UNIVERSITY OF EXETER

Examining experiences of incorporating spirituality into psychological therapy

Submitted by Ruvimbo Jane Stevens (Mugadza), to the University of Exeter

as a thesis for the degree of Doctor of Clinical Psychology, August 2022

I certify that all material in this thesis which is not my own work has been identified and that any material that has previously been submitted and approved for the award of a degree by this or any other University has been acknowledged.

Signature: 

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SCHOOL OF PSYCHOLOGY

DOCTORATE IN CLINICAL PSYCHOLOGY

LITERATURE REVIEW

What are the challenges of incorporating spirituality into psychotherapy for psychotherapists?

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Target Journal: (appendix A) The Journal of Psychology and Theology

Word Count: 8581 words (excluding abstract, table of contents, tables. list of figures, references, footnotes, appendices)

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

Abstract

Background. There is consistency in the literature about clinical psychologists feeling unready in discussing spiritual issues with their clients when the topic is raised. The prevalence of mental health difficulties are similar in both religious people and those who are neither religious nor spiritual. A significant amount of people accessing health services have spirituality, religion or faith as an important part of their identity. It would be beneficial to explore the literature in order to understand the challenges that CPs experience, which may influence their ability to incorporate spirituality into psychological therapy. *Method.* This systematic review was conducted using the Sample, Phenomenon of Interest, Design, Evaluation, Research (SPIDER) reporting tool. The sample for this review were the psychological practitioners who deliver psychological interventions directly to clients such as CPs, counsellors, psychotherapists, and psychologists, including trainee and qualified practitioners. The phenomenon of interest was the sample having provided interventions or therapy to clients with clearly defined religious, faith or spiritual needs. Literature of a qualitative and mixed methods studies were included. The evaluation that was explored was 'challenges' reported by the sample. *Results.* A total of 11 articles were included in this review. The four themes were outlined in the literature as challenges which were; medical model & theoretical framework challenges, organisational/ systemic barriers & clinical supervision barriers, professional challenges and cultural barriers**.** *Conclusions* implications of the findings highlight a critical issue that a significant amount of the literature on spirituality in UK is unpublished. In addition to the limited research, there was emphasis on the lack of evidence based theoretical frameworks used in the UK indicates a professional issue that likely impacts on the quality of care given clients of spiritual orientation.

1. Introduction

The aim of this section is to introduce the nature of the topic of spirituality, offer clarification of the concepts proposed for research, and outline the importance and relevance of this topic area within Clinical Psychology and within the National Health Service (NHS).

Spirituality, Religion and Faith

For clarity of reading, this section will begin by outlining the definitions of the three key terms used in the present research paper: Spirituality, Religion, and Faith.

Spirituality

Spirituality is argued to pertain to an individual's personal understanding, relationship, and connection with reality (e.g., nature) and/or a higher power, indifferent of religious affiliation (Drew & Banks, 2019). Other authors argue that spirituality is associated with the quality and meaning of life in connection with others and the planet (Paul Victor & Treschuk, 2020).

Religion

Contrastingly, religion is often understood as an institutionalised tradition and community, with beliefs, values, morals and symbols about divine power, or deity (Henay & Rollock, 2020). In addition, religion is attributed to traditional values and practices related to a certain group of people and is often guided by tradition, rules and culture (Paul Victor & Treschuk, 2020).

Faith

Comparatively, faith is understood to be different from religion as although it is also argued to be aligned with a set of beliefs, values, morals and symbols about a

divine power or God similar to religion (Haney & Rollock, 2020; Drew & Banks, 2019), it is suggested that this occurs outside of the individual's lifestyle (Shaw et al., 2016). The literature describes faith as more personal, subjective, and deeper than organized religion, and relates to the relationship with God or other spiritual entities (Paul Victor & Treschuk, 2020).

Although the three constructs can be defined distinctively, there has been lack of consistency within the global literature in how they are defined (Kapunscinki & Masters, 2010; Newman, 2004; Masters et al., 2022; Paul Victor & Treschuck, 2020). Some authors argue that faith, religion and spirituality are overlapping concepts with unique characteristics, yet difficult to define and thus challenging to measure (Masters et al., 2022).

A shared theme between the three constructs of faith, spirituality and religion, is how they help people to understand and manage negative and difficult life events such as divorce, onset of mental health difficulties, bereavement, financial loss and physical illness (Jenkins & Pargament, 2014; Wortmann & Park, 2008). Some authors suggest negative life events are a test from God, and followers of the religion are showing their reliance in their deity to support them through hardship (Emmons, 2005). Particularly in studies of people presenting with psychosis with delusions of religious content, research has found many people believe their difficulties are directly related to their religious beliefs (Menezes & Moreira-Almeida, 2010; Pierre, 2001). Other authors argue people can understand hardship based on their behaviour towards others e.g., in the sense of 'karma' (Stanford, 2007). Further, studies have found faith has been used to explain a personal resonance with events that occur in life (Exline et al., 2005).

Use of definitions

It is worthy of note that all three terms have distinct definitions, however, these are often used interchangeably in the literature (Newman, 2004). It is evident that there are close similarities between the three terms, although each term is individually complex in their conceptual components. Within its complexity, the concepts of spirituality, religion or faith can serve many functions, including providing people with a sense of identity (Ebstyne - King, 2003); support (Modood, 2010); and guidelines on how one should live their life (Nelson, 2009). In some cases, it can be viewed that a person may use all three constructs as part of their identity rather than just one. For example, a person who follows Hindu practices may identify as religious due to the connection with being part of a religious community and culture (Mysoreka, 2006). Followers of Hinduism may also identify as having a faith because of the choice in beliefs, and their influence on their lifestyle. Further, it could be argued they could also identify as spiritual due to a sense of connection with themselves, the world, and supernatural elements (Michaels, 2021). In other cases, people from the same group may choose to identify with different constructs varying on the level of importance they place on them, as has been observed in Christianity. Makrides (2012) argued that some followers of Christianity identified as religious because of their identification with an orthodox institution, community, and culture. Other authors have found some Christians identify as spiritual but not religious, due to their beliefs and perceived interaction on a personal level with God and the supernatural world (Nasel, 2004; Worthington et al., 2011). Taken together, it could be argued that this could provide an explanation for why most of the research on these constructs have used the terms interchangeably, despite their differential definitions and meanings (Lunn, 2009; Pargament & Sanders, 2007; Paul Victor & Treschuck, 2020).

Spirituality, Faith, and Religion have been chosen as the constructs of interest for the present paper, because studies show that many people have held onto their spiritual beliefs with more flexibility (Behere et al., 2013). For this reason, it can be argued that psychology and its various approaches have not replaced religious thinking as a means of guidance, but may have joined it (Pargament et al., 2013). Although the three terms have been used interchangeably in research studies, this review will mostly use the term spirituality to refer to the three constructs. However, in some places references may be made to the other terms when reporting the findings to remain faithful to the language used by the researchers.

1.1. The Prevalence Of Religion, Faith And Spirituality In The United Kingdom

A number of studies have provided statistics on the prevalence of religiosity and spirituality in the United Kingdom (UK) in people accessing mental health services. A survey by King et al. (2006) found 69.2% of surveyed people held a religious view of life; 13.1% held a spiritual view with no religious participation; and 17.7% held neither religious nor spiritual beliefs. Another survey of a clinical population found 35% of participants reported having a religious understanding of life; 19% identified as being spiritual but not religious; and 46% reported they were neither religious nor spiritual (National Psychiatry Morbidity study, 2013).

Further, studies have reported the prevalence of mental health disorders to be similar in both people who identified as belonging to a religion, and those who did not, as well as people who did not identify with any spiritual orientation (King et al., 2013). The same study also found people who identified as belonging to a religion were less likely to have ever used drugs. However, it is worthy of note the study relied on self-report measures, and the results may not be completely valid or accurate for example

due to demand characteristics or bias due to perceived judgement around disclosing substance misuse.

It can be indicated from the aforementioned research studies that a significant amount of people accessing health services may have spirituality, religion or faith as an important part of their identity. Research also demonstrates that people turn to their spirituality, religion or faith during times of crises (Proffitt et al., 2007). As many people access mental health services when in a period of crisis (Dalmida, 2006), it can be inferred that people who have a faith, religion or spirituality, may turn to these constructs to make sense of their experiences and possibly find ways of coping with their presenting problems (Pargament et al., 1998). The next section of the paper will explore the relationship between spirituality, mental health and therapy outcomes.

1.2. Relationship Between Spirituality, Mental Health And Therapy Outcomes

There is evidence suggesting that religion, faith and spirituality are positively related to mental health. A meta-analysis by Garssen et al., (2021) found that there was evidence for a positive association between Religion, Spirituality & Faith and mental health, however this effect was small. Other studies have found that people who reported higher levels of religious and spiritual wellbeing were likely to experience a reduction in mental health symptoms (Brown et al., 2013; Pardini et al., 2000).

Religious practises have been found to have an indirect impact on mental health by accumulation of psychological resources, and by preventing or reducing the link between stress exposure and poor mental health outcomes (Ano & Vasconcelles, 2005). The manner of accumulation of psychological resources may differ in the various religious groups. Christians are likely to meet consistently in ‘small groups’ in which

they offer psychological and emotional support to each other regularly in life matters that are important to each member of the group (Bade & Cook, 2008). Psychological and emotional support is often achieved in the manner of actively providing a space for each individual to be able to talk freely, and receive validation and compassionate responses from the group (McMinn et al., 2001). Other mental health resources include deep spiritual commitment to a life of meditation, high levels of commitment to family and community, values of persistence and patience, and reliance on religious or spiritual communities for spiritual hope and meaningful interpersonal relationships (McMinn et al., 2001). In addition, there is evidence suggesting that some religious, faith based or spiritual practices fall closely in line with psychological practices that are used in therapy such as meditating and reflecting, and letting go of what one cannot control to focus on values (Bade & Cook, 2008). In addition to symptom reduction and self-development, it could be argued that clients of spiritual orientation may identify additional goals, such as developing a greater connection with their deity (Drew & Banks, 2019).

On the other hand, it can be argued that following a religion has the ability to detrimentally impact mental health for its followers, through increased exposure to specific stressors. For example, a contradiction between religious values and personal identity, e.g. on the practice of sexuality for people who are gay or queer and follow religions that promote heteronormative ideology (van Der Toorn et al., 2020; Wortmann, 2013). Negative perceptions of mental health have also been found to exacerbate the stress of poor mental health, for example beliefs that mental difficulties are the result of personal sin or ‘demons’ (Stanford 2007). Maladaptive forms of coping associated with religious and faith-based practice have been found to be linked to adverse mental health (Lee et al., 2013). Examples of maladaptive religious coping include: beliefs that one has been neglected by God, or being punished, and feeling

ashamed of oneself (Pargament et al., 2011; Wortmann, 2013). According to research, bad religious coping, misunderstandings and miscommunication, as well as unfavourable beliefs, can all have a negative impact on one's mental health (Weber & Pargament, 2014).

Some studies suggest that spirituality and religion are differentially associated with mental health, for example, in collective trauma responses, Mclntosh et al., (2011) found that religiosity was associated with more positive affect, lower incidence of mental ailments and fewer cognitive intrusions than spirituality in the population of people that encountered the 9/11 attacks. In addition, some authors have argued that those who identify with spirituality more than religiosity were more likely to be depressed than those who identified as religious (Vittengl, 2018). In contrast others argue that those who are religious, but not spiritual are more likely to have self-focused, fruitless rumination and subsequently depression symptoms (Currier and Eriksson, 2017). As stated previously, spirituality, faith and religion have been defined differently by some authors (Drew & Banks, 2019; Paul Victor & Treschuk, 2020), they have emphasised that there yet to be a consensus on the definitions of these constructs. The majority of the literature on spirituality, religion and faith and mental health (Hackney & Saunders, 2003; James & Wells; Kent, 2020), tend to use the constructs interchangeably rather than differentially. Therefore, the validity of the literature suggesting a differential association between spirituality/religion/faith and mental health could be questioned. It is likely that the lack of consistency in how the constructs are defined around the world and the nature of their ambiguity would make it difficult to validly differentiate them as predictor variables for a particular outcome variable. Although studies examining religion, spirituality, and mental health generally indicate positive and negative associations, there is a need for more advanced methodology,

greater discrimination between various traditions and cultures and greater integration of theological contributions to this area (Dein et al., 2012).

It is well known that people can turn to spirituality when coping with life stressors (Pargament et al., 1998), and this can coincide with seeking professional assistance in the form of therapy. In clinical practice, current and future psychologists may find themselves confronted with a wide diversity of religious and spiritual backgrounds of their clients. In the past, few psychologists received professional training concerning religion and spirituality, despite the increase in the diverse backgrounds of people accessing therapy (Brawer et al., 2002).

According to research, some therapists are unprepared to speak with their clients about spiritual difficulties when the subject is brought up (Pargament & Saunders, 2007). The British Psychological Society practice guidelines offer direction for most clinical psychologists (CPs) and practitioner psychologists on working with people of faith, religion and spirituality (British Psychological Society [BPS], 2017). However, it is noted that the guidance only advises psychologists to respect clients' beliefs, include them [clients] provisionally into the intervention if useful, and to be aware that in some circumstances the clients' beliefs may be counterproductive to intervention (BPS, 2017, p. 34). It could be argued the lack of clear direction and guidance in the guidelines may leave practitioners feeling uncertain about how to sensitively approach and explore this topic in therapy. It can be argued that it is crucial to address religiosity and spirituality in clinical practice, as research indicates that authenticity within therapy for clinicians and clients is associated with better mental health and therapeutic outcomes (Burks & Robbins, 2012; Schmid, 2001). Studies indicate that for clients, authenticity involves the ability to feel able to use therapeutic space to explore themselves honestly and openly and a develop a good relationship with their therapist (Stevens, 2017). Authors

have also found that for therapists, authenticity involves the ability to have honest conversations with their clients, including issues that may be out of their comfort zone (Burks & Robbins, 2012). Authentic conversations can aid the development of more appropriate formulations for client, which then can support any necessary adaptations to the client's psychological therapy (Pachankis, 2009). For the purposes of this paper, it is argued that exploring religiosity and spirituality for clients who hold such beliefs and believe they are important to them, is part of having authentic conversations with clients.

It can be argued that adapting psychological therapy to clients' spiritual framework may positively influence the effects of treatment in many ways. First, understanding the client's faith and their relationship to it can help discover important risk and protective factors, as well as conceptualise the causes of psychological discomfort (Oman, 2019). This could entail examining the patient's spirituality in relation to their past, present, and future functioning as well as any problematic areas (e.g., spiritual struggles). Second, spiritually tailored psychological therapy may provide a broader context which could allow both the therapist and client to better understand the client's reasons for attending psychological therapy (Paulerk et al., 2011). Awareness of this for the client may be helpful in formulation and treatment (Stone, 2013). There are limited frameworks specifically used to address spirituality in therapy in clinical psychology in the UK. The dialogical model for engaging spirituality in therapy (Mutter & Neves, 2010) is a theoretical framework which focuses as recognising the client's spiritual narrative and the therapists' spiritual narrative. It focuses on a person's concept of who they are as both an individual, and in relation to each other. The framework also outlines that the client's spiritual narrative is shaped by their spiritual and religious views, which can also significantly affect how well they feel about themselves. The framework postulates that the therapist should pay particular

attention to how the client describes their identity as a member of a certain group, and the influence it has on their daily routines and interactions.

This use of this model allows both the client and the therapist to explore the nuances in which the client's experiences are framed by client but also heard/understood by the therapist. This model is largely used in the United States of America (USA), which differs significantly from the UK in regard to social, cultural and political integration of spirituality (Mutter et al., 2010; Lambert, 2010).

Research indicates clients in the UK access psychological therapy via the NHS as a form of treatment for mental health difficulties (Richards & Bower, 2011). Other papers argue that clients in the USA are more likely to access psychological therapy as part of general lifestyle and wellbeing (Rakow, 2013). There is also a financial difference in how services are accessed – in the USA the predominant model is health insurance, where clients pay to receive services, whilst in the UK, clients have access to free healthcare via the NHS as well as the option to access private healthcare (Schoen et al., 2007). It can be argued that clients in the USA may have more agency in selecting healthcare providers due to the insurance-based market nature of accessing support, whilst clients in the UK accessing therapy via the NHS are resigned to who they have been allocated to based on need and availability of the service provision (Tingle, 2020). For this reason, it could be suggested clients in the USA may feel more able to bring topics important to them to discuss, such as their spirituality, whilst clients in the UK may feel they do not have as much say in how their therapy is structured and what it includes.

In light of these differential reasons for accessing therapeutic support, it is unclear, the extent to which the dialogical model for engaging spirituality in therapy is compatible with use alongside other medical and psychological frameworks used to

understand and treat mental health difficulties in therapy such as the Diagnostic and Statistical Manual (DSM), and Cognitive and Behavioural based therapy models.

There are a number of psychological models and frameworks used in therapy which offer flexibility to be adapted to fit the individual's value system and how they make meaning of their life and the world. These models include Compassion Focused Therapy (Gilbert, 2009), Acceptance and Commitment Therapy (Hayes et al., 2004) and Systemic Therapy (Butler, 2017; Errington, 2017), all of which are widely used in the UK by CPs and other psychological therapists. Studies indicate that these models can be adapted to fit the needs of the client based on their age (Secker, 2004; Stallard et al., 2013), language spoken or culture (Naeem et al., 2021), and religious and spiritual needs (Lim et al., 2014: Naeem et al., 2015).

However, it can be viewed that when such models are adapted, it is often done in line with the original framework, and under clinical supervision to ensure that adaptations made remain congruent and faithful to the psychological model being used (Hall et al., 2016). For this reason, it is important to consider whether the issue of integrating spirituality into therapy may be due to the lack of adequate frameworks to support this [the integration], or rather, due to other internal and external obstacles to the profession .

There is a large body of evidence suggesting that in many cases when clients access therapy, their spirituality can either act as a pillar of support, or can contribute to the presenting problem however it is most often associated improved therapeutic outcomes across a range of mental health disorders (Currier et al., 2019; Drew and Bank, 2019; Moreira-Almeida, 2014). There has been a growing body of evidence suggesting that some CPs lack confidence in empowering clients to feel able to raise issues of spirituality to guide their therapy (Challis, 2017). It can be argued that this

could potentially hinder the outcome of therapy, as potential factors which could improve a client's experience of therapy, are not being included in the therapeutic process. This is important to consider, as the aim of psychological professionals treating clients is to do so in an effective, evidence-based manner.

As CPs are key in delivering, leading on and overseeing services providing treatment to clients, it is therefore crucial that CPs are appropriately qualified to supervise, consult, and educate other professionals to ensure the therapeutic work is holistic, individualised and tailored to the person's identity. It can be argued this includes the spiritual orientation of the client. Given that research has shown that incorporating spirituality into therapy for clients accessing mental health services has been associated with better outcomes of therapy, it is important to understand the barriers and challenges that may prevent this adaptation from being integrated into clinical practice.

1.3. Challenges

Research has found that many CPs report they do not feel adequately prepared to work with, supervise, consult or train other clinicians working with clients of spiritual orientation (Brown, 2013; Challis, 2017; Gonsiorek, et al., 2009). It would be beneficial to explore the literature in order to understand the challenges that CPs and people in psychological therapist roles experience, which may affect their ability to incorporate clients' spirituality into their clinical practice.

Challenges in this paper will be categorised in by indirect and direct barriers that CPs and psychological therapists perceive and experience when working therapeutically with clients which impact on their perceived ability to incorporate spirituality into the therapeutic process. First, it can be argued these barriers can be observed from an individual perspective in terms of clinicians' own views, beliefs, attitudes, commitment,

and interests towards spirituality and/or the client. Second, the barriers may also be observed from organisational and systemic levels; for example, standardised service assessment protocols and prescriptive and manualised treatment guides which do not include items on spirituality.

Finally, the barriers may also be observed in the more complex interaction between the individual and the wider community, in regard to moral and ethical issues and dilemmas. For example, this may involve incongruence in morality and values between the therapist and/ or organisational values and those of the client's spirituality such as freedom of sexual identity, or the morality of abortion. Professionally, according to BPS guidelines (Ahmed, 2008) CPs are obligated to take a neutral stance, in addition to ensuring that they do no harm to their clients by showing incongruence with the client's beliefs.

1.4.Aim Of Systematic Review

The aim of this systematic literature review is to explore the following question: 'What challenges are reported by UK-based CPs in addressing and incorporating client spirituality in therapy?'

Critically evaluating and compiling these findings will be helpful to inform clinical and educational practice in the UK, with the ultimate aim to improve therapy outcomes for clients.

Methods

2.1. Search Strategy

This systematic review was conducted using the Sample, Phenomenon of Interest, Design, Evaluation, Research (SPIDER) tool (Cooke & Booth, 2012) which is

a process for assessing qualitative and mixed method research. The SPIDER search strategy tool defines the key elements of the literature review question. The SPIDER search tool was derived as the alternative search strategy tool for qualitative/mixed methods to the more commonly used Population, Intervention, Comparison, Outcome (PICO) method (Amir-Behghadami & Janati, 2020). The PICO method is often used for defining elements of a review question for quantitative studies. To ensure that sufficient research representing the topic area was captured, the search terms were diversified using relevant synonyms. Table 1 shows the search terms that were used for the search on the 1st of March 2022. These search terms were clustered and truncated in the relevant databases using the Boolean operators of "OR" and "+". No date limitations were placed on the database search.

Table 1

Search Terms

Construct	Search Terms
Sample	Psychotherapist* OR Psychologist* OR Psychological Practitioner* OR Counselor* OR Counsellor* OR Therapist* OR Wellbeing Practitioner*
Phenomenon of Interest	Spiritual* OR Religio* OR Faith OR Sacred
Evaluation	Experience* OR Attitud* OR View* OR perspectiv* OR opinion* OR Challeng* OR difficult* OR obstacle* OR dilemma* OR barrier* OR frustration8* OR troubl* OR obstruct* OR stress* OR strain* OR perception* OR impact* OR reflect* OR impress* OR motivat* OR characteristic* OR expect* OR impact* OR belie* OR insight* OR issues OR feeling* OR evaluat* OR understanding* OR learn* OR know* OR story OR Process*

2.2. Eligibility Criteria

The sample for this review were the psychological practitioners who deliver psychological interventions directly to clients such as CPs, counsellors, psychotherapists, and psychologists, including trainee and qualified practitioners. Papers recruiting a sample of other allied health professionals that work with clients and employ psychological skills such as mental health nurses, social workers and assistant psychologists were not included. This was decided because it was argued that professionals belonging to this group may not have undertaken intensive masters or doctoral-level training or have the expected competencies of practitioner psychologists

of working complexly with psychological therapy interventions. Initially considerations were made to include papers from outside the UK; however, following a scoping search, it was apparent that countries vary in the nuances in which spirituality and religion are integrated into the culture and possibly academia. Therefore, findings from the literature from outside of the UK may not be transferable to the population of CPs and practitioner psychologists in the UK.

The phenomenon of interest was the sample having provided interventions or therapy to clients with clearly defined religious, faith or spiritual needs. Given the definition used in this paper for spirituality (Drew & Banks, 2019; Paul Victor & Treschuck, 2020). Qualitative and mixed methods studies were included to gather rich data on the phenomenon of interest. Unpublished theses were also included in the search. The evaluation that was explored was ‘challenges’ reported by the sample. There were no date limitations These are detailed in further in the inclusion/ exclusion criteria are detailed in Table 2.

