Spirituality and religion in clinical practice:

The experiences of psychologists in the integration of spirituality and religion in

therapy in Aotearoa New Zealand

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Table of Contents

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 or a university or other institution of higher learning.

Signed: ……………………………………….

Dated: ……………………………………….

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Abstract

While spiritual and religious beliefs and practices have been found to have positive impacts on wellbeing, many clinicians do not address spiritual and religious issues in therapy, and there is some ambiguity around the practicalities of integrating spirituality and religion in psychological practice. The present study aimed to gain a better understanding of this existing concern and explored the experiences of clinical psychologists in integrating the client's spirituality and religion into their practice. A thematic analysis of six interviews with clinical psychologists in Aotearoa New Zealand identified themes around techniques, meanings, barriers and the importance of the integration of spirituality and religion in clinical practice. It is hoped that the findings will raise awareness and facilitate changes to training and attitude regarding spirituality and religion in clinical practice.

Introduction

The importance of religion and spirituality is universally acknowledged. According to Taylor (2002), for example, religion constitutes an influential and important role in all cultures, and Azar (2010) points to the fact that religion has survived for over 100,000 years, exists across cultures, and that more than 85% of the world's population ascribe to some form of religious belief.

Statistics New Zealand (2016) report that over half of the Aotearoa New Zealand population identify with at least one religion. While the number of people who identify with a Christian religion may be declining, Christianity remains the largest religion in Aotearoa New Zealand. Additionally, there is more diversity of faiths emerging in Aotearoa New Zealand as seen by the steady rise in the percentage of people affiliating with other religions such as Sikh and Hinduism. However, there has also been an increase in people reporting having no religion in Aotearoa New Zealand, as seen in other countries (Statistics New Zealand, 2016). In 2013, 42% of the Aotearoa New Zealand population reported having no religious affiliation which is a significant increase from 30% in the 2001 census (Statistics New Zealand, 2016).

Despite the decline, however, religion may still hold significant meaning for over half of the Aotearoa New Zealand population who identify with at least one religion (Statistics New Zealand, 2016). This may be of particular relevance for Māori, as over half of the Māori population who are the tangata whenua (indigenous people) of Aotearoa New Zealand are estimated to have a religious affiliation. Additionally, eighty-three percent of Pacific peoples who make up 7% of the Aotearoa New Zealand population report having at least one religious affiliation (Statistics New Zealand, 2016; Statistics New Zealand and the Ministry of Pacific Island Affairs, 2010). The Asian population also represent 12% of the Aotearoa New Zealand population and 70% of this ethnic group in Aotearoa New Zealand reported having a religious affiliation (Statistics New Zealand, 2016).

Spirituality is also an important concept for many people in Aotearoa New Zealand, particularly for Māori as it is considered one of the four cornerstones of *hauora* (Māori health). Tāne Ora Alliance (2016) noted that

Māori have always recognised the importance of wairua (spirituality) for health and argued it is even considered the most significant requirement for wellbeing by many Māori. "Spirit is unique – the life force – I can't describe it, but it drives all people the way we 'do'" (Hopkirk & Wilson, 2014, p. 161). For Māori, spirituality is also intimately connected with issues of empowerment, threatened identity and life purpose (Abbott & Durie, 1987). Furthermore, an important value held by both Māori and mental health professionals like counselling psychologists is holistic care; looking beyond the individual and at the wider context and taking an integrative approach to health (Durie, 2003). Therefore, it is important to understand the cultural diversity of Māori including spirituality and religion to ensure the protection of Māori wellbeing.

Considering the pertinence of spirituality and religion, it is likely that mental health professionals will work with religious or spiritual clients in clinical practice (Aten & Hernandez, 2004). For example, tangata whenua are over-represented in Aotearoa New Zealand mental health (Oakley Browne, Wells & Scott, 2006) and, as mentioned above, spirituality and religion are meaningful for many Māori. The aforementioned statistics also suggest that religion may be important components of many other clients' culture and identity in Aotearoa New Zealand. This reinforces the significance of this area in research.

Studies have suggested that spirituality and religion can produce positive effects on the people's wellbeing (Chai, 2009; Hsu, Krägeloh, Shepherd & Billington, 2009; Koenig, 2009; Koenig, McCullough & Larson, 2001). For example, Hsu et al. (2009) found a significant correlation between spirituality and psychological quality of life in young adults. Koenig (2009) conducted a review of studies in this area of research and found that recent studies have identified that religion can serve as a psychological resource for coping with stress. Therefore, spirituality and religion are important topics of interest for mental health professionals and should be investigated to provide the best quality of care to clients.

While the interest in spirituality and religion have recently emerged in psychology (Atan & Hernandez, 2004; Eck, 2002), some negative attitudes toward spirituality and religion that were evident in the Freud era have persisted (Azar, 2010; Delaney, Miller & Bisonó, 2013). These negative attitudes included beliefs that religion is not beneficial nor relevant to mental health (Azar 2010;

Delaney et al., 2013). It is however, important that psychologists are competent in respectfully working with culturally and socially diverse clients including those who are spiritual or religious. This is entrenched in the ethical code of many countries including the US, UK and Aotearoa New Zealand (American Psychological Association, 2002; New Zealand Psychologists Board, 2009; New Zealand Psychological Society, 2002; The British Psychological Society, 2009). However, studies have found that spirituality and religion are rarely included in clinical practice and there is generally an absence of training (Begum, 2012; Delaney et al., 2013; Florence, 2009; Mueller, 2012). One UK study found that trainee clinical psychologists received little education and guidance on the topic both academically and in supervision (Begum, 2012). Begum (2012) argued that a large body of psychologists do not address nor explore spiritual and religious issues, and thus an important part of a client's worldview may be neglected.

The present study explores the integration of spirituality and religion into therapy from the perspective of psychologists to contribute to research in the area and to gain a better understanding of these issues and inform current clinical practice. Most studies on spirituality and religion in mental health settings are based on US and UK populations. This study was conducted in Aotearoa New Zealand and as such also offers insight into Māori spirituality in clinical practice. Semi-structured interviews and inductive thematic analysis were employed to explicate the experiences of psychologists in integrating spirituality and religion into clinical practice.

Literature review

The following section will review the current literature on spirituality and religion in the context of psychological practice. It will cover definitions, the effects of spiritual and religious beliefs on mental health, attitudes of clients and therapists towards spirituality and religion and their place in therapy, advancements, limitations and recommended practices in relation to this area of interest. The rationale for the present study in light of the current literature is also provided.

Definitions of spirituality and religion

Everts and Agee (1995) defined spirituality as "having to do with a person's innermost being and its connection with a universal force or divine presence which gives purpose and meaning to people's lives" (p. 291). According to Frame (2003), "spirituality includes one's values, beliefs, mission, awareness, subjectivity, experience, sense of purpose and direction, and a kind of striving towards something greater than oneself. It may or may not include a deity" (p. 3). Spirituality has also been defined as a significant and guiding influence on everyday life (Aten & Leach, 2009). While there is no universal consensus for the definition of spirituality, these are a few of the many definitions of spirituality identified in literature (Aten & Leach, 2009; Zinnbauer, Pargament & Scott, 1999).

However, the definition of religion is less ambiguous and disparate. As Koenig et al. (2001) stated, religion is generally acknowledged as "an organised system of beliefs, practices, rituals and symbols designed to facilitate closeness to the sacred or transcendent through fostering an understanding of one's relationship and responsibility to others living together in a community" (p. 18).

While spirituality and religion are closely related and share similar meanings, there are differences between the terms (Rose, 2001; Zinnbauer et al., 1999). Rose (2001) investigated the term 'spirituality' among religious professionals such as priests, monks and rabbis, which revealed differences as well as similar characteristics. Rose (2001) found that spirituality was not dependent on belonging to a religion, and it included some form of religious or comparable experience, maintained practice or effort, and experiences of love.

There has been a shift in how religion and spirituality are viewed in society over the past three decades (O'Brien, Denny, Clark, Fleming, Teevale & Robinson, 2013). Spirituality and religion are now understood to exist independently from each other (Aten & Leach, 2009; O'Brien et al., 2013). Religion can be a structure for human spirituality, but an individual can identify as religious and not spiritual, or vice versa (Cashwell & Young, 2011). There has also been an increase in the number of people who identify themselves as spiritual, but not religious (Vieten, Scammell, Pilato, Ammondson, Pargament & Lukoff, 2013).

Spirituality and religion in mental health

Spirituality and religion can play a significant role in a person's wellbeing. As Bein (2014) argued, many people rely and lean on spirituality and religion to experience wellbeing, serenity, meaning, hopefulness and happiness. Studies suggest that spirituality and religion can have a positive impact on mental health. (Chai, Krägeloh, Shepherd & Billington, 2012; Gardner, Krägeloh & Henning, 2014; Hsu et al., 2009). Chai et al. (2012) found that religion or spirituality functioned as a stress coping mechanism in tertiary international students in Aotearoa New Zealand. Krägeloh, Henning, Billington and Hawken (2015) conducted a cross-sectional study of 275 medical students at the University of Auckland. Participants completed the WHOQOL-BREF quality of life and the WHOQOL-SRPB for personal beliefs, spirituality and religiousness questionnaires to investigate the effects of religiousness, spirituality and personal beliefs on quality of life. The study concluded that reduced hope and meaning in life were the strongest markers of psychological distress for both religious and nonreligious participants. For religious students, existential beliefs were positively correlated to quality of life.

One study in Aotearoa New Zealand took a sample of high school students from the Ministry of Education database in 2006 and found that 56.9% students reported attending places of worship (O'Brien et al., 2013). Additionally, over half (52.8%) of the respondents reported that their spiritual beliefs were very important. The study found that those who disclosed having strong spiritual beliefs reported fewer mental health concerns and health risk

behaviours compared to those who attend religious communities but do not have spiritual beliefs. Specifically, students with low levels of spiritual beliefs were 1.5 times more likely to report high levels of depressive symptoms in comparison to students with high levels of spirituality. Furthermore, there were significantly fewer suicide attempts among students with medium to high levels of spirituality compared to students with low levels of spirituality. The findings from the aforementioned studies suggest spirituality and religion are associated with mental health and are important to many adolescents and young adults in Aotearoa New Zealand.

Research also suggests spirituality and religion lead to positive mental health outcomes for older adults (Heydari-Fard, Bagheri-Nesami, Shirvani & Mohammadpour, 2014; Krause, 2015; Levin, 2014). For example, Heydari-Fard et al. (2014) found an association between mental health and a high level of religious coping in older adults in Iran. Similarly, Levin (2013) found that religious participation was associated with greater optimism and lower levels of depression in Israeli middle-aged and older adults. Krause (2015) also found that a greater trust in God was associated with fewer symptoms of depressed affect in Christian older adults in the US. Overall, research shows that the positive impacts of religion and spirituality on mental health are noticeable in many different types of populations, including age and culture (Chai, 2009).

However, spirituality and religion may not always lead to positive outcomes for certain individuals. For example, some people may feel condemnation and excessive guilt because of religion or experience distress when they do not feel they are meeting God's standards of virtue (Exline, 2002; Koenig, 2007). Although if this is the case, it would be important to address and explore in therapy. Therefore, all these studies suggest that religion and spirituality are significant for wellbeing and thus it is important to consider their integration into therapy.

Spirituality and religion in psychology

Developments

Since the beginning of psychology, some psychologists have perceived religiosity as pathological and a force that encourages ritualistic behaviour and

irrational thoughts (Azar, 2010). Gerson, Allen, Gold and Kose (2000) stated it was generally believed that clinical interventions ought to be guided by professional beliefs and practice, and that personal beliefs such as religious beliefs should be kept outside of therapy as that would be problematic. Bartholomew and O'Dea (1988) suggested that there is a tendency to medicalise deviant or unfamiliar behaviour with dysfunctional labels. For example, for clients of unfamiliar religious groups religious fervour was regarded as a medical problem in mainstream psychiatry (Bartholomew & O'Dea, 1988). Bartholomew and O'Dea (1988) recommended recognising the scope and breadth of human diversity to reduce the risk of marginalising people with different beliefs and values.

