ends.

The role of a psychotherapist compared to that of a RS teacher and how one decided whether they had reached the edge of that role, was an area determined variously by participants in this study. Ada posed the trenchant question, "What are the bounds of our paradigm as psychotherapists that we really shouldn't transgress?". The word "transgress" itself suggests some religious impropriety. Some participants who held to a particular RS tradition shared by their clients were more likely to venture into the territory of religious teaching, especially when they did not trust some of what was on

offer in a particular RS community. Gonsiorek et al. (2009) commented that a personal RS affiliation does not substitute for competence in that tradition. From my observation psychotherapists wonder about the ethics of RS professionals engaging in counselling their flock without appropriate education, or even with, given the boundary difficulties. How would RS professionals consider psychotherapists venturing into what could be perceived as their territory? The only research which considered this role conflict was a quantitative survey analysed phenomenologically by Lennon (1970), who investigated the role conflict in priest-therapists. Many of these participants experienced some degree of conflict over which "hat" they were wearing. This decision-making process requires a lot of awareness.

The obstacles regarding RS which participants encountered as they engaged with RS in the therapeutic process clearly establish the need for both psychotherapist awareness and knowledge. Conflicting worldviews have the potential to derail the therapeutic process. Psychotherapists' awareness of their RS perspectives and the potential impact these may have in interactions with clients, is crucial. When a client's RS presentation is outside the psychotherapist's knowledge, skills are needed; the "unknowable" requires the development of greater capacity to bear "not knowing". Participants reported that they found their way through these challenges in a number of ways.

Finding ways through obstacles

Participants negotiated the various challenges by using a variety of strategies. Which strategies were used and the order in which they were utilised was influenced by several conditions: the nature of the challenge experienced; the perceived availability of resources; and the needs of the client**.**

Risking. Risk-taking was a strategy employed by participants as a response to client need in an area often perceived as outside the participant's scope of practice, or beyond their knowledge. Research exploring risk-taking by Knox (2007) and a case study reported by Stiver (2000) found that risking usually facilitated greater therapeutic connection with clients. Both Stiver and the eight person-centred counsellors who participated in Knox's (2007) study experienced anxiety about their risking; Knox reported, "Most described feeling as though they had done something 'naughty,' transgressing the limits of their role as counsellor" (p. 323). Although the study and

Stiver's (2000) report were not specifically in the area of RS, the findings of therapists believing that they had done something wrong when they took risks which exceeded what they understood to be the bounds of their practice, and that deeper therapeutic connection usually ensued with these actions, were replicated in my study.

Responding to an article on risk-taking by Eusden (2011), Monin (2011) commented that education, supervision and deep personal therapy all support therapist self-knowledge and enable clinicians to evaluate the risks they take; therefore, enabling them to take risks in an informed manner. While this sounds reasonable in theory, it may not, however, translate to practice in the field of RS since the factors which Monin suggested support self-knowledge, are lacking in this area. These dynamics may militate against evaluative and informed risking. Since participants' risk-taking was associated with actions which were perceived as beyond the scope of their practice, it follows that they then engaged in protective strategies.

Taking protective action. Risking was closely aligned with protecting by participants in this study. Simone, for example, did not discuss with her client either the reasons for the client asking her to pray to open the therapy session, and what it meant for both of them that Simone agreed to this; neither was this interchange discussed in supervision. She reflected that this was not an area which she had discussed with colleagues. When some participants were afraid that their actions may be outside the scope of practice, they were reluctant to disclose them. These findings were supported by Rosenberg's (2005) research in ANZ. She reflected that Māori psychotherapists were reticent about talking of experiences with inexplicable phenomena with Pākehā colleagues, for fear of being pathologised. She added that the shaming responses they received when attempting to discuss these matters in supervision, caused them to cease disclosure. Rosenberg also found that participants in her study excluded discussion about spirituality in particular from supervision and discussion with colleagues because "the view that these experiences are undermining to psychoanalysis and/or will be pathologised still has a powerful hold" (p. 69).

In the preface to her work about ethical complaints, Kearns (2011) said many contributors to her book chose anonymity because of the culture of fear regarding complaints in counselling and psychotherapy. Writing in the UK context, Eusden (2011)

commented on the increasingly litigious and paranoid societal culture in which therapists practise, which can mean that admitting to a mistake or behaving unethically can be difficult to acknowledge professionally. My findings suggest that this paranoia seems to be evident even when the "mistake" is only one that is perceived as one in the mind of the therapist, derived from their idiosyncratic understanding of what belongs in therapy. What is lost in the protecting may be an opportunity for growth in the therapeutic process together with therapists being able to potentially engage in more supportive collegial interactions. Mearns and Thorne (2000) asserted:

> The kind of risk-taking which comes with a full engagement with life is becoming increasingly difficult in the world of counselling and psychotherapy. Professionalisation with its creeping tendency toward institutionalisation has created a prevailing climate where many practitioners are fearful rather than courageous. It is not easy for a therapist to be life-affirming or fully present to a client when there is the nagging suspicion that it would be wiser to watch one's own back (p. 212).

The need to protect oneself from negative professional evaluation is pertinent. Exploring the supervision experience of some mainstream counsellors who integrated prayer in counselling, Gubi (2007) found that counsellors did not discuss, in supervision, that they prayed for clients "because of fear: of not being understood; of being judged; of losing respect and credibility; of being thought of as transgressing" (p. 114). In a literature search for the terms (religion or spirituality) and (supervision or training) and (psychotherapy) from 1990 to 2006, Bienenfeld and Jager (2007) found of the 62 pertinent articles gleaned in the search, "just five actually described or reported elements of religion and spirituality in psychotherapy supervision" (p. 179). In the light of my research findings, supported by those of other studies, one wonders whether the absence of RS material reported in supervision may be attributed to clinicians hiding aspects of their practice for fear of professional opprobrium.

Hiding, as a protective action, was also reported by some participants in their pre-qualifying psychotherapy education, a finding supported by Simmonds (2004) and Wilde (2008). Wilde (2008) interviewed 17 new psychology graduates about values training in education. He found that some participants hid their religious values during their education when these conflicted with their non-religious programmes. In an earlier qualitative study involving 25 senior psychoanalytic practitioners in London, Sydney

and Melbourne, Simmonds (2004) reported that some participants "were concerned about taking spiritual matters to analysts because they were candidates in psychoanalytic training institutes ... [One participant thought in hindsight] that he didn't take spiritual issues in order to be 'pleasing to the analyst and the establishment'" (p. 962). Some reported they felt freer to discuss RS in their therapies, after qualifying.

In her article "A Spiritual Coming Out", Perlstein (2001), a lesbian psychotherapist, commented, "[I] realize that I am more closeted about my spirituality in my professional therapist community, than I ever was about my lesbianism" (p. 176). Perlstein's spirituality embraced meditation and shamanic journeying. She commented that, although often initiated by clients, she "would carefully offer" (p. 177) a spiritual dimension to clients struggling with issues of meaning and connection or somatic symptoms. However, Perlstein did not elaborate what "carefully offer" entailed.

As well as protecting themselves by hiding, another finding in my research was that participants also protected themselves by distancing from clients' RS material which they found difficult. This finding is supported by research by Magaldi-Dopman et al. (2011) who reported clinician participants used theoretical language to distance themselves from religious content. Magaldi-Dopman et al. further reported that "Theory served as a protective tool to help psychologists manage clients' painful or difficult religious content, which otherwise might have been too activating or disturbing to them" (p. 297-298). Diagnostic biases, reflective of conflicting ideologies between therapist and client were also noted by Gartner, Harmatz, Hohmann, Larson, and Gartner (1990).

Some participants in my study also demonstrated distancing from clients whose RS orientation differed from theirs. This distancing included ignoring or devaluing clients' views and making diagnostic decisions. This finding is supported by research conducted in the USA by Scalise (2011), Ruff (2008) and O'Connor and Vandenberg (2005) and Ruff (2008) who reported clinician bias towards religiously dissimilar clients.

Investigating psychotherapist's value conflicts and the effects of these on therapy with clients, Garrott (2008) interviewed ten clinicians who were working with clients in the area of bondage, discipline and sadomasochism. The research found that consultation assisted participants become more aware of their own values, and therefore value

conflicts, as well as increasing their knowledge in this area, thus leading to greater clinical effectiveness. One participant reported negotiating the value conflict by finding a part of themselves which identified with the client. Conversely, some clinicians avoided the area, failing to obtain supervision because of their own discomfort with the topic. The findings of Garrott's study support my research findings of the resourcing and protecting strategies utilised by participants when they encountered challenge regarding the RS material brought by clients.

In order to understand how psychotherapists negotiated value conflicts and considered the role of values in psychotherapy, Williams and Levitt (2007) conducted grounded theory analysis with 14 expert psychotherapists of different theoretical orientations. These researchers found that participants took two courses of action, not mutually exclusive, when client values differed from those of the therapist. The more typical solution was to try and work with the client's values by letting them lead the therapy and make their own decisions. The other path taken was to challenge clients to change their beliefs to ones considered healthier by the therapist. These two pathways were clearly demonstrated by Luke, one of the participants in my research, as he worked with his Jehovah's Witness client. He initially attempted to challenge the client's perspective. However, since the client was not open to reconsidering his values, Luke learnt what the client found supportive and encouraged his engagement in an activity of the client's choosing which ameliorated his distress. Protecting may lead to resourcing.

Psychotherapists resourcing themselves. As well as risking and protecting, as a response to the challenges they faced regarding attending to RS in practice, participants in this study also resourced themselves, when they perceived that resources were available. Resourcing was sought within the psychotherapy profession, and outside it; and in learning from the client, as well as drawing on participants personal and RS resources.

Resourcing within the psychotherapy community. Resourcing within the psychotherapy community was a strategy used by many participants in terms of collegial contact as well as supervision. However, participants needed to have confidence that they could discuss RS matters safely within supervision, in order to discuss this material. Some participants chose supervisors who were known to be open to inclusion of RS matters, implying that this was not always the case. What can be

concluded from my study and other research in ANZ (Rosenberg, 2005; Sleeman, 2007) is that supervisory responses in the area of RS have been reported as variable, ranging from openness to shaming.

Relating a case study where his RS beliefs differed markedly from those of his client, Aten (2011) said that he was able to process his reactions in supervision, suggesting that supervision or consultation was essential in such instances. Aten and Hernandez (2004) asserted that training needs to be given to supervisors so that clinicians can be resourced for exploring clients' RS issues. A literature search of RS in clinical supervision between 1990-2006, conducted in the USA, by Bienenfeld and Yager (2007), "resulted in only 62 citations–of these just five actually described or reported elements of religion and spirituality in psychotherapy supervision" (p. 179). Although this may simply mean that RS in supervision has not been much researched, the findings from my study demonstrate wariness on the part of some participants in raising RS matters in supervision.

The influence of modality on participants' expectation of openness to RS within the psychotherapy community was of note. Lucille commented that she would find discussing RS occurrences with a "psychoanalytic" supervisor as being "a bit challenging". Ella said:

> I can have a voice within the psychosynthesis arena because the spiritual dimension is germane to what that's about, but I find that in the wider psychotherapeutic community that might not be especially accepted or acceptable given the whole Freudian perspective.

However, although Ella believed that the wider psychotherapy community might not be so receptive to discussing RS, when I asked her, she could recall no actual instances where that had occurred, but noticed "I don't have many conversations with people about [RS, outside of the psychosynthesis context]". The influence of Freud in the psychotherapy community in ANZ was noted by Anastasia, who reflected, "The psychotherapeutic community is basically neo-Freudian. I think Freud's bias and his idea that religion is an escape and a defence still seriously colours their belief systems and ideas of what they think it is".

Chapter Eight: Discussion

It is evident that Freudian thinking regarding RS is not just part of the history of psychotherapy, but continues to influence present views within the psychotherapy community. Whether this influence is real or imagined is a moot point since this perception appears to inhibit conversation within the whole therapy community. This was highlighted by the incident I recounted in Chapter one, where a retiring clinician at a branch meeting demurred when asked from the floor to discuss her RS position.

According to Shibutani (1955), as has been noted in Chapter three, our participation in groups becomes the means by which group perspectives are internalised, perspectives which are derived from the internalisation of group norms. This suggests that groups' perspectives can change as norms are reviewed. This offers hope that through open conversation about RS matters within psychotherapy, beyond the occasional "daring" alluded to by Younger (2015, p. 43), group norms may be changed.

Resourcing from outside the psychotherapy domain. However, given the current concerns about receptiveness regarding RS within the psychotherapy community, it is not surprising to find that participants resourced themselves by bringing in knowledge from outside the psychotherapy domain, sometimes covertly–as in the case of Xavier, who saw himself as a "smuggler",–but often overtly, as participants sought to expand their ability to respond therapeutically to clients' RS issues. This resourcing was sometimes partial, such as the inclusion of Māori models of health into treatment with non- Māori clients. It was also complete, as in the creation of He Ara Māori, the Māori pathway, and integrative, as indicated by the incorporation of spiritual direction into treatment. All of these initiatives suggested that what participants were able to offer clients within the limits of their own practice of psychotherapy, was not enough.

The influence of biculturalism on RS in psychotherapy in ANZ is an important finding in this research. Some participants reported that the use of Māori models of health gave them permission to include RS in their practice with non-Māori clients. Is Māoridom providing something of a permission for RS in clinical practice? Ethan reflected, "We don't talk about spirituality in psychotherapy very often at all. And here we have got the indigenous people saying; "This is part of our psychotherapy. In fact, this is where we start". For a number of years, Bowden (2000, 2003, 2010, 2013), a senior clinician in the ANZ psychotherapy community, has advocated for psychotherapy in this country

which is reflective of our bicultural context, suggesting that "Transferring therapeutic method from one country to another can have a colonising effect" (Bowden, 2010, p. 9). Tudor (2012), an immigrant to ANZ, reiterated this call, advocating for "Southern psychotherapies" (p. 116), reflecting both the multiplicity of psychotherapy as well as arguing for psychotherapies which move away from predominant Western or Northern perspectives.

Castell (2013) wondered what impact "the focus on Māori spirituality in mental health care policy and training in New Zealand has had on the consideration of healthcare for non-Māori" (p. 212). My research findings demonstrate that this does have an impact. Simone was clear that it was her exposure to Māori cultural expectation within a DHB context, and the frameworks for discussing RS with Māori learnt in this context, which, she asserted, gave her "permission to talk about that kind of stuff" with clients in her private practice.

The need to have culturally responsive therapy services was identified by Melder and Simmonds (2008) who conducted qualitative research in Australia with eight indigenous teachers and students, identifying the obstacles to take-up of counselling services by indigenous students. In order to arrive at an African psychotherapy, which met the needs of these populations, Madu (2013), an African psychotherapist, advocated a "melting/blending" (p. 7) of the universal principles of human behaviour in psychotherapy approaches, whilst sifting out Western cultural components, replacing them with African cultural perspectives. He also suggested that African traditional and religious healing approaches be sieved to extract psychotherapeutic ingredients, adding that "psychotherapists in Africa should be broad-minded in their definition of psychotherapy to include some effective emotional healing activities of the African traditional healers/rulers, religious faith healers and the in-Africa-originated forms of psychotherapy" (p. 8). These initiatives reflect changes needed on a macro-level to psychotherapy, as a response to learning from clients.

Psychotherapists resourcing from clients. Although learning from their clients was a strategy employed by some participants in this research when their client's RS perspective was unfamiliar, the literature offers varying views about the appropriateness of taking this course of action. Both Thomas and Schwarzbaum (2006) and Ahern (2011) recommended that therapists ask their clients to teach them about their RS

culture when it is unfamiliar to them. I would argue that this stance is important whether or not clients' RS perspectives are considered familiar or not, given that RS beliefs are often held idiosyncratically, a point noted by Gonsiorek, Richards, Pargament and McMinn (2009). Ahern suggested that "It may be helpful to think of [a] therapist's role in a religious conversation as that of a student rather than an authority" (p. 94).

However, it may be difficult to adopt a "teach me" stance when a client's RS beliefs are distasteful to the therapist. Aten (2011), who was repulsed by his client's RS perspective, and did not want to engage in any exploration, found that asking to be taught helped him hold his own perspective more clearly, as well as gain valuable information about what his client believed.

Although learning from the client regarding their RS traditions can increase a therapist's knowledge, Qasqas and Jerry (2014), speaking particularly about Muslim populations, questioned this practice when the client becomes the major source of the clinician's knowledge. They argued that a client should not be used to benefit the clinician in this manner. Whilst this argument has merit, a sharing of information by the client may enhance therapeutic connection, as was demonstrated by the interactions Luke, a participant in my study, had with his client. Although adopting this stance, these authors also noted the paucity of therapeutic literature available to assist clinicians in working with Muslim clients, a reality which limits a therapist's ability to resource themselves.

Psychotherapists using their own RS resources. Utilising their own RS resources to support the challenging work of being psychotherapists, as well as at times when meeting specific difficulties with clients, was a strategy engaged in by a number of participants. This strategy was employed both in therapy and for self-care outside of the therapeutic process. This seems somewhat ironic given that fewer participants spoke of eliciting clients' RS resourcing during the process of engaging.

The finding of therapists drawing on their own RS resources for personal support because of the demands of clinical work is one widely noted in the literature (Baker & Wang, 2007; Carlson, 1997; Carney, 2007; Case & McMinn, 2001; Dura-Vila, Hagger, Dein & Leavey, 2011; Vandenberghe, Prado & de Camargo, 2012). As well as resourcing outside of the therapeutic process, phenomenological studies by Fredenberg (2001) and Solomon (2006), exploring the experience of Buddhist therapists in therapy,

found that participants meditation practices enhanced their ability to be present with the client and also present to their internal processes. Psychotherapists utilising their RS in their practices may enhance their therapeutic work.

Choices have consequences

The choices participants made regarding their attention to RS in the therapeutic process had a range of consequences. The iterative nature of the process of deciding what belongs meant those consequences were not necessary static, since shifting perspectives under different conditions had the potential for shifting outcomes, in a fluid process of change. Although some research (Coyle & Lochner, 2011; Dura-Vila et al. 2011; Stiver, 2000) has spoken to the expanding and presenting as legitimate aspects of these outcomes, the findings of these researchers have not been concluded as the result of a process, rather observations of discrete occurrences. Therefore, the outcomes of the process delineated in my research: those of expanding practice; maintaining the status quo; and presenting as legitimate, add new knowledge to the field.

The consequences which ensued from this process depended to a degree on the resources accessible to participants, since resourcing was a major condition in expanding practice. Having said this, choosing whether or not to resource was also predicated upon participants' perspectives, moderated by their work contexts. Nevertheless, resources need to be available for changes to be made in practice. Professional expectation, as is evidenced by the NZAP's *Code of Ethics* (NZAP, 2008) and the PBANZ's *Standards of Cultural Competence* (PBANZ, 2011a), is insufficient. Indeed, the importance of ethics has been central to psychotherapy practice since the formation of the NZAP in 1947.

It is interesting that presenting as legitimate, an outcome of the choices of some participants, was connected more to reputations in the psychotherapy community, and meeting the expectations of employment, rather than any external professional demands. In the absence of open dialogue and acceptance of different perspectives being embedded in psychotherapy culture, it would appear that psychotherapists will continue to hide their actions regarding RS, in order to be perceived as acceptable. People give meaning to interactions observed, gleaning an understanding about what is or is not acceptable in any given community, and adjust their own actions accordingly. When

protecting becomes a response to RS challenges, opportunities are not created for new ways of working to be considered. Thus, in addition to presenting as legitimate, the status quo is maintained.

Some participants practised within the proscribed boundaries of their education/modality in conjunction with the context in which they worked, and did not venture outside of those parameters, thus maintaining the status quo. In order to consider other ways of seeing things, one has to be open to them and also engage in interactions where one's own perspective is challenged. As I have noted above, it is possible to protect oneself from the possibility of change by therapeutic distancing, when RS material presented by the client challenges one's own position. Speaking about action, change and maintaining stability, Strauss (1993) noted that "Stability of phenomena are contributed to by actors whose interactions maintain the stability" (p. 54). This research has demonstrated that when education does not include attention to RS, clinicians educated under those conditions may continue that exclusion in their practices, thus perpetuating these conditions. Noam and Wolf (1993) referred to this as a psychotherapy by precedent, which occurs when the example set by previous generations of therapists, where RS was not examined, is passed on to the present generation.

Conclusion

RS expression and experience is complex. Attending to this area within psychotherapy is extremely challenging since, as this research has demonstrated, psychotherapists bring varying perspectives to the field, largely influenced by their education, modality and RS views. On the one hand, the need to be respectful of a client's RS worldview cannot be denied; on the other, the need to explore thinking which cause a client distress and conflict is a fundamental therapeutic task. However difficult the challenge, it cannot be avoided since RS is part of human existence, therefore, as Winton (2013) asserted, "Religion that is not allowed in the door may slip in through the window" (p. 356). The expectation of cultural competence is demanding and needs to be more than "tick-box" compliance. Although Plante (2014) has suggested that increasing cultural competence depends in part on treating RS as any other aspect of cultural diversity, I disagree with his view. This research has demonstrated that RS encompasses a complexity which defies simplistic attention.

In addition, this study has found that psychotherapists attend to clients' RS matters in the therapeutic context by deciding what belongs. Deciding what belongs was shown to comprise a range of decisions, in a range of contexts, under a variety of conditions. In all these areas psychotherapist self-awareness was important. However, awareness does not occur without interaction. These research findings have shown that change is needed in many contexts if psychotherapists are to attend to clients' RS issues in a way which respects individuals' cultural expression.

What is possible and desirable? Nigel, one of the participants in this study reflected, "My ideal of therapy [is] where it's this totally free space where people bring in themselves in their totality. I mean that's naïve". Although there may be a number of reasons why Nigel's ideal is naïve, it is both necessary and possible that psychotherapists become aware enough of their own RS dynamics in order that they have some understanding of the potential impact of these on the therapeutic process, so that space may be created together. However, since symbolic interactionists assert, and, as this research has demonstrated, changes in an individual's choices involve environmental interactions, in the manner of reciprocal influencing (Blumer, 1969); therefore, changes necessitate complex interactions.

