



What Can and Cannot be Said: Discourses of Spirituality and Religion in Clinical Psychology

Submitted by Elizabeth Challis, to the University of Exeter
as a thesis for the degree of Doctor of Clinical Psychology, May 2017

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SCHOOL OF PSYCHOLOGY

DOCTORATE IN CLINICAL PSYCHOLOGY

LITERATURE REVIEW

**The Attitudes, Beliefs and Practices of Clinical Psychologists in the UK
Towards Spirituality and Religion**

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Abstract

Background: Spiritual and religious experiences can impact mental wellbeing positively or negatively. It has been suggested that a comprehensive formulation should include consideration of the way that an individual's spiritual and/or religious beliefs impact on their health and their worldview. Despite national documents recommending that the religious needs of NHS service users be assessed and attended to, the majority of the evidence looking at clinical psychology practice originates in the United States.

Objectives: This review summarises and synthesises the literature examining the attitudes, beliefs and practice of clinical psychologists in the UK around spirituality and religion in professional practice.

Method: Systematic review of all literature to date using PubMed, PsycINFO, and Web of Knowledge databases with a narrative discussion.

Results: Thirteen papers were reviewed, eleven utilising a qualitative methodology and two using a quantitative design.

Conclusions: There is a relatively small cohort of studies examining these topics in the UK, mainly conducted by religiously committed trainee psychologists. The results suggest that clinical psychologists recognise spirituality and religion as potentially important to clients and that they should be discussed when this is the case. However, they report a lack of training and guidance, and find these matters difficult to talk about. Aspects of the NHS and wider culture are viewed as constraining how these topics can be addressed. Areas for further research are outlined.

Keywords: Clinical Psychology, Spirituality, Religion, Culturally Sensitive Practice.

Introduction

The United Kingdom (UK) is a nation of increasing religious diversity. Minority religions are steadily growing, particularly Islam, while a significant but declining percentage of individuals identify as Christian (Office for National Statistics, 2012). Whilst the census may over-represent religious affiliation (Zurlo & Johnson, 2016; YouGov, 2014), many people endorse some non-theistic spiritual beliefs (Ipsos MORI, 2007). Spirituality and religion are personally meaningful for many individuals with mental health difficulties (Hefti, 2011), including depression (Fitchett, Burton, & Sivan, 1997; Bosworth, Park, McQuoid, Hays, & Steffens, 2003), schizophrenia (Mohr, Brandt, Borrás, Gillieron, & Huguelet, 2006), substance misuse (Flynn, Joe, Broome, Simpson, & Brown, 2003) and physical comorbidities (Hebert, Zdaniuk, Schulz, & Scheier, 2009).

National documents recommend attending to the religious and spiritual preferences and needs of service users across a range of settings where clinical psychologists (CPs) work (Commission for Healthcare Audit and Inspection, 2007; Department of Health, 2009; Mental Health Foundation, 2006; Royal College of Psychiatrists, 2013). However, there is no guidance specific to UK psychology, other than that it should be addressed as an area of diversity (British Psychological Society [BPS], 2009; Health Professions Council, 2008) and considered in a culturally sensitive formulation (BPS, 2011).

Practitioners can be hesitant to bring up spirituality if not first introduced by the client (Lee & Baumann, 2013), but many clients who value religion do not raise it with their clinicians (Huguelet, Mohr, Borrás, Gillieron, & Brandt, 2006). Individuals in the UK who hold spiritual beliefs report using them to cope with

psychological problems (Mayers, Leavey, Vallianatou, & Barker, 2007), and voice concerns that secular-based help may be insensitive to their beliefs, or weaken their faith (Mayers et al., 2007; Mitchell & Baker, 2000). Clinicians are often unaware that clients experience conflict between their spiritual beliefs and treatment (Huguelet et al., 2006).

Spirituality may be an unfamiliar concept for many CPs. Research in the United States of America (US) has found that psychologists report lower levels of religious affiliation and spirituality than the general population, or other mental health professions (Bergin & Jensen, 1990; Bilgrave & Deluty, 1998). Worryingly, a mismatch between clinician and client ideology has been linked to reduced therapist empathy, and assessments of clients as less mature and less open to therapy (Gartner, Harmatz, Hohmann, Larson, & Gartner, 1990). Research suggests that many professionals pathologise religious beliefs and practices (McClure & Livingston, 2000), whilst even those who view spirituality as important rarely discuss it (Ellis, Vinson, & Ewigman, 1999).

If spirituality is of high importance to clients, but not addressed in therapeutic work individuals may drop out of therapy, potentially influencing both current and future treatment outcomes. The attitudes of CPs to spirituality may further impact treatment efficacy via the therapeutic alliance, which may be more difficult to establish if CPs take a negative view of those with religious beliefs (Gartner et al, 1990 and McClure & Livingston, 2000) or clients perceive beliefs which are important to them as being overlooked. Without an understanding of CP attitudes to spirituality and religion in the UK this cannot be assessed or addressed.

There is evidence that spiritual beliefs and/or practices benefit physical and emotional wellbeing for some individuals (Larson & Larson, 2003), including those with mental health diagnoses (Mohr et al., 2006). However, religion has been used to legitimise both physical and emotional abuse (Capps, 1992), and religious distress can exacerbate negative emotional states (Exline, Yali, & Lobel, 1999). Negative experiences with spirituality or religion can have a detrimental impact on mental health, increasing a person's sense of alienation, depression and hopelessness (Bussema & Bussema, 2000; Exline, 2002; Exline, Yali, & Sanderson, 2000).

Whether the impact is positive or negative, an individual's spiritual history, practice and beliefs, should be assessed if the most comprehensive support and accurate formulation is to be developed (Hathaway, Scott, & Garver, 2004). Spiritual beliefs and practices can influence individuals' worldviews, social functioning and expressions of distress (Mitchell & Baker, 2000; Richards & Bergin, 1997).

Defining Religion and Spirituality

The terms spirituality and religion are difficult to separate and some have recommended that they remain undifferentiated in research (Oman, 2013; Masters, 2010). However, they are distinct constructs (Saucier & Skrzyńska, 2006), with some groups being more likely to describe themselves as spiritual than religious (Phillips, 2010). Spirituality is considered an umbrella term concerned with individual experiences and personal meaning (Zinnbauer & Pargament, 2005), with religion forming a subset of spirituality as expressed in behaviour and rituals (Huguelet & Koenig, 2009). The term spirituality is used here to encompass both broader spirituality and religion.

Systematic Review Rationale

Despite increasing interest in spirituality within UK clinical psychology, there have been no systematic reviews of the literature to determine how CPs in the UK address this area. Much of the literature on spirituality in clinical psychology practice originates in the US. There are significant cultural and demographic differences between the UK and the US, with religion forming a larger part of mainstream culture in America. Only 15% of the US population report having no religious affiliation (United States Census Bureau, 2010), compared to 25% in England and Wales (Office for National Statistics, 2011). Unlike the UK, some accredited training courses in the US are run by explicitly religious institutions (Campbell, 2011). The substantial variations in healthcare delivery between the two countries also mean that evidence from America must be treated with caution when extrapolating to the UK.

Clinicians' attitudes towards spiritual issues appear to influence whether service users raise them in appointments (Koenig, Bearon, & Dayringer, 1989). Personal attitudes have also been found to influence therapeutic practice more than clinical training (Shafranske & Malony, 1990). It is therefore important to review the current literature to gain an understanding of UK CPs' attitudes towards spirituality in their professional practice.

Aim of the Review

This systematic review aimed answer the question: What are the attitudes, beliefs and practices of CPs in the UK regarding raising, considering or discussing spiritual issues in any part of their practice? Critically evaluating and compiling these findings was considered helpful as research in this area remains sparse, with the majority carried out in the US.

Methods

This systematic review was conducted using an adapted version of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) reporting protocol (Moher, Liberati, Tetzlaff, & Altman, 2009). It is important to follow clear guidelines to ensure that a review is systematic, unbiased and repeatable. The PRISMA guidelines were developed with a focus on randomised trials, and are particularly designed for evaluations of interventions (PRISMA Homepage, 2015). Adaptation was therefore necessary, as some aspects were less relevant for qualitative, non-interventive studies. For example, the focus on PICOS (participants, interventions, comparators, outcomes, study design) required alteration, with participants' occupation and location, and the concepts studied, instead forming the inclusion and exclusion criteria.

As there has not been extensive research into this area in the UK, the search terms were kept broad to ensure all relevant papers would be captured.

The searches comprised the following terms:

- 1 spiritual*
- 2 religio*
- 3 faith
- 4 sacred
- 5 clinical psycholog*
- 6 1 OR 2 OR 3 OR 4
- 7 6 AND 5

The search terms were applied to the PubMed, PsychInfo and Web of Knowledge databases in line with their respective search grammars and structures (Appendix A).

Screening Procedure

Inclusion/Exclusion Criteria. Inclusion criteria were studies where the participants were CPs working and/or training in the UK. Studies which examined more than one profession were included if clinical psychology results were reported separately, or formed the majority (>50%) of the sample with other professions being closely allied to clinical psychology (i.e., counselling psychologists, psychological therapists, counsellors, psychoanalysts). Both quantitative and qualitative papers were included if they constituted research into the beliefs, attitudes, or practices of clinical psychology as related to spirituality. This included surveys of professional practice, questionnaire assessment of beliefs or practice which specifically ask about spiritual or religious matters, and qualitative research addressing spirituality and/or religion.

Initial screening of titles and abstracts was carried out to identify potentially relevant papers. Research papers where the participants were not CPs, for example those looking at nursing attitudes or service user experience, were excluded. Where participants were clearly identified as practising outside the UK papers were also excluded at this stage.

The remaining papers were accessed in full where possible and screened to check that they were original research, carried out with CPs from the UK, and addressing spirituality in relation to clinical practice (including training). Duplicate results or papers based on duplicate data were excluded at this stage. The grey literature was searched via GoogleScholar and the British

Library's electronic record of UK doctoral theses (EThOS), using the terms above. A manual search of the references of identified papers was also carried out. Finally, the resulting cohort of studies was quality assessed, using the critical appraisal skills programme (CASP) qualitative checklist (CASP, 2013) to evaluate qualitative studies in the sample. One point was awarded for each criterion fully met (Appendix B).

Results

The initial searches of the PubMed, PsychInfo and Web of Knowledge databases returned 2,804, 3,728 and 94 results respectively, totalling 6,626 records (including duplications). After applying inclusion and exclusion criteria to titles and abstracts, 28 articles remained. Most papers were excluded from titles only, as they focussed on non-psychology professionals, client outcomes or client population characteristics. After reviewing abstracts, papers which included CPs but were carried out outside the UK (mainly in the US), or did not report original research, were excluded.

Of the 28 papers reviewed in full, 25 were excluded due to not meeting inclusion criteria. Fifteen studies were conducted exclusively outside the UK, with a further three not including UK psychologists in their sample. Three papers did not state where participants lived and worked. However, as all authors worked at US institutions or the articles were published in US state journals, they were excluded. Two papers did not report original research and two were based on duplicated data. Three papers remained for inclusion in the qualitative synthesis.

A search of the grey literature (GoogleScholar and EThOS) was undertaken using the search terms above. Six additional results meeting inclusion criteria were identified from these sources. Finally, a manual search of the references of identified papers returned a further four studies that met inclusion criteria, giving a total of thirteen papers for review.