Spirituality and religion are becoming more widely accepted in psychology as there is an increased awareness of the importance of religion in clients' lives (Atan & Hernandez, 2004). Eck (2002) argued that there is now a recognition in the therapeutic community that spirituality and religion are just as relevant to clinical practice as any other part of the client's orientation to life such as their culture, ethnicity and gender. The American Psychological Association (APA) has published books on psychology and religion, approved religion-oriented doctoral programmes, and updated the ethical guidelines to include spirituality and religion (Aten & Hernandez, 2004).

In response to the lack of training in spiritual and religious issues, Vieten et al. (2013) proposed 16 spiritual and religious competencies for psychologists which have been published by APA. Vieten et al. (2013) based these competencies on a literature review, a focus group of clinicians and scholars, and an online survey of 184 experienced clinicians and scholars. The following competencies are provided below (Vieten et al., 2013):

Attitudes
1. Psychologists demonstrate empathy, respect, and appreciation for clients from diverse spiritual, religious, or secular backgrounds and affiliations.
2. Psychologists view spirituality and religion as important aspects of human diversity, along with factors such as race, ethnicity, sexual orientation, socioeconomic status, disability, gender, and age.
3. Psychologists are aware of how their own spiritual and/or religious background and beliefs may influence their clinical practice, and their attitudes, perceptions, and assumptions about the nature of psychological processes.

Knowledge

4. Psychologists know that many diverse forms of spirituality and/or religion exist, and explore spiritual and/or religious beliefs, communities, and practices that are important to their clients.
5. Psychologists can describe how spirituality and religion can be viewed as overlapping, yet distinct, constructs.
6. Psychologists understand that clients may have experiences that are consistent with their spirituality or religion, yet may be difficult to differentiate from psychopathological symptoms.
7. Psychologists recognize that spiritual and/or religious beliefs, practices, and experiences develop and change over the lifespan.
8. Psychologists are aware of internal and external spiritual and/or religious resources and practices that research indicates may support psychological well-being, and recovery from psychological disorders.
9. Psychologists can identify spiritual and religious experiences, practices, and beliefs that may have the potential to negatively impact psychological health.
10. Psychologists can identify legal and ethical issues related to spirituality and/or religion that may surface when working with clients.

Skills

11. Psychologists are able to conduct empathic and effective psychotherapy with clients from diverse spiritual and/or religious backgrounds, affiliations, and levels of involvement.
12. Psychologists inquire about spiritual and/or religious background, experience, practices, attitudes and beliefs as a standard part of understanding a client's history.
13. Psychologists help clients explore and access their spiritual and/or religious strengths and resources.
14. Psychologists can identify and address spiritual and/or religious problems in clinical practice, and make referrals when necessary.
15. Psychologists stay abreast of research and professional developments regarding spirituality and religion specifically related to clinical practice, and engage in ongoing assessment of their own spiritual and religious competence.
16. Psychologists recognize the limits of their qualifications and competence in the spiritual and/or religious domains, including any responses to clients' spirituality and/or religion that may interfere with clinical practice, so that they (a) seek consultation from and collaborate with other qualified clinicians or spiritual/religious sources (e.g. priests, pastors, rabbis, imam, spiritual teachers, etc), (b) seek further training and education, and/or (c) refer appropriate clients to more qualified individuals and resources.

Further descriptions on these competencies are provided in Vieten et al.'s (2013) article. Overall, the proposed competencies of attitude, knowledge and skills acknowledge the importance of spirituality and religion and endorse their inclusion in therapy. However, a consultation with psychologists who are not experts or who do not have strong favour towards the integration of spirituality

in clinical practice is required in order to establish these competencies as standards for psychological practice (Vieten et al., 2013).

Although there have been developments in regards to spirituality and religion, some negative attitudes around spirituality and religion have remained in the psychological field. For example, Delaney et al. (2013) found that, in a national sample of 258 APA psychologists, only half of those who reported having no religious affiliation believed religion can be beneficial to mental health.

Religiosity of psychologists

Research suggests psychologists are less religious or spiritual than the general public (Delaney, Miller & Bisonó, 2013). Rosmarin, Green, Pirutinsky and McKay (2013) systematically surveyed 262 US practitioners of cognitive-behavioural therapy. Fifty-four percent of the respondents reported a strong sense of spirituality, whereas 51% reported that religion had little or no personal importance to them. Additionally, the percentage of those who consider themselves religious was substantially lower than that of the general US population (Rosmarin et al., 2013). Similarly, in a US national survey of clinical psychologists, psychiatrists, marriage and family therapists, and social workers, results showed low rates of religious affiliation and participation (Bergin & Jensen, 1990). Out of the aforementioned groups, psychologists had the highest percentage of atheist and agnostic religious preferences (Bergin & Jensen, 1990). Furthermore, Delaney et al. (2013) found that psychologists were far less religious than the clientele. Forty-eight percent of the sample of psychologists as opposed to 15% of the general US population stated that religion is not very important in their lives (Delaney et al., 2013).

Some studies have suggested that the attitude of therapists towards spirituality and religion in clinical practice can potentially have significant implications on treatment. In a survey-based study of 285 APA members, results suggested that the more importance therapists placed on spirituality in their personal lives the less likely they were to view the mystical experiences of their clients as pathological (Allman et al., 1992). Allman et al. (1992) argued that if therapists regarded mystical experiences as symptoms of psychosis, they

may more readily suggest medication or even hospitalisation to clients. Additionally, Butcher (2013) explored the attitudes and practices of psychiatrists in Aotearoa New Zealand regarding spiritual and religious issues in mental health, and found those who identify as New Zealanders were less likely to believe in God, see value in religious involvement, and refer clients to spiritual advisors or carers. It is important that the attitudes of mental health professionals around spirituality and religion do not jeopardise their ability to competently treat religious clients (Delaney et al., 2013). Therefore, clinicians should respect clients with religious worldviews and develop skills on how to acknowledge religiosity in therapy.

Clients' views of spirituality and religion in therapy

Some clients feel they cannot freely approach their therapists with the subject of spirituality and religion. For example, Florence (2009) argued that Christian clients may seek mental health practitioners who are also Christian because they fear that their faith would be pathologised. Furthermore, Young, Dowdle and Flowers (2009) argued that the more spiritual clients are, the more they may feel sceptical about working with secular therapists because spiritual commitment has been historically viewed as dysfunctional and a potential problem by secularly trained therapists.

Many religious clients prefer therapy that is consistent with their spiritual and/or religious frames of reference (Aten & Hernandez, 2002; Bergin & Jensen, 1990). A US study assessed the beliefs of psychotherapy clients about the appropriateness of discussing spiritual and religious issues in therapy and found that clients believed that it was appropriate and preferred to discuss such issues in counselling (Rose, Westefeld & Ansley, 2001). In a survey-based study, 53% of clients reported that they would seek help from a pastoral care centre if it was available (Quackenbos, Privette & Klentz 1985). Additionally, a review of 148 empirical studies on religion and counselling found that religious people generally prefer religious counsellors (Worthington, Kurusu, McCullough & Sandage, 1996).

Integration of spirituality and religion into therapy

There are various ways of integrating spirituality and religion into therapy. In the present study, this integration is defined as ways of acknowledging and involving the client's religion and/or spirituality in clinical practice. Everts and Agee (1995) argued that having a framework that incorporates spirituality and religion is essential in therapy as spirituality is closely related to issues around birth and death, and feelings of wonderment, joy, grief and loss. It can provide huge support in counselling or can be a source of deep anger, pain or guilt which counselling addresses (Everts & Agee, 1995). As suggested by Bein (2014), spirituality and religion can be liberating for many clients.

Research suggests the inclusion of spirituality and religion in clinical practice has produced positive results for clients (Worthington, Hook, Davis & McDaniel, 2011). A meta-analysis of 46 studies examining the outcomes of religious/spiritual accommodative therapies and non-religious/spiritual therapies found that spiritually/religious oriented psychotherapy can result in greater improvements in psychological and spiritual outcomes than alternative secular psychotherapies (Worthington et al., 2011). The authors recommend incorporating religion and spirituality into psychotherapy for highly spiritual or religious clients. However, it may not always be possible or appropriate to integrate spirituality and religion into clinical practice. For example, it has been suggested by some authors that intense religious experiences may lead to psychotic episodes and religious exploration in therapy may fuel a client's psychotic ruminations (Aten & Hernandez, 2004; Reeves, Beazley & Adams, 2011).

Despite these findings, many psychologists do not integrate spirituality and religion into therapy. Begum (2012) argued that a large body of psychologists do not address nor explore spiritual and religious issues, and thus an important part of a client's worldview may be neglected. Similarly, 14-17% of psychologists in an APA survey also reported that they never/rarely assess their clients' religion or spirituality and never/rarely provide treatment relevant to spiritual or religious issues (Delaney et al., 2013).

A considerable number of psychologists do not feel comfortable incorporating spirituality and religion into therapy. Rosemarin et al. (2013) surveyed a sample of 262 participants who are members of the Association for

Behavioural and Cognitive Therapies (ABCT) and found that 36% of respondents revealed they felt some discomfort addressing spirituality and religion with their clients. Similarly, an Aotearoa New Zealand sample of therapists also disclosed feeling anxious working with spiritual and religious issues in clinical practice (Begum, 2012). A possible reason to why psychologists do not incorporate spirituality and religion into clinical practice is insufficient competence due to a lack of training.

Training

There is generally an absence of training in spirituality and religion within psychology and psychotherapy (Begum, 2012; Florence, 2009; Mueller, 2012). In 1995, an Aotearoa New Zealand study of 24 counsellor trainees at the University of Auckland found that despite the university's overt acknowledgment and acceptance of spirituality, there were no systematic opportunities available to engage this content in the programme (Everts & Agee, 1995). More recent studies suggest that this concern is still relevant in clinical practice. "Despite the increased interest in and acceptance of religion by many psychologists and the American Psychological Association, it still appears that very few supervisees receive the proper training and supervision necessary to competently address religion in therapy" (Aten & Hernandez, 2004, p. 152). This is supported by Eck (2002) who argued that despite the increased awareness of religion and spirituality in mental health it has not been incorporated into training nor practice. For example, Kilmer (2012) argued that many counselling programmes insufficiently address the use of religion and spirituality in practice. Similarly, a UK study found that trainee clinical psychologists received little education and guidance on the topic both academically and in supervision (Begum, 2012). Additionally, 71% of a sample of ABCT members reported having little-to-no training in this area (Rosemarin et al., 2013). Furthermore, a US survey-based study of 87 psychotherapists examined the effects of professional and religious beliefs on clinical judgment (Gerson et al., 2000). The results showed that this sample of therapists had reasonably strong religious beliefs and believed religious issues may be important in therapy but were not sufficiently trained to address these issues.

Spirituality and religion in counselling

There seems to be a larger body of literature regarding spirituality and religion in therapy in the field of counselling than psychology. The discipline of counselling has dedicated more time and effort into recognising the importance of spirituality and religion, and their impact on counselling practice. The Association for Spiritual, Ethical and Religious Values in Counselling (ASERVIC) (2014) is an organisation of more than 4,000 members that has been in development as early as 1951 and believes spiritual and religious values are essential to the development of an individual (ASERVIC, 2016). In 1995, a group of counsellors came together for a summit on spirituality and developed a list of spiritual competencies that was accepted and endorsed by ASERVIC (Cashwell & Watts, 2010). As declared in the American Counselling Association Code of Ethics (2014), counsellors should "recognise diversity and embrace a cross-cultural approach in support of the worth, dignity, potential, and uniqueness of people within their social and cultural contexts" (p. 3). In adherence to this ethical code, ASERVIC is committed to respecting spiritual and religious diversity and strives to integrate spiritual and religious values in counselling practice (ASERVIC, 2016). This illustrates the advancement of the counselling scope in terms of recognising and incorporating spirituality and religion in its practice. ASERVIC published new competencies for addressing religious and spiritual issues in counselling in 2009 (Cashwell & Watts, 2010):

> Culture and Worldview
> 1. The professional counsellor can describe the similarities and differences between spirituality and religion, including the basic beliefs of various spiritual systems, major world religions, agnosticism, and atheism.
> 2. The professional counsellor recognizes that the client's beliefs (or absence of beliefs) about spirituality and/or religion are central to his or her worldview and can influence psychosocial functioning.
> Counsellor Self-Awareness
> 3. The professional counsellor actively explores his or her own attitudes, beliefs, and values about spirituality and/or religion.
> 4. The professional counsellor continuously evaluates the influence of his or her own spiritual and/or religious beliefs and values on the client and the counselling process.
> 5. The professional counsellor can identify the limits of his or her understanding of the client's spiritual and/or religious perspective and is acquainted with religious and spiritual resources, including leaders, who can be avenues for

consultation and to whom the counsellor can refer.