Table 2

Inclusion and Exclusion Criteria

	Inclusion	Exclusion
Sample	Psychological practitioners that deliver psychological therapy interventions directly with clients such as counsellors, psychotherapists, and psychologists. Both qualified and trainee practitioners. Study carried out in the UK on UK professionals	Counselling educators Psychology and psychotherapy educators Mental health nurses/ social workers Assistant Psychologists (Not qualified or trained psychological practitioners). Clients Professionals from other countries (due to cultural and societal differences of nuances around spirituality).
Phenomenon of Interest	Exploring challenges around working with clients with clearly defined religious, faith or spiritual needs. New Age' type spirituality, nature worship, metaphysical/occult beliefs will also be included.	Cultural beliefs and needs (they may overlap with spirituality) but cannot be the phenomenon of interest.
Design	Qualitative or mixed methods design	
Evaluation	Challenges including: Ethical barriers Moral dilemmas Attitudes and beliefs Organisation/ systemic barriers.	Reports of psychologists' own views and attitudes of spirituality where no challenges are articulated.
Research Type	Primary research. Grey literature – Doctoral theses	Systematic Reviews Meta analytic Reviews

2.3. Databases And Information Sources

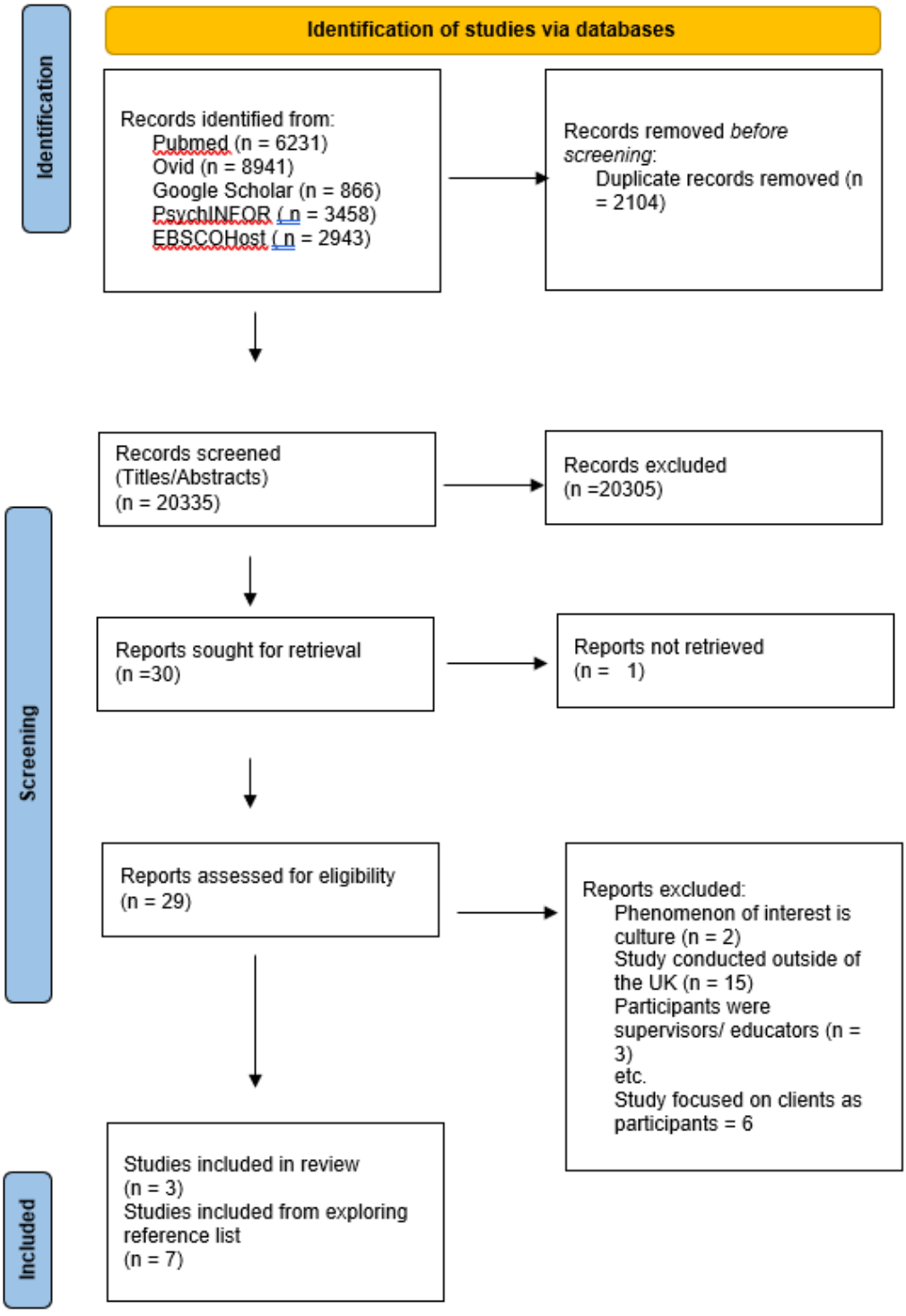
Searches were carried out using the following databases: Ovid, PsycINFO, EBSCOHost, and PubMed. In addition, a search of the grey literature on Google Scholar was conducted. Further, at the final stage of screening the reference lists of the retained papers were screened for additional relevant papers.

2.4. Screening And Selection

This process was conducted in accordance with the PRISMA guidelines (Page, 2021), which are highlighted in Figure 1. Papers retrieved from the databases were screened by examining the titles and abstracts in the first stage, and then the full texts were screened in a second stage. Rayyaan, a web-based system for managing literature reviews (Ouzzani et al., 2016) and Zotero a web-based reference manager (Mueen Ahmed et al., 2011) were used to manage the screening and selection process. The inclusion/ exclusion criteria were used to guide the screening of the titles and abstract. Largely the phenomenon of interest and sample were used to exclude articles at this stage. Majority of the excluded articles were focusing on experiences from a client perspective, use of psychiatric medication, diagnosis of psychiatric medical conditions.

Figure 1

Prisma Flow Diagram



Results were initially filtered by excluding books, essays and articles that were not written in the English language. This was done using the automatic filters options provided by the databases. Filtering then continued by screening the titles and abstracts of articles; the majority were excluded because they were focusing on client perspective or explored educational and training experiences. A total of 30 papers were screened by reading the full text. After this initial screening, the finalised papers' references were examined for any further pertinent articles (Armstrong et al., 2005). Majority of the articles found (n =7) were not retrieved through entering the search terms in the database because they were unpublished doctoral thesis.

At this stage, to confirm the validity of the procedure, an additional independent rater assessed 50% of the articles. Between the researcher and the second rater, there was complete agreement regarding the omitted or included studies, ensuring the legitimacy of this method. Ten articles in all were used for this review.

2.5. Quality Evaluation

The final articles were reviewed using the Critical Appraisal Skills Programme (CASP) checklists for qualitative studies, case-control studies, randomised control studies (CASP, 2018). The CASP checklist tool for qualitative studies has been evidenced to perform quality appraisal as part of a systematic review and qualitative evidence synthesis (Long et al., 2020; Majid & Vanstone, 2018; Williams et al., 2020). The broad issues which were considered when appraising the qualitative studies were the appropriateness of methodology/method; whether the study results are valid; clarity of the study results; consideration of bias or limitations; and whether the results will help locally. The second independent rater for the screening process was also asked to use the CASP checklist to perform a quality appraisal on the 10 articles. The final

findings and were discussed between the raters and there was agreement that all articles reviewed were granted a good rating.

2.6. Synthesis

As the majority of studies were qualitative studies, the findings from the selected studies were analysed using Thomas and Harden's (2008) thematic synthesis method. The three stages of this process are as follows: 1) coding the text from the authors' papers, 2) going line-by-line, 3) developing "descriptive themes," and 4) creating "analytical themes." The analytical themes indicate a stage of interpretation where the reviewers "move beyond" the source research and produce new interpretive constructions, explanations, or hypotheses, whereas the creation of descriptive themes remains "near" to the underlying studies (Thomas & Harden, 2008). In the study using mixed methods, only the qualitative findings of the research were analysed. A line-by-line analysis using an inductive approach was used to identify initial codes relating to challenges in the data from each article, according to its meaning and content. Line-by-line coding allowed for the translation of concepts between studies and the development of descriptive themes. A table of the thematic synthesis is in Appendix D.

2.7. Reflexivity And Epistemological Stance

The synthesis was conducted by the researcher who has an interest in the topic and has a faith as part of their identity.

The researcher is a trainee CP who identifies with some of the experiences shared in the literature on the challenges of incorporating spirituality into therapy. For example, the researcher considered the perceptions they brought to the analysis of the review findings and has chosen to explore the literature with the epistemological stance of social constructionism. In order to comprehend what happens in society and create knowledge based on this understanding, social constructivism emphasises the

significance of culture and context (Kim, 2001). The two key tenets of this epistemology are (a) the presumption that people reason their experiences by building models of how the social world works and (b) the conviction that language is the primary tool used by people to construct reality. (Amineh & Asi, 2015).

3. Results

A total of 10 articles were included in this review and are detailed in table 3 below.

Table 3

CASP Summary of the 10 studies

Reference	CASP Score	2nd Rater CASP Score	Aim	Design and Analysis	Data	Risk of bias/Limitation	Findings in relation to the systematic literature review question.
1. Challis, E. (2017). What can and cannot be said: Discourses of spirituality and religion in clinical psychology.	9/9	8/9	To answer the 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?	Design: Qualitative focus group design and Discourse Analysis methodology.	3 focus groups with semi structured interviews. 2 of the groups were trainee CPs and 1 focus group of qualified CPs.	One of the focus groups had Trainee Clinical Psychologists, in the same cohort, whom were aware of the researcher's personal religious beliefs.	Participant reported challenges around balancing medical and therapeutic discourses for example when working with people with 'psychosis'. Participants also reported challenges around negotiating what can be said. This was particularly around self-disclosure of personal spiritual views.
2. Crossley, J. P., & Salter, D. P. (2005). A question of finding harmony: A grounded theory study of clinical psychologists' experience of addressing spiritual beliefs in therapy. *Psychology and Psychotherapy: Theory, Research and Practice*, *78*(3), 295-313.	9/9	8/9	To explore how clinical psychologists address spirituality in therapy.	Design: Qualitative semi structured interviews Analysis: Grounded theory analysis	Semi structured interviews conducted on 8 qualified CPs.	No clear description of limitations of the study, which may indicate some bias.	Spirituality was also characterised by the lack of discussion of the topic within the professional and training context of Clinical Psychology. There was a strong emphasis in some of the interviews of the unease that is associated with debate on spirituality at a cultural level. There was a theme of not engaging with spirituality because of factors related to the participant's background. Some participants reported not inquiring about spiritual beliefs, because of the limited significance of this area to the therapist. The diversity and flexibility of the meaning of spirituality made some participants suggest that boundaries to the concept of spirituality were necessary.

Table 3

CASP Summary of the 10 studies (Continued)

Reference	CASP Score	2nd Rater CASP Score	Aim	Design and Analysis	Data	Risk of bias/Limitation	Findings in relation to the systematic literature review question.
3. Woodhouse, R., & Hogan, K. F. (2020). "Out on the edge of my comfort": Trainee counsellor/psychotherapists' experiences of spirituality in therapy—A qualitative exploration. *Counselling and Psychotherapy Research*, *20*(1), 173-181.	8/9	8/9	To explore trainee counsellor and psychotherapists' perceptions and experiences of integrating spirituality into therapy trainees' personal understanding of spirituality and how it may impact on the therapeutic alliance, and their perceptions of what spiritual issues may present in therapy.	Design: semi structured interviews. Analysis: Thematic Analysis	Inductive qualitative approach of listening to participants' lived experiences. 6 trainee counselling psychologists.	All participants were of white British demographics. This may have influenced cultural perceptions aligned with the topic.	Whilst spirituality is viewed as a framework for clients to explore meaning and purpose, it was also viewed as creating conflicts. There is a sense of confusion and avoidance on how to integrate spirituality into the therapeutic relationship. The ethical dilemma is around being person centred. Is it sorely for the client to lead and bring? However, some participants felt the onus was on the therapist. Assessments can explore a client's spirituality; however, the challenge was around integrating it into therapy. There is a perceived link between expressions of spirituality and mental health disorders. This propensity to characterise some spiritual practices as pathology may reflect a lack of training around the distinctions between spiritual experience, whether ecstatic or normative, and psychopathological conditions. Spirituality being a very personal issue to talk about, like sex. Therapists can be restricted through a fear of offending or getting something wrong. There was minimal training on the spirituality and the perpetuated the feelings of ill preparedness for the therapists. Experiences or worries about being judged may prevent the exploration of spirituality.

Table 3

CASP Summary of the 10 studies (Continued)

Reference	CASP Score	2nd Rater CASP Score	Aim	Design and Analysis	Data	Risk of bias/Limitation	Findings in relation to the systematic literature review question.
4. Harbidge, P. R. (2015). *An Exploration of How Clinical Psychologist make Sense of the Roles of Religious and Spiritual Beliefs within their Therapeutic Work with Adults who have Experienced Trauma?* (Unpublished Doctoral dissertation, University of East London).	7/9	8/9	To explore how clinical psychologists define and understand their own values with regard to religion and spirituality.	Design: Individual Semi structured interviews Analysis: Thematic Analysis	8 psychologists were interviewed.	There was no representation of males. It is acknowledged that a more systematic approach, such as recruitment from within additional NHS sites and seeking out targeted representation, may have enabled a richer data sample to be drawn.	Spirituality not easy to talk about and likened to sex in the nature of the social appropriateness of discussing this. Other participants alluded on how on some level these topics may be experienced as heavy and potentially charged, thus, needing to counter balanced through humour and light talk. Spirituality largely absent in the practice of participants because of constraints on the NHS, with limited time and sessions. Participants described not being able to work with the whole person. Working in contexts with the medical model was described as another challenge as spirituality does not align with the medical model. This was particularly around diagnostic and treatment terminology. The role of a psychologist, holding responsibility to implement evidence-based interventions rooted within objective evidence. This was harder to do because of ambiguity of spirituality

Table 3

CASP Summary of the 10 studies (Continued)

Reference	CASP Score	2nd Rater CASP Score	Aim	Design and Analysis	Data	Risk of bias/Limitation	Findings in relation to the systematic literature review question.
5. Baker, M., & Wang, M. (2004). Examining connections between values and practice in religiously committed UK clinical psychologists. *Journal of Psychology and Theology*, *32*(2), 126-136.	6/9	6/9	The focus of the study was to detail and analyse how the intersection of workplace experience and religious values may enhance and/or detract from the practice of respondents	Not described well, assumption is that this was a mixed method design. With an experiment task and semi structured interviews. Grounded theory analysis.	Respondents were 14 religiously committed U.K. clinical psychologists practicing in a teamwork situation alongside secular colleagues, under the regulation of an employing organization, the National Health Service (N.H.S.), and a professional accrediting body, the B.P.S.		NHS policy restricts psychologists from being authentic in matters of spirituality. The idea that practitioners could be punished for talking about spirituality e.g. for a dying client.

Table 3

CASP Summary of the 10 studies (Continued)

Reference	CASP Score	2nd Rater CASP Score	Aim	Design and Analysis	Data	Risk of bias/Limitation	Findings in relation to the systematic literature review question.
6. Begum, N. (2012). *Trainee clinical psychologists talking about religion and spirituality in their work* (Unpublished Doctoral dissertation, University of East London).	7/9	8/9	To explore trainee clinical psychologists' experiences of religion and spirituality, and how this relates to and impacts upon their professional training.	Qualitative individual semi structured interviews Analysis: interpretative phenomenological analysis	8 Trainee CPs with different religious/non-religious backgrounds.	A decision to adopt an opportunistic sampling method was made for practical reasons; to gain participants who were immediately available and freely consenting to participate. The homogenous sample consisted of all female, White participants taken from the same cohort year group, with a mean age of 29 years.	Participant (CP) personal views can make it difficult to understand a client with strong beliefs. This can lead to lack of collaboration and religion is avoided due to the assumption that there is a line between the profession and religious beliefs. Supervision in clinical practice lacks engagement in talking about spirituality. This adds the barriers to discussing it in therapy. Models of psychology can facilitate formulation and therapeutic intervention with spiritual or religious frameworks. However, there was lack of theoretical teaching on this. There was a sub theme that it was difficult to disentangle religion from culture which influenced avoidance of religion or spirituality as its own factor for some clients.

Table 3

CASP Summary of the 10 studies (Continued)

Reference	CASP Score	2nd Rater CASP Score	Aim	Design and Analysis	Data	Risk of bias/Limitation	Findings in relation to the systematic literature review question.
7. Arthur, Y. (2018). Narratives of Christian and Muslim Qualified and Trainee Clinical Psychologists Working in the NHS (Doctoral dissertation, University of East London).	7/9	7/9	To explore any conflicts or dilemmas that may have arisen for these psychologists due to their religion/spiritual beliefs; in order to understand how they manage such occurrences.	Face to Face individual interviews Analysis: Narrative Analysis	5 individual interviews with 2 trainee CPs and 3 qualified CPs	Sample was limited to only Muslim and Christian qualified and trainee CPs.	CP doctorate and discipline of psychology focuses on trainees and qualified practitioners being neutral and professional. Safety to discuss spirituality is needed for both the client and the practitioner in the room. Safety is not provided by supervisors, training courses and the wider profession. 1
8. Arshad, R. (2007). *How do clinical psychologists work with religious themes in psychosis?*. University of Leicester (United Kingdom).	8/9	7/9	To gain an insight into how clinical psychologists address the religious themes that emerge in the therapeutic encounter with clients experiencing psychosis, particularly when religion is an important.	Quality study with individual interviews. Grounded theory analysis.	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.	Nature of service and professional context only allowed for religious themes to be explored if they are related to the presenting problem. Explicit reason needed to explore religious themes due to fear that, exploration could potentially sabotage rather than complement the psychological work being done. Limited guidance and resources for exploring themes of spirituality. The topic area is also not supported in teams.

Table 3

CASP Summary of the 10 studies (Continued)

Reference	CASP Score	2nd Rater CASP Score	Aim	Design and Analysis	Data	Risk of bias/Limitation	Findings in relation to the systematic literature review question.
9. Betteridge, S. (2012). *Exploring the clinical experiences of Muslim psychologists in the UK when working with religion in therapy* (Doctoral dissertation, University of East London).	7/9	7/9	To provide a more detailed examination of what is occurring for therapists and clients within that faith	Qualitative research methods were chosen and used from a critical realist philosophical framework. Grounded theory analysis used.	Semi structured interviews of six Muslim psychologists' experience of religion in therapy	This study was not necessarily looking at current cases and was therefore retrospective in nature. It is difficult to ascertain how accurate therapists' accounts of what they did are; it also did not look at therapy outcomes and although participants felt that there was a better connection with spiritual clients and that	Difficulties were often associated with a lack of congruence around having religion in therapy, different beliefs between therapist and client, or a therapeutic model that is not congruent with the client's religious framework. Clinical, therapeutic, and ethical dilemma regarding whether to bring it up for the client or waiting for the client to bring it up.

1

positive experiences.

Table 3

CASP Summary of the 10 studies (Continued)

Reference	CASP Score	2nd Rater CASP Score	Aim	Design and Analysis	Data	Risk of bias/Limitation	Findings in relation to the systematic literature review question.
10. Mills, J. (2010). *An exploration of trainee clinical psychologists' experiences of engaging with psycho spiritual issues in clinical practice* (Doctoral dissertation)	9/9	8/9	To gain perspectives regarding the importance of religion and spirituality within training and clinical practice	Design: Mixed methods. A survey. A questionnaire survey of UK Doctorate in Clinical Psychology courses to determine the provision of religious and spiritual teaching currently provided. A qualitative study involved a semi-structured interviews	Semi-structured interview of 8 third-year trainee clinical psychologists to explore their experiences of engaging in psycho-spiritual constructs in clinical practice.	A potential limitation of the study was the reliance on self-report. The participants may have had a desire to provide contrived responses, to avoid displaying clinical weakness or inadequacies. However, as the interviews progressed,	Preliminary survey: Inconsistent findings were noted. Courses varied in the time allocated to religious and spirituality teaching, ranging from no teaching to two-and-a-half days over the three year course. Curriculum content also varied, with an inconsistency of opinion of what should be included in teaching. Five superordinate themes emerged; provision of religious and spirituality training, trajectory of clinical practice, locus of control, existential issues and personal religion and spirituality ideology. There are theoretical limitations to incorporating religion and spirituality and in addition there was a worry described around the possibility of causing offence.

		Analysis: Interpretative phenomenological Analysis.	personal narratives evolved providing honest and frank accounts of their practice. A mixed gender sample may have provided an opportunity for further interpretation to be considered.	Some models/interventions such as Mindfulness which is derived can create personal and professional religious dilemmas. There are uncertainty about the role of religion and spirituality in Mental health services. Contradictory message relayed from the psychology profession, course staff, NHS Trusts and clinical supervisors. These cause confusion on whether religion and spirituality should be explored. This makes it an unsafe territory. An experience of criticism of wearing a fashionable silver cross from a supervisor, left one participant feeling religion was not a safe area to discuss. Participants also articulated other barriers which are better placed as external locus of control. Many factors appeared to be influenced by systemic factors which were thought to be outside of participants' control. Organisational issues provided the greatest number of external factors. These included: NHS Trust and service philosophies; political and societal viewpoints; an absence of professional guidelines or training and knowledge of the profession's ill-defined position on incorporating religious and spiritual into clinical practice. Participants reported challenges of concern in distinguishing between healthy or unhealthy religious belief.

4. Findings

The aims of the appraised studies were all exploratory, looking to investigate how religious or spiritual topics were conceptualized, addressed in clinical practice, and/or raised in supervision. None of the papers specifically looked at challenges, however, all papers reported "challenges" within their findings. The findings from the reviewed studies were synthesised to focus on the reported "challenges" that CPs and psychological therapist face regarding incorporating spirituality and religion into their therapeutic work with their clients (see appendix B for synthesised summary of systematic review findings).

4.1. Medical Model and Theoretical Framework Challenges

Within the papers reviewed, there was an emphasis on the limitations of the framework which CPs and other psychological therapists use within the NHS or other organisations that deliver similar services. Firstly, the medical model was described to be one of the challenges that CPs found when working with people that had religious faith or spiritual backgrounds. The issues raised particularly gave reference to the diagnostic model in mental health which focuses on certain experiences that may be deemed associated with religion and spirituality as symptoms of mental health problems (Harbidge, 2015). Therefore, if work was considered within a medical model, this would mean treatment would also not include incorporation of the individual's religion, faith or spirituality, and any experiences associated with spirituality could be pathologized as 'abnormal' (Ouwehand et al., 2020; Sandage et al., 2022). In addition, concerns around distinguishing between healthy and unhealthy religious beliefs were described as a challenge in mental health services working with medical model, for example 'psychosis' (Challis, 2017). There is a perceived link between expressions of spirituality and mental health disorders (Mills, 2010). This inclination

to characterise some spiritual practices as pathology may reflect a lack of training or UK socio-cultural perceptions around the distinctions between spiritual experience, whether ecstatic or normative, and psychopathological conditions (Woodford & Hogan, 2019). Adequate training could help CPs competently distinguish between religious or spiritual experiences and psychotic experiences. Although both share non-rational experiences, it is important to establish an evidence-based framework which can be used to guide the distinction between them (DeHoff, 2015).

In regard to theoretical framework challenges, the findings of various papers alluded to the role of a psychologist and holding responsibility to implement evidence-based interventions rooted within objective evidence (Harbidge, 2015). Difficulties were often associated with a lack of congruence around the value of religion between the therapist and client and different beliefs between therapist and client, or a therapeutic model that is not congruent with the client's religious framework (Betteridge, 2012). However, there are multiple psychological models that allow flexibility to incorporate religion and values such as Compassion Focused Therapy (Gilbert, 2009), Acceptance and Commitment Therapy (Hayes et al., 2004) and Systemic Therapy (Butler, 2017; Erringtom, 2017). It could be argued that the challenges may lay with the perspectives and attitudes of the therapist rather than the therapeutic models used.

4.2. Organisational/ Systemic Barriers and Clinical Supervision Barriers

The findings on the topic also articulated further external barriers influenced by systemic factors which were thought to be outside of participants' control. Organisational problems contributed the most external variables. Political and social beliefs, a lack of professional rules or training, a lack of knowledge of the profession's ill-defined position on incorporating religious and spiritual topics into clinical practise, and NHS Trust and service

philosophies were among them. (Mills, 2010). These barriers presented in two forms, firstly organisational policy barriers. One paper found that CPs felt that NHS policy restricts psychologists from being authentic in matters of spirituality (Arshad, 2007), due to the notion that practitioners could be punished for talking about spirituality, e.g., for a dying client (Baker & Wang, 2004). Although, none of the papers mentioned a specific NHS policy, these findings are in line with research that contends that there are no agreed definitions of spirituality or spiritual care, although NHS Trusts are mandated to respect patients' religion and beliefs (Harlow, 2010). Subsequently, NHS Trusts are left to find a model for the delivery of holistic care that fulfils the expectations of those who practice a religion and those who do not, within the boundaries of Human Rights legislation (Harlow, 2010; Sango & Jones, 2014). The papers reflected the uncertainty about the role of religion and spirituality in mental health services, which is experienced in contradictory messages on whether religion and spirituality should be explored, hence making it an unsafe territory (Mills, 2010). There was also emphasis that the nature of service and professional context only allowed for religious themes to be explored if they are related to the presenting problem (Arshad, 2007).

The second form in which these barriers present, was conveyed to within the immediate wider system of their work, through team practice, and clinical/managerial supervision. These barriers presented in the form of being 'judged' when considering spirituality in meeting settings (Woodgate & Hogan, 2019). Supervision in clinical practice was described to be lacking engagement in talking about spirituality which added to the challenges of addressing the topic in therapy (Harbidge, 2015). In one paper the findings expressed an experience of criticism for wearing a fashionable silver cross from a supervisor, leaving a participant believing that incorporating spirituality into therapy could lead to further criticism (Begum, 2012). Aten and Heenandez (2004) argue that very few supervisees receive the training and supervision necessary to competently address religion in therapy. Despite the

availability of models to guide the learning and discussion around spirituality and religion in clinical supervision (Aten & Heenandez, 2004, Bienenfeld & Yager, 2007; Bishop et al., 2003), the lack of engagement in this topic may be associated with individual and socially held biases and interest in the topic areas (Gutierrez et al., 2020).