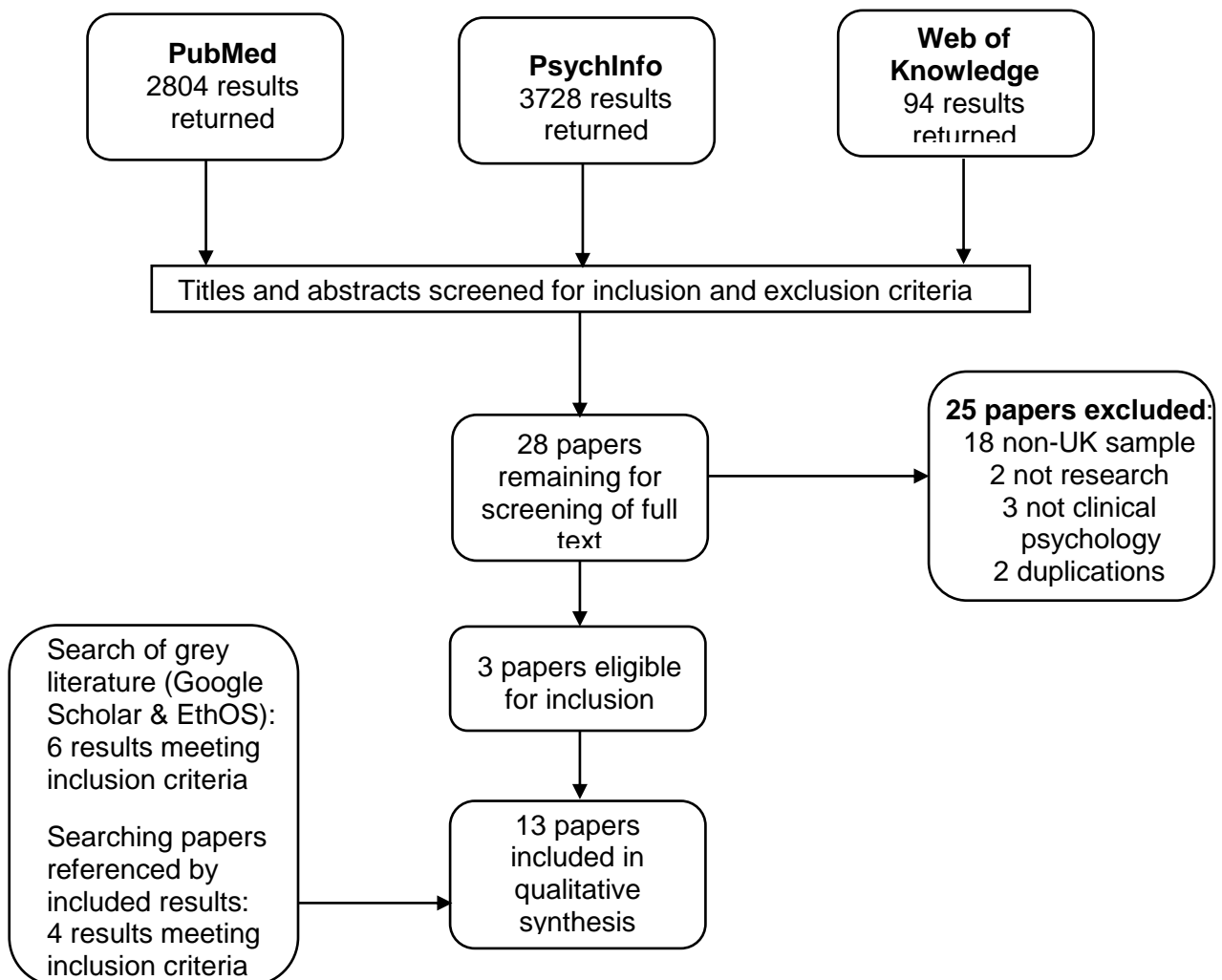


Figure 1. Flow diagram showing the number of records identified and excluded through the different phases of the review.

Table 1
 Summary of main findings from the systematic review

Reference	CASP Score	Aim	Design and Analysis	Data	Risk of bias/ Limitations	Findings and Clinical Relevance
Arshad, R. (2007). <i>How do clinical psychologists work with religious themes in psychosis?</i> (Doctoral dissertation). Retrieved from British Library e-thesis online service (uk.bl.ethos.697398)	7/8	How do clinical psychologists address religious themes in work with individuals with psychosis. Including how their values may impact their practice in this area.	Qualitative study. Grounded Theory analysis of interview transcripts.	Semi structured interviews with 10 qualified clinical psychologists working with psychosis for over a year.	Volunteers likely to have a particular interest in this area. Response rate is not clear. Notes that the identity of the researcher as a British Muslim would influence both the interviews and analysis.	Core category ‘unravelling’ and three main categories; defining roles, unpicking cases and interacting with religious themes. Highlighted limited guidance, lack of reflection and the defined boundaries of the clinical psychologist role (we don’t impose our beliefs and work to reduce distress). Challenging; drawing out discrepancies between the individual’s beliefs and a religious source to which the client attributes authority and meaning. The area is seen as “hard work” in part due to the “impermeability of a higher power” to challenge.
Baker, M. & Wang, M. (2004). Examining connections between values and practice in religiously committed U.K. clinical psychologists. <i>Journal of Psychology and Theology</i> , 32(2), 126-136.	6/8	To investigate the interaction of personal Christian values, and clinical psychological practice.	Qualitative study. Grounded theory analysis of semi-structured phone interview transcripts, based on repertory grid responses.	Telephone interviews with 14 qualified clinical psychologists who were working in the NHS and members of “network of Christians in psychology”.	Lack of consideration of the influence of the researcher on the interviews and analysis. Acknowledges that the sample is likely to hold extreme rather than representative views.	Added value: enhanced performance and spiritual support. Speaking Out: religious disclosure to colleagues, and to clients. This was an area of tension, as training advocated non-disclosure. Hostility and disrespect were expected from colleagues. Challenge: value clash between beliefs and wider society or psychology. Harmony: value congruence with non-judgement and respect. The Big Picture: the sense of broader involvement in kingdom of God and as psychologists who were also members of the Christian community.

<p>Begum, N. (2012). <i>Trainee clinical psychologists talking about religion and spirituality in their work</i> (Doctoral dissertation). Retrieved from British Library e-thesis online service (uk.bl.ethos.575830)</p>	<p>6/8</p>	<p>To explore trainee clinical psychologists' experiences of religion and spirituality, and how this relates to and impacts upon their professional training. Including how trainee clinical psychologists define and understand their own values with regards to religion and spirituality.</p>	<p>Qualitative study. Interpretive phenomenological analysis (IPA) on transcripts of semi-structured interviews.</p>	<p>Eight interviews with 2nd and 3rd year clinical psychology trainees.</p>	<p>Opportunistic sampling via word of mouth. The sample were all white female trainees. Use of IPA at odds with the fact that individuals talked academically rather than about their experience.</p>	<p>Conceptualising religion and spirituality: spirituality as free-flowing, yet 'containing' religion which is rigid. A preference for spirituality was stated, but the majority of discussion covered religion, which seemed easier to consider. Self within a religious/ spiritual context: Influences (e.g. family and school) and identity (e.g. spiritual but not religious or Jewish but not believing in God) Experiences of religion and spirituality as a trainee clinical psychologist: shared framework with clients (or lack of). Belief is not actively explored. Topics are hard to bring to supervision if not shared with supervisor or client. Culture and stereotypes, assuming more relevance for ethnic minorities. 'There's no space for religion'; attributing blame. Clinical psychology as tending not to address religion and spirituality although it could. The profession as mirroring secular society and scientist-practitioner model being inconsistent with religion or spirituality. Facilitating religion and spirituality – finding less stigmatising words to use (e.g. faith, strengths or values rather than spirituality/religion) and struggling to articulate themselves, as these topics are difficult to think and talk about.</p>
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<p>Betteridge, S. (2012). <i>Exploring the clinical experiences of Muslim psychologists in the UK when working with religion in therapy</i> (Doctoral dissertation). Retrieved from British Library e-thesis online service (uk.bl.ethos.637577)</p>	<p>6/8</p>	<p>How do Muslim psychologists trained in the UK experience religion in a therapeutic setting and what does it mean to them? How do the religious beliefs of Muslim psychologists in the UK impact upon their therapeutic approach with religious clients?</p>	<p>Qualitative study. Grounded theory analysis of semi-structured interview transcripts.</p>	<p>Interviews with six qualified psychologists who identified as Muslim. Four clinical psychologists, two counselling psychologists.</p>	<p>Sampling bias due to emailing people whose names appeared to be Muslim. Lack of clarity in write up between cultural and religious Muslim identities of participants.</p>	<p>Religious journeys in therapy: Important to listen, give permission to discuss religion, respect potential importance and be at ease with religious language. Therapeutic approaches: Adapt models to fit with the client and their religious beliefs; use explicitly religious strategies; identify and encourage religious strategies used previously. Therapeutic relationship: Matching religion may not be beneficial. Therapists enjoy work with shared beliefs more. When relevant, difference should be proactively addressed. Therapist' identity: Personal beliefs impact management of religion in therapy. Disclosure was seen as complicated by religious dress and most helpful to other Muslims. Context of therapy: NHS limits time, modality, and discussion of religion. Cultural context of 'islamophobia'.</p>
<p>Crossley, J. P. & Salter, D. P. (2005). A question of finding harmony: A grounded theory study of clinical psychologists' experience of addressing spiritual beliefs in therapy. <i>Psychology and Psychotherapy: Theory, Research and Practice</i>, 78, 295–313.</p>	<p>5/8</p>	<p>To develop an account of the way in which clinical psychologists understand and address spirituality within therapy.</p>	<p>Qualitative study. Grounded theory analysis of semi-structured interview transcripts.</p>	<p>Interview transcripts with eight qualified clinical psychologists</p>	<p>Relationship between researcher and participants not adequately considered. Potential sampling bias, individuals volunteered, response rate not clear.</p>	<p>Spirituality as an elusive concept, avoided in clinical psychology due to cultural unease, personal irrelevance and lack of familiarity with appropriate language. Participants aimed to understand and respect client beliefs and to suspend judgment. This became difficult when beliefs were contributing to distress. They would then disengage from the beliefs, seek understanding that reduces distress but fits with beliefs, or refer on to a religious leader.</p>

<p>Harbidge, P. R. (2015). <i>An exploration of how clinical psychologists make sense of the roles of religion and spirituality in their clinical work with adults who have experienced trauma</i> (Doctoral dissertation). Retrieved from British Library e-thesis online service (uk.bl.ethos.667987).</p>	<p>7/8</p>	<p>To explore: How clinical psychologists define and understand their own values with regard to religion and spirituality. The role of religion and spirituality within clinical psychologists' therapeutic work with adults who have experienced trauma.</p>	<p>Qualitative study. Thematic analysis of transcripts of semi-structured interviews.</p>	<p>Interview transcripts with eight qualified clinical psychologists with experience of working with trauma.</p>	<p>Recruitment methods are not clearly stated. Researcher acknowledges that her identity as a Christian may impact the interviews and analysis. All female sample.</p>	<p>Participants felt more connected with spirituality than religion. They found these topics difficult to discuss and their talk contained contradictions. The influence of personal experiences and psychological theory was noted. Participants felt there was a lack of psychological theory beyond religion as symbolic or a psychological defence. Wider contexts: NHS time constraints, the medical model, radicalisation and terrorism all influence practice. Trauma: Theoretical definition versus subjective experience. Religion as an anchor in extreme distress and central to meaning making, which can be helpful or can increase distress. Aim to be curious, to value client's beliefs, and to notice difference. However, participants could give few examples of working with these topics.</p>
<p>Malins, S. (2011). <i>Clinical psychologists' experiences of addressing spiritual issues in supervision: An interpretative phenomenological analysis</i> (Doctoral dissertation). Retrieved from British Library e-thesis online service (uk.bl.ethos.580379)</p>	<p>6/8</p>	<p>To explore how clinical psychologists address spiritual issues in supervision.</p>	<p>Qualitative study. Interpretive phenomenological analysis on transcripts of semi-structured interviews.</p>	<p>Interview transcripts with seven qualified clinical psychologists.</p>	<p>Recruitment biased to those who had successfully raised the topic in supervision. Impact of the religious beliefs of researcher not considered.</p>	<p>The Ineffable Nature of Spirituality: Spirituality as difficult to put into words and hard to challenge. Struggles with Spirituality: Tension between exploring clients' experiences and psychological theory. Caution about revealing personal views due to potential judgment from colleagues. Negotiating Struggles: Recognising what they do get from supervision and that risk has to be a priority. Substituting acceptable terms such as existential questions or death anxiety for spiritual or religious terms.</p>

<p>Mills, J. (2010). <i>An exploration of trainee clinical psychologists' experiences of engaging with psycho spiritual issues in clinical practice</i> (Doctoral dissertation). Retrieved from British Library e-thesis online service (uk.bl.ethos.522435)</p>	<p>6/8</p>	<p>To explore trainee psychologist's experience of engaging with psycho spiritual constructs in clinical practice.</p>	<p>Questionnaires sent to clinical psychology course staff, asking about provision of training on spirituality.</p> <p>Interviews with third year trainees.</p>	<p>12 courses responded to questionnaire asking about training provision</p> <p>Eight individual interviews asking about experiences.</p>	<p>Sample bias. 75% described themselves as religious. Lack of consideration of the impact of researcher's own faith on interviews or analysis. All female sample.</p>	<p>Range of teaching reported: 0-2.5 days (25% = 0). Provision of training on religion and spirituality was seen as inadequate. Scientist practitioner model viewed as reducing openness to spiritual ideas. Personal history and training were recognised as impacting practice. Existential issues: dilemmas arose around life and death issues, which participants felt unprepared to discuss. Locus of control: Internal barriers: fear of compromising the therapeutic relationship through bias, ignorance, invested interest & personal disclosure. External barriers: NHS philosophies; socio-political views; lack of training or professional guidelines, psychology's lack of clarity on including religion and spirituality into clinical practice. Personal beliefs as causing tension around disclosure, confidentiality, bias, assumptions and causing offence.</p>
<p>Mulla, A. (2012). <i>How British NHS Clinical Psychologists talk about their experiences of considering spirituality in therapeutic sessions</i> (Doctoral dissertation). Retrieved from British Library e-thesis online service (uk.bl.ethos.542399)</p>	<p>5/8</p>	<p>How do clinical psychologists talk about their experiences of dealing with spirituality in therapeutic sessions, the clinical skills required and how these skills develop?</p>	<p>Qualitative study. Grounded theory analysis of interview transcripts.</p>	<p>Interviews with 12 qualified clinical psychologists working in the NHS.</p>	<p>Lack of clarity about how the final participants were recruited. Researcher acknowledges the impact of her Muslim faith and dress on the interviews and analysis.</p>	<p>Including people's spiritual beliefs was seen to improve engagement and outcome. Tolerance, open discussion and better training were desired. Competence as based on experience, knowledge, confidence and training. Negative staff reactions to discussing spirituality were reported, resulting in avoidance in discussions or training. Religion as a 'luxury topic' and not a priority, particularly in supervision. Spirituality located in the otherness of patients, including race.</p>

