HOW DO CLINICAL PSYCHOLOGISTS WORK WITH RELIGIOUS THEMES IN PSYCHOSIS?

Thesis submitted for the degree of Doctorate in Clinical Psychology at the University of Leicester

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Declaration

This thesis constitutes original work by the named author. It has not been submitted for any other qualification, or to any other institution.

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'So, verily, with every difficulty, there is relief'.

The Quran (94:5)

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The literature review (Section A) and the research report (Section B) follow the general style of the British Journal of Clinical Psychology (Appendix A).

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Abstract

This thesis comprises of three sections:

Section A: Literature Review
Title: How Are Religious Themes Worked With In the Therapy Room?

This review consists of a discussion centering on qualitative studies of the practice of therapists/ clinical psychologists in the UK. The review identifies studies suggesting that therapists are less likely to use techniques specifically religious in nature. Studies also highlight therapists' views that addressing religious and spiritual themes was a neglected area in their training.

SECTION B: Research Report
Title: How Do Clinical Psychologists Address Religious Themes When Working With Clients Experiencing Psychosis?

Aims
This study aims to explore how clinical psychologists work with religious themes in the psychosis specialty.
Method
Ten clinical psychologists working in a psychosis related service are interviewed using semi-structured interviews. Interviews are transcribed and analysed using a Grounded Theory qualitative methodology.
Results
A core category called 'unravelling' and three main categories ('defining roles', 'unpicking cases' and 'interacting with religious themes') comprise a process model that is developed from the data analysis. This captures the processes that participants described utilising in working with religious themes in psychosis.
Conclusions
Results highlight the stresses and strains experienced in trying to unravel religious themes for this client group and the factors possibly contributing to this. Implications and suggestions for future research are highlighted.

SECTION C: Critical Appraisal

This section is a review of the author's experience of the research process. The reflexive journal is drawn upon along with memos and notes from supervision to highlight issues relating to the development of the research, challenges in the process and the researchers personal influence on the research as a British Pakistani female who is visibly Muslim.

SECTION A: Literature Review

How are Religious Themes worked with in the Therapy Room?

Abstract

Purpose

This review discusses approaches used in working with religious themes in therapy. Frameworks and models suggesting clinical approaches for this are briefly outlined in advance of a detailed discussion centering on qualitative studies of the practice of therapists and clinical psychologists in the UK.

Methods

International studies are included, although the focus of this review is on studies situated in the UK over the last twenty years.

Results

Three areas of literature are discussed. Firstly, studies relating to proposed frameworks and models in guiding therapists when working with religious themes in therapy. Secondly, studies relating to the experiences and views of therapists with regards to the topic, and finally, studies relating to the actual reported practice of therapists.

Conclusions

The studies reviewed suggest that therapists are less likely to use techniques that are specifically religious in nature when working with religious themes in therapy. Therapists reported their personal experiences as an important factor influencing their approach to the area. Religious therapists were most likely to be involved in trying to integrate religion or spirituality and therapy together. The studies also highlight therapists' views that religious and spiritual themes are neglected in training.

1. Introduction

The topic of religion and therapeutic practice has gained attention in the UK relatively recently compared to the USA literature, where it has been considered and debated for longer. Whereas individual therapists and psychologists have started to disseminate writings on guidelines for work in this area, fewer studies have looked at how religious themes are worked with in the actual therapeutic encounter. Literature indicates that the majority of therapists may actually find it uncomfortable to work with explicit religious themes within secular health care settings (Worthington, Kurusu, McCullough, & Sandage, 1996). For this reason it is imperative to understand the issues therapists face and how best to meet their needs in order to raise competence in this area.

This literature review includes international studies, but the focus where possible, will be on UK-based studies to enhance applicability. The review begins by introducing the context in which this topic area's relevance is apparent. This includes the importance of meeting diverse needs and attending to service user preferences, as well as addressing training needs that have been highlighted in this area. Secondly, the review will briefly discuss possible ways in which religion could be worked with in therapy according to frameworks and models proposed in the literature. The focus of the review will then centre on UK qualitative studies looking at therapists' views and experiences in relation to religious themes and therapy. Finally, the way in which therapists work with religious themes in the therapeutic encounter, as reported in these UK-based studies, is considered. Methodological issues and ideas for future research are also discussed.

2. Methods

Defining Terms

The review will attempt to focus on research relating to one specific professional group - clinical psychologists. However, it will also include studies of counselling psychologists and therapists from other training backgrounds as studies sometimes use mixed participant groups. The difference in training and background will be referred to. The word 'therapist' will be used as a general term when referring to those from alternative training backgrounds to differentiate clinical psychologist studies from others.

Religion will be used in the context of Pargament's (1997, p32) broad definition which refers to it as 'a search for significance in ways related to the sacred'. This definition identifies a sacred or holy source and a sense of searching influenced by this. This definition is broad enough to include organised religion as well as individual spirituality related to a sacred source.

Search strategy

The search terms used included; religion, spirituality, faith, psychology, therapy, counselling and mental health. These key words were used to search the 'PsychINFO', 'EMBASE', and 'MEDLINE' databases. Searches were also conducted manually on the internet and authors of recent unpublished studies were also contacted. As mentioned previously, a large proportion of studies are USA based. However the focus of the review will be on UK studies where possible, due to differences in culture, training and health services across contexts.

3. Results

3.1. Why consider how religious themes are worked with in therapy?

This section discusses the context of this review and the reasons why this topic area is important to consider. Some of the important reasons include government initiatives for cultural competence that recognise client individual needs such as spirituality[1], and the potential significance religious themes can have on the quality of the therapeutic alliance[2] with clients. Other factors include client preferences, the possibility of working with clients who hold alternative explanatory models of illness that may involve spiritual attributions, and studies which indicate this is an area with a training need. Some of these factors are explored below.

Client preferences

Studies suggest that clients would like their religious concerns acknowledged by services (Gorsuch & Miller, 1999; Miller & Thoresen, 1999; Rose, Westefield & Ansley, 2001); however they fear being judged by them. UK qualitative studies have found highly committed Christians perceiving their faith and spirituality integral to their coping strategies and emotional lives (Mitchell & Baker, 2000; Cutland, 2000). They showed interest with the approach that their helpers took towards religion (Cutland, 2000), and were particularly concerned about receiving help from secular

[1] Examples include the 'Inside/ Outside' report (DoH, 2003), the Delivering Race Equality Scheme (DoH, 2005), Celebrating Our Cultures (DoH, 2004) and a consultation project by NIMHE (NIMHE, 2003). These reports advocate cultural sensitivity and awareness of spiritual and religious issues when working with clients, especially those from ethnic groups who may be more likely to hold spiritual value systems.

[2] The neglect of important issues, such as individual religious or spiritual themes, in working with mental health difficulties could influence the therapeutic alliance in a negative way (Lambert, 2004).

professionals, due to fear that their beliefs maybe criticised and their spirituality may be neglected. Additionally, they stated that they would refuse treatment from psychologists who did not themselves have a religious commitment (Mitchell & Baker, 2000). Further, religious beliefs have been found to play an important role in coping with the stress of caring for relatives who are mentally unwell (Rammohan, Rao & Subbakrishna, 2002). These studies imply that working with religious themes in therapy could meet the preferences of some clients, as well as assist in engagement and help to consolidate religious coping strategies in use.

Explanatory models of illness and ethnic diversity

Some research into the explanatory models of mental health that patients hold suggests that certain ethnic populations view mental health differently to the dominant Western/ Secular discourse. Understanding the client's explanatory model can be fundamentally important for successful treatment. Dissonance between the explanatory frameworks of clinicians and clients can have an impact on clients' help seeking behaviour, treatment satisfaction and culturally sensitive clinical practice (Bhugra, 1996; Callan & Littlewood, 1998; MacCarthy, 1998).

McCabe and Priebe (2004) conducted a study which highlighted the issue of diversity. Their study was concerned with the relationship between explanatory model of illness held by patients with a diagnosis of schizophrenia, and psychological characteristics. A comparison of four groups took place involving second generation African Caribbean, Bangladeshi, West African and UK White origin patients with

schizophrenia. It was found that the white groups would cite biological causes of schizophrenia more frequently whereas non-white groups would ascribe the cause more frequently to supernatural causes. Furthermore, interviews with Bangladeshi patients revealed that patients who ascribed their symptoms to supernatural causes had preferences for religious treatment or activities, or no treatment at all. White patients who ascribed their symptoms to biological and social causes preferred medication and counselling treatment options. Wahass and Kent (1997) compared a UK sample with a sample in Saudi Arabia. They found that beliefs about the illness were related to treatment choice. The Saudi sample ascribed their auditory hallucinations to black magic and believed religious assistance would be most helpful.

There is a danger that mental health professionals and therapists could misinterpret beliefs of minority groups as pathological if the relevance of context and differing explanatory models is not adequately considered (Crossley, 1995; Fernando, 2002; Laungani, 2004; Lukoff, Lu & Turner, 1995). This is especially relevant for psychosis where beliefs or spiritual and mystical experiences of some religious and spiritual groups could be confused with psychotic pathology (Clarke, 2001; Greenberg & Witztum, 1991). Indeed Allman, Roche, Elkins, and Weathers (1992) found this in their survey of 285 American therapists. Factors such as theoretical orientation, personal views on spirituality, personal experience of different traditions or exposure to relevant literature influenced their attitudes to clients reporting mystical information. A lack of awareness of alternative explanatory frameworks seemed to contribute to inappropriate diagnostic judgements.