4.3. Professional Challenges: Ethical Challenges and Lack of Training

Ethical Challenges

Approximately half of the papers noted that there were challenges based on ethical dilemmas. These papers found that Clinical Psychology doctorate and discipline of psychology focuses on trainees and qualified practitioners being neutral and professional (Authur, 2018). In addition, safety to discuss spirituality is needed for both the client and the practitioner in the room. However, the findings suggested that safety is not provided by supervisors, training courses and the wider profession (Betteridge, 2012). Provision of the needed safety would involve authentic permission for the supervisee to explore their thoughts and perspectives without criticism or judgement and validation of any difficult and uncomfortable emotions associated with discussion of the issue (Halpert et al., 2007). For the space to be experienced as safe it must provide empowering and respectful clinical supervision rather than neutral, critical and punitive clinical supervision (Halpert et al., 2007; McMahon & Errity, 2013). This aligns with the argument that when Clinical Psychology as a profession, focuses on taking a neutral stance, it facilitates the reinforcement of inequalities (Patel, 2010). In this instance, the profession may reinforce inequalities in the quality of therapy provided to religious/spiritual clients. Discussions of spirituality may conflict with the scientist-practitioner model, which many CPs are trained and work in (Petocz, 2018). In this model, emphasis should be placed on the successful integration of science and practice, where the relationship between the two variables is carefully considered (Jones & Mehr, 2007). However, spirituality may be challenging to integrate within this model, as it is often

viewed as ambiguous and difficult to clearly define in a generalisable and reliable manner (Pesut et al., 2008).

In most studies, there was a sense of confusion and avoidance on how to integrate spirituality into the therapeutic relationship. However, one paper discussed in detail an ethical dilemma around being person centred, whether this was sorely up to the client to take the lead by linking their spirituality into the desired therapy outcomes, or even as a resource or challenge in relation to their wellbeing. Other participants felt the onus was on the therapist; the argument was that comprehensive psychological assessments can explore a client's spirituality, this could also be observed in the psychological formulation, however the challenge was around integrating it into therapy (Woodford & Hogan, 2019). This reiterates the findings that there is no clear support provided in the profession regarding how CPs can incorporate spirituality in the therapy of clients.

Lack of Training

The systematic review found that spirituality was also characterised by the lack of discussion of the topic within the professional and training context of Clinical Psychology (Crossely & Salter, 2005). There was minimal training on spirituality and this perpetuated feelings of ill-preparedness for the therapists (Woodford & Hogan, 2019). In addition, the findings suggested that psychological models could facilitate formulation and therapeutic intervention with spiritual or religious frameworks. However, there was lack of theoretical teaching on this (Begum, 2012). Majority of Clinical Psychology programmes and psychology faculties in universities have limited research relating to spirituality and religion| in mental health (Schafer et al., 2009). Read et al. (2016) surveyed trainee CPs and only about 35% of them reported a religious identity, suggesting there may be limited interest in

the topic. The lack of interest and research in this topic area also poses as a barrier to the development of appropriate teaching frameworks.

The literature also focused on the need to ensure that the therapeutic relationship was protected. The fear of offending a client, getting it wrong and rupturing the therapeutic relationship impacted significantly on the outcomes (Arshad, 2007). There are theoretical limitations to incorporating religion and spirituality and in addition there was a worry described around the possibility of causing offence (Challis, 2017).

4.4 Cultural Barriers

Findings of four studies highlighted British cultural nuances regarding appropriateness of discussing spirituality. There was emphasis on the topic being viewed as 'personal' and was likened to sex in the nature of the social appropriateness of discussing this (Harbidge, 2015; Woodford & Hogan, 2019). In one paper, participants alluded to how on some level these topics may be experienced as heavy and potentially charged, thus, needing to be counterbalanced through humour and light talk (Harbidge, 2015). Often in the UK, when cultural barriers are considered as teaching, training and practice, it does not often consider the British cultural barriers that may be brought to the therapeutic settings (Turpin & Coleman, 2010). Some of the papers emphasised in their outcomes that one of the challenges associated with the unease of topic, is associated with difficulties of understanding spirituality at a cultural level (Crossely & Salter, 2005). It can be argued that the cultural diversity within the UK may be linked to the spiritual diversity, however, for the CPs with limited exposure to diverse communities, understanding the nuances and complexities that may present between spirituality and culture may be difficult.

5. Discussion

The present systematic review explored the challenges reported by clinical psychologists and psychological therapists in addressing client spirituality and religion in therapy. Overall, the published literature in the UK on the area of spirituality and religion in therapy practice is limited. The majority of the literature in this review was unpublished Clinical Psychology doctoral theses. It is important to consider possible constraints for the publication of literature around spirituality. According to research, the peer-review process has social and subjective aspects that influence this perspective, including important stakeholders' communication, such as authors, editors, and peer reviewers (Glonti & Hren, 2018).

The studies included a mixture of participants with and without religious/ spiritual affiliations. It is interesting to observe that despite this difference, there were shared experiences and perceptions of challenges described by qualified and trainee CPs across the UK. It was not clear in a majority of the studies the locations in the UK in which the participants were working in. Clarity on this, could provide insight into whether there were any differences reported in challenges for therapists working in locations with multi-faith populations.

The findings reported reflect the clinical implications of the debate of how religion and spirituality are understood within a medical model and the scientist-practitioner framework (Jones & Mehr 2007; Scafer et al., 2011; Shapiro, 2002). It can be suggested that the reflective practitioner model (Lilienfeld & Baterfield, 2020) could be used to bridge the gap currently posed in this field. This model blends functional competence approaches for practitioners and personal competence approaches (Cheetham & Chivers, 1998), allowing CPs to hold value, not only the functional competences, that are expected of the profession e.g assessment, formulation, organisational leadership, but also hold to value the competences around, reflection, self-awareness and self-examination (Handley, 2017).

However, particularly for CPs in the UK, professional emphasis is held on being reflective on the impact of one's own beliefs, attitudes and practice which also aligns with the reflective practitioner model. The findings of illustrated that there was a sense of 'lack of safety' around the topic of spirituality. Despite religion, spirituality and faith being protected characteristics in the UK (Limb, 2021; Talati, 2016), the findings illustrate that this is an area that is clinically ambiguous and the organisations that navigate how CPs train and practice have no clear guidelines or expectations of practice. This lack of clarity makes incorporation of spirituality into clinical practice appropriately for clients to be perceived as professionally and ethically unsafe for CPs. It would be important for DClinPsy training course and organisations such as the BPS to consider how this safety can be provided for qualified and trainee CPs.

5.1. Methodological Implications

Limitations Of the Evidence Base

The culture of the researcher can influence the interpretation of data collected using interview transcripts from a study into psychotherapy and spirituality (West, 2009). All studies reported that a majority of participants were female; it would be helpful to understand the perspectives on the topic from more male participants. However, the majority of trainee and qualified CPs in the UK are female, therefore this can be expected given the population in which the studies sampled. All studies also recruited a volunteer sample, likely drawing a sample particularly from people who had an affiliation or interest to this topic area. This could influence the types of challenges likely observed in the literature. Mostly qualitative studies were reviewed due to the nature of the phenomenon of interest, and although the researchers clearly stated the phenomenological stance in which they analysed and the reported the data, the nature of their affiliation and interest with the topic would likely influence the challenges reported. Another constraint of this literature is the high proportion

of unpublished doctoral theses. The absence of the peer review process which examines the bias through the publication process (Rowland, 2002) can also help in the quality appraisal of the research. The quality appraisal of the studies was strong despite being unpublished, the assumption was held that these studies were held to a doctoral standard and not including them, would lead to also attaining a publication bias (Dwan, et al., 2008).

Strengths Of This Review

The review offered a narrow focus on exploring practices and perceptions of spirituality in practice for clinical psychologists. The systematic review followed evidence-based procedures (SPIDER, 2012; PRISMA, 2021 and CASP, 2018) which guided the comprehensive search for evidence, the criterion-based selection of relevant evidence, the rigorous appraisal of quality and risk of bias, and the qualitative summary, and the evidence-based inferences**.** Another strength of this review was that a second researcher was able to assess the eligibility of a portion of search results for inclusion. Using a second reviewer throughout the entire study screening process can increase the number of relevant studies identified for use in a systematic review (Stoll et al., 2019). Although spirituality could be viewed as a subjective and abstract topic to conceptualise, a strength of this review was that the search used various synonyms and terms that could account for how other researchers would conceptualise spirituality to reduce the likelihood of studies being missed.

Limitations Of This Review

The use of hand-searching the grey literature rather than using a targeted database alone is a limitation of the review, as this limits the reliability of the review methodology. In addition, the search terms used were broad, around the topic of faith, spirituality and religion, use of specific search terms such as “Buddhist, Catholic, Muslim and Pegan” may have yielded search outcomes more relevant to the phenomenon of interest.

This review chose to exclude studies from outside the UK in order to examine issues that were culturally, politically and socio-economically relevant to the UK. Although this meant the findings of this study can be generalised across the population of CPs and psychological therapists in the UK, including the papers from outside of the UK may have offered clarity on the challenges that may present cross-culturally. In addition, the findings may have offered insight in how the barriers reflected in the studies in the UK may provisionally be overcome in other countries. This would be helpful for considering theoretical implications of this review in the UK.

Whilst all unpublished studies scored reasonably well on the quality appraisal, it is crucial to note that this process is also prone to bias (Long et al., 2020). The CASP tool was found to provide lower agreement within and between reviewers compared to the other evaluation methods, but it did provide a good indication of the procedural features of a study and the information that should be reported (Dixon-Woods et al., 2007). The use of a second independent rater on the quality appraisal of the studies may have reduced likelihood of bias, and any differences between the raters as the differences between the raters were dicuseed.

5.2. Implications

The findings of this review focus on the need for clear evidence based theoretical frameworks of incorporating spirituality into teaching. Where there is limited evidence, it may be helpful to draw on models used abroad such as the dialogical model for engaging spirituality in therapy (Mutter & Neves, 2010). However, there is currently limited evidence on clinical and educational use of this model. In addition, considerations should be made about whether the models used in other countries may also be inappropriate for use in the UK due to differences in organisational and national laws and policies around spirituality. Majority of the evidence around spirituality originates from countries such as the United States of America (USA), Israel, and South Africa. Although these countries tend to use

similar therapeutic, evidence-based models as those used within the UK, political and socio-cultural views regarding spirituality may be significantly different to those current existing in the UK. It may be beneficial for future research to explore current practice-based evidence with CPs and psychological therapists that have experience and competence of effectively incorporating spirituality into psychological therapy in the UK.

Results of this review suggest that many CPs may not believe that there are clear and consistent guidelines on how to incorporate spirituality appropriately into practice within the NHS and other organisations. Spirituality appears to not be accepted well in medical contexts with current mental health diagnosis model allowing for bias based on the professional's awareness of spirituality (Challis, 2017). There are psychological models that allow the integration of spirituality into therapeutic practice such as Acceptance & Commitment Therapy (ACT; Hayes et al., 2004) and the Power Threat Meaning Framework (Johnstone & Boyle, 2018). ACT is a values-driven therapy that promotes transcendence of physical, mental, and emotional experience to lessen human suffering (Santiago & Gall, 2016). The values – based work allows spirituality to be considered more easily. However, again there is no clear guidance on using these models to incorporate spirituality and it may be up to the discretion of the CPs in deciding how they use these frameworks.

Spirituality is one of the protected characteristics of the Equality Act (2010, section 10). As a result, it is important for all clients who access psychological therapy to not experience a disadvantage in the quality of their treatment due to professional lack of competence in addressing and incorporating spirituality into therapy. The BPS encourages CPs to incorporate spirituality into interventions and recognises that lack of consideration of this may impede on engagement in the intervention (BPS 2017, p. 34). Whilst there has been increasing pressure for the Psychology profession to move away a from a stance of avoidance and neutrality in issues regarding prominent parts of people's identities such as gender, race,

and disability (Keville, 2018), this review has synthesised holistically, the previous underreported professional issues associated with avoidance of integration of spirituality in therapy for clients. Given the themes described in the findings it would be important for further systematic reviews to explore practices of teaching spirituality on the doctorate in clinical psychology courses across the UK and consider expanding this search to the Doctor of Counselling Psychology Courses in the UK.

6. Conclusion

The present systematic review explored the current literature on spirituality and current practice of CPs in the UK. The aim of the review was to explore challenges reported by UK-based CPs in addressing and incorporating client spirituality in therapy. A total of 11 studies were reviewed and four overall themes were developed from the findings of the studies. The themes highlighted a range of primarily professional issues educationally, academically, organisationally, and clinically that limited CPs from integrating spirituality into therapy for their clients. The discussion of the implications of the findings highlights a critical issue that a significant amount of the literature on spirituality in UK is unpublished. In addition to the limited research, the lack of evidence based theoretical frameworks used in the UK indicates a professional issue that likely impacts on the quality of care given clients of spiritual orientation.

7. References

Ahmed, B. (2008). Teaching critical psychology of 'race'issues: problems in promoting anti-racist practice. *Journal of Community & Applied Social Psychology, 18*(1), 54-67. https://doi.org/10.1002/casp.912

Amineh, R. J., & Asl, H. D. (2015). *Review of Constructivism and Social Constructivism*. 9.

Amir-Behghadami, M., & Janati, A. (2020). Population, Intervention, Comparison, Outcomes and Study (PICOS) design as a framework to formulate eligibility criteria in systematic reviews. *Emergency Medicine Journal*, *37*(6), 387–387. https://doi.org/10.1136/emermed-2020-209567

Ano, G. G., & Vasconcelles, E. B. (2005). Religious coping and psychological adjustment to stress: A meta-analysis. *Journal of Clinical Psychology, 61*, 461–480.

Appraising qualitative research for inclusion in systematic reviews: A quantitative and qualitative comparison of three methods. (2007). *Journal of Health Services Research & Policy*, *12*(1), 42–47. https://doi.org/10.1258/135581907779497486

Armstrong, R., Jackson, N., Doyle, J., Waters, E., & Howes, F. (2005). It's in your hands: The value of handsearching in conducting systematic reviews of public health interventions. *Journal of Public Health*, *27*(4), 388–391. https://doi.org/10.1093/pubmed/fdi056

Aten, J. D., & Hernandez, B. C. (2004). Addressing Religion in Clinical Supervision: A Model. *Psychotherapy: Theory, Research, Practice, Training*, *41*(2), 152–160. https://doi.org/10.1037/0033-3204.41.2.152

Bade, Mary K., and Stephen W. Cook. "Functions of Christian prayer in the coping process." *Journal for the Scientific Study of Religion* 47, no. 1 (2008): 123-133.

Benefiel, M., Fry, L. W., & Geigle, D. (2014). Spirituality and religion in the workplace: History, theory, and research. *Psychology of Religion and Spirituality*, *6*(3), 175–187. https://doi.org/10.1037/a0036597

Bienenfeld, D., & Yager, J. (n.d.). *Issues of Spirituality and Religion in Psychotherapy Supervision*. 10.

Bishop, D. R., Avila-Juarbe, E., & Thumme, B. (2003). Recognizing Spirituality as an Important Factor in Counselor Supervision. *Counseling and Values*, *48*(1), 34–46. https://doi.org/10.1002/j.2161-007X.2003.tb00273.x

Brown, O., Elkonin, D., & Naicker, S. (2013). The Use of Religion and Spirituality in Psychotherapy: Enablers and Barriers. *Journal of Religion and Health*, *52*(4), 1131–1146. https://doi.org/10.1007/s10943-011-9551-z

Burks, D. J., & Robbins, R. (2012). Psychologists' authenticity: Implications for work in professional and therapeutic settings. *Journal of Humanistic Psychology*, *52*(1), 75-104.

Butler, C. (2017). Intersectionality and systemic therapy. *Context, 151*, 16-18.

Cheetham, G., & Chivers, G. (1998). The reflective (and competent) practitioner: A model of professional competence which seeks to harmonise the reflective practitioner and competence-based approaches. *Journal of European Industrial Training*, *22*(7), 267–276. https://doi.org/10.1108/03090599810230678

Cooke, A., Smith, D., & Booth, A. (2012). Beyond PICO: The SPIDER Tool for Qualitative Evidence Synthesis. *Qualitative Health Research*, *22*(10), 1435–1443. https://doi.org/10.1177/1049732312452938

Currier, J. M., Foster, J. D., Witvliet, C. vanOyen, Abernethy, A. D., Root Luna, L. M., Schnitker, S. A., VanHarn, K., & Carter, J. (2019). Spiritual struggles and mental

health outcomes in a spiritually integrated inpatient program. *Journal of Affective Disorders*, *249*, 127–135. https://doi.org/10.1016/j.jad.2019.02.012

Dalmida, S. G. (2006). Spirituality, mental health, physical health, and health-related quality of life among women with HIV/AIDS: integrating spirituality into mental health care. *Issues in mental health nursing*, *27*(2), 185-198. https://doi.org/10.1080/01612840500436958

DeHoff, S. L. (2015). Distinguishing Mystical Religious Experience and Psychotic Experience: A Qualitative Study Interviewing Presbyterian Church (U.S.A.) Professionals. *Pastoral Psychology*, *64*(1), 21–39. https://doi.org/10.1007/s11089-013-0584-y

Dein, S., Cook, C. C., & Koenig, H. (2012). Religion, spirituality, and mental health: current controversies and future directions. *The Journal of nervous and mental disease*, *200*(10), 852-855. Https://doi.org/10.1097/NMD.0b013e31826b6dle

Dwan, K., Altman, D. G., Arnaiz, J. A., Bloom, J., Chan, A.-W., Cronin, E., Decullier, E., Easterbrook, P. J., Elm, E. V., Gamble, C., Ghersi, D., Ioannidis, J. P. A., Simes, J., & Williamson, P. R. (2008). Systematic Review of the Empirical Evidence of Study Publication Bias and Outcome Reporting Bias. *PLOS ONE*, *3*(8), e3081. https://doi.org/10.1371/journal.pone.0003081

Emmons, R. A. (2005). Striving for the sacred: Personal goals, life meaning, and religion. *Journal of Social Issues*, *61*(4), 731-745. https://doi.org/10.1111/j.1540-4560.2005.00429.x

Equality Act 2010. (n.d.). [Text]. Statute Law Database. Retrieved 7 July 2022, from https://www.legislation.gov.uk/ukpga/2010/15/section/10/2010-10-01

Errington, L. (2017). The Uncomfortably Important Place of Spirituality in Systemic Therapy. *Australian and New Zealand Journal of Family Therapy*, *38*(1), 168–178. https://doi.org/10.1002/anzf.1196

Exline, J. J., Smyth, J. M., Gregory, J., Hockemeyer, J., & Tulloch, H. (2005). " Religious Framing by Individuals With PTSD When Writing About Traumatic Experiences". *The International Journal for the Psychology of Religion*, *15*(1), 17-33. https://doi.org/10.1207/s15327582ijpr1501_2

Faiver, C. M., O'Brien, E. M., & Ingersoll, R. E. (2000). Religion, Guilt, and Mental Health. *Journal of Counseling & Development*, *78*(2), 155–161. https://doi.org/10.1002/j.1556-6676.2000.tb02573.x

Gilbert, P. (2009). Introducing compassion-focused therapy. *Advances in Psychiatric Treatment*, *15*(3), 199–208. https://doi.org/10.1192/apt.bp.107.005264

Glonti, K., & Hren, D. (2018). Editors' perspectives on the peer-review process in biomedical journals: Protocol for a qualitative study. *BMJ Open*, *8*(10), e020568. https://doi.org/10.1136/bmjopen-2017-020568

Gonsiorek, J. C., Richards, P. S., Pargament, K. I., & McMinn, M. R. (2009). Ethical challenges and opportunities at the edge: Incorporating spirituality and religion into psychotherapy. *Professional Psychology: Research and Practice*, *40*(4), 385–395. https://doi.org/10.1037/a0016488

Gutierrez, D., Hiatt, K., & Lee, A. (2020). Spiritually competent orientation in supervision: Application of the cultural third. *The Clinical Supervisor*, *39*(2), 210–228. https://doi.org/10.1080/07325223.2020.1824835

Hackney, C. H., & Sanders, G. S. (2003). Religiosity and mental health: A meta–analysis of recent studies. *Journal for the scientific study of religion*, *42*(1), 43-55. https://doi.org/10.1111/1468-5906.t01-1-00160

Hall, G. C. N., Ibaraki, A. Y., Huang, E. R., Marti, C. N., & Stice, E. (2016). A meta-analysis of cultural adaptations of psychological interventions. *Behavior therapy*, *47*(6), 993-1014. https://doi.org/10.1016/j.beth.2016.09.005.

Halpert, S. C., Reinhardt, B., & Toohey, M. J. (2007). Affirmative Clinical Supervision. In *Handbook of counseling and psychotherapy with lesbian, gay, bisexual, and transgender clients, 2nd ed* (pp. 341–358). American Psychological Association. https://doi.org/10.1037/11482-014

Harlow, R. (2010). Developing a spirituality strategy – why, how, and so what? *Mental Health, Religion & Culture*, *13*(6), 615–624. https://doi.org/10.1080/13674676.2010.488426

Hayes, S. C., Strosahl, K. D., Bunting, K., Twohig, M., & Wilson, K. G. (2004a). What Is Acceptance and Commitment Therapy? In S. C. Hayes & K. D. Strosahl (Eds.), *A Practical Guide to Acceptance and Commitment Therapy* (pp. 3–29). Springer US. https://doi.org/10.1007/978-0-387-23369-7_1

Hayes, S. C., Strosahl, K. D., Bunting, K., Twohig, M., & Wilson, K. G. (2004b). What Is Acceptance and Commitment Therapy? In S. C. Hayes & K. D. Strosahl (Eds.), *A Practical Guide to Acceptance and Commitment Therapy* (pp. 3–29). Springer US. https://doi.org/10.1007/978-0-387-23369-7_1

James, A., & Wells, A. (2003). Religion and mental health: Towards a cognitive-behavioural framework. *British journal of health psychology*, *8*(3), 359-376. https://doi.org/10.1348/135910703322370905

Jones, J. L., & Mehr, S. L. (2007). Foundations and Assumptions of the Scientist-Practitioner Model. *American Behavioral Scientist*, *50*(6), 766–771. https://doi.org/10.1177/0002764206296454

Kent, B. V. (2020). Religion/spirituality and gender-differentiated trajectories of depressive symptoms age 13–34. *Journal of religion and health*, *59*(4), 2064-2081. https://doi.org/10.1007/s10943-019-00958-9

Keville, S. (2018). Across the great divide: Reflecting on dual positions in clinical psychology to enhance equality and inclusion between those working in and those referred to services. *Reflective Practice*, *19*(6), 791–805. https://doi.org/10.1080/14623943.2018.1539654

King, M., Marston, L., McManus, S., Brugha, T., Meltzer, H., & Bebbington, P. (2013). Religion, spirituality and mental health: Results from a national study of English households. *The British Journal of Psychiatry*, *202*(1), 68–73. https://doi.org/10.1192/bjp.bp.112.112003

King, M., Weich, S., Nazroo, J., & Blizard, B. (2006). Religion, mental health and ethnicity. EMPIRIC – A national survey of England. *Journal of Mental Health*, *15*(2), 153–162. https://doi.org/10.1080/09638230600608891

Lambert, F. (2010). Religion in American Politics. In *Religion in American Politics*. Princeton University Press.

Lee, S. A., Roberts, L. B., & Gibbons, J. A. (2013). When religion makes grief worse: Negative religious coping as associated with maladaptive emotional responding patterns. *Mental Health, Religion & Culture*, *16*(3), 291-305.

Lim, C., Sim, K., Renjan, V., Sam, H. F., & Quah, S. L. (2014). Adapted cognitive-behavioral therapy for religious individuals with mental disorder: a systematic review. *Asian journal of psychiatry*, *9*, 3-12. https://doi.org/10.1016/j.ajp.2013.12.011

Lilienfeld, S. O., & Basterfield, C. (2020). Reflective practice in clinical psychology: Reflections from basic psychological science. *Clinical Psychology: Science and Practice*, *27*(4), e12352. https://doi.org/10.1111/cpsp.12352

Lipner, J. (2004). On Hinduism and Hinduisms: The way of the banyan. In *The hindu world* (pp. 21-46). Routledge.