<p>Myers, J. & Baker, M. (1998). Religiously committed clinical psychologists, talking. <i>Clinical Psychology Forum</i>, 117, 30-32.</p>	4/8	Not clearly stated.	Qualitative study. Grounded theory analysis of interview transcripts.	Interviews with 5 religiously committed NHS clinical psychologists.	Recruitment methods not clear. All female sample. Lack of clarity in aims of the research. No consideration of the impact of the researcher on the research.	Capabilities of religious psychologists: Attunement to client (religious) issues. Religious understanding could inform assessment and intervention. Professional self-care: linking with the infinite and energising work. Serious inattention paid to the religious dimension: Neglect of client's religious concerns by secular colleagues, negative talk towards religion in the workplace. Concerns not shared as expected them to be dismissed. Psychological theory and training were seen to overlook religion, perpetuating neglect.
<p>Read, R., Moberly, N. J., Salter, D., & Broome, M. R. (2016). Concepts of mental disorders in trainee clinical psychologists. <i>Clinical Psychology and Psychotherapy</i>. DOI: 10.1002/cpp.2013</p>	N/A	To explore the attitudes of trainee clinical psychologists towards mental disorders.	Online questionnaire. Quantitative analysis.	Maudsley Attitude Questionnaire. (MAQ) Responses on a Likert scale. 289 respondents.	Not clear what proportion of those invited to take part responded to the questionnaire. Acknowledges that the MAQ has not been validated with a clinical psychology sample.	The hierarchy of model endorsement (from most to least) was: social realist, social constructionist, cognitive, psychodynamic, behavioural, biological, nihilist and spiritual [with the mean score for spiritual falling between disagree and strongly disagree across all four components for all four diagnoses]. Psychologists endorsed the spiritual model more strongly than psychiatrists for schizophrenia but not for the other diagnostic categories. A significant association between religion and a "psychodynamic-spiritual" dimension was found. The atheist group had a significantly lower average score on the psychodynamic-spiritual dimension than the Christian, agnostic and no religion groups.

<p>Smiley, T. (2001a). <i>Non-religious psychologists talking: What happens when a psychologist who is not committed to any religion encounters religious beliefs from clients?</i> (Unpublished qualitative research project). Retrieved from British Library e-thesis online service (uk.bl.ethos.699806)</p>	<p>5/8</p>	<p>To explore what happens when a psychologist who is not committed to a particular religion encounters religious beliefs from clients.</p>	<p>Qualitative study. Interpretive phenomenological analysis on interview transcripts.</p>	<p>Interviews with six psychologists (five clinical, one counselling) without religious affiliation or belief.</p>	<p>Impact of the researcher on the process of research is not considered. Recruitment process and sample population not clear.</p>	<p>Dominant theme was the difference between therapist and client beliefs, particularly ignorance about client beliefs, which was seen as potentially positive or negative, and disagreement with client beliefs, which was primarily seen as harmful to engagement. Including religion in clinical work was rare. When raised most said it might be in the formulation but less agreement on inclusion in intervention planning. All discussed potential negative impacts of religion, five of six discussed potential positive impacts.</p>
<p>Smiley, T. (2001b). <i>Clinical psychology and religion: A survey of the attitudes and practices of clinical psychologists in South East England</i> (Doctoral dissertation). Retrieved from British Library e-thesis online service (uk.bl.ethos.699806)</p>	<p>N/A</p>	<p>Survey the religious orientations and attitudes of a population of clinical psychologists and their experience of, and approach to, religion in the clinical setting.</p>	<p>Descriptive statistics. Comparisons between different groups and with research carried out in the USA.</p>	<p>Developed a survey based on past research. Sent by post to clinical psychologists working in the South Thames Region. 246 responses.</p>	<p>Likely bias in those taking the time to respond. Use of a scale developed for the research rather than validated or previously used tools.</p>	<p>62% of respondents did not identify with a religion. 52% reported non-traditional forms of spirituality (NTS) as important in their lives. 68% indicated religious affiliation or value of NTS. 56% say therapy can be conducted independent of metaphysical beliefs. 73% disagreed that therapy is more helpful when beliefs are shared. 76% of respondents felt it was often or always appropriate to consider client religious values, but only 36% felt it was appropriate to often or always ask about them at assessment. The most frequently reported religious issues were existential (19%). Religious psychologists were more likely to report that their orientation influences and enhances clinical work.</p>

Findings

A summary of the 13 studies included for review is presented in Table 1. The majority of the research utilized qualitative methods, with only two papers following a quantitative design. Eleven studies conducted interviews with CPs, analysed using: grounded theory (six papers), IPA (four papers) or thematic analysis (one paper). Nine studies were conducted with qualified psychologists, two with trainees. Two focused on particular areas of work, trauma (Harbidge, 2015), and psychosis (Arshad, 2007). Four identified participants based on their beliefs: no religion (Smiley, 2001a), Muslim (Betteridge, 2012) or Christian (Baker & Wang, 2004; Myers & Baker, 1998). One paper selected participants who had raised spirituality in supervision (Malins, 2011).

The quantitative studies administered questionnaires to CPs. One was developed specifically for the study in question based on prior research (Smiley, 2001b) and administered by post to CPs working in South East England. The other delivered the Maudsley Attitude Questionnaire (MAQ) to clinical psychology trainees online. Smiley (2001b) found that although the majority (62%) of respondents did not identify with a religion, a minority could be considered “strongly religious” (18%), and 52% valued non-traditional forms of spirituality. Although roughly similar proportions of religious and non-religious psychologists believed that therapy can be offered without the influence of one’s metaphysical beliefs (an average of 56%), more religious psychologists reported that their beliefs impact on, and enhance, their practice. A strong majority (76%) felt it was appropriate to consider client religious values, but only 36% felt it was appropriate to routinely ask about them at assessment. When asked to provide examples of the sorts of religious issues clients bring to

therapy, the most common category was existential issues (19% of responses), although there was variation depending on specialism.

The MAQ was developed to assess trainee psychiatrists' concepts of mental illness (Harland et al., 2009). It examines eight conceptual models (biological, cognitive, behavioural, psychodynamic, social realist, social constructionist, nihilist, spiritual) across the domains of aetiology, classification, research and treatment, for four diagnoses. Read et al. (2016) found that trainee psychologists endorse the spiritual model for schizophrenia more than trainee psychiatrists, although the spiritual model was the least endorsed overall. Three components were identified which accounted for 57.54% of the variance of the aggregated attitude scores, loading psychodynamic and spiritual understandings onto one dimension. Individuals identifying as atheists were less likely than their peers to endorse this understanding of mental health diagnoses.

The aims of the studies were all exploratory, looking to investigate how religious or spiritual topics are conceptualized, addressed in clinical practice, and/or raised in supervision. The impact of personal beliefs on this process was included for seven studies (Arshad, 2007; Baker & Wang, 2004; Begum, 2012; Betteridge, 2012; Harbidge, 2015; Read et al., 2016; Smiley, 2001b).

There were several themes which occurred consistently across most qualitative studies. These included participants reporting insufficient training, theory and/or guidance on addressing spiritual issues in clinical practice (Arshad, 2007; Baker & Wang, 2004; Harbidge, 2015; Malins, 2011; Mills, 2010; Mulla, 2012; Myers & Baker, 1998). Spirituality was described as hard to discuss and to put into language (Begum, 2012; Crossley & Salter, 2005;

Harbidge, 2015; Malins, 2011) and in line with the BPS code of ethics and conduct (BPS, 2009) the importance of maintaining a curious, open therapeutic stance which respects and addresses differences in beliefs was emphasized (Arshad, 2007; Betteridge, 2012; Crossley & Salter, 2005; Harbidge, 2015; Malins, 2011). However, in Harbidge (2015) it was noted that although these therapeutic aims were widely endorsed, when requested, few examples of engaging with spirituality in practice were forthcoming.

The impact of wider context was also noted across several studies. NHS culture and time constraints of public sector work were seen as limiting what can be discussed, and spirituality was reported to be a secondary, 'luxury' topic (Betteridge, 2012; Harbidge, 2015; Malins, 2011; Mills, 2010; Mulla, 2012). The scientist-practitioner model espoused by clinical psychology was considered to be at odds with openness to spiritual ideas in two studies (Begum, 2012; Mills, 2010).

A reluctance to disclose one's own position to colleagues or clients was also reported in several studies (Baker & Wang, 2004; Betteridge, 2012; Malins, 2011; Mills, 2010). This may link to the wider social discomfort around these topics which was identified (Betteridge, 2012; Crossley & Salter, 2005; Harbidge, 2015), and to individuals' expectation of negative reactions from colleagues (Baker & Wang, 2004; Betteridge, 2012; Malins, 2011; Mulla, 2012; Myers & Baker, 1998). Three of the five studies where negative colleague reactions were reported or anticipated were those which specifically interviewed religious CPs. It may be that the experience of being a religious psychologist working in the NHS increases the expectation of a hostile response. As Malins (2011) and Mulla (2012) did not report the levels of religiosity in their samples, it

is not possible to examine its impact. The sense of risk in discussing these topics in a work setting contrasts with Harbidge's (2015) report that participants talked about these topics lightly. This difference may partially be due to the majority of Harbidge's sample having no religious affiliation.

Participants in qualitative studies that specifically recruited religious individuals viewed their religiosity as enhancing their ability to engage with spirituality, and bolstering personal resilience at work (Baker & Wang, 2004; Betteridge, 2012; Myers & Baker, 1998). This is consistent with Smiley's (2001b) finding that a greater proportion of religious individuals than non-religious individuals, reported that their beliefs enhanced clinical practice.

Beyond these core themes, disparate findings were reported across the studies, in part reflecting variations in the research questions investigated and methods of analysis. The influence of past experiences on current practice was recognised (Begum, 2012; Harbidge, 2015; Mills, 2010), and participants described feeling more comfortable with spirituality than religion (Begum, 2012; Harbidge, 2015). An increased sense of difficulty was reported when aspects of clients' beliefs were disagreed with (Smiley, 2001a) or appeared to contribute to client distress (Crossley & Salter, 2005). Some studies reported an acknowledgement that religion can be either helpful or detrimental depending on the meanings made and how religious beliefs relate to negative experiences (Crossley & Salter, 2005; Harbidge, 2015; Smiley, 2001a).

One study reported that participants aimed to challenge unhelpful religious beliefs, but saw this area as 'hard work' (Arshad, 2007). Trainees in Mill's (2010) study reported fearing being seen as biased or ignorant, and that their lack of expertise may damage the therapeutic relationship. Similarly, Smiley's

(2001a) non-religious psychologists spoke of their ignorance regarding religious issues. Two studies reported that these topics may be rephrased in order to be acceptable in clinical settings, such as referring to 'existential issues' or 'values' (Begum, 2012; Malins, 2011). Mulla (2012) noted that her participants distanced themselves from religion, viewing it as 'other'.

Discussion

This review covered thirteen papers, eleven qualitative interview studies and two quantitative questionnaire studies. Psychologists taking part in the research tended to report a lack of training and guidance in this area, and discomfort with the topic. Overall, religiously committed individuals are more likely to view their beliefs as positively influencing their practice, and report reluctance to disclose these beliefs at work. Trainee psychologists do not endorse a spiritual understanding of mental illness, but are less opposed to this than psychiatry trainees. NHS culture, societal attitudes and the scientist-practitioner model were all reported as constraining the profession's engagement with these topics. The importance of maintaining a curious and open stance which respects clients' beliefs and addresses difference in therapy was also highlighted.

A notable limitation of this review is the high proportion of unpublished doctoral theses included. Whilst including unpublished studies in a systematic review when eligible and appropriate can help to minimise publication bias (Higgins & Green, 2011), it can introduce other biases. For example, researchers may be more reluctant to share unpublished studies with no significant results, and unpublished studies may be poorer quality than published studies (Egger, Jüni, Bartlett, Holenstein, & Sterne, 2003), although

this has been disputed (Hopewell, 2004). The absence of peer review which can call unpublished studies into question (Higgins & Green, 2011), is less relevant for the studies included here, as they have been examined at doctoral level. Whilst most of the unpublished studies scored reasonably on the CASP, scores on rating scales are themselves prone to bias (Petticrew & Roberts, 2006).