Human and Spiritual Development

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

Communication

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

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

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

Assessment

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

Diagnosis and Treatment

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

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

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

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

In summary, ASERVIC acknowledged that spirituality and religion can affect mental health and that spiritual and religious models of human development and practices as techniques should be applied in counselling.

Hull, Suarez and Hartman (2016) built on these competencies in hopes of increasing the overall clinical competency regarding spirituality in counselling. Recommendations included attending a spiritual gathering that is different from the counsellor's personal belief system (Culture and Worldview), analysing the counsellor's own spiritual and/or religious history (Counsellor Self-Awareness), seeking spiritual mentorship for complex cases (Human and Spiritual Development), developing a professional disclosure statement (Communication), reviewing assessments for spiritual content (Assessment), and developing a spiritual interventions toolbox (Diagnosis and Treatment).

However, despite having these competencies, it may not necessarily be carried out in practice.

Recommendations

Some suggestions on how to integrate spirituality and religion in therapy have been provided in the literature. Aten and Hernandez (2004) identified specific actions that promote psychologists' competence to work with religious clients and issues across eight domains: theoretical orientation, assessment, interpersonal assessment, client conceptualisation, individual and cultural differences, treatment plans and goals, intervention, and professional ethics. Some examples of the recommended actions are: using religious scripture for cognitive restructuring, determining the impact and influence religion has on the client's presenting problem, and developing treatment plans that are compatible with the client's religious values, beliefs and practices.

Eck (2002) also reviewed spiritual practices and disciplines in literature and found that these spiritual interventions can help address dysfunctional thoughts, behaviour and relationships. Eck (2002) suggested that working with spiritual issues in therapy begins with therapists creating a space for spiritual expression by inviting clients to share their spiritual or religious views, values and concerns as they would with any other area of their lives. The researcher recommended an assessment that identifies and explores clients' religion or spirituality as well as a self-assessment of the therapist to determine whether spiritual interventions are within his or her scope of training and experience.

Ideas around ways to enhance overall care of clients by integrating religion into therapy were also generated in a panel discussion in 2008 at the Annual Conference of the British Association of Behavioural and Cognitive Psychotherapy (Waller et al., 2010). Such ideas included sensitively raising religious issues, working jointly with religious and other mental health professionals, and highlighting clients' values such as acceptance and forgiveness (Waller et al., 2010).

Ybañez-Llorente and Smelser (2014) suggested using the tree-ring technique for clients who are experiencing difficulty which arise from spiritual issues. This technique proposes six levels to assist in assessment and the

inclusion of the client's spirituality in counselling (Ybañez-Llorente & Smelser, 2014):

Level 1: Counsellor's self-awareness of spirituality and spiritual
competence
Level 2: Client's spiritual history
Level 3: Client's current spiritual perspective
Level 4: Client's spiritual conflict
Level 5: Client's support system within the religious community
and family system
Level 6: Counsellor's consultation with colleagues, supervisors,
and spiritual leaders

These levels represent aspects of the client's spirituality and allow the counsellor to learn about the client's spiritual development. Questions to facilitate each level or ring of the tree are provided in Ybañez-Llorente and Smelser's (2014) article which has been published by the American Counsellor Association (ACA).

Aten and Worthington (2009) has recommended better clinical definitions of spirituality and religion, greater collaboration between clinicians and clergy, the development and testing of new methods in clinical practice that incorporates both Western and Eastern spirituality and religion, and more clinical research in this area. There is also empirical evidence for CBT that has been adapted into different religions including Judaism and Christianity, which can be used in clinical practice (Waller, Trepka, Collerton & Hawins, 2010).

Spirituality can be incorporated to enhance practice with Māori clients (Hopkirk & Wilson, 2014). There are a range of Māori models of health that incorporate spirituality such as Te Whare Tapa Whā (Durie, 1998). In Aotearoa New Zealand, there is Kaupapa Māori research, which is led by a Māori worldview and principles including Taonga Tuku Iho (cultural aspiration) that allows spiritual awareness to be taken into account (Rangahau, 2016). By acknowledging and accepting the client's spiritual beliefs and values in therapy through the aforementioned recommendations, the therapeutic alliance between the client and practitioner may be enhanced which is fundamental for successful outcomes in therapy (Young et al., 2009).

Rationale

Psychologists have a responsibility to respond to the increasing multi-cultural society both on a national and international level. As Worthington et al. (1996) noted, "the world has changed dramatically, creating a different climate within which to see the role and future of research on religion and counselling" (p. 480). With the shifts in spiritual and religious attitudes and beliefs, it is important to keep up-to-date research in this area.

Current literature predominantly consists of studies from the US and the UK. As Passmore (2003) and Snider and McPhedran (2014) argued, the US has made significant contributions to religious issues in counselling while research and clinical applications have generally been less active in Australia. The author added that discussion around religious issues in counselling are not seen or heard by most Australian psychologists and are largely restricted to interest groups and conference presentations. There is also a shortage of Aotearoa New Zealand studies on this topic despite the country's well-known cultural diversity and emphasis on cultural competence and respect for diversity in clinical practice. This Aotearoa New Zealand study includes spirituality of indigenous peoples.

Additionally, there is a greater interest in spirituality and religion in counselling than psychology, as reflected in literature. Much of the research on spirituality and religion relevant to psychological practice typically involve multiple groups of mental health professionals. While there are a few individual studies on psychologists in this area of research, they are predominantly survey-based and therefore do not explore the experiences of psychologists in this area in depth. The present qualitative study aims to provide rich information and insight in this field of research, and uniquely focus on psychologists and their experiences.

It is also hoped that this study will provide present and future psychologists more understanding and confidence to approach religious and spiritual content in therapy. Another potential benefit of this research is increasing the awareness of participants, clinicians and academics about the role of spirituality in clinical practice.

Methodological approach

Qualitative research is a methodological approach for exploring and understanding meanings that a group or individuals ascribe to a social or human area (Creswell, 2014). There is a general focus on the texture and quality of experience, and how people experience events and make sense of the world (Willig, 2013). The objective of qualitative research is not to predict but rather describe and explain experiences and events (Willig, 2013, p. 9). With this objective, qualitative research can capture and probe personal experiences and unanticipated ideas in this area of research. Qualitative research is also guided by research questions. The research question of the present study is: "What are the experiences of psychologists in integrating spirituality and religion into clinical practice?" Rich and meaningful personal experiences of religion and spirituality in therapy can be expressed well with a qualitative approach.

Social constructionism

Methodology is informed by the ontological and epistemological positions of the researcher. These positions create a theoretical framework from which researchers approach and interpret data (Willig, 2013). Social constructionism has become an increasingly influential approach and researchers with a social constructionist perspective argue that there are different constructions of the world, and that these different constructions have implications for subjectivity or experience (Willig, 2013). There is no single definition or type of social constructionism as the term encompasses a range of approaches which are only united by "a family resemblance" (Burr, 2003, p. 2). Nevertheless, research that takes a social constructionist approach focuses on the manner in which people speak about their experiences and the world (Galbin, 2014). This type of research is concerned with the social construction of knowledge and how versions of reality are constructed by people through the use of language. The present study takes a social constructionist approach and therefore 'religion' and 'spirituality' cannot be collectively defined. From a social constructionist perspective, there may be multiple constructions of religion and spirituality. Hence, the study leaves it open for the participants to define what they mean by

religion and spirituality. These various constructions position participants in different ways and may lead to different experiences for participants in incorporating religion and spirituality into clinical practice.

Reflexivity

A researcher contributes to the construction of meaning throughout the research process and cannot be completely impartial about the subject while conducting research (Willig, 2013). That is, a researcher's involvement in the study influences and informs the research process (Willig, 2013). Reflexivity can be organised into two types: personal reflexivity and epistemological reflexivity.

Epistemological reflexivity involves an awareness of how knowledge has been generated and how the questions posed can give rise to particular constructions or understandings of the topic (Willig, 2013). The researcher believed social constructionism to be the appropriate approach throughout the research process because this approach acknowledges that the experiences of psychologists integrating religion and spirituality into clinical practice may be shaped by how they construct meanings of religion and spirituality. Moreover, the opening questions of the interview which explore the participants' personal meanings of spirituality and religion can inform the researcher about why they integrate spirituality and religion in the way that they do in clinical practice. Therefore, these questions which are aligned with social constructionism allow the researcher to gain a fuller understanding of participants' integration of spirituality and religion in clinical practice.

Personal reflexivity refers to reflecting on how the researcher's values, beliefs, experiences and interests shape his or her research. The researcher's interest in this area of research developed from her own experiences as a counselling psychology student and a Christian. Having personally experienced the significance of faith in mental health, the researcher wanted to learn how people's religion or spirituality can be incorporated into clinical practice to support their recovery. There was limited training in the area of spirituality and religion in the university programme so the researcher chose to study this topic for her practice research project in hopes of learning how to integrate spirituality and religion into therapy and develop her skills in this area as a counselling

psychologist. As the research holds personal significance for the researcher, it was important that this did not lead to any bias in her research. The researcher's supervisors provided feedback throughout the stages of the research process which screened for partiality. The researcher was conscious of her words and behaviour in the interviews as an attempt to not influence the participants. She also endeavoured to be aware of and reflect on her personal feelings that arose in the interviews. In alignment with social constructionism which suggests objectivity is impossible (Burr, 2003), the researcher acknowledged having some influence in the research process. Through her comments and questions in the interviews, the researcher had the opportunity to steer the interview to ensure the research question is answered. It was important to have a good balance between control and allowing space for participants to express their understandings and even redefine the topic. This required continual self-reflection of the researcher during the interview process.

Rigour

It is important to ensure that rigour, or trustworthiness, is established in qualitative research. Researchers have identified common strategies that help achieve rigour such as triangulation, thick description, external auditors, member checking and reflexivity. All these strategies were implemented to add to the rigour of this research. For example, reflexivity was an ongoing process that helped to make the research transparent and open (Jootun, McGhee & Marland, 2009). Information from the research team, participants, interviews and theoretical perspectives were also gathered and triangulated to justify themes and support findings (Creswell, 2014; Hays et al., 2016). Thick and detailed descriptions that convey the findings of the study also led to richer results (Creswell, 2014). They also allow other researchers to apply the findings or replicate the study (Hays et al., 2016). A voice recorder was used during interviews to ensure that findings were authentic representations of data collected (Hays et al., 2016). The current study used Parker's (2005) guidelines on transcription which recommended verbatim accounts that only indicate main speech features such as emotional indicators (e.g. laughing) and pauses (noted as '…'). Member checking is another technique used by the researcher to add

rigour to the research. During the interviews, the researcher summarised information and then questioned participants to determine accuracy. Upon the completion of the study, participants will receive a summary of the findings which would allow them to critically analyse and comment on the findings. All these strategies were used to strengthen the rigour of qualitative research.

Ethical considerations

The researcher ensured that her research is ethically sound and met the current standards of research practice. The ethics application for this study was approved by Auckland University of Technology Ethics Committee (AUTEC Reference number 16/110) prior to data collection (Appendix D).

The present study met ethical principles of responsible caring, informed consent, and confidentiality in accordance to the Code of Ethics (New Zealand Psychological Society, 2002). Participants gave informed consent prior to the interview by reading the Participant Information Sheet (Appendix A) and completing the Consent Form (Appendix B). No deception was involved in this research. The researcher also checked in and debriefed with the participant at the end of the interview. No harm was inflicted on participants and they had the right to withdraw at any time prior to the completion of data collection, as explicitly stated in the Consent Form. Confidentiality was protected in that any identifying information was omitted during transcription and all names were replaced with pseudonyms. Data was stored on a password-protected computer and permanently deleted after the competition of the research. Additionally, personal disclosure of the researcher's Christian faith was disclosed in recruitment emails to participants, as suggested by Braun and Clarke (2013) which can encourage people to participate.

Method

Recruitment

Participants were recruited through supervisor contacts and networks. People who were interested in the study and gave permission to be approached were directly contacted by the researcher through email. The Participant Information Sheet (Appendix A) and an invitation for an interview were included in the emails. The location of the interview was a private meeting room at Auckland University of Technology or their workplace, whichever was most convenient for the participant.