Long, C. G., & Hollin, C. R. (1997). The Scientist–Practitioner Model in Clinical Psychology: A Critique. *Clinical Psychology & Psychotherapy*, *4*(2), 75–83. https://doi.org/10.1002/(SICI)1099-0879(199706)4:2<75::AID-CPP116>3.0.CO;2-E

Long, H. A., French, D. P., & Brooks, J. M. (2020a). Optimising the value of the critical appraisal skills programme (CASP) tool for quality appraisal in qualitative evidence synthesis. *Research Methods in Medicine & Health Sciences*, *1*(1), 31–42. https://doi.org/10.1177/2632084320947559

Long, H. A., French, D. P., & Brooks, J. M. (2020b). Optimising the value of the critical appraisal skills programme (CASP) tool for quality appraisal in qualitative evidence synthesis. *Research Methods in Medicine & Health Sciences*, *1*(1), 31–42. https://doi.org/10.1177/2632084320947559

Lunn, J. (2009). The role of religion, spirituality and faith in development: A critical theory approach. *Third World Quarterly*, *30*(5), 937-951.

Majid, U., & Vanstone, M. (2018). Appraising Qualitative Research for Evidence Syntheses: A Compendium of Quality Appraisal Tools. *Qualitative Health Research*, *28*(13), 2115–2131. https://doi.org/10.1177/1049732318785358

Makrides, V. N. (2012). Orthodox Christianity, modernity and postmodernity: Overview, analysis and assessment. *Religion, State and Society*, *40*(3-4), 248-285.

Masters, K., Vagnini, K.M., & Rush, C.L. (2022). Religion, Spirituality, and Health. Routledge. https://doi.org/10.4324/9780367198459-REPRW67-1

McIntosh, D. N., Poulin, M. J., Silver, R. C., & Holman, E. A. (2011). The distinct roles of spirituality and religiosity in physical and mental health after collective trauma: a national longitudinal study of responses to the 9/11 attacks. *Journal of Behavioral Medicine*, *34*, 497-507. https://doi.org/10.1007/s10865-011-9331-y

McMahon, A., & Errity, D. (2014). From New Vistas to Life Lines: Psychologists' Satisfaction with Supervision and Confidence in Supervising. *Clinical Psychology & Psychotherapy*, *21*(3), 264–275. https://doi.org/10.1002/cpp.1835

Menezes, A., & Moreira-Almeida, A. (2010). Religion, spirituality, and psychosis. *Current psychiatry reports*, *12*, 174-179. https://doi.org/10.1007/s11920-010-0117-7

Michaels, A. (2021). Hinduism. In *Hinduism*. Princeton University Press.

Moreira-Almeida, A., Koenig, H. G., & Lucchetti, G. (2014). Clinical implications of spirituality to mental health: Review of evidence and practical guidelines. *Brazilian Journal of Psychiatry*, *36*, 176–182. https://doi.org/10.1590/1516-4446-2013-1255

Mueen Ahmed, K. K., & Dhubaib, B. E. A. (2011). Zotero: A bibliographic assistant to researcher. Journal of Pharmacology and Pharmacotherapeutics, 2(4), 304-305.

Mutter, K. F., & Neves, C. M. (2010). A Dialogical Model for Engaging Spirituality in Therapy. *Clinical Social Work Journal*, *38*(2), 164–173. https://doi.org/10.1007/s10615-008-0178-9

Mysorekar, U. (2006). Eye on religion: Clinicians and Hinduism. *Southern Medical Journal*, *99*(4), 441-442.

Naeem, F., Latif, M., Mukhtar, F., Kim, Y. R., Li, W., Butt, M. G., ... & Ng, R. (2021). Transcultural adaptation of cognitive behavioral therapy (CBT) in Asia. *Asia-Pacific Psychiatry*, *13*(1), e12442. https://doi.org/10.1111/appy.12442

Naeem, F., Phiri, P., Munshi, T., Rathod, S., Ayub, M., Gobbi, M., & Kingdon, D. (2015). Using cognitive behaviour therapy with South Asian Muslims: Findings from the

culturally sensitive CBT project. *International Review of Psychiatry*, *27*(3), 233-246. https://doi.org/10.3109/09540261.2015.1067598

Nasel, D. D. (2004). *Spiritual orientation in relation to spiritual intelligence a consideration of traditional Christianity and New Ageindividualistic Spirituality* (Doctoral dissertation, University of South Australia).

Newman, L. L. (2004). Faith, Spirituality, and Religion: A Model for Understanding the Differences. *College Student Affairs Journal*, *23*(2), 102-110.

Nonye Sango, P., & Forrester-Jones, R. (2014). Spirituality and learning disability: A review of UK Government guidance. *Tizard Learning Disability Review*, *19*(4), 170–177. https://doi.org/10.1108/TLDR-01-2014-0005

Ouwehand, E., Braam, A. W., Renes, J. W., Muthert, H. J. K., & Zock, H. T. (2020). Holy Apparition or Hyper-Religiosity: Prevalence of Explanatory Models for Religious and Spiritual Experiences in Patients with Bipolar Disorder and Their Associations with Religiousness. *Pastoral Psychology*, *69*(1), 29–45. https://doi.org/10.1007/s11089-019-00892-3

Ouzzani, M., Hammady, H., Fedorowicz, Z., & Elmagarmid, A. (2016). Rayyan—a web and mobile app for systematic reviews. Systematic reviews, 5(1), 1-10.

Pachankis, J. E. (2009). The use of cognitive-behavioral therapy to promote authenticity. *Pragmatic Case Studies in Psychotherapy*, *5*(4), 28-38.

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., Akl, E. A., Brennan, S. E., Chou, R., Glanville, J., Grimshaw, J. M., Hróbjartsson, A., Lalu, M. M., Li, T., Loder, E. W., Mayo-Wilson, E., McDonald, S., … Moher, D. (2021). The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. *BMJ (Clinical Research Ed.)*, *372*, n71. https://doi.org/10.1136/bmj.n71

Pargament, K., Feuille, M., & Burdzy, D. (2011). The Brief RCOPE: Current psychometric status of a short measure of religious coping. *Religions*, *2*(1), 51-76.

Pargament, K. I., & Saunders, S. M. (2007). Introduction to the special issue on spirituality and psychotherapy. *Journal of Clinical Psychology*, *63*(10), 903-907.

Patel, N. (2003). Clinical Psychology: Reinforcing Inequalities or Facilitating Empowerment? *The International Journal of Human Rights*, *7*(1), 16–39. https://doi.org/10.1080/714003792

Paul Victor, C. G., & Treschuk, J. V. (2020). Critical Literature Review on the Definition Clarity of the Concept of Faith, Religion, and Spirituality. *Journal of Holistic Nursing*, *38*(1), 107–113. https://doi.org/10.1177/0898010119895368

Pesut, B., Fowler, M., Taylor, E. J., Reimer-Kirkham, S., & Sawatzky, R. (2008). Conceptualising spirituality and religion for healthcare. *Journal of Clinical Nursing*, *17*(21), 2803–2810. https://doi.org/10.1111/j.1365-2702.2008.02344.x

Petocz, A. (2004). Science, meaning and the scientist-practitioner model of treatment. In *Working with Dangerous People*. CRC Press.

Pierre, J. M. (2001). Faith or delusion? At the crossroads of religion and psychosis. *Journal of Psychiatric Practice®*, *7*(3), 163-172.

Pirutinsky, S., Rosmarin, D. H., & Holt, C. L. (2012). Religious coping moderates the relationship between emotional functioning and obesity. *Health Psychology*, *31*(3), 394.

Proffitt, D., Cann, A., Calhoun, L.G. *et al.* Judeo-Christian Clergy and Personal Crisis: Religion, Posttraumatic Growth and Well Being. *Journal of Religion and Health* 46, 219–231 (2007). https://doi.org/10.1007/s10943-006-9074-1

Rakow, K. (2013). Therapeutic culture and religion in America. *Religion Compass*, *7*(11), 485-497.

Rowland, F. (2002). The peer-review process. *Learned Publishing*, *15*(4), 247–258. https://doi.org/10.1087/095315102760319206

Richards, D. A., & Bower, P. (2011). Equity of access to psychological therapies. *The British Journal of Psychiatry*, *198*(2), 91-92. https://doi.org/10.1192/bjp.bp.110.083485

Sandage, S. J., Jankowski, P. J., Paine, D. R., Exline, J. J., Ruffing, E. G., Rupert, D., Stavros, G. S., & Bronstein, M. (2022). Testing a relational spirituality model of psychotherapy clients' preferences and functioning. *Journal of Spirituality in Mental Health*, *24*(1), 1–21. https://doi.org/10.1080/19349637.2020.1791781

Santiago, P. N., & Gall, T. L. (2016). Acceptance and Commitment Therapy as a Spiritually Integrated Psychotherapy. *Counseling and Values*, *61*(2), 239–254. https://doi.org/10.1002/cvj.12040

Schafer, R. M., Handal, P. J., Brawer, P. A., & Ubinger, M. (2011). Training and Education in Religion/Spirituality Within APA-Accredited Clinical Psychology Programs: 8 Years Later. *Journal of Religion and Health*, *50*(2), 232–239. https://doi.org/10.1007/s10943-009-9272-8

Schmid, P. F. (2001). Authenticity: The person as his or her own author. Dialogical and ethical perspectives on therapy as an encounter relationship. And beyond. *Rogers' therapeutic conditions: Evolution, theory and practice*, *1*, 213-228.

Schoen, C., Osborn, R., Doty, M. M., Bishop, M., Peugh, J., & Murukutla, N. (2007). Toward Higher-Performance Health Systems: Adults' Health Care Experiences In Seven Countries, 2007: Actual experiences with health care systems bring to light, and to life, the systemwide problems in these countries. *Health Affairs*, *26*(Suppl2), w717-w734. https://doi.org/10.1377/hlthaff.26.6.w717

Secker, D. L., Kazantzis, N., & Pachana, N. A. (2004). Cognitive behavior therapy for older adults: Practical guidelines for adapting therapy structure. *Journal of rational-emotive*

and cognitive-behavior therapy, *22*, 93-109. https://doi.org/10.1023/B:JORE.0000025440.38005.7e

Shapiro, M. B. (1967). Clinical Psychology as an Applied Science. *British Journal of Psychiatry*, *113*(502), 1039–1042. https://doi.org/10.1192/bjp.113.502.1039

Stanford, M. S. (2007). Demon or disorder: A survey of attitudes toward mental illness in the Christian church. *Mental Health, Religion and Culture*, *10*(5), 445-449.

Stallard, P., Graham, P., & Reynolds, S. (2013). Adapting cognitive behaviour therapy for children and adolescents. *Cognitive behaviour therapy for children and families*, *3*, 22-33.

Stevens, F. L. (2017). Authenticity: A mediator in the relationship between attachment style and affective functioning. *Counselling Psychology Quarterly*, *30*(4), 392-414.

Stoll, C. R. T., Izadi, S., Fowler, S., Green, P., Suls, J., & Colditz, G. A. (2019). The value of a second reviewer for study selection in systematic reviews. *Research Synthesis Methods*, *10*(4), 539–545. https://doi.org/10.1002/jrsm.1369

Talati, S. (2016). What are equality and diversity? *Dental Nursing*, *12*(8), 430–431. https://doi.org/10.12968/denn.2016.12.8.430

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology*, *8*(1), 45. https://doi.org/10.1186/1471-2288-8-45

Tingle, J. (2020). Is patient safety in the NHS in England a postcode lottery? *British Journal of Nursing*, *29*(6), 378-379. https://doi.org/10.12968/bjon.2020.29.6.378

Turpin, G., & Coleman, G. (2010). Clinical Psychology and Diversity: Progress and Continuing Challenges. *Psychology Learning & Teaching*, *9*(2), 17–27. https://doi.org/10.2304/plat.2010.9.2.17

Van der Toorn, J., Pliskin, R., & Morgenroth, T. (2020). Not quite over the rainbow: The unrelenting and insidious nature of heteronormative ideology. *Current Opinion in Behavioral Sciences*, *34*, 160-165. https://doi.org/10.1016/j.cobeha.2020.03.001

Weber, S. R., & Pargament, K. I. (2014). The role of religion and spirituality in mental health. *Current Opinion in Psychiatry*, *27*(5), 358–363. https://doi.org/10.1097/YCO.0000000000000080

West, W. (2009). Situating the researcher in qualitative psychotherapy research around spirituality. *Counselling Psychology Quarterly*, *22*(2), 187–195. https://doi.org/10.1080/09515070903171934

Williams, V., Boylan, A.-M., & Nunan, D. (2020). Critical appraisal of qualitative research: Necessity, partialities and the issue of bias. *BMJ Evidence-Based Medicine*, *25*(1), 9–11. https://doi.org/10.1136/bmjebm-2018-111132

Worthington Jr, E. L., Hook, J. N., Davis, D. E., & McDaniel, M. A. (2011). Religion and spirituality. *Journal of clinical psychology*, *67*(2), 204-214.

Wortmann, J. (2013). Religious Coping. In: Gellman, M.D., Turner, J.R. (eds) Encyclopedia of Behavioral Medicine. Springer, New York, NY. https://doi.org/10.1007/978-1-4419-1005-9_665

Wortmann, J. H., & Park, C. L. (2008). Religion and spirituality in adjustment following bereavement: An integrative review. *Death studies*, *32*(8), 703-736. https://doi.org/10.1080/07481180802289507

Appendices

APPENDIX A: Journal of Psychology and Theology Publication Guidelines

Manuscript Submission Guidelines:
Please read the guidelines below then visit the Journal's submission site https://mc.manuscriptcentral.com/jpt to upload your manuscript. Please note that manuscripts not conforming to these guidelines may be returned**.**

Only manuscripts of sufficient quality that meet the aims and scope of *Journal of Psychology & Theology* will be reviewed.

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As part of the submission process you will be required to warrant that you are submitting your original work, that you have the rights in the work, and that you have obtained and can supply all necessary permissions for the reproduction of any copyright works not owned by you, that you are submitting the work for first publication in the Journal and that it is not being considered for publication elsewhere and has not already been published elsewhere. Please see our guidelines on prior publication and note that *Journal of Psychology & Theology* may accept submissions of papers that have been posted on pre-print servers; please alert the Editorial Office when submitting (contact details are at the end of these guidelines) and include the DOI for the preprint in the designated field in the manuscript submission system. Authors should not post an updated version of their paper on the preprint server while it is being peer reviewed for possible publication in the journal. If the article is accepted for publication, the author may re-use their work according to the journal's author archiving policy.

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1. What do we publish?

1.1 Aims & Scope

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1 Theoretical, research and applied articles dealing with relevant issues in psychology and theology from an evangelical perspective.
2 Reviews of articles in other journals relevant to the integration of psychology and theology
3 Responses to current or past journal articles.
4 Book reviews from the field of psychology and theology.

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2. Editorial policies

2.1 Peer review policy

SAGE does not permit the use of author-suggested (recommended) reviewers at any stage of the submission process, be that through the web-based submission system or other communication. Reviewers should be experts in their fields and should be able to provide an objective assessment of the manuscript. Our policy is that reviewers should not be assigned to a paper if:

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All parties who have made a substantive contribution to the article should be listed as authors. Principal authorship, authorship order, and other publication credits should be based on the relative scientific or professional contributions of the individuals involved, regardless of their status. A student is usually listed as principal author on any multiple-authored publication that substantially derives from the student's dissertation or thesis.

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All contributors who do not meet the criteria for authorship should be listed in an Acknowledgements section. Examples of those who might be acknowledged include a person who provided purely technical help, or a department chair who provided only general support.

Please supply any personal acknowledgements separately to the main text to facilitate anonymous peer review.

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Where an individual who is not listed as an author submits a manuscript on behalf of the author(s), a statement must be included in the Acknowledgements section of the manuscript and in the accompanying cover letter. The statements must:

- Disclose this type of editorial assistance – including the individual's name, company and level of input
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APPENDIX B: Synthesised Summary of Systematic Review Findings

Initial themes	Codes	Authors
Medical model and theoretical framework challenges.	challenges around balancing medical and therapeutic discourses for example when working with people with 'psychosis'.	Challis, 2017 Mills, 2010
	Participants reported challenges of concern in distinguishing between healthy or unhealthy religious belief.	Woodford & Hogan 2019
	There is a perceived link between expressions of spirituality and mental health disorders. This propensity to characterise some spiritual practices as pathology may reflect a lack of training around the distinctions between spiritual experience, whether ecstatic or normative, and psychopathological conditions	Harbidge, 2015
	Working in contexts with the medical model was described as another challenge as spirituality does not align with the medical model. This was	

	particularly around diagnostic and treatment terminology. The role of a psychologist, holding responsibility to implement evidence-based interventions rooted within objective evidence.	
Lack of training on how to incorporate this into therapeutic practice.	Spirituality was also characterised by the lack of discussion of the topic within the professional and training context of Clinical Psychology. There was minimal training on the spirituality and the perpetuated the feelings of ill preparedness for the therapists. Models of psychology can facilitate formulation and therapeutic intervention with spiritual or religious frameworks. However, there was lack of theoretical teaching on this.	Crossely & Salter, 2005 Woodford & Hogan, 2019 Begum (2012).
Uncertainty about the boundaries between spirituality and culture. Both from a therapist and client perspective	There was a strong emphasis in some of the interviews of the unease that is associated with debate on spirituality at a cultural level. There was a sub theme that it was difficult to disentangle religion from culture which influenced avoidance of religion or spirituality as its own factor for some clients.	Crossely & Salter (2005) Begum (2012)
Professionsal and ethical challenges	The diversity and flexibility of the meaning of spirituality made some participants suggest that boundaries to the concept of spirituality were necessary. There is a sense of confusion and avoidance on how to integrate spirituality into the therapeutic relationship. The ethical dilemma, is around being person centred. Is it sorely for the client to lead and bring? However some participants felt the onus was on the therapist. Assessments can explore a clients spirituality, however the challenge was around integrating it into therapy. Participant (CP)\ personal views can make it difficult to understand a client with strong beliefs. This can lead to lack of collaboration and religion	Crossely & Salter (2005). Wooddford & Hogan (2019) Authur (2018)

	is avoided due to the assumption that there is a line between the profession and religious beliefs.	
	CP doctorate and discipline of psychology focuses on trainees and qualified practitioners being neutral and professional.	Arshad (2007)
	Safety to discuss spirituality is needed for both the client and the practitioner in the room. Safety is not provided by supervisors, training courses and the wider profession.	Betteridge (2012)
	Nature of service and professional context only allowed for religious themes to be explored if they are related to the presenting problem.	
	Difficulties were often associated with a lack of congruence around having religion in therapy, different beliefs between therapist and client, or a therapeutic model that is not congruent with the client's religious framework.	Mills (2010)
	Clinical, therapeutic, and ethical dilemma regarding whether to bring it up for the client or waiting for the client to bring it up.	
	Some models/interventions such as Mindfulness which is derived can create personal and professional religious dilemmas.	
Social and cultural and personal barriers	Spirituality being a very personal issue to talk about, like sex.	Woodford & Hogan (2019)
	Spirituality not easy to talk about, and likened to sex in the nature of the social appropriateness of discussing this. Other participants alluded on how on some level these topics may be experienced as heavy and potentially charged, thus, needing to counter balanced through humour and light talk.	Harbridge (2015)

Protecting the therapeutic relationship	Therapists can be restricted through a fear of offending or getting something wrong.	
	Explicit reason needed to explore religious themes due to fear that, exploration could potentially sabotage rather than complement the psychological work being done.	Arshad (2007)
	There are theoretical limitations to the incorporating religion and spirituality and in addition there was a worry described around the possibility of causing offence.	Challis (2017)
	Participants also reported discourses around negotiating what can be said. This was particularly around self-disclosure of personal spiritual views.	
Previous negative clinical experiences	Experiences or worries about being judged may prevent the exploration of spirituality.	Woodgate & Hogan, 2019
	Supervision in clinical practice lacks engagement in talking about spirituality. This adds the barriers to discussing it in therapy.	Harbidge (2015)
	An experience of criticism of wearing a fashionable silver cross from a supervisor, left one participants.	
Organisational and systemic barriers	Spirituality largely absent in the practice of participants because of constraints on the NHS, with limited time and sessions. Participants described not being able to work with the whole person.	Begum (2012)
	NHS policy restricts psychologists from being authentic in matters of spirituality. The idea that practitioners could be punished for talking about spirituality e.g for a dying client.	Ashad (2007)
	Limited guidance and resources for exploring themes of spirituality. The topic area is also not supported in teams.	Mills (2010)

	There are uncertainty about the role of religion and spirituality in Mental health services. Contradictory message relayed from the psychology profession, course staff, NHS Trusts and clinical supervisors. These cause confusion on whether religion and spirituality should be explored. This makes it an unsafe territory.
	Participants also articulated other barriers which are better placed as external locus of control. Many factors appeared to be influenced by systemic factors which were thought to be outside of participants' control. Organisational issues provided the greatest number of external factors. These included: NHS Trust and service philosophies; political and societal viewpoints; an absence of professional guidelines or training and knowledge of the profession's ill-defined position on incorporating religious and spiritual into clinical practice.

SCHOOL OF PSYCHOLOGY

DOCTORATE IN CLINICAL PSYCHOLOGY

EMPIRICAL PAPER

Examining the relationship between incorporation of spirituality into therapy, and therapeutic engagement & working alliance for Christians. A mixed methods study

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Target Journal: Journal of Psychology and theology (appendix E)

Word Count: 8893 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

Background: Spirituality is a common concept which many people's lifestyles are centred around. Within the UK and many other parts of the world Christians are a large part of the group of people recognized as spiritual, religious or living by faith. There is evidence suggesting that Clinical Psychologists (CPs) do not feel comfortable with incorporating spirituality into therapy for their clients. However, incorporation of spirituality into therapy is associated with positive client outcomes, but there is limited research on its association with therapeutic engagement and therapeutic alliance.

Objectives: Using a mixed methods approach, the aim of the study was to examine quantitatively the relationship between spirituality and engagement in therapy, and to qualitatively explore what is important about spirituality and therapy for Christians in order to best engage with therapy.

Method: Participants (N = 133) completed an online survey examining their daily spiritual experiences at the time they received therapy, perceived incorporation of spirituality into therapy and retrospective perceived engagement and working alliance in therapy. Five participants were then randomly picked to participate in in-depth semi structured interviews.

Analyses: Two moderated multiple linear regression analyses were conducted to evaluate the prediction of the two outcomes: perceived retrospective engagement in therapy and perceived retrospective working alliance. The qualitative interviews were analysed using thematic analysis. The findings of the study quantitatively suggest that the incorporation of spirituality into therapy and daily spiritual experiences explain unique variance with a positive association for both predictors. Qualitatively the study found that clients valued authentic conversations about spirituality, and incorporation of this into therapy supported engagement

and working alliance. However, there was a strong consensus that therapists often dismissed the topic and which some participants found harmful.

Conclusions: It is, therefore, crucial to consider how CPs can be supported to address this need. Firstly, doctoral training programmes should review the context of teaching offered to support clinical psychologists in learning how to incorporate spirituality into therapy. Secondly, CPs should ensure that there is an active reflective process in practice when working with Christians.

Introduction

Spirituality, Faith and Religion

The concept of Spirituality, Faith and Religion has been an evolving, and criticised phenomenon within western academia and philosophy (Pargament & Sauders, 2007). The terms are often used interchangeably due to their similarities, however, need to be defined distinctively due to their differences. For example, religion is frequently the root of spirituality, but not everyone who practises religion is always spiritual, and not everyone who practises spirituality is necessarily religious (Lunn, 2009). Currently, there is limited consistency on the definitions of the terms (Reinert & Koening, 2013). Spirituality can be defined as a person's relationship with and experience of the supernatural realm or sense of deep awareness and connection with the natural realm (Lunn, 2009). Faith can be defined as the belief in a transcendent reality. Religion is an institutionalised system of beliefs and activities relating to the supernatural (Deneulin & Rakodi, 2011). Although the terms spirituality, faith and religion have been used interchangeably in research studies, this study will mainly use the term spirituality but will occasionally refer to faith and religion, in discussing this complex phenomenon.

Christianity in Spirituality, Faith and Religion

Spiritual people are a diverse population with various beliefs, in order to narrow down such a broad topic area, the research focuses on Christians as the spiritual group of choice as they are numerically dominant population in the UK in comparison to other spiritual populations. Christianity is observed as one of the most common religions (Bates, 1994), however, it also largely described as a faith (Borg, 2009). Those who describe it as a religion refer to the institutional way of life that guides many groups of people around the world, whilst those that describe it as a faith refer to the personal and individual values and beliefs that influence a connection with those that follow a similar set of values (Kraemer, 2002).

Supernatural experiences can be common for some but not all Christians depending on the doctrine and theological beliefs they follow (Kraft, 2005); therefore Christianity is also identified as strongly linked to spirituality for some Christians.

Fifty per cent of the people in UK identified as being affiliated with the Christian faith in 2011 (England & Wales Census, 2011). There is likely a change in these statistics, and of those that report being affiliated with Christianity, many may not find it of importance. Despite statistics suggesting a decrease in the people identifying as having a religion they follow (Office for National Statistic, 2012), there has been a significant increase in online church attendance during the recent COVID-19 health pandemic (Brooke & Jackson 2020).