Training Needs: Working with Religion in Therapy

Many studies point to a training need in the area of how religious themes are worked with in therapy. For example, two studies were conducted to investigate whether client religious or spiritual functioning was adequately addressed in clinical practice (Hathaway, Scott & Garver, 2004). The studies involved sampling clinics and a national survey of 1000 clinical psychologists from the American Psychological Association. Both studies found that clinical psychologists do think that the clients' spiritual or religious functioning is an important area of well-being, although most of the psychologists did not address this area in treatment or in their goals of therapy. This suggests that this area is not being addressed adequately as a diversity domain (Hawkins & Bullock, 1995; Yarhouse, 2003). Although these findings cannot be generalised to the UK, they do raise questions about the potential discrepancy between recognising these issues as important and actually working with them.

It could be argued, however, that there are still many issues that remain to be addressed in diversity training (Bhugra, 1996), and that there is research pointing to opposite findings of clinicians endeavouring to show sensitivity in this sphere of work (Quackenbos, Privette & Klenz, 1986).

Nevertheless, Yarhouse and Fisher (2002) raised concerns that psychologists may not receive as much training on working with religious and spiritual themes in therapy compared to other diversity issues such as race, ethnicity and gender. Others have also expressed concern that clients may be reluctant to see a mental health professional out

of worry that their beliefs and values may be pathologised (Bergin, 1991; Post, 1993; Smiley, 2001). However Smiley's (2001) survey of UK clinical psychologists suggests that approximately 1 in 5 psychologists identify themselves as 'strongly religious' and that 76% of the sample perceived clients' religious issues arising 'sometimes' or 'often' in therapy. Yet, even these religious psychologists seemed cautious to use religious techniques. It is important to note, however, that Smiley's figure that 1 in 5 psychologists surveyed were highly religious could be an artefact of a selective sample with religious psychologists opting into his study more than non-religious psychologists. The above discussion suggests, nevertheless, that psychologists do not purposely ignore religious themes, but do not address them explicitly and most likely do not have adequate training in this area.

3.2. Frameworks and models for working with religious themes.

This section will briefly consider the literature relating to techniques and frameworks proposed as possible ways of understanding how to work with religious themes in therapy. Firstly the idea of implicit, explicit and specifically religious integration techniques will be discussed followed by a brief overview of psychological models that incorporate religious themes.

Implicit and explicit integration techniques

A general framework for understanding how religious and spiritual themes and resources can be integrated into therapy is the idea of implicit and explicit levels at which one can interact in the therapeutic encounter (Tan, 1996). In general, implicit approaches to integration emphasise the spiritual nature of therapy and the spiritual

environment that can be formed where the spiritual realm can be experienced. This is often marked by a unique form of relationship between the client and therapist capturing qualities such as love, compassion, healing, empathy, being open and non-judgemental, and authenticity (Spooner, 2001; Miller & Thoresen, 1999). These qualities however are somewhat abstract and difficult to define. Some of them also seem at odds with the mainstream culture and training of clinical psychology, e.g. the idea of loving clients. Other qualities like being open and non-judgemental seem similar to mainstream ideas used in engagement. This raises the question of at which point do implicit approaches differ from some of the more general mainstream therapeutic tools already being used.

Explicit approaches to integration are more directly concerned with religious and spiritual issues of concern for the client. They can involve a spectrum of techniques varying in how much they involve specifically religious or spiritual material, for example; direct assessment of client religious and spiritual beliefs and concerns (West, 2000, Hodge, 2000; Nino, 1997), integrating spiritual goals into therapy and matching of therapists and clients according to values (Worthington, 1986). In the USA, self disclosure for the purpose of matching clients to therapists is promoted by some authors as an ethically desirable option for clients (Hall & Hall, 1997; Richards & Bergin, 1997) which is consistent with the findings that client values often change in the direction of therapist values (Beutler & Bergin, 1991; Kelly & Strupp, 1992; Worthington, 1991). However the majority of UK clinical psychologists surveyed by Smiley (2001) felt that it was rarely appropriate to disclose their faith. Some therapists

employ religious and spiritual practices from traditional sources as a resource in therapy. Examples include prayer, meditation and the use of scripture and texts (Kurtz, 1999; Miller & Thoresen, 1999; Spooner, 2001; Tan, 1996; West, 2000). However these practices are advised to be used with a level of competency and sensitivity as there is potential for misinterpretation of unfamiliar practices (Tan, 1996).

In general, it seems that techniques at the more explicitly religious end of the spectrum are less likely to be utilised by psychologists in secular settings, whether they personally adhere to a faith or not (Shafranske & Gorsuch, 1984; Shafranske & Malony, 1990). Religious settings however have been found to have a higher frequency of implicit and explicit integration techniques practised by religious psychologists in comparison to secular settings (Worthington et al.1996). UK psychologists, according to Smiley's (2001) survey, do not tend to enquire about religion routinely and a small number also believe that religious issues should not be included even when raised by a client. This survey indicated a greater level of hesitancy in comparison to similar surveys of US psychologists (e.g. Bergin & Jenson, 1990; Shafranske & Malony, 1990).

Integration of religious techniques with psychological models

Religious techniques, such as prayer, have been found to have beneficial therapeutic effects on clients (McCullough, 1995). Studies have also looked at non-Christian faiths to find similar effects, for example for Muslim prayer and scriptures (El-azayem & Hedayat-Diba, 1994). Furthermore, alongside these specifically religious techniques,

there has also been the development of models and frameworks that attempt to integrate religious resources (e.g. Helmeke & Bischof, 2002; James & Wells, 2003). A review of studies on religion-accommodative counselling for depression suggests that these interventions may be as effective as standard interventions, and that highly religious clients would benefit from being given the choice between them, although more research is needed (McCullough, 1999). Another example is of Christian CBT for use with religious clients (Hawkins, Tan & Turk, 1999). It has also been suggested that these approaches do not necessarily have to be delivered by a religious therapist (Propst, Ostrom, Watkins, Dean, & Mashburn, 1992). A step further from specific techniques is models which are intrinsically based on a faith perspective. The classic Alcoholics Anonymous model used in addiction services is an example of this. This model is based on surrendering to a higher power, which the individual can attribute to as God. In addition, this model involves practices such as meditation, forgiveness and prayer (Tonigan, Toscova, & Connors, 1999). Eastern models are also available such as the Nafsiyat model of Islamic psycho-spirituality, also known as Sufi psychology or Nafsiyat (Frager, 1999; Haeri, 1989). This incorporates the idea of maintaining balance at different levels of the soul which is affected by the interplay of diet, emotions and exercise (Chishti, 1991). Based on Islamic medicine (Tibb), this approach has started to capture the attention of Muslim therapists (e.g. Badri, 2000; Skinner, 1989).

This section highlights that techniques, frameworks and models for integration are available and are being developed. There is also developing evidence of their efficacy and value in use with clients who have religious beliefs. However it seems that they are

used by a minority and are absent from mainstream training and professional discourse.

3.3. What do UK psychologists think about working with religious themes and what do they do in practice?

Specific frameworks and models that have focused on how to work with religious themes in therapy have been briefly discussed previously. However, in order to obtain greater clarity on what UK therapists do in practice, it is necessary to focus on studies that have attempted to elaborate on understandings of this area. Although the American literature is more abundant and has largely been discussed and reviewed elsewhere (Jones, 1994; Smiley, 2001; Worthington et al. 1996), generalisations from this literature to the UK must be done with caution due to the differences in health services and culture. This has led to the development of some, predominantly qualitative, studies in the UK. This has been advantageous in promoting an understanding of some of the finer details of this very complex topic. These UK qualitative studies have focused on two areas, namely that of therapists' experiences and reflections on issues relating to religion or spirituality and practice, and secondly how therapists understand and/ or practise integration between religion and spirituality in therapeutic practice. Both of these areas will be considered in turn. A summary table of the main studies to be discussed is found below.

Table 1: Summary table of UK qualitative studies

Study	*Country*	*Participants*	*Professional training*	*Method*	*Main themes*
Myers & Baker (1998)	*UK*	*5 Judeo-Christian*	*Clinical psychology*	*Grounded theory*	*Feeling silenced/ neglected topic area*
Martinez & Baker (2000)	*UK*	*8 Christian*	*Psychodynamic*	*Grounded theory*	*Feeling silenced/ neglected topic area*
Smiley (2000)	*UK*	*6 Non-religious*	*5 clinical psychology/ 1 counselling psychology*	*IPA*	*Spiritual/religious issues are unfamiliar, uncomfortable or overlooked*
Golsworthy & Coyle (2001)	*UK*	*12 Majority with spiritual beliefs*	*Bereavement therapists*	*IPA*	*Importance of the spiritual dimension*
Baker & Wang (2004)	*UK*	*23 Christian*	*Clinical psychology*	*Grounded theory*	*Experience of shifting between a professional mode and a Christian mode*
Crossley & Salter (2005)	*UK*	*8 Various faith backgrounds (Judeo-Christian, Agnostic, Atheist)*	*Clinical psychology*	*Grounded theory*	*Spirituality – a vague concept and difficult to define*
Suarez (2005)	*UK*	*10 clients 10 therapists (deeply interested in spirituality)*	*Various*	*Grounded theory*	*Differing levels of integration between spirituality and therapy*

Therapist Views on working with religious/ spiritual themes

Qualitative studies outlined in the table above have been conducted with clinical psychologists and therapists of religious, non-religious or a mixture of faith views. These studies have focused on clinical psychologists' and therapists' experiences and views of spiritual and religious issues in therapy. These will be discussed below. The following section will then lead into a discussion specifically on how therapists report

working with these themes in practice.