Participants

For participants to be eligible, they had to be registered psychologists who currently practise in Aotearoa New Zealand. Six clinical psychologists located in the Auckland region were recruited for the study. All participants were female and currently work in the District Health Board and/or private practice. Five of the participants identified themselves as Christian and one as spiritual drawing from her Māori culture.

Data collection

It is important to choose a method that allows the researcher to provide answers to his or her research question. While there is some flexibility in regards to a researcher's choice of methods, not all methods are compatible with particular methodologies and epistemologies. Semi-structured interviewing was chosen as the method for data collection. This is a relevant method for the present study and its research question. The study's aim is explorative and this type of interviewing involves open-ended questions that can facilitate new or unanticipated experiences and meaning (Willig, 2013). While this type of interview is systematic, there is freedom to digress and explore topics spontaneously initiated by the participant (Berg, 2009).

Semi-structured interviewing is one of the most widely used methods of data collection in qualitative psychology (Willig, 2013). In semi-structured interviews, the interviewer is able to modify the questions and language to meet

the unique style of each participant. Open-ended questions were used to invite participants to share their personal views, as done by qualitative researchers with the constructionist worldview (Creswell, 2014). Interview content are co-constructions between the interviewee and interviewer (Mann, 2010). In other words, both the interviewer and participant shape the data.

All interview questions were open-ended, as shown in Appendix C. The first two questions ("What does spirituality mean to you?", "What does religion mean to you?") were asked to explore the meaning of 'religion' and 'spirituality' for each participant because such terms are uniquely constructed in a social constructionist framework. The last question of the interview ("Is there anything I have missed you think is important to bring up?") ensures that participants contribute to the construction of the interview content.

All interview questions are provided in Appendix C. The duration of the interviews was approximately an hour. The interviews were recorded on an audio recording device and data was later transferred to non-verbatim transcriptions where light edits were made to remove fillers, stutters and false starts. Parker (1999) highlights that transcription can be a process of analysis because a way of reading and representing what has been said are offered. Transcription produces something different – another text, and it is this translation which is subject to analysis. In social constructionism, the researcher is seen as part of the research and she is involved in editing details of the transcription such as deciding where punctuations fit in sentences.

Method of analysis

The present study employed an inductive, interpretative thematic analysis to analyse the collected data. Thematic analysis became a recognised method after thematic coding was employed for several decades in social sciences (Braun & Clarke, 2013). This type of method identifies and organise patterns in meaning and content in qualitative data (Willig, 2013).

There are several strengths of thematic analysis including its flexibility to work with a broad range of epistemological approaches, research questions, sample sizes, and methods of data collection (Braun & Clarke, 2013). Thematic analysis from a social constructionist approach identifies patterns as socially

produced but does not conduct discursive analysis (Braun & Clarke, 2006). While it recognises the constitutive nature of discourse and language, it does not usually involve a micro-analysis of language.

Interpretation is a part of qualitative research, as researchers would not be able to make sense of their data without some form of interpretation (Willig, 2013). Therefore, both explicit content of what participants have said and interpretations that the researcher makes of what participants have said can be focused in the study's thematic analysis.

Thematic analysis can work with a variety of materials including interview transcripts. Interviewing is a popular method used amongst researchers who employ thematic analysis (Joffe, 2012). Six is the minimum number of participants recommended for small projects where interviews and thematic analysis are employed (Braun & Clarke, 2013). Therefore, the recommended number of participants needed for this particular type of study was met.

According to Braun and Clarke (2006), thematic analysis involves a six-phase process that identifies, analyses and reports themes across a dataset:

1. Familiarising data: Transcription, immersion (multiple readings of data), active readings of data (searching for patterns and meanings), and note-taking initial ideas or codes. Any codes generated at this stage must be developed and defined in the next stage.

2. Generating initial codes: Coding interesting features in the entire dataset in a systematic manner such as colour-coding. It is important to code for as many potential patterns or themes as possible. However, these codes may differ from themes that will be developed later in the analysis.

3. Identifying themes: There is a refocus on a broader level of patterns or themes. Codes are arranged into potential themes. Different codes may be combined into an overarching theme. This may be achieved by using tables, mind-maps or playing around with pieces of paper that have codes written on them.

4. Reviewing themes: Checking themes in relation to codes and the entire dataset, and generating a thematic 'map'. Some themes may overlap and be combined into one theme whereas a larger theme may be broken down into multiple themes.

5. Defining and naming themes: Refining themes and overall story of analysis, generating clear definitions of themes. It is important to ensure that themes do not overlap one another. If this is the case, sub-themes may need to be created.

6. Producing the report: Select vivid examples, relate back to literature and write up a report of the analysis. This report must provide sufficient evidence for the themes drawn from the data. Vivid examples must compellingly illustrate the story and make an argument for the research question.

Results

Four themes were identified from the data: 1) the multiple meanings of spirituality, 2) the importance of spirituality and religion for therapy, 3) integrating religion and spirituality into clinical practice, and 4) barriers that hinder the successful integration of spirituality and religion into clinical practice. A description of sub-themes that were identified within the four themes will also be presented. A summary of the themes and sub-themes are shown in Figure 1.

Theme 1: The multiple meanings of spirituality

This theme describes the multiple meanings of spirituality held by people and is divided into three categories: 1) beliefs, 2) Māori spirituality, and 3) integral view of spirituality.

Sub-theme 1.1. Beliefs

Participants often used the words 'spirituality' and 'beliefs' interchangeably. The meaning of spirituality is diverse and can be associated with multiple beliefs. For Sybil, her "spirituality and religion are all the same thing. They're all about the same relationship with God." Some participants shared a similar view:

> Diana: "Spirituality is like a broad term. It could include specific religious beliefs... For me personally, it would be related to Christianity."

> Anne: "For me specifically, [spirituality] is a belief in God… but also brings with it the religious behaviour or religious practices, going to church, home groups, those sorts of things."

Participants also described spirituality as a broad belief system. Sybil describes how spirituality is "so broad and unique from person to person." Anne also commented that it is about "the bigger picture in terms of the spirit world and the spirit realm." As Diana pointed out, spirituality can also include meanings around nature, music and culture.

Themes		Sub-themes

The meaning of spirituality

- Beliefs
- Māori spirituality
- Integral view of spirituality

The importance of spirituality and religion for therapy

- Relevant
- Beneficial
- Affects the therapeutic relationship

Integrating religion and spirituality into practice

- Flexibility of application to different modalities
- Techniques

Barriers that hinder the successful integration of spirituality and religion into clinical practice

- Lack of training
- Negative attitudes around spirituality and religion
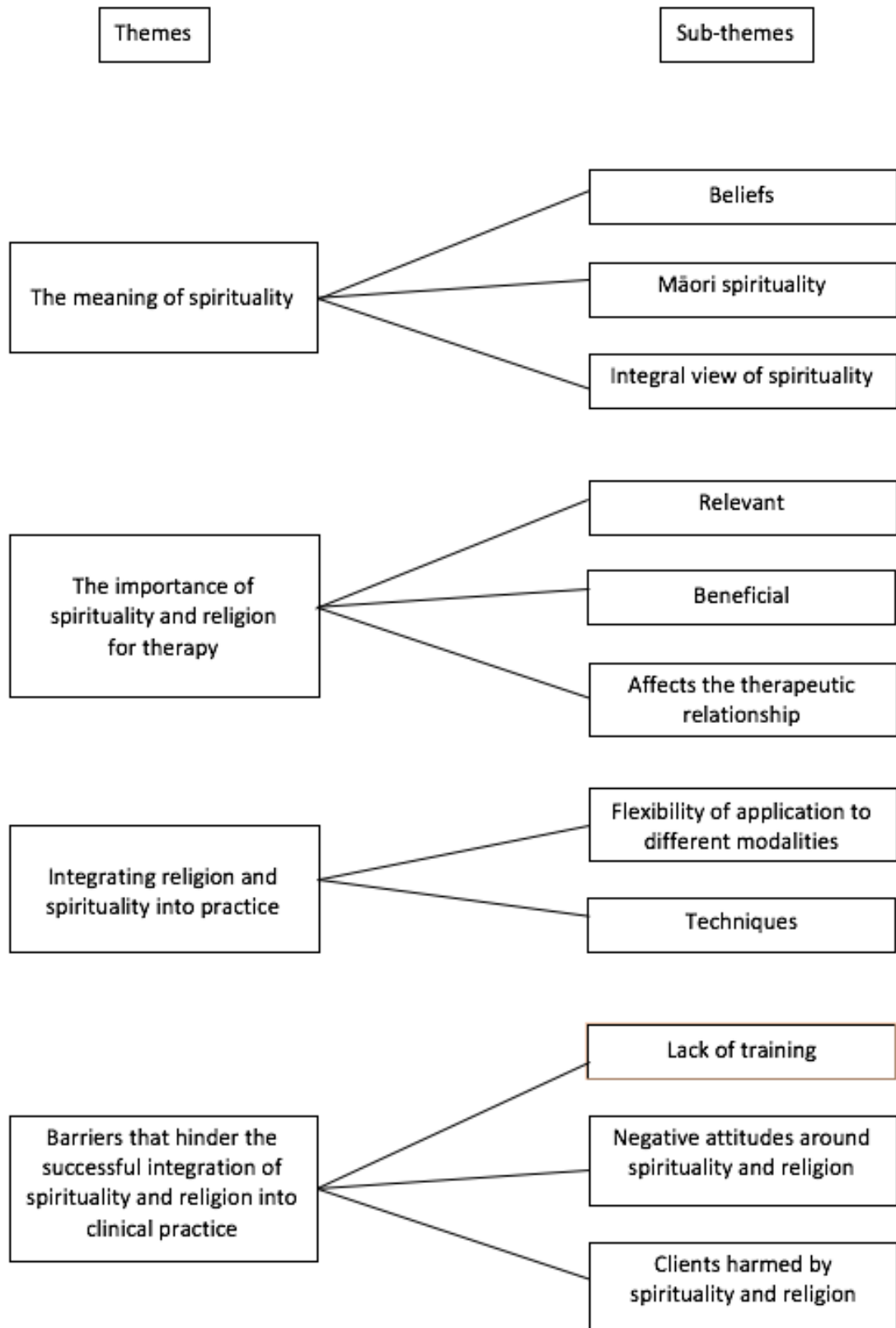- Clients harmed by spirituality and religion

Figure 1. Themes and sub-themes.

Sub-theme 1.2. Māori spirituality

This theme focuses on the spirituality of the indigenous peoples in Aotearoa New Zealand. Spirituality tends to be seen as referring to traditional Māori beliefs, in contrast to Christianity that has arrived with the colonisers, and this adds additional complexity. With Christians, there can be Christian spirituality and Christian religiosity. With Māori, there can be Christian religiosity, Christian spirituality as well as Māori spirituality. There are three aspects mentioned:

Māori spirituality is fundamental to their culture.

> *Juliet: "Spirituality took on a whole different meaning because it meant more than just religion, it meant more than a single god, and much more around gods who were acknowledged and practised…*

Māori spirituality also relates to whakapapa (genealogy), ancestors and nature.

> *Juliet: We were always taught that they were your ancestors… There's a way of being held by an essence of your ancestors… The spiritual stuff about the way we thought about it as Māori was much more about balance and harmony with nature and it makes sense in terms of our whakapapa."*

> *Sybil: "The Māori and Pacific community… have worked so hard to have recognition of the fact that spirituality and religion are really closely intertwined with culture and that they're very significant in people's lives."*

Spirituality as a key element in Māori culture has been recognised in mental health settings in Aotearoa New Zealand. Laurel, for example, comments that, "there's more respect about Maori spirituality" and Juliet describes how:

> *Juliet: "[Spirituality] is talked about a lot even with young people who may not have been brought up and then you've got people who gone through Kaupapa Māori and have a very, very strong spiritual sense and they might do a lot of work on their own in their therapy… [Spirituality] just comes if they*

are Māori… I think it's really easy for Māori because it's embedded into our culture."

Sub-theme 1.3. Integral view of spirituality

Some participants took an integral view of spirituality and defined it as a facet of an individual's life. Spirituality was described as relevant to every individual, irrespective of religion.