A further limitation of this review is the lack of availability of a second researcher to assess the eligibility of a portion of search results for inclusion. Similarly due to a lack of resources, inherent in undertaking a review as part of a doctoral research project, it was not possible to include a second rater to check the assessment of study quality.

The lack of publication may indicate that this area is not a priority for clinical psychology, or may be an artefact of the context in which the research was generated, as many doctoral theses are not submitted for publication. The research reviewed spans two decades; this has increased over the last five years, with almost half the studies being carried out in that time. This suggests interest in these areas is increasing. A lack of training and guidance was raised in even the most recent qualitative research (Harbidge, 2015), indicating that the lack of publication has resulted in poor dissemination of the results and minimal impact on training.

All of the studies were undertaken as part of doctoral training. This may have made themes related to training quality particularly salient. Similarly, of the twelve authors, nine have their own religious faith (six Christians and three Muslims), and two reported religious heritage but current non-practice (one Jewish, one Muslim). Only for one study was the spiritual background of the

researcher not discernable. The religious beliefs of the researchers may introduce bias at various stages. It may affect the choice of research question or methodology. For qualitative research, it may influence the interview schedule, as well as impacting on analysis and the salience of different themes. In some studies the potential influence of the researcher on the interviews or on the development of themes during analysis was acknowledged. Attempts to address this were made in some studies, for example, by making possible concerns explicit in the interview, or asking supervisors and non-religious peers to check qualitative analysis.

As all of the studies relied on individuals volunteering to take part, the participants were more likely to be interested in, or have strong views about, spirituality. This is the case for all except Read et al. (2016), which did not focus solely on spirituality. The extent of this bias could not be fully assessed across all studies as several did not report the proportion of the total population that took part.

One author acknowledged that, because the topic was uncomfortable, people talked generally rather than about their personal experiences, making IPA less appropriate as a method of analysis. This discomfort may have introduced a bias across the qualitative papers, with participants potentially speaking in abstract and politically correct ways.

The literature reviewed above has all been based on either questionnaire or individual interview data. It could be argued that research has failed to attend to the social aspect of decision making and influence of professional training, culture, and colleagues on values and practice (Goffman, 1986). Future research should examine the impact of professional discourses and group

dynamics on how these topics may, or may not, be addressed in training cohorts and staff teams. As it is designed and delivered, the impact of training on staff and clients should be studied, with training modified and reassessed on the basis of the findings.

Questionnaire research has looked at attitudes in the South East of England. It would be helpful for this to be repeated in other areas of the UK to see whether responses differ. Building on the consistent report of a lack of training in this area, future research could examine the effectiveness and acceptability of proposed training methods or models across trainee or qualified psychologists.

Conclusion

A relatively small number of studies have been conducted in the UK exploring the attitudes, beliefs and practices of CPs in relation to spirituality. Some CPs are religiously committed and view their faith as enhancing their clinical practice. However, population studies suggest that the majority are not religiously affiliated and believe their practice to be value free. Most studies find that psychologists describe these topics as difficult and report insufficient training and guidance.

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Appendix A

Search Terms and Results

03/11/16 – Searched PubMed

2,804 Results

((Spiritual*[Title/Abstract] OR religio*[Title/Abstract] OR faith[Title/Abstract] OR sacred[Title/Abstract]) OR (Spiritual*[Supplementary Concept] OR religio*[Supplementary Concept] OR faith[Supplementary Concept] OR sacred[Supplementary Concept]) OR (Spiritual* OR religio* OR faith OR sacred[MeSH Major Topic])) OR (Spiritual*[MeSH Subheading] OR religio*[MeSH Subheading] OR faith[MeSH Subheading] OR sacred[MeSH Subheading])) OR (Spiritual* OR religio* OR faith OR sacred[MeSH Terms])) AND ((clinical psycholog*[Title/Abstract]) OR (clinical psycholog*[Supplementary Concept]) OR (clinical psycholog*[MeSH Major Topic]) OR (clinical psycholog*[MeSH Subheading]) OR (clinical psycholog*[MeSH Terms]))

04/11/16 – Searched PsychInfo Via open Athens HDAS 3,728 Results

Document title, abstract, identifier (keyword), Exact major subject heading, Exact subject heading, subject heading, subject heading all, word in major subject heading

- 1 Spiritual*
- 2 religio*
- 3 faith
- 4 sacred
- 5 clinical psycholog*
- 6 1 OR 2 OR 3 OR 4
- 7 6 AND 5

13/12/2016 – Searched Web of knowledge

94 results

TS=((Spiritual* OR religio* OR faith OR sacred) AND “clinical psycholog*”)

Appendix B**CASP Qualitative Research Checklist**

(CASP, 2013)

Item	Question
1	Was the research design appropriate to address the aims of the research?
2	Was the recruitment strategy appropriate to the aims of the research?
3	Was the data collected in a way that addressed the research issue?
4	Has the relationship between researcher and participants been adequately considered?
5	Have ethical issues been taken into consideration?
6	Was the data analysis sufficiently rigorous?
7	Is there a clear statement of findings?
8	Is the research valuable?



SCHOOL OF PSYCHOLOGY

DOCTORATE IN CLINICAL PSYCHOLOGY

EMPIRICAL PAPER

**What Can and Cannot be Said: Discourses of Spirituality and Religion in
Clinical Psychology**

Trainee Name: **Elizabeth Challis**

Primary Research Supervisor: **Dr Janet Smithson**

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Secondary Research Supervisor: **Professor Ed Watkins**

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Professional Doctorates

Target Journal: **Qualitative Health Research**

Word Count: 7,995 words (excluding abstract, table of contents, list of figures, references, footnotes, appendices)

**Submitted in partial fulfilment of requirements for the Doctorate Degree in
Clinical Psychology, University of Exeter**

Abstract

Objective: To examine the discourses used by trainee and qualified clinical psychologists from the South West of England to manage discussions of spirituality and religion as they relate to clinical practice.

Methods: Four focus groups were carried out with a total of 25 qualified and trainee clinical psychologists. Transcripts were analysed using discourse analysis.

Results: Three key discourses were identified, giving insight into how cohorts of qualified and trainee clinical psychologists manage discussions of these difficult topics. These were: balancing medical and therapeutic discourses, particularly when discussing psychosis and religious or spiritual beliefs; positioning and the Other, including religion and spirituality as a proxy for talking about race; and negotiating what can or cannot be said, principally when sharing personal views.

Conclusion: Ensuring that clinical psychologists have an awareness of the different discourses in use within the profession and how these may impact practice is important. Explicit discussion of the medical and therapeutic discourses likely to arise across different settings should be encouraged, including how these can constrain discussions around difficult topics such as spirituality and religion, race, and sexuality. Training should equip psychologists to have an awareness of othering, particularly in relation to religion or spirituality and race, and the potential effects this could have on power and engagement in therapy and broader work.

Keywords: Discourse Analysis, Spirituality, Religion, Culturally Sensitive Practice, Clinical Psychology

Introduction

Spirituality and Clinical Psychology

Over a decade ago the Mental Health Foundation (MHF, 2006) reviewed the literature examining the impact of spirituality on mental health, and recommended that spiritual and religious needs routinely be discussed with service users in mental health settings. However, qualified clinical psychologists (CPs), and trainees (TCPs) report a lack of training and guidance on addressing spiritual and/or religious material in clinical practice (Arshad, 2007; Baker & Wang, 2004; Harbidge, 2015; Malins, 2011; Mills, 2010; Mulla, 2012; Myers & Baker, 1998). While national guidelines for including spirituality and religion into healthcare are available (Commission for Healthcare Audit and Inspection, 2007; Department of Health [DoH], 2009), their primary focus is physical health services. The British Psychological Society (BPS) only broadly acknowledges that religious diversity should be recognised and respected in ethical conduct and psychological formulations (BPS, 2009; 2011).

An apparent 'discomfort' between UK clinical psychology and religion has been noted (Peden, 2012), supported by research in which CPs and TCPs report difficulty discussing spirituality and religion (Begum, 2012; Crossley & Salter, 2005; Harbidge, 2015; Malins, 2011). This difficulty likely impacts training provision, guideline development and reflection by individuals and teams. Given national documents promoting discussion of spirituality and religion in mental health services, the perceived lack of training and guidance, and that clinician attitudes impact clinical decision making (Gartner, Harmatz, Hohmann, Larson, & Gartner, 1990), clinical psychology as a profession needs to better engage with these topics. This is key as they may influence

engagement, from both clinician and client, which in turn has been shown to impact therapeutic outcomes (Horvath, 2001).

The current literature on clinical psychology, spirituality and religion is based almost exclusively on interview data (e.g., Harbidge, 2015; Malins, 2011; Mills, 2010; Mulla, 2012). However, practice is constrained and shaped by professional roles, training, and the expectations of colleagues (Goffman, 1986). Individuals' responses vary depending on context, who is addressed and how one is positioned in relation to them (Billig, 1988; Willig, 2000). What individuals say during interviews with researchers who are investigating this area, may therefore differ from the normative professional discourses that exist in wider professional training and work contexts.

This study builds on previous research on the attitudes of individual psychologists by conducting focus groups with professional colleagues to see how they negotiate these controversial topics. Although not a natural setting, focus groups can provide access to a population within its social context (Hoppe, Wells, Wilsdon, Gilmore, & Morrison, 1994; Kitzinger, 1994). Analysis looking at what strategies and discourses are used in discussing spirituality and religion can inform the design and delivery of future training. As prior research has particularly identified a reluctance to disclose one's own beliefs to colleagues (Baker & Wang, 2004; Betteridge, 2012; Malins, 2011; Mills, 2010) attending to examples of where and how this reluctance is overcome (if at all) may be particularly useful.

Focus Groups and Discourse Analysis

Focus groups produce interactive data which allow for the negotiation and construction of meaning to be studied (Wilkinson, 1998) and public discourses

examined (Smithson, 2000). Focus groups can be particularly useful for identifying obstacles preventing adherence to guidance, or limiting behaviour modification (Wilkinson, 1998). This is relevant to the discussion of spirituality and religion, which is recommended (DoH, 2009; MHF, 2006) but uncomfortable for CPs (Peden, 2012).

Discourse analysis (DA) views language as performing social actions like persuasion, entertainment, blame or justification, rather than expressing stable internal states such as attitudes or opinions (Potter & Wiggins, 2007). It is more than a method of analysis, encapsulating a social constructionist or critical realist epistemology (Billig, 1997), and recognising the role discursive practices play in constructing, rather than simply describing, reality. It is supported by research demonstrating that people express different views in different settings (Billig, 1988), and that power and position are (re)negotiated and maintained using discursive practices (van Dijk, 1993). A glossary of key DA terms used in this study is provided in Appendix A.

When studying individuals within professional and institutional settings discourse is a key domain for research (Edwards & Potter, 2001). Positioning theory (Davies & Harré, 1990) is one aspect of DA which examines what an individual may or may not do or say within a professional context; how their positions and subsequent actions are constrained (Harré, Moghaddam, Cairnie, Rothbart, & Sabat, 2009). It asks: "Who speaks? In whose name do they speak? Who do they address? Who do they speak for?" (Georgaca & Avdi, 2011, p. 155). The ways individuals and groups position themselves, each other, and the clients they serve will define how CPs practice.

Attending to the detail of focus group talk, participants' rhetorical strategies and discursive agendas, is key when the topic is sensitive or potentially inflammatory, and individuals risk accusations of prejudice, bias or unprofessionalism (Potter & Wetherell, 1988). Individuals may speak to forestall argument or portray an utterance as objective, rather than opinion or evaluation (Jørgensen & Phillips, 2002).

This study expands the existing literature by examining the discursive strategies which may impact the construction of professional discourses in this area. Where past research has looked only at interview or survey data, and has not considered discursive influences, the use of DA and focus groups in this study allows for the interactions between CPs and TCPs to be explored.

This study aims to answer the following research question: What discourses do TCPs and CPs from South West England use to manage discussions of spirituality and religion as they relate to clinical practice?

Method

Participants

Trainee and qualified psychologists from Exeter University and Somerset Partnership NHS Foundation Trust were approached to participate in focus groups between October 2016 and January 2017. First year trainees were excluded as at this time they had minimal clinical experience on training. All second and third year trainees were approached to participate. To facilitate open discussion the focus groups were carried out as professional cohorts. Trainees were not in focus groups with qualified psychologists; second and third year trainees were in separate groups. Qualified groups were planned within specialisms.