Summary of this study's contributions to psychotherapy

This research makes a significant contribution to the field of psychotherapy, specifically in the context of ANZ. Whilst Magaldi-Dopman et al. (2011) elicited some categories such as "challenges", which includes "conflicts" and a category of "exploration" which are similar to my research findings, these categories were not conceptualised into a process which explains what therapists do when meeting certain conditions. The overarching theoretical process of deciding what belongs with the concepts of engaging, encountering challenge and the strategies which comprise therapists' actions as they negotiate a challenge, with subsequent outcomes, is a key addition to current findings in the field. Although the concept of perspective is implicit in much research, my research has found that a therapist's perspective is influential in deciding what belongs. The significance of this research is summarised in the following:

- That psychotherapists decide what belongs, regarding RS, in the therapeutic process.

- That psychotherapists' perspectives in decision-making regarding attention to RS in the therapeutic process comprise a range of conditions, sometimes beyond their awareness, making this a complex process.
- That psychotherapists are seen to shift their perspectives on RS in the therapeutic process in response to client need and collegial interactions.
- That these perspectives may be put to the background or highlighted, depending on work contexts.
- That there is a definite correlation between psychotherapists' actions in the therapeutic process and their experiences during their education.
- That the psychotherapeutic community influences psychotherapists' deciding what belongs regarding RS in the therapeutic process.
- That it demonstrates that the focus on Māori RS in healthcare influences clinicians' work with non-Māori clients.
- That it provides a model which explains the processes with which psychotherapists engage when making decisions regarding RS in the therapeutic encounter.
- That this model, which is an original tool, is useful for psychotherapists' self-reflection and other educational purposes.

Limitations of the study

This study was intended to be foundational, since no similar research initiatives have taken place in ANZ. As such, I have explored this topic solely from the perspective of psychotherapists as participants; the views of clients have been interpreted through the lens of these participants. There are also other stakeholders whose views have not been included in this research; perspectives of allied professions–counsellors and psychologists–need to be canvassed. The perspectives of religious leaders concerning their impressions of psychotherapy in relation to RS have not been gleaned; neither were psychotherapy education providers approached for their views. As such, the full picture is lacking.

In addition, I have felt my own limitations during this study as a Pākehā when working with Māori. Whilst I have endeavoured to faithfully interpret the views of Māori participants, and have consulted a Māori supervisor in this research, I am not Māori. My

limitations were brought home to me on some occasions during interviews. Ursula commented that "Spirituality is easier to talk about with my indigenous colleagues". Janene reflected, "If you were Māori I might use different words". Even though I was aware of the generosity of my Māori participants as they worked hard to communicate with me, and were encouraging of the study, I did wonder what more, what else, would have been said, had I been Māori.

Implications for education and practice

This thesis has provided new knowledge concerning the processes with which psychotherapists engage, as they make decisions regarding RS and psychotherapy. As such, it offers valuable information to the psychotherapy community in ANZ and beyond, and particularly in the area of education, practice and research. In addition, a model has been formulated which encapsulates these processes in an easily accessible manner. As was also noted by some participants, the model has wider applicability beyond the psychotherapy domain, as it gives evidence about processes which may be engaged in when challenges are met in an area which is contentious.

Implications for education. There is a plethora of research attesting to the fact that education in the field of RS is lacking in clinical training programmes (Schulte, Skinner & Claiborn, 2002; Walker, Gorsuch & Tan, 2004), resulting in clinicians feeling ill-equipped to deal with RS issues with their clients (Aten & Hernandez, 2004; Wilde, 2008). Somewhat prophetically, Mahoney (1995), reflecting on the challenges which would face 21st century practitioners, commented that therapists would be asked to confront the relationship between professional lives, and ethics, values and spirituality, suggesting that "the training of future psychotherapists is likely to be enhanced when such issues are included in the professional preparation of 21st century psychotherapists" (p. 483). Twenty years later, this study, supported by other literature in the field, has uncovered a continuing lack of education regarding RS in psychotherapy education in ANZ.

The need to teach self-reflection and enhance therapist awareness has been noted (Bienenfeld &Yager, 2007). In the concluding comments of Castell's (2013) research, she suggested that "self-practice/self-reflection may be a particularly useful training tool in assisting practitioners to identify and modify their own assumptions, attitudes, and

concerns regarding the role of RS in practice". A number of experiential exercises for psychotherapists have been suggested by Bartoli (2007), to increase self-awareness of strengths and areas for growth. With the aim of reducing reactivity during couple and family sessions, Frame (2001) gave directions for constructing a spiritual genogram, so that clients could see the influence their RS histories have on current family functioning. Since reactivity in the area of RS is not just the domain of clients, this would be a useful tool for psychotherapist awareness.

Because education is an evaluative process, it is important that education providers, in their personal attitudes as well as in curriculum content, demonstrate the acceptance of diversity so that students feel free to be themselves, without fear of negative appraisal (Wilde, 2008).

Given that qualifying education is needed to enhance self-awareness and open exploration of personal RS perspectives by students, as well provide knowledge in the area of RS, both systematic inclusion together with targeted topics, are needed: The following is suggested:

- Content on RS diversity, including broad parameters of a range of RS beliefs.
- Education in RS in human development.
- Teaching on the assessment and diagnosis regarding the health or otherwise of a client's RS perspective.
- Opportunities created for self-reflection of student's RS and the impact this may have on the therapeutic process.

Since my research demonstrated that a lack of qualifying education meant that a number of participants were under-resourced in the area of RS, post-qualifying resources need to be made available.

I suggest the following implementations within the psychotherapy community:

- Educational opportunities regarding RS such as seminars at local and national levels. These could include visiting speakers and panel discussions inclusive of a range of perspectives, and be targeted at educators/trainers and supervisors as well as clinicians.

- The formal inclusion of clinicians' RS awareness in the ACP assessment for full admission to NZAP.
- Changes to the ACP forms to include RS as a discrete aspect of culture.
- Funding of research initiatives in RS by NZAP.

Implications for practice. The following practice implementations are suggested:

- That psychotherapists work towards having consultation and referral sources for RS matters, if they do not have these in place.
- That psychotherapists give particular attention to the interface between therapists' and clients' RS.
- That psychotherapists attend to their own RS perspectives in their own psychotherapy.
- That consideration is given to the role a psychotherapist assumes in the advent of shared RS perspectives.
- That where RS perspectives are shared with clients, psychotherapists are aware of the danger of unexplored assumptions.
- That psychotherapists are aware that culture is complex. Examining psychotherapists' assumptions regarding the salience of one aspect of a client's culture over another is recommended.
- That psychotherapists become aware of the perspective of their chosen modality on RS.
- That part of the consenting to therapy process to include discussion concerning how the psychotherapist attends to RS.

Recommendations for further research.

Some suggestions for further research are as follows:

- Research by Māori psychotherapists to extend knowledge of indigenous perspectives.
- Research to investigate the current practices and views of psychotherapy education providers.
- Research to explore the perspectives of RS clergy and leaders regarding psychotherapy as a referral source for their congregations.

- Research of the current/former clergy within the psychotherapy profession to explore how they experience the interface between psychotherapy and RS.
- Research to ascertain current and former clients' perceptions of how their RS matters were/are attended to within psychotherapy.
- Research to identify clinicians' own experiences of how RS was/is attended to within their own therapy.
- More research into the allied professions of counselling and psychology to compare clinicians' experiences of attending to RS within therapy.
- Research to compare the attention to RS in therapy, between psychotherapists who work in private practice and those employed in the public sector.

A personal reflection in closing

This project has been life-changing, both professionally and personally. I have been challenged academically, psychologically, emotionally and spiritually. In the presuppositions recorded prior to beginning this study, I stated that I expected to find that participants would only engage with RS if this was raised by the client, and even then I expected that the lens, through which it was observed, would be a pathologising one. Contrary to my expectations, I was largely heartened by the variety of participants' experiences and depth of work undertaken by some participants in the area of RS. Interactions I had with participants, together with my reflective process in relation to these interactions, have changed me profoundly and influenced how I practise. I am, therefore, hopeful, that change, through brave, honest, deep, thoughtful and extensive interactions about the issues raised in this study, is also possible in the psychotherapy profession in ANZ, so that rather than "spirituality [lurking] around the edges of our profession", [that we talk about in a] "forbidden language", as Younger (2015, p. 43) observed, it may become a central and welcome aspect, of psychotherapeutic conversation.

References

Abernethy, A. D., Houston, T. R., Mimms, T., & Boyd-Franklin, N. (2006). Using prayer in psychotherapy: applying Sue's differential to enhance culturally competent care. *Cultural Diversity & Ethnic Minority Psychology, 12*(1), 101-114. doi:10.1037/1099-9809.12.1.101

Abernethy, A. D., Lancia, J. D (1998). Religion and the psychotherapeutic relationship: Transferential and countertransferential dimensions. *The Journal of Psychotherapy Practice and Research, 7*(4), 281-289. Retrieved from: http://ovidsp.tx.ovid.com.ezproxy.aut.ac.nz/sp-3.14.0b/ovidweb.cgi?&S=PEHMFPDDOHDDJDGANCLKPEDCKDMPAA00&Complete+Reference=S.sh.21%7c1%7c1

Adelowo, A. (2012). *The adjustment of African women living in New Zealand: A narrative study* (Master's thesis, Auckland University of Technology, Aotearoa New Zealand). Retrieved from http://aut.researchgateway.ac.nz/discover?query=The+adjustment+of+African+women+living+in+New+Zealand%3A+A+narrative+study+

Ahern, J. (2011). *Encountering questions of religion in psychotherapy: A hermeneutical-phenomenological study of religious patients' experiences* (Doctoral dissertation). Retrieved from http://digital.library.duq.edu/cdm4/item_viewer.php?CISOROOT=/etd&CISOPTR=154074

Allport, G. W., & Ross, J. M. (1967).Personal religious orientation and prejudice.*Journal of Personality and Social Psychology, 5*(4), 432-443. Retrieved from http://ovidsp.tx.ovid.com.ezproxy.aut.ac.nz/sp-3.14.0b/ovidweb.cgi

APA. (1994) *Diagnostic and statistical manual of mental disorders.*Washington, DC.: American Psychological Association.

APA. (2010). *Concise rules of APA style* (6th ed.). Washington, DC: APA.

APA. (2013a). Other conditions that may be a focus of clinical attention. In *Diagnostic and statistical manual of mental disorders* (5th ed.). doi:10.1176/appi.books.9780890425596.VandZcodes

APA. (2013b). Cultural formulation. In *Diagnostic and statistical manual of mental disorders* (5th ed.). doi:10.1176/appi.books.9780890425596.CulturalFormulation

Assagioli, R. (1974). Jung and Psychosynthesis.*Journal of Humanistic Psychology, 14*(35), 35-55. doi: 10.1177/002216787401400104

Aten, J. D. (2011). Addressing religious differences in therapy: A case study from behind bars.*Journal of Psychology and Christianity, 30*(1), 81-84. Retrieved from http://ezproxy.aut.ac.nz/login?url=http://search.proquest.com/docview/879430471?accountid=8440

References

Aten, J. D., & Hernandez, B. C. (2004).Addressing Religion in Clinical Supervision: A Model.*Psychotherapy: Theory, Research, Practice, Training, 41*(2), 152-160. doi:10.1037/0033-3204.41.2.152

Aten, J. D., Mangis, M. W., & Campbell, C. (2010).Psychotherapy with rural religious fundamentalist clients *Journal of Clinical Psychology, 66*(5), 513-523. doi:10.1002/jclp.20677

AUT. (2014). *What is psychotherapy?* Retrieved from http://www.aut.ac.nz/study-at-aut/study-areas/health-sciences/psychotherapy/what-is-psychotherapy

Baetz, M., Griffin, R., Bowen, R., & Marcoux, G. (2004). Spirituality and psychiatry in Canada: Psychiatric practice compared with patient expectations. *Canadian Journal of Psychiatry, 49*(4), 265-271.

Bageant, R. (2012). The hakomi method:Defining its place within the Humanistic tradition. *Journal of Humanistic Psychology 52*(2), 178-189. doi:10.1177/0022167811423313

Bailey, P., & Tudor, K. (2011).Letters across the "Ditch". In K. Tudor (Ed.), *The turning tide* (pp. 77-95). Auckland, New Zealand: L C Publications.

Baird, V. (2012).*A qualitative study of Nichiren Buddhists' experiences of engaging in personal therapy* (Unpublished master's thesis).Auckland University of Technology, Auckland.

Baker, M. W. (1998). The loss of the selfobject tie and religious fundamentalism.*Journal of Psychology and Theology, 26*(3), 223-231. Retrieved from http://ovidsp.tx.ovid.com.ezproxy.aut.ac.nz/sp-3.14.0b/ovidweb.cgi?&S=MLJLFPOCOBDDJDCBNCLKECMCFLJMAA00&Complete+Reference=S.sh.21%7c1%7c1

Barker, P., & Kerr, B. (2001).*The process of psychotherapy*. Oxford, England: Butterworth-Heinemann.

Baker, M., & Wang, M. (2004). Examining connections between values and practice in religiously committed U.K. clinical psychologists. *Journal of Psychology and Theology, 32*(2), 126-136.

Barnett, J. E., & Johnson, W. B. (2011).Integrating spirituality and religion into psychotherapy: Persistent dilemmas, ethical issues, and a proposed decision-making process. *Ethics & Behavior, 21*(2), 147-164. doi:10.1080/10508422.2011.551471

Bartoli, E. (2003). Psychoanalytic practice and the religious patient: A current perspective. *Bulletin of the Menninger Clinic, 67*(4), 347-366. doi: 10.1521/bumc.67.4.347.26984

References

Bartoli, E. (2007). Religious and spiritual issues in psychotherapy practice: Training the trainer. *Psychotherapy: Theory, Research, Practice, Training, 44*(1), 54-65. doi:10.1037/0033-3204.44.1.54

Bathgate, D. (2003). Psychiatry, religion and cognitive science.*Australian and New Zealand Journal of Psychiatry 37*(277-285). doi:10.1046/j.1440-1614.2003.01178.x

Bateman, A., Brown, D., & Pedder, J. (2000).*Introduction to psychotherapy* (3rd ed.). London, England: Routledge.

Battista, J. R. (1996a). Abraham Maslow and Roberto Assagioli: Pioneers of transpersonal psychology. In B. W. Scotton, A. B. Chinen, & J. B. Battista (Eds.), *Textbook of transpersonal psychiatry and psychology* (pp. 52-84). New York, NY: Basic Books.

Battista, J. R. (1996b). Offensive spirituality and spiritual defenses. In B. W. Scotton, A. B. Chinen, & J. R. Battista (Eds.), *Textbook of transpersonal psychiatry and psychology* (pp. 250-260). New York, NY: Basic Books

Bazeley, P. (2007). *Qualitative data analysis with NVivo*. London, England: Sage.

Beit-Hallahmi, B. (1992). Between religious psychology and the psychology of religion. In M. Finn & J. Gartner (Eds.), *Object relations theory and religion:Clinical applications* (pp. 119-128). Westport, WA: Greenwood Press.

Bergin, A. E., & Jensen, J. P. (1990). Religiosity of psychotherapists: A national survey. *Psychotherapy, 27*, 3-7. doi:10.1037/0033-3204.27.1.3

Berne, E. (1961). *Transactional analysis in psychotherapy.* New York, NY. Grove Press.

Bienenfeld, D., & Yager, J. (2007).Issues of spirituality and religion in psychotherapy supervision.*The Israel Journal of Psychiatry and Related Sciences, 44*(3), 178-186

Bilgrave, D. P., & Deluty, R. H. (2002). Religious beliefs and political ideologies as predictors of psychotherapeutic orientations of clinical and counselling psychologists.*Psychotherapy: Theory, Research, Practice, Training, 39*(3), 245-260. doi: 10.1521/bumc.67.4.347.26984

Bion, W. R. (1970). *Attention and interpretation: A scientific approach to insight in psycho-analysis and groups*. London, England: Karnac.

Birks, M., & Mills, J. (2011).*Grounded theory: A practical guide*. London, England: Sage.

Black, D. M. (2000).The functioning of religions from a modern psychoanalytic perspective.*Mental Health, Religion & Culture, 3*(1), 13-26. doi:10.1080/13674670050002063

References

Black, R. (2000). Political implications of the name "Pakeha".*Living Justly in Aotearoa* (3), 1.

Blatner, A., & Blatner, A. (1988).*Foundations of psychodrama: History, theory, and practice.* New York, NY: Springer.

Blumer, H. (1969). *Symbolic interactionism*. Berkely, CA: University of California Press.

Bolletino, R. C. (2001). A model of spirituality for psychotherapy and other fields of mind-body medicine.*Advances In Mind-Body Medicine, 17*, 90-107. Retrieved from http://ovidsp.tx.ovid.com.ezproxy.aut.ac.nz/sp-3.14.0b/ovidweb.cgi?&S=MBDFFPOCCGDDJDNKNCLKPCJCJHEJAA00&Complete+Reference=S.sh.41%7c1%7c1

Bond, T. (2011). Intimacy, risk, and reciprocity in psychotherapy: Intricate ethical challenges. In A. Kearns (Ed.), *The mirror crack'd: When good enough therapy goes wrong and other cautionary tales for the humanistic practitioner* (2nd ed., pp. 148-166). London, England: Karnac.

Boscaglia, N., Clarke, D. M., Jobling, T. W., & Quinn, M. A. (2005).The contribution of spirituality and spiritual coping to anxiety and depression in women with a recent diagnosis of gynaecological cancer.*International Journal of Gynaecological Cancer, 15*, 755-761. doi:10.1111/j.1525-1438.2005.00248.x

Bowden, A. R. (2000). Psychotherapy as a containier for bi-cultural practice in Aotearoa.*Psychotherapy in Australia*, *7*(1), 10-15.

Bowden, A. R. (2003). *Choosing to cross by sea*.Paper presented at the meeting of the World Congress for Psychotherapy Regional Conference. London, Canada.

Bowden, A. R. (2010). Beyond definition and method: The next era for counselling and psychotherapy. *Asia Pacific Journal of Counselling and Psychotherapy, 1*(1), 4-14. doi:10.1080/21507680903570235

Bowden, A. R. (2013). Cultural counselling: Beyond method and modality. In M. Agee, N, T. McIntosh, P. L. Culbertson, & C. O. Makasiale (Eds.), *Pacific Identites and Well-being: Cross-Cultural Perspectives* (pp. 158-169). Dunedin, New Zealand: Otago University Press.

Bowers, B. J. (1988). Grounded theory. In B. Sarter (Ed.), *Paths to knowledge: Innovative research methods for nursing* (pp. 33-59). New York, NY: National League for Nursing.

Bowers, B., Fibich, B., & Jacobson, N. (2009). Example: Care-as-Service, Care-as-Relating, Care-as-Comfort. In J. M. Morse, P. N. Stern, J. Corbin, B. Bowers, K. Charmaz, & A. E. Clarke (Eds.), *Developing grounded theory: The second generation.*(pp. 107-126.). Walnut Creek, CA: Left Coast Press.

References

Bowers, B., & Schatzman, L. (2009).Dimensional analysis. In J. Morse, M, P. N. Stern, J. Corbin, B. Bowers, K. Charmaz, & A. E. Clarke (Eds.), *Developing grounded theory: The second generation.* (pp. 86-106). Walnut Creek, CA: Left Coast Press.

Bravo, G., & Grob, C. (1996). Psychedelics and transpersonal psychiatry. In B. W. Scotton, A. B. Chinen, & J. R. Battista (Eds.), *Textbook of transpersonal psychiatry and psychology* (pp. 176-194). New York, NY: Basic Books.

Brawer, P. A., Handal, P. J., Fabricatore, A. N., Roberts, R., & Wajda-Johnston, V. A. (2002). Training and education in religion/spirituality within APA-accredited clinical psychology programs.*Professional Psychology: Research and Practice, 33*(2), 203-206. doi:10.1037/0735-7028.33.2.203

Brett, C. (2010). Transformative crises. In I. Clarke (Ed.), *Psychosis and spirituality: Consolidating the new paradigm* (pp. 155-174). Chichester, England: John Wiley and Sons.

Brodley, B. T. (2001). A client-centred approach to religious and spiritual experiences.In S. King-Spooner & C. Newnes (Eds.), *Spirituality and psychotherapy* (pp. 148-156). Ross-on-Wye: PCCS Books.

Brooke, R. (2001). Emissaries from the underworld. In P. Young-Eisendrath & M. E. Miller (Eds.), *The psychology of mature spirituality: Integrity, wisdom, transcendence*. Hove, England: Brunner-Routledge.

Brown, A. M. (2006). *Religion, spirituality and psychotherapy: A qualitative analysis of therapists' practices* (Doctoral dissertation).Available from ProQuest Dissertations and Theses database. (UMI No. 3220771)

Brown, L. S. (2008). *Cultural competence in trauma therapy: Beyond the flashback*. Washington, DC: American Psychological Association.

Brown, O., Elkonin, D., & Naicker, S. (2013). The use of religion and spirituality in psychotherapy: Enablers and barriers. *Journal of Religion and Health, 52*(4), 1131-1146. doi:10.1007/s10943-011-9551-z

Browne, J. (2004). Grounded theory analysis: Coming to data with questioning minds. In V. Minchiello, G. Sullivan, K. Greenwood, & R. Axford (Eds.), *Handbook of research methods for nursing and health science* (pp. 624-673). Frenchs Forest, Australia: Prentice Hall Health.

Bryant, A., & Charmaz, K. (2007).Introduction. Grounded theory research: Methods and practices. In A. Bryant & K. Charmaz (Eds.), *The Sage handbook of grounded theory* (pp. 1-28). London, England: Sage.