Diana: "[Spirituality] is a crucial part, especially if one comes from a more holistic approach.

Laurel: "Spirituality, for me, is at the centre of every human being."

April: "I see spirituality as part of being a whole person, part of a holistic view of a human being that we are an, ideally, integrated system of body, mind, soul, spirit and it's really difficult to separate those from each other. They interact, they interplay, and so I see that spiritual element and spirituality as part of being whole."

One participant conveyed the significance of spirituality in her own life. This illustrated how spirituality can encompass and influence many areas of life.

Laurel: "[Spirituality] means everything. Spirituality, for me being a Christian, is my relationship with God. And it's everything. It contains every other aspect of my life rather than being another aspect of my life. So it's the core of who I am and gives meaning to everything I do."

Theme 2: The importance of spirituality and religion for therapy

This theme signifies the importance of spirituality and religion for therapy and has been organised into three major categories: 1) relevant, 2) beneficial, and 3) affecting the therapeutic relationship.

Sub-theme 2.1. Relevant

Participants noted the relevance of spirituality and religion to therapeutic practice,

> *April: "There's a lot of questions, too, that come up around death. You know, people are facing their own mortality; not just people who might be unwell, but when you start looking at yourself and doing therapy, often you end up with existential type of questions, and so I really enjoy having those conversations with people… a lot of people are interested in spirituality."*

Therapy can be a space in which existential issues are brought to the fore, especially in addressing issues of loss and grief. Diana, for example, describes how she finds it helpful to include some of the clients' religious or spiritual beliefs in grief work. Likewise, Juliet described how spirituality comes up in therapy often around loss and grief:

> *Juliet: "[Spirituality] often comes up when young people lose a parent. They talk about where they've gone and a belief about wanting to believe they're being held somewhere. A belief that they might be watching them have a good life."*

Discussions around spirituality and religion have also been relevant in existential-type therapies for both religious and non-religious clients.

> *April: "Many people are looking for meaning… that's a really human pursuit."*

> *Sybil: "Some of them, are doing a lot of questioning about the meaning of life… 'What if I get a good job, make some money, I make a difference in people's lives but then I die? Why not just kill myself now?' … 'What's the point of all this running around, being busy, having families, doing things that you love but at the end of the day, you're going to die? So what is the ultimate value?' And I feel like those questions are placed in everyone's heart… All of them so far that I have seen, they've been non-religious, they've been atheists, the kids who fit into that category."*

Sub-theme 2.2. Beneficial

Participants shared that spirituality and religion can have positive psychological outcomes for clients and can even be pivotal to their recovery.

Laurel: "I've worked with clients whose spirituality has been the most crucial factor in their recovery. And I've had clients who have increased their connection with God and that has been the exact thing that has gotten them better."

April: "I have clients for whom their faith is a big part of their recovery."

Sybil: "It was like once she reconnected with God, a whole lot of other things seemed to fall into place a lot faster in therapy."

Two participants disclosed how they have benefited from their personal experiences of spirituality and religion in terms of their own mental health and therapy.

Sybil: "I know for myself, the times that I have been most anxious and most low are often also times that I haven't been turning to God."

April: "When I'm feeling the most stretched or overwhelmed or challenged, it is when I come back to… faith that means there's something bigger than me that holds me and reassures me and contains… I've got something that's much bigger than me I fit into, and that's very reassuring… I think first and foremost it fortifies me."

Possible reasons for religious beliefs leading to improvement were suggested by Sybil:

Sybil: "I think it was because it really shifted her self-esteem and her sense of self-confidence and from there she was more willing to reach out to other people and develop friendships and connect with her family so there are times when the work has felt really pivotal for the client."

Sybil: "I've come back to His understanding of unconditional love. Then it's healed a lot of other things in my life as well. It's made a huge impact in my mood, in my ability to overcome difficulties."

Sub-theme 2.3. The effect on the therapeutic relationship

This theme identified the positive and negative effects that spirituality and religion can have on the therapeutic relationship. Participants shared their experiences in therapy when their inclusion of spirituality and religion had a positive impact on the therapeutic relationship. Juliet, Sybil, Anne and Laurel all described the integration of spirituality and religion in therapy as a bonding experience. Laurel, Sybil and Anne also shared that:

Laurel: "It can allow the client to feel understood, empathised with, they know that you get it. And that's a huge part of the therapeutic relationship."

Sybil: "When clients know that they are really safe to talk about their faith and that you have a base-level understanding and you feel so comfortable talking about it you can check out the things where you might see differently and when they know you are not just going to tolerate them talking about it but you're interested genuinely. I think that helps build rapport and trust and openness."

Anne: "If a client is a Christian and knew that I was, and they were struggling, I think it could really enhance the relationship. So it would probably depend on the situation."

These accounts explored how the therapeutic relationship can be strengthened when clients feel that their religion or spirituality are understood and acknowledged.

Two participants discussed caution around self-disclosure of personal beliefs in therapy as the disclosure of religious or spiritual beliefs can be detrimental to the therapeutic relationship if the therapist and client hold different views. One participant in particular shared how this can lead to the termination of therapy:

Laurel: "On the other hand, it can be a barrier if your beliefs are different… I wear a cross and I had a client who took offence to the fact that I was wearing a cross and didn't want to work with me. Also, you've got to be careful in what you say. Sometimes, our view of the world can leak through little things that we don't think have a meaning. So, that same client was offended because… I questioned if things can happen for a reason and for her that was a value statement and it was completely against her view of the world. She didn't like that, and she chose to not work with me anymore… It was the only time that has ever happened to me. So, in my nine years, I've had one experience like that. But it just shows that it could happen."

Similarly, Anne described how,

"It could also put obstacles… if you have a client that is very loudly anti-God (laughs), which we do. Then it's not going to enhance the therapeutic relationship for that client to know that I'm a Christian."

Therefore, the therapeutic relationship can be strengthened or harmed depending on the beliefs of therapists and clients. The implications will be discussed in the discussion section.

Theme 3: Integrating religion and spirituality into practice

This theme relates to how religion and spirituality can be integrated into clinical practice using multiple modalities and other methods. Participants shared a

broad range of experiences around the integration of religion and spirituality into therapy.

Sub-theme 3.1. Flexibility of application to different modalities

Participants have suggested the spirituality and religion may be integrated into several modalities such as cognitive-behavioural therapy (CBT), acceptance and commitment therapy (ACT) and dialectical behavioural therapy (DBT).

CBT

CBT is a psychological intervention that proposes that feelings, thoughts, body and behaviour are interrelated and influence one another (Dobson & Dobson, 2009). It focuses on challenging unhelpful thinking in order to change dysfunctional behaviour, or vice versa. Participants described how cognitive restructuring and challenging dysfunctional thoughts with positive, helpful beliefs that are aligned with a client's spirituality or religion may be useful in therapy.

> Laurel: "When they have a belief skewed, dysfunctional or, what you call in CBT, a core belief that is unhelpful or automatic thoughts that are unhelpful, maybe you can challenge…"

In particular, as Diana suggested, a therapist and client can explore the validity of the client's beliefs. Similarly, Sybil described finding evidence in Scripture that contradicted a client's thoughts around her self-esteem and the importance of other people's views of her.

Socratic questioning was also mentioned by some participants as a way to facilitate clients' thinking in terms of their religious and/or spiritual perspectives:

> Laurel: "If you're working with a Christian client you'd ask, 'What does God show you about this?' or 'What do you know from your reading from

the Bible?', 'What does the Bible say about this?' It's about getting them to think from their religious point of view."

Diana: "Some people who have strong religious kind of beliefs might feel really guilty about certain things. And then, to try to understand why they feel guilty and linking it back to what they actually believe more on a religious level can actually help them just to get that clarity. For instance, why they feel so guilty and then it's about asking them 'Okay in terms of your beliefs what would be helpful in this situation?' When people feel guilty… 'Could someone who has similar beliefs to what you have… What would they recommend you actually do?'"

ACT

This therapy incorporates mindfulness and values-guided behavioural interventions to facilitate psychological flexibility and effective actions that are guided by the client's deepest values (Berryhill & Lechtenberg, 2015). In ACT, clients can discover what is most important to their true self by exploring their values (Santiago & Gall, 2016). Spirituality is one of the values that can be explored in therapy. Diana suggested spirituality and religion work well with values-work and decision-making:

Diana: "[Values] is a concept I find very helpful in therapy as well, especially when people struggle to make decisions, or their feelings, or relationship issues. Just to talk a bit about 'Okay, what are their underlying beliefs?', 'What are their drivers in life, really?', and it helps people to get a better sense of what is really important and what would be really helpful in this situation… So, first, it's about identifying the values and the second part is about using the values to help people make decisions."

DBT

DBT is a third-wave therapy that explores skills of mindfulness, distress tolerance, emotion regulation and interpersonal effectiveness (Linehan,

2015). It uses the wise mind which integrates emotion and reason to achieve a calm and centred state of mind (Linehan, 1993). One participant discussed the suitability of integrating spirituality and religion into DBT, particularly around mindfulness and the wise mind:

Laurel: "So, the wise mind, Christians call the voice of God. It's that voice within that when you're still and quiet, tells you what is the thing that is going to be effective for you. So, it ties very well. So, DBT is changing your behaviour to change your mood. And also using mindfulness as a vehicle to access the wise mind."

Laurel: "Mindfulness is about being present, being in the present moment; that's part of spirituality and Christian spirituality, being in touch with creation and appreciating what's around you and being grateful for things."

Laurel illustrated how mindfulness and Christianity "tie in very well together" and provided examples such as including the Holy Spirit in mindfulness:

Laurel: "Sometimes, when you do body scan exercises and focusing exercises, people become aware of sensory experiences that they didn't know before and that can be part of their experience of the Holy Spirit. And this is different for every Christian. It's no recipe, it's just getting them to be aware with their body. And then it's like, 'Wow, my hands are tingling, my forehead feels funny, or I have the sensation in my chest.' Each one has their own experiences and it's wonderful to bring them out to surface."

Another example Laurel gave was contemplative prayer in mindfulness which involves "being quiet and still, emptying your mind in prayer." She also made links between mindfulness in DBT and Eastern religions and Christianity:

Laurel: "So, mindfulness can be Eastern practice… and it is part of Christian spirituality… And even the person who wrote the DBT book and devised the whole course, Martha Linehan. She was a Catholic then explored Eastern religions and you can see the flavour of spirituality in her teaching."

Sub-theme 3.2. Techniques

In addition to discussing how spirituality and religious could be integrated within specific therapeutic modalities such as CBT, DBT, and ACT, participants recommended several more generic ways in which psychologists can integrate spirituality and religion into therapy. Techniques that were identified include assessment of spirituality and religion, acknowledgment, acceptance, whakapapa, myths and stories, involving kaumatua and kuia, karakia/prayer, and religious scripture.

Assessment, acknowledgment and acceptance

Participants suggest that the integration of spirituality and religion begin from assessment. They advocated that assessments include a comprehensive assessment of the client's spirituality and religion in order to gain a broader understanding of the individual.

Laurel: "It all starts from a better, more thorough assessment, so having part of the assessment that explores spirituality. 'Does the person have a spirituality?', 'How important is it to them?', 'What part of life does it contain?', 'How would they like it integrated in therapy?' And even asking religious persons 'Do you go to church?' and 'How often?', 'Do you go to home groups?', 'Are they helpful?' Exploring how the social part of their church is affecting their lives, just talking specifically about Christian religion, obviously they can be extended to other religions as well. So, starting with assessment and then exploring the person's paradigm.

Diana: "I think it would be really helpful to actually at least just ask a few basic questions whether people have specific beliefs."

Anne discussed further how she asks her clients about their faith and what they reveal dictates how much it is emphasised in the therapy process. This is the result of a thorough assessment.

Some participants also suggested acknowledging and accepting that spirituality and religion may be important to the client and his or her wellbeing.

Diana: "Just acknowledging it… It's hard to work with something if you don't really acknowledge it or believe in it…"

April: "I can't realistically deal with one little piece of a person without these other pieces, at least having an influence or acknowledging that they're there. I might not necessarily acknowledge [spirituality] out loud, but certainly in the way that I'm formulating it and thinking about it, but then that may will allow for that to come into the conversation at another time. So, I guess allowing those various dimensions to be able to come into the process if that's relevant and important, not cutting off or denying those realities."