Potential participants were contacted by email with a brief description of the study and participant information sheet (Appendix B). They were invited to ask questions and express interest via email. Trainee psychologists were also approached as a cohort to request participation, particularly of those with little interest in religious or spiritual matters.

Participants were not asked explicitly about demographic categories such as ethnicity, gender or religious affiliation. DA acknowledges that the context of how, where and by whom people are addressed will influence how they respond or the positions they take up. Asking for demographic information via a questionnaire or at the start of the focus groups would set a particular context, and may have constrained the positions which individuals felt were available to them in subsequent discussions. Not asking participants to choose a particular 'category' for their religious or spiritual views also aimed to avoid unduly influencing how I interacted with them and their discourses during facilitation, transcription or analysis, based on how they had identified.

Four focus groups were carried out, three with trainees and one with qualified psychologists. Of the 14 individuals in the second year of training at Exeter, nine (64%) participated. Of the 13 trainees in year three, 12 (92%) took part across two groups. The qualified focus group included all four psychologists present at the bimonthly specialism meeting. Overall 81% of those contacted agreed to participate.

Design

The study used a qualitative focus group design. DA methodology was used to examine how professional cohorts discussed the inclusion of spirituality and religion in clinical work.

Procedure

Ethical Approval. The study was approved by the University of Exeter School of Psychology Ethics Committee and the Health Research Authority (Appendix C). At the start of the focus group individuals were asked to read the participant information (Appendix B) and opportunity was given to ask questions. The voluntary nature of the research and right to withdraw were emphasised. Participants were asked to respect the confidentiality of other group members and the limits of confidentiality for research carried out in a group setting were highlighted. If happy to participate individuals then signed a consent form (Appendix D). A debrief sheet (Appendix E) was provided after the group.

Focus Group Schedule. A focus group schedule was developed based on the existing literature, covering participants' views on and experience of talking about spiritual and religious matters with clients, supervisors, and in training. A pilot interview was conducted with a Band 7 clinician from specialist psychological services. This identified possible prompts, checked intelligibility and ensured flow of topics. It also served as an opportunity for me to prepare for the role as researcher and group facilitator. The resulting schedule (Appendix F) was applied flexibly to maintain the flow of discussion as far as possible. Slight changes were made to adapt the schedule for use with qualified staff (e.g. asking about current practice as supervisors rather than future expectations). The groups lasted between 45 and 70 minutes and were audio-recorded.

I transcribed each focus group within a week of completion using Jefferson notation (Jefferson, 2004; see Appendix G). Completing transcription prior to

the subsequent group aimed to increase recall of non-verbal communication and aid with sections of poor sound quality.

Method of Analysis

The analysis was based on a discursive psychology approach, a form of DA concerned with how psychological business is conducted in talk. In particular, I focussed on how people attend to identities, attitudes and cognitions (Potter & Wiggins, 2007). I also focussed on positioning theory (Davies & Harré, 1990), looking at how individuals' discourses were used to position themselves and others to construct relevant identities, and participants' discursive agendas (Georgaca & Avdi, 2011), the rhetorical strategies individuals employed to manage and influence the interaction. Although discourse analysts typically emphasise the importance of the overall approach rather than specific rules, seven steps to good practice in discursive research have been put forward by Potter and Wiggins (2007) and were used to guide this research (Appendix H).

The transcripts were initially coded in NVivo, identifying discourses which emerged from the transcripts when focusing on positioning, discursive agendas, and the influence of power and context on the discussion. Key discourses were chosen for in-depth analysis based on emergence across all four focus groups with reasonable coverage (summary table in Appendix I). Discourses which occurred across all groups were chosen to minimise bias. Representative extracts were selected illustrating the discourses and discursive practices in use (Jørgensen & Phillips, 2002), ensuring consistency with the analysis of the transcripts as a whole (Potter & Wetherell, 1987). Extended extracts are included to allow the reader to judge the coherence and plausibility of the

analysis. Coherence and plausibility form the basis of validity in DA, alongside grounding analysis in previous research (Wetherell, 2001).

Quality Checks

DA acknowledges that research is itself a discursive activity and the context of the research and the researcher cannot be partialled out from the analysis (Jørgensen & Phillips, 2002). Coherence and plausibility form the basis of validity in DA, alongside grounding analysis in previous research (Wetherell, 2001). Coherence requires that analytic claims form a coherent discourse, with all aspects of the analysis being consistent with the analytic account. Plausibility is in part achieved by situating the research within existing knowledge, and requires that the account appears plausible and persuasive (Wood & Kroger, 2000). Extended extracts have been presented in this write up to allow the reader to assess both coherence and plausibility in the analysis (Madill, Jordan, & Shirley, 2000).

Fidelity to DA methodology was ensured by presenting extracts from the data at a DA researchers' group and discussing the analysis and findings with clinical psychology qualitative students. Further the analysis and findings were reviewed by both my primary supervisor, a discourse analyst, and secondary supervisor, a clinical psychologist.

Results

Analysis

The key discourses selected for analysis were: balancing medical and therapeutic discourses, particularly when discussing psychosis and religious or spiritual beliefs; positioning and the Other, including religion and spirituality as a

proxy for talking about race; and negotiating what can or cannot be said, principally when sharing personal practice. Definitions of othering, and medical and therapeutic discourses are provided in Appendix A.

Balancing medical and therapeutic discourses. The medical discourse attributes individuals' religious or spiritual experiences to a diagnosis of psychosis (Georgaca, 2004). It views symptoms as indicative of a diagnosable disorder, usually of organic aetiology, and positions individuals as "ill". This discourse was present in all groups, alongside, and in contrast to, a therapeutic discourse, in which religious or spiritual experiences were viewed as either helpful or unhelpful (Georgaca & Avdi, 2011). Couching discussions of spirituality or religion within the medical discourse strongly positions clients as pathological (Georgaca, 2004).

Extract one. This extract comes from group three, which had eight members, all third year trainees. It was coded primarily under balancing medical and therapeutic discourses, but includes disclosure of personal spiritual beliefs (lines 14-16). The extract is split into two parts for ease of reading.

Extract 1a

8 C5: mine was with a adult, because she had a psychotic ↑episode and
9 it was all around her, it was all around like religious ideas and stuff so
10 she'd had experience of kind of erm, something kind of coming into her
11 and she, something she described as God, and she talked a lot about
12 like her religious beliefs and this idea that she was like innately bad
13 and it was like God punishing her in some way, so that was quite
14 interesting. And quite hard for me, because I don't believe in God,
15 (slight laugh) so, I was, I was trying to manage that in terms of my own
16 (slight laugh) what do I believe about this kind of thing.

Medical, religious and therapeutic understandings of patient experience are illustrated in this extract. It forms the response given to my initial question

about people's experience of discussing religion or spirituality in clinical work, and focusses on religious, rather than spiritual beliefs. In starting the discussion, the speaker is responding to the demands of the focus group setting and my question (Myers, 2007). She establishes the case as relevant by specifying that the client attributed the experience to God, which also serves to distance her from that interpretation (line 11). With this vignette she orients the group to religion within a medical discourse, with religious experiences attributed to psychosis (Goffman, 1986; Georgaca, 2004). However, the rising tone she uses when introducing the term "psychotic episode" (line 8) and her repeated use of the discourse markers "kind of", "like", and "and stuff", signal to the group that she is not overly invested in that description were they to disagree (Billig, 1988).

The ways in which spiritual experiences are unhelpful to the client (lines 12-13) are prefixed with "like" and followed with the comment that this is "quite interesting" (lines 13-14). In describing these things non-factually ("like"), and as the view of the client, she has taken up a particular stance (DuBois, 2007), and protected her own position as a non-judgmental, scientist practitioner (Myers, 2010). The speaker reports discomfort in addressing this topic in therapy (lines 14-16), and displays unease around disclosing and questioning her beliefs, which she dispels by laughing (Jefferson, 1984).

Extract 1b

17 R: And how was that

18 C5: Erm... yeah it was ok (2 secs) erm, but I, maybe it was easier
19 because she was kind of very much, although she was religious she
20 was very much putting like that experience down to her psychosis and,
21 and experience of psychotic episode, as opposed to (1.5 secs) actually
22 kind of saying I do actually think kind of God entered me and all of this
23 stuff. So I suppose I was, it was easier for me to manage it because I

24 could put it down to a mental health ↑thing as well, because that's how
25 she was interpreting it. (1.5 sec) but I don't know, I can't imagine how
26 difficult it would be if you're saying but I genuinely believed God, in
27 God, and I believe that God touched me in some way and other people
28 are just saying "yeah but that's just your psychosis", and like (1.5 secs)
29 I don't know how that would have played out if people were doing that
30 differently.

In the second half of the extract, the speaker differentiates the client's religiosity from her beliefs with religious content which are labelled as psychosis. She pauses in line 21, appearing to avoid contrasting the attribution of experience to psychosis with 'really believing it'. The use of the phrases "actually", "kind of", and "and all of this stuff" (lines 21-22) reduce the impact of what is being said. The client is described as using the medical discourse to make sense of her experiences (lines 20-21), which the speaker found "easier" to manage within a mental health setting (Coyle, 2008).

The speaker positions herself alongside the hypothetical 'believer' whose 'genuine' beliefs are being dismissed as "just psychosis" (lines 25-28), distancing herself from those making that judgment. This shift from the medical discourse, which positions the client as psychotic (lines 8-13), to the therapeutic discourse where one is positioned as alongside the client, accepting their interpretation of experiences (lines 24-25), meets the requirement for CPs to respect diverse beliefs (BPS, 2009)

Extract two. The second example of balancing medical and therapeutic discourses is also drawn from focus group three. The extract has been split.

Extract 2a

46 C7: yeah, that's really interesting 'cause I've had similar experiences
47 about people having protective, erm, things around errr, their religion.
48 So, erm, when I was working on the inpatient ward actually

49 interestingly it came up more than anywhere else since I've been
50 working. And we had a lady who was very psychotic, and she had
51 some negative, erm, voices, and she had some positive voices. The
52 negative voices went away with medication, but the positive voices
53 didn't. The positive voice was God telling her she was ok. She was a
54 nice person, that er, she was valuable and she should be here. Erm (.)
55 and, interestingly, had a quite interesting conversation with the
56 psychiatrist about why, that meant that then she ↑couldn't go home
57 because she still had, these voices. I said those are protective for her,
58 they (.) they help her function. They are really (.) helping her still get on
59 with her life. Erm (.) and he was, yeah, he was very [no she has voices]

60 C1: [s-,s-,s-, so] because it didn't
61 coincide with his view of reality, that was, erm, blocking her from
62 returning °back to the community°.

As she introduces this service user the speaker emphasises her psychosis, stating that she was “very psychotic” (line 50). It seems important to establish her as a legitimate or even archetypal ‘psychotic patient’, reinforced by the “negative voices” having resolved with medication (line 52), aligning with the medical discourse. The distinction between someone who is very psychotic and someone whose beliefs are helpful is emphasised. From that point the medical discourse is attributed to the psychiatrist and religious discourse to the client. The speaker positions herself outside the medical discourse, arguing against the psychiatrist, drawing on a therapeutic discourse (Georgaca & Avdi, 2011), emphasising the helpfulness or unhelpfulness of the voices (lines 57-59).

C1's interjection amplifies the argument against the position attributed to the psychiatrist (lines 60-62). Her phrasing suggests that the psychiatrist's view of reality is no more valid than the client's, unusual given the power differential between physician and patient (Pilnick & Dingwall, 2011). This permits the possibility of alternative truths, again aligning with the therapeutic discourse

rather than the medical. However, the drop in volume of her voice as she finished speaking may be a recognition of psychiatry's continuing power within mental health services (Georgaca, 2004).

Extract 2b

63 C7: yeh (.) And then, an-, and so that kind of started off a conversation
 64 (1.5 secs) erm, between me and some of the other patients as well
 65 about, religion and religion in terms of erm, mental health, and just that
 66 kind of thing of (.) erm (.) I don't know people might disagree with me,
 67 but if people say "I am the son of god" or "I am", erm, you know "god
 68 speaks through me" or whatever (.) instantly in our line of work, they're
 69 psychotic, there's something really wrong with them, they're grandiose,
 70 they're psychotic. (2 secs) but actually I wonder whether, sometimes,
 71 you know, if it were, if it was a different circumstance and it was a
 72 religious group where people were ↑°speaking in tongues or
 73 ↑whatever° [(2 secs), quiet mm's of agreement] would you see it as
 74 ↑psychotic °experience, I don't know°. It's just interesting in how it can
 75 be protective in some (.) situations and not protective in others.