Relationship Between Spirituality and Therapy

Research indicates that psychology has joined spirituality as a popular source for guidance in life, as people have generally become more sophisticated consumers of scientific knowledge (Andersson & Asmundson, 2007). Many people have held onto to their spiritual beliefs with more flexibility, as we move into a "pick and mix" postmodernist era of choosing elements of a belief that benefits them (Esposito, Fasching, & Lewis, 2002). Religion, spirituality, and faith have long been neglected in development of psychological theory, policymaking, and practise (Lunn, 2009).

There is strong evidence that the question of motivation or volition is at the heart of therapeutic results, perhaps because beneficial and long-lasting effects are more likely to occur when a client gets actively involved and personally invested in change (Ryan et al., 2011). However, it can be argued that the client's active engagement and investment in therapeutic outcomes are mostly mediated by their experience of influences on their life also being merged in their therapy (Oman, 2019). These life influences are often everyday

experiences (e.g., spirituality, faith & religion) that shape the client's views in life (Rego & Nunes, 2019).

A substantial body of research indicates that when patients seek therapy, their spirituality frequently serves as a pillar of support or contributes to the presenting issue but is most frequently linked to enhanced therapeutic outcomes across a range of mental health conditions. (Drew & Bank, 2019). Many psychological frameworks such as compassion focused therapy (CFT) and cognitive behaviour therapy (CBT) can be adapted to the context of the client's values and how they make meaning of their experiences and the world, for example culture and spirituality (Arrundell, et al., 2021; Hall et al., 2016; Heim & Kohrt, 2019). CFT incorporates elements of Buddhist, social, developmental, and evolutionary psychology. Using compassionate mind training to assist people to develop and work with feelings of inner warmth, safety, and comfort through self-compassion is one of its main concerns (Gilbert, 2009). In CBT, the emphasis is on how attitudes, beliefs, and thoughts impact feelings and behaviours (Carvalho, 2017). Adaptions within the CBT model involve the integration of religious material to perform cognitive restructuring, psychoeducation, and motivation were the most common religious adaptations. Engagement in religious practices like behavioural activation, meditation, or prayer to aid cognitive restructuring, use religious values, and as coping mechanisms were also very common (de Abreu Costa, & Moreira-Almeida, 2021).

Despite this, there is a growing body of evidence suggesting that some CPs lack the confidence in discussing issues of spirituality in therapy (Challis, 2017). It is, therefore, of paramount importance that CPs understand the interactions between spirituality, therapeutic engagement and therapeutic alliance.

Spirituality, Therapeutic Engagement and Therapeutic Alliance

In clinical psychology, the emphasis on evidence-based treatments has resulted in attention being paid to compiling specific, often manualised, methods designed to change targeted behavioural outcomes (Deci & Ryan, 2008). Despite the multitude of research supporting the use of evidence-based manuals in the United Kingdom (UK) (Bronfort et al., 2010), services often report an association between clients' disengagement from therapy and lower therapeutic outcomes (Mander, 2014). Low therapeutic involvement or treatment discontinuation may have detrimental effects on clinical results (Tetley et al., 2011), causing services to become cost-ineffective and undermining staff and client optimism (Hinkeldey et al., 2018). From a clinical perspective, engagement can often be defined by core dimensions. These include: a suitable working relationship with the therapist, treatment attendance, treatment completion, homework completion, expected contribution to therapy sessions, including self-disclosure and/or other duties or activities (Tetley et al., 2011).

In order to enhance client engagement and therapeutic working alliance, therapists are encouraged by means of good practice guidance to incorporate adaptions into interventions, being mindful of factors such as protected characteristics (e.g., religion or faith) or lifestyle (e.g., spirituality; Curtis & Davis, 1999; Maher, 2006, p. 21). Further evidence suggests that when clients of spiritual orientation perceive that their spirituality has been incorporated into therapy, this correlates with an increase in positive engagement with therapeutic intervention and working alliance with their therapist (Weisman de Mamani et al., 2010).

Clients often desire to be able to speak about issues that matter to them during psychological therapy such as religious belief and those with prominent spiritual identities will benefit from its integration into their psychological therapy (Wade et al., 2007) however CPs and other psychological therapists in the UK feel poorly prepared to do so (Begum, 2017; Challis, 2017; Crossely & Salter, 2009; Mills, 2010). There is limited evidence on the provisional percentage of clients of spiritual orientation, not receiving spiritual support in

psychological therapy interventions. The lack of systematic recording of adaptations made for psychological interventions leading to the scarcity of auditable data (Slay, 2022) leaves the population of spiritual clients at risk of not receiving adequate care. Therefore; it is important for research to focus on understanding the experiences of spiritual clients, and how their needs can be met in relation to key elements of psychological interventions, engagement with the treatment and working alliance with their therapist.

Given that CPs are trained to have the competencies necessary to build therapeutic alliance, have conversations that may be difficult and uncomfortable, and work in ways that allow their clients to engage with them and the systems supporting them (Baker & Wang, 2004), understanding how practice affects therapeutic relationship and therapeutic engagement is crucial for clinical psychology. Research appears to primarily focus on engagement in psychological therapies from the service or clinical standpoint (Captari et al., 2018). However, there is limited emphasis on understanding engagement in psychological therapies from the client standpoint. This is especially essential for spiritual clients.

Theoretical underpinning

Psychological theories and frameworks, aim to not only make sense of behaviours, particularly those that cause distress, however, also aim to provide a framework around making sense of individuals and groups "meaning making" of themselves, and themselves in relation to others and the rest of the world (Helminiak, 2006). This process is often termed "psychological formulation" (Leeming et al., 2009), CPs can often draw from one or more psychological models to help formulate the client's meaning making process and how it can be linked to how they have coped with distress (Usher & Ryan, 2019). CP is encouraged to take into account that both individuals bring their own frameworks for understanding the world into the therapeutic relationship, and that dissecting these with a client can provide

opportunities for understanding how psychological distress is experienced and maintained, the CP needs to be mindful of their decision-making process of how they incorporate what is important or has influence for the client's life into their formulation, alongside ensuring that they develop maintain the therapeutic working alliance and support the client to remain engaged in therapy.

Rationale

Spiritual people are a diverse population ranging with various beliefs, some which may be associated with a community of beliefs. In contrast, others may be based on the individuals own developed spiritual views. In order to narrow down such a broad topic area, the researcher will look at Christians as the spiritual group of choice as it will be highly relevant in the South West of England. Fifty per cent of the people in South West England identified as being affiliated with the Christian faith in 2011 (England & Wales Census, 2011). There is likely a change in these statistics, and of those that report being affiliated with Christianity, many may not find it of spiritual importance.

There is a need for research and Clinical Psychology to understand how clients who value spirituality in their daily living, experience therapy and their engagement in psychological therapy. Particularly in the South West of England due to the nature of the demographics, Clinical Psychologists are likely to encounter and work with people from a Christian background. Previous research listed above has focused the therapeutic outcomes; however, there is currently limited research exploring the link between spirituality and therapeutic engagement (Captari 2018; Cummings et al., 2014; Mardiyono et al., 2011).

There is a need for research and Clinical Psychology to understand how clients who value spirituality in their daily living experience therapy and their engagement in

psychological therapy. CPs are likely to encounter and work with people from a Christian background. Previous research has focused on therapeutic outcomes (Captari, 2018; Cummings et al., 2014); however, there is currently limited research exploring the relationship between spirituality, client's perception of integration of their spirituality in therapy and therapeutic engagement and alliance (Mardiyono et al., 2011).

It is helpful to address the evidence gap using a mixed methods approach, particularly given that the topic is sensitive but has significant implication on client experiences, treatment policy and overall treatment outcomes. Exploring the phenomenon qualitatively will offer insight into Christian clients' experiences, narratives and perspectives on the integration of their faith into therapy. This can also be used to contextualise the quantitative results on the relationship between level of spirituality for Christians, and their perceived engagement in therapy and perceived working alliance.

Ontology

The researcher recognises ontological positioning focuses on the nature of existence within the structure of reality (Goertz & Mahoney, 2012). The researcher believes that reality can be understood and observed within multiple lenses and perspectives (Goldman et al., 2018) therefore is not capturable by sole use of quantitative or qualitative methods. A mixed methods approach allows the researcher to gain an in-depth examination of the phenomenon of interest qualitative methods will allow exploration of multiple realities (Bleiker et al., 2019).

The aim of the research is to:

1) Offer quantitative clarification on the interactive relationship between spirituality, perceived incorporation of this in therapy and client's engagement, and working alliance in therapy.

2) To qualitatively explore the experiences of Christians regarding addressing their spirituality in therapy.

Research questions and hypotheses

Quantitative: How are Christians' spiritual experiences of daily life and their perceived integration of spirituality into therapy associated with their experience of engagement in therapy?

Hypotheses:

1. Perceived integration of spirituality into therapy will predict greater perceived engagement and working alliance in therapy.
2. Perceived integration of spirituality into therapy received will moderate the relationship between experiences of spirituality in daily life and perceived engagement & working alliance in therapy. Engagement and alliance will be greatest for more spiritual persons who perceive greater incorporation in therapy.

Qualitative: What are the experiences of Christians who value spirituality in their daily lives when engaging in psychological therapy?

Method

Design

The present research employed a concurrent triangulation mixed methods design approach. Quantitatively, the study used cross – sectional self –report questionnaires and the qualitative part of the study used individual semi structured interviews.

Quantitative Method

Power Analyses and Justification of Sample Size

A power analysis was conducted to establish the sample size that would be needed for the study. The expected large effect size was derived from the Captari et al. (2018) meta-analysis which examined the relationship between therapy outcomes and religion adapted therapy for spiritual and religious clients (g = .74).

The G power analysis was conducted for a multiple linear regression; the power of .80 was used for this analysis for the test of a single regression coefficient. The results reflected that the minimum sample size required for this population would be 55, as depicted in Figure 1 below.

Eligibility Criteria

Participants had a reported history of having accessed psychological therapy in the past. Table 1 below depicts the inclusion and exclusion criteria used for the recruitment of participants.

Table 1

Eligibility criteria

Inclusion Criteria	Exclusion Criteria
History of accessing psychological therapy for a mental health difficulty.	Participants that were still in receipt of psychological therapy at the time of the study.
Aged 18 years and older.	
Identified as a Christian at the time that they accessed psychological therapy.	

Recruitment

Ethical Approval was sought from the University of Exeter Ethics Committee, prior to commencement of the recruitment (see appendix A). The study was advertised via online platforms and participants were led to a Qualtrics online survey. The beginning of the survey provided information regarding the study and the participants had to confirm that they had read the information and provided consent to continue. The questions in the first section of the survey were constructed to assess eligibility. Only participants that met the eligibility criteria were able to access the full survey and be counted in the study. At the end of the online survey participants were asked if they were open to taking part in an interview about their experiences. If participants ticked 'yes', they were given the options to write their contact details. Participants were then provided with debrief information at the end of the survey. For the qualitative interviews all participants were recruited from those who completed the questionnaire, therefore would have met the eligibility criteria.

Participants

Overall, 168 people completed the survey eligibility criteria, however 35 people did not meet the eligibility criteria and did not complete the study survey. Out of the 133 participants who met the eligibility criteria and accessed the full survey, one participant did not complete one of the outcome measures. All participants' ages ranged between 18 and 77 years of age. The demographic details are depicted in Table 2.

Table 2

Sample characteristics

Ethnicity n (%)	
White	92 (68.7)
Black	7 (5.2)
Asian	28 (20.9)
Mixed and other	7 (6.2)
Gender n (%)	
Female	101 (75.4)
Male	33 (24.6)
Other	0 (0)

The questionnaire responses were sampled at random and five participants that had provided consent to interview were emailed from the contact details that they had provided asking whether they were still interested in participating in the study with an information sheet on the details of the qualitative part of the study attached. Eight to twelve participants are recommended for qualitative research (Boddy 2016), however, four to eight are recommended for mixed methods in-depth interviews (Driscoll et al., 2007).

All participants confirmed interest in being interviewed. The demographics of the participants recruited are detailed in table 3 below.

Table 3

Demographics of participants interviewed

Participant Number	Pseudonym	Age	Duration of Interview (mins)	Disclosed Demographics	Therapy
1	Jacob	31	1 hour	Mixed Race (Black Caribbean and White Irish). Male	Bereavement NHS IAPT NHS Private - BUPA
2	Katherine	21	35 minutes	White British Female	CAMHS NHS Private – Christian CBT
3	Rita	23	40 minutes	White Female	University Counselling (CFT)
4	Stacy	29	45 minutes	Black British Female	University CBT IAPT counselling NHS Family Therapy NHS
5	Alice	57	30 minutes	White British Female	Family Therapy NHS

Measures

The following measures were used for the Quantitative study (see appendix B):

Daily Spiritual Experience Scale (DSES). The DSES (Underwood & Teresi, 2002) is a 16-item self-report measure of spiritual experience. It aims explicitly to measure ordinary, or daily, spiritual experiences – not mystical experiences (e.g., hearing voices) and their influence on the individual's everyday life. The measure was used to assess an

individual's value on spiritual importance. The Cronbach's alpha in this sample was .890 which indicated that the measure has good internal validity.

Incorporation of spirituality. A Likert scale question developed by the researcher was used to measure participants' perceived incorporation of spirituality into therapy (see appendix B).

Engagement Measure (EM). The Engagement Measure (EM) is an observer-rated behavioural measure of engagement in measure of engagement in mental health (Hall et al., 2001) that was adapted self-report for this study. The EM has good test-retest reliability and high interrater reliability, in addition to good, reported validity (Hall et al., 2001; Meaden et al., 2009). The EM assesses six areas behavioural engagement: a) appointment keeping, b) client therapist interactions, c) communication and openness, d) client's perceived usefulness of intervention, e) collaboration with treatment, and f) compliance with treatment elements. This measure was selected because of its simplicity and face validity, which the researcher deemed important for reporting retrospective engagement.

Working Alliance Inventory – Short Revised (WAI- SR). The WAI-SR (Hatcher & Gillaspy, 2006; and Horvath & Greenberg, 1989) is a measure of the therapeutic alliance that assesses three key aspects of the therapeutic alliance: (a) agreement on the tasks of therapy, (b) agreement on the goals of therapy and (c) development of an affective bond (Munder et al., 2010). The WAI-SR has good reliability and internal validity (Hatcher & Gillaspy, 2006).

Qualitative Methodology

Epistemological stance

In this paper, the researcher uses critical realism, which is an epistemology that distinguishes between 'factual' and 'observable' experiences (Bhaskar, 1998). The 'factual'

cannot be observed or exist independently of human perceptions, theories, and constructs, which are the 'observable' entities, according to a critical realism perspective (Goski, 2013).

Data Collection

The project used a qualitative approach to collecting data via individual semi-structured interviews. Due the study occurring at the time of the COVID19 pandemic, it was decided that conducting individual interviews would be more appropriate as the data were collected via video interviews. Semi-structured interviews allow for the examination of respondents' perspectives and opinions on difficult and occasionally sensitive topics as well as the ability to elicit more information and explanation of responses (Brown & Danaher, 2017; Barriball & While 1994).

During the first ten minutes of the interview, summarised information on the study was provided verbally. Participants were asked to confirm that they understood the information provided, consented to proceeding and the interview being recorded. At the end of the interview participants were provided with an opportunity to describe how they found the interview experience. All participants reported no negative feelings from the interview; however, the researcher also provided them the information of where to receive further support if needed. The researcher kept a reflective journal which was completed after each interview.

Ethical Considerations and Service User Involvement

Exeter's Lived Experience Group (LEG) members were consulted for feedback regarding the study process, information and debrief sheet and further considerations around improving accessibility for participants in the study. As the study explored complex and sensitive topics, the researcher consulted the LEG members for feedback on the questions that were to be asked to participants. Ethical Approval application was obtained from the University of Exeter Ethics Committee.

Analysis

Quantitative Data

Data Cleaning

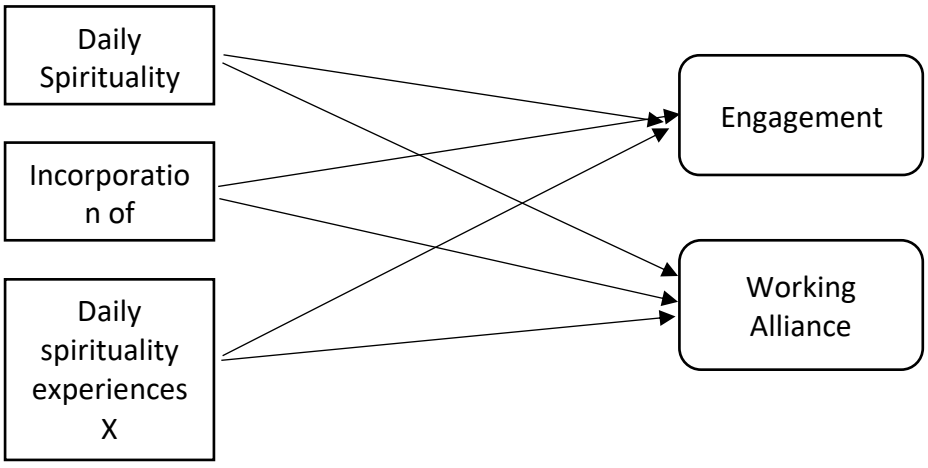
The overall survey time completion time was assessed to observe if there any unreasonably fast responses however none were found. Participants' responses on the survey were also checked for inappropriately consistent responding across the questionnaire items that would indicate untrustworthy data. No patterns were observed.

Analysis Strategy

The analysis plan was finalised prior to the data being unblinded, and the data were analysed using IBM SPSS statistics software (Version 28). Following bivariate correlation analysis, two moderated multiple linear regression analyses were conducted to evaluate the prediction of the two outcomes: perceived retrospective engagement in therapy and perceived retrospective working alliance (see figure 2).

Figure 1

Moderated Linear Regression



Two hierarchical multiple linear regression analyses were conducted in SPSS. The researcher checked assumptions of linearity using a scatterplot, independence of errors using a histogram and the Durbin-Watson test. All the assumptions of linearity, homoscedasticity and normality of residuals were all met.

Qualitative Data

Thematic Analysis (Braun & Clarke, 2006) was used to extract the key themes from the interviews. The recorded interviews were transcribed. Once transcribed, Braun and Clarke's (2019) new model for thematic analysis was used to transcribe the data. This model procedure followed three steps to analyse the qualitative data. An inductive approach was used by coding participants' data with no pre-existing coding frame. Themes were identified at a semantic level, and the researcher used a critical and reflective approach to base themes on what participants had discussed (see appendix C). At this point the researcher made use of the reflections made in the reflective journal to attempt to be observant of the perspective they took when establishing codes and themes from the data.

Results

Quantitative results

There were significant positive correlations between working alliance, engagement and daily spirituality experience (see appendix C), this is reflected in table 4 below.

Table 4

Correlations and descriptives

	DSES	Working Alliance	Engagement	Incorporation	M	SD
DSES	--	.288***	.286***	.337***	48.36	12.38
Working Alliance		--	.542***	.264***	33.65	12.42
Engagement			--	.283***	43.32	7.13
Incorporation				--	2.40	1.24

*Note: *** $p < .001$.*

Hierarchal Multiple Linear Regressions

The researcher ran two hierarchical multiple regressions to examine whether daily spirituality experiences and the perceived incorporation of spirituality into therapy predicted firstly engagement in therapy and secondly working alliance in therapy. In the first regression model, the researcher entered daily spirituality experiences as a predictor of engagement (see table 5) in block 1, perceived incorporation of spirituality was added to first predictor in block 2 and in block 3, daily spiritual experiences multiplied by perceived incorporation. Both DSES and incorporation uniquely predicted greater engagement in therapy, but that there was no interaction between them.

Table 5

Multiple hierarchical regression for engagement

	R square	Adjusted R Square	d.f	Sig F Change	Unstandardised Coefficient	St. error	β	t	p
Block 1									
DSES					.164	.048	.286	3.421	<.001
	.082	.075	1, 131	<.001					
Block 2									
DSES					.109	.500	.189	2.151	.033
Incorporation					1.478	.504	.258	2.930	.004
	.139	.126	1,130	.004					
Block 3									
DSES					.148	.095	.257	1.556	.122
Incorporation					2.379	1.912	.415	1.244	.216
DSES x Incorporation					-.019	.039	-.198	-.489	.626
	.140	.120	1,129	.626					

The second regression model repeated the same blocks to examine the relationship between the predictors and working alliance. Overall, a similar pattern emerged for both DSES and incorporation uniquely predicted working alliance in therapy, but there was no interaction between them (See table 6). The results suggested an additive effect of perceived incorporation of spirituality on engagement but not an interaction.

Table 6

Multiple hierarchical regression for working alliance

	R Square	Adjusted R Square	*d.f*	Sig F Change	Unstandardised Coefficient	St. error	β	*t*	*p*
Block 1									
DSES					.288	.084	.288	3.435	<.001
	.083	.076	1, 131	<.001					
Block 2									
DSES					.203	.089	.203	2.277	.024
Incorporation					2.215	.885	.223	2.503	.014
	.126	.112	1, 130	.014					
Block 3									
DSES					.255	.167	.255	1.523	.130
Incorporation					3.395	3.349	.342	1.014	.313
DSES x Incorporation					-.025	.069	-.150	-.365	.715
	.127	.106	1, 129	.715					

Qualitative results

From the five interviews there were two main themes generated (see table 7).

Table 7

Themes

Theme 1. Authentic conversations about spirituality
Theme 2. Full formulation needed to understand spirituality

Theme One: Authentic Conversations about Spirituality

The first theme looks at the overarching experiences described by the participants of discussing their spirituality and their therapists, all participants had received more than one episode of psychological therapy and were able to reflect on the experiences of being able or not able to have authentic conversations about their spirituality with their psychological therapist. This theme related to the notion that inclusion of or lack of discussion about the person's spirituality and faith can be damaging or helpful to the therapeutic relationship and can impact on the extent to which the person engages in the therapy.

Many participants reported experiences in which, although the therapist was aware of their spirituality and faith background, when the person brought it up in therapy, this was often met with lack of acknowledgement of the importance of spirituality for the person and often dismissed in relation to incorporating it into their therapy. Some participants shared experiences of when they shared aspects of their spirituality to be incorporated into a therapeutic task and this was often dismissed. Jacob described an occasion when he was explaining how he made sense of his bereavement by explaining that his father was in Heaven, however he felt that this was met with a dismissing response.

"*When I did try to share, share my beliefs on that on the, when I was getting bereavement counselling with the NHS, they never, erm they (pause) it's like they disregarded the spiritual aspect and change the topic."* (Jacob).

During his interview Jacob also alluded that in another episode of therapy where he received Cognitive Behavioural Therapy (CBT), when he was asked about activities he used to enjoy doing, he added church to a list of other social activities but the focus on the session was on other activities such as social occasions and sporting hobbies. Jacob further uses a powerful statement about how he was made to feel about the 'place' of spirituality in therapy.

"*There was no place for spirituality in that room. It was all cognitive. Okay. All action based, everything, everything made sense by the book."* (Jacob).

Jacob's statement about 'making sense by the book' may allude to the scientist practitioner model aspect of the NHS as an organisation. Rita also spoke about her experience of CBT from her university, in which she felt there was limited conversations about her spirituality. Throughout the interview she made references to a sense of awkwardness when she brought up the topic.

"*I would bring it up a few times, but the practitioner I worked with never brought it up…And I think sometimes it kind of felt like it caught her a bit off guard when I would bring it up."* (Rita).

Stacy also spoke about the avoidance of the topic from therapist, however, it appeared that for Stacy, this had become an expectation of secular therapy from the NHS. However, she also reflected on her preference for therapists to be the ones that initiate the conversation about spirituality.

"It's never brought up by the therapist, but I would have loved to have been the case" (Stacy).

Alice spoke about her experience of receiving family therapy with two psychological practitioners. Like the other participants Alice spoke about the therapists 'staying clear' of the conversation around spirituality. For Alice she spoke about her mental health diagnosis of bipolar disorder and expressed her feeling that, despite knowing that she was a Christian who

attended church every Sunday, her therapists may not have felt comfortable to explore her spirituality. Alice also wondered whether lack of affiliation with any faith, religion, or spirituality in general also fuelled the avoidance of the topic.

"Well, it's (spirituality) something that they don't, well, I think they avoid all costs, (chuckle)… Yeah. But I can't imagine. I imagine not many psychotherapists are Christians. Really? I don't know. It's not a question I've ever asked…." (Alice).

There was a strong sense from all participants that although they would have preferred for their therapists to take the lead on bringing up the conversation about their spirituality and faith, when some of the participants took the lead themselves this was met with a sense of being silenced and dismissed about the topic.