Results suggest that clients want to know if their therapists will be open to talking about their spirituality or religion. The acknowledgement and acceptance allow clients to freely discuss it in therapy and therefore promotes openness.

Diana: "It opens the door because then they know it gets acknowledged then people are more free to talk about it. Otherwise they do tend to be quiet about it."

April: "I do notice a person who's tentatively testing the waters to see whether they can talk about their faith, and I can get a sense that this is something that's significantly meaningful for them, I encourage them to

talk about it and even then I don't necessarily say what my beliefs are but I will encourage them and validate their experience and their meaning."

Anne: "Clients generally are pretty good at reading us as clinicians, and if they perceive that the clinician would be open to that, then they would share it. But if they perceived they wouldn't."

A participant shared how therapists can acknowledge their clients' spirituality and/or religion by asking questions and exploring what their beliefs are around the issues that they are facing:

Laurel: "If they're depressed, what does their religion say about that? How do they feel about other Christians knowing they're depressed? Are they feeling shame that they're depressed therefore they don't belong? Are they shame issues, guilt issues that they've offended God? So, these are all things that need to be explored in therapy."

Whakapapa, myths and stories

One participant described incorporating whakapapa into her practice with Māori clients:

Juliet: "It's more about spirituality and the essence of that and being able to help clients to see that they were and are descended from these godly beings and they will have those godly qualities, all those nice qualities and they'll also have some of the not-so-nice qualities. And, so, really for me, it's about a balancing up of which of those ancestors are you most listening to and I've used it almost like a self-analysis. If I'm working with young people, 'Which of the gods from your area, Ngāpuhi or wherever do you know about who were either acknowledged for those qualities or who have a particular relevance for you?'"

Juliet also mentioned that myths and stories form whakapapa for Māori. In the context of whakapapa, Māori clients may "discuss some of their belief

systems and… Pūrākau and Pakiwaitara which are Māori stories about creation."

Inclusion of kaumatua and kuia

The involvement of kaumatua and kuia (Māori elders) for specific spiritual practices was identified as a way of integrating Māori spirituality into clinical practice.

> Juliet: "Occasionally, we have had kaumatua and kuia who have lifted tapu off clients, sexually-abused clients... They wanted a name-lifting ceremony and we have been able to provide that with kaumatua and kuia who've got those specific spiritual skills to be able to do that part of the process… There would be a lot of ceremonial stuff around karakia and lifting off the tapu from the abused young person. I must admit, it doesn't come up as often as it used to."

Karakia/prayer

Prayer was identified by most participants as a method of healing that incorporated spirituality and religion into therapy.

> Juliet: "I've had young kids write their own karakia for certain bits where they felt they needed more strength… It creates what we call whakawātea, that space… a clean, cleansing space where you can bring into it what you need to bring into it and the end it will be clean and cleansing again."

> Laurel: "Being able to relate with them on that level and to tap into that spirituality and to pray together and to bring the power of prayer into the therapy session."

> Sybil: "Another client wanted us to start and end every session with prayer, and that's great to start off with, because she was socially anxious and wanted me to do the prayer; and that's fine for a few

sessions and as part of meeting your goals as well, I think it's important for you to be taking that lead as well. So, she agreed she would do the praying after that."

Juliet also described that karakia is more accepted and used with Māori clients in Māori agencies. Similarly, Anne found that prayer was more accepted in cultural settings:

Anne: "If I had a Samoan cultural advisor, they will say to the family 'Do you want to pray?' and if the family says 'Yes', we pray. But it's seen as okay if it's done culturally but not seen as okay if I started the session with 'Does anyone want to pray?' (laughs). That would be seen as odd, which I find curious."

Scripture

Participants also identified bringing in Scripture into therapy as another technique to integrate religion and spirituality into clinical practice. Scripture was used to discuss certain issues and find truth, as described by Sybil and Laurel:

Laurel: "I've heard of a psychologist who brings the Bible into session and looks through the Bible to see what it says about the issues. People that are very strong in their knowledge of the Bible can use that as a tool."

Sybil: "Using Scripture as source of them finding truth that feels; because, for a Christian, if you genuinely believe the Bible is God's Word then it has so much more authority than any thoughts. Any kind of evidence you can come up with yourself or that other people in your life come up with, so it's a very powerful source."

Theme 4: Barriers

Participants have identified barriers to the integration of spirituality and religion in clinical practice. Within this theme, types of barriers have been categorised

into: 1) lack of training, 2) negative attitudes around spirituality and religion, and 3) clients harmed by spirituality and religion.

Sub-theme 4.1. Lack of training

While participants described various ways of integrating spirituality and religion into practice, they also discussed that a key barrier that hinders successful integration of spirituality and religion in therapy was a lack of training.

> *Diana: "And I think including spirituality a bit more in training would really be helpful as well because there are many people out there who believe and acknowledge that it's important to include it; but it's not always so clear how you actually do it in your practice."*

> *Laurel: "I haven't come across [a training] about Christian spirituality… One thing that struck me… is just how much more need there is for training on integrating spirituality in clinical practice and how much our clients need it. I think there was a research by the DHB that asked something about that and showed that people really wanted their spirituality integrated."*

> *Sybil: "Offering some brief training on how you ask those questions and then what do you do if they say, yeah, it's really important and how do you follow up on it, how could you potentially bring it into therapy."*

Sub-theme 4.2. Negative attitudes around spirituality and religion

Resistance, shame and anxiety regarding spirituality and religion from both clients and psychologists were identified. These negative attitudes served as barriers to the incorporation of religion and spirituality in clinical practice.

Resistance and shame

Most participants identified resistance to spirituality and religion in mental health settings and communities that cause difficulties for both clients and psychologists.

Juliet: "For some reason, spirituality is less tolerated than other issues. Abuse, trauma all seems to be tolerated. Even anger, discontent, all of those kinds of stuff, but I think spirituality is less well acknowledged…"

Laurel: "I know that there are a lot of Christian psychologists who don't bring it into therapy and, of course, there's lots of psychologists who don't bring it in at all because they don't have spiritual beliefs… What is sad is that, for a lot of people who don't have spirituality, spirituality is omitted, left out of therapy, and I think that's a big issue, just leaving a huge part of the client's life unexplored."

Results also suggested that there are negative attitudes about spirituality and religion among mental health professionals:

Juliet: "Pākehā people are pretty used to karakia and stuff, but other people coming into New Zealand are often like 'I don't believe in God', 'I don't have to listen to this' and 'I think it's unfair that your religion should overtake my lack of religion'. So, we've had some interesting discussions… often filled with tension and difficulties."

Anne: "That does disappoint me when you hear that someone will present a case in a team environment and they'll say 'Oh, you know the client said that God wants him to change schools or God wants him to go to another church' and people will sort of go 'Pff' and 'Poo poo that', which is a shame."

Anne commented further about how their negative attitudes could lead to pathologising clients' religious or spiritual practices:

Anne: "It used to really irritate me that often mainstream psychiatry and psychology would see that as evidence of disorder if somebody wanted to carry their Bible with them; that meant they were unwell. Or, if somebody had a particular Scripture that they wanted to read, over and over again, that meant that they were unwell and we need to up their

medication or we need to think about other options… But I think, too often, very unwell clients wanting to draw close to God is seen as an illness as opposed to wellness."

As a result, many individuals do not bring up the topic of spirituality and religion in therapy. At the most, Anne commented that "a client's faith may be just mentioned in their notes at the beginning of an assessment and that's about it." Further reflections include:

Juliet: "The spiritual stuff is often the stuff that's left behind. Even though for Māori we have great models which says it's there, but I will tell you that a lot of Māori clinicians leave it out because either they don't believe it themselves or they are worried that it might be off-putting for the young person."

Sybil: "We don't often initiate those conversations, like a lot of people don't actually ask, so, some clients then would probably feel they're not necessarily allowed to talk about it… I think it will probably in their best interest to start doing more routinely because you don't know what you're missing otherwise."

In comparison, counsellors seem to be "much more accepting than psychologists" about religion and spirituality. Juliet noted that:

Juliet: "There are Christian counsellors, and they've got their own association in New Zealand, and they have their own little conferences and stuff. Counsellors do a lot of talking about stuff like that."

Anxiety

Participants also identified anxiety that is experienced by both clients and psychologists in relation to talking about spirituality and religion in therapy.

Laurel: "There can be a lot of fear in practising Christian spirituality or integrating a spirituality… People are really scared of prayer or asking

those questions because they may impose values or they may do the wrong thing.”

April: “When you choose a therapist you want to choose somebody who you feel you can be yourself with, and I think a lot of clients are probably a bit anxious about their faith and whether it’s going to be respected and not dismissed. I think that a lot of Christian clients do come into therapy wondering… they don’t know that the beliefs or attitudes of the therapist will be… I think often they get a little anxious about how open they can be about their faith and whether it’s going to be validated or whether it’s going to be explained a way as some sort of psychological phenomenon that’s not actually real. So, I think my experiences, particularly with Christian clients, is that they are often a little cautious to start with about how they talk about their faith. I think they’re a little cautious, a little reserved… I think for clients for whom it is important that they see somebody who is sympathetic to their faith, of course, it makes a big difference there because they are then relaxed and more confident that they can be open with their own faith. It can be as simple as a female wanting to see a female therapist because there’s a shared ground, but obviously it’s a bit more than that.”

Similarly, Sybil described a sense of mistrust that some clients experience in therapy because their values may not be accepted or aligned with the therapist. Then she shared a case where a Christian client felt very grateful that she could openly discuss her faith:

Sybil: “She felt like that was what she most needed and she said she wouldn’t have felt comfortable raising those things and have the kind of exploration she felt she needed.”

Sub-theme 4.3. Clients harmed by spirituality and religion

This sub-theme focuses on 1) the need for discernment and 2) challenging dysfunctional spiritual and/or religious beliefs when clients are harmed by spirituality and religion. As April commented, “sometimes while faith and belief

can be a very wonderful and powerful strength for people, it can also have its restrictions."

Need for discernment

Participants identified a need for discernment to determine what is psychosis and what is a spiritual experience.

April: "Being able to be discerning about when somebody's faith or the way their faith is being practised is actually problematic, when to challenge it and when to support it, and to be able to have confidence in that discernment."

Anne: "Things like a client who prays regularly to God having that put under the box of disorder or disease and especially if clients say that they hear back from God. That's usually not viewed positively in mental health services, whereas for most of us that's (laughs), you know, part in parcel of a relationship with God."

Juliet: "I think the only concerns I have is when I'm not sure of the difference between when they're spiritual and well, and spiritual and unwell. I think that the concern is when they're very unwell that the way in which they're hearing or feeling held spiritually or religiously is very skewed and that it can actually be harmful for them. Like one of the clients I had had; this whole thing about purity, so, would dress in white even in hospital… so, would do very derogatory stuff to hospital members or be very aggressive or violent towards them when they're unwell."

Laurel: "Things that can be very normal for a Christian and the Christian view of the world such as laying hands and healing people that can be normative and normal but for someone with psychosis that can be a valued idea… I just started discerning a bit more what was psychosis and what was a religious experience."

Challenging dysfunctional spiritual and/or religious beliefs

Some clients present with spiritual and/or religious beliefs that are dysfunctional or unhelpful for their recovery. Participants have shared their experiences of challenging such beliefs in therapy.

April: "Sometimes, I find that religion can be used very powerfully as a defence. People build up all sorts of mechanisms to defend themselves. I'm thinking of a woman I saw years and years and years ago who… it was almost like her faith… she used her faith, unconsciously, as a way of almost not taking responsibility. We used to finish the sessions very often having got to something quite significant, something about her… she had some terrible trauma and it was very difficult for her to talk openly about her pain and her wounds and we would get to a point like we've finally managed to something important and the session would come to a close and I would say let's pick that up next time. And the next time she would come in and she would say 'Oh no that's all fine, God dealt with that.' And I would be so frustrated (laughs) because… not that I don't believe God could deal with it but I felt very strongly that part of God's way of allowing her an opportunity to deal with it was through the relationship she had with me. It was a barrier. It was a way that perhaps was even harder for me to challenge because then here's me put in the position of challenging God, not challenging her defences… I gently and persistently try to challenge my clients around their beliefs and about being authentic and about really connecting with their own sense of self and meaning."