Buckley, C. A., & Waring, M. J. (2013).Using diagrams to support the research process: Examples from grounded theory.*Qualitative Research, 13*(2), 148-172. doi:10.1177/1468794112472280

References

Cabassa, L. J., & Baumann, A. A. (2013). A two-way street: Bridging implementation science and cultural adaptations of mental health treatments. *Implementation Science, 8*(1), 1-14. doi:10.1186/1748-5908-8-90

Cannon, L. D. (1998). *The effects of client religious orientation and clinician religious orientation and training on clinical judgment.*(Doctoral dissertation) Available from ProQuest Dissertations and Theses database. (UMI No. 3028766)

Carlson, B. (1997). *A spectrum of approaches to spirituality in secular psychotherapy: A Qualitative study of Minnesota licenced psychologists* (Doctoral dissertation). Available from ProQuest Dissertations and Theses database. (UMI No. 9734669)

Carney, S. A. (2007).*A qualitative study of women therapists' experiences of spirituality in the counseling process* (Doctoral dissertation).Available from ProQuest Dissertations and Theses database. (UMI No. 3265913)

Caron, C. D., & Bowers, B. J. (2000). Methods and applications of dimensional analysis: A contribution to concept and knowledge development in nursing. In B. L. Rodgers & K. A. Knafl (Eds.), *Concept development in nursing: Foundations, techniques and applications* (2nd ed., pp. 285-319). Philadelphia, USA: W B Saunders.

Carson, R., Farrell, M., & Manning, S. (Eds.). (2008). *A history of a decade: 1997-2006*. Wellington, New Zealand: The New Zealand Association of Psychotherapists. Te Roopu Wharaora Hinengaro.

Case, P. W., & McMinn, M. R. (2001).Spiritual coping and well-functioning among psychologists.*Journal of Psychology and Theology, 29*(1), 29-40.

Casement, P. (2002). *Learning from our mistakes*. New York, NY: The Guilford Press.

Castell, B. D. (2013). *Missing pieces? Considering religion and spirituality in mental health care* (Doctoral dissertation). Retrieved from http:www.nzresearch.co.nz

Centers for Disease Control and Prevention.(n.d.).*International Classification of Diseases Ninth Revision Clinical Modification (ICD-9-CM)*. Retrieved from http://www.cdc.gov/nchs/icd/icd9cm.htm

Chai, P. P. M. (2009). *Religion/spirituality as a stress coping mechanism for international students* (Master's thesis, Auckland University of Technology, Auckland, Aotearoa New Zealand).Retrieved from http://aut.researchgateway.ac.nz/discover?query=Religion%2Fspirituality+as+a+stress+coping+mechanism+for+international+students+

Charmaz, K. (2000). Grounded theory: Objectivist and constructivist methods. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed.). Thousand Oaks, CA: Sage.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis.* London, England: Sage.

References

Charmaz, K. (2008). Grounded theory as emergent method.In S. N. Hesse-Bilber & P. Leavy (Eds.), *Handbook of emergent methods* (pp. 155-170). New York, NY: The Guilford Press.

Charmaz, K. (2009). Shifting the grounds. Constructivist grounded theory methods. In J. M. Morse, P. N. Stern, J. Corbin, B. Bowers, K. Charmaz, & A. E. Clarke (Eds.), *Developing grounded theory: The second generation* (pp. 127-193). Walnut Creek, USA: Left Coast Press.

Charmaz, K. (2014). *Constructing grounded theory* (2nd ed.). London, England: Sage.

Charon, J. M. (2010). *Symbolic interactionism* (10th ed.). Boston, MA: Prentice Hall.

Cilitira, K., & Foster, N. (2012). Attention to culture and diversity in psychoanalytic trainings. *British Journal of Psychotherapy, 28*(3), 353-373. doi:10.1111/j.1752-0118.2012.01298.x

Claridge, R. (2010). Spiritual experience: Healthy psychoticism? In I. Clarke (Ed.), *Psychosis and spirituality: Consolidating the new paradigm* (2nd ed., pp. 75-88). Chichester, England: Wiley-Blackwell.

Clarke, I. (2001). Psychosis and spirituality: Finding a language. In S. King-Spooner & C. Newnes (Eds.), *Spirituality and psychotherapy* (pp. 87-97). Ross-on-Wye, England: PCCS Books.

Clarke, A. E. (2003). Situationalanalyses: Grounded theory mapping after the postmodern turn. *Symbolic Interaction, 26*(4), 553-576.

Clarkson, P. (1990). A multiplicity of psychotherapeutic relationships.*British Journal of Psychotherapy, 7*(2), 148-163. doi:10.1111/j.1752-0118.1990.tb01329.x

Clarkson, P. (1995). *The therapeutic relationship*. London, England: Whurr Publishers.

Cohen, A. B., Hall, D. E., Koenig, H. G., & Meador, K. G. (2005). Social versus individual motivation: Implications for normative definitions of religious orientation. *Personality and Social Psychology Review, 9*(1), 48-61. doi:10.1207/s15327957pspr0901_4

Cohen, P. (1994). An interesting contradiction: A study of religiously committed, psychoanalytically oriented clinicians. *Journal of Psychology and Theology, 22*(4), 304-318. Retrieved from http://ovidsp.tx.ovid.com.ezproxy.aut.ac.nz/sp-3.14.0b/ovidweb.cgi?&S=CAAOFPLOAODDIDFENCLKMAFBDEDJAA00&Complete+Reference=S.sh.41%7c4%7c1

Cohen, M. (2003). Frontline: The affirmation of a religious (not merely spiritual!) orientation in clinical treatment. *Journal of American Academic Psychoanalysis, 31,* 269-273. doi: 10.1521/jaap.31.2.269.22111

Collins, C. M., O'Neill-Arana, M. R., Fontes, L. A., & Ossege, J. M. (2014). Catholicism and childhood sexual abuse: Women's coping and psychotherapy.

References

Journal of Child Sexual Abuse, 23(5), 519-537. doi:10.1080/10538712.2014.918071

Cooper-White, P. (2008). Interrogating integration, dissenting dis-integration: Multiplicity as a positive metaphor in therapy and theology. *Pastoral Psychology, 57*, 3-15. doi:10.1007/s11089-008-0135-0

Corbett, L. (2013). Jung's approach to spirituality andreligion. In K. I. Pargament, A. I. Mahoney, & E. P. Shafranske (Eds.), *APA handbook of psychology, religion and spirituality* (Vol. 2, pp. 147-167). Washington, DC: American Psychological Association.

Corey, G. (1996). *Theory and practice of counseling and psychotherapy* (5th ed.). Pacific Grove, CA: Brooks/Cole.

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

Crossley, J. P., & Salter, D. P. (2005). A question of finding harmony: A grounded theory study of clinical psychologists' experience of addressing spiritual beliefs in therapy. *Psychology and Psychotherapy, 78*(3), 295-313. doi:10.1348/147608305X26783

Crotty, M. (1998).*The foundations of social research: Meaning and perspective in the research process*. St Leonards, Australia: Allen & Unwin.

Culbertson, P. L. (1998). The shadow of the transcendent: Valuing spirituality in psychotherapy. *Forum: The Journal of the New Zealand Association of Psychotherapists, 4*(14-37).

Cummings, J. P., Carson, C. S., Stanley, M. A., & Pargament, K. I. (2014).A systematic review of relations between psychotherapist religiousness/spirituality and therapy-related variables.*Spirituality in clinical practice, 1*(2), 116-132. doi:10.1037/scp00000.14

Damon, A. (2010). *Spirituality in the therapeutic process* (Master's dissertation).Available from ProQuest Dissertations and Theses database. (UMI No. 1482012)

D'Angelo, M. E. (2013). *Spirit matters: A heuristic investigation of the psychotherapist's experience of attending to spirituality in psychotherapy* (Doctoral dissertation). Available from ProQuest Dissertations and Theses database. (UMI No. 3592411)

Daniels, C., & Fitzpatrick, M. (2013).Integrating spirituality into counselling and psychotherapy: Theoretical and clinical perspectives.*Canadian Journal of Counselling and Psychotherapy, 47*(3), 315-341. Retrieved from http://ezproxy.aut.ac.nz/login?url=http://search.proquest.com/docview/1428438780?accountid=8440

References

Davies, M. H. (1976). The origins and practice of psychodrama.*The British Journal of Psychiatry, 129,* 201-206. doi:10.1192/bjp.129.3.201

de Castella, R., & Simmonds, J. G. (2013). "There's a deeper level of meaning as to what suffering's all about": Experiences of religious and spiritual growth following trauma. *Mental Health, Religion & Culture, 16*(5), 536-556. doi:10.1080/13674676.2012.702738

Dein, S. (2004).Working with patients with religious beliefs.*Advances in Psychiatric Treatment, 10*(4), 287-294. doi:10.1192/apt.10.4.287

Denney, R. M., Aten, J. D., & Gingrich, F. C. (2008).Using spiritual self-disclosure in psychotherapy.*Journal of Psychology and Theology 36*(4), 292-302. Retrieved from http://search.proquest.com/docview/223666184?pq-origsite=summon

Dey, I. (1999).*Grounding grounded theory*. San Diego, CA: Academic Press.

Dillon, G. (2011). The road to registration. In K. Tudor (Ed.), *The turning tide: Pluralism and partnership in psychotherapy in Aotearoa New Zealand* (pp. 31-38). Wellington, Aotearoa New Zealand: First Edition.

Doherty-King, B., & Bowers, B. J. (2013).Attributing the responsibility for ambulating patients: A qualitative study.*International Journal of Nursing Studies, 50*(9), 1240-1246. doi:10.1016/j.ijnurstu.2013.02.007

Dowd, E. T., & Nielsen, S. L. (Eds.). (2006). *The psychologies in religion: Working with the religious client*. New York, NY: Springer.

Draucker, C. B., Martsolf, D. S., Ross, R., & Rusk, T. B. (2007).Theoretical sampling and category development in grounded theory.*Qualitative Health Research, 17*(8), 1137-1148. doi:10.1177/1049732307308450

Drinnan, A., & Lavender, T. (2006).Deconstructing delusions: A qualitative study examining the relationship between religious beliefs and religious delusions.*Mental Health, Religion & Culture, 9*(4), 317-331. doi:10.1080/13694670500071711

Du Freshne, K. (2013). Holy smoke.*New Zealand Listener, 238*(3804), 16-20.

Dura-Vila, G., Hagger, M., Dein, S., & Leavey, G. (2011). Ethnicity, religion and clinical practice: A qualitative study of beliefs and attitudes of psychiatrists in the United Kingdom. *Mental Health, Religion & Culture, 14*(1), 53-64. doi:10.1080/13674676.2010.495111

Durie, M., H. (1985).A Māori perspective of health.*Social Science Medicine, 20*(5), 483-486. doi:10.1016/0277-9536(85)90363-6

Durie, M. (2001).*Whaiora Māori health development.* South Melbourne, Australia: Oxford University Press.

References

Durie, M. (2003).*Whaiora Māori health development* (2nd ed.). Oxford, England: Oxford University Press.

Durie, M. (2004).*Whaiora: Māori health development* (2nd ed.). South Melbourne, Australia: Oxford University Press.

Durie, M. (2007). Counselling Māori: Marae encounters as a basis for understanding and building relationships. *New Zealand Association of Counsellors, 27*(1), 1-8.

Ecumenical Coalition for Justice Aotearoa New Zealand (2004).*Missionary involvement in the Treaty of Waitangi*. Retrieved fromhttp://www.socialjustice.org.nz/?sid=115

Elkins, D. (2005). A humanistic approach to spiritually oriented psychotherapy. In L. Sperry & E. P. Shafranske (Eds.), *Spiritually oriented psychotherapy* (pp. 131-151). Washington, D.C: American Psychological Association.

Emmons, R., Cheung, C., & Tehrani, K. (1998).Assessing spirituality through personal goals: Implications for research on religion and subjective well-being.*Social Indicators Research, 45*, 391-422. doi:10.1023/A:1006926720976

Eshun, S., & Gurung, R. A. R. (2009).Introduction to culture and psychopathology.In S. Eshun & R. A. R. Gurung (Eds.), *Culture and mental health*. West Sussex, England: Blackwell.

Eusden, S. (2011).Minding the gap: Ethical considerations for therapeutic engagement.*Transactional Analysis Journal, 41*(2), 101-113. doi:10.1177/036215371104100202

Evangelical. (2007). *Collins English Dictionary* (9th ed.). Gloucester, England: Harper Collins

Florence, H. J. (2009). *What are the therapeutic implications of psychoanalytic conceptualisations of God when working psychoanalytically with Christian clients?* (Master's dissertation, Auckland University of Technology, Auckland, New Zealand). Retrieved from http://aut.researchgateway.ac.nz/browse?value=Florence%2C+Helen+Jane&type=author

Forbes, E. D. H. (1995). *Therapist religious belief and clinical praxis* (Doctoral dissertation).Available from ProQuest Dissertations and Theses database. (UMI No. 9616829)

Frame, M. W. (2001). The spiritual genogram in training and supervision.*The Family Journal, 9*(2), 109-115. doi:10.1177/1066480701092004

Frankl, V. (1964).*Man's search for meaning: An introduction to logotherapy*. London, England: Hodder and Stoughton.

Frawley-O'Dea, M. G. (2015). God images in clinical work with sexual abuse survivors: A relational psychodynamic paradigm. In D. F. Walker, C. A. Courtois, & J. D.

References

Aten (Eds.), *Spiritually oriented psychotherapy for trauma* (pp. 169-188). Washington, DC: American Psychological Association.

Frazier, R. E., & Hansen, N. D. (2009). Religious/spiritual psychotherapy behaviors: Do we do what we believe is important? *Professional Psychology Research and Practice, 40*, 81-87. doi:10.1037/a0011671

Fredenberg, J. R (2002).*The Buddhist psychologist: An exploration into spirituality and psychotherapy* (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses database. (UMI No. 3049731)

Freud, S. (1927/2010). *The future of an illusion*. Lexington, KY: Pacific Publishing Studio (Original work published 1927).

Fromm, E. (1950). *Psychoanalysis and religion*. New Haven, CT: Yale University Press.

Frosh, S. (2006). Psychoanalysis and Judaism.In D. M. Black (Ed.), *Psychoanalysis and Religion in the 21st Century: Competitors or collaborators* (pp. 205-222). London, England: Routledge.

Fulford, B. (2010). Linguisitic analysis and values-based practice: One way of getting started with some kinds of philosophical problems at the interface between psychiatry and religion. In P. J. Verhagen, M. M. Van Praag, J. J. Lopez-Ibor, J. L. Cox, & D. Moussaoui (Eds.), *Religion and psychiatry: Beyond the boundaries* (pp. 39-62). Chichester, England: Wiley-Blackwell.

Ganje-Fling, M. A., & McCarthy, P. (1996). Impact of childhood sexual abuse on client spiritual development: Counseling implications. *Journal of Counseling & Development, 74*(253-258). doi:10.1002/j.1556-6676.1996.tb01861.x

Garb, H. N. (1997).Race bias, social class bias, and gender bias in clinical judgment.*Clinical Psychology: Science and Practice, 4*(2), 99-120. doi:10.1111/j.1468-2850.1997.tb00104.x

Garrott, R. (2008). *The effects of psychotherapists' values on their work with clients who practice consensual sexual sadomasochism* (Doctoral dissertation).Available from ProQuest Dissertations and Theses database. (UMI No. 3322250)

Gartner, J., Harmatz, M., Hohmann, A., Larson, D., & Gartner, A. F. (1990). The effect of patient and clinician ideology on clinical judgment: A study of ideological countertransference *Psychotherapy: Theory, Research, Practice, Training, 27*(1), 98-106. doi:10.1037/0033-3204.27.1.98

Geekie, J. (2007). *The experience of psychosis: Fragmentation, invalidation and spirituality* (Doctoral thesis, Auckland University, Auckland, Aotearoa New Zealand). Retrieved from https://researchspace.auckland.ac.nz/docs/uoa-docs/rights.htm

References

Genia, V. (2000).Religious issues in secularly based psychotherapy.*Counseling and Values, 44*(3), 213-222. Retrieved from http://search.proquest.com/docview/207607188?accountid=8440

Gibson, T. L. (2001). Wholeness and transcendence in the practice of pastoral psychotherapy from a Judeo-Christian perspective. In P. Young-Eisendrath & M. E. Miller (Eds.), *The psychology of mature spirituality: Integrity, wisdom, transcendence* (pp. 175-186). Hove, England: Brunner-Routledge.

Giddings, L. S., & Wood, P. J. (2000). The methodological journey of a grounded theorist: An interview with Denise Dignam. *Nursing Praxis in New Zealand, 16*(2), 4-16.

Giddings, L. S., & Wood, P. J. (2006). How to survive (and enjoy) doing a thesis: The experiences of a methodological working group. *Nursing Praxis in New Zealand, 22*(1), 11-22.

Giglio, J. (1993). The impact of patients' and therapists' religious values on psychotherapy*Hospital & Community Psychiatry, 44*(8), 768-771.

Gilling, B. (1998). Karaiti and culture.*Stimulus, 6*(2), 2-3

Gilmore-Bykovski, A. L., & Bowers, B. J. (2013). Understanding nurses decisions to treat pain in nursing home residents with dementia. *Residential Gerontological Nursing., 6*(2), 127-138. doi:10.3928/19404921-20130110-02

Glaser, B., & Strauss, A. L. (1967).*The discovery of grounded theory*. Chicago, Ill: Aldine.

Goedde, C. (2000). *A qualitative study of the client's perspectives of discussing spiritual and religious issues in psychotherapy* (Doctoral dissertation).Available from ProQuest Dissertations and Theses database. (UMI No. 9985193)

Gonsiorek, J. C., Richards, P. S., Pargament, K. I., & McMinn, M. R. (2009). Ethical challenges and opportunities at the edge: Incorporating spirituality and religion into psychotherapy. *Professional Psychology: Research and Practice, 40*(4), 385-395. doi:10.1037/a0016488

Goreng Goreng, T. (2012).Living in shadows, healing in the law: An Aboriginal experience of recovery using psychotherapy and Aboriginal spiritual practice.*Psychotherapy and Politics International, 10*(3), 205-218. doi:10.1002/ppi.1273

Gorton, D. (1987). Gestalt Therapy: The historical influences on Frederick S. Perls. *Gestalt Theory, 9*(1), 28-39.

Green, J. E., Gardner, F. M., & Kippen, S. A. (2009).Healing of the soul: The role of spirituality in recovery from mental illness.*International Journal of Psychosocial Rehabilitation, 13*(2), 65-75.

References

Green, S., Tudor, K., Dillon, G., Duncan, A., Fay, J., Land, C., ... Woodard, W. (2014). Ngā Ao e Rua | The two worlds: Psychotherapy, biculturalism, and professional development in Aotearoa New Zealand. *Psychotherapy and Politics International, 12*(2), 129-150. doi:10.1002/ppi.1329

Greer, J. M. (1995). Religion in clinical psychoanalysis: Some reflections on process and content. *Applied Psychoanalysis, April*(1), 4-7.

Griffith, J. (2006). Managing religious countertransference in clinical settings.*Psychiatric Annals, 36*(3), 196-203. Retrieved from: http://ezproxy.aut.ac.nz/login?url=http://search.proquest.com/docview/217054528?accountid=8440

Griffith, J. L., & Griffith, M. E. (2002).*Encountering the sacred in psychotherapy*. New York, NY: The Guilford Press.

Grof, S., & Grof, C. (Eds.). (1989). *Spiritual Emergency: When personal transformation becomes a crisis*. New York, NY: Jeremy P. Tarcher/Putnam

Grossman, F. K., Sorsoli, L., & Kia-Keating, M. (2006). A gale force wind: Meaning-making by male survivors of childhood sexual abuse. *American Journal of Orthopsychiatry, 76*(4), 434-443. doi:10.1037/0002-9432.76.4.434

Gubi, P. M. (2007). Exploring the supervision experience of some mainstream counsellors who integrate prayer in counselling.*Counselling and Psychotherapy Research: Linking research with practice 7*(2), 114-121. doi:10.1080/14733140701342544

Guntrip, H. (1961). *Personality structure and human interaction*. New York, NY: International Universities Press.

Guntrip, H. (1969). Religion in relation to personal integration.*British Journal of Medical Psychology, 42*(323-333).

Hackney, C. H. (2010). Religion and mental health: What do you mean when you say "Religion"?What do you mean when you say "Mental Health"? In P. J. Verhagen, M. M. Van Praag, J. J. Lopez-Ibor, J. L. Cox, & D. Moussaoui (Eds.), *Religion and psychiatry* (pp. 343-360). Chichester, England: Wiley-Blackwell.

Hackney, C. H., & Sanders, G. S. (2003). Religiosity and mental health: A meta-analysis of recent studies. *Journal of the Scientific Study of Religion, 42*, 43-55. doi:10.1111/1468-5906.t01-1-00160

Hage, S. M., Hopson, A., Siegel, M., Payton, G., & De Fanti, E. (2006). Multicultural training in spirituality: An interdisciplinary review. *Counseling and Values, 50*(3), 217-234. Retrieved from http://ezproxy.aut.ac.nz/login?url=http://search.proquest.com/docview/207567710?accountid=8440

Hakomi Institute. (n.d) Retrieved from http://hakomiinstitute.com/

References

Hall, A. (2009). *Waka Oranga: Te Ao Hurihuri: The world of dualities*. New Zealand Association of Psychotherapists Newsletter.

Hall, A., Morice, M., & Wilson, C. (2012). Waka Oranga: The development of an indigenous professional organisation within a psychotherapeutic discourse in Aotearoa New Zealand. *Psychotherapy and Politics International, 10*(1), 7-16. doi:10.1002/ppi.1255

Hanson, J. (2005). Should your lips be zipped? How therapist self-disclosure and non-disclosure affects clients. *Counselling & Psychotherapy Research, 5*(2), 96-104. doi:10.1080/17441690500226658

Harbourne, L. (2012). *Psychotherapy and spiritual direction.* London, England: Karnac Books.