A few studies have found that religious clinical psychologists in NHS settings have experiences of feeling 'silenced' about this topic area. These studies also highlight that religious clinical psychologists and therapists view this topic area as neglected by colleagues. A Grounded Theory approach was used by Myers and Baker (1998) who interviewed five religiously committed UK clinical psychologists, all from a Judeo-Christian tradition. Their study highlighted the theme of serious inattention to the religious dimension. Participants described their dissatisfaction with the 'neglect of clients' religious concerns' by mainstream services. They also perceived a prejudiced discourse from psychologists in general about religion. Thus, they expected their own views on religion to be dismissed by colleagues which had an impact on their practice by silencing them on this area. This led to them privately dealing with value clashes or tensions in their clinical work, such as with abortion counselling. Participants also felt that theories and models of clinical psychology were deficient in that they were perceived to exclusively project a materialistic worldview.

These findings led the authors to postulate that there may be a clash of values at a certain level of the profession when thinking about religion and therapy. Indeed, for these participants the perceived neglect had a personal impact on use of supervision and personal safety in being able to openly be reflexive about these issues. A difficulty with this study however, is that it only represents views of five female psychologists. Therefore, categories from the data may not have undergone sufficient theoretical

sampling to broaden perspectives.

A similar study was carried out with eight Christian psychodynamic therapists (Martinez & Baker, 2000). Participants in this study also held the opinion that religious themes were not given space and would also anticipate prejudice and disrespect from colleagues. This impacted on how they used supervision and some participants even started to omit client religious issues. Most participants also reported that they experienced their trainers as disapproving of religious issues. Paradoxically, participants' assumptions that their trainers were anti-religious were incorrect. This highlighted that, at times, not knowing their trainers' position led to the assumption that they would be unhelpful and anti-religious.

In light of this, it may be useful to consider that processes leading to neglect may involve several factors, including practical institutional considerations. An example of this could be the constraint of following guidelines which do not explicitly give reference to work with religious themes. Consideration of a range of possible factors leading to neglect may be important in order to avoid the risk of reducing the complexity involved in this topic area. However, a comprehensive exploration of this was not readily apparent in Martinez and Baker's (2000) account of the study.

Studies have also highlighted that clinical psychologists and therapists experience many dilemmas in this area of work. Examples of this include decisions about self disclosure of faith beliefs to clients and colleagues and how to manage value

differences in the work setting.

A larger Grounded Theory study was conducted with 23 Christian clinical psychologists by Baker and Wang (2004). They found that their sample of Christian psychologists experienced a dilemma on speaking out about their personal faith, which centred on the tension between the profession's stance on non-disclosure and Christian values of disclosing their position on faith. Overall most were very concerned not to influence clients, despite the tension that this created with personal religious beliefs. Most would respond if requested to disclose by the client, although some exercised greater caution on self-disclosure.

This study also highlighted that the experience of these Christian clinical psychologists involved two selves or modes. They described shifting between a professional identity and a Christian identity. At times professional practice seemed to compete with the Christian identity for some of the Christian psychologists, for example when work involved an overt clash of values. They tried to control for this through organising themselves in such a way that head-on confrontation could be deterred or avoided.

Although these are insightful findings, there is a methodological difficulty with this study in that the participants were all selected from a specific organisational group called the Network for Christians in Psychology. Therefore the findings may be context specific. Another consideration of the studies discussed above is that they all involve

the same author (e.g. Baker). Thus it would be important to be aware of the potential that these studies may largely reflect a specific position on the subject which could be influenced by this author. Accordingly it is important to consider that there may be many other perspectives which would add to this discussion.

Another dilemma experienced by therapists related to the tension of trying not to reduce clients' religious and spiritual explanations and experiences. Suarez (2005) conducted a Grounded Theory study of ten therapists and ten clients who were working in therapy that involved integration. She found that the therapists were concerned to not reduce spirituality and were aware of the differences which came about in framework conflict, e.g. ideas of hell and heaven, ideas about evil and how the meaning of death at times could conflict with ideas about the importance of earthly life. Clients sometimes raised questions or brought issues that forced therapists to face these issues. The resolution of conflicts occurred through a variety of approaches discussed in the next section. These therapists also experienced a dilemma around self-disclosure. They were worried about their own spirituality becoming exposed in explicit spiritual discussions and were also concerned of the pitfall of going too far and becoming 'evangelical'. Working with spiritual themes seemed to conflict with the secular setting of their practice and some moved to private practice in order to gain more control on being explicit about the importance of spirituality for clients.

Spirituality was also perceived as 'vague' and 'awkward' by some clinical psychologists. There was also the perception that, although religion and spirituality

could be positive for clients, it could also have quite negative effects. The role of personal values and attitudes was also acknowledged as having an influence on whether clinical psychologists were inclined towards trying to integrate religious and spiritual themes into practice. These findings are discussed below.

Crossley and Salter (2005) conducted a Grounded Theory study of eight clinical psychologists who held varying personal positions on faith and spirituality. They found that spirituality was perceived as an elusive concept by participants. Similar to the studies discussed previously, these clinical psychologists also viewed it as a subject that clinical psychology was perceived to be disengaged from. Participants postulated reasons for this which included unease with the subject which related to topics of life and death. Religion in particular was seen as a difficult or 'awkward subject to discuss'. Personal views were discussed as potential influences on whether or not spirituality was discussed in therapy. Some psychologists reflected that maybe they did not inquire about spirituality as it was not relevant or important to them personally, or because they viewed religion as a problematic area. Participants also felt that there was a limited language for the topic

An Interpretative Phenomenological Analysis (IPA) study of six non religious therapists, five of whom were clinical psychologists, was conducted by Smiley (2000). He found that participants perceived religion as having positive and negative effects. The positives were largely related to social support whereas the negatives related to the potential for psychotic clients' delusions to become confused with religious beliefs and

ideas. Another perceived negative aspect of religion was the idea that religion could be used by clients to avoid responsibility. Participants realised the centrality of religion in the lives of some clients. However they also pointed to the lack of inclusion of religion in their therapeutic work due to unfamiliarity, feeling uncomfortable or simply overlooking it. However these findings were limited to only six participants and, therefore, are to be considered with caution.

The studies discussed above highlight the experiences and views of clinical psychologists and therapists of the area of religion, or spirituality, and therapy. The studies suggest a variety of experiences; for example, some participants felt silenced, experienced dilemmas and value tensions, and some perceived it as a vague and awkward area to work with. The idea that personal views could influence feelings participants had about integrating religion and spirituality into practice was also highlighted. The studies also suggest that the more religious or spiritual the therapist is, the more likely they are to be open to, or be involved in some form of spiritual integration. Further the studies suggest that religious therapists perceive themselves in a position to understand clients' religious themes and are suspicious that their colleagues are neglecting this area. However, suspicions of colleagues were not always accurate as some colleagues did hold a faith but did not make it explicit. Therapists were also concerned with the issue of self disclosure which was an active dilemma for some and religious therapists and psychologists felt split between their religious and professional selves. It was also suggested that the neglect of this area may stem from spirituality being a vague concept and religious issues sometimes being perceived as irrelevant or

problematic.

Although these are tentative speculations from a small pool of studies, they provide insight into the experiences and perceptions of clinical psychologists and therapists, and how personal faith may interact with this. It may also be important, however, to reflect on the usefulness of comparisons based on therapist faith positions. It could be argued that crude comparisons between religious and non-religious therapists for example, may actually lead to feelings of resistance and defensiveness in a profession which is already struggling to incorporate ideas pertaining to religion or spirituality in training.

Therapists' reported Practice on working with religious themes

This section is concerned with how therapists and clinical psychologists work with religious themes in the climate of neglect that has been described in many of the qualitative studies discussed above. This section takes a closer look at studies, including those from the previous section, to elucidate what occurs in practice.

Studies indicate that clinical psychologists and therapists use varying approaches, such as in assessment, when working with client religious and spiritual beliefs. For example, Crossley and Salter (2005) found that some assessed spiritual beliefs directly without prior prompts, whereas others considered the area if mentioned by clients first – assuming that significant areas of a client's life would naturally come out through the assessment process. Further, these clinical psychologists of various faith positions tried to find harmony with client spiritual beliefs. This involved trying to understand and

respect beliefs. Understanding beliefs was seen within the wider context of the psychologist's role of being aware of significant areas of a client's life. With regards to respecting beliefs, participants discussed suspending their own judgments in order to be empathic.