Laurel: "Being open-minded and being respectful of their point of view and their beliefs whilst challenging them gently if they seem to be dysfunctional."

Sybil: "Their relationship with God is marked by this big struggle because they don't have a sense of His love or acceptance… So, with a couple of clients, that's been a big part of our work has been looking at who God

is, where those views have come from and how their experience of God actually relates back to their parents…"

Sybil then shared how this type of work in therapy resulted in clients reconnecting with their faith which lead to positive changes in their mental health.

Conclusion

This chapter presented the results of a thematic analysis on six interview transcripts of clinical psychologists working in Aotearoa New Zealand. It identified meanings of spirituality, the advantages and challenges of integrating spirituality and religion into therapy, and practical suggestions to incorporate spiritual and religious practices into therapy.

Discussion

The purpose of the present study was to explicate the experiences of psychologists in integrating spirituality and religion into their clinical practice. The following section provides a discussion of results within the context of current literature such as the positive experiences and challenges regarding this integration. The ways in which psychologists can incorporate spiritual and religious content into therapy are also discussed.

A key finding of the study was the positive experiences of the integration of spirituality and religion into therapy. When spirituality and religion are included in therapy, clients can benefit from positive effects on their wellbeing. Participants recounted how religion and spirituality had contributed to their clients' recovery. One participant shared working with clients whose close connection to God had led to improvements in their wellbeing. Another participant noted that faith was pivotal for a client's recovery as reconnecting with God shifted her self-esteem and helped her to connect with others. This may be because she felt personally valued by God as Christianity assures believers that they have been created by God for a personal calling (Batson & Stocks, 2004). Christian theologians argued that this message of God's personal love for believers can form a strong sense of self-worth in individuals (Myers, 2008). Similarly, Joshanloo and Daemi (2015) pointed out that the Quran reminds Muslims of their worth and importance and therefore promotes their self-esteem. They also conducted a study in Iran which found that self-esteem mediates the relationship between wellbeing and spirituality (Joshanloo & Daemi, 2015). These findings reinforce the idea that spirituality and religion have positive effects on wellbeing (Chai et al., 2012; Gardner et al., 2014; Hsu et al., 2009; Krägeloh et al., 2015), and indicate the importance of religion and spirituality on people's wellbeing.

The integration of religion and spirituality was also helpful in therapy because of its relevance particularly around the areas of addressing loss, grief, guilt and existential issues. Contemporary researchers have generally agreed that grieving is a multi-dimensional and multi-layered process where a person restructures his or her self, relationships and world to the reality of the loss

(Corr & Doka, 2001). During times of loss and death, clients may explore the meaning of life and the afterlife (Walsh, 2004). Some may find comfort in greater meaning (e.g. they are part of God's greater plan) whereas others may question, distance or even abandon their religious beliefs (Marrone, 1999; Walsh, 2004). In any case, counsellors need to know their clients' spiritual or religious beliefs about death because they may use these beliefs to cope and make meaning out of loss (Frame, 2003). Participants reported that many clients showed interest in spirituality and a higher power, and participants shared spiritual and/or religious conversations with clients around existential questions particularly as they are faced with issues around death or loss. This strengthened Everts and Agee's (1995) advocacy of incorporating spirituality and religion in therapy because of its close relation to issues around grief, loss, and death, and the support in counselling they can provide. By not exploring spiritual and religious beliefs, particularly in the aforementioned areas, therapists could be overlooking a helpful source of counselling support and a critical part of a client's worldview (Begum, 2012; Everts & Agee, 1995).

Despite these findings that suggest the usefulness and importance of integrating spirituality and religion into therapy, it is not often exercised. Participants disclosed that many psychologists do not bring spirituality and religion into therapy because they do not hold spiritual or religious beliefs themselves, or are worried about the clients' reactions. Most participants noted it is not common in their own practice and shared the limited experiences of spirituality and religion in clinical practice they had for the purposes of this research. This is reinforced by Begum (2012) and Delaney et al. (2013) who reported that many psychologists do not assess nor explore their clients' spirituality or religion in therapy. These findings from the UK, US and Aotearoa New Zealand suggest this is a global concern in the psychological field of clinical practice. In adherence to the ethical principles of respect and responsible caring (New Zealand Psychological Society, 2002), psychologists should be responsive to cultural and social diversity and help clients meet their cultural and social needs. As cultural and social diversity includes spirituality and religion, it is encouraged that psychologists integrate spirituality and religion into therapy when it is appropriate.

Another major finding was the challenges experienced by psychologists that hindered the integration of spirituality and religion in clinical practice. In particular, participants experienced and/or witnessed resistance and shame in the area of religion and spirituality. One participant stated that spirituality is less acknowledged and tolerated than other issues such as abuse and anger. In contrast, she found that counsellors talk more about spirituality and religion. This reflects current literature on spirituality and religion in clinical practice which is dominated by studies from the field of counselling. Further, the New Zealand Christian Counsellors Association (NZCCA) (2016) facilitates presentations and annual conferences that explore spirituality and religion in counselling. Certainly in Aotearoa New Zealand, counsellors have shown more interest in this area than psychologists. Similarly, the US discipline of counselling have published studies on spirituality and religion in clinical settings much earlier than the psychological field. Only recently, there has been a surge of psychological studies on spirituality and religion in literature (Aten & Hernandez, 2004; Eck, 2002).

There also seems to be stronger negative attitudes with regards to religion than spirituality. One participant stated that spirituality was viewed more favourably than religion and speculated that this may be due to the increase in the popularity of spirituality and the belief that religion is outdated. This is supported by Vieten et al. (2013) who found that more people are identifying themselves as spiritual but not religious. Researchers have noted negative attitudes towards religion since the early days of psychology when it was generally believed to be pathological and problematic (Azar, 2010; Bartholomew & O'Dea, 1988; Gerson et al., 2000). While there is emerging interest in research on religion and spirituality in the psychological field (Atan & Hernandez, 2004; Eck, 2002), the findings from the present study indicate that resistance and shame are still present with regards to religion in psychological practice today. For example, a participant shared how a psychologist's faith had caused difficulties in an agency and therefore was negatively perceived by her fellow colleagues. This confirmed the finding from Delaney et al. (2013) that negative perceptions of religion exist amongst some psychologists. The implications of these negative attitudes are discussed in the next section.

Feelings of anxiety from both psychologists and clients about bringing in spirituality and religion into therapy were also reported by participants. Clients were hesitant about disclosing their faith because they did not know if it would be acknowledged and validated. This finding is supported by Florence (2009) and Young et al. (2009) who reported that Christian clients fear their faith may be pathologised by non-Christian psychologists. The present study also found that some psychologists were afraid to ask questions around spirituality and religion. This is reinforced by Begum (2012) who found that psychotherapists in Aotearoa New Zealand felt anxious working with spiritual and religious issues in therapy. A survey-based study also revealed that many US psychologists felt uncomfortable addressing religion and spirituality with clients. These findings suggest a lack of confidence to integrate spirituality and religion in clinical practice. As one participant revealed, psychologists are afraid to integrate spirituality because of the negative attitudes or they might be doing it wrong. Training may be a helpful solution to this current issue.

It was unanimously agreed that there is a lack of training in this area of clinical practice. Participants also discussed that many of their clients need spirituality and religion integrated into therapy and psychologists need the training for it. Similarly, UK and Aotearoa New Zealand studies on psychologists and psychotherapists have indicated an absence of training and confidence in this area (Begum 2012; Florence, 2009; Mueller, 2012). This is an ethical concern regarding competence. As participants shared, practitioners need more training in this area as spirituality and religion are relevant and important in clinical practice to many clients.

The present study offers various ways therapists can integrate spirituality and religion into clinical practice, as shared by participants. Participants commented on incorporating spirituality and religion through the use of specific psychological interventions or modalities. In particular, they discussed the relevance of religion and spiritualty for use in CBT, which aims to change unhelpful thinking and behaviour (Dobson & Dobson, 2009). They reflected on how clients' negative or dysfunctional beliefs could be challenged by using key constructs and beliefs fundamental to their religious perspective. This is supported by Aten and Hernandez (2004) and Eck (2002) who recommended using spiritual and/or religious interventions to address dysfunctional thoughts.

DBT was also mentioned as a modality that could fit well with spiritual and religious beliefs. For example, participants suggested that wise mind and mindfulness in DBT could be used appropriately with Eastern religions and Christianity. While mindfulness is traditionally rooted in Buddhism, Trammel (2015) highlighted the congruence between mindfulness and a Christian framework in social work practice because of their recognition of the importance of values. Similarly, the present study discussed this congruence which was found in psychological practice. This supports the generalisability of religious mindfulness in multiple contexts such as therapy.

Furthermore, spirituality and religion were held to fit well with ACT. ACT is a therapeutic orientation that explores the psychological processes of issues clients bring into therapy (Santiago & Gall, 2016). It aims to develop open acceptance, transcendence of immediate thought and emotion, and commitment to value-oriented action (Santiago & Gall, 2016). Spirituality is one of the life domains that is examined in values work in ACT, and values is an integral part of both spirituality and ACT (Dahl, 2015; Frame, 2003). For example, ACT believes suffering arises from individuals' experiences of their experiences, which is similar to some spiritual traditions such as Buddhism (Santiago & Gall, 2016). According to Hayes, Strosahl and Wilson (2012), ACT possesses an inherent spiritual quality. Santiago and Gall (2016) added to this by describing ACT as a spiritually integrated therapeutic modality because it is a value-driven therapy that facilitates transcendence of mental, emotional and physical experience to relieve human suffering, helps clients create life meaning and access spiritual resources, and supports the resolution of spiritual issues. Therefore, spirituality and religion can be appropriately incorporated into CBT and third-wave CBTs such as ACT and DBT which are increasingly popular psychological interventions (Hunot et al., 2013).

Participants also suggested that spiritual and religious content can be integrated as techniques, or methods, to provide additional support in clinical practice. For example, a thorough assessment of a client's spirituality and/or religion was identified as one method. According to the Code of Ethics, psychologists should respect a client's religion to promote ethical and responsible care (New Zealand Psychological Society, 2002). Psychologists need to firstly identify the clients' religion and/or spirituality in order to respect it.

The present study identified multiple meanings of spirituality which reflected the numerous definitions found in literature, as mentioned in the literature review. These diverse meanings suggest that the definition of spirituality may be subjective. Therefore, therapists need to assess the personal meaning of spirituality for a client as that will influence what and how spiritual content is integrated into therapy. As one participant stated, the emphasis of spirituality in therapy would depend on what the clients reveal about their faith and what it means to them. Additionally, a client may be religious but may not wish to explore their faith in therapy or, alternatively, a client may not be religious but would like to explore spiritual or religious content. Hence therapists must do a comprehensive assessment to gain a holistic understanding of the client as well as to decide the extent to which religion and/or spirituality are integrated into therapy. Because it is dependent on the clients and their needs, it is important that the integration of spirituality and religion are client-led. Meeting clients where they are at is a key concept in humanistic psychology which Elkins (2005) argued has always considered spirituality as an integral part of an individual. For example, Maslow (1962), one of the major theoretical architects of the humanistic movement, considered the need for religion or its equivalence to live and understand life as important as sunlight, calcium or love.

Psychologists should also acknowledge and accept the religious and/or spiritual beliefs of their clients (Waller et al., 2010). Participants expressed that acknowledging and involving spirituality and religion in therapy can have a positive impact on the therapeutic relationship, which is fundamental for successful outcomes in therapy (Young et al., 2009). This may occur because understanding and accepting a client's spirituality and/or religion can develop empathy which strengthens the therapeutic relationship (Bohart, Elliot, Greenberg & Watson, 2002; Horvath & Bedi, 2002). Gockel (2011) reinforced this idea with her study where participants conceptualised counsellors' qualities such as empathy, warmth, openness and congruence as spiritual qualities which helped develop their therapeutic relationships. The clients considered spirituality as a key aspect of the therapeutic relationship (Gockel, 2011). So, the incorporation of spirituality and religion can enhance the therapeutic relationship and therefore contribute to successful outcomes in therapy which

reinforces the finding that spirituality and religion can have have positive effects on clients.