Hathaway, W. L. (2003). Clinically significant religious impairment.*Mental Health, Religion & Culture, 6*, 113-129. doi:10.1080/1367467021000038174

Hathaway, W. L., Scott, S. Y., & Garver, S. A. (2004). Assessing religious/spiritual functioning: A neglected domain in clinical practice? *Professional Psychology: Research and Practice, 35*(1), 97-104. doi:10.1037/0735-7028.35.1.97

Hawkins, I. L., & Bullock, S. L. (1995). Informed consent and religious values: A neglected area of diversity. *Psychotherapy, 32*(2), 293-300. doi:10.1037/0033-3204.32.2.293

Helmeke, K. B., & Bischof, G. H. (2002). Recognizing and raising spiritual and religious issues in therapy. *Journal of Family Psychotherapy, 13*(1-2), 195-214. doi:10.1300/J085v13n01_10

Henwood, K., & Pidgeon, N. (2003).Grounded theory in psychological research. In P. M. Camic, J. M. Rhodes, L. Yardley, & M. Bamberg (Eds.), *Qualitative research in psychology: Expanding perspectives in methodology and design* (pp. 131-155). Washington, DC: American Psychological Association.

Hicks, M. W. (2003).*Christianity and strong values in Psychotherapy: Clinical judgment and supervision at university counseling centers* (Doctoral dissertation). Available from ProQuest Dissertations and Theses database. (UMI No. 3103317)

Hill, P. C., Smith, E., & Sandage, S. J. (2012).Religious and spiritual motivations in clinical practice. In J. D. Aten, K. A. O'Grady, & E. L. Worthington (Eds.), *The psychology of religion and spirituality for clinicians* (pp. 69-99). New York, NY: Routledge.

Hirsch, I. (2008). *Coasting in the countertransference*. New York, NY: The Analytic Press.

Hoffman, M. T. (2011). *Toward mutual recognition: Relational psychoanalysis and the Christian narrative*. New York, NY: Routledge.

References

Hofmann, L., & Walach, H. (2011). Spirituality and religiosity in psychotherapy: A representative survey among German psychotherapists. *Psychotherapy Research, 21*(2), 179-192. doi:10.1080/10503307.2010.536595

Holmes, J., & Lindley, R. (1989).*The values of psychotherapy*.London, England: Oxford University Press.

Holmes, J. (1997). Values in psychotherapy.*Australian & New Zealand Journal of Psychiatry 31*(3), 331-339. doi:10.3109/00048679709073842

Holton, J. A. (2007). The coding process and its challenges.In A. Bryant & K. Charmaz (Eds.), *The Sage handbook of grounded theory*. London, England: Sage.

Hood, R. W., & Chen, Z. (2013).Mystical, spiritual and religious experiences.In R. F. Paloutzian & C. Park, L (Eds.), *Handbook of the psychology of religion and spirituality* (2nd ed., pp. 422-440). New York, NY: The Guilford Press.

Hoverd, W. J. (2008). No longer a Christian country?Religious demographic change in New Zealand 1966-2006. *New Zealand Sociology, 23*(1), 41-64. Retrieved fromhttp://yu7rz9hn8y.scholar.serialssolutions.com.ezproxy.aut.ac.nz/?sid=google&auinit=WJ&aulast=Hoverd&atitle=No+longer+a+Christian+country%3F+Religious+demographic+change+in+New+Zealand+1966%E2%80%932006&title=New+Zealand+sociology&volume=23&issue=1&date=2008&spage=41&issn=0112-921X

Hubback, J. (1999). Reflections of an analytical psychologist. In S. M. Stein (Ed.), *Beyond belief: Psychotherapy and religion* (pp. 82-98). London, England: Karnac.

Ihimaera, L. (2004). *He ara ki te ao mārama : A pathway to understanding the facilitation of taha wairua in mental health services* (Master's thesis). Retrieved from http://hdl.handle.net/10179/990

Ingersoll, R. E. (1994). Spirituality, religion, and counseling: Dimensions and relationships. *Counselling and Values, 38*(2), 98-111. doi:10.1002/j.2161-007X.1994.tb00827.x

Jackson, M. C. (2010). The paradigm-shifting hypothesis: A common process in benign psychosis and psychotic disorder. In I. Clarke (Ed.), *Psychosis and spirituality:Consolidating the new paradigm* (pp. 139-154). Chichester, England: Wiley-Blackwell.

James, M. (1981). TA in the 80's: The inner core and the human spirit. *Transactional Analysis Journal, 11*, 54-65.

James, W. (1902/2008).*The varieties of religious experience*. L.L.C, USA: Megalodon Entertainment.

Jim, J., & Pistrang, N. (2007). Culture and the therapeutic relationship: Perspectives from Chinese clients. *Psychotherapy Research, 17*(4), 461-473. doi:10.1080/10503300600812775

References

Johanson, G. (2011). In memorium Ronald S. Kurtz 1934-2011.*Body, Movement and Dance in Psychotherapy: An International Journal for Theory, Research and Practice 6*(1), 175-180. doi:10.1080/17432979.2011.568761

Johnson, W. B., Ridley, C. R., & Nielsen, S. L. (2000). Religiously sensitive rational emotive behavior therapy: Elegant solutions and ethical risks. *Professional Psychology: Research and Practice, 31*(1), 14-20. doi:10.1037/0735-7028.31.1.14

Johnson, E. L., & Sandage, S. J. (1999). A postmodern reconstruction of psychotherapy: Orienteering, religion, and the healing of the soul. *Psychotherapy: Theory, Research, Practice, Training, 36*(1), 1-15. doi:10.1037/h0087824

Jones, G. (2013). *Clinician experience of addressing clients' religion and spirituality in therapy.*Available from ProQuest Dissertations and Theses database. (UMI No. 3594064)

Jones, M. S. (2006). Culture as religion and religion as culture in the philosophy of Lucian Blaga.*Religion, Culture, Ideology, 15*, 66-87.

Josephson, A. M., Peteet, J. R., & Tasman, A. (2010).Religion and the training of psychotherapists. In P. J. Verhagen, M. M. Van Praag, J. J. Lopez-Ibor, J. L. Cox, & D. Moussaoui (Eds.), *Religion and psychiatry: Beyond boundaries* (pp. 571-586). Chichester, England: Wiley-Blackwell.

Jung, C. G. (1958). *Psychology and religion: West and East*. London, England: Routledge and Kegan Paul.

Kahle, P., A. (1997). *The influence of the person of the therapist on the integration of spirituality and psychotherapy* (Doctoral dissertation).Available from ProQuest Dissertations and Theses database. (UMI No. 9804904)

Kandathil, G., & Kandathil, C. (1997). Autonomy: Open door to spirituality. *Transactional Analysis Journal, 27*, 24-29.

Karasu, T. B. (1986). The specificity versus nonspecificity dilemma: Toward identifying therapeutic change agents. *The American Journal of Psychiatry, 143*(6), 687-695.

Kearns, A. (Ed.). (2011). *The mirror crack'd : When good enough therapy goes wrong and other cautionary tales for the humanistic practitioner* (2nd ed.). London, England: Karnac.

Keating, A. M., & Fretz, B. R. (1990).Christians' anticipations about counselors in response to counselor descriptions.*Journal of Counseling Psychology, 37*(3), 293-296.doi: 10.1037/0022-0167.37.3.293

Kehoe, N., & Gutheil, T. (1993). Ministry or therapy: The role of transference and countertransference in a religious therapist. In M. Randour (Ed.), *Exploring sacred landscapes* (pp. 55-80). New York, NY: Columbia University Press.

References

Kim, Y., & Seidlitz, L. (2002). Spirituality moderates the effect of stress on emotional and physical adjustment. *Personality and Individual Differences, 32*(8), 1377-1390. doi:10.1016/S0191-8869(01)00128-3

King, B., Gilmore-Bykovskyi, A. L., Roiland, R. A., Polnaszek, B. E., Bowers, B. J., & Kind, A. J. H. (2013). The consequences of poor communication during transitions from hospital to skilled nursing facility: A qualitative study. *JAGS, 61*, 1095-1102. doi:10.1111/jgs.12348

King, M., Weich, S., Nazroo, J., & Blizard, B. (2006).Religion, mental health and ethnicity.EMPIRICA national survey of England.*Journal of Mental Health, 14*(2), 153-162. doi:10.1080/09638230600608891

Knox, R. (2007). Experiencing risk in person-centred counselling: A qualitative exploration of therapist risk-taking. *British Journal of Guidance & Counselling, 35*(3), 317-330. doi:10.1080/03069880701419449

Knox, S., Catlin, L., Casper, M., & Schlosser, L. Z. (2005).Addressing religion and spirituality in psychotherapy: Clients' perspectives 1.*Psychotherapy Research, 15*(3), 287-303. doi:doi:10.1080/10503300500090894

Kochems, T. (1983).*The relationship of background variables to the experiences and values of psychotherapists in managing religious material* (Doctoral dissertation).Available from ProQuest Dissertations and Theses database. (UMI No. 8311196)

Koenig, H. G., McCullough, M. E., & Larson, D. B. (2001).*Handbook of religion and health*. New York, NY: Oxford University Press.

Kohut, H. (1971). *The analysis of the self*. New York, NY: Columbia University Press.

Kools, S., McCarthy, M., Durham, R., & Robrecht, L. (1996). Dimensional analysis: Broadening the conception of grounded theory. *Qualitative Health Research, 6*(3), 312-330. doi:10.1177/104973239600600302

Krägeloh, C. U., Henning, M. A., Billington, R., & Hawken, S. J. (2015).The Relationship between Quality of Life and Spirituality, Religiousness, and Personal Beliefs of Medical Students.*Academic Psychiatry : The Journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry*. doi:10.1007/s40596-014-0158-z

Krägeloh, C. U., & Shepherd, G. S. (2014). Quality of life of community-dwelling retirement-aged New Zealanders: The effects of volunteering, income, and being part of a religious community. *VOLUNTAS: International Journal of Voluntary and Nonprofit Organizations*, 1-17. doi:10.1007/s11266-014-9524-4z

Kung, H. (1979). *Freud and the problem of God*. New Haven, CT: Yale University Press.

References

Lambie, D., Egan, R., Walker, S., & MacLeod, R. (2015). How spirituality is understood and taught in New Zealand medical schools. *Palliative & Supportive care, 13*(1), 53-58. doi:10.1017/S147895151300062X

Lambrecht, I., & Taitimu, M. (2012).Exploring culture, subjectivity and psychosis. In J. Geekie, P. Randal, D. Lampshire, & J. Read (Eds.), *Experiencing psychosis: Personal and professional perspectives* (pp. 44-54). Hove, England: Routledge.

Lannert, J. L. (1991). Resistance and countertransference issues with spiritual and religious clients.*Journal of Humanistic Psychology, 31*(4), 68-76. doi:10.1177/0022167891314005

La Roche, M. J., Davis, T. M., & D'Angelo, E. (2015). Challenges in developing a cultural evidence-based psychotherapy in the USA: Suggestions for international studies. *Australian Psychologist, 50*(2), 95-101. doi:10.1111/ap.12085

Lavric, M., & Flere, S. (2011). Intrinsic religious orientation and religious rewards: An empirical evaluation of two approaches to religious motivation. *Rationality and Society, 23*(3), 217-233. doi:10.1177/1043463111404670

Lawrence, C. (1983). Redecision and repentance: Reframing redecision work for the religious client. *Transactional Analysis Journal, 13*(158-162).

Lederberg, M. S., & Fitchett, G. (1999). Special Issue: Spiritual and religious beliefs and coping with cancer. *Psycho-Oncology, 8*(5), 375–377. doi:10.1002/(SICI)1099-1611(199909/10)8:5<375::AID-PON418>3.0.CO;2-C

Lempert, L. B. (2007). Asking questions of the data: Memo writing in the grounded theory tradition.In A. Bryant & K. Charmaz (Eds.), *The Sage handbook of grounded theory* (pp. 245-264). London, England: Sage.

Lennon, P. F. (1970). *The experience of role conflict in priest-therapists* (Doctoral dissertation).Duquesne University, Pittsburg, PA.Available from ProQuest Dissertations and Theses Database. (No UMI recorded)

Lestina, V. L. (2008). *An examination of psychologists' personal and professional variables and how they relate to the use of spirituality as a treatment tool in psychotherapy* (Doctoral dissertation). Available from ProQuest Dissertations and Theses database. (UMI No. 3290662)

Lett, J. (1990). Emics and etics: Notes on the epistemology of anthropology. In T. Headland, K. Pike, & M. Harris (Eds.), *Emics and etics: The insider/outsider debate* (pp. 127-142). Newbury Park, CA: Sage.

Lett, J. W. (1996). Emic/etic distinction.In D. Levinson & M. Ember (Eds.), *Encyclopedia of cultural anthropology* (Vol. 2, pp. 382-383). Markham, Canada: Henry Holt.

Lewin, K. (1963). *Field theory in social science*. New York, NY: Harper. (Original work published 1951)

References

Lincoln, Y. S., & Guba, E. G. (1985).*Naturalistic inquiry*. Newbury Park, CA: Sage.

Lindgren, K. N., & Coursey, R. D. (1995). Spirituality and serious mental illness: A two part study. *Psychosocial Rehabilitation Journal, 18*(3), 93-111.

Lijtmaer, R. M. (2009). The patient who believes and the analyst who does not.*Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry, 37*(1), 99-110. doi:10.1521/jaap.2009.37.1.99

Ljungberg, K. L. (2006). *The soul of psychotherapy: Incorporating spirituality and religion into diversity training* (Doctoral dissertation). Available from ProQuest Dissertations and Theses database. (UMI No. 3202833)

Loewenthal, K. (2007). *Religion, culture and mental health.* Cambridge, England: Cambridge University Press

Long, S. (2001). Working with organizations: The psychoanalytic discourse.*Organizational and Social Dynamics, 1*(2), 174-198.

Lovinger, R. (1984).*Working with religious issues in therapy.* Oxford, UK: Aronson.

Luck, S. M. (2010).*Spirituality as a coping resource in adult female survivors of childhood sexual abuse* (Doctoral dissertation).Available from ProQuest Dissertations and Theses database. (UMI No. 3408017)

Lukoff, D. (1988). Transpersonal perspectives on manic psychosis: Creative, visionary, and mystical state. *Journal of Transpersonal Psychology, 20*(2), 111-139.Retrieved from http://atpweb.org.ezproxy.aut.ac.nz/jtparchive/trps-20-88-02-111.pdf

Lukoff, D. (2000). The importance of spirituality in mental health.*Alternative Therapies, 6*(6), 81-87.

Lukoff, D. (2012). Spirituality and psychosis. In J. Geekie, P. Randal, D. Lampshire, & J. Read (Eds.), *Experiencing psychosis: Personal and professional perspectives* (pp. 66-76). Hove, England: Routledge.

Lukoff, D., Cloninger, C. R., Galanter, M., Gellerman, D. M., Glickman, L., Koenig, H. G., ... Yang, C. P. (2010). Religious and spiritual considerations in psychiatric diagnosis: Considerations for the DSM-V. In P. J. Verhagen, H. M. v. Praag, J. J. Lopez-Ibor, J. L. Cox, & D. Moussaoui (Eds.), *Religion and psychiatry: Beyond boundaries* (pp. 423-444). Chichester, England: Wiley-Blackwell.

Lukoff, D., & Turner, R. (1998). From spiritual emergency to spiritual problem: The transpersonal roots of the new DSM-1V Category. *Journal of Humanistic Psychology 38*(2), 21-50. doi:10.1177/00221678980382003

Madu, S. N. (2013). Psychotherapy: Unity in diversity. *Ife Psychologia, 21*(3), 1-11. Retrieved from http://ezproxy.aut.ac.nz/login?url=http://search.proquest.com/docview/1439812902?accountid=8440

References

Magaldi-Dopman, D. (2009). *Psychologists' experience of spiritual and religious material in counseling through the lens of their own spiritual/religious, non-religious identity.*(Doctoral dissertation) Available from ProQuest Dissertations and Theses database. (UMI No. 3361358)

Magaldi-Dopman, D., Park-Taylor, J., & Ponterotto, J. G. (2011). Psychotherapists' spiritual, religious, atheist or agnostic identity and their practice of psychotherapy: A grounded theory study. *Psychotherapy Research: Journal of the Society for Psychotherapy Research, 21*(3), 286-303. doi:10.1080/10503307.2011.565488

Mahoney, M. J. (1995). The modern psychotherapist and the future of psychotherapy. In B. Bongar & L. E. Beutler (Eds.), *Comprehensive textbook of psychotherapy: Theory and practice* (pp. 475-488). New York, NY: Oxford University Press

Malony, H. N., & Spilka, B. (Eds.). (1991). *Religion in psychodynamic perspective: The contributions of Paul W. Pruyser*. New York, NY: Oxford University Press.

Manchester, R., & Manchester, B. (1996).*Notes towards a history: A chronology of the first fifty years 1947-1997*. Wellington, New Zealand: New Zealand Association of Psychotherapists. Te Roopu Wakaora Hinengaro.

Manning, S. (2013). Code names: Reflections on DSM-V and other codebooks. *New Zealand Association of Psychotherapists Newsletter, October* 32-40.

Māori Dictionary.(n.d.).Māori dictionary online. Retrieved from http://www.maoridictionary.co.nz/

Mark, G. T., & Lyons, A. C. (2010).Māori healers' views on wellbeing: The importance of mind, body, spirit, family and land. *Social Science & Medicine, 70,* 1756-1764. doi:10.1016/j.socsimed.2010.02.001

Marks, L. (2005). Religion and bio-psycho-social health: A review of and conceptual model. *Journal of Religion and Health, 44,* 173-186. doi:10.1007/s10943-005-2775-z

Maslow, A. (1943). A theory of human motivation.*Psychological Review, 50*(4), 370-396. doi:10.1037/h0054346

Massey, R. F., & Dunn, A. B. (1999).Viewing the transactional dimension of spirituality through family prisms.*Transactional Analysis Journal, 29*(2), 115-129. doi:10.1177/036215379902900205

Mayers, C., Leavey, G., Vallianatou, C., & Barker, C. (2007). How clients with religious or spiritual beliefs experience psychological help-seeking and therapy: A qualitative study. *Clinical Psychology & Psychotherapy,* 4(4), 317-327. doi:10.1002/cpp.542

McDargh, J. (1993). Concluding clinical postscript: On developing a psychotheological perspective. In M. Randour (Ed.), *Exploring sacred landscapes* (pp. 172-193). New York, NY: Columbia University Press.

References

McFadden, D. (2006). *An investigation of the lived experience of spirituality and religion in the lives of those diagnosed with a severe or chronic mental illness* (Doctoral dissertation). Available from ProQuest Theses and Dissertations database (UMI No. 3214738)

McLaughlin, B. R. (1994). Devastated spirituality: The impact of clergy sexual abuse on the survivor's relationship with God and the church. *Sexual Addiction & Compulsivity, 1*(2), 145-158. doi:10.1080/10720169408400039

McRobie, S., & Makasiale, C. (2013).On values and spirituality in trauma counselling. In M. N. Agee, T. McIntosh, P. L. Culbertson, & C. O. Makasiale (Eds.), *Pacific identities and well-being: Cross-cultural perspectives* (pp. 146-157). Dunedin, New Zealand: Otago University Press.

McWilliams, N. (2000). On teaching psychoanalysis in antianalytic times: A polemic. *American Journal of Psychoanalysis, 60*(4), 371-391. doi:10.1023/A:1002046915249

McWilliams, N. (2004). *Psychoanalytic psychotherapy*: *A practitioner's guide*. New York, NY: The Guilford Press.

Mead, G. H. (1934/1967). *Mind, self and society: From the standpoint of a social behaviorist*. Chicago, Ill: The University of Chicago Press

Meador, K. G., & Koenig, H. G. (2000). Spirituality and religion in psychiatric practice: Parameters and implications. *Psychiatric Annals, 30*(8), 549-555. doi:10.3928/0048-5713-20000801-10

Mearns, D., & Thorne, B. (2000).*Person-centred therapy today*. London, England: Sage.

Meehl, P. E. (1959). Some technical and axiological problems in the therapeutic handling of religious and valuational materials.*Journal of Counseling Psychology, 6*, 255-259.

Melder, N., & Simmonds, J. G. (2008). 'Someone who can understand us': Identifying and addressing barriers to counselling for indigenous students. *The Australian Journal of Counselling Psychology, Spring*, 4-11. Retrieved from http://search.informit.com.au.ezproxy.aut.ac.nz/documentSummary;dn=200900299;res=IELAPA>

Miller, A. J. (2010). Alexander Lowen (1910–2008): Reflections on his life. *Body, Movement and Dance in Psychotherapy: An International Journal for Theory, Research and Practice 5*(2), 197-202. doi:10.1080/17432979.2010.494854

Miller, R., & Thoresen, C. (2000).*Spirituality and health, in integrating spirituality into treatment: Resources for practitioners*. USA: American Psychological Association.

Mills, C. W. (1973). *The sociological imagination* (4th ed.). Harmondsworth, England: Penguin Books.

References

Mitchell, S. A., & Black, M., J. (1995).*Freud and beyond: A history of modern psychoanalytic thought*. New York, NY: Basic Books.

Mohr, S., & Huguelet, P. (2004).The relationship between schizophrenia and religion and its implications for care.*Swiss Medical Weekly, 134*(25-26), 369-376

Monin, S. (2011). The art of minding the gap: A counselor's ethical challenge. *Transactional Analysis Journal, 41*(2), 118-122. doi:10.1177/036215371104100204

Moon, P. (2014) Bible in schools: Battlers denying our heritage.*New Zealand Herald.* February 13.Retrieved from http://www.newzealandherald.co.nz

Morice, M. P., & Woodard, W. (2011).Māori psychotherapy and the requirements to register under the Health Practitioners Competence Assurance Act 2003. In K. Tudor (Ed.), *Turning the tide: Pluralism and partnership in psychotherapy in Aotearoa New Zealand*. Wellington, New Zealand: L C Publications.