An IPA study of 12 bereavement therapists by Golsworthy and Coyle (2001) found that therapists purposely tried to enter the frame of reference of clients through bringing religious or spiritual issues directly into assessment, or tried to be alert to clients' subtle cues and described explicitly responding to spiritual and religious cues as they arose. Non religious clinical psychologists and therapists included religion in formulation if they knew about the client's faith (Smiley, 2000), for example faith could feature as a maintaining or compounding factor, and God could feature as a significant other. Martinez and Baker's (2000) study of Christian psychodynamic therapists illustrated that therapists were involved in building acceptance and validation of clients' beliefs but could also be involved in challenging these as well. This was through making interpretative links with clients which involved their faith. They also used the religious language of the client to enhance engagement, thus creating a shared language and conveying acceptance and validation.

A large scale Grounded Theory study (Suarez, 2005) which explicitly looked at the process of integration, from the perspective of ten therapists and ten clients on the receiving end of therapy, found that integration occurred at many levels. All therapists were deeply interested in spirituality and explicitly attempted integration in their

practice. The therapists identified a discursive level of integration which was in relation to explicit discussions with clients on spiritual or religious issues in therapy. As with studies mentioned above, therapists would pick up cues and hints from clients and give permission to clients to talk on the topic. Some therapists also went a step further and assessed and explored the issues directly with them. Examples of issues raised by clients included; struggling with their religious faith, disillusionment, issues of forgiveness and issues of the meaning of life. Dying or bereaved clients presented with feeling disconnected from God and psychotic clients raised beliefs and experiences of possession of evil forces and a fear of going to hell.

Suarez (2005) found that clients receiving spiritually integrated therapy expressed comfort at raising religious or spiritual issues, but they also described that it could take a long time before they would raise issues and sometimes would never get there. Clients described feeling more comfortable if they knew that the therapist shared the same model or view, and were more cautious when this was unknown. Clients were fearful to raise themes at times due to worry of being undermined or of having their views dissected and analysed. Some did not want to know their therapist's views in case they were different and then they would feel prejudice towards the therapist. Some worried it could cause conflict and have a negative effect on the therapeutic relationship. However, some clients did not want spiritual issues to be raised by their therapist as it could feel meaningless or frightening, and lead them to withdraw. Other clients tested boundaries and looked out for signs that the therapist would be open to integrate spiritual themes in therapy; for example they looked at factors like the

therapeutic model used, the therapy environment, and whether therapists had written on the subject. They would monitor therapists' reactions when raising the topic and look for signs of resistance or discomfort. Clients who had experience of more than one type of therapy felt less able to bring spiritual issues to therapy with certain approaches when they had prior knowledge of the therapist's approach; for example they perceived Cognitive Behavioural Therapy (CBT) as too practical and psychoanalytic as too antagonistic. However they did not mind integrative, existential and transpersonal approaches.

Clients also felt that integration at the discursive level was limited at times. This was because talking sometimes felt removed from the experiential side of their spirituality. Direct experience of spirituality was said to help the flow of words in therapy and for change to occur. Integration at an experiential level therefore was important for some clients and therapists. This involved therapists feeling connected to a spiritual realm in therapy, and being strengthened by this to be with distressed clients. The spiritual realm 'directed' therapists at times, for example through the interpretation of images. Some therapists were also involved in seeking the spiritual realm for clients by prayer, meditation or the use of visualizations. However few therapists helped clients to explicitly connect to the spiritual realm in therapy, but when this did occur most stated that their therapists used different techniques to help the client connect to the spiritual realm. The techniques involved attention to dreams, art work and awareness of body, guided visualizations and meditation. Therapists were said to use these techniques at different times in therapy such as when a client was feeling

confused, blocked, overwhelmed, upset or tense. These techniques helped clients to move into a spiritual place and feel a greater sense of clarity or connection to the higher realm. Some clients did not always find this helpful and felt 'resistant' when techniques were offered but most clients described these techniques having a positive impact. Clients also valued the use of religious or spiritual stories, for example the use of comparisons to Christ regarding issues of responsibility, struggles and difficulties, and loneliness. They found it useful that their spirituality had been acknowledged without it being dissected.

Suarez (2005) concludes that therapists involved in integrating spirituality and therapy used different approaches but favoured approaches towards the implicit end of the spectrum. Explicit approaches were also used however usually when the client raised the subject. The findings also indicate that matching between therapist and client beliefs, or disclosure beforehand, may help in allaying client's anxiety about bringing up religious issues. This has also been suggested by others (Golsworthy & Coyle, 2001; Smiley, 2000). There were mixed views from clients about whether therapists should make some effort in initiating the topic, as some felt it would definitely help them to be open and come to the subject quicker in therapy, yet others felt more ambivalent and felt that it may not be what they want and that it could be meaningless or alarming. The different array of opinions suggests that it is a matter that needs to be tailored individually with clients and that a balanced approach may be more appropriate, rather than therapists adopting the opposite and extreme position to what appears to be the current state of neglect regarding religious or spiritual themes in

therapy.

Spiritual dimensions of therapeutic work have also been explored by Golsworthy and Coyle (2001). Their study of bereavement therapists, the majority of whom held Christian or other spiritual beliefs, suggests that religious and spiritual issues were expressed in two main ways. The first related to the therapeutic relationship encompassing a spiritual nature, and the second related to being engaged in actual work with a client's individual concerns - which could involve entering the frame of reference of the client as mentioned earlier.

These therapists perceived the therapeutic relationship as embodying a spiritual dimension described as the 'meeting of souls' or the elements involved in 'healing'. Participants described this as difficult to articulate in language. This was differentiated from the emotional connection that could be experienced in therapy. Instead, the spiritual connection was described as a form of unconscious communication in which the therapist's readiness and ability to address spiritual and religious issues of concern were communicated covertly through the participants being present to clients' concerns.

Spiritual dimensions were particularly described as a topic at the centre of therapy when client beliefs were challenged by the bereavement. Participants described client processes of change and awareness through the conceptualisation of a spiritual journey, where they encouraged clients to 'look inwards' in a process of creating purpose and meaning. Exploration of distress, and the beliefs causing distress was also facilitated by

participants; for example, when clients felt confused over issues such as why God would allow bad things to happen to good people. However, Golsworthy and Coyle (2001) note that exploration and challenge of beliefs could be threatening when clients have relied on certain beliefs for a large part of their life. The authors, therefore, suggest that therapists should support clients' original spiritual frameworks, as creating a new one may be hard at a vulnerable time such as bereavement. Indeed 'bereavement work involving religious and spiritual dimensions needs to be able to create a safe environment in which frameworks of meaning and conflict may be explored without creating rupture in the therapeutic relationship or devaluing clients beliefs' (Golsworthy & Coyle, 2001. p 200). This study raises the important issue of using a client's original frame of reference during vulnerable times, such as bereavement, as authors advocate a cautious approach to exploring issues outside of this as it could be threatening. This study was limited to only two male perspectives and few perspectives from therapists who did not have personal religious or spiritual beliefs were included.

Although studies suggest that clinical psychologists and therapists have some strategies for approaching work with religious themes, either directly or indirectly, many of the studies also highlight that challenges are encountered in this sphere of work. Some of these include the difficulty in negotiating personal or theoretical value differences when working with client issues, whereas others experience the challenge in relation to grasping the boundary between spirituality and therapy.

Crossley and Salter's (2005) study of clinical psychologists found that respecting beliefs was problematic when beliefs were perceived to be linked to distress. This would often lead to a dilemma concerning how to respect these beliefs. For example one participant described ceasing discussion on the belief in order to maintain respect, this was in comparison to others who tried to find a meaning that would decrease distress but also be congruent with the client's beliefs. The latter involved encouraging the client to consider alternatives that did not conflict with their beliefs. Talking through the issues with a relevant religious figure was also suggested, although infrequently, when a client sought help concerning the validity of their spiritual beliefs.

Crossley and Salter (2005) conclude that spirituality is conceptually hard to understand and clinically has an array of different potential approaches that could be utilised to work with it. This study also highlighted that participants' engagement with this topic area was hindered by the discomfort felt by some and by personal negative experiences of religion and spirituality. This suggests that the personal view of participants may have a strong influence on whether or not spiritual issues are worked with. The authors advocate increased reflexivity and training to enable clinical psychologists to integrate spirituality into practice, and to allow the subject to be accessible in the field of clinical psychology.

Processes that could occur with non religious clinical psychologists working with clients with religious themes of concern were highlighted by Smiley's (2000) IPA study. It was suggested that a difference in therapist-client belief could have a negative

effect on the therapeutic relationship or process in two ways. The first way it could impact was through the psychologist's ignorance about the client's beliefs. This was seen to potentially hinder the therapeutic relationship due to the inappropriate or insensitive questioning that could occur. Alternatively it could create a barrier with clients who assume that they will not be understood. Several participants felt that there would inevitably be something about the client's world that the therapist may be ignorant about, and that this was not unique to religious issues. Similar problems could also be present for other issues, such as culture, and they felt there would always be something that could limit the therapeutic process. In fact, some participants thought that having no religion could be useful in helping them to be open minded about the religion of others and that this allowed them to be 'neutral' regarding religion. However Smiley (2000) notes that this assumption contradicted the atheist views that these participants held, especially the perception that a client's religious beliefs are an incorrect view of reality.