There was a sense of therapists' ignorance on spirituality being harmful to client engagement. Katherine starts off by expressing frustration at the therapist's ignorance to the conflict of therapeutic interventions recommended and a person's faith. Katherine also spoke about feeling that she needed to 'protect' her faith against the therapist assumptions and therefore often found herself unable to feel fully safe within the therapeutic sessions. Katherine spoke about the therapist's being aware that she had very strong Christian faith, however, neglected to observe that the mindfulness, which is an intervention largely derived from Buddhism concepts, could conflict with her faith values.

"a lot of what was being suggested to help me was mindfulness that was like the feeling is that almost every session, I was being told to practise mindfulness. And I hadn't made up my mind myself, if I felt comfortable doing mindfulness, … So, I would only ever kind of do it half-heartedly, so but not really can fully admit that either because at the same time, I didn't want that to give my faith a bad name of why don't you want to do mindfulness?.... I think it would be really important to be able to potentially say, I know that

your this is your religion, is this something that sits comfortable with you or not?" (Katherine).

Rita also reflected on an experience where her therapist made assumptions about her lifestyle because she was a Christian, she reflected on how the therapist's assumptions limited the questions they asked her, and how she engaged with the therapist. She spoke about only observing towards the end of therapy that the therapist never asked her about alcohol use.

"*I guess one thing I did notice was my second therapist would like make assumptions. For example, I would never drink, for example, because I was a Christian. And I found that quite interesting because I was doing it at the weekend, like there's stuff there that I think she'd assumed that made me get a sense that actually, she didn't know that much about the faith and the religion and what my life looks like for young, a young, modern (Christian), you know, what that looks like in the modern world? I don't know if that then kind of maybe limited me… She's [therapist] just doesn't really have an understanding of what this was about. So, it's not really worth exploring."* (Rita)

Rita also reflected on experiences with a different therapist, who even though they attempted to incorporate conversations about her spirituality in therapy, also presented assumptions that her faith was always only a protective factor, as a result Rita struggled to express some of the personal struggles she was experiencing with her faith at the time.

"Sometimes she would kind of bring in things and say, okay, you know, can we use your religion in this way to be a positive tool? And which I think it brought challenges for me,… I think sometimes it's really helpful to acknowledge people's faith but actually also spend time acknowledging where the church can cause pain to people contribute to their difficulties," (Rita)

Some participants also described lack of safety from the experienced dismissal of their faith, Jacob reported being very aware in one of the sessions that as a black man, there could be adverse consequences if he was honest to one of the therapists he worked with.

"*And it made you as a black person as well, it made you feel more like they're they are the police and they are the authority and kind of disconnect yourself in terms of what you can say. In terms of having voices like the Holy Spirit, you would not tell them because you think they say you are psycho or put you on a list. So I didn't feel safe enough to be Got to be open about my relationship with God, no chance."* (Jacob).

Theme Two: Full Formulation Needing To Understand Spirituality

This theme focuses on the client's views of the interaction between mental health and spirituality, there was a consensus from all participants that spirituality and faith was a strong part of their identity and lens in which they viewed the world and their experiences, however, some participants also spoke of the interaction between their mental health and spirituality. For some participants, there was a sense that there were challenges they experienced as Christians which impacted on their mental health. Whilst for other participants who received interventions for OCD and Bipolar, there was a strong sense that their mental health difficulties also negatively interlinked with their spirituality and their spirituality needed to be addressed in order to fully understand the nature of their mental health difficulties.

Some of the participants reported experiences of the challenges they experienced with their faith and the impact this had on their mental health. Jacob spoke about feeling shame in the church because he had a sexual relationship with his partner before marriage. Rita spoke about struggling with how she viewed herself and her relationship with God, she expressed that she struggled to accept herself because of sin.

"in hindsight, I always kind of struggled when she [therapist] brought that up, because, I was really struggling to kind of accept myself, I was really kind of overwhelmed with my own sin. And I was finding it quite hard to I guess, lean, on God in that way…… At the time, I was feeling really punished by God I was going through quite a few hard things in my life at the time and I remember I was kind of getting when we spoke in therapy I was kind of getting this harmfully weird but especially imagery of the devil" (Rita).

There was a sense that some of the mental issues were also strongly linked to the spiritual identity but not necessarily the same as their spiritual identity. The participants expressed that although they were aware of this, it appeared to be difficult to properly explain to their therapist. Alice spoke about the difficulties of being able to clearly explain this intersection.

"Yeah. my thoughts, my spirituality, which gets a bit confusing, because you think you're having a spiritual experience. And that's your illness, isn't it? Well it can be? Well, a lot of mine (mental health diagnosis) was wrapped up with my faith." (Alice).

Stacy also spoke about the importance of recognising intersectionality and needing to consider all elements of a person's life to develop and enhance formulation. She also gave reference to what spirituality may look like for someone different to her.

"Because my Christianity has a bigger role on how I behave than any cultural thing about me, be it my rate, you know, my race, my gender, the country of origin that I'm from, you know, my background, my class, whatever it is, my sexual identity, my faith is of more importance than every other thing. So if I had a, you know, language barrier, you'd be conscious to that. If I had a disability either visible or invisible, you'd be conscious of that. … you know where the overlaps are with me being a Straight Black Christian, Nigerian, British woman of a certain age, you know. You have to let me tell you which one is more prominent." (Stacy).

Rita spoke about the importance of adding faith or spirituality history to a formulation, including for people that may no longer be practising. She gave an example of purity culture in American Christian populations causing a lot of shame to a lot of women which would have affected their mental health.

"I think to get that kind of deeper, and fuller sense of actually, where people have come from, and where, you know, where did the beliefs or practices or behaviours where they'll derive from much actually having a sense of someone's spirituality, and that can mean quite broad sense as well. It doesn't have to be, you know, that kind of traditional religion, you know, it could be a whole range of things. It's still valuable." (Rita).

For participants, the experiences of being able to talk about their spirituality and faith with their therapist improved their engagement and perceived value of what the therapist offered. For some participants this was a safe interaction in which their therapist also shared their stance on faith and spirituality, whether they shared the same faith, had previous experiences of being raised within the context of Christianity, having another faith or not ascribing to any faith at all. Jacob speaks about his last therapist who had had grown up attending church, and this allowed him to feel that he could open about the challenges he experienced in the church. Katherine spoke about her therapist also being a Christian and being able to have honest conversations about what Katherine's convictions were as a Christian. Stacy spoke about being able to tell her therapist the importance of her faith for herself, however, she was pleased that her therapist was able to share her different experiences and her perspectives. Participants reported a sense of desire to engage more with their therapist and build working alliance with them.

"though my counsellor was, although she was not a Christian, she had her own personal and private faith,.... and that really helped because you don't need to be a Christian to give good counselling advice" (Stacy).

Most participants indicated that they valued what the therapist had to offer once they were able to have authentic conversations about spirituality and were also aware of the therapists' stance on the topic. There was a general consensus that therapist's disclosure actually enhanced the participants' curiosity and openness to what their therapists had to offer. Rita reflected on how her faith was integrated into the therapeutic framework that was used for her intervention, whilst Katherine spoke of her experience of engaging better in her CBT. Jacob also spoke about finding therapy most helpful when he was able to talk freely about harm that his spirituality caused to his mental health, alongside recognising how it was key to his mental health and could be integrated into therapy.

"she used to like compassion focus therapy work, so finds the work of Paul Gilbert, for example. And I remember, one of the things that she would mention would be like, you know, you've got your religion and your faith, that's a really important aspect of your life, is there a way that you can kind of encompass that to have a kind of compassionate figure, someone to kind of rely and lean on." (Rita).

"I just think to emphasise that the engagement when I was able to speak about faith was completely different." (Katherine)

Discussion

Main Findings

The quantitative results of this study suggested that both daily spiritual experiences and perceived incorporation of spirituality in psychological therapy are positively associated with working alliance and engagement in therapy. Although these predictors did not have a significant interaction, both had an additive effect on the relationship with the outcome variables. These findings provide evidence that there is value in incorporating spirituality

into therapy for Christian clients who value spirituality, but there may be no special additional benefit for people who are especially high in spirituality. The outcomes of this study could be used to support existing evidence suggesting that the incorporation of spirituality enhances therapeutic outcomes for Christians (Captari et al., 2018; Captari et al., 2021; Hodge, 2011; Hook et al., 2009), particularly engagement in therapy and development of working alliance with therapist. The findings were unexpected as the researcher had hypothesised that for Christians who value spirituality more, integration of their faith into therapy would naturally improve engagement and working alliance in therapy. In addition, it was expected that lack of perceived integration would reduce their engagement and working alliance in therapy. Given that this population of interest is of diverse demographics, covariates such as ethnicity, age and culture may have interacted with the outcome variable, therefore controlling for covariates may have improved the likelihood for a significant result for the interaction between the predictor variables and the outcome variables.

One question posed from the findings is why Christians who valued spirituality had higher engagement and working alliance in therapy. Mayers et al. (2007) qualitatively explored how Christians experience therapy in the NHS, and found that many participants preferred secular psychological therapy. In the present study, the researcher was surprised to find that the three out of five participants expressed that they found it helpful to talk to secular therapists. For some participants' there was value in being able to also talk about the difficulties that came with their spirituality, whilst another participant reported that their faith allowed them to engage with their emotions (i.e., through talking to other in small group settings) however, they also valued evidence-based support. Other studies found that participants valued faith-based psychological support (Greenidge & Baker, 2012; Mitchell & Baker, 2000). Given these findings, it could be hypothesised that Christians who value their spirituality more in their daily lives are likely to have more engagement and working alliance

in both secular and Christian psychological therapy more than those with lower value of spirituality. It could be considered this is because spirituality may equivocally correlate with other beneficial factors that facilitate therapy such as optimism, openness to exploring emotions, and capacity to address problems (Downie, 2014; Holdsworth et al., 2014), which would be an alternative explanation for the findings.

The qualitative findings comprised two main themes. The first theme explored the narratives around authentic conversations about the participants' spirituality. This highlighted that most participants reported experiences of the topic of spirituality being avoided or dismissed in therapy. This does not align with the practice guidelines of the British Psychological Society (BPS) which encourage CPs to recognise the importance of incorporating spirituality into their direct work with clients were appropriate (BPS, 2017, p. 35). The second theme highlighted the importance of incorporating a person's spirituality in order to be able to develop a good formulation. This supports the argument that therapists who are familiar with a variety of spiritual worldviews and who are aware of the therapeutic implications of their patients' spiritual practises and beliefs are better able to meet the needs of their patients (Hage et al., 2006). The findings of the qualitative study emphasised that authentic conversations about spirituality, would allow the therapist to develop a comprehensive formulation, which also impacted on the therapeutic relationship and clients' engagement. Additionally, the qualitative study found that participants found some of the current psychological frameworks such as CBT and CFT helpful when they were adapted to accommodate their spirituality.

The findings of this study put onus on therapists to hold an authentic and curious position in order to enhance therapeutic engagement. There is a long-standing research base which suggests the effectiveness of psychological therapy with spiritual clients may be boosted if the client's views are not only acknowledged but also included during the

intervention (Knox et al., 2007; Plant & Shama, 2001). The findings of this study, and other studies (Greenidge & Baker, 2012; Leavey et al., 2012; Mayer et al., 2007, Mitchell & Baker, 2000) revealed that most of the participants wished to talk about religious or spiritual matters in therapy.

Clinical Implications

Both this study and earlier research (Wade et al., 2007) have shown clients' desire to have authentic discussions about spiritual issues in therapy, and have their experiences included in the formulation that forms their treatment. In addition, incorporation of their spiritual beliefs into treatment could add to working alliance and engagement which have been found to be linked to therapeutic outcomes (Mander, 2014). It is therefore, crucial to consider how CPs can be supported to address this need. Firstly, doctoral training programmes should review the context of teaching offered on their training courses, and the availability of safe and reflexive discussions about the topic (Mills, 2010; Russell & Yarhouse, 2019). Despite clinical psychology attending to areas of diversity and identity, spirituality is yet to receive full attention in comparison to other areas of identity and protected characteristics (Plante, 2019). Training and clinical placements should support trainee CPs to develop competencies in exploring client's spiritual orientation, the incorporation into formulation and use of theoretical frameworks in integration of spirituality into therapy (Hartz, 2005). Secondly, the findings indicated that for clients, there was value placed on the theoretical knowledge their therapist offered to help make sense of their difficulties, however it was most helpful in contexts where they were able to talk about their spirituality safely and authentically. Some of the participants in the qualitative study were aware of the type of therapy they received. One participant expressed that her therapist used CFT to incorporate God as their compassionate and safe place. Another participant spoke

about working with a Christian CBT therapist who was able to focus on incorporating her spirituality into how she understood and managed her diagnosis of obsessive compulsive disorder. The findings reflected that therapists were able to adjust the widely used therapeutic frameworks to meet the needs of the individual's need, by holding authentic and curious conversations with the individual. Therefore, it could be argued that there is little need for the development of new frameworks to aid the incorporation of spirituality into the therapy, as many theoretical interventions can be adapted to meet the client's needs, such as CBT, compassion focused therapy (CFT) and acceptance and commitment therapy (ACT; Crisp & Turner, 2011). Therefore, it is crucial for CPs to establish an attitude of curiosity about the client, and to endeavour to become aware of their own cynicisms and certainties about spirituality (Knox et al., 2004).

The Role Of The Researcher

When conducting qualitative research, it is crucial for the researcher to consider their role in the manner in which the qualitative research is conducted and reported (Patton, 1990). Parker (2005) offers a framework in which researchers can engage in the process of reflexivity, through three stages: confessions, positions and theorising.

First-person reflections – confessions

The researcher believes that their own position and worldview towards spirituality have influenced the initial interest in the research topic, generation and development of the research question and the research methodology. The researcher identifies as a Christian, who has throughout their lifetime held varying positions on whether they are practising and the extent to which spirituality has been an important part of their identity.

Second person reflections – positions

The researcher is a trainee CP with experience in working with individuals from multiple faith populations conducting psychological therapy. The researcher also has people in their life circles that hold a spiritual or faith identity who have spoken about their experiences of therapy. One Muslim friend described disengaging in psychological therapy because they did not feel that therapeutic intervention aligned with their spiritual beliefs. These occurrences and reflection of their own practice when working people from multiple-faith backgrounds influenced the interest in the research topic.

Third Person Reflections – Theorising

Interactions between the researcher and interviewees play a crucial and beneficial part in the research, and it is vital to reflect on these interactions (Parker, 2005; Stanbacka, 2001). Establishing rapport is a crucial part of the interview process (DiCicco-Bloom & Crabtree, 2006). As the research was conducted via video call, the interviewer built initial rapport with the participants by introducing themselves and the study and informing them of the expected process and schedule of the interview by describing the themes of the questions. The interviewer also allowed the participants an opportunity to ask questions about the interviewer and the process. At the end of the interview, Stacy, reported that she "*could have carried on talking for hours*" and was surprised how much she enjoyed the interview. Although the researcher did not disclose their position on spirituality, their role as a psychological therapist was apparent in the introduction and in their responses/ follow-up questions to the participant's answers. It is likely that participants' being aware of this may have impacted on the responses participants gave. However, from the interview reflections and reflections of the transcription of the interviews, the researcher did not note any possible occurrences of this. It is also possible that the participants may have assumed that the researcher held a Christian identity by virtue of their topic. This in addition, may have influenced the responses from the clients.

Strengths and limitations

A key strength of this study was the use of a mixed methods approach to give insight into the phenomenon of interest. The majority of the literature on this area uses qualitative approaches, however the incorporation of a quantitative study in the research allows for results to be generalised to the population of interest and the study could be replicated in the future. The findings for both parts of the study were consistent, and in addition the qualitative findings contextualised the qualitative findings which was helpful for drawing conclusions from study. Although there is some research into spiritual clients' experiences when engaging in psychological therapy, this area of research has been limited particularly in the UK and the majority of studies exploring the issue from a client's perspective solely use qualitative methods. The use of quantitative methods in this study means that the results can be generalised to the Christian population.

A key issue with use merging qualitative and quantitative methods is that often, one set of data turns out to be more interesting than the other set, which may result in more interesting data set being given priority (Bryman, 2007). From the researcher's perspective, in the present study, the qualitative data was more interesting therefore there may have been more priority given to the reporting of qualitative findings over the quantitative results. It could also be argued that because the researcher's methodological predilection towards qualitative methods also influenced which dataset was observed as more interesting and how this is reported in the present study. In addition, use of a mixed approach limits the researcher's ability to report and discuss in detail findings of both methods of the study.

Another limitation is that the study may not have had enough power to detect the moderated effect if there was one, particularly given the sample size because interactions may be smaller than main effects. The validity of retrospective self – report methods is another

limitation to be considered. This may have increased size of associations because the method was identical so similar response styles will tend to push up the correlation between variables (regardless of measure content). Whilst use of a cross-sectional self-report design is beneficial particularly for looking at sample characteristics that predict beneficial aspects of therapy, one limitation of this method is the general tendency for positive reporting which could have contributed to the pattern of positive correlations observed in this study.

Further Research

Further research is needed to understand why Christians who value spirituality more are more likely to have higher engagement and working alliance in therapy. This could be achieved quantitatively by examining which factors of Christianity are associated with higher engagement and working alliance in therapy, or what variable mediates Christian views and better engagement & working alliance in therapy. Alternatively, this could be explored in more detail qualitatively.

The researcher found that there are limited theoretical frameworks that could be used to explain the findings of the present research. Therefore, it is apparent that there is need for clinical and research psychologists within the UK to engage developing theoretical frameworks that can inform clinical practice.

Future research could further examine whether increase in training and provision of a safe space for reflection and discussion around issues of spirituality for CPs is related to increased competence and willingness to engage client spirituality needs. Particularly in this UK, there is need to bridge the gap between quantitative research and qualitative research on this topic with an increase in quantitative studies. Given that the UK, holds a spiritually diverse population (Office of National Statistics, 2020), future studies should also focus on addressing generalisability to other people from other faiths.

Conclusion

The aim of the present study was to quantitatively offer clarification on how spirituality is associated with therapeutic engagement and to qualitatively explore experiences of Christians when engaging in psychological therapy to understand what is harmful to their therapeutic engagement and therapeutic alliance. This study used a mixed methods approach which aimed at quantitatively examining whether spirituality is associated with therapeutic engagement. The findings of the study quantitatively suggest that the incorporation of spirituality into therapy does not moderate the interaction between daily spiritual experiences and engagement & working alliance in therapy, however does have an additive effect. Qualitatively the study found that clients valued authentic conversations about spirituality, and incorporation of this into therapy supported engagement and working alliance.

References

Arundell, L. L., Barnett, P., Buckman, J. E., Saunders, R., & Pilling, S. (2021). The effectiveness of adapted psychological interventions for people from ethnic minority groups: A systematic review and conceptual typology. *Clinical psychology review*, *88*, 102063.

Bates, D. (1994). Christianity, culture and other religions (Part 1): The origins of the study of world religions in English education. *British Journal of Religious Education*, *17*(1), 5–18. https://doi.org/10.1080/0141620940170102

Bleiker, J., Morgan-Trimmer, S., Knapp, K., & Hopkins, S. (2019). Navigating the maze: Qualitative research methodologies and their philosophical foundations. *Radiography*, *25*, S4–S8. https://doi.org/10.1016/j.radi.2019.06.008

Boddy, C. R. (2016). Sample size for qualitative research. *Qualitative Market Research: An International Journal*, *19*(4), 426–432. https://doi.org/10.1108/QMR-06-2016-0053

Borg, M. J. (2009). *The Heart of Christianity: Rediscovering a Life of Faith*. Zondervan.

Brown, O., Elkonin, D., & Naicker, S. (2013). The Use of Religion and Spirituality in Psychotherapy: Enablers and Barriers. *Journal of Religion and Health*, *52*(4), 1131–1146. https://doi.org/10.1007/s10943-011-9551-z

Bryman, A. (2007). Barriers to Integrating Quantitative and Qualitative Research. *Journal of Mixed Methods Research*, *1*(1), 8–22. https://doi.org/10.1177/2345678906290531

Captari, L. E., Hook, J. N., Hoyt, W., Davis, D. E., McElroy-Heltzel, S. E., & Worthington Jr., E. L. (2018). Integrating clients' religion and spirituality within psychotherapy: A comprehensive meta-analysis. *Journal of Clinical Psychology*, *74*(11), 1938–1951. https://doi.org/10.1002/jclp.22681

Captari, L. E., Sandage, S. J., & Vandiver, R. A. (2021). Spiritually integrated psychotherapies in real-world clinical practice: Synthesizing the literature to identify best practices and future

research directions. *Psychotherapy*, No Pagination Specified-No Pagination Specified. https://doi.org/10.1037/pst0000407

Carson, D., Gilmore, A., Perry, C., & Gronhaug, K. (2001). *Qualitative Marketing Research*. SAGE.

Carvalho, S., Martins, C. P., Almeida, H. S., & Silva, F. (2017). The evolution of cognitive behavioural therapy–The third generation and its effectiveness. *European Psychiatry*, *41*(S1), s773-s774.

Cragun, C., & Friedlander, M. (2012). Experiences of Christian Clients in Secular Psychotherapy: A Mixed-Methods Investigation. *Journal of Counseling Psychology*, *59*, 379–391. https://doi.org/10.1037/a0028283

Crisp, R. J., & Turner, R. N. (2011). Cognitive adaptation to the experience of social and cultural diversity. *Psychological Bulletin*, *137*(2), 242–266. https://doi.org/10.1037/a0021840

Curtis, R. C., & Davis, K. M. (1999). Spirituality and Multimodal Therapy: A Practical Approach to Incorporating Spirituality in Counseling. *Counseling and Values*, *43*(3), 199–210. https://doi.org/10.1002/j.2161-007X.1999.tb00143.x

Daniels, C., & Fitzpatrick, M. (2013). Integrating Spirituality in Counselling and Psychotherapy: Theoretical and Clinical Perspectives. *Canadian Journal of Counselling and Psychotherapy*, *47*(3), Article 3. https://cjc-rcc.ucalgary.ca/article/view/60807

de Abreu Costa, M., & Moreira-Almeida, A. (2021). Religion-Adapted Cognitive Behavioral Therapy: A review and description of techniques. *Journal of religion and health*, 1-24.

Deneulin, S., & Rakodi, C. (2011). Revisiting Religion: Development Studies Thirty Years On. *World Development*, *39*(1), 45–54. https://doi.org/10.1016/j.worlddev.2010.05.007

DiCicco-Bloom, B., & Crabtree, B. F. (2006). The qualitative research interview. *Medical Education*, *40*(4), 314–321. https://doi.org/10.1111/j.1365-2929.2006.02418.x

Downie, A. (2014). A spirituality of openness: Christian ecofeminist perspectives and inter-religious dialogue. *Feminist theology*, *23*(1), 55-70. https://doi.org/10.1177/0966735014542378

Driscoll, D. L., Appiah-Yeboah, A., Salib, P., & Rupert, D. J. (2007). Merging Qualitative and Quantitative Data in Mixed Methods Research: How To and Why Not. *Ecological and Environmental Anthropology (University of Georgia)*. https://digitalcommons.unl.edu/icwdmeea/18

EPISTEMOLOGICAL VS. ONTOLOGICAL RELATIONALISM IN QUANTUM MECHANICS: RELATIVISM OR REALISM? | Probing the Meaning of Quantum Mechanics. (n.d.). Retrieved 20 June 2022, from https://www.worldscientific.com/doi/abs/10.1142/9789813276895_0015

Exploring religion in England and Wales—Office for National Statistics. (n.d.). Retrieved 29 July 2022, from https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/religion/articles/exploringreligioninenglandandwales/february2020

George, M. (2013). Teaching Focus Group Interviewing: Benefits and Challenges. *Teaching Sociology*, *41*(3), 257–270. https://doi.org/10.1177/0092055X12465295

Gilbert, P. (2009). Introducing compassion-focused therapy. *Advances in psychiatric treatment*, *15*(3), 199-208. https://doi.org/10.1192/apt.bp.107.005264

Glenn, D., Golinelli, D., Rose, R. D., Roy-Byrne, P., Stein, M. B., Sullivan, G., Bystritksy, A., Sherbourne, C., & Craske, M. G. (2013). Who gets the most out of cognitive behavioral therapy for anxiety disorders? The role of treatment dose and patient engagement. *Journal of Consulting and Clinical Psychology*, *81*(4), 639–649. https://doi.org/10.1037/a0033403

Gockel, A. (2011). Client perspectives on spirituality in the therapeutic relationship. *The Humanistic Psychologist*, *39*(2), 154–168. https://doi.org/10.1080/08873267.2011.564959

Goertz, G., & Mahoney, J. (2012). Concepts and measurement: Ontology and epistemology. *Social Science Information*, *51*(2), 205–216. https://doi.org/10.1177/0539018412437108

Goldman, M. J., Turner, M. D., & Daly, M. (2018). A critical political ecology of human dimensions of climate change: Epistemology, ontology, and ethics. *WIREs Climate Change*, *9*(4), e526. https://doi.org/10.1002/wcc.526

Greenidge, S., & Baker, M. (2012). Why do committed Christian clients seek counselling with Christian therapists? *Counselling Psychology Quarterly*, *25*(3), 211–222. https://doi.org/10.1080/09515070.2012.673273

Hage, S. M., Hopson, A., Siegel, M., Payton, G., & DeFanti, E. (2006). Multicultural Training in Spirituality: An Interdisciplinary Review. *Counseling and Values*, *50*(3), 217–234. https://doi.org/10.1002/j.2161-007X.2006.tb00058.x

Hall, A. M., Jo Smith, Chris Jones, Marianne. (2001). Brief report: The development and psychometric properties of an observer-rated measure of engagement with mental health services. *Journal of Mental Health*, *10*(4), 457–465. https://doi.org/10.1080/09638230124439

Hall, G. C. N., Ibaraki, A. Y., Huang, E. R., Marti, C. N., & Stice, E. (2016). A meta-analysis of cultural adaptations of psychological interventions. *Behavior therapy*, *47*(6), 993-1014.