Morris, P. (2012). *Diverse religions.Te Ara - the Encyclopedia of New Zealand*. Retrieved from http://www.teara.govt.nz/en/diverse-religions

Morrison, J. Q., Clutter, S. M., Pritchett, E. M., & Demmitt, A. (2009).Perceptions of clients and counseling professionals regarding spirituality in counseling.*Counseling and Values, 53*(3), 183-194. doi:10.1002/j.2161-007X.2009.tb00124.x

Morse, J. M. (1995). The significance of saturation.*Qualitative Health Research, 5*, 147-149. doi:10.1177/104973239500500201

Morse, J. M., Stern, P. N., Corbin, J., Bowers, B., Charmaz, K., & Clarke, A. E. (Eds.). (2009). *Developing grounded theory: The second generation*. Walnut Creek, CA: Left Coast Press, Inc.

Mowbray, R. (1997). A case to answer. In R. House & N. Totton (Eds.), *Implausible professions* (pp. 71-86). Ross-on-Wye, England: PCCS Books.

Murray-Swank, A., & Murray-Swank, N. A. (2013). Spiritual and religious problems: Integrating theory and clinical practice. In R. F. Paloutzian & C. L. Park (Eds.), *Handbook of the psychology of religion and spirituality* (pp. 421-437). New York, NY: Guilford Press.

Musick, M. A., Blazer, D. G., & Hays, J. C. (2000). Religious activity, alcohol use, and depression in a sample of elderly Baptists.*Research on Aging, 22*, 91-116. doi:10.1177/016402750022201

Nachowitz, T. (2007). New Zealand as a multireligious society: Recent census figures and some relevant implications.*Aotearoa Ethnic Network Journal, 2*(2), 17-25.

Nelson, J. E. (1990). *Healing the split*. Los Angeles, CA: Jeremy P. Tarcher.

References

New Zealand Herald. (2014). Second complaint laid over school's religious classes.*New Zealand Herald*. Retrieved from www.nzherald.co.nz

Nicholas, N. J. (2013). Revealed: Hand of God in schools. *New Zealand Herald*.July 31. Retrieved from http://www.nzherald.co.nz

Noam, G., & Wolf, M. (1993). Psychology and spirituality: Forging a new relationship. In M. Randour (Ed.), *Exploring sacred landscapes* (pp. 194-207). New York, NY: Columbia University Press.

Norcross, J. C., & Saltzman, N. (1990). The clinical exchange: Toward integrating the psychotherapies. In N. Saltzman & J. C. Norcross (Eds.), *Therapy wars: Contention and convergence in differing clinical approaches* (pp. 1-14). San Franscisco, CA.: Jossey-Bass.

NZAP.(2008). *Code of ethics*. Retrieved from http://nzap.org.nz/handbook/code-of-ethics/

NZAP. (2014). *Advanced clinical practice: Assessment policy and procedures*. Retrieved from http://nzap.org.nz/wp-content/uploads/2014/09/Orange_Book_Sept-2014.pdf

NZAP.(2015). *Supervision agreements for 2015*. Retrieved from http://nzap.org.nz/supervision-agreements-for-2015/

O'Connor, S., & Vandenberg, B. (2005).Psychosis or faith?Clinicans' assessment of religious beliefs.*Journal of Consulting and Clinical psychology, 73*(4), 610-616.doi:10. 1037/0022-006X.73.4.610

Oman, D. (2013). Defining religion and spirituality.In R. F. Paloutzian & C. L. Park (Eds.), *Handbook of the psychology of religion and spirituality* (2nd ed., pp. 23-47). New York, NY: The Guilford Press.

Orange, C. (2013). *The story of a Treaty* (2nd ed.). Wellington, New Zealand: Bridget Williams Books.

Overstreet, K. R. (2008).*Addressing spiritual or religious issues in psychotherapy: A phenomenological analysis* (Unpublished doctoral dissertation).James Madison University, Harrisonburg, VA.

Palmer, M. (2009).*Freud and Jung on religion*. Hove, England: Routledge.

Palmer, H. (2010). *Psychosynthesis in the South Pacific ontological and epistemological considerations in the context of Aotearoa New Zealand* (Master's thesis).Middlesex University, London.

Pargament, K. I. (2002). The bitter and the sweet: An evaluation of the costs and benefits of religiousness. *Psychological Inquiry, 13*(3), 168-181. doi:10.1207/S15327965PLI1303_02

References

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

Park, C. L. (2005). Religion as a meaning-making framework in coping with life stress.*Journal of Social Issues, 61*(4), 707-729. doi:10.1111/j.1540-4560.2005.00428.x

Passmore, N. L. (2003). Religious Issues in counselling: Are Australian psychologists "dragging the chain"? *Australian Psychologist, 38*(3), 183-192. doi:10.1080/00050060310001707197

PBANZ.(n.d.).*Policy statement on psychotherapist clinical supervision*. Retrieved from http://www.pbanz.org.nz/docs/APC_Renewals/Policy%20Statement%20on%20Psychotherapist%20Clinical%20Supervision.pdf

PBANZ. (2011a). *Standards of cultural competence* Retrieved from http://www.pbanz.org.nz/index.php?PsychotherapistStandards

PBANZ.(2011b). *Psychotherapist standards of ethical conduct*. Retrieved from http://www.pbanz.org.nz/docs/For_Psychotherapists/Standards%20of%20Ethical%20ConductAug2013..pdf

PBANZ.(2013). *Scopes of practice*. Retrieved from http://www.pbanz.org.nz/docs/APC_Renewals/20130110GAZ%20Scope%20of%20practice.pdf

Pearlman, M. (1981).*Knowing the doctrines of the Bible*. Springfield, MO: Gospel Publishing House.

Pere, R. T. (1997).*Te Wheke* (2nd ed.). Auckland, New Zealand: Ao Ako Global Learning New Zealand.

Perlstein, M. (2002). A spiritual coming out: The use of ritual in a psychotherapy practice. *Women & Therapy 24*(3-4), 175-192. doi:10.1300/J015v24n03_11

Pesut, B., Fowler, M., Taylor, E. J., Reimer-Kirkham, S., & Sawatzky, R. (2008). Conceptualising spirituality and religion for healthcare.*Journal of Clinical Nursing, 17*(21), 2803–2810. doi:10.1111/j.1365-2702.2008.02344.x

Peteet, J. R. (1994). Approaching spiritual problems in psychotherapy.*Journal of Psychotherapy Practice and Research, 3*(3), 237-245.

Pharo, D. (1997). *A qualitative investigation of psychotherapists' beliefs about spirituality and psychotherapy* (Doctoral dissertation).Available from ProQuest Dissertations and Theses database. (UMI No. 9721200)

Plante, T. G. (2007). Integrating spirituality and psychotherapy: Ethical issues and principles to consider.*Journal of Clinical Psychology, 63*(9), 891-902. doi:10.1002/jclp.20383

References

Plante, T. G. (2009). *Spiritual practices in psychotherapy*. Washington D.C: American Psychological Association.

Plante, T. G. (2014). Four steps to improve religious/spiritual cultural competence in professional psychology. *Spirituality in Clinical Practice, 1*(4), 288-292. doi:10.1037/scp0000047

Plante, T., & Sherman, A. C. (2001).Research on faith and health.In T. G. Plante & A. C. Sherman (Eds.), *Faith and health*. New York, NY: The Guilford Press.

PDM Task Force.(2006). *Psychodynamic Diagnostic Manual*. Silver Spring, MD: Alliance of Psychoanalytic Organisations.

Post, B. C., & Wade, N. G. (2009). Religion and spirituality in psychotherapy: A practice-friendly review of research [Review]. *Journal of Clinical Psychology, 65*(2), 131-146. doi:10.1002/jclp.20563

Postle, D. (2000). Statutory regulation: Shrink-wrapping psychotherapy. *British Journal of Psychotherapy, 16*(3), 335-346. doi:10.1111/j.1752-0118.2000.tb00525.x

Priester, P. E., Khalili, S., & Luvathingal, J. E. (2009).Placing the soul back into psychology: Religion in the psychotherapy process.In S. Eshun & R. A. R. Gurung (Eds.), *Culture and Mental Health* (pp. 92-114). Great Britain: Wiley-Blackwell.

Qasqas, M. J., & Jerry, P. (2014).Counselling Muslims: A culture-infused antidiscriminatory approach.*Canadian Journal of Counselling and Psychotherapy, 48*(1), 57-76.

Raimy, V. (Ed.). (1950). *Training in clinical psychology*. New York, NY: Prentice-Hall.

Randal, P. (2012).Subjective experience of spirituality and psychosis. In J. Geekie, P. Randal, D. Lampshire, & J. Read (Eds.), *Experiencing Psychosis* (pp. 57-65). Hove, England: Routledge.

Randal, P., & Argyle, N. (2005). "Spiritual emergency" -A useful explanatory model?: A literature review and discussion paper. *Spirituality and Psychiatry Special Interest Group of the Royal College of Psychiatrists: Publications Archive*. Retrieved from:http://www.rcpsych.ac.uk/systempages/gsearch.aspx?cx=001100616363437152483%3aidnunf1yavs&cof=FORID%3a9&q=Randal+and+Argyle

Reber, A. S., Allen, R., & Reber, E. S. (Eds.). (2009). *The Penguin dictionary of psychology* doi:Retrieved from https://networkservices.aut.ac.nz/ezproxy.cgi?url=http%3A%2F%2Fsearch.credoreference.com.ezproxy.aut.ac.nz%2Fcontent%2Fentry%2Fpenguinpsyc%2Fintrapsychic%2F0

Rennie, D. L. (1994).Clients' deference in psychotherapy.*Journal of Counselling Psychology, 41*(4), 427-437.

References

Rennie, D. L. (1996). Fifteen years of doing qualitative research on psychotherapy. *British Journal of Guidance & Counselling, 24*(3), 317-327. doi:10.1080/03069889600760291

Rennie, D. L. (2001).Grounded theory methodology as methodical hermeneutics. In J. Frommer & D. L. Rennie (Eds.), *Qualitative psychotherapy research: Methods and methodology* (pp. 32-49). Lengerich, Germany: Pabst.

Richards, P. S., & Bergin, A. E. (Eds.).(2000). *Handbook of psychotherapy and religious diversity*. Washington, DC: American Psychological Association.

Rizzuto, A. M. (1979). *The birth of the living God*. Chicago, ILL: University of Chicago Press.

Rizzuto, A., & Shafranske, E. P. (2013).Addressing religion and spirituality in treatment from a psychodynamic perspective. In K. I. Pargament, A. I. Mahoney, & E. P. Shafranske (Eds.), *APA handbook of psychology, religion and spirituality* (Vol. 2, pp. 125-146). Washington, DC: American Psychological Association.

Robertson, K. (2015). *Report to NZAP AGM: From the president*. April. Wellington, New Zealand: New Zealand Association of Psychotherapists.

Robrecht, L. C. (1995). Grounded theory: Evolving methods. *Qualitative Health Research, 5*(2), 169-177. doi:10.1177/104973239500500203

Rohner, R. P. (1984). Toward a conception of culture for cross-cultural psychology.*Journal of Cross-Cultural Psychology*, *15*, 111-138.

Rose, E. M., Westefeld, J. S., & Ansley, T. (2001). Spiritual issues in counseling: Clients' beliefs and preferences. *Journal of Counselling Psychology, 48*(1), 61-71. doi:10.1037//0022-0167.48.1.61

Rosenberg, L. (2005). *Psychotherapists' and counsellors' experiences and understandings of inexplicable phenomena while working with clients* (Master's thesis, Auckland University of Technology, Auckland, New Zealand). Retrieved from http://aut.researchgateway.ac.nz/browse?value=Rosenberg%2C+Linde&type=author

Rossetti, S. J. (1995). The impact of child abuse on attitudes toward God and the Catholic church. *Child Abuse & Neglect, 19*(12), 1469-1481. doi:10.1016/0145-2134(95)00100-1

Rossey, L. (2002). *Religious and spiritual issues in psychotherapy practice*.(Doctoral dissertation).Available from ProQuest Dissertations and Theses database. (UMI No.3060137)

Roth, S. (1987). *Psychotherapy: The art of wooing nature*. Northvale, NJ: Jason Aronson.

References

Rowan, J. (1990).Spiritual experiences in counselling.*British Journal of Guidance & Counselling, 18*(3), 233-249. doi:10.1080/03069889008253576

Rowan, J. (1993).*The transpersonal: Psychotherapy and counselling*. London, England: Routledge.

Rubin, J. B. (2006).Psychoanalysis and spirituality. In D. M. Black (Ed.), *Psychoanalysis and religion in the 21st century: Competitors or collaborators?* (pp. 132-153). Hove, England: Routledge.

Ruff, J. (2008).*Clinician religiosity and response to divergent patient religiosity: An investigation into the effects of implicit and explicit stereotyping on empathy and prognosis in initial responding to patients who are religiously diverse from psychologists* (Doctoral dissertation). Available from ProQuest Dissertations and Theses database. (UMI No. 3310405)

Ryan, K. (2007). *Stepping through different realities: A phenomenological hermeneutic study of psychotherapists' spiritual experience* (Master's thesis.Auckland University of Technology, Auckland, New Zealand). Retrieved from http://aut.researchgateway.ac.nz/browse?value=Ryan%2C+Kay&type=author

Urquart, C. (2007). The evolving nature of grounded theory method: The case of the information systems discipline. In A. Bryant & K. Charmaz (Eds.), *The Sage Handbook of Grounded Theory*. London, England: Sage.

Saroglou, V., & Munoz-Garcia, A. (2008). Individual differences in religion and spirituality: An issue of personality traits and/or values. *The Society for the Scientific Study of Religion, 47*(1), 83-101. doi:10.1111/j.1468-5906.2008.00393.x

Saunders, S. M., Miller, M. L., & Bright, M. M. (2010).Spiritually conscious psychological care.*Professional Psychology: Research and Practice, 41*(5), 355-362. doi:10.1037/a0020953

Scalise, D. (2011). *The roles of client religion, counselor religiosity, and spiritual competence in counselors' clinical judgment* (Doctoral dissertation).Available from ProQuest Dissertations and Theses database. (UMI No. 3465176)

Schafer, R. M., Handal, P. J., Brawer, P. A., & Ubinger, M. (2011). Training and education in religion/spirituality within APA-accredited clinical psychology programs: 8 Years Later. *Journal of Religion and Health, 50*(2), 232-239. doi:10.1007/s10943-009-9272-8

Schatzman, L. (1991). Dimensional analysis: Notes on an alternative approach to the grounding of theory in qualitative research. In D. R. Maines (Ed.), *Social organization and social process.Essays in honour of Anselm Strauss* (pp. 303-314). New York, NY: Aldine De Gruyter.

Schatzman, L., & Strauss, A. L. (1973).*Field research strategies for a natural sociology*. Englewood Cliffs, NJ: Prentice -Hall.

References

Schulte, D. L., Skinner, T. A., & Claiborn, C. D. (2002). Religious and spiritual issues in counseling psychology training.*The Counseling Psychologist, 30*(1), 118-134. doi:10.1177/0011000002301009

Scott, S., Garver, S., Richards, J., & Hathaway, W. (2003). Religious issues in diagnosis: The V-Code and beyond. *Mental Health, Religion & Culture, 6*, 161-173. doi:10.1080/1367467021000038200

Scotton, B. W. (1996). The contribution of C.G. Jung to transpersonal psychology. In B. W. Scotton, A. B. Chinen, & J. R. Battista (Eds.), *Textbook of transpersonal psychiatry and psychology* (pp. 39-51). New York, NY: Basic Books.

Segal, H. (1988). *Introduction to the work of Melanie Klein* (2nd ed.). London, England: Karnac.

Serlin, L. (2004). Spiritual diversity and clinical practice. In J. L. Chin (Ed.), *The psychology of prejudice and discrimination.* (Vol. 4, pp. 27-49). Westport, CT: Praeger.

Shafranske, E. P. (1997). Spirituality and psychoanalysis.*Journal of Psychology and Christianity, 17*(1), 20-22.

Shafranske, E. P., & Molony, H. N. (1990).Clinical psychologists' religious and spiritual orientations and their practice of psychotherapy.*Psychotherapy 27*(1), 72-78

Shafranske, E. P., & Malony, H. N. (1996). Religion and the clinical practice of psychology: A case for inclusion. In E. P. Shafranske (Ed.), *Religion and the clinical practice of psychology* (pp. 561-586). Washington, DC: American Psychological Association.

Shalin, D. N. (1986).Pragmatism and social interactionism.*American Sociological Review, 51*(February), 9-29.

Sherrard, E. M. (2005). *A TA Analysis of God: From Theism to Atheism*. Powerpoint Presentation

Sherrard, E. M. (2011). Once was a psychotherapist. In K. Tudor (Ed.), *The turning tide: Pluralism and partnership in psychotherapy in Aotearoa New Zealand* (pp. 119-125). Wellington, New Zealand: LC Publications.

Sherry, A., Adelman, A., Whilde, M., R, & Quick, D. (2010). Competing selves: Negotiating the intersection of spiritual and sexual identities. *Professional Psychology: Research and Practice, 41*(2), 112-119. doi:10.1037/a0017471

Shibutani, T. (1955). Reference groups as perspectives. *American Journal of Sociology, 60*(6), 562-569.

Shorrock, A. (2008). *The transpersonal in psychology, psychotherapy, and counselling*. Basingstoke, England: Palgrave MacMillan.

References

Sibley, C. G., & Bulbulia, J. (2012). Faith after an earthquake: A longitudinal study of religion and perceived health before and after the 2011 Christchurch New Zealand earthquake. *PLoS ONE, 7*(12), 1-10. doi:10.1371/journal.pone.0049648

Siddle, R., Haddock, G., Tarrier, N., & Faragher, E. B. (2002). Religious delusions in patients admitted to hospital with schizophrenia. *Social Psychiatry and Psychiatric Epidemiology 37*(3), 130-138. doi:10.1007/s001270200005

Sieve, C. (1999).*Countertransference experiences in the analysis of religious material in psychoanalytic psychotherapy: An intersubjective analysis*.(Doctoral dissertation) Available from ProQuest Dissertations and Theses database. (UMI No. 9930451)

Simmonds, J. G. (2004). Heart and spirit: Research with psychoanalysts and psychoanalytic psychotherapists about spirituality. *International Journal of Psychoanalysis, 85*, 951-971. doi:10.1516/FW41-8025-5BTJ-A7TG

Simmonds, J. G. (2006). Being and potential: Psychoanalytic clinicians' concepts of God. *International Journal of Aplied Psychoanalytic Studies, 3*(3), 221-241. doi:10.1002/aps.107

Sleeman, L. (2007). *The forgotten feminine* (Master's thesis.Auckland University of Technology, Auckland, New Zealand). Retrieved from http://aut.researchgateway.ac.nz/browse?value=Sleeman%2C+Lauren&type=author

Smith, D. P., & Orlinsky, D. E. (2004). Religious and spiritual experiences among psychotherapists.*Psychotherapy: Theory, Research, Practice, Training, 41*(2), 144-151. doi:10.1037/0033-3204.41.2.144

Smith, A., & Simmonds, J. G. (2006).Help-seeking and paranormal beliefs in adherents of mainstream religion, alternative religion and no religion.*Counselling Psychology Quarterly, 19*, 331-341.doi:10. 1080/09515070601095724

Solomon, P. (2006). *Psychotherapists who meditate: A phenomenological study* (Master's thesis. Auckland University of Technology, Auckland, New Zealand.) Retrieved from http://aut.researchgateway.ac.nz/bitstream/handle/10292/44/SolomonP.pdf?sequence=2&isAllowed=y

Sorenson, A. M., Grindstaff, C. F., & Turner, R. J. (1995). Religious involvement among unmarried adolescent mothers: A source of emotional support? *Sociology of Religion, 1*(56), 71-81.

Sorenson, R. L. (1997). Transcendence and intersubjectivity.In C. Spezzano & G. Gargiulo (Eds.), *Soul on the couch* (pp. 163-200). Hillsdale, NJ: The Analytic Press.

Sorenson, R. L. (2004). *Minding spirituality*. Hillsdale, NJ: The Analytic Press.

References

Sperry, L., & Miller, L. (2014). Spirituality in clinical practice and you: Welcome from the editors. *Spirituality in Clinical Practice, 1*(1), 1-2. doi:10.1037/scp0000011

Spillers, C. S. (2011).Spiritual dimensions of the clinical relationship. In R. J. Fourie (Ed.), *Therapeutic processes for communication disorders: A guide for clinicians and students* (pp. 249-325). Hove, England: Psychology Press

Spoonley, P., & Bedford, R. (2012).*Welcome to our world? Immigration and the reshaping of New Zealand*. Auckland, New Zealand: Dunmore Publishing.

Standards New Zealand (2008).*Health and disability services (core) standards.* Retrieved from https://www.health.govt.nz/system/files/documents/pages/81341-2008-nzs-health-and-disability-services-core.pdf

Statistics New Zealand (2001). New Zealand Census: 2001.

Statistics New Zealand. (2013). New Zealand Census: 2013.

Stern, P. N. (2007). On solid ground: Essential properties for growing grounded theory. In A. Bryant & K. Charmaz (Eds.), *Handbook of grounded theory* (pp. 86-98). London, England: Sage.

Stern, P. N., & Porr, C. J. (2011).*Essentials of accessible grounded theory*. Walnut Creek, CA: West Coast Press.

Stewart, S. P., & Gale, J. E. (1994). On hallowed ground: Marital therapy with couples on the religious right. *Journal of Systemic Therapies, 13*(3), 16-25.