C7 qualifies the strength of her statement about the assumptions made in mental health settings (line 66), perhaps pre-empting disagreement and signalling she does not have an axe to grind (Edwards, 2003). Most members of the focus group are working in mental health, and an outright challenge of the medical discourse dominant in this setting (Bassett & Baker, 2015) may result in counter-argument. However, despite this qualification, she identifies with clinical psychology ("in our line of work", line 68) to support her claim that individuals reporting religious experiences are positioned as "grandiose", ill and "psychotic" (lines 69-70). Her discussion of religious settings (lines 72-75) is more hesitant, with rising intonation and softly spoken phrases. It seems that C7 is less confident to speak to these settings, possibly as some group members are religiously committed.

In this extract and in other groups the term 'protective' (Rutter, 1985) was used of religious beliefs as part of the therapeutic discourse (lines 47,57,75). This allowed the impact of the belief on individuals' mental wellbeing to be assessed, without the need to address their truth or whether TCPs agree. This is one way that CPs have engaged with spirituality in clinical settings (Arshad, 2007; Crossley & Salter, 2005).

Positioning and the Other. Although race was not directly asked about, in all groups it was suggested that discussing spirituality is rare because of ethnic homogeneity in the South West. Mulla (2012) highlighted that CPs in her study located spirituality in the otherness of patients. Othering has been defined as "a process (...) through which identities are set up in an unequal relationship" (Crang, 1998, p.61). Constructing the other is a discursive means to constructing the self and maintaining position and power (Lin & Kubota, 2011; Johnson et al., 2004; Kitzinger & Wilkinson, 1996). By defining the Other as "them", different from ourselves, a self-identity can be established for "us" which positions us favourably. Othering often occurs on the basis of race or culture (Johnson et al., 2004; Lin & Kubota, 2011). There are examples of othering in extracts one and two, as speakers distance themselves from the client's position (extract one line 11; extract two lines 47-50). Within psychology othering of clients, particularly those with psychosis, can be achieved by positioning them as ill or irrational (Boyle, 1996).

Extract three. This extract comes from group two, which had four members, all third year trainees. It follows a question from me about training, and a joke from B4.

464 B2: It wou-, I, I personally would have found it really helpful to know
465 more about religion and spirituality because, I, I'm gonna say I am very
466 ignorant, erm, ok our demographics down here don't have huge variety
467 of religions, but elsewhere in the country we would encounter a lot
468 more [difference] so it would be really interesting to have a bit of
469 teaching around that to know, you know.

470 B4:[exactly]

471 B2: Some very basics of what you can and cannot say in certain
472 situations. I dunno, I [think it would've been really helpful]

473 B4: [I wonder if part of it] is a sort of south west trap maybe, that the
474 course has fallen into that trap a little bit it's just th-, that the
475 demographic's taken as yeah, white (.) and rural

B2 describes herself as “very ignorant” of spiritual and religious topics (lines 464-465), and emphasizes a desire for more teaching in this area, which would be *really* helpful (line 464) and *really* interesting (line 468). Despite initially referencing both spirituality and religion, in line with previous research (Begum, 2012) she goes on to talk only about religion, apparently meaning religions beside indigenous Christianity (lines 466-469). Perhaps to forestall argument, she prefixes her statement with the disclaimer “personally” (line 464), acknowledging that the desire for more training may not be shared. Her suggestion that it would be good to cover “the very basics” (line 471) positions her as an interested student whose needs have not been met.

The purpose of further training is to know “what you can and cannot say” (line 471), apparently linked to a wish not to offend people of diverse ethnicities or religious beliefs. B4 agrees, suggesting that the course has made assumptions that the local area is “white and rural” (line 475), implying that spirituality and religion are not relevant, or at least not problematic, in white, rural areas.

The location of spirituality and religion within the Other has been noted in previous research (Mulla, 2012). All focus group members were white. By constructing a discourse of these topics as relevant elsewhere in the country (lines 466-468), rather than the white South West (line 475), the speakers distance themselves from spirituality or religion as personally relevant. This may avoid the uncomfortable thoughts about personal beliefs reported in extract one, and establish individuals as speaking from a more objective, external position. In focus group one an individual highlighted the othering process she felt was occurring in the group.

136 A6: I think in my experience it's been almost a bit othering, I think if it
137 was sort of a predominant sort of Christian religion it won't necessarily
138 be attended to, but I think if there's someone from a different ethnic
139 background or something that some people start thinking about religion
...

156 A6: I, it, it's felt to me sometimes like services, when they're looking at
157 people, perhaps from a different ethnic background or something it's
158 like, it, they're somehow different therefore be different, therefore in
159 that sort of respect rather than the kind of religion being central to their
160 presentation or their difficulties.

This extract reinforces that religion is only considered relevant when non-indigenous, other and unknown. This is linked by A6 to ethnicity (lines 138,157), and therefore race (van Dijk, 1996), being restated with the qualification that it was how things had felt to her (line 156), dispelling argument. Othering often occurs on the basis of race (Johnson et al., 2004), preserving the status quo and silencing the Other (Kitzinger & Wilkinson, 1996). As noted in previous research (Arshad, 2007; Mulla, 2012), religion appears to be aligned with race, sometimes under the broader heading of culture.

Extract four. The following extract is from group four, which had four qualified CP members. It follows me asking about spirituality and religion in training.

495 D3: And I mean I remember pre-training I worked up in the West
496 Midlands and it was rea-, obviously very multi-cultural. And we had, we
497 had training on, on all the different religions and spirituality etc.
498 Because of the, um, the great possibility of putting our, a big foot in
499 (laughing) putting our foot in it.

500 Mmm

501 D3: um, and that, but that was very useful but, down in Somerset it,
502 (laughing) I haven't had much use for a lot of that. Um (.)

503 D4: it's changing a little bit [(.) occasionally, I had] a, a very spiritual...
504 Burmese, lovely lady, who used to=

505 D3: [a little, you see a little]

506 D4: =Salom'ed me when she came in. She was, you just have to
507 take it in your stride. [mm] and get her up off the floor and sit her in a
508 chair (.) And she was absolutely charming

This extract is an example of race and spirituality being combined under the heading "culture". The more culturally diverse West Midlands is assumed to be somewhere that ideas of spirituality and religion are more relevant. Having positioned herself as someone who knows about diversity of spiritual and religious beliefs because of previous work (lines 495-497), D3 paints Somerset as somewhere that her existing religious and racial knowledge and sensitivity is not required (lines 501-502). She laughs when discussing the possibility of 'putting one's foot in it' when working with individuals from another race or religion (lines 498-499), apparently expressing discomfort at the thought (Jefferson, 1984). This may be due to how negative it is to be seen as prejudiced or racist, particularly at work (Potter & Wetherell, 1988).

As race is a taboo topic (Augoustinos & Every, 2007), the link made between religion, spirituality and race may make these topics even more difficult to discuss. By situating spiritual concerns as things that happen “elsewhere” in the country, in the Other of a different ethnic group, it perhaps becomes easier for group members to discuss them, as they position themselves as external and objective. The overall message from D3 in this extract appears to be that although it may be regrettable that these topics are not discussed, it is a product of geography and demographics, rather than clinician choice (lines 501-502).

The lack of spiritual or religious material in Somerset is challenged by D4 (line 503), and D3 acquiesces, acknowledging that there is ‘a little’ (line 505). D4 then talks about a past client, presenting her nationality and spirituality together, furthering the alliance of spirituality and religion with ethnicity (lines 503-504). She speaks highly positively of the “lovely” lady, who was “absolutely charming” (lines 504,508), but discusses her spiritual behaviour as an idiosyncrasy to be “taken in your stride” (line 507). The matter appears not to be taken seriously, as you need to “get her up off the floor and sit her in a chair” (lines 507-508), implying that then the real work can continue.

Extract five. The next, brief, extract comes from focus group three, comprised of eight third year trainees. The group had been asked which patient groups they would be more or less likely to discuss spirituality or religion with. They suggested that spirituality and religion were less relevant in CAMHS, as young people are “less religiously orientated”. The below exchange followed.

563 C1: what about young people that are being radicalised?

564 (4 secs)

565 C2: not in North Devon

566 Group: (laughter/giggles)

567 C3: only with this surfing cult.

568 Group: (deeper laughter)

C1 challenges the discourse that was in place in the discussion, namely that these topics were not relevant for CAMHS settings. Although explicit mention is not made of race, the introduction of the racially loaded term “radicalisation” produces a long pause (line 564), before its relevance is denied and discomfort diffused by laughter (lines 565-568).

Radicalisation is an increasingly common phrase, including within the NHS (e.g. prevent training; NHS England, n.d., para. 4), and is, like terrorism (Jenkins, 1980), a power-loaded term. While radicalisation is not defined in terms of religion or race, Muslim individuals form the majority of referrals to the UK’s Channel programme, which aims to support and divert those at risk of radicalisation (National Police Chief’s Council, n.d., para.1).

The discomfort both of the challenge and the introduction of a political and racial term is managed in this extract by denial and humour (Jefferson, 1984). Jokes are made and the laughter of the group intensifies, in line with how race is often managed in popular culture (Howells, 2006). I reoriented the group to think about why spirituality and religion did not feel appropriate to discuss in CAMHS, but the idea of radicalisation was not returned to, possibly as that discourse had been effectively avoided within this exchange.

Negotiating What Can Be Said. Across the groups some participants shared their personal religious or spiritual views and practices. As prior research has reported CPs’ and TCPs’ reluctance to disclose their position to

colleagues or to clients (Baker & Wang, 2004; Betteridge, 2012; Malins, 2011; Mills, 2010), how this topic is negotiated within professional groups is key for facilitating meaningful discussion.

Extract six. This extract is from focus group one, carried out with nine second year trainees, with whom I had minimal previous contact. This extract occurred close to the end of the hour long group. The extract is split into two parts.

Extract 6a

722 A4: I wonder if people are less willing to invest time into it because it's not
723 spoken about that much in this day and age and thinking about extremist
724 views like Richard Dawkins that religion's going to die out, it won't exist one
725 day so is that just us like (inaudible) it as well

726 R: he goes further than that, he says it's um, damaging doesn't he=

727 A4: =yeah, he does yeah.

728 A1: But then if you flip it round you're like is science not just another form of
729 religion that people have blind faith that you can find the truth.

730 (inaudible) (Group laughter)

731 A2: it's really interesting having this conversation actually in a clinical
732 setting compared to when I was working in research where I was pretty
733 much the only person who practiced a religious (.) faith. And that was
734 seen as like this major, flaw (laughs) [in my ability to think clearly or
735 something] ((blushed))

736 (Group laughter)

A4 has previously disclosed his position as an atheist within the focus group, which received no comment. Here he begins to expand on that position with reference to a prominent atheistic scientist. While drawing on his theories, A6 distances himself from Dawkins' views, calling him 'extremist' (line 723). When I introduce the more controversial of Dawkins' arguments, that religion is

harmful (line 726), this discourse is rejected by the group, with a hitherto unmentioned discourse of science as a version of religion presented (lines 728-729). The group laughs, signalling their solidarity and togetherness (Adelswärd, 1989). A1 equates scientific and religious views of reality (lines 728-729), permitting alternative truths as part of the therapeutic discourse (as in extract one). A2 then discloses her own religious faith (line 733). She appears embarrassed (blushing, line 735) and laughs, in contrast to stating that previous colleagues viewed her as flawed and irrational (line 734). The group join with her laughter, perhaps working to mitigate her embarrassment (Adelswärd, 1989). A2 had not directly addressed her beliefs previously in the group; her cohort might have known of her beliefs, but I did not.

A2's statement that past colleagues considered her thinking to be compromised because of her religion, and dismissal of this view with the phrase "or something" (line 735), may have functioned to forestall similar argument from the group (Billig, 1988). This discourse of religious belief as indicating irrationality is similar to the medical discourse of psychosis mentioned above (Boyle, 1996). The distinction she draws between her previous academic setting and the current clinical context (lines 731-732) highlights that different discourses may be at work, and makes positioning her as irrational less accessible from the current clinical frame. There is similarity between the academic and medical discourses on the one hand, and clinical, therapeutic discourses on the other.

Extract 6b

737 A6: That's crazy

738 A2: tha-that's the science that informs our practice of course

739 A6: Yeah (.) yeah that's true, it's interesting to think actually. I think we
 740 can quite often overlook it as a resource as well because there's so
 741 much there with the religious communities that's really positive and you
 742 know we go to the third sector organisations like charities and you
 743 know all sorts of things but I think we're I dunno maybe I'm over
 744 generalising but we're maybe more reluctant to kind of get involved,
 745 you know if someone does hold a religion, then getting involved with
 746 their network [their] religious network, whatever that might be=

747 A1: [yeah] =And absolutely actually
 748 because my cousin, um struggles with um bipolar and her like my
 749 cousin and family are all, um Mormon, and actually the support they
 750 received from the community is massive, erm, like not even j-, like
 751 financially as well because if you think about a lot of churches people
 752 pay in money to support the community and stuff and like financial
 753 when she couldn't work, she'd been admitted and all that stuff like, it-I,
 754 you are right actually, there's a lot of stuff we could tap into there=

755 A6: =The really like practical aspects of religion

Following A2's disclosure A6's response is supportive, calling the attitudes of past academic colleagues "crazy" (line 737). She appears keen not to alienate other members of the group, adding "I dunno maybe I'm over generalising" (lines 743-744) before speaking from a position within psychology, of a professional reluctance to engage with religious groups (lines 744-746). She simultaneously distances herself from religious individuals (lines 745-746), making reference to religious communities, a phrase which can be shorthand for minority ethnic groups (Bauman, 1996).