The second way in which difference in therapist-client belief could impact was through disagreement with the client's beliefs. Most participants were able to locate times that they had disagreed with a client's religious position. Disagreement was believed to have a higher negative impact than ignorance about beliefs and it was felt that it could lead to less effective therapy. The approach to disagreement was to either ignore it, agree to disagree, or to challenge the client's beliefs.

The Grounded Theory study conducted by Suarez (2005) highlighted different issues that were experienced as a challenge for therapists, namely related to a fear of inappropriately violating the border between spirituality and therapy e.g. by going too far into the spiritual territory. This was not a simple process as the parameters of deciding the border could shift depending on the context, client group or therapeutic model used. Therapists also experienced theoretical based conflicts with clients experiencing psychosis and would try to respond in a psychological way but also worried that they were reducing or missing something and were compromising the therapeutic relationship. They wondered if clients thought that they were being taken seriously. Other participants responded to this by asking more about the spirits to learn about them for a sense of control in their mind over what they were for the clients. Clients sometimes questioned or brought issues forward that forced therapists to consider issues that introduced framework conflict, e.g. ideas of hell, heaven, evil and death conflicting with the importance of earthly life. The resolution of conflicts occurred through a variety of approaches; for example some switched between psychological and spiritual discourses, some simply dropped out the incompatible parts of one of the discourses, others were trying to reconcile good and evil through considering the complexity of both concepts. This study suggests that explicit approaches in working with religious themes may bring up many dilemmas for therapists, such as the confusion about where the border between therapy and spirituality should appropriately be placed.

The challenges described by bereavement therapists (Golsworthy & Coyle, 2001) in addressing clients' concerns were in relation to conflicting values between the client and therapist. Therapists described challenges to meaning-making with clients, especially in relation to clients questioning beliefs or feeling angry at God, and described meaning making as an ongoing process in which the clients' framework of understanding may be expanded rather than negated. Golsworthy and Coyle advocate that there is a need for therapists to know their limitations in responding to cues from clients, and suggest that at times it may be appropriate to refer the client to a different therapist.

To conclude, it seems that religious and spiritual themes are worked with in varying ways. Clinical psychologists and therapists vary in the initial approach to assessment with the majority opting to follow cues from the clients as to whether to follow up the topic area. Some however, incorporate religious themes in assessment directly. Religious themes are also used in formulation and studies suggest that clinical psychologists and therapists are involved in a process of trying to respect client beliefs. Religious themes seem to be addressed at an explicit and implicit level. When religious issues are addressed explicitly, it can take the form of exploring religious beliefs and values, understanding the client's frame of reference, the use of Christian stories to instil hope and the provision of religious guidance to clients. An implicit spiritual level of integration was also described in studies, although this is more difficult to encapsulate, referring to a non-verbal level of communication with the client and with the spiritual realm.

Studies also highlighted challenges that were faced by clinical psychologists and therapists. Despite having personal spiritual beliefs, some therapists with religious and spiritual beliefs still encountered value clashes. This suggests that variability in beliefs held by therapists and clients can lead to tensions that are not just experienced by non-religious therapists.

4. Conclusions

There are many reasons to support the idea that religion and spirituality are an important part of diversity and should be considered in the therapeutic encounter with clients including client preferences for this, an increasingly multicultural Britain and government drives in addressing cultural competency. Most importantly religious and spiritual explanations may be held by clients in making sense of their mental health and existence. If this is ignored or not utilised, it may lead to therapy being experienced as less meaningful than it could otherwise be.

Smiley's (2000) survey suggests that religious issues are more commonly and comfortably worked with by therapists who themselves hold religious or spiritual beliefs. Although this is informative, and may be due to increased familiarity and awareness, qualitative studies highlighted that some therapists with faith beliefs were cautious and even felt silenced concerning this topic area (Martinez & Baker, 2000; Baker & Wang, 2004).

Working with religious themes seems to be a challenging task. This appears to be the case for therapists of all faith backgrounds, even for religious therapists who experience the secular work environment and professional codes as conflicting with ideas such as self disclosure (Baker & Wang, 2004). Even therapists practising integration of therapy and spirituality struggle with distinguishing the border of therapy and spirituality at times and are cautious with the use of specific religious techniques (Suarez, 2005). Some have even moved to private practice to enable them to have the freedom to be more explicit about their ideas on this topic area (Suarez, 2005). Value clashes can also occur between therapists with religious or spiritual values and their clients (Baker & Wang, 2004; Martinez & Baker, 2000; Suarez, 2005). This highlights the issue of individual differences within and between different spiritual and religious values, and the need for an emphasis on reflexivity for all therapists when working in this area, and not specifically for those with secular views alone. Studies highlight that the majority of therapists seem reluctant to initiate the topic area with clients and that they adopt the style of following cues from clients on judging whether to follow the topic or not (e.g. Crossley & Salter, 2005). The lack of training on the area further fails to equip therapists to work in this area and to think about managing challenges or boundaries.

As well as the general issue highlighted surrounding the lack of training and guidance for working in this area, one of the main issues may also be in relation to the approach to be used when spiritual/ religious issues are not directly raised by the client.

This is because there seemed to be an overall consensus of findings that the majority of therapists and clinical psychologists showed a desire to explore religious themes if initiated by the client (e.g. Crossley & Salter, 2005; Smiley, 2000; Suarez, 2005). However, it is also highlighted that clients will not always initiate the subject and may test their therapists' non verbal responses before raising the topic (Suarez, 2005). Therefore, an important area for consideration may be in relation to the lack of engagement that could occur if psychologists are not comfortable with the topic, as this may not create an environment where the client would feel comfortable to disclose issues surrounding faith and spirituality. Crossley and Salter (2005) suggest psychologists should consider conducting routine assessments of spirituality as clients may not disclose readily in the current culture in which religion and spirituality is neglected. They also caution against equating the need to respect client beliefs with withdrawing or avoiding the topic as this may be interpreted negatively by clients (Crossley and Salter, 2005; Suarez, 2005; Martinez & Baker, 2000). Therapist matching has also been suggested as a possible way forward to meet client needs (e.g. Smiley, 2001). However, it may be important to adopt a balanced perspective to including religious or spiritual themes in therapy, given that there is the potential for some clients to experience ambivalence about the topic area (e.g. Suarez, 2005).

4.1. Methodological Implications

There are some general difficulties with the studies discussed. Firstly, there does not appear to be a consistent definition of religion or spirituality used between the studies. The studies also vary on the focal point of what is being researched which

further restricts the comparisons that can be drawn between findings, especially when definitions were unclear or were not offered at all. It was not possible to comment on specific trends from the studies reviewed, other than the points already discussed, due to this variation between the studies. It would be important for future studies to make explicit the definitions used and the form of religion or spirituality focused upon. More focused research is advocated to address this weakness. It was also apparent that the majority of the qualitative studies reviewed investigated the functional dimension of religion or spirituality. Few studies concentrated on additional dimensions such as the experiential nature of religion and spirituality. However it can be argued that the omission of additional dimensions could serve to misrepresent the multi-dimensional nature of the concepts being researched.

Specific limitations from the UK studies reviewed include that the samples used would have benefited from the perspectives of non-white participants and those who held beliefs from other world religions. Male perspectives were also limited in some studies (e.g. Golsworthy & Coyle, 2001; Myers & Baker, 1998). Participant selection bias may have influenced study outcomes where those therapists with strong feelings on the topic area may have opted into studies, whereas those with other views may not have considered taking part (e.g. Smiley, 2001). Some studies included therapists from varying training backgrounds and professional groups; however training background may be an important factor that could account for some of the findings, for example counselling psychologists may be more familiar with existential and transpersonal models of therapy. Training could therefore influence prior exposure to varying

interpretative frameworks which may be more inclusive of spiritual type issues. Recruitment of participants from within a faith based psychology group in one study may have influenced the findings due to the organisational context (e.g. Baker & Wang, 2004). Some studies also had few participants (e.g. Myers & Baker, 1998; Smiley, 2000) which may therefore represent a narrow range of perspectives compared to studies with many participants.

It can be argued that studies distinguishing between religious and non-religious therapists could have a counter-productive effect on raising awareness of this diversity domain, for example it could lead to feelings of defensiveness and consequently a greater divide between psychologist views on the area. This may be the case especially for non-religious psychologists who may feel uncomfortable with the subject and may consequently feel unsafe and defensive about exploring it further. There is also a danger that such a distinction may force psychologists into groups of religious and non religious, where a continuum of beliefs may be more appropriate. This could further reduce the complexity of the subject area.

4.2. Suggestions for future studies

It has been suggested that religious themes may arise in certain specialties more than others (Smiley, 2001). It may be conducive to explore this further in future research. This would help to establish the nature of the issues that arise and the awareness of therapists of those issues, as well as establishing what training might be useful to support therapists in working with those specialty-specific themes. This is relevant for severe and enduring mental health services and bereavement services

where making meaning and understanding existence may be particularly prevalent. In particular mental health problems such as psychosis would benefit from research as participants in some studies pointed out that they struggled with differentiating faith beliefs and delusions (Smiley, 2001; Suarez, 2005), which potentially could lead to religious and spiritual beliefs being pathologised. Depression is another area where useful investigation could occur as this area has also been found to have frequent religious themes that could potentially include issues relating to sense of self in relation to faith and spirituality (Smiley, 2001). More research is needed on the process of integration in UK NHS settings. This could help to model how religious themes can be worked with successfully to meet client needs. Research involving ethnic minority groups that have longstanding residence in the UK is also called for.