Stifoss-Hanssen, H. (1999). Religion and spirituality: What a European ear hears. *International Journal for the Psychology of Religion, 9*(1), 25-33. doi:10.1207/s15327582ijpr0901_4

Stiver, I. P. (2000). The therapists' voice expanding the therapeutic boundary: Taking risks for change. *Eating Disorders: The Journal of Treatment & Prevention, 8*(3), 247-251. doi:10.1080/10640260008251232

Strauss, A. L. (1987). *Qualitative analysis for social scientists*. New York, NY: Cambridge University Press.

Strauss, A. L. (1993). *Continual permutations of action*. New Brunswick, NJ: Aldine Transaction.

Strauss, A. L., & Corbin, J. (1990).*Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage.

Strauss, A. L., & Corbin, J. (1998).*Basics of Qualitative Research Techniques and Procedures for Developing Grounded Theory* (2nd ed.). London, England: Sage.

Strawn, B. D. (2007). Slouching toward integration: Psychoanalysis and religion in dialogue.*Journal of Psychology and Theology, 35*(1), 3-14.

References

Strength, J. M. (1998).Expanding Davanloo's interpretive triangles to explicate the client's introjected image of God. . *Journal of Psychology and Theology, 26*(2), 179-187.

Stricker, G. (2003). The many faces of self-disclosure.*Journal of Clinical Psychology, 59*(5), 623-630. doi:10.1002/jclp.10165

Strozier, C. B. (2003). Kohut and God. In A. Roland, B. Ulanov, & C. Barbre (Eds.), *Creative dissent: Psychoanalysis in evolution*. Westport, CT: Praeger.

Stryker, S. (1980).*Symbolic interactionism: A social structural version*. Caldwell, NJ: The Blackburn Press.

Sue, D. W., & Sue, D. (2003).*Counseling the culturally diverse: Theory and practice* (4th ed.). New York, NY: John Wiley & Sons.

Sullivan, J. P. (1997). *The impact of psychotherapists' spirituality on their practice.*(Doctoral dissertation.).Available from ProQuest Dissertations and Theses database. (UMI No. 9706615)

Symington, N. (1994). *Emotion and spirit: Questioning the claims of psychoanalysis and religion*. London, England: Cassell.

Symington, N. (1996). *The making of a psychotherapist*. London, England: Karnac.

Symington, N. (1999). Religion and science in psychoanalysis. In S. M. Stein (Ed.), *Beyond Belief: Psychotherapy and Religion* (pp. 162-178). London: England: Karnac.

Taitimu, M. (2007).*Nga whakawhitinga: Standing at the crossroads. Māori ways of understanding extra-ordinary experiences and schzophrenia* (Unpublished Doctoral Thesis).University of Auckland, Auckland, New Zealand. Retrieved from https://researchspace.auckland.ac.nz/docs/uoa-docs/rights.htm

Tauvona, L. (2010). Psychodrama: Active group psychotherapy using the body in an intersubjective context. *Body, Movement and Dance in Psychotherapy: An International Journal for Theory, Research and Practice 5*(3), 257-267. doi:10.1080/17432979.2010.530058

Taylor, D. (2010). Psychoanalytic approaches and outcome research: Negative capability or irritable reaching after fact and reason? *Psychoanalytic Psychotherapy, 24*(4), 398-416. doi:10.1080/02668734.2010.513560

Tepper, L., Rogers, S. A., Coleman, E. M., & Malony, H. N. (2001).The prevalence of religious coping among persons with persistent mental illness. *Psychiatric Services, 52*(5), 660-665. doi:10.1176/appi.ps.52.5.660

The Treaty in Brief.(n.d). *New Zealand history*. Retrieved from http://www.nzhistory.net.nz/politics/treaty/the-treaty-in-brief

References

Thomas, A. J., & Schwarzbaum, S. (2006). *Culture and identity: Life stories for counselors and therapists*. Thousand Oaks, CA: Sage.

Thornberg, R. (2012). Informed grounded theory.*Scandinavian Journal of Educational Research, 56*(3), 243-259. doi:10.1080/00313831.2011.581686

Thorne, B. (1998). *Person-centred counselling and Christian spirituality: The secular and the holy*. London, England: Whurr.

Thorpe, M., & Thorpe, M. (2008).Immigrant psychotherapists and New Zealand clients.*Forum: The Journal of the New Zealand Association of Psychotherapists, 14*, 30-45.

Tillich, P. (1970). *Theology of culture* (3rd ed.). New York, NY: Oxford University Press.

Tisdale, T. C., Key, T. L., Edwards, K. J., Brokaw, B. F., Kemperman, S. R., Cloud, H., Okamato, T. (1997). Impact of treatment on God image and personal adjustment, and correlations of God image to personal adjustment and object relations development. *Journal of Psychology and Theology, 25*(2), 227-239.

Trautmann, R. L. (2003). Psychotherapy and spirituality.*Transactional Analysis Journal, 33*(1), 32-36. doi:10.1177/036215370303300105

Tudor, K. (2011a). Introduction. In K. Tudor (Ed.), *The turning tide* (pp. 15-27). Auckland, New Zealand: LC Publications.

Tudor, K. (2011b). The question of regulation and registration. In K. Tudor (Ed.), *The turning tide: Pluralism and partnership in psychotherapy in Aotearoa New Zealand* (pp. 129-158). Auckland, Aotearoa New Zealand: LC Publications.

Tudor, K. (2012). Southern psychotherapies.*Psychotherapy and Politics International, 10*(2), 116-129. doi:10.1002/ppi.1265

Tudor, K., Cockburn, G., Daniels, J., Goulding, J., Hubbard, P., Larsen, S., Stuthridge, J. (2013). Reflexive theory: Critical reflections on Western psychotherapy. *Ata: Journal of Psychotherapy Aotearoa New Zealand, 17*(1), 27-51.

Tummala-Narra, P. (2009). The relevance of a psychoanalytic perspective in exploring religious and spiritual identity in psychotherapy.*Psychoanalytic Psychology, 26*(1), 83-95. doi:10.1037/a0014673

Turnbow, R. C. (2008). *Spiritual and religious intervention: Psychotherapist and client perspective* (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses database. (UMI No. 3329850)

Ulanov, A. B. (2001). *Finding space: Winnicott, God, and psychic reality*. Louisville, KY: Westminster John Knox Press.

References

UNESCO.(2015). *Cultural diversity*. Retrieved from http://www.unesco.org/new/en/social-and-human-sciences/themes/international-migration/glossary/cultural-diversity/

Vaccarino, F., Kavan, H., & Gendall, P. (2011).Spirituality and religion in the lives of New Zealanders.*The International Journal of Religion and Spirituality in Society, 1*(2), 85-96.

Vandenberghe, L., Prado, F. C., & de Camargo, E. A. (2012). Spirituality and religion in psychotherapy: Views of Brazilian psychotherapists. *International Perspectives in Psychology: Research, Practice, Consultation, 1*(2), 79-93. doi:10.1037/a0028656

van Deurzen-Smith, E. (1997). *Existential counselling in practice*. London, England: Sage.

van Manen, M. (1990). *Researching lived experience*. Albany, New York: State University of New York Press.

van Praag, M. M. (2010). God's champions and adversaries: About the borders between normal and abnormal religiosity. In P. J. Verhagen, M. M. Van Praag, J. J. Lopez-Ibor, J. L. Cox, & D. Moussaoui (Eds.), *Religion and Psychiatry* (pp. 236-251). Oxford, UK: Wiley-Blackwell.

Vaughan, F. (1986).*The inward arc*. Boston, MA: Shambhala.

Vaughan, F., Wittine, B., & Walsh, R. (1996).Transpersonal psychology and the religious person. In E. P. Shafranske (Ed.), *Religion and the Clinical Practice of Psychology* (pp. 484-509). Washington, DC: American Psychological Association.

Verbeck, E. G., Arzoumanian, M. A., Estrellado, J. E., Delorme, J., Dahlin, K., Hennrich, E., ... Dalenberg, C. (2015). Religion, spirituality, and the working alliance with trauma survivors.In D. F. Walker, C. A. Courtois, & J. D. Aten (Eds.), *Spiritually Oriented Psychotherapy for Trauma* (pp. 103-126). Washington DC: American Psychological Association.

Verhagen, P. J., Van Praag, M. M., Lopez-Ibor, J. J., Cox, J. L., & Moussaoui, D. (Eds.). (2010). *Religion and psychiatry: Beyond boundaries*. Chichester, England: Wiley-Blackwell.

Vonarx, N. (2015). Cancer patients and spiritual experiences: Redefining the self through initiatory ordeals..*Palliative and Supportive Care, 13*(1), 27-40. doi:10.1017/S1478951513000175

Walsh, R. N., & Vaughan, F. (1980). Beyond the ego: Toward transpersonal models of the person and psychotherapy. *Journal of Humanistic Psychology, 20*, 5-31. doi:10.1177/002216788002000102

References

Walker, D. F., Courtois, C. A., & Aten, J. D. (Eds.). (2015). *Spiritually oriented psychotherapy for trauma*. Washington, DC: American Psychological Association.

Walker, D. F., Gorsuch, R. L., & Tan, S.-Y. (2004). Therapists' integration of religion and spirituality in counseling: A meta-analysis. *Counseling and Values, 49*(1), 69-80. doi:10.1002/j.2161-007X.2004.tb00254.x

Wensley, D. (2014). Let's not keep our kids in the dark about Bible.*New Zealand Herald*.February 14. Retrieved from http://www.newzealandherald.co.nz

West, W. (2000).*Psychotherapy and spirituality: Crossing the line between therapy and religion*. London, England: SAGE Publications.

White, W., & Tenney, M. C (1978). *Spirit* [The Zondervan Encyclopedia of the Bible]. Grand Rapids, MI: Zondervan.

WHO. (2014). *Mental health: A state of well-being*. Retrieved from http://www.who.int/features/factfiles/mental_health/en/

Wilde, S. V. (2008). *Value conflicts in psychotherapy: Psychology graduates' perspectives* (Doctoral dissertation). Available from ProQuest Dissertations and Theses database. (UMI No. 3345002)

Williams, L. (2006). Spirituality and Gestalt: A Gestalt-Transpersonal perspective. *Gestalt Review, 10*(1), 6-21.

Williams, D. C., & Levitt, H. M. (2007). A qualitative investigation of eminent therapists' values within psychotherapy: Developing integrative principles for moment-to-moment psychotherapy practice. *Journal of Psychotherapy Integration, 17*(2), 159-184. doi:10.1037/1053-0479.17.2.159

Winnicott, D. W. (1949). Hate in the counter-transference. *The International Journal of Psychoanalysis, 30*, 69-74.

Winnicott, D. W. (1953). Transitional objects and transitional phenomena.*International Journal of Psycho-Analysis, 34*(2), 89-97.

Winter, I. (2013). Whakawhanauangatanga: Establishing relationships. In B. Broom (Ed.), *Transforming clinical practice using the mindbody approach* (pp. 167-179). London, England: Karnac.

Winton, S. (2013).Religion in the consulting room.*British Journal of Psychotherapy, 29*(3), 346-357. doi:10.1111/bjp.12033

Woodard, W. (2014). *Politics, psychotherapy, and the 1907 Tohunga Suppression Act* [Manuscript submitted for publication].

Worthington, E., Kurusu, T. A., McCullough, M. E., & Sanders, S. J. (1996). Empirical research on religion and psychotherapeutic processes and outcomes: A ten-year

review and research prospectus. *Psychological Bulletin, 119*, 448-487. doi:10.1037/0033-2909.119.3.448

Worthington, E. L., & Sandage, S. J. (2002).Religion and spirituality. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients.* (pp. 371-387). New York, NY: Oxford University Press.

Wulf, R. (1998). The historical roots of gestalt therapy theory.*Gestalt Journal, 21*(1), 81-92.

Wyatt, J. (2004). Counseling and religious faith.*Psychodynamic Practice, 10*(1), 27-43. doi:10.1080/14753630310001655992

Yarhouse, M. A., & Johnson, V. (2013). Values and ethical issues: The interface between psychology and religion. In K. Pargament, I (Ed.), *APA handbook of psychology, religion and spirituality (Vol. 2 An applied psychology of religion and spirituality*, pp. 43-70). Washington, D.C: American Psychological Association.

Yontef, G., & Jacobs, L. (2011).Gestalt therapy. In R. J. Corsini & D. Wedding (Eds.), *Current Psychotherapies* (pp. 342-382). Belmont, CA.: Brooks/Cole.

Younger, J. (2015). Book review. Sanctuary: The discovery of wonder by Julie Leibrich. *New Zealand Association of Psychotherapists Newsletter, May* 43-44.

Zenkert, R. L., Brabender, V., & Slater, C. (2014).Therapists' responses to religious/spiritual discussions with trauma versus non-trauma clients.*Journal of Contemporary Psychotherapy*.doi:10.1007/s10879-014-9264-1

Zinnbauer, B. J. (2013). Models of healthy and unhealthy religion and spirituality.In K. I. Pargament (Ed.), *APA handbook of psychology, religion, and spirituality* (Vol. 2 An applied psychology of religion and spirituality, pp. 71-89). Washington, D.C: American Psychological Association.

Zinnbauer, B. J., & Pargament, K. I. (2000).Working with the sacred: Four approaches to religious and spiritual issues in counseling.*Journal of Counseling & Development, 78*(2), 162-171. doi:10.1002/j.1556-6676.2000.tb02574.x

Glossary

Indigenous terms. These terms are offered "with a caution that it is impossible to offer direct translations from one language to another, in this case te reo Māori to English, especially when the two languages represent cultures with very different worldviews" (Tudor & Hall, 2013, p. 125). The free online Māori dictionary (Māori Dictionary, n.d), has been used to explain these terms, unless otherwise attributed.

Aroaro Face, front, before, in the presence of.

Atua Ancestor with continuing influence, god, demon, supernatural being, deity, ghost, object of superstitious regard, strange being. Although often translated as 'god' and now also used for the Christian God, this is a misconception of the real meaning. Many Māori trace their ancestry from *atua* in their *whakapapa* and they are regarded as ancestors with influence over particular domains. These *atua* also were a way of rationalising and perceiving the world. Normally invisible, *atua* may have visible representations.

Hinengaro Mind, thought, intellect, consciousness, awareness.

Hui Gathering, meeting, assembly, seminar, conference.

Iwi Tribe

Kanohi ki te kanohi face to face, in person, in the flesh.

Karakia Incantation, ritual chant, chant, intoned incantation, charm, spell a set form of words to state or make effective a ritual activity. *Karakia* are recited rapidly using traditional language, symbols and structures.

Kaumatua Elder (Male)

Kaupapa Topic, policy, matter for discussion, plan, purpose, scheme, proposal, agenda, subject, programme, theme, issue, initiative.

Koha Gift, present, offering, donation, contribution especially one maintaining social relationships and has connotations of reciprocity.

Glossary

Kuia Elder (female)

Marae Courtyard, the open area in front of the *wharenui*, where formal greetings and discussions take place. Often also used to include the complex of buildings around the marae

Mauri Life principle, vital essence, special nature, a material symbol of a life principle, source of emotions, the essential quality and vitality of a being or entity. Also used for a physical object, individual, ecosystem or social group in which this essence is located.

Mihi whakatau Speech of greeting, official welcome speech acknowledging those present at a gathering. For some tribes a *pōhiri*, or *pōwhiri*, is used for the ritual of encounter on a *marae* only. In other situations where formal speeches in Māori are made that are not on a *marae* or in the *wharenui* (meeting house) the term *mihi whakatau* is used for a speech, or speeches, of welcome in Māori.

Ngā Ao e Rua The two worlds

NgāMahukorero The domain of time

Pākehā "Pākehā is a unique and indigenous word for the non-Maori settler of Aotearoa/New Zealand [and] implies an acceptance of Maori as a separate cultural entity …a relationship with Maori as a Treaty partner, a cultural identity for people of Northern European origin and a sense of uniquely belonging to Aotearoa/New Zealand" (Black, 2000).

Papatūnuku Earth, Earth mother and wife of Ranginui all living things originate from them.

Poroporaki Farewell ceremony at the end of a hui.

Pōwhiri Welcome ceremony on the marae.

Ranginui *Atua* of the sky and husband of Papatūnuku, from which union originate all living things

Rōpū Group, party of people, company, gang, association, entourage

Glossary

Tangata whenua Local people, hosts, indigenous people. People born of the whenua, i.e. of the placenta and of the land where the people's ancestors have lived and where their placenta are buried.

Tangi Rites for the dead, funeral.

Tauiwi Foreigner, European, non-Māori, colonist

Te ao Māori The Māori world.

Te reo Language, dialect, tongue, speech

Tikanga Correct procedure, custom, habit, lore, method, manner, rule, way, code, meaning, plan, practice, convention.

Tinana Body, trunk (of a tree), the main part of anything. Self, person, reality, as opposed to an apparition.

Tino rangatiratanga Self-determination, sovereignty, autonomy, self-government, domination, rule, control, power

Tīpuna Ancestors, grandparents

Tohunga Skilled person, chosen expert, priest, healer a person chosen by the agent of an *atua* and the tribe as a leader in a particular field because of signs indicating talent for a particular vocation.

Tukutuku panel Ornamental lattice work used particularly between carvings around the walls of meeting houses

Wairua Spirit, soul, spirit of a person which exists beyond death. It is the non-physical spirit, distinct from the body and the mauri. To some, the wairua resides in the heart or mind of someone, while others believe it is part of the whole person and is not located at any particular part of the body.

Wānanga Place of indigenous learning

Glossary

Whakapapa Genealogy, genealogical table, lineage, descent. Reciting *whakapapa* was, and is, an important skill and reflected the importance of genealogies in Māori society in terms of leadership, land and fishing rights, kinship and status.

Whanaungatanga Relationship, kinship, sense of family connection a relationship through shared experiences and working together which provides people with a sense of belonging. It develops as a result of kinship rights and obligations, which also serve to strengthen each member of the kin group. It also extends to others to whom one develops a close familial, friendship or reciprocal relationship.

Whare House, building, residence, dwelling

Wharenui Main building of a marae where guests are accommodated.

Whatumanawa Seat of emotions, heart, mind.

Other terms

Archetype "The word "type" is … derived from the Greek … "blow" or "imprint"; thus an "archetype" presupposes an imprinter. (Jung, 1974, p. 339)

Aura soma A healing method associated with colour therapy which uses specifically prepared bottles of elixirs containing a range of elements designed to alter and rebalance energies. Each bottle is prepared by a spiritual practice and their use is potentiated by the practitioner's connection to spiritual energies in their administration.

Chakra system Derived from the practice of yoga, the chakra system is a way to integrate body, mind, and spirit. "This … system is a cornerstone of modern medicine and psychiatry in most Oriental countries" (Nelson, 1990, p. 161).

Collective unconscious "A reservoir of unconscious contents that have never been in consciousness but which are … primordial images common to all humanity" (Palmer, 2009, p. 100).

Glossary

Countertransference All the feelings a psychotherapist has towards their client. Countertransference is more complexly divided into two categories: that which the psychotherapist brings to the therapeutic process from their own life and history, often termed "proactive" countertransference; and feelings which are in direct response to what the client brings, or "reactive" countertransference (Clarkson, 1995).

Evangelical A member of any Protestant denomination who believes in "the importance of personal conversion and faith in atonement through death of Christ as a means of salvation" (Evangelical, 2007, p. 567).

Evidence-based practices EBPs are defined by La Roche, Davis and D'Angelo (2013) as "psychotherapy approaches that share the assumption that it is necessary to utilise empirical evidence generated from research findings to inform what is effective in treating presenting problems, and then to directly apply these findings in generating and selecting a comprehensive treatment plan for implementation for particular individuals" (p. 95).

Frame "The ground rules, the reliable circumstances under which the therapy takes place" (McWilliams, 2004, p. 100). These are the conditions under which a psychotherapist chooses to work and the agreements with clients around these conditions. Common aspects of the frame are: where the therapy is to take place and for how long, payment for sessions and missed sessions, and the undertaking of the therapist to listen. The nature of the frame is variable, and may change over time depending on socio/cultural conditions.

Free association A practice, originated by Freud, designed to elicit the unconscious, where the client is encouraged to say whatever comes to their mind, without censoring.

Fundamentalism "The conviction that one's R/S beliefs and values are absolutely, eternally true and superior to different beliefs and values". (Cummings, Carson, Stanley, & Pargament (2014, p. 118).

Holding Creating "a space in which it is possible for the person to tell the truth of his or her experience" (McWilliams, 2004, p. 134).

Glossary

Intrapsychic Of anything assumed to arise or take place within the mind. Intrapsychic conflicts are interactions between internal, covert factors; e.g. *intrapsychic conflicts* are conflicts between beliefs, needs, desires, etc (Reber, Allen & Reber, 2009).

Interpsychic Conflicts between people.

Neurosis "The disturbed and anxious expression of normal and ineradicable human needs" (Guntrip, 1969, p. 323).

Object relations Internal mental representations of others and self

Pacifika people People living in the Pacific Islands. According to the latest ANZ census (Statistics New Zealand, 2013), the majority of immigrants from the Pacific Islands to ANZ are Samoan, Cook Islanders, Tongan, Niuean, Tokalauan, Fijian and Tuvalauan.

Peak experiences "Altered and spiritual states of consciousness" (Bravo & Grob, 1996, p. 179).

Projection "Attribution of one's own disowned strivings to others" (McWilliams, 2004, p. 15).

Psychoanalysis The method of psychological therapy originated by Sigmund Freud in which free association, dream interpretation, and analysis of resistance and transference are used to explore repressed or unconscious impulses, anxieties, and internal conflicts, in order to free psychic energy for mature love and work. (Reber, Allen & Reber, 2009).

Selfobject An entity which functions to develop and sustain a person's sense of self (Mitchell & Black, 1995).

Shadow "The shadow is an evocative term used in analytic psychology to refer to unconscious aspects of the personality that have been repressed. The personal shadow consists of traits that are unacceptable to the ego and do not fit the image that one is consciously trying to present to the world" (Vaughan, 1986, p. 49).