Hatcher, R. L., & Gillaspy, J. A. (2006). Development and validation of a revised short version of the working alliance inventory. *Psychotherapy Research*, *16*(1), 12–25. https://doi.org/10.1080/10503300500352500

Hayes, A. F. (2018). Partial, conditional, and moderated moderated mediation: Quantification, inference, and interpretation. *Communication Monographs*, *85*(1), 4–40. https://doi.org/10.1080/03637751.2017.1352100

Hefti, R. (2011). Integrating Religion and Spirituality into Mental Health Care, Psychiatry and Psychotherapy. *Religions*, *2*(4), 611–627. https://doi.org/10.3390/rel2040611

Heim, E., & Kohrt, B. A. (2019). Cultural adaptation of scalable psychological interventions. *Clinical Psychology in Europe*, *1*(4), 1-22.

Helminiak, D. A. (2001). Treating Spiritual Issues in Secular Psychotherapy. *Counseling and Values*, *45*(3), 163–189. https://doi.org/10.1002/j.2161-007X.2001.tb00196.x

Helminiak, D. A. (2006). The role of spirituality in formulating a theory of the psychology of religion. *Zygon®*, *41*(1), 197-224.

Hodge, D. R. (2011). Alcohol Treatment and Cognitive-Behavioral Therapy: Enhancing Effectiveness by Incorporating Spirituality and Religion. *Social Work*, *56*(1), 21–31. https://doi.org/10.1093/sw/56.1.21

Hook, J. N., Worthington Jr., E. L., Davis, D. E., Jennings II, D. J., Gartner, A. L., & Hook, J. P. (2010). Empirically supported religious and spiritual therapies. *Journal of Clinical Psychology*, *66*(1), 46–72. https://doi.org/10.1002/jclp.20626

Jenkins, R. A., & Pargament, K. I. (2014). Religion and spirituality as resources for coping with cancer. In *Psychosocial resource variables in cancer studies: Conceptual and measurement issues* (pp. 51-74). Routledge. https://doi.org/10.4324/9781315859316

Knox, S., Catlin, L., Casper, M., & Schlosser, L. Z. (2005a). Addressing religion and spirituality in psychotherapy: Clients' perspectives1. *Psychotherapy Research*, *15*(3), 287–303. https://doi.org/10.1080/10503300500090894

Knox, S., Catlin, L., Casper, M., & Schlosser, L. Z. (2005b). Addressing religion and spirituality in psychotherapy: Clients' perspectives. *Psychotherapy Research*, *15*(3), 287–303. https://doi.org/10.1080/10503300500090894

Knox, S., Catlin, L., Casper, M., & Schlosser, L. Z. (2005c). Addressing religion and spirituality in psychotherapy: Clients' perspectives. *Psychotherapy Research*, *15*(3), 287–303. https://doi.org/10.1080/10503300500090894

Kraemer, H. (2002). *Religion and the Christian Faith*. James Clarke & Co.

Kraft, C. H. (2005). *Christianity with Power: Your Worldview and Your Experience of the Supernatural*. Wipf and Stock Publishers.

Leeming, D., Boyle, M., & MacDonald, J. (2009). Accounting for psychological problems: How user-friendly is formulation?. In *Clinical Psychology Forum* (Vol. 200, pp. 12-15). The British Psychological Society.

Lobe, B., & Morgan, D. L. (2021). Assessing the effectiveness of video-based interviewing: A systematic comparison of video-conferencing based dyadic interviews and focus groups. *International Journal of Social Research Methodology*, *24*(3), 301–312. https://doi.org/10.1080/13645579.2020.1785763

Magaldi-Dopman, D., Park-Taylor, J., & Ponterotto, J. G. (2011). Psychotherapists' spiritual, religious, atheist or agnostic identity and their practice of psychotherapy: A grounded theory study. *Psychotherapy Research*, *21*(3), 286–303. https://doi.org/10.1080/10503307.2011.565488

Mallinckrodt, B., & Tekie, Y. T. (2016). Item response theory analysis of Working Alliance Inventory, revised response format, and new Brief Alliance Inventory. *Psychotherapy Research*, *26*(6), 694–718. https://doi.org/10.1080/10503307.2015.1061718

Martinez, J. S., Smith, T. B., & Barlow, S. H. (2007). Spiritual interventions in psychotherapy: Evaluations by highly religious clients. *Journal of Clinical Psychology*, *63*(10), 943–960. https://doi.org/10.1002/jclp.20399

Mayers, C., Leavey, G., Vallianatou, C., & Barker, C. (2007a). How clients with religious or spiritual beliefs experience psychological help-seeking and therapy: A qualitative study. *Clinical Psychology & Psychotherapy*, *14*(4), 317–327. https://doi.org/10.1002/cpp.542

Mayers, C., Leavey, G., Vallianatou, C., & Barker, C. (2007b). How clients with religious or spiritual beliefs experience psychological help-seeking and therapy: A qualitative study. *Clinical Psychology & Psychotherapy*, *14*(4), 317–327. https://doi.org/10.1002/cpp.542

Mayers, C., Leavey, G., Vallianatou, C., & Barker, C. (2007c). How clients with religious or spiritual beliefs experience psychological help-seeking and therapy: A qualitative study. *Clinical Psychology & Psychotherapy*, *14*(4), 317–327. https://doi.org/10.1002/cpp.542

Mayers, C., Leavey, G., Vallianatou, C., & Barker, C. (2007d). How clients with religious or spiritual beliefs experience psychological help-seeking and therapy: A qualitative study. *Clinical Psychology & Psychotherapy*, *14*(4), 317–327. https://doi.org/10.1002/cpp.542

Meaden, A., Nithsdale, V., Rose, C., Smith, J., & Jones, C. (2004). Is engagement associated with outcome in assertive outreach? *Journal of Mental Health*, *13*(4), 415–424. https://doi.org/10.1080/09638230410001729852

Mills, J. (2010). *An exploration of trainee clinical psychologists' experiences of engaging with psycho spiritual issues in clinical practice* [University of Leicester]. http://oatd.org/oatd/record?record=handle%5C%3A2381%5C%2F8593

Mitchell, J. R., & Baker, M. C. (2000). Religious commitment and the construal of sources of help for emotional problems. *British Journal of Medical Psychology*, *73*(3), 289–301. https://doi.org/10.1348/000711200160471

Munder, T., Wilmers, F., Leonhart, R., Linster, H. W., & Barth, J. (2010). Working Alliance Inventory-Short Revised (WAI-SR): Psychometric properties in outpatients and inpatients. *Clinical Psychology & Psychotherapy*, *17*(3), 231–239. https://doi.org/10.1002/cpp.658

[No title found]. (n.d.). *Global Academic Journal of Humanities and Social Sciences*.

Ouzzani, M., Hammady, H., Fedorowicz, Z., & Elmagarmid, A. (2016). Rayyan—a web and mobile app for systematic reviews. Systematic reviews, 5(1), 1-10.

Pargament, K. I., Murray-Swank, N. A., & Tarakeshwar, N. (2005). An empirically-based rationale for a spiritually-integrated psychotherapy. *Mental Health, Religion & Culture*, *8*(3), 155–165. https://doi.org/10.1080/13694670500138940

Pargament, K. I., & Saunders, S. M. (2007). Introduction to the special issue on spirituality and psychotherapy. *Journal of Clinical Psychology*, *63*(10), 903–907. https://doi.org/10.1002/jclp.20405

Parker, I. (2005). Lacanian Discourse Analysis in Psychology: Seven Theoretical Elements. *Theory & Psychology*, *15*(2), 163–182. https://doi.org/10.1177/0959354305051361

Patton, M. Q. (1990). *Qualitative evaluation and research methods, 2nd ed* (p. 532). Sage Publications, Inc.

Plante, T. (2019). Relationship between Religion, Spirituality, and Psychotherapy: An Ethical Perspective. *Psychology*. https://scholarcommons.scu.edu/psych/328

Reinert, K. G., & Koenig, H. G. (2013). Re-examining definitions of spirituality in nursing research. *Journal of Advanced Nursing*, *69*(12), 2622–2634. https://doi.org/10.1111/jan.12152

Rose, E. M., Westefeld, J. S., & Ansely, T. N. (2001). Spiritual issues in counseling: Clients' beliefs and preferences. *Journal of Counseling Psychology*, *48*(1), 61–71. https://doi.org/10.1037/0022-0167.48.1.61

Russell, S. R., & Yarhouse, M. A. (2006). Training in religion/spirituality within APA-accredited psychology predoctoral internships. *Professional Psychology: Research and Practice*, *37*(4), 430–436. https://doi.org/10.1037/0735-7028.37.4.430

Slay, N. (2022). Provision and Barriers of Psychological Support for Psychosis in a Community Mental Health Team: A Care Coordinator Enquiry Audit. *Research Portfolio Submitted in Part Fulfilment of*, 43.

Stenbacka, C. (2001). Qualitative research requires quality concepts of its own. *Management Decision*, *39*(7), 551–556. https://doi.org/10.1108/EUM0000000005801

Usher, E., & Ryan, P. (2019). Meaning making in formulation. In *Enhancing Clinical Case Formulation* (pp. 11-29). Routledge.

Wade, N. G., Worthington, E. L., & Vogel, D. L. (2007). Effectiveness of religiously tailored interventions in Christian therapy. *Psychotherapy Research*, *17*(1), 91–105. https://doi.org/10.1080/10503300500497388

Watts, R. E. (2001). Addressing Spiritual Issues in Secular Counseling and Psychotherapy: Response to Helminiak's (2001) Views. *Counseling and Values*, *45*(3), 207–217. https://doi.org/10.1002/j.2161-007X.2001.tb00198.x

Weber, S. R., & Pargament, K. I. (2014). The role of religion and spirituality in mental health. *Current opinion in psychiatry*, *27*(5), 358-363.

Weisman de Mamani, A. G., Tuchman, N., & Duarte, E. A. (2010). Incorporating Religion/Spirituality Into Treatment for Serious Mental Illness. *Cognitive and Behavioral Practice*, *17*(4), 348–357. https://doi.org/10.1016/j.cbpra.2009.05.003

Worthington Jr., E. L., Wade, N. G., Hight, T. L., Ripley, J. S., McCullough, M. E., Berry, J. W., Schmitt, M. M., Berry, J. T., Bursley, K. H., & O'Connor, L. (2003). The Religious Commitment Inventory--10: Development, refinement, and validation of a brief scale for research and counseling. *Journal of Counseling Psychology*, *50*(1), 84–96. https://doi.org/10.1037/0022-0167.50.1.84

APPENDIX A: Ethics Documentation

Ethics Approval

UNIVERSITY OF EXETER

Research Ethics Committee Review Outcome

Dear RUVIMBO MUGADZA

Ethics Application ID: 502984
Title: Legacy App - eCLESPsy002020 2.2 - Spiritual clients, perceived integration of spirituality into therapy and association with therapeutic engagement. A mixed-methods approach to exploring spirituality and engagement in psychological therapy. *(Version: 0)*
Proposed Project Duration: 1 Feb 2021 - 1 Apr 2022

Your research study ethics application submitted above on 8 Feb 2021 has been reviewed by the CLES Psychology Ethics Committee.

Outcome decision by Research Ethics committee: Approved

Anna Adlam commented, The statements about withdrawal from the study are a bit confusing - on the one hand the participant is told that they can withdraw at any point during or after the study; on the other hand, the participant is told that as their data is anonymous, their data cannot be withdrawn once they have submitted their responses/completed the interviews. Can the 'rights to withdraw' be more clearly explained on all information provided to participants please (e.g., information sheets, consent forms, debrief sheets, study adverts)

Decision Date: 19 Mar 2021*

You can only start your research once you have received an **Approved outcome. The start date of your research will be no sooner than the Ethics Committee Approval decision date above.*

Research Ethics Committee Approval End Date:

Regards,

CLES Psychology Ethics Committee

Qualtrics Participant Information sheet

Principal Researcher: Jane Stevens
Supervisors: Dr Nick Moberly and Dr Cordet Smart

You are being invited to take part in a study which aims to explore what is important about therapy for spiritual people. Before deciding whether you would like to take part in this study, please read through the following information which will clarify why the study is being conducted and what your involvement will be.

What is the purpose of the study?

The aim of the study is to explore what is important about spirituality and therapy for spiritual people in order to best connect with therapy. The findings could hopefully offer clarification for how spiritualty might influence therapeutic engagement. The study will form the basis of a Doctor of Clinical Psychology thesis being undertaken by the principal researcher (Jane Stevens, see contact details below).

What does participation involve?

You can participate by completing online questionnaires that ask about your experience of therapy and your spirituality. These will take approximately 30 minutes to complete. There is an option to complete individual interviews with the researcher at a later stage, and you are asked to provide contact details at the end of the survey if you wish to be considered for this.

Am I required to take part?

It is entirely up to you if you wish to take part. If you do decide to take part, and then you change your mind during completion of the survey, just exit the survey. However if you change your mind after you have completed the survey, we will not be able to withdraw your data after you have completed the study as it will be anonymous.

Expenses and payment

If you take part, you will have the option to be entered in a prize draw to win £50 amazon voucher. You can do this by entering you email at the completion of the survey.

Are there any disadvantages of taking part in the study?

There are no known disadvantages of taking part in the study. However, as it does involve thinking and talking about therapy, this may bring up difficult feelings you may have been

experiencing at the time. Remember that you may quit the study at any time. After you have completed the study you will be provided with some information about services you can contact if the study has raised some difficult emotions.

What if I get upset or need more help?

If you wish to talk further about any emotions that may arise from participating in the study, you can also talk to:

- Your GP
- A telephone support service such as the Samaritans (116 123)

This information will be provided again after completion of the survey. You can also contact the researcher to inform them and they will sign post you to any other relevant services.

What if there is a problem?

If you wish to complain, or have any concerns about any aspect of the way you have been approached or treated during the course of this study, you can contact the University of Exeter Ethics and Research Governance Manager, Gail Seymour, g.m.seymour@ex.ac.uk

Will my taking part in the study be kept confidential?

All study data will be kept confidential, stored on password-protected university servers, and will only be shared among the research team.

Personally identifiable information (name and email addresses) will be requested at the end of the survey if you wish to be included in the prize draw and/or if you are interested in taking part in a follow-up interview. These names and email addresses will be stored on secure university servers with the rest of the study data until the end of data collection (Spring 2022), when they will be deleted along with any other personal data.

For participants who are interviewed after the survey, the researcher will audio record the interviews with personal/identifying data removed during transcription to protect participants' anonymity. The researcher will transcribe the data independently, and only the researcher and the project supervisors will have access to the transcribed and recorded data. Once the audio recordings are transcribed, they will be deleted. The transcribed data will be stored on a highly secure university-based server (one drive 365). Only the researcher and the project supervisors will have access to the transcribed and recorded data and the personal data (emails) before the latter are deleted.

All information which is collected from you during the research would be kept strictly confidential within the limits of the law. For the purposes of data storage, you will be allocated your own unique study code, ensuring that all information that you give will contain a number instead of your name. Any identifiable information (e.g., names, emails) will be deleted at the end of data collection. In accordance with British Psychological Society research guidelines, all anonymised data from the study will be securely stored for 20 years and will be destroyed after this time.

Due to the recent regulatory changes in the way data are processed (General Data Protection Regulations 2018 and Data Protection Act2018), University of Exeter's lawful basis to process personal data for purposes of carrying out research is termed as a task in the public interest. The University will endeavour to be transparent about its processing of your personal data and this information sheet should provide clear explanation of this. If you have any queries about the university's processing of your personal data that cannot be resolved by the research team, further information may be obtained by the universities data protection officer by emailing dataprotection@exeter.ac.uk .

What will happen to my results?

It is planned that the results will be written up in order to inform clinicians and researchers who are interested in integrating spirituality into therapy. No participant will be personally identifiable in any write-up of the study results.

Who has reviewed this study?

This study has been reviewed and approved by the Psychology Ethics Committee, University of Exeter (reference: eCLESPsy002020).

Researcher	Supervisors
Jane Stevens **Clinical Psychology Doctoral Program** **Washington Singer Laboratories** **Perry Road** **Exeter** **EX4 4QG**	**Dr Nick Moberly and Dr Cordet Smart** **Mood Disorders Centre** **Washington Singer Laboratories** **Perry Road** **Exeter** **EX4 4QG** **n.j.moberly@exeter.ac.uk**

rjs262@exeter.ac.uk	
University Research Ethics Manager **Gail Seymour** **g.m.seymour@ex.ac.uk**	

- I have read the study information.

PARTICIPANT CONSENT FORM
Title: Spiritual people, perceived integration of spirituality into therapy and association with therapeutic engagement.

Researcher	Supervisors
Jane Stevens	Dr Nick Moberly and Dr Cordet Smart
Clinical Psychology Doctoral Program	Mood Disorders Centre
Washington Singer Laboratories	Washington Singer Laboratories
Perry Road	Perry Road
Exeter	Exeter
EX4 4QG	EX4 4QG
Rjs262@exeter.ac.uk	n.j.moberly@exeter.ac.uk

Please the read statements below and confirm whether you agree with them to continue with the study

I confirm that I have read and understood the information sheet for the above study.

YES
NO

I am aware that my participation is voluntary and that I can withdraw my consent at any point during the study without providing a reason. However, as this study is anonymous, I cannot withdraw my participation after I have completed the study.

YES

NO

I understand that my data will be shared among members of the research team and may be viewed by certain individuals from Exeter University for regulatory and audit purposes.

YES
NO

I agree to take part the in this study.

YES
NO

Interview Participant Information sheet

Title: Spiritual people, perceived integration of spirituality into therapy and association with therapeutic engagement.
Principal Researcher: Jane Stevens
Supervisors: Dr Nick Moberly and Dr Cordet Smart
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What is the purpose of the study?
The aim of the study is to explore what is important about spirituality and therapy for spiritual people in order to best connect with therapy. The findings could hopefully offer clarification for how spiritualty might influence therapeutic engagement. The study will form the basis of a Doctor of Clinical Psychology thesis being undertaken by the principal researcher (Jane Stevens, see contact details below).
Am I required to take part?
It is entirely up to you if you wish to take part. If you do decide to take part, you are welcome to change your mind anytime until May 2022 when the study will be closed and the thesis write up will be complete, without providing an explanation to the researcher.

What does participation involve?
Participation will involve an interview with the researcher for approximately 1hr about you experiences integrating your spirituality into therapy. This can be done over the phone, via a video call or face to face depending on your location and national guidelines regarding social distancing at the time of the study.

Expenses and payment
You will receive a £20 voucher as a reward for taking part in the study.

Are there any disadvantages of taking part in the study?
There are no known disadvantages of taking part in the study. However, as it does involve thinking and talking about therapy, this may bring up difficult feelings you may have been experiencing at the time. Remember that you may quit the study at any time. After you have completed the study you will be provided with some information about services you can contact if the study has raised some difficult emotions.
What if I get upset or need more help?
If you wish to talk further about any emotions that may arise from participating in the study, you can also talk to:
- Your GP
- A telephone support service such as the Samaritans (116 123)

This information will be provided again after the interview. You can also contact the researcher to inform them and they will sign post you to any other relevant services.

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All information which is collected from you during the research would be kept strictly confidential within the limits of the law. For the purposes of data storage, you will be allocated your own unique study code, ensuring that all information that you give will contain a number instead of your name. Any identifiable information (e.g., names, emails) will be deleted at the end of data collection. In accordance with British Psychological Society research guidelines, all anonymised data from the study will be securely stored for 20 years and will be destroyed after this time.
Due to the recent regulatory changes in the way data are processed (General Data Protection Regulations 2018 and Data Protection Act 2018), University of Exeter's lawful basis to process personal data for purposes of carrying out research is termed as a task in the public interest. The University will endeavour to be transparent about its processing of your personal data and this information sheet should provide clear explanation of this. If you have any queries about the university's processing of your personal data that cannot be resolved by the research team, further information may be obtained by the universities data protection officer by emailing dataprotection@exeter.ac.uk .

What will happen to my results?
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Who has reviewed this study?

This study has been reviewed and approved by the Psychology Ethics Committee, University of Exeter (reference: . eCLESPsy002020 v2.2)

Researcher

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Interview Participant Consent form

Title: Exploring the experiences of Christians when engaging in psychological therapy.

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Jane Stevens	Dr Nick Moberly and Dr Cordet Smart
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Please read the statements below and place your initial box to agree

I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information and ask questions and have had these answered satisfactorily.	

I understand I will also have the opportunity to ask further questions when I meet with the researcher before the interview commences.	
I am aware that my participant is voluntary and that I can withdraw my consent at any point during the study and upto May 2022without providing reason.	
I understand that I have the right to obtain information about the findings of the research when it is completed.	
I agree to my name and contact details being kept on a secure and confidential database. ☐ I understand that my recorded data will be stored on a highly secure server (one drive 365), and paperwork will be scanned onto a digital computer and held in a locked office. (Please tick). ☐ I understand that only the researcher and the project supervisors will have access to the transcribed and recorded data. (Please tick).	
I understand, that after my data is made anonymous, it may be looked at by members of the research team and individuals from Exeter University.	
I agree to take part in this study	

Name of Participant	Date	Signature

Participants debrief form

Debrief form

Thank you for taking part in our study. As we have stated the purpose of the study is to explore what is important about spirituality and therapy for spiritual people in order to best connect with therapy. The findings could hopefully offer clarification for how spiritualty might influence therapeutic engagement

What happens next?

The information from your questionnaire responses will be analysed. A thesis will be written and submitted to the University of Exeter DClinpsy programme.

What if I change my mind?

As the study is anonymous we cannot withdraw your data from the study. However If you would like to withdraw your details from the Prize draw or withdraw from being contacted for the second part of the study for an interview. Please contact the researcher on the details below.

What if there is a problem or I am not happy about my experience of participating in the study?

If you wish complain, or have any concerns about any aspect of the way you have been approached or treated during the course of this study, you can contact the **University Research Ethics and Governance Manager, Gail Seymour at g.m.seymour@ex.ac.uk**

What if I have get upset or need help after the study?
Talking about your experiences of being in therapy and spirituality may bring some difficult emotions.
If you wish to talk further about any difficult emotions that may arise from participating in the study, you can also talk to:

- Your GP
- A telephone support service such as the Samaritans (116 123)

Contact Details

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Chair of Psychology Ethics

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APPENDIX B: Measures

Engagement Measure

Thinking about your most memorable course of therapy, please answer the following questions about how you engaged in that particular therapy.

1.To what extend did attend therapy appointments

1	2	3	4	5
Never kept appointments	Rarely kept appointments	Sometimes kept appointments	Usually kept appointments	Always kept appointments

To what extend did you relate well with the therapist

1	2	3	4	5
Did not relate well with the therapist	Rarely related well with therapist	Sometimes related well with therapist	Usually related well with the therapist	Always related well with the therapist

To what extend to did you volunteered personal material, were open in discussing feelings, problems and your situation at the time.

a) Personal feelings (i.e anger, depression etc)

1	2	3	4	5
Never discussed personal feelings	Rarely discussed personal feelings	Sometimes discussed personal feelings	Usually discussed personal feelings	Always discussed personal feelings

b) Personal problems (i.e difficulties in life situation at the time)

1	2	3	4	5
Never discussed personal feelings	Rarely discussed personal feelings	Sometimes discussed personal feelings	Usually discussed personal feelings	Always discussed personal feelings

c) Symptoms

1	2	3	4	5
Never discussed personal symptoms	Rarely discussed personal symptoms	Sometimes discussed personal symptoms	Usually discussed personal symptoms	Always discussed personal symptoms

Area 4) Your perceived usefulness of therapy

To what extend did you perceive therapy as useful?