5) References

Allman, L.S., De La Roche, O., Elkins, D.N. & Weathers, R. S. (1992). Psychotherapists' attitudes towards clients reporting mystical experiences. *Psychotherapy, 29*, 564-569.

Badri, M. (2000). *Contemplation. An Islamic Psychospiritual Study.* Surrey: Cambridge University Press.

Baker, M. & Wang, M. (2004). Examining connections between values and practice in religiously committed U.K. clinical psychologists. *Journal of Psychology and Theology, 32*(2), 126-136.

Bergin, A. E (1991). Values and religious issues in psychotherapy and mental health. *American Psychologist, 46*, 394-403.

Bergin, A. & Jensen, J. (1990). Religiosity of psychotherapists: a national survey. *Psychotherapy, 27,* 3-7.

Beutler, L. & Bergin, J. (1991). Value change in counselling and psychotherapy: a search for scientific credibility. *Journal of Counselling Psychology, 38,* 16-24.

Bhugra, D. (1996). *Psychiatry and religion.* London and New York: Routledge.

Callan, A. & Littlewood, R. (1998). Patient satisfaction: Ethnic origin or explanatory model? *International Journal of Social Psychiatry, 44*, 1-11.

Chishti, H.M. (1991). *The book of Sufi healing.* Vermont: Inner Traditions International.

Clarke, I. (2001). Psychosis and spirituality: The discontinuity model. In I. Clarke. (Ed). *Psychosis and spirituality: Exploring the new frontier.* (pp.191-207). London: Whurr.

Crossley, D. (1995). Religious experience within mental illness: opening the door on research. *British Journal of Psychiatry, 166*, 284-286.

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*, 295-313.

Cutland, T. (2000). *Intrinsic Christianity, psychological distress, and help-seeking.* Unpublished doctoral thesis, University of Leeds, UK.

Department of Health (2003). *'Inside Outside': Improving Mental Health Services for Black and Minority Ethnic Communities in England.* London: Stationary Office.

Department of Health (2004). *Celebrating our cultures: Mental health promotion with refugees and asylum seekers*. London: Stationary Office.

Department of Health (2005). *Delivering race equality in mental health care, an action plan for reform inside and outside services; and an independent inquiry into the death of David Bennett*. London: The Stationary Office.

El-azayem, G. & Hedayat-Diba, Z. (1994). The psychological aspects of Islam: Basic principles of Islam and their psychological corollary. *International Journal for the Psychology of Religion, 4*, 41-52.

Fernando, S. (2002). *Mental Health, Race and Culture*. (2nd edn). Hampshire: Palgrave.

Frager, R. (1999). *Heart, self and soul: The Sufi psychology of growth, balance and harmony*. Wheaton: Quest Books.

Golsworthy, R. & Coyle, A. (2001). Practitioners' accounts of religious and spiritual dimensions in bereavement therapy. *Counselling Psychology Quarterly, 14*(3), 183-202.

Gorsuch, R. L. & Miller, W. R. (1999). Assessing spirituality. In W. R. Miller (Ed.). *Integrating spirituality into treatment: resources for practitioners* (pp.47-64). Washington DC: American Psychological Association.

Greenberg, D. & Witztum, E. (1991). Problems in the treatment of religious patients. *American Journal of Psychotherapy, 45*(4), 554-565.

Haeri, S.F. (1989). *The Journey of the Self.* New York: Harper Collins

Hall, M. & Hall, T. (1997). Integration in the therapy room: An overview of the literature. *Journal of Psychology and Theology, 25,* 86-101.

Hathaway, W.L., Scott, S.Y., & Garver, S.A. (2004). Assessing religious/ spiritual functioning: A neglected domain in clinical practice? *Professional Psychology: Research and Practice, 35*(1), 97-104.

Hawkins, I.L., & Bullock, S.L. (1995). Informed consent and religious values: A neglected area of diversity. *Psychotherapy: Theory, Research, Practice, Training, 32*(2), 293-300.

Hawkins, R., Tan, S., & Turk, A. (1999). Secular versus Christian inpatient cognitive behavioural therapy programs: impact on depression and spiritual well-being. *Journal of Psychology and Theology, 27,* 309-318.

Helmeke, K.B. & Bischof, G.H. (2002). Recognizing and raising spiritual and religious issues in therapy: Guidelines for the timid. *Journal of Family Psychotherapy, 13*(1-2), 195-214.

Hodge, D. R. (2000). Spiritual ecomaps: A new diagrammatic tool for assessing marital and family spirituality. *Journal of Marital and Family Therapy, 26*, 217-228.

James, A. & Wells, A. (2003). Religion and mental health: Towards a cognitive-behavioural framework. *British Journal of Health Psychology, 8*, 359-376.

Jones, S.L. (1994). A constructive relationship for religion with the science and profession of psychology: Perhaps the boldest model yet. *American Psychologist, 49*(3), 184-199.

Kelly, T. & Strupp, H. (1992). Patient and therapist values in psychotherapy: perceived changes, assimilation, similarity, and outcome. *Journal of Consulting and Clinical Psychology, 60,* 34-40.

Kurtz, E. (1999) The historical context. In W. R. Miller (Ed.). *Integrating spirituality into treatment: resources for practitioners* (pp.19-46). Washington DC: American Psychological Association.

Lambert, M. J. (Ed). (2004). *Bergin and Garfield's handbook of psychotherapy and behaviour change.* Hoboken, NJ: Wiley.

Laungani, P. (2004). *Asian Perspectives in Counselling and Psychotherapy.* New York: Brunner-Routledge.

Lukoff, D., Lu, F.G. & Turner, R. (1995). Cultural considerations in the assessment and treatment of religious and spiritual problems. *Psychiatric Clinics of North America, 18,* 467-485.

MacCarthy, B. (1998). Clinical work with ethnic minorities. In Watts, F. (Ed.). *New Developments in Clinical Psychology.* (Vol. 11, pp. 122-139). Chichester: John Wiley and Sons.

Martinez, S. & Baker, M. (2000). 'Psychodynamic and Religious?' Religiously committed psychodynamic counsellors, in training and practice. *Counselling Psychology Quarterly, 13*(3), 259-264.

McCabe, R. & Priebe, S. (2004). Explanatory models of illness in schizophrenia: Comparison of four ethnic groups. *The British Journal of Psychiatry, 185,* 25-30.

McCullough, M. (1995). The effects of prayer: Conceptual issues, research review, and research agenda. *Journal of Psychology & Theology, 23,* 15-29.

McCullough, M.E. (1999). Research on religion accommodative counseling: Review and Meta-Analysis. *Journal of Counseling Psychology, 46*(1), 92-98.

Miller, W. R. & Thoresen, C. E. (1999). Spirituality and health. In W. R. Miller (Ed.). *Integrating spirituality into treatment: resources for practitioners* (pp.3-18). Washington DC: American Psychological Association.

Mitchell, J. & Baker, M. (2000). Religious commitment and the construal of sources of help for psychological problems. *British Journal of Medical Psychology, 73,* 289-301.

Myers, J. & Baker, M. (1998). Religiously committed clinical psychologists, talking. *Clinical Psychology Forum, 117*, 30-32.

National Institute of Mental Health in England. (2003). *Inspiring hope: Recognising the importance of spirituality in a whole person approach to mental health.* London office: Mental health stationary.

Nino, A. G. (1997). Assessment of spiritual quests in clinical practice: Workshop at the 7th conference of the EAP, Rome, 25-29 June 1997. *International Journal of psychotherapy*, *2*, 193-212

Pargament, K. I. (1997). *The Psychology of Religion and Coping. Theory research and practice.* Guildford Press: New York.

Post, S. G. (1993). Psychiatry and ethics: The problematics of respect for religious meanings. *Culture, Medicine and Psychiatry, 17,* 363-383.

Propst, L., Ostrom, R., Watkins, P., Dean, T., & Mashburn, D. (1992). Comparative efficacy of religious and non-religious cognitive behavioural therapy for the treatment of clinical depression in religious individuals. *Journal of Consulting and Clinical Psychology, 60,* 94-103.

Quackenbos, S., Privette, G. & Klenz, B. (1986). Psychotherapy and religion: rapprochement or antithesis? *Journal of Counseling and Development, 65*, 82-85.

Rammohan, A., Rao, K. & Subbakrishna, D.K. (2002). Religious coping and psychological wellbeing in carers of relatives with schizophrenia. *Acta Psychiatrica Scandinavica, 105,* 356-362.

Richards, P. & Bergin, A. (1997). *A Spiritual Strategy for Counseling and Psychotherapy.* Washington: American Psychological Association.

Rose, E.M., Westefield, J.S. & Ansley, T.N. (2001). Spiritual issues in counseling: Clients' beliefs and preferences. *Journal of Counseling Psychology, 48*(1), 61-71.