Glossary

Spiritual bypassing Using spirituality to avoid emotional difficulties (Battista, 1996b).

Spiritual direction A discipline that involves a director coming alongside a spiritual seeker, accompanying them on their spiritual journey, assisting the director explore and deepen their connection with God (Harbourne, 2012).

Spiritual emergency "Crises when the process of growth and change becomes chaotic and overwhelming. Individuals experiencing such episodes may feel that their sense of identity is breaking down, that their old values no longer hold true, and that the very ground beneath their personal realities is radically shifting. In many cases, new realms of mystical and spiritual experience enter their lives suddenly and dramatically, resulting in fear and confusion. They may feel tremendous anxiety, have difficulty coping with their daily lives, jobs, and relationships, and may even fear for their own sanity" (Grof & Grof, 1989, back cover). Acccording to Grof and Grof, these experiences have a positive potential, the term, "suggesting both a crisis and an opportunity of rising to a new level of awareness, or"spiritual emergence" (p. x).

Transference The feelings a client has towards their therapist.

Transpersonal "The transpersonal perspective holds that a large spectrum of altered states of consciousness exist, that some are potentially useful and functionally specific (i.e. possessing some functions not available in the usual state but lacking others) and that some of these are true 'higher' states" (Walsh & Vaughan, 1980, p. 11).

V-codes. The V -codes are so named in the DSM in order that conditions correspond to "The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD 9 CM) [which] is based on the World Health Organization's Ninth Revision, International Classification of Diseases (ICD 9). ICD 9 CM is the official system of assigning codes to diagnoses and procedures associated with hospital utilization in the United States" (Centers for Disease Control and Prevention,International Classification of Diseases, Ninth Revision, Clinical Modification (ICD 9 CM), n. d. para. 1). This classification system was modified in 2012, the modification now called ICD 10 CM, with the modifications usually called Z codes.

Appendices

Appendix A: Abbreviations

Term	Abbreviation
Accident Compensation Corporation	ACC
Advanced Clinical Practice	ACP
American Psychological Association	APA
Aotearoa New Zealand	ANZ
Auckland Institute of Technology	AIT
Auckland University of Technology	AUT
Childhood sexual abuse	CSA
District Health Board	DHB
Grounded Dimensional Analysis	GDA
New Zealand Association of Counsellors	NZAC
New Zealand Association of Psychotherapists	NZAP
New Zealand Christian Counsellors' Association	NZCCA
New Zealand Institute of Psychoanalytic Psychotherapists	NZIPP
Nga Ao e Rua	NAER
Non-Government Organisation	NGO
Psychotherapists' Board of Aotearoa New Zealand	PBANZ
Religion and/or Spirituality	RS
United Nations Educational, Scientific and Cultural Organisation	UNESCO
Work and Income New Zealand	WINZ
World Health Organisation	WHO

Appendix B: Ethics approval

M E M O R A N D U M

Auckland University of Technology Ethics Committee (AUTEC)

To:	KeithTudor
From:	**Dr Rosemary Godbold** Executive Secretary, AUTEC
Date:	19 March 2012
Subject:	Ethics Application Number 12/44**Spirituality, religion and psychotherapy: A grounded theory study.**

Dear Keith

I am pleased to advise that the Auckland University of Technology Ethics Committee (AUTEC) approved your ethics application at their meeting on 12 March 2012, subject to the following conditions:

1. Clarification of how the dimensional analysis described in section C.4.1 of the application relates to the chosen methodology of grounded theory;
2. Inclusion of the AUT logo on the advertisement;
3. Provision of a letter from AUT counselling indicating their agreement to offer counselling to your participants;
4. Amendment of the Information Sheet as follows:
    a. Inclusion of information that participants will be reimbursed for agreed travel costs incurred;
    b. Revision of the last sentence of the section on benefits to clearly explain to participants the attainment of a qualification at the completion of the study;
    c. Revision of the section on privacy which reflects that given the small pool size of participants it may be possible to offer only limited confidentiality;
    d. Revision of the last sentence of the section on privacy which reflects the standard retention protocol of 6 years;
    e. Inclusion of contact details for AUT counselling in the section on alleviation of discomforts and risks.

AUTEC wishes to commend the researcher and yourself on the quality of this application, in particular the response to the B.7. AUTEC noted that the indicative questions may not elicit responses specifically about Maori spirituality and suggests revising them to be more focussed on the topics of interest.

I request that you provide me with a written response to the points raised in these conditions at your earliest convenience, indicating either how you have satisfied these points or proposing an alternative approach.AUTEC also requires written evidence of any altered documents, such as Information Sheets, surveys etc.Once this response and its supporting written evidence has been received and confirmed as satisfying the Committee's points, you will be notified of the full approval of your ethics application.

When approval has been given subject to conditions, full approval is not effective until *all* the concerns expressed in the conditions have been met to the satisfaction of the Committee.Data collection may not commence until full approval has been confirmed.Should these conditions not be satisfactorily met within six months, your application may be closed and you will need to submit a new application should you wish to continue with this research project.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all written and verbal correspondence with us.Should you have any further enquiries regarding this matter, you are welcome to contact me by email at ethics@aut.ac.nz or by telephone on 921 9999 at extension 6902. Alternatively you may contact your AUTEC Faculty Representative (a list with contact details may be found in the Ethics Knowledge Base at http://www.aut.ac.nz/research/research-ethics/ethics).

Yours sincerely Dr Rosemary Godbold **Executive Secretary Auckland University of Technology Ethics Committee**

Appendix C: Ethics approval (amended)

MEMORANDUM
Auckland University of Technology Ethics Committee (AUTEC)

To:	KeithTudor
From:	**Dr Rosemary Godbold** Executive Secretary, AUTEC
Date:	27 April 2012
Subject:	Ethics Application Number 12/44**Spirituality, religion and psychotherapy: A grounded theory study.**

Dear Keith

Thank you for your request for approval of amendments to your ethics application, which was approved by Auckland University of Technology Ethics Committee (AUTEC) on 29 March 2012. I am pleased to advise that I have approved the minor amendment to your ethics application allowing alterative storage arrangements for Consent Forms. This delegated approval is made in accordance with section 5.3.2 of AUTEC's *Applying for Ethics Approval: Guidelines and Procedures* and is subject to endorsement at AUTEC's meeting on 14 May 2012.

I remind you that as part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through http://www.aut.ac.nz/research/research-ethics/ethics. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 29 March 2015;
- A brief report on the status of the project using form EA3, which is available online through http://www.aut.ac.nz/research/research-ethics/ethics. This report is to be submitted either when the approval expires on 29 March 2015 or on completion of the project, whichever comes sooner;

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are reminded that, as applicant, you are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

Please note that AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to make the arrangements necessary to obtain this.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all written and verbal correspondence with us. Should you have any further enquiries regarding this matter, you are welcome to contact me by email at ethics@aut.ac.nz or by telephone on 921 9999 at extension 6902. Alternatively you may contact your AUTEC Faculty Representative (a list with contact details may be found in the Ethics Knowledge Base at http://www.aut.ac.nz/research/research-ethics/ethics).

On behalf of AUTEC and myself, I wish you success with your research and look forward to reading about it in your reports.

Yours sincerely, Dr Rosemary Godbold**Executive Secretary Auckland University of Technology Ethics Committee**

Appendix D: Participant information sheet (original)

Participant Information Sheet

Date Information Sheet Produced:
21 February 2012.

Project Title
Spirituality, religion and psychotherapy: A grounded theory study

An Invitation
You are invited to take part in a research project exploring how psychotherapists attend to spirituality and/or religion in the therapeutic process. My name is Helen Florence and I am a psychotherapist undertaking this research study for my doctoral thesis. Your participation in this project is entirely voluntary, and, should you choose to participate you may also choose to withdraw your participation at any time during the process. You will not be identified in any writing up of the findings.

What is the purpose of this research?
I hope that the information gained in this study will be useful for psychotherapist education as well as clinical practice. Although overseas studies exist which address this topic, it is important to have research which reflects the bicultural context of Aotearoa New Zealand. You may also find that participating in the research will provide you with an opportunity for self- reflection around this topic. I anticipate presenting the research findings at various conferences as well as submitting them for publication in relevant psychotherapy and spirituality journals.

How was I identified and why am I being invited to participate in this research?
You are being invited to participate in this research as you are a psychotherapist. You would have been identified as you have responded to a general invitation issued to psychotherapists by e-mail to NZAP, local branches, The New Zealand Institute for Psychoanalytic Psychotherapy, Psychosynthesis, Gestalt and Transactional Analysis Associations, or have indicated your interest at a meeting with Waka Oranga. You may also have been identified by word of mouth by someone who knew about the study or had participated and thought you might be interested.

What will happen in this research?
The study involves interviews with psychotherapists. These interviews will be digitally recorded. If you choose to take part, you will be asked to spend between 60 and 90 minutes being interviewed about spirituality, religion and psychotherapy. Depending on the information obtained during the initial interview, a follow-up interview of about 30 minutes duration, clarifying or expanding on what you have already said, may be requested. You may choose to discontinue your participation at any time.

What are the discomforts and risks?
Spirituality and religion is felt by many to be a deeply personal arena. You may experience a degree of vulnerability when discussing this topic.

How will these discomforts and risks be alleviated?
You may choose to have the recorder turned off at any point during the interview and withdraw from the interview/research process at any time. You may find it helpful to discuss your experience in clinical supervision or utilise the services of a counsellor at the Health and Wellbeing Clinic at AUT, which also offers counselling to research participants. The Health and Wellbeing Clinic can be contacted on 099219999 ext. 9998 (Akoranga Campus),) and 099219999 ext. 9992 (Wellesley St Campus).

What are the benefits?
Participating in this research will give you an opportunity to reflect on spirituality and/or religion in your work as a psychotherapist. This may add to your professional and personal development. This research will provide information relating to the work of psychotherapists with spiritual and/or religious issues pertinent to our bicultural context. The findings could be used by institutions responsible for psychotherapy education and also to inform clinical practice. I will also benefit from the research as it will add to my understanding as a psychotherapist and I will obtain a PhD. at the completion of the study.

How will my privacy be protected?
Your digitally recorded interview will be transcribed only by me. Your identity will be kept confidential by the use of a pseudonym and any potentially identifying information will be excluded from the final report and any verbal presentations of the material. However, given the small size of the pool of psychotherapists it may only be possible to offer limited confidentiality. Identifying demographics with participant identification numbers will be stored separately from the research data, as will signed consent forms. All material involved in the research will be secured in a locked filing cabinet and destroyed after six years.

What are the costs of participating in this research?
The only cost involved in you participating in this research is your time. As indicated earlier, if you choose to take part, this will involve an interview of up to 90 minutes. You may be also asked for a further interview, depending on the course the research takes. I will meet you for the interview at a place of your choosing. Agreed travel costs will be reimbursed.

What opportunity do I have to consider this invitation?
I would find it helpful if you could let me know within a month whether or not you wish to participate in the research.

How do I agree to participate in this research?
You will need to complete the consent form included with the Participant Information Sheet to participate in this research.

Will I receive feedback on the results of this research?
I will post or e-mail you a copy of the summary of the research findings if you would like to receive this information. This could be between 1-3 years after you are interviewed depending at which stage of the research you are interviewed.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Dr Keith Tudor, keith.tudor@aut.ac.nz ph. 921 9999 ext. 7221

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEC, Dr Rosemary Godbold, rosemary.godbold@aut.ac.nz , 921 9999 ext 6902.

Whom do I contact for further information about this research?

Researcher Contact Details: Helen Florence The Bungalow Counselling and Psychotherapy Centre, 268 Mt Albert Rd, Sandringham. Ak 1041 ph. 629 2199 helenflorence@slingshot.co.nz

Project Supervisor Contact Details: Dr Keith Tudor, keith.tudor@aut.ac.nz ph. 921 9999 ext. 7221

Approved by the Auckland University of Technology Ethics Committee on 30 March 2012 AUTEC Reference number 12/44

Appendix E: Consent form (original)

Consent Form

For use when interviews are involved.

Project title: ***Spirituality, religion and psychotherapy: A grounded theory study***

Project Supervisor: ***Dr Keith Tudor***

Researcher: ***Helen Florence***

○ I have read and understood the information provided about this research project in the Information Sheet dated 21 February -2012

○ I have had an opportunity to ask questions and to have them answered.

○ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.

○ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.

○ If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.

○ I agree to take part in this research.

○ I wish to receive a copy of the report from the research (*please tick one*): Yes○ No○

Participant's signature: .....

Participant's name:.....

Participant's contact details (if appropriate):

……..

……..

……..

Date: _____

Approved by the Auckland University of Technology Ethics Committee on 30 March 2012AUTEC Reference number AUTEC 12/44

Note: The Participant should retain a copy of this form.

Appendix F: Participant information sheet (amended)

Participant Information Sheet

Date Information Sheet Produced:

21 February 2012.

Project Title

Spirituality, religion and psychotherapy: A grounded theory study

An Invitation

You are invited to take part in a research project exploring how psychotherapists attend to spirituality and/or religion in the therapeutic process. My name is Helen Florence and I am a psychotherapist undertaking this research study for my doctoral thesis.Your participation in this project is entirely voluntary, and, should you choose to participate you may also choose to withdraw your participation at any time during the process.You will not be identified in any writing up of the findings.

What is the purpose of this research?

I hope that the information gained in this study will be useful for psychotherapist education as well as clinical practice.Although overseas studies exist which address this topic, it is important to have research which reflects the bicultural context of Aotearoa New Zealand.You may also find that participating in the research will provide you with an opportunity for self- reflection around this topic.I anticipate presenting the research findings at various conferences as well as submitting them for publication in relevant psychotherapy and spirituality journals.

How was I identified and why am I being invited to participate in this research?

You are being invited to participate in this research as you are a psychotherapist.You would have been identified as you have responded to a general invitation issued to psychotherapists by e-mail to NZAP, local branches, The New Zealand Institute for Psychoanalytic Psychotherapy, Psychosynthesis, Gestalt and Transactional Analysis Associations, or have indicated your interest at a meeting with Waka Oranga. You may also have been identified by word of mouth by someone who knew about the study or had participated and thought you might be interested.

What will happen in this research?

The study involves interviews with psychotherapists.These interviews will be digitally recorded.If you choose to take part, you will be asked to spend between 60 and 90 minutes being interviewed about spirituality, religion and psychotherapy.Depending on the information obtained during the initial interview, a follow-up interview of about 30 minutes duration, clarifying or expanding on what you have already said, may be requested. If you prefer, follow-up may be conducted by e-mail or phone if that is your preference.You may choose to discontinue your participation at any time.

What are the discomforts and risks?

Spirituality and religion is felt by many to be a deeply personal arena.You may experience a degree of vulnerability when discussing this topic.

How will these discomforts and risks be alleviated?

You may choose to have the recorder turned off at any point during the interview and withdraw from the interview/research process at any time.You may find it helpful to discuss your experience in clinical supervision or utilise the services of a counsellor at the Health and Wellbeing Clinic at AUT, which also offers counselling to research participants.The Health and Wellbeing Clinic can be contacted on 099219999 ext. 9998 (Akoranga Campus),) and 099219999 ext. 9992 (Wellesley St Campus).

What are the benefits?

Participating in this research will give you an opportunity to reflect on spirituality and/or religion in your work as a psychotherapist.This may add to your professional and personal development.This research will provide information relating to the work of psychotherapists with spiritual and/or religious issues pertinent to our bicultural context.The findings could be used by institutions responsible for psychotherapy education and also to inform clinical practice.I will also benefit from the research as it will add to my understanding as a psychotherapist and I will obtain a PhD. at the completion of the study.

How will my privacy be protected?

Your digitally recorded interview will be transcribed only by me. Your identity will be kept confidential by the use of a pseudonym and any potentially identifying information will be excluded from the final report and any verbal presentations of the material.However, given the small size of the pool of psychotherapists it may only be possible to offer limited confidentiality.Identifying demographics with participant identification numbers will be stored separately from the research data, as will signed consent forms. All material involved in the research will be secured in a locked filing cabinet and destroyed after six years.

What are the costs of participating in this research?

The only cost involved in you participating in this research is your time.As indicated earlier, if you choose to take part, this will involve an interview of up to 90 minutes.You may be also asked for a further interview, depending on the course the research takes. I will meet you for the interview at a place of your choosing.Agreed travel costs will be reimbursed.

What opportunity do I have to consider this invitation?

I would find it helpful if you could let me know within a month whether or not you wish to participate in the research.

How do I agree to participate in this research?

You will need to complete the consent form included with the Participant Information Sheet to participate in this research.

Will I receive feedback on the results of this research?

I will post or e-mail you a copy of the summary of the research findings if you would like to receive this information.This could be between 1-3 years after you are interviewed depending at which stage of the research you are interviewed.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Dr Keith Tudor, keith.tudor@aut.ac.nzph. 921 9999 ext. 7221

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEC, Dr Rosemary Godbold, *rosemary.godbold@aut.ac.nz* , 921 9999 ext 6902.

Whom do I contact for further information about this research?

Researcher Contact Details:Helen Florence The Bungalow Counselling and Psychotherapy Centre, 268 Mt Albert Rd, Sandringham. Ak 1041 ph. 629 2199helenflorence@slingshot.co.nz

Project Supervisor Contact Details: Dr Keith Tudor, keith.tudor@aut.ac.nz ph. 921 9999 ext. 7221

Approved by the Auckland University of Technology Ethics Committee on *30 March 2012* AUTEC Reference number *12/44*

Appendix G: Consent form (amended)

Consent Form

For use when interviews are involved.

Project title: ***Spirituality, religion and psychotherapy: A grounded theory study***

Project Supervisor: ***Dr Keith Tudor***

Researcher: ***Helen Florence***

○ I have read and understood the information provided about this research project in the Information Sheet dated 21 February -2012

○ I have had an opportunity to ask questions and to have them answered.

○ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed. I understand that follow-ups may be conducted by email or phone rather than by face-to-face interview if that is my preference.

○ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.

○ If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.

○ I agree to take part in this research.

○ I wish to receive a copy of the report from the research (*please tick one*): Yes○ No○

Participant's signature: .....

Participant's name:.....

Participant's contact details (if appropriate):

……..

……..

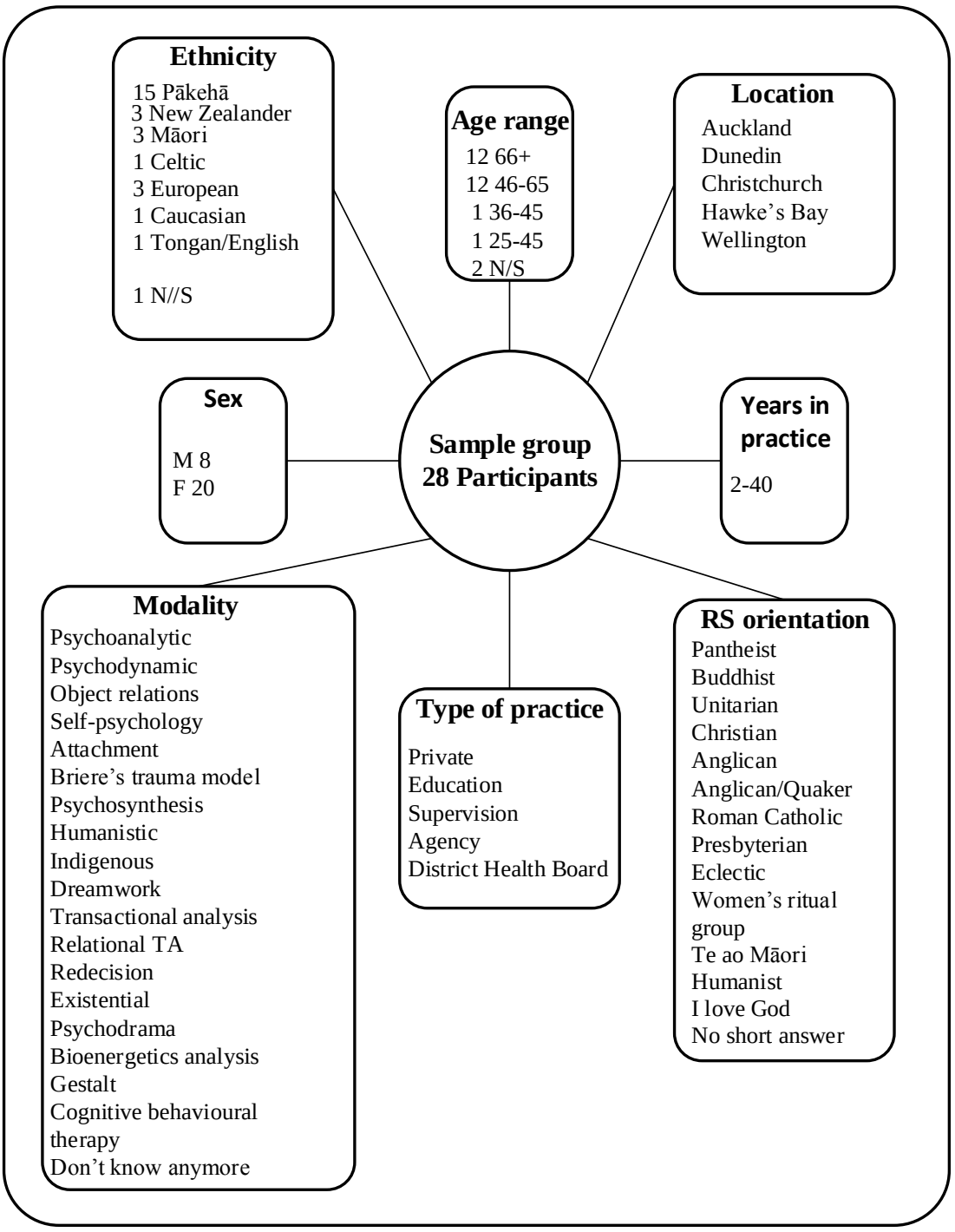
……..