1	2	3	4	5

Never perceived therapy as useful	Rarely perceived therapy as useful	Sometimes perceived therapy as useful	Usually perceived therapy as useful	Always perceived therapy as useful

Area 5) Collaboration with Therapy

To what extent did you agree with the rational/principles therapy, and what was involved in carrying it out i.e keeping diaries, doing homework etc.

a) Agreement with therapy

1	2	3	4	5
Never agreed with proposed therapy	Rarely agreed with proposed therapy	Sometimes agreed with proposed therapy	Usually agreed with proposed therapy	Always agreed with proposed therapy

b) Involvement with therapy i.e carrying out 'homework'

1	2	3	4	5
Were never actively involved in therapy	Were rarely actively involved in therapy	Were sometimes actively involved in therapy	Were usually actively involved in therapy	Were always actively involved in therapy

c) Active involvement in therapy

(Active involvement: wanted to involve themselves in the treatment process).

1	2	3	4	5
Were never actively involved in therapy	Were rarely actively involved in therapy	Were sometimes actively involved in therapy	Were usually actively involved in therapy	Were always actively involved in therapy

Incorporation of spirituality in therapy

During the course of therapy that you used to answer the questions above, to what extent did you feel that your therapist included your spirituality in the sessions?

1	2	3	4	5
Never included my spirituality in the therapy	Rarely included my spirituality in the therapy	Sometimes included my spirituality in the therapy	Usually included my spirituality in the therapy	Always included my spirituality in the therapy

Daily Spirituality Experiences Scale

	Many times a day	*Everyday*	*Most Days*	*Some Days*	*Once in a While*	*Never or Almost Never*
I felt God's presence X	1	2	3	4	5	6
I experienced a connection all life X	1	2	3	4	5	6
During worship, or at other times when connecting with God, I felt joy, which lifted me out of my daily concerns X	1	2	3	4	5	6
I found strength in my religion or spirituality X	1	2	3	4	5	6
I felt deep inner peace and harmony X						
I asked God's help in the midst of daily activities X						
I felt God's love for me through others X	1	2	3	4	5	6
I was spiritually touched by the beauty of creation X	1	2	3	4	5	6
I felt thankful for my blessings X	1	2	3	4	5	6
I felt thankful for my blessings	1	2	3	4	5	6
I felt a selfless caring for others X	1	2	3	4	5	6
I accepted others even when they did things that I thought were wrong X	1	2	3	4	5	6
I desired to be closer to God or in union HimX	1	2	3	4	5	6
In general, how close did you feel close to God	Not Close at All 1	Somewhat Close	Very Close		As Close as Possible 4	

Working alliance Inventory short - revised

Working Alliance Inventory – Short Revised (WAI-SR)

Instructions: Below is a list of statements and questions about experiences people might have with their therapy or therapist. Some items refer directly to your therapist with an underlined space – as you read the sentences, mentally insert the name of your therapist in place of _____ in the text. Think about your experience in therapy, and decide which category best describes your own experience.

IMPORTANT!!! Please take your time to consider each question carefully.

1. As a result of these sessions I am clearer as to how I might be able to change.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

2. What I am doing in therapy gives me new ways of looking at my problem.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

3. I believe___likes me.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

4. ___and I collaborate on setting goals for my therapy.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

5. ___and I respect each other.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

6. ___and I are working towards mutually agreed upon goals.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

7. I feel that___appreciates me.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

8. _____ and I agree on what is important for me to work on.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

9. I feel _____ cares about me even when I do things that he/she does not approve of.

①	②	③	④	⑤

Seldom Sometimes Fairly Often Very Often Always

10. I feel that the things I do in therapy will help me to accomplish the changes that I want.

⑤ ④ ③ ② ①
Always Very Often Fairly Often Sometimes Seldom

11. _____ and I have established a good understanding of the kind of changes that would be good for me.

⑤ ④ ③ ② ①
Always Very Often Fairly Often Sometimes Seldom

12. I believe the way we are working with my problem is correct.

① ② ③ ④ ⑤
Seldom Sometimes Fairly Often Very Often Always

 Goal Items: 4, 6, 8, 11; Task Items: 1, 2, 10, 12; Bond Items: 3, 5, 7, 9

APPENDIX C: Analysis And Result Tables

Interview codes and subthemes table

CODE	SENTENCE	REFERENCE
Faith dilemmas being aligned with mental health difficulties.	Christian I'd never been hopeless before and through. OK, I was able to discuss, you know, that was a challenge of my faith not knowing.	Stacy 06.37
	And then it was really doing that in my mind and my heart. From from when I was young, yeah. Because from a religious side of it, sex is wrong until you're married. And I was always made to feel like I was bad and wrong about it.	Jacob 6.40
	,….. I think sometimes it's really helpful to acknowledge people's faith but actually also spend time acknowledging where the church can cause pain to people contribute to their difficulties, because I think my therapist always saw it as being a really positive thing and for the most part,	Rita 22.40
	I knew that it wasn't my faith causing that it was OCD, twisting things	Kathrine 4..46
Therapists disclosing their spirituality being helpful	through my counselor was, although she was not a Christian, she had her own personal and private faith, but she encouraged me to do all the things I used to do to lift myself and to feel fuller, and that really helped because you don't need to be a Christian to give good counselling advice	Stacy 06.58
	And he he was able to connect to me but understand my spirituality. Well, because he grew up at church when he was younger, was able to relate and understand where conflicts were with my heart and my mind. So sexuality as well. So in terms of I always thought that I had a too high libido and loved women too much. And he was just like, well, you're normal.	Jacob 2.37

Valuing knowledge and insight from a non religious perspective	you don't need to be a Christian to give good counselling advice. But what you do need to be is sensitive.	Stacy 06.58
	And so the principle of what the counsellor told me was that I was too hard on myself and that and that I shouldn't. The way the lens that I assess myself on is too strict. And in terms that helped me realise exactly what the Bible was saying and actually get me closer to God because to be honest, and I was able to be honest with God, and with my counsellor and he really felt me helped me feel that that was a safe	Jacob 2.37
	she didn't tell me anything to read because she's not a Christian, but she there was a point me back to what worked before, you know, allow yourself space to do and enjoy those things and it did work. So yeah, that was really helpful.	Stacy 07.30
Therapists supporting participants to reconnect with their faith	she never gave me any biblical truth or any prayers that you have a counsellor through and through. But she helped me to see. I don't need to disqualify my faith. I don't need to, you know, pause that when it's such an integral part of who I am, my identity and how I feel about myself.	Stacy 09.34
Perspective that it is unethical to bring up spirituality before the client	Ah, this is hard. I disagree, but I would disagree because I'm a Christian who loves talking about her Christianity. So of course I'm going to disagree. And I think any attempt to repress or suppress the sharing of tips, advice that may be beneficial to somebody who's going through a difficult time, I think it's horrible. I think there is a way to bring in faith and spirituality that could be softening.	Stacy 10.19
	And you know, how could this be in a moment of actually catastrophe? Faith is missing and faith could help lift. So why would you not bring it forward? I would say.	Stacy 14.08
	I guess, it's hard, isn't it? Because, actually, you know, well whether you identify as a, you know, a practising person of faith or not, you know, you may have been brought up with certain values. And actually, that does just affect, you know, your view of the world. And the way that you see yourself, I think, you know, when when we think of the purity culture within in America, for example, you know, actually, a lot of shame was an internalised by a lot of women, you know, which I'm sure had a knock on effect on their mental health and the way they were viewed, whether they stayed as a	Rita 16.33

	Christian, you know, after being, you know, brought up in that teaching or not. So, I think it would be a shame to people to not ask the question and raise it.	
	But I think at the same time, as someone who myself works in NHS, I appreciate how time limited services and professionals are. So sometimes it doesn't always feel like the most relevant thing if the individual was bringing it up itself. But I yeah, I think to get that kind of deeper, and more fuller sense of actually, where people have come from, and where, you know, where did the beliefs or practices or behaviours where they'll derive from much actually having a sense of someone's spirituality, and that can mean quite broad sense as well. It doesn't have to be, you know, that kind of traditional religion, you know, it could be a whole range of things. It's still valuable.	Rita 16.33
	I think it's important to have the opportunity to talk about faith if you want to, but it's still down to the clients choice	Katherine 11.37
Why and how they faith is brought into the sess	It's never brought up by the therapist, but I would have loved to have been the case, my influence is I'm able to weigh up their their words a bit better because I know therapy is just therapy and my faith Trump's therapy. My faith Trump's what the counselor tells me. And if the counselor tells me something in case some point I	Stacy 14.51
	I have always been quite upfront about it. Because I think for me, it's such an important component of my life that I feel like I can't really take it out as a separate issue…….And my first therapist, my faith has played a really big role. And that therapy, I would say, we spoke about it a lot. And my therapist wasn't a Christian, but she was very open to talking about it. And I did find that helpful at the time. Sometimes she kind of took the lead and brought it into aspects.	Rita 6.24
	I would bring it up a few times, but the practitioner I worked with never brought it up, really compared to in my first therapy. And I think sometimes it kind of felt like it caught her a bit off guard when I when I would bring it up.	Rita 19.13
	relationship with God was intertwined with what we was discussing. It wasn't, I wasn't made to feel that way, because I had faith. In fact, it was actually encouraged. And I don't think that would have been encouraged on the NHS, but this was private.	Jacob 2.37

	when I did try to share, share my beliefs on that on the when I was getting bereavement counselling with the NHS, they never they it's like they disregarded the spiritual aspect and change the topic. We're never really focused on it or spent time on it.	Jacob 2.37
Dis Congruence between therapy teaching and faith	If my counsellor tells me something that doesn't align with my Christian, I know not to do it, for example not to forgive and to cut of people that are hurtful to me. I don't think that's the best way to be.	Stacy 15.22
	My therapist made presumptions without considering or asking about my faith convictions. (Didn't think they made an effort to consider her faith and adapt it).	Stacy 17.26
Intersectionality and faith	Factors they need to be aware of, spiritual differences and spiritual factors. Because my Christianity has a bigger role on how I behave than any cultural thing about me, be it my rate, you know, my race, my gender, the country of origin that I'm from, you know, my background, my class, whatever it is, my sexual identity, my faith is of more importance than every other thing. So if I had a, you know, language barrier, you'd be conscious to that. If I had a disability either visible or invisible, you'd be conscious of that.	Stacy 20.59
	Yeah, and intersectionality. I should say. That is such a key issue. And it's so good that you mentioned it because it's about understanding that where I, you know where the overlaps are with me being a straight black Christian, Nigerian, British woman of a certain age, you know.	Stacy 22.40
	You have to let me tell you which one is more prominent. If I'm talking to a man who is a a gay man who is also a Muslim man who's also doing with precarious immigration status, I can't presume which one is most important to him. I need to think about, well, actually there's a cultural issue huge from Pakistan and in Pakistan, this is how its viewed. But hold on. He's in the closet store. His family don't know that he is gay, but maybe his community where he lives with his housemates are fully aware.	Stacy 22.48
Cultural lack of respect of faith as a protected characteristic.	Different. Think about being visible differences as well. Think about the fact that we have faith that in this day and age, how comfortable is it for someone to talk about faith? I would say not very. I would say that faith is under attack and unlike every other protected characteristic faith feels like the one thing that we can still laugh and joke about. And as a Christian I would dare go as far as say	Stacy 23.59

	Christianity remains the one faith that you can insult without much consequence without many ramifications because.	Stacy 25.09
	Not to mention the fact that Christianity in the media, whether it's movies, TV, you know, the one swear that you often hear is the name of Jesus Christ.	
	It should be celebrated going back to the point you said about councillors bringing it up, why shouldn't you?	Stacy 27.53
	If it wasn't for my spirituality and my faith, I think I could have been suicidal. I think I would have done in being honest.	Jacob 23.48
Choosing NHS therapy vs Christian based therapy	But I wanted and I've always sought out, you know, NHS, you know, generic, non Christian counseling because I want to get that unbiased view of what I think and what I feel. I already know that I'm gonna filter everything that happens through a lens of Christianity. You know, I have my feelings, but I didn't have the word. What does the word teach you and encourage me to do to say to behave like so when I speak to a counselor, I don't expect them to give me a Christian take but I expect them to be aware of the fact that.	Stacy 28.34
	I've kind of always gravitated towards working with secular professionals in a way because I feel like the in a way there is that less judgement, because then they're not, you don't know necessarily what worldview they're coming from.	Rita 19.13
	Fortunately, I was able to do that with this private professional. Yeah, as I said, in NHS, it was not some not an avenue that opened up to me.	Jacob 8.54
	And like, I've definitely noticed a difference in how comfortable I feel compared to when it's been with a Christian, who I can tell was, like, openly inviting me to not like she, someone that's openly ready to receive that. And you can just you can just tell that they have a natural understanding and reciprocation of like, yeah, just being able to kind of help you speak about faith and encouraged.	Katherine 3.16

		Katherien 4.46
	But I did find it a lot easier to talk to a Christian about it, because I knew that they wouldn't blame my faith and blame God. They know the truth of my faith and the the joy and the goodness that brings as opposed to what OCD was twisting things to make me fearful about faith related topics and stuff like that.	
		Katherine 5.53
	And whereas I felt like, if I was talking to someone that wasn't a Christian, I was almost trying to protect my faith. At the same time, I felt like I didn't want to show my faith as something it isn't because the OCD was twisting. But it made me because my faith is so important to me.	
Expectations from therapists with different beliefs or views of spirituality.	To share with my counselor my faith and tell them why my faith overrides every other thinking, every other idea in my head because it is that important. I've never had a bad experience. Thank God we've counselling. I've always been met with respect.	
	And that is the most important thing about me. So the benefit of going through Councilling and actually having my faith acknowledged has been, I feel, strengthened to talk more about my faith. I feel strengthened even.	Stacy 29.10
		Stacy 29.45
	I've had a counselor who subscribes to a completely different faith and I respect them back and I think it's often brought a chance for us to bond if I can say that where they can even tell me how they take their faith and that's been something I didn't think possible. So it's been for me a way in to build rapport as a client with a counsellor, but also to build confidence that, you know, I'm able to share everything. Because if I couldn't talk about my faith, I would not be able to talk about the other aspects of my life.	Stacy 32.11
	Yeah, yeah, you don't. I mean, it doesn't take. You don't need to be a Christian for a good counsellor. You just need to be able to listen and actually acknowledge the fact that faith was important.	Stacy 33.19
	You know, during hard time and that's good to hear from someone who is not of my ink, not from my parish. If you don't mind the phrase. But yeah, having a counselor who just respects faith, they respect of of what their faith is or isn't respecting and appreciating faith is a must.	

		Rita 22.40
	actually acknowledging, you know, just because someone goes to church, you're not actively involved, you know, that has good and bad experiences. And that's okay, as well, because that's no church gets it. Right.	
		Katherine 20.05
	So I suppose that it would be amazing to know that therapists have learned about different religions and different Yeah, they might, that their clients might not be comfortable with.	
Integrating spirituality with therapeutic frameworks	she she used to like compassion, focus, therapy work, so finds the work of Paul Gilbert, for example. And I remember, one of the things that she would mention would be like, you know, you've got your religion and your faith, that's a really important aspect of your life, is there a way that you can kind of encompass that to have a kind of compassionate figure, someone to kind of rely and lean on.	Rita 6.24
Therapists lack of awareness or sensitivity to challenges of having faith and links to mental health	in hindsight, I always kind of struggled when she brought that up, because, I was really struggling to kind of accept myself, I was really kind of overwhelmed with my own sin. And I was finding it quite hard to I guess, lean, on God in that way…… At the time, I was feeling really punished by God I was going through quite a few hard things in my life at the time and I remember I was kind of getting when we spoke in therapy I was kind of getting this harmfully weird but especially imagery of of the devil.	Rita 6.24
	I think it'd be so freeing and helpful with if therapists knew that if someone had a certain religion, that there might be some things they're not comfortable with.	Katherine 18.30
Acknowlegdement of faith experienced as helpful and positive	And actually, when I came to the end of my treatment, she, my therapist gave me like a small card with the poem footsteps in the sand and which difference in the sand, which again, I thought was a really thoughtful gesture and actually kind of acknowledged just the role and value that my face had had in my life.	Rita 6.24
	So the using using God in therapy and being able to really recognise where God was in the midst of my mental health issues, it was fundamental to healing for me, I think without Yeah, honestly,	Katherine 26.28

	without without my faith, without God, I don't know where I'd be now. I think that's what's kept me alive. That's what's, you know, helped me heal. And it was.	
Therapists making assumptions about the clients life based on spirituality	I guess one thing I did notice was my second therapist would like make assumptions. For example, I would never drink, for example, because I was a Christian. And I found that quite interesting because I was doing it at the weekend.	Rita 11.44
	like there's stuff there that I think she'd assumed that made me get have a sense that actually, she didn't know that much about the faith and the religion and what my life looks like for young, a young, modern, you know, what that looks like in the modern world? I don't know if that then kind of maybe limited me.	Rita 11.44
	I think she'd like made an assumption that I didn't go out at university (clubbing) or something like that, which is funny because I was going out probably twice a week. And I didn't see that being any problem.	Rita 14.38 Rita 14.38
	I was like, well, clearly She's just doesn't really have an understanding of what this was about. So it's not really worth exploring.	Rita 22.40….
	Maybe, you know, I don't know if you can argue too much adaptations, because, as I say, sometimes she would kind of bring in things and say, okay, you know, can we use your religion in this way to be a positive tool? And which I think it brought challenges for me,….. I think sometimes it's really helpful to acknowledge people's faith but actually also spend time acknowledging where the church can cause pain to people contribute to their difficulties, because I think my therapist always saw it as being a really positive thing and for the most part,	
Perceptions of adaptions made to the therapy	I think I'd say in CBT, no, adaptions were made, in my opinion, really? I can't think of anything really active that I would think of other than there being a bit of scope to talk about it in my assessment that, yeah, I think in the second one, I mean, yeah, a lot. A lot of adaptions were made.	Rita 22.40
	My faith really was kind of the main focus in a way of what we spoke about linked in with the self esteem stuff. So yeah, I think in that respect, actually, a lot of work went in on the therapist to kind of make sure I had that space.	Rita 22.40

	There was no place for for spirituality in that room. It was all cognitive. Okay. All action based, everything, everything made sense by the book.	Jacob 27.01
	I'd say with the example with cams when I was younger, I don't know it's hard for me to think adaptations really, because I'd really feel like there was apart from maybe agreeing with my acknowledgement that my faith isn't the same as OCD. But I would have liked to maybe have gone into more detail about that.	Katherine 22 29
Dilemmas/ challenges of feeling misunderstood in therapy.	I remember feeling frustrated, because I was like, I just wished you had a bit more biblical knowledge and a bit more of an understanding of, you know, some of the pressures I feel under being a Christian and going to church because she felt that she didn't really, she just saw church as being, you know, a fantastic support network for me, and, you know, great.	Rita 28. 10
Lack of safety in disclosing faith/ spirituality	Yeah. And it made you as a black person as well. It made you feel more like they're they are the police and they are the authority and kind of disconnect yourself in terms of what you can say. In terms of having voices like the Holy Spirit, you would not tell them because you think they say you are psycho or put you on a list.	Jacob 13.54
	So I didn't feel safe enough to be Got to be open about my relationship with God no chance.	Jacob 13.54
	I never quite opened up and was completely honest, which meant that I didn't, I didn't really feel safe. And I didn't, I felt stuck.	Katherine 12.51
	I never mentioned that to the psychologist they weren't really into (pause) yeah (pause) i think they stayed clear of my faith really to be honest I think	Alice 10.00

Value of being able to freely discuss spirituality	Because as it's been like, as it's such a core thing, for me, it's really important for me to be able to, it's been really important for me to talk about that in therapy.	Katherine 3.16
	I just think to emphasise that the engagement when I was able to speak about faith was completely different.	Katherine 28.49
Faith being important in supporting and understanding context of mental health	But it was Yeah, so then it was fundamental for me to talk about faith in therapy because well, I always I always describe it as like OCD will take things that you really care about and kind of twists and makes them into something else and makes them into something that causes harm and anxiety to you.	Katherine 4.46
	Well, a lot of mine (mental health diagnosis) was wrapped up with my faith.	Alice 8.57
Worry about pay being misconstrued as problem because of therapists lack of knowledge	I feel more like more confident that my faith would be protected. And people would be able to understand that OCD was doing something different to what my faith stood for.	Katherine 12.51
Lack of alignment between therapy suggestions and faith beliefs	a lot of what was being suggested to help me was mindfulness that was like the feeling is that almost every session, I was being told to practice mindfulness. And I hadn't made up my mind myself, if I felt comfortable doing mindfulness, because there's some Christian beliefs that say that they don't agree with the practices of mindfulness or like, suggest finding Christian alternatives.	Katherine 13.56
	So I would only ever kind of do it half heartedly, so but not really can fully admit that either because at the same time, I didn't want that to give my faith a bad name of why don't you want to do mindfulness?	Katherine 14.28

Importance of understanding individual convictions	So I would only ever kind of do it half-heartedly, so but not really can fully admit that either because at the same time, I didn't want that to give my faith a bad name of why don't you want to do mindfulness? And then they if they were allowed to, that's in a circumstance where I think it would be really important to be able to potentially say, I know that your this is your religion, is this something that sits comfortable with you or not?	Katherine 17.57 Katherine 18.30
Increase in engagement and therapeutic outcomes when able to speak about faith	I just think to emphasise that the engagement when I was able to speak about faith was completely different. not talking about my faith would be like, keeping such a huge percentage of myself to myself. And I feel at least speaking from my own experience, to to really get something out of therapy, you need to be completely transparent, completely honest and share your whole self, which is difficult to do and very vulnerable to do.	Katherine 28.49 Katherine 29.00
Beliefs and faith not explored even though presenting problem had aspects of religion	No I dont think Christianity was brought up at all, or my beliefs, I do not think, I wouldn't say that it was brought up at all. I wasn't really asked, they didn't mention church, although I still went to church or what my faith was, why I had given up believing in it, no that subject wasn't brought up at all.	Alice 7.33 Alice 8.04
Feeling abused by NHS system by overall treatment	I tried to take them to court at one time. I think there's been many erm, cuase they had sectioned me. I was really angry with being sectioned so I tried to find someone to take them to court. So I spent many hours to trying to write exactly what they did to me because they held me down and injected me. And so I was very angry about that.	Alice 13.21
Inability to distinguish, between health spirituality and mental health related delusions.	So I suppose it was brought up a lot more conversation if we had had the talk on my ,Yeah. my thoughts, my spirituality, which gets a bit confusing, because you think you're having a spiritual experience. And that's your illness, isn't it? Well it can be?	Alice 23: 44
Therapists avoiding discussion around faith	So I suppose it was brought up a lot more conversation if we had had the talk on my ,Yeah. my thoughts, my spirituality, which gets a bit confusing, because you think you're having a spiritual experience. And that's your illness, isn't it? Well it can be?	Alice 25.38

Assumptions that most therapists do not have views that align with spirituality	Yeah. But I can't imagine. I imagine not many psychotherapists are Christians. Really? I don't know. It's not a question I've ever asked.	Alice 27.08

Analysis outcomes for Engagement and DSES

Correlations

		EngTotal	DSEStot
Pearson Correlation	EngTotal	1.000	.286
	DSEStot	.286	1.000
Sig. (1-tailed)	EngTotal	.	<.001
	DSEStot	.000	.
N	EngTotal	133	133
	DSEStot	133	133

Variables Entered/Removed[a]

Model	Variables Entered	Variables Removed	Method
1	DSEStot[b]	.	Enter

a. Dependent Variable: EngTotal

b. All requested variables entered.

Model Summary[b]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics					Durbin-Watson
					R Square Change	F Change	df1	df2	Sig. F Change	
1	.286[a]	.082	.075	6.85329	.082	11.703	1	131	<.001	1.919

a. Predictors: (Constant), DSEStot

b. Dependent Variable: EngTotal

ANOVA[a]

Analysis outcomes for Working Alliance and DSES

Correlations

		WAltotal	DSEStot
Pearson Correlation	WAltotal	1.000	.288
	DSEStot	.288	1.000
Sig. (1-tailed)	WAltotal	.	<.001
	DSEStot	.000	.
N	WAltotal	132	132
	DSEStot	132	132

Variables Entered/Removed[a]

Model	Variables Entered	Variables Removed	Method
1	DSEStot[b]	.	Enter

a. Dependent Variable: WAltotal

b. All requested variables entered.

Model Summary[b]

					Change Statistics					
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	R Square Change	F Change	df1	df2	Sig. F Change	Durbin-Watson
1	.288[a]	.083	.076	11.89711	.083	11.800	1	130	<.001	1.930

a. Predictors: (Constant), DSEStot

b. Dependent Variable: WAltotal

ANOVA[a]

APPENDIX D: Dissemination Statement

The researcher intends to share the findings of the study with colleagues at the University of Exeter. Consideration will also be made on submitting findings for publication within the Division of Clinical Psychology in the British Psychological Society. This thesis will also be submitted for peer review and consideration for publication in the Journal of Psychology and Theology.

APPENDIX E: Journal of Psychology and Theology Publication Guidelines

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