Shafranske, E. & Malony, H. (1990). Clinical Psychologists' religious and spiritual orientations and their practice of psychotherapy. *Psychotherapy, 27,* 72-8.

Shafranske, E. & Gorsuch, R. (1984). Factors associated with the perception of spirituality in psychotherapy. *Journal of Transpersonal Psychology, 16,* 231-41.

Skinner, A-R. (1989, July). *Traditions, paradigms and basic concepts in Islamic psychology.* Unpublished paper presented at the Theory and Practice of Islamic Psychology conference organised by the International Institute for Islamic Thought (IIIT), Birbeck College, University of London.

Smiley, T. (2000). *Non-religious psychologists talking: What happens when a psychologist who is not committed to any religion encounters religious beliefs from clients?* Unpublished doctoral coursework, University of Surrey, UK.

Smiley, T. (2001). *Clinical psychology and religion: A survey of the attitudes and practices of clinical psychologists in south east England.* Unpublished doctoral thesis, University of Surrey, UK.

Spooner, S. K. (2001). The place of spirituality in psychotherapy. In S. K. Spooner and C. Newnes (Eds.). *Spirituality and psychotherapy* (pp.35-47). Hertfordshire: PCCS Books.

Suarez, V.B. (2005). *A portfolio of academic, therapeutic practice and research work including an investigation of psychotherapists' and clients' accounts of the integration of spirituality into psychotherapeutic practice.* Unpublished doctoral thesis, University of Surrey, UK.

Tan, S. (1996). Religion in clinical practice: implicit and explicit integration. In E. P. Shafranske (Ed.). *Religious and the clinical practice of psychology* (pp.365-387). Washington: American Psychological Association.

Tonigan, J. S., Toscova, R. T. & Connors, G. J. (1999) Spirituality and the 12-step programs: a guide for clinicians. In W. R. Miller (Ed.). *Integrating spirituality into treatment: resources for practitioners* (pp.111-132). Washington DC: American Psychological Association.

Wahass, S. & Kent, G. (1997). A comparison of public attitudes in Britain and Saudi Arabia towards auditory hallucinations. *International Journal of Social Psychiatry, 43* (3), 175-183.

West, W. (2000). *Psychotherapy and Spirituality: crossing the line between therapy and religion.* London: Sage Publications

Worthington, E. (1986). Religious counselling: A review of empirical research. *Journal of Counselling and Development, 64,* 421-31.

Worthington, E. (1991). Psychotherapy and religious values: an update. *Journal of Psychology and Christianity, 10,* 211-23.

Worthington, E., Kurusu, T., McCullough, M., & Sandage, S. (1996). Empirical research on religion and psychotherapeutic processes and outcomes: A 10-year review and research prospectus. *Psychological Bulletin, 119,* 448-87.

Yarhouse, M. A. (2003). Ethical issues in considering 'religious impairment' in diagnosis. *Mental Health, Religion and Culture, 6,* 131-147.

Yarhouse, M.A. & Fisher, W. (2002). Levels of training to address religion in clinical practice. *Psychotherapy: Theory, Research, Practice and Training, 39*(2), 171-176.

SECTION B: Research Report

How do Clinical Psychologists Address Religious Themes When Working With Clients Experiencing Psychosis?

Abstract

Aims

- To gain an insight into how clinical psychologists address religious themes that emerge in the therapeutic encounter with clients experiencing psychosis. To consider this when religion may be an important way of life for the client and the client's family.
- To gain an insight into the impact clinical psychologists feel that their own values may have on their practice when working with religious themes.

Method

Ten participants were interviewed using semi-structured interviews. All participants were qualified clinical psychologists who had been working in a psychosis related service for more than one year. Interviews were recorded, transcribed, and analysed using Grounded Theory.

Results

The core category **UNRAVELLING** and three main categories; **defining roles**, **unpicking cases** and **interacting with religious themes,** comprise a process model that was developed from the data analysis. This captured the processes that participants described using in working with religious themes in psychosis. The model and further subcategories are described using transcript extracts.

Conclusion

This study is a step towards elucidating clinical psychology practice in relation to religious themes. Results highlight the difficulties experienced in trying to unravel religious themes for this client group and the factors that may contribute to this. Implications and suggestions for future research are highlighted.

1) Introduction

The question of how clinical psychologists work with religious themes with clients experiencing psychosis is pertinent for many reasons. Firstly, it has been found that many clients with schizophrenia have spiritual and faith beliefs which have an important role in their recovery. For example, a study that assessed religion and coping with 115 clients with a diagnosis of schizophrenia found that 70% viewed religion positively in coping (Mohr, Borras, Gillieron, Brandt & Huguelet, 2006). Further to this, 60% said that they used religion in coping and 45% viewed it as central to their life (Mohr, Gillieron, Borras, Brandt & Huguelet (2007). However, it has been suggested that mental health professionals are not always aware of the significant role religion can have in clients' lives. For example, a similar study involved interviews with a hundred outpatients diagnosed with psychosis, and 34 clinicians who were involved in their care (Huguelet, Mohr, Borras, Gillieron & Brandt, 2006). Although the majority of clients stated that religion and spirituality were important to them, only 36% raised the topic with their clinicians. In addition, the clinicians had an inaccurate perception of clients' religiosity and the role that it had in their coping. Clinicians were also largely unaware that some clients experienced conflict between their spiritual beliefs and treatment. The authors of these studies concluded that religion is important for many clients experiencing psychosis, and that it is not always related to delusional content. They recommended that religion and spirituality should be included in the psychosocial dimension of care and that a sensitive approach is needed for clients' individual spiritual or religious journey (Huguelet, et al. 2006; Mohr, et al. 2007).

Further, a qualitative survey of 40 respondents, who previously had a serious mental illness, found that approximately half of them reported that spiritual beliefs were crucial to their success in recovery. Spiritual beliefs helped them in meaning making, solving dilemmas and offered them social support (Sullivan, 1993). Case studies have also been published which highlight that working with religious issues may provide an element of stability in the client's life where religion was important for them before the onset of their psychosis experience (Walsh, 1995).

The need to be able to address religious issues in psychosis is also evident from the important role of the therapeutic alliance, and the way in which a lack of sensitivity to issues deemed important to clients could weaken the alliance (Lambert, 2004). This is also important as clients, particularly from minority ethnic backgrounds, can hold differing explanatory models of illness which can include supernatural explanations (Karim, Saeed, Rana, Mubbashar, & Jenkins, 2004; Malik, 2000; McCabe & Priebe, 2004). However, clinicians who are not fully aware of this could potentially attribute these explanations to delusions. This is also relevant as it has been suggested that dissonance between the explanatory models of the client and the clinician could have an impact on treatment satisfaction (MacCarthy, 1998).

Government initiatives, such as 'Inside Outside' (DoH, 2003), Delivering Race Equality (DoH, 2005), and the focus on spirituality and mental health by the National Institute of Mental Health England (NIMHE, 2003), have initiated dialogue with the aim of meeting individual cultural, religious and spiritual needs. This has provided a

foundation to encourage awareness of marginalised issues of concern, including religious needs of clients from minority ethnic backgrounds. Despite theses efforts, some authors have raised concern as to whether religion and spirituality are treated adequately as a diversity domain in the health profession. For example, it has been suggested that these issues are not sufficiently addressed in training (Yarhouse & Fisher, 2002). In addition, a study by Hathaway, Scott and Garver (2004) has suggested that therapists do appreciate the importance of spiritual and religious beliefs however; the majority of therapists do not work with these issues or include them in therapy goals. Issues relating to religion and psychosis could also present challenges for therapists, such as in differentiating between delusions and religious beliefs, as suggested in a survey of UK clinical psychologists (Smiley, 2001), and a large scale qualitative study of therapists and clients (Suarez, 2005). A survey has also highlighted that clinicians and therapists feel uncomfortable with raising religious issues with clients experiencing mental health difficulties, such as psychosis (Sheridon, Bullis, Adcock, Berlin, & Miller, 1992). All of the above factors require further investigation in order to elucidate how religious and spiritual themes of concern to clients are addressed in practice, and what difficulties are involved in this process. This is important to serve client needs, but also to gain insight into some of the challenges that clinical psychologists may be struggling with.

The current literature in the area of religion and psychosis has largely focussed on the nature of religious delusions, and the connection between religious beliefs and religious delusions (e.g. Drinnan & Lavender, 2006; Ensworth, 1984; Getz, Fleck &

Strakowski, 2001; Stompe, Baver, Ortwein-Swoboda, Schanda & Karakula, 2006). Few studies have also investigated this in relation to treatment outcomes and have suggested that strong religious beliefs or religious delusions do not adversely affect treatment response (Siddle, Haddock, Tarrier, & Faragher, 2002; Siddle et al. 2004), however more research is needed. An overview of the literature by Koenig, McCullough and Larson (2001) concludes that a causal association between religious beliefs and an episode of psychosis is unlikely. Instead, they asserted that the literature more clearly suggests that religious beliefs can be a very important source of comfort, hope and help for clients experiencing psychosis.