A Māori psychologist shared that conversations about whakapapa, myths and stories in relation to self-analysis can also be incorporated to enhance practice particularly with Māori clients. This is reinforced by Hopkirk and Wilson (2014) who noted that spirituality is vital for Māori and can assist in occupational therapies. The participant also commented on the relevance of involving kaumatua and kuia with specific spiritual skills in her treatment with Māori clients. Similarly, Ybañez-Llorente and Smelser (2014) recommended consulting with religious and/or spiritual leaders when clients experience distress from religious or spiritual issues. Additionally, ASERVIC published in their spiritual competencies that professional counsellors should refer clients to or consult spiritual leaders when limited by their own understanding of the client's religious or spiritual perspective (Cashwell & Watts, 2016). Therefore, the involvement of spiritual leaders and the inclusion of whakapapa and stories are some practical ways of integrating spirituality into clinical practice, particularly for Māori.

As a participant said, Māori are fortunate because spirituality is embedded into the Māori culture and Māori services have processes that are aligned to involve spirituality. Therefore, spirituality may be more easily integrated into therapy for Māori than other groups, and psychologists can employ specific practices to ensure spirituality is acknowledged for Māori clients. However, this does not imply that spirituality is well integrated into therapy for Māori clients by psychologists. One participant shared that despite having helpful Māori models for practice, there are many Māori clinicians who leave spirituality out of therapy with their clients. Therefore, the lack of integration of spirituality and religion by psychologists applies to both Māori and non-Māori clients.

Karakia (prayer) and religious scripture were the most common methods of integrating spirituality and/or religion into therapy described by participants. Prayer was used for strength, healing and to open therapy sessions. Knabb (2012) argued that centring prayer was a suitable treatment alternative for many Christians who were in remission from depressive episodes. Bennett also found that incorporating Māori principles such as karakia decreased depressive

symptoms substantially for Māori clients (Bennett, 2009; Bennett, Flett & Babbage, 2008). These findings suggest the positive effects of prayer for clients' wellbeing in clinical contexts and therefore encourage its integration in therapy.

Furthermore, religious scripture was brought into therapy by psychologists to explore religious perspectives on certain issues. For example, a participant noted that the Bible was a very powerful source to 'find truth' and challenge negative thoughts because for Christians the Bible is God's Word and has absolute authority. Moriarty and Hoffman (2007) suggested that there is considerable congruence between religious scripture and CBT. For example, the Bible supports the assumption in CBT that thoughts have significant implications for individuals' wellbeing (Moriarty & Hoffman, 2007). Aten and Hernandez (2004) also recommended religious scripture for cognitive interventions which can provide comfort and relief. While there is little research on this topic of scripture and therapy, the present study indicated that religious scripture has been included in therapy by some psychologists. One participant noted that people with extensive knowledge of the Bible could use it as a tool. Therefore, this technique may be limited to certain psychologists. However, if psychologists lack knowledge in religious scripture but wish to use it in therapy for the benefit of their clients, they could consult a religious leader of the clients' faith.

Implications and recommendations

The present study endeavoured to explicate the experiences of psychologists' integration of spirituality and religion into clinical practice in Aotearoa New Zealand. The study confirms that many psychologists do not integrate spirituality and religion into their clinical practice despite their usefulness and significance in therapy. This may be due to the lack of training and negative attitudes around spirituality and religion that persist in mental health settings and society in general. The stigma around spirituality and religion can prevent the discussion of spiritual and religious content in therapy and therefore the implication is that there needs to be a change in the way psychologists view spirituality and religion. Mental health services, training universities and larger

institutions such as the New Zealand Psychological Society and the New Zealand Psychologists Board need to be aware of these findings and the implications. Additionally, more positive attitudes are necessary for psychologists and clients to feel comfortable about bringing up spirituality and religion in therapy. As well as increasing awareness, actions need to be taken to promote the acceptance of religion and spirituality in mental health services. For example, informative posters that welcome religion and spirituality in therapy can be displayed in waiting rooms to encourage clients to share their religious and/or spiritual beliefs in therapy. Mental health services should also emphasise the need for respect and sensitivity around individuals' religion and spirituality to their staff and offer presentations and trainings on integrating religion and spirituality into clinical practice. Services can also partner with spiritual or religious advisors who can provide informational support to mental health professionals.

Additionally, participants stressed the need for improvement in clinical training in the area of spirituality and religion in Aotearoa New Zealand. Acknowledgement, acceptance and addition of spiritual and religious beliefs in psychological interventions, as discussed in earlier sections, are some practical suggestions for the integration of spirituality and religion into clinical practice that can be learned in training programmes. The various meanings of spirituality provided by psychologists suggest a lack of clarity in this area which may affect the integration of spirituality into clinical practice. Therefore, definition(s) of spirituality and a set of guidelines concerning the integration of spirituality and religion in therapy for psychologists could also be established to promote a cohesive practice in this area. These are important issues to address and change in order to promote the best quality of care for all clients. As Chandler, Holden and Kolander (1992) suggested, one does not have to adhere to a particular theoretical orientation to attend to clients' spiritual component of wellness however one does need appropriate training, an understanding and a willingness to work with their spirituality.

Limitations and future research

Several limitations were identified in the present study. One of the limitations was that the sample was not representative of the clinical psychologists in Aotearoa New Zealand. While six participants were an adequate size for this study design which employed thematic analysis and semi-structured interviews for a practice research project (Braun & Clarke, 2013), it was a small sample size and therefore its findings are not generalisable to all psychologists in Aotearoa New Zealand. Moreover, all participants were religious and/or spiritual and this does not represent the religiosity of psychologists nationally nor globally. Research suggests a lack of religiosity amongst psychologists (Bergin & Jensen, 1990; Delaney et al., 2013; Rosmarin et al., 2013) whereas five out of six participants in the present study identified with a religion. Therefore, this sample may have represented the experiences of a sub-group population of religious and/or spiritual psychologists who integrate religion and spirituality into clinical practice. Participants may have chosen to take part in the study because they are spiritual or religious and wanted to discuss their ideas in this area of research.

Additionally, psychologists who are not spiritual nor religious may not have participated in this study because they did not have much experience integrating religion and spirituality into clinical practice. As one participant suggested, non-religious psychologists may not see the significance of integrating religion in therapy. And as mentioned earlier, Delaney et al. (2013) found that many non-religious psychologists do not believe religion can be beneficial to mental health. It is important to note that a representative sample of psychologists was not intended for the purposes of this study.

While data on the experiences of psychologists who do not have religious and spiritual beliefs was not gathered, this may be an area for future research. Adding onto the studies on psychologists' religiosity (or lack of) in clinical practice, the experiences of non-religious psychologists may widen the scope of insight into this area of research and increase awareness of the importance of religion and spirituality in clinical practice to non-religious psychologists.

Other areas recommended for future research include the exploration of client experiences regarding the integration of spirituality and religion in therapy, and intervention-focused empirical studies. In particular, a study that explores the effectiveness of spirituality and religion-inclusive treatment by incorporating the proposed spiritual and religious competencies for psychologists (Vieten et al., 2013) is encouraged.

Conclusion

The present study explored the experiences of psychologists in integrating religion and spirituality into clinical practice in Aotearoa New Zealand through semi-structured interviewing and thematic analysis. It contributes to the body of literature by highlighting the significance, methods and barriers of integrating religion and spirituality into therapy. The study highlights the importance of integrating spirituality and religion into clinical practice and the need to improve awareness, increase training, and change negative attitudes to achieve successful integration of spirituality and religion in therapy.

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Appendix A

Participant Information Sheet

Project Title
Spirituality and religion in clinical practice: How psychologists in Aotearoa New Zealand integrate spirituality and religion in therapy

An Invitation
Kia Ora,

My name is Dana Lee and I am a Masters student in Psychology at Auckland University of Technology. I am doing this research project to fulfil the requirements of my degree. I chose this topic as I am very interested in spirituality and religion and their effects on mental health. I am training to become a psychologist and am interested in how mental health professionals can integrate spirituality and religion into therapy to promote the client's wellbeing. In our training, we have had only a few classes on spirituality and wellbeing, and I am curious to know how psychologists and psychotherapists incorporate spirituality and religion in their clinical practice.

If you wish to participate in this study, you will be asked to take part in an individual interview with me where I will ask you some questions about your ideas and experiences regarding this topic. Please note that participation is voluntary and you may withdraw at any time prior to the completion of data collection (end of June).

What is the purpose of this research?
The research will be used to write up a dissertation and is likely to be published as a journal article. It is hoped that the study will provide present and future mental health professionals more understanding of and confidence in approaching religious and spiritual content in therapy.

How was I identified and why am I being invited to participate in this research?
Potential participants were contacted using *PsychDirect* (on the New Zealand Psychological Society website) and the New Zealand Association of Psychotherapists (NZAP) register. Professionals who indicated some elements of interest to the research on these publicly available forums were approached.

What will happen in this research?
You will be asked for a one-on-one interview which will be approximately an hour in length. The questions asked will be around your experiences with spirituality and religion in clinical practice as well as your ideas on how to integrate spirituality and religion in therapy. These interviews will be taped for the purposes of transcription. The transcripts will be returned to you for editing prior to the analysis of data.

What are the benefits?

This is a practice research project required to fulfil the requirements of my Masters degree in Psychology. It is hoped that through sharing your experiences this research will inform ways in which clients' welfare, including their spiritual and religious welfare, may be promoted in practice.

How will my privacy be protected?

It may be that your views regarding this topic are already well known within the professional community. In efforts to protect your privacy, any identifying information will be omitted or disguised during transcription and all names will be replaced with pseudonyms.

How do I agree to participate in this research?

By completing a consent form provided by the researcher prior to the interview.
Will I receive feedback on the results of this research?
Please indicate on the consent form if you are interested in receiving feedback of this research. The researcher will then send you a summary of the findings upon the completion of the research.

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 Sonja Goedeke, sonja.goedeke@aut.ac.nz, (+64) 921 9999 EXT. 7186.*
Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz* , 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:
Researcher Contact Details:
Dana Lee
dnx4348@autuni.ac.nz
Project Supervisors Contact Details:
Dr Sonja Goedeke
sonja.goedeke@aut.ac.nz
Dr Chris Krägeloh
chris.krageloh@aut.ac.nz

Appendix B

Consent Form

Project title: *Spirituality and religion in clinical practice: How mental health professionals in Aotearoa New Zealand integrate spirituality and religion in therapy.*
Project Supervisor: **Dr Sonja Goedeke**
Researcher: **Dana Lee**

○ I have read and understood the information provided about this research project in the Information Sheet dated 27 March 2016.
○ I have had an opportunity to ask questions and to have them answered.
○ I understand that the interviews 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:

....………………………………………………………
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Participant's name:

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Participant's contact details:

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Date:

Approved by the Auckland University of Technology Ethics Committee on 5th April 2016 AUTEC Reference number 16/110
Note: The Participant should retain a copy of this form

Appendix C

Interview Questions

1. What does spirituality mean to you?
2. What does religion mean to you?
3. How do you think spirituality and religion fit with mental health?
4. What are some of your experiences working with spiritual or religious clients?
5. How does the therapy change to meet the needs of spiritual or religious clients?
6. What are some considerations and concerns you have when you work with a spiritual or religious client?
7. What challenges have you faced when working with spiritual or religious clients?
8. How can spirituality and/or religion affect the therapeutic relationship?
9. What are your thoughts on exploring spiritual or religious issues in therapy?
10. How should a psychologist/psychotherapist integrate spirituality and/or religion into therapy?
11. What do you think about the integration of spirituality and religion in Aotearoa New Zealand practices?
12. What improvements can be made in clinical practice to ensure spirituality and religion is recognised and addressed in therapy?
13. Is there anything I have missed you think is important to bring up?
14. Any advice for trainees or new psychologists about this topic?

Appendix D

Ethics Approval

27 April 2016
Sonja Goedeke
Faculty of Health and Environmental Sciences

Dear Sonja

Re Ethics Application: **16/110 Spirituality and religion in clinical practice: How mental health professionals in Aotearoa New Zealand integrate spirituality and religion in therapy.**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC). Your ethics application has been approved for three years until 27 April 2019.

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/researchethics. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 27 April 2019;

- A brief report on the status of the project using form EA3, which is available online through http://www.aut.ac.nz/researchethics. This report is to be submitted either when the approval expires on 27 April 2019 or on completion of the project.

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 responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this.

To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research,

Kate O'Connor
Executive Secretary
Auckland University of Technology Ethics Committee