A6 describes religion as a possible resource which psychology could tap into (line 740-724). A1 agrees with her (line 747) and recounts personal experience of religion being socially and financially helpful (lines 748-754). An explicit move is made away from the difficult topics of personal belief and professional disagreements. A1 differentiates "just" social or spiritual support

from financial support (lines 751-753), which is furthered by a latched statement from A6 highlighting the “practical aspects” of religion (line 755). These more concrete and positive ideas seem easier for the group to discuss than the more controversial topics of what individuals do or do not believe.

Discussion

This study aimed to explore what discourses TCPs and CPs from South West England used to manage discussions of spirituality and religion in clinical practice. The key discourses identified demonstrate how Othering (Johnson et al., 2004), particularly in terms of race (Lin & Kubota, 2011), can be used to position spirituality as something distant, allowing discussions to appear more objective and not relevant to work in the South West (extract four). The medical discourse of spiritual and religious experiences as indicative of psychosis (Georgaca, 2004) was also drawn on. TCPs could thereby partially avoid engaging with their own beliefs (extract one), but experienced tension with the therapeutic discourse (extract two). The analysis illustrated how medical and therapeutic discourses were used in turn to allow TCPs and CPs to occupy positions both as distant from religious experiences, and yet distant from the medical discourse which might be seen to pathologise them.

An apparent distinction exists between acceptable personal beliefs and what can be expressed in professional settings (extract six). This is not unique to psychology, with the UK media reporting cases where personal beliefs and professional practice have been differentiated, including bakers refusing an order due to religious beliefs (BBC, 2016), and a potential headscarf ban in some workplaces (BBC, 2017). This analysis demonstrated how groups of clinical psychologists can reject or take up different discourses in order to

manage the demands of a focus group (Myers, 2007) whilst also moderating the views expressed or permitted within the group.

The analysis shows some discursive strategies TCPs and CPs use when discussing spirituality in focus group settings, which are common to other taboo topics. These include laughter (Jefferson, 1984), tentative or personalised speech (Edwards, 2003) and discourse markers such as “you know” or “like” (Edwards, 2003). Although spirituality and religion were asked about, most of the talk focused on religion, despite a preference being stated for “spirituality”. This is similar to past research (Begum, 2012; Harbidge, 2015), and may be linked to poor familiarity with appropriate language (Crossley & Salter, 2005) or the inadequacy of language to capture spiritual ideas (Coyle, 2008). Analysis of the discourses in use expanded previous findings by highlighting that not only was religion discussed more frequently than spirituality, particularly when discussing examples from clinical experience, it was often, though not exclusively, connected with othering on the basis of race, culture or ethnicity.

The extracts and analysis provide insights into how spirituality and religion are discussed and negotiated within groups of TCPs and CPs. Although limited to a relatively small number of clinicians in South West England, some possible implications for training and practice can be cautiously drawn out.

Implications for Clinical Psychology Practice

Psychology’s dual position as an academic discipline and clinical profession creates tension for TCPs. Spirituality appears to be more acceptable in clinical or therapeutic contexts than in medical or academic ones, and TCPs are explicitly positioned between the two. The medical discourse linking spirituality with psychosis (Georgaca, 2004) must be reconciled with the

requirement for culturally sensitive formulation (BPS, 2014), recognition of vital nonspecific relational factors such as validation (BPS, 2014), and the ethical value of respect (BPS, 2009). This tension was highlighted in extracts one and two, arising across all groups. Making the contrast explicit in training may allow more dialogue and reflection about how different professional identities can be accommodated.

Race is a key area of diversity and has been poorly differentiated from religion by CPs in some past research (Arshad, 2007; Mulla, 2012). In this study TCPs and CPs across all groups linked religion and race, and viewed the South West's ethnic homogeneity as explaining the lack of engagement with spirituality and religion in their practice. Facilitating discussion of othering in training, for example when discussing social identity theory (Tajfel, 1981), may be helpful for TCPs, and could highlight the potential for religion and spirituality to function as shorthand for many kinds of othering. Clinical vignettes could promote discussion of how religion or spirituality may present, serving to reduce the stereotype that it occurs primarily with clients from minority ethnic groups or diagnosed with psychosis. This may help to counter the position taken up within the focus groups of participants as interested (extract three) or informed (extract four) clinicians, who do not discuss spirituality due to its irrelevance to local populations.

Clinicians may avoid addressing these topics if they view the risk of offending clients as more damaging than the omission of spirituality. However, it is possible to equip non-religious professionals to interact helpfully around religion with individuals for whom it is important (Good, 2010; Worthington & Sandage, 2001). Facilitating discussion of spirituality during training may equip

TCPs to talk more helpfully and comfortably with clients when qualified. For example, experience of taking a spiritual history from patients while training improves clinicians' view of, and comfort in, doing so (Gonçalves et al., 2016). If discussing spiritual or religious matters was included as a competency in training, this may increase exposure and help to decrease difficulty in these areas.

NHS Education for Scotland (2009) recommends that spiritual education for health professionals incorporates time to discuss personal and professional experiences of spirituality. However, psychologists who value religious beliefs or spiritual experiences may fear being positioned as irrational (Boyle, 1996) if they share their position. In this study participants used rhetorical strategies to avoid offending others, and positioning and stance-taking to preserve their sense of identity whilst expressing potentially controversial views. The inclusion of facilitated debates in training which require individuals to adopt a more extreme stance, could give permission for controversial ideas to be expressed and considered without threatening trainees' identity as "good" TCPs.

The idea of religion as a potential protective factor or resource (extracts two and six) may help scientist-practitioner TCPs and CPs to engage meaningfully with spirituality (Thayne, 1998). Focussing on the potential benefits (or risks) of spirituality could make discussion of how to integrate this into practice more manageable, as the truth of beliefs and personal positions can be avoided.

Limitations

This study relied on individuals volunteering to participate, which may have resulted in a bias towards those with strong views about spiritual and

religious topics. Specifically highlighting the value of hearing from disinterested parties aimed to reduce this, and positively the majority of potential participants did volunteer.

The study was skewed towards the views of current trainees (three of four groups). Two qualified groups were planned, but the second was cancelled by the host Trust due to budget constraints. As the context of clinical psychology training is one of assessment and performance, with individuals regularly observed and evaluated, there is a need to be seen to “get it right” and respond with acceptable clinical psychology discourses. Although this research aimed to examine the normative discourses which focus groups generally (re)produce (Smithson, 2000), this also limits what will have been shared. This is likely to have been particularly pronounced in trainee groups where participants knew each other well and professional norms were developing (Leask, Hawe, & Chapman, 2001). The participants who are part of my training cohort know that I have personal religious beliefs, and other participants may have assumed my motivation for this research. This will have influenced what was said, as individuals maybe tried not to offend, to educate, or challenged assumed views.

Demographic information, including religious and/or religious beliefs, was not collected for TCPs and CPs taking part in this research. Whilst this meant that these labels did not influence my interpretation as a researcher, it also means that impact of beliefs cannot be systematically explored, nor individuals self-identified ethnicities examined.

All participants live and work in South West England. As noted in the groups, the area is ethnically homogenous, and a lack of exposure to cultural and religious diversity was reported. It is possible that this lack of exposure

means individuals were less comfortable discussing these topics, and findings may not be generalizable to clinicians working elsewhere. Furthermore, that the majority of the participants (both CPs and TCPs) had an existing relationship with myself will have impacted how the focus group was facilitated, what participants felt able to share, and, to an extent, the analysis. There may also have been concerns from TCPs taking part about the limits of confidentiality for research being undertaken in the department where they were also training.

Researcher Reflexivity

In qualitative research on spirituality (West, 2009) the relationship of the researcher to the material needs to be made clear via personal reflexivity (Madill et al., 2000), which acknowledges how personal interests and values influence research from initial ideas to outcome (Banister, Burman, Parker, Taylor, & Tindall, 1994). Functional reflexivity is key in DA and requires “continuous, critical examination of the practice/process of research to reveal its assumptions, values and biases” (Wilkinson, 1988, p.495).

My own position as a committed Christian and TCP influenced my interest and opinions on spirituality and religion, and the saliency of discourses during analysis. My clinical experience of individuals of faith expressing fear of judgment or criticism for their beliefs also influenced my choices and interpretations. As a member of the clinical psychology profession, and of the same training cohort as two of the groups, there may have been aspects of culture or professional discourses which I overlooked. This was mitigated by receiving feedback from discursive researchers outside the profession. Such ‘confessions’ do not bracket the influence of these factors (West, 2009), and should not reduce criticism of observed stake and interest (Potter, Edwards, &

Wetherell, 1993), but hopefully can help readers to critically assess their impact on this research.

The assumptions of DA about the function and use of language have been outlined above. My choice to focus on positioning, rhetorical strategies and identity influenced the discourses identified from the transcripts. With more time and resources further analysis would be possible and other discourses could be identified.

Further research with professional cohorts working in areas which are more ethnically diverse would help to establish whether positioning religion as Other occurs generally on the basis of race, or if this is heightened by a lack of exposure in clinical practice. Similarly, repeating this research with cohorts which are more ethnically diverse would also be useful. Conducting DA on course materials which address spirituality could also help to examine the ways that training may influence and perpetuate professional discourses in this area.

Conclusion

This study adds to previous research into the professional attitudes of psychologists to spirituality and religion by examining the normative discourses that were constructed between professional cohorts during focus group discussions. Three key discourses were identified, giving insight into how professional cohorts of TCPs and CPs manage discussion of these difficult topics. These were: balancing medical and therapeutic discourses, particularly when discussing psychosis and religious or spiritual beliefs; positioning and the Other, including religion and spirituality as a proxy for talking about race; and negotiating what can or cannot be said, principally when sharing personal practice.

Ensuring that clinical psychologists have an awareness of the different discourses in use within the profession and how these may impact clinical practice is important. Explicit discussion of the medical and therapeutic discourses likely to arise across different settings should be encouraged, including how these can constrain discussions around difficult topics. Training should equip psychologists to have an awareness of othering, particularly in relation to religion or spirituality and race, and the potential effects this could have on power and engagement in therapy and broader work. The discursive practices highlighted here, and implications for training, have relevance not only to spirituality and religion, but also to other “difficult” topics, including sexuality, ethnicity and race.

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Appendix A

Glossary of Key Terms

Discourse: The term discourse describes a formal way of thinking that can be expressed through language. Discourses define what can be said about a topic and form the totality of codified language (vocabulary) used in a given field of intellectual enquiry. This results in a specific way of perceiving, talking about and understanding the world (or parts of it), based on certain assumptions. Discourses are governed and reproduced by exclusion and inclusion, and are therefore closely linked to power.

Medical Discourse: The medical discourse is made up of the language and signs used in and about illness, healing, curing, or treatment. People are positioned as patients; clinical objects with diagnosable problems located within themselves, which have an organic aetiology. Therefore, physical (e.g., surgical or pharmacological) treatments are indicated and context is generally overlooked. Symptoms are viewed as meaningless (aside from signifying the presence of disease) and outside of personal control.

Othering: Othering has been defined as “a process (...) through which identities are set up in an unequal relationship” (Crang, 1998, p.61). Othering positions individuals and groups as inherently or essentially different to oneself or one’s group. By attributing certain qualities or characteristics to the Other or ‘them’, one’s own position or ‘us’ is constructed in contrast, usually favourably.

Positioning: Individuals take up different positions when speaking which can have a variety of functions, e.g. to distance the speaker from what is being said or to endow what is being said with authority. Discourses entail specific subject positions and, when participants draw upon certain discourses, they are

positioned and call upon others to be positioned accordingly. The medical discourse, for example, determines a pathological subject position for the identified patient. Positioning determines what can and should be done by individuals.

Religion: Religion has specific behavioural, social, doctrinal, and denominational characteristics and involves “belief in a supernatural power or transcendent being, truth or ultimate reality, and the expression of such a belief in behaviour and rituals” (Huguelet & Koenig, 2009, p. 1).

Spirituality: Spirituality is considered a more general term than religion, concerned with individual experiences and personal meaning. It addresses “the dynamic dimension of human life that relates to the way persons (individual and community) experience, express and/or seek meaning, purpose and transcendence, and the way they connect to the moment, to self, to others, to nature, to the significant and/or the sacred” (European Association for Palliative Care, 2010).