Date: _____

Approved by the Auckland University of Technology Ethics Committee on 30 March 2012AUTEC Reference number AUTEC 12/44

Note: The Participant should retain a copy of this form.

Appendix H: Participants' characteristics



Appendix I: Recruitment advertisement

PARTICIPATION IN DOCTORAL RESEARCH

Are you a registered psychotherapist, or a member of the New Zealand Association of Psychotherapists or Waka Oranga?

You are offered an opportunity to take part in research

Topic: **Spirituality, Religion and Psychotherapy in Aotearoa New Zealand**

Doctoral research is being conducted by Helen Florence at the AUT University.
.
Primary supervisor: Dr Keith Tudor PhD, MSc, MA, BA(Hons), CQSW, Dip. Psychotherapy, CTA, TSTA.

For information please contact Helen Florence at helenflorence@slingshot.co.nz

Appendix J: Recruitment letter

Opportunity to be involved in research about religion, spirituality and psychotherapy

My name is Helen Florence. I am a registered psychotherapist and a full member of NZAP.

I am undertaking doctoral research exploring religion, spirituality and psychotherapy. No research exists in our bicultural context which investigates how psychotherapists attend to spirituality within the therapeutic process.

You may be aware that the Psychotherapists' Board of Aotearoa New Zealand has recently been consulting on cultural competencies which include religion and spirituality. Participating in the research will provide an opportunity for self-reflection around this important area. The findings of this study may be useful for informing psychotherapist education and enhancing clinical practice.

This study is being undertaken at Auckland University of Technology and my primary supervisor is Dr Keith Tudor PhD MSc MA BA CQSW Dip. Psychotherapy CTA TSTA.

If you would like to be sent an Information Sheet which outlines what your participation would entail, please contact me by email on jhss@slingshot.co.nz

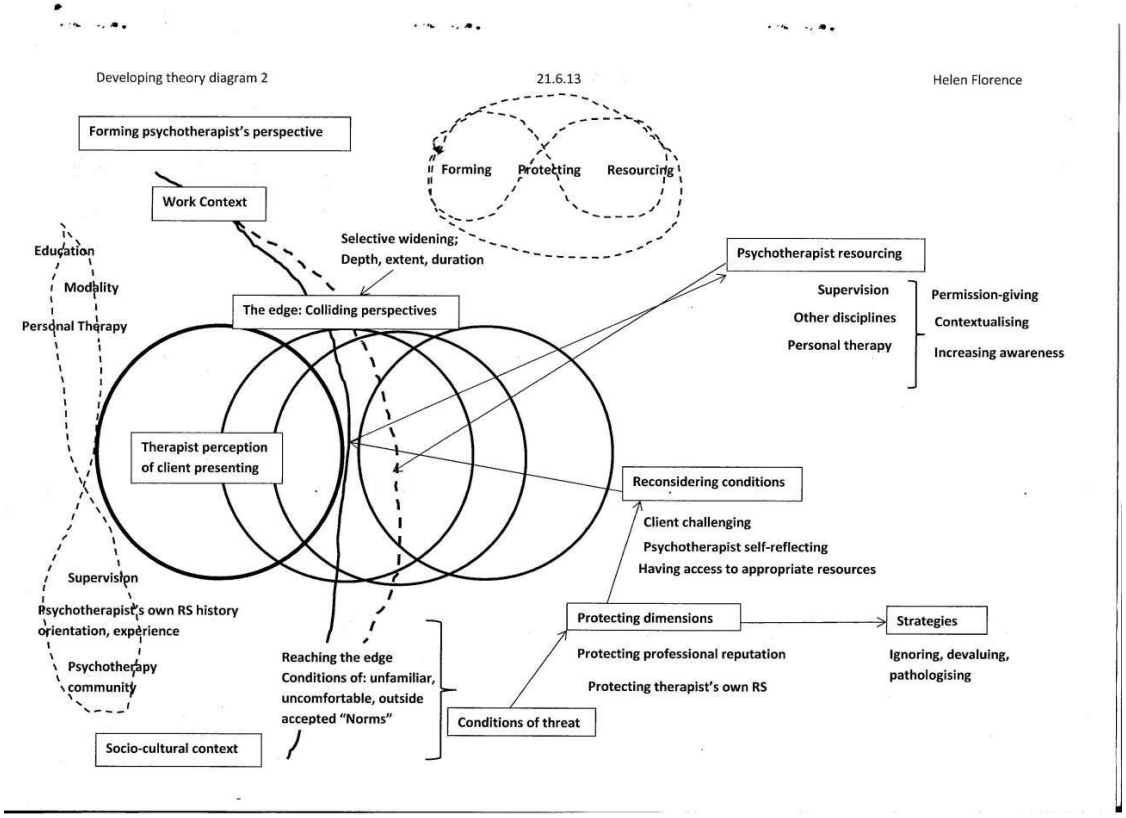
Helen Florence.

Appendix K: NVivo codes

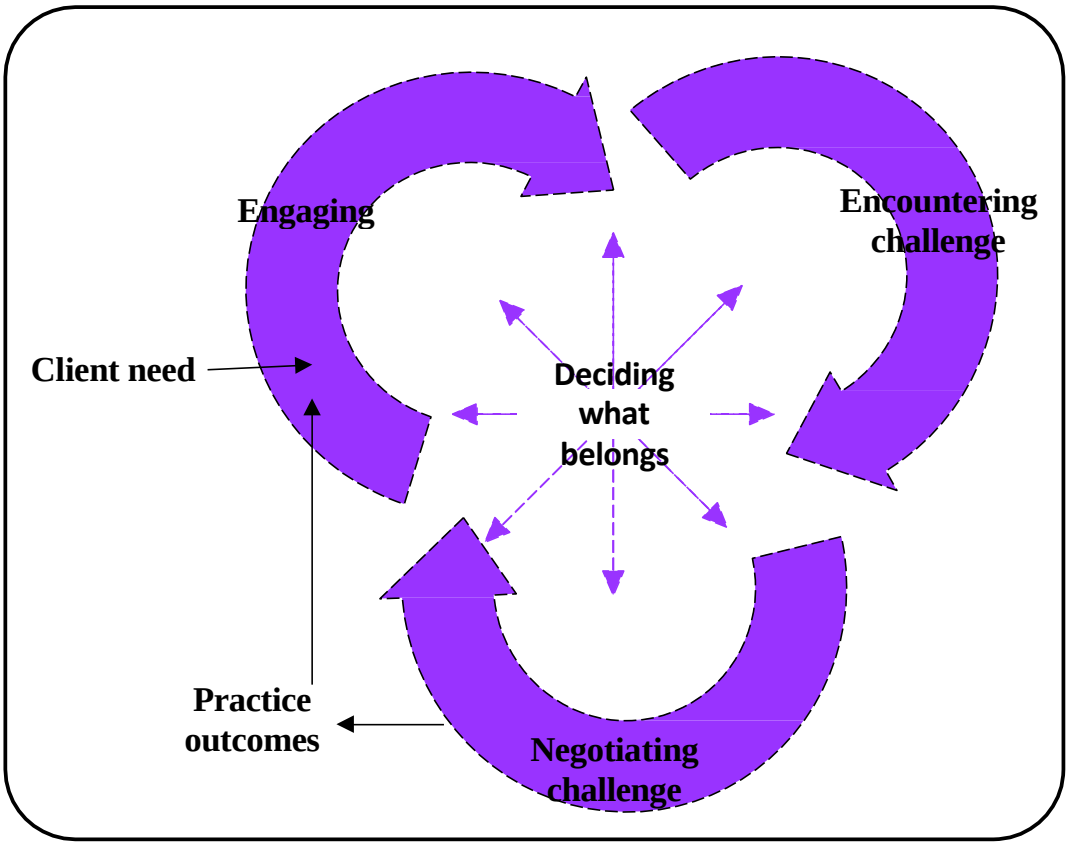
Nodes

Name	Sources	References	
Assessing	8	11	
Beginning	2	3	27/0
client need	1	4	17/0
Defensive uses	2	3	17/0
delusional	2	5	17/0
Psychosis and Spirituality	3	7	3/03
Unhelpful belief systems	9	19	17/0
Linking with parents	1	1	15/1
Helpful belief systems	2	2	22/0
Therapist looking for client resourcing	9	16	1/03
Maori cultural development	1	2	20/0
Religious areas being negotiated with psychotherapist	1	1	17/0
Religious commitment	1	1	11/0
Religiously focused assessing	1	1	7/02
Spirituality and psychosis	1	1	12/1
Taking time	1	1	6/08
Using categories	1	2	8/02
Being aware	5	11	
Being with the familiar	1	1	
Client changes in RS as a consequence of psychotherapy	3	8	
Client groups	3	6	
Commenting on the model	3	3	
Culture	7	7	
Definition of Religion	13	15	
Definition of Spirituality	16	25	
Developing RS	2	4	
Developing competence	1	1	
Different ways of holding RS belief systems	2	4	
Disclosing	4	4	
DSM classifying	1	1	
Education Conditions	6	12	
Exploring belief systems	5	12	
Extending territory	1	2	
Facilitating client process	2	5	
Finding parallels between psychotherapy and RS	8	20	
Gatekeeping	3	10	
Geographical conditions	1	1	
Great Quotes	15	23	
Incorporating	3	4	
Initiating	11	15	
joining	2	2	
Language	10	20	
Legitimizing	6	13	

Appendix L: Diagram depicting early analysis 21.06.13



Appendix M: Diagram depicting later analysis 29.05.15



Appendix N: Memo: One page thesis

15.1.13

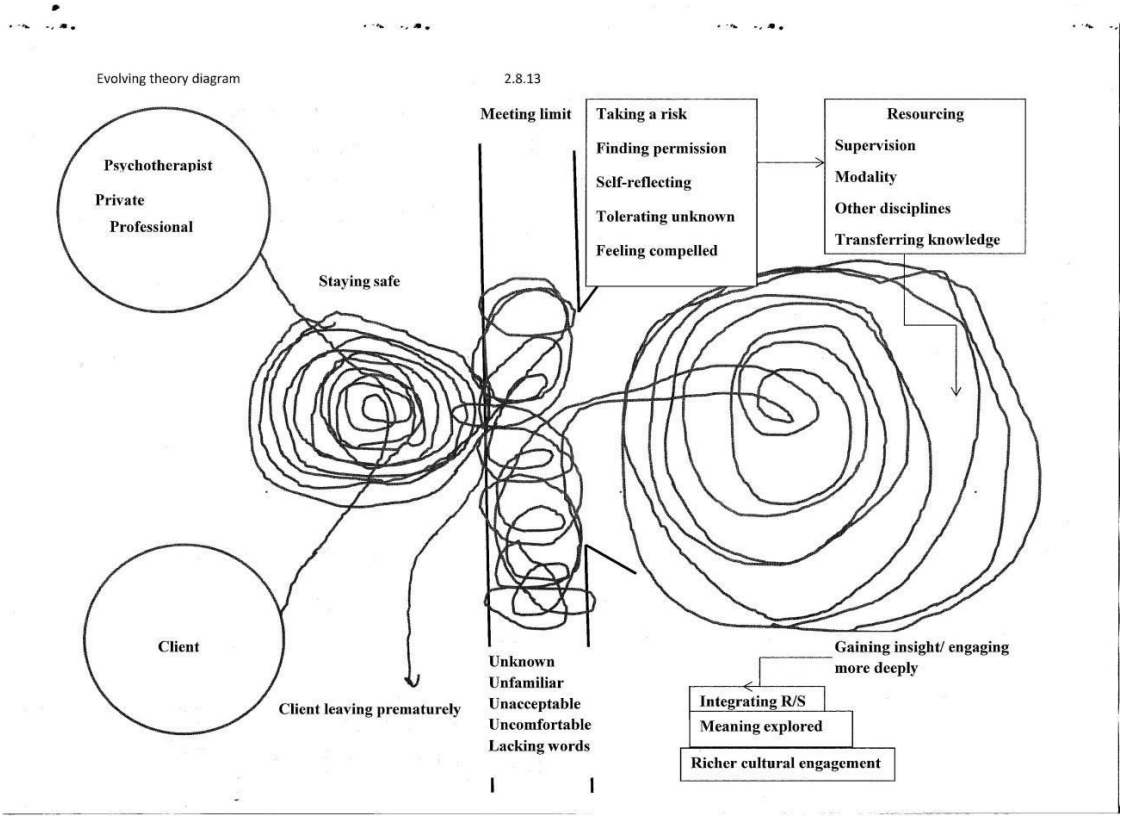
Memo: One page thesis

How the psychotherapist perceives the place of religion and/or spirituality (RS) in the therapeutic encounter shapes the therapeutic process.

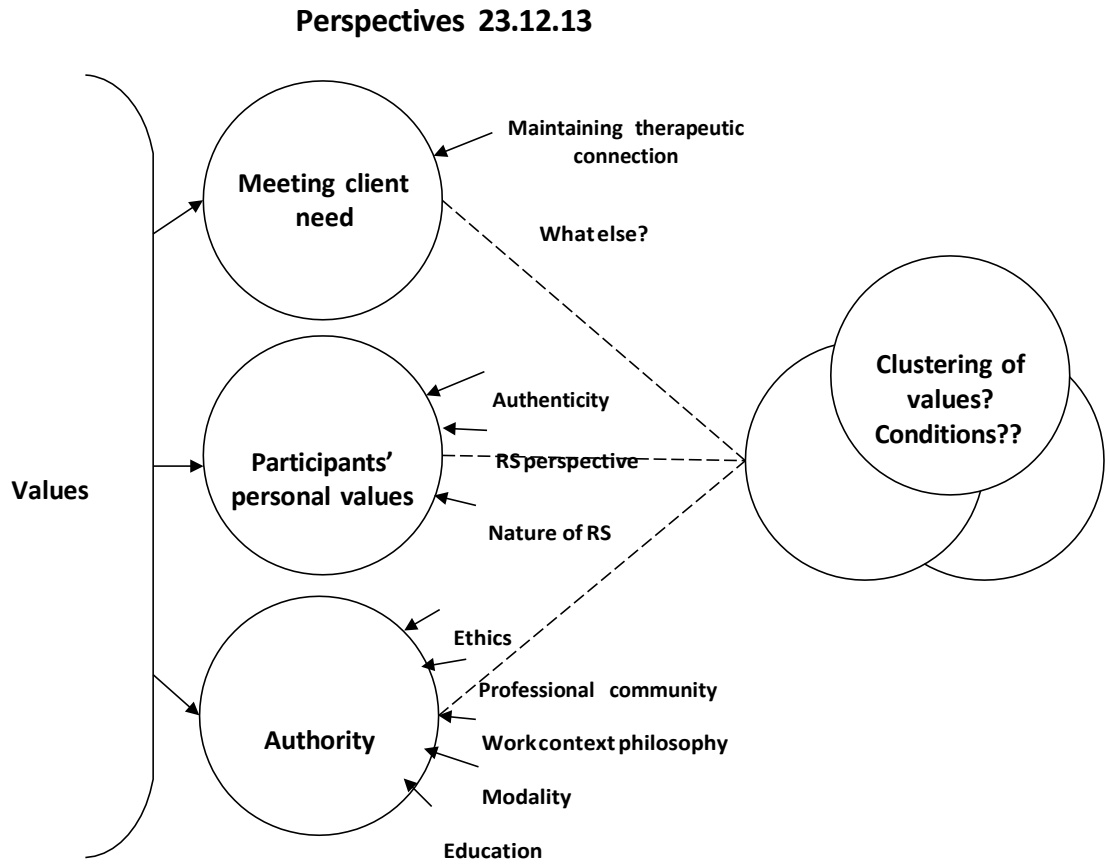
"What the therapist brings", seems to be a central dimension to RS in psychotherapy, a consequence of many other conditions. The therapist's own psychotherapy education and chosen modality, what is "trending" in the wider psychotherapy environment, how the therapist interacts with their own RS history, as well as their work context, are all part of what the therapist brings. For some, the particular psychotherapy education is chosen with a mind to how RS is seen in the modalities offered, for others the choice of education is about availability. How RS is attended to in the therapist's education is often modelled by the therapist in their own practice. All these conditions underpin how a psychotherapist responds to a client's initiating of RS material. However, whether the therapist has processed their relationship with their own RS is a most salient dimension in how they interact with the RS of clients, more important than education or chosen modality. With all these conditions in mind, whether a client's initiating of RS matters is picked up on by the therapist depends on how the therapist perceives the client's offering. Where it is deemed not important, not part of psychotherapy, threatening, unfamiliar or the therapist doesn't know what to do with it, it may be ignored or devalued. A challenge by the client to this response may result in self-examination and greater attention to client material. However, it often occurs that such material is not raised again, as the client learns what not to bring to therapy or leaves. Where a client's presenting of RS matters is heard, welcomed and encouraged, a facilitating and exploration of such material occurs. Therapists rarely initiate discussion of RS material with clients unless they are looking for resources which support the client. For some client groups, such as Māori or those wrestling with existential issues, RS issues are most important. Cultural supervision is sought for working with Māori spirituality when there are available and known resources, with the consequence of increased therapist confidence and the utilizing of Māori models which include spirituality with other client groups. However, whether therapists take RS issues to general supervision depends on how therapists perceives they will be responded to, perhaps in a way which reflects the manner and degree to which RS issues are raised by clients. Therapists also resource

themselves to work with RS by incorporating material gleaned from other disciplines which enriches their work with clients. Therapists at times resource themselves with RS rituals or symbols in the room which include seeking divine support inwardly, and lighting of lamps and candles which for some, signify spiritual presence.

Appendix O: Evolving theory diagram showing “meeting limit”



Appendix P: Perpsectives 23.12.13

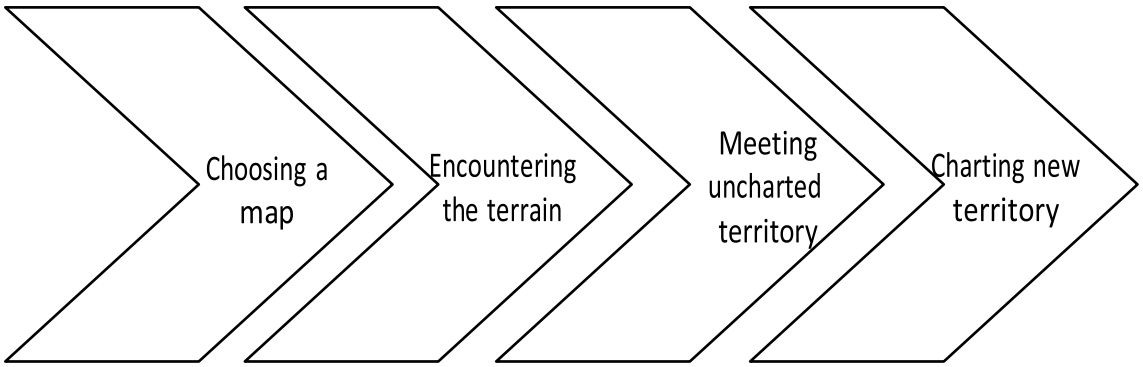


Appendix Q: Trajectory concept

Trajectory Concept

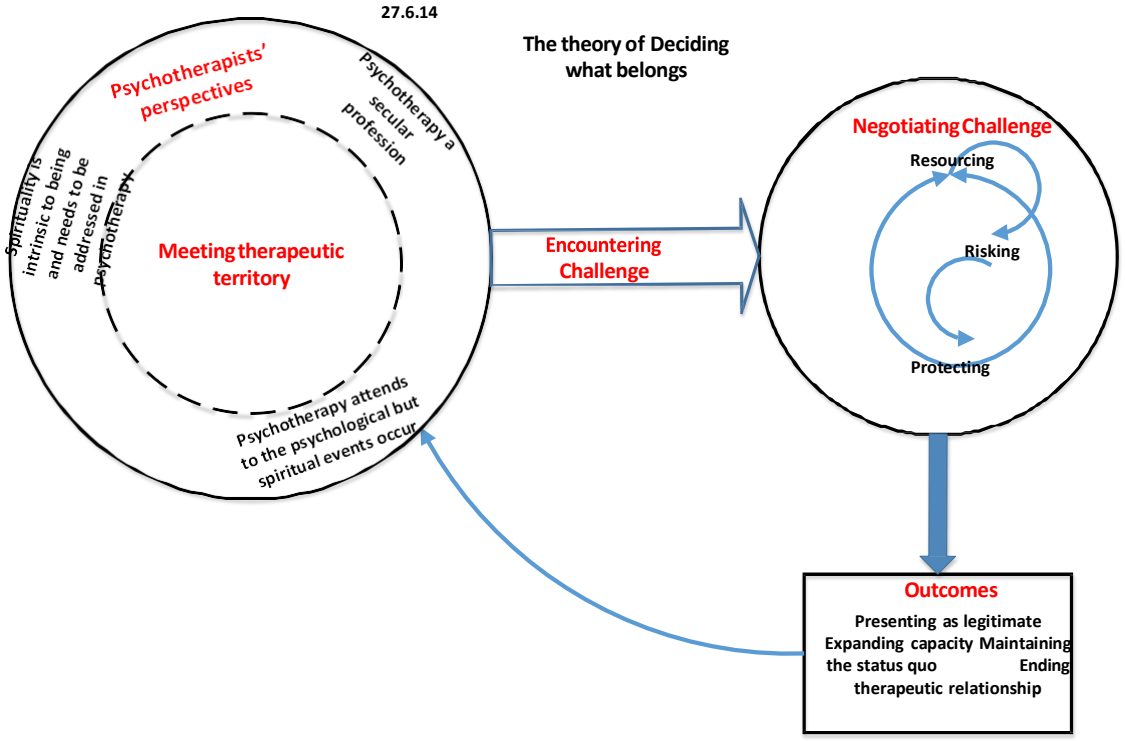
AUT Doctoral Conference
27.11.13

4 Phase Process



Appendix R: An iterative process

An Iterative Process



Appendix S: The theory as a learning tool

The Theory as a learning tool