Therapeutic Discourse: The therapeutic discourse is made up of the language and signs used in and about therapy, coping, or adaptation. People’s internal worlds and past experiences are viewed as central to their difficulties. Symptoms (including unusual beliefs or behaviours) are seen as having meaning, and are understood on the basis of an individual’s inner world and interactional context. The impact of personal histories and individual experience is focussed on, often to the exclusion of considerations of social and political oppression. Talking therapies are therefore the primary intervention, with normalising, helpfulness of beliefs, and acceptance being central.

Appendix B

Information for Participants

Title of study: Constructing the limits of the acceptable: How clinical psychologists in the UK talk together about addressing ideas of religion and spirituality in clinical work.

Name and contact details of Principal Investigator:

Liz Challis
Doctoral Student in Clinical Psychology
University of Exeter
Email: ec402@exeter.ac.uk
Telephone: 07814 256 800

Invitation

As part of my doctoral training as a clinical psychologist I am investigating how clinical psychologists talk together about the acceptability of discussing religion and spirituality in their clinical practice. I am inviting trainee and qualified psychologists to take part in (separate) focus groups to discuss this area.

If you wish to seek general advice about taking part in research you can contact the Somerset Partnership patient advice and liaison service:

Telephone: 01278 432022
pals@sompar.nhs.uk

Email:

Address: Somerset Partnership NHS Foundation Trust PALS, Mallard Court,
Express Park, Bristol Road, Bridgwater TA6 4RN

Purpose of the study

Studies that look at religion and spirituality suggest clients experience positive effects within both therapeutic contexts and in their personal lives. Much of the literature looking at the attitudes and practice of clinical psychologists originates in the USA, and what research has taken place in the UK has tended to focus on individual attitudes to spirituality and religion personally and professionally. By looking at how this topic is discussed within a group of professionals this research aims to broaden the understanding of how attitudes and practice in this area are constructed and maintained. The findings of this research may have implications for professional guidelines, training and clinical practice.

Participation in the study

You will be asked to attend a focus group with myself, the researcher, and between 2 and 7 other clinical psychologists, which will last for about an hour. If you agree to participate, you will be asked to read and sign a consent form – you will be free to leave the focus group at any time and withdraw from the study if you wish, at any point. The interview will be audio recorded and the final study may contain direct quotes although all participant responses will remain anonymous. Interviews will take place at a mutually agreed venue. Findings of the study can be forwarded on to you at your request.

Ethical approval for this study has been granted by the University of Exeter. Approval has also been granted by the Health Research Authority.

Confidentiality

All the information obtained from you will remain confidential. The only exception to this is that in the unlikely event of significant risk of harm, safeguarding concerns, evidence of criminal activity or professional negligence coming to light this information would be shared as necessary with Somerset Partnership NHS Foundation Trust.

From the point of transcription individuals will be identified only by a participant number. Any information gathered during the research and focus group process, including audio recordings and transcripts will be seen by the researcher and her supervisor, stored securely and destroyed following the completion of this research project. If you are willing to participate or would like further information, please contact me using the details above.

Liz Challis

Trainee clinical psychologist.

Appendix C

Ethical Approval Documents

Psychology on line Ethics approval system -

Elizabeth Challis

[Create new application](#)

Your applications

2016/1277	Elizabeth Challis	Constructing the limits of the acceptable: How clinical psychologists in the UK talk about addressing ideas of religion and spirituality in clinical work	conditional acceptance	9/06/2016	Track A
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Health Research Authority

Ms Elizabeth Challis
 Trainee Clinical Psychologist
 Taunton and Somerset NHS Foundation Trust
 Doctorate in Clinical Psychology
 Washington Singer Building
 Exeter University
 EX4 4QG

Email: hra.approval@nhs.net

06 December 2016

Dear Ms Challis

Letter of HRA Approval

Study title: Constructing the limits of the acceptable: How clinical psychologists in the UK talk together about addressing ideas of religion and spirituality in clinical work.

IRAS project ID: 214404

Protocol number: 1617/004

REC reference: 16/HRA/5617

Sponsor Exeter University

I am pleased to confirm that HRA Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Appendix D**Consent Form**

Title of Study: Constructing the limits of the acceptable: How clinical psychologists in the UK talk together about addressing ideas of religion and spirituality in clinical work.

The nature, aims and risks of the research have been explained to me. I have read and understood the Information for Participants and understand what is expected of me. All my questions have been answered fully to my satisfaction.

I understand that if I decide at any time during the research that I no longer wish to participate in this project, I can notify the researchers involved and be withdrawn from it immediately without having to give a reason.

I agree to volunteer as a participant for the study described in the information sheet and give full consent.

I understand that all information will remain anonymous and kept confidential by the principal researcher.

I understand that the interview will be audio-taped and that direct quotes may be used in the written study.

Participant Name:

Date:

Signature:

I confirm that I have explained the nature of the study as detailed in the participant information sheet and I believe that the consent given by this participant is based on their clear understanding, in my opinion.

Researcher Name:

Date:

Signature:

Name and contact details of researcher:

Liz Challis, Doctoral Student in Clinical Psychology University of Exeter

Email: ec402@exeter.ac.uk

Telephone: 07814 256 800

A copy of this consent form will be emailed to you securely from a Somerset Partnership email address for your records. The original will be viewed only by the researcher and her academic supervisors.

Appendix E

Debrief Sheet

Thank you for taking part in this study, your time is greatly appreciated.

This study involved taking part in a focus group with other clinical psychologists to discuss the inclusion of spirituality into clinical practice. There is evidence that including spiritual aspects to therapy can improve outcomes for individuals who are spiritual or religious, but some have noted a discomfort in addressing these topics within clinical psychology. To date much of the evidence looking at attitudes to addressing spirituality in practice has originated from the USA, where the societal attitudes to spirituality, and in particular religion, are very different from the UK. What research has been carried out in the UK has focussed on the individual views of psychologists, expressed in interviews or surveys.

This study aims to examine how the limits of what is acceptable in this area are constructed within a group of professionals. There is evidence that strongly held beliefs of a few individuals can influence the practice of groups, even where the majority of individual opinions might indicate otherwise. The process of discussion and negotiation of views is therefore important to understanding how professional practice is established and maintained.

It is hoped that the results of this study will help to inform professional guidelines, training and clinical practice.

If you experience distress following this study:

It is not anticipated that participating in this study will cause distress, however if you do find that this is the case please inform the principal researcher and/or contact your G.P., or one of the following helplines:

- * Samaritans: 116 123
- * MIND: 0300 123 3393
- * SANE: 0300 304 7000

The focus groups will now be transcribed and anonymised before being analysed using discourse analysis. The recordings and transcripts will be stored securely until the end of my studies in September 2017. The data you have provided will be held anonymously and it will not be possible to trace the information back to you.

If you have any questions or comments about the study, would like your data to be removed, or would like the results of the study to be sent to you, please contact the researcher using the details overleaf.

Principle researcher: Liz Challis

Doctorate in Clinical Psychology, College of Life and Environmental Sciences,
University of Exeter,
Washington Singer Building, Perry Road, Exeter EX4 4QG

Email: EC402@exeter.ac.uk

If you have any questions or concerns about the ethics of this study,
please contact the chair of the Psychology Research Ethics Committee:
Email: L.A.Leaver@exeter.ac.uk Phone: +44 (0) 1392 724626

Address: College of Life and Environmental Sciences, University of
Exeter, Washington Singer Building, Perry Road, Exeter EX4 4QG

Appendix F

Focus Group Schedule

1 Welcome and warm up topics

- Thanks and welcome, outline of expectations, running time, confidentiality and researcher role.
- How are you finding term so far?
- If comfortable: what area are you currently on placement in?
- What are you looking forward to most about qualified practice?

2 Professional Experience of Religious/Spiritual issues

- What have been your experiences, if any, of discussing religion or spirituality in assessment or therapeutic work?
- How appropriate do you think it is for us as clinical psychologists to broach this area with individuals we see?
- Have you ever sought guidance from or referred on to a spiritual leader (e.g. imam, Trust chaplain) as part of your clinical practice? If so what prompted you to do this?

3 The Ethics of Religious/Spiritual Talk in Clinical Practice

- Are there any areas of work where you might be more or less likely to discuss religious or spiritual matters? [from the literature: cancer patients, OA, psychosis, ethnic minorities]
- Some people argue that it is not ethical for clinical psychologists or other professionals to raise spirituality or religion if this has not already been brought up by the client. What do you think about that?

- Is there anything else which might make you feel uneasy or more comfortable about assessing or discussing religion or spirituality as part of your clinical work?

4 Training and clinical psychology practice

- Have topics of religion and/or spirituality been covered in your training as a clinical psychologist so far?
- Have spiritual or religious matters ever been discussed with or by you in supervision? If so, what was your experience?
- If you were working with a client who brought these topics to therapy, do you think you would include this in supervision? How would you manage this?
- Looking forward to when you are qualified, how would you feel about managing these topics if they were brought up by someone you were supervising?
- What implications do you think these topics have for clinical psychology practice?

5 Summing up and ending

- Is there anything that anyone feels they have not had chance to say which they would like to share at this point?
- Thank yous and goodbyes

Appendix G

Jefferson Transcription Conventions

Adapted from Jefferson, 2004

- (0.5) Number in brackets indicates a time gap in tenths of a second.
- (.) A dot enclosed in brackets indicates a pause in the talk of less than two-tenths of a second.
- = 'Equals' sign indicates 'latching' between utterances.
- [] Square brackets between adjacent lines of concurrent speech indicate the onset and end of a spate of overlapping talk.
- (()) A description enclosed in a double bracket indicates a non-verbal activity.
- A dash indicates the sharp cut-off of the prior sound or word.
- :
- Colons indicate that the speaker has stretched the preceding sound or letter.
- (inaudible) Indicates speech that is difficult to make out. Details may also be given with regards to the nature of this speech (eg. shouting).
- .
- A full stop indicates a stopping fall in tone. It does not necessarily indicate the end of a sentence.
- ↑↓ Pointed arrows indicate a marked falling or rising intonational shift. They are placed immediately before the onset of the shift.
- Under Underlined fragments indicate speaker emphasis.
- CAPITALS Words in capitals mark a section of speech noticeably louder than that surrounding it.
- ◦ Degree signs are used to indicate that the talk they encompass is spoken noticeably quieter than the surrounding talk.

Appendix H

Seven Steps in Good Quality Discourse Analysis

Potter and Wiggins (2007)

Devising a research question: Guided by an interest in a particular form of interaction.

Gaining access and consent

Ethical and practical considerations for accessing the data.

Data collection and building a corpus

DA requires a thorough examination of a collection of similar instances

Transcription

Features of talk that are relevant are represented (emphasis, overlap, pauses, intonation etc.)

Coding

Iterative process of sifting through the data for instances of a phenomenon. Issues may emerge or disappear at this point.

Analysis

Focus on how discourse is constructed, constructs of different versions of events, is situated in interaction, and bound up with actions.

Application

Analysis and findings are linked to the context under study.

Appendix I

Table of Frequency and Sources for Identified Discourses

Discourse	Focus Group One		Focus Group Two		Focus Group Three		Focus Group Four	
	References	Coverage	References	Coverage	References	Coverage	References	Coverage
Telling clinical stories	4	4.81%	6	15.32%	12	22.54%	7	21.39%
Asking about religion or spirituality as a tick box exercise	5	9.31%	1	1.72%	2	2.68%	1	0.50%
Religion as a threat to psychology	1	2.71%	0	-	3	2.53%	0	-
Spiritual and religious discourses as distinct	2	8.39%	1	0.44%	1	1.96%	0	-
Balancing medical and therapeutic discourses*	2	4.79%	1	3.90%	2	4.98%	3	6.19%
Positioning and the Other (Race)*	8	15.40%	3	7.02%	4	2.58%	2	1.85%
Negotiating what can or cannot be said (personal practice)*	2	3.23%	3	9.06%	8	5.89%	1	1.99%
Spirituality and religions are “not our business” (inappropriate discourse)	8	13.52%	1	0.39%	2	0.93%	1	3.75%
Discourse of feared ignorance	1	2.38%	1	1.09%	0	-	0	-
Barriers to discussing religion or spirituality	3	5.98%	1	0.77%	0	-	0	-

* Key discourses

Appendix J

Dissemination Statement

The results of this study will be disseminated to interested parties through feedback, journal publication and presentation.

Dissemination to participants and NHS services.

Participants will be sent a summary of study findings by email. They will also be given the opportunity to request a full copy of the write up via email if they are interested. A copy of the summary will also be sent to the research and development lead at Somerset Partnership NHS Foundation Trust for inclusion in the Trust newsletter.

Journal Publication

It is expected that the study will be submitted for publication with the Qualitative Health Research (Impact factor 1.403).

Presentation

On 12th June 2017, my research findings will be presented to an academic audience, for peer review, as part of the Doctorate in Clinical Psychology at the University of Exeter.