Another area of the literature is related to the idea of psychosis and spirituality forming a continuum. These studies have concentrated on investigating members of the population, not in contact with mental health services, who also experience some of the positive symptoms found in psychosis (e.g. Jackson & Fulford, 1997). A number of studies have also compared religious participants with 'delusional' patients and control groups (Davies, Griffin & Vice, 2001; Peters, Day, Mckenna, & Orbach, 1999). Relating to this, the discontinuity model (Clarke, 2001) has been offered as an explanatory model that attempts to describe how people experience less focussed psychotic or spiritual states along a continuum. However, this model can be criticised due to the need to work effectively with clients who may view things from a tradition where dichotomy may be more prevalent in understanding the world (Elam, 2000).

Although the literature has focussed on religious beliefs, religious delusions, and the idea of a continuum of experience - the area of how religious issues are worked with in psychosis appears to be under-researched. However, the question of how religious themes are worked with in psychosis is important for clinical practice, especially in light of the Government's move towards cultural competence as mentioned earlier.

In order to address the gap in the literature, it would be helpful to explore the experiences of clinical psychologists in this area of work. As this is a new area of research concerning exploration of psychologists' experiences and perspectives, a qualitative approach was deemed suitable for use. It is anticipated that such a study would provide increased insight into current therapeutic work in this area, which would contribute to the enhancement of clinical practice.

Aims

The principle aim of this study is to add to an area not fully considered in the research literature. Whilst religious themes may be highly personal and relevant to therapeutic practice, little UK research has looked at how clinical psychologists work with this or how value differences are negotiated. This study aims 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 way of life for the client and the client's family.

Research is also needed in the area of how clinical psychologists manage value differences, especially when working with clients who's cultural, religious or value based reference points differ from the clinical psychologist's. Therefore, the current study also aims to gain an insight into what impact clinical psychologists feel that their own values may have on their practice, and how they manage potential value clashes.

2) METHOD

2.1. The research question and research design

The research question of concern in this study is how clinical psychologists work with religious themes, in the therapeutic encounter, with clients who experience psychosis. A qualitative approach was used for this study for several reasons. Firstly, there has been little research previously conducted in this area and therefore there were no established theories to test from the available literature. A qualitative design would also allow for more comprehensive and sensitive exploration of the way in which religious issues are addressed by clinical psychologists in psychosis.

Grounded Theory (GT) was chosen as the method of analysis as it is a rigorous and distinctive procedure aimed at producing rich categories from the data. The combination of the reflexivity of the researcher and the simultaneous data collection and analysis of the raw data leads to a rich conceptual understanding (Strauss & Corbin, 1994). Grounded theory is different from other qualitative methodologies as it attempts to generate a model or theory from the data to help to explain how phenomenon may

occur (Strauss & Corbin, 1998). This is different from other approaches that may cease analysis after generating themes from the data. The current study was predominantly informed by the Grounded Theory methodology outlined by Strauss and Corbin (1998), although Charmaz's (2006) revision of Grounded Theory was also used.

2.2. The researcher's position

The researcher identified herself towards a critical realist perspective as described by Madill, Jordan and Shirley (2000). This position views the account of participants as having a close relationship to their ideas and beliefs, while also being influenced by context and expectations. According to this perspective research can lead to an understanding of participants' perspectives, although it is also accepted that the accounts would have been influenced by participants' expectations of how the findings would be utilised. Accordingly, it is important to note that the researcher is from a British Pakistani Muslim background. It is important to consider, therefore, the potential influence of this on the data. This is explored in the critical appraisal found in Section C of this volume.

2.3. Procedure

Ethical approval was obtained on 22.02.06 from Leicestershire, Northamptonshire and Rutland ethics committee 2 (see Appendix B). The research and development departments of three NHS trusts (Leicestershire, Worcestershire, Birmingham and Solihull) also approved the study.

2.3.1. Recruitment

Qualified clinical psychologists were recruited by the researcher contacting the lead psychologist for psychosis related services in each of the three NHS Trusts mentioned above. The lead psychologist then advertised the research to all the psychologists within their teams by distributing participant information sheets (Appendix C). Reply slips from participants wishing to take part in the research were received by the researcher, who then made contact with the potential participants to discuss consent and to arrange an interview date.

2.3.2. Participants

The present study sought to investigate the varying ways in which clinical psychologists approached religious themes with clients experiencing psychosis. For this reason a homogeneous sample was not sought after, as is consistent with GT practice. Ten qualified clinical psychologists who were currently working with clients who experienced psychosis were interviewed. Participants were recruited from three NHS trusts in the UK. This was to enable a broad sample of clinical psychologists according to geographical location and a greater diversity of clients being worked with. Selection was initially based on a sample of convenience from those who were forthcoming to participate at psychology specialty meetings. It is recommended that a Grounded Theory study for a doctorate in clinical psychology should have a minimum of five participants (Turpin, Barley, Beail, Saige, Slade, & Walsh, 1997) and that saturation of data should guide and determine the number of participants selected overall in the study. Saturation is achieved when data sets reveal no new categories or relationships

between emerging themes (Strauss & Corbin, 1998). This study did not reach saturation due to the limited time frame in which it was conducted, although the categories that were developed did reach a suitable level of conceptual density.

All participants were White British with the exception of one participant who was White, but had lived outside of Europe previously. The age range of participants was between 28-55 years with a mean age of 36 years. Participants described familiarity with a range of models, such as systemic and psychodynamic approaches. However, the vast majority felt that Cognitive Behavioural Therapy (CBT) described a large part of their approach to clinical work. Years of practice as a clinical psychologist ranged from 1-18 years, with a mean of 11 years. Five males and five females were interviewed with similar numbers from each Trust. Faith backgrounds of participants included four who identified with a Christian faith, two who described themselves as atheist and four who identified themselves as agnostic.

2.3.3. Interviews

The interviews were conducted and audio-recorded by the researcher using a semi-structured interview guide (Appendix D) to inform the direction of the interview, although the questions were flexible to allow for exploration relevant to the main research question. The interview schedule was initially piloted with the researcher's academic supervisor, who was a key informant on the subject area, before being used with participants. The interviews began with the collection of background information to build engagement. Later interviews also incorporated a statement by the researcher to

acknowledge the researcher's position as someone from a faith background and to express a desire for this not to inhibit any views that the participant wanted to express. This was incorporated to allow openness in the interview process and to try to manage the impact of the researcher as she may have been perceived as an expert on the topic, as it was apparent that she was from an ethnic minority and a faith community.

Participants were asked to anonymise identifiable information about any clients discussed in the interview. The researcher also took measures to ensure identifiable information was removed from the transcripts, for example with the use of pseudo-names in paperwork and transcripts.

2.3.4. Analysis

Analysis began by building themes from simple codes which developed into a theory which was well bedded in the interview data. The process of analysis was circular in that emerging themes were constantly compared to the data for refinement. This involved moving backwards and forwards between data collection and analysis to check for similarities and differences between codes, comparisons between the transcripts as well as within the same transcript, and developing links between categories as they were refined by this process. The steps that were followed during analysis are summarised below:

- **Open coding and focused coding.**

This process involved analysing the transcripts line by line in the first four transcripts, moving onto focused coding of later transcripts using the coding system obtained in this initial analysis. Open coding refers to the analysis of each chunk of the data, i.e. a few words or a line, and assigning a label to it which is grounded in the data but also represents a unit of meaning (see Appendix E for an example). Focused coding involved a process by which codes obtained through line by line coding were linked along their common properties and developed into more abstract codes. These were used to code larger chunks of text in later interviews (see Appendix F).

- **Axial coding, category building and memo writing.**

The codes were analysed and linked together according to similarity of theme or conceptual significance. These groupings were given a label and formed categories which represented processes. Axial coding is the process of linking main categories to sub-categories. This process helped to determine the developing dimensions of these categories. A paper trail in the form of memos (see Appendix G for an example) was also used throughout the analysis to record the process of category development, ideas and thoughts about the developing model and category dimensions, and the reasoning behind the linking of subcategories and codes. This helped to identify gaps which informed the researcher on areas to explore in further interviews. The later stages of analysis involved mapping out all the categories and sub-categories in the form of a process model, diagrams were used to aid this process.

- **Parallel data collection and data analysis, constant comparison and theoretical sampling**

Data collection was conducted in stages. Interviews took place between April 2006 and April 2007. Initially six interviews were conducted followed by a three month break. A further two interviews were conducted followed by a three month break, during which time the researcher presented initial findings at a conference. The final two interviews had been selected for theoretical sampling and took place in Spring 2007 (see Appendix H for more discussion). The process of constant comparison involved constant checking, between and within transcripts, of new data with older codes to look for variations. This helped to check for alternative interpretations and instances in the data. Themes from the data also had an influence on further data collection. This occurred through theoretical sampling via participant selection in order to broaden perspectives in the data. Participants for theoretical sampling were chosen on the basis that the majority of participants interviewed used Cognitive Behavioural Therapy (CBT) as their main model in working with psychosis. As the model was developing a sub-category called *challenging*, the researcher was interested to test whether or not this subcategory was specific to the CBT model or whether someone who used a different model would also engage in *challenging*. A participant from a psychodynamic theoretical orientation was interviewed and it was found that *challenging* was still a process that occurred. This interview also substantiated another subcategory called *analysing*. Further, theoretical sampling occurred according to how familiar and reflective participants felt they were in relation to the topic area. This was in response to the emerging category '*not reflecting enough*'. A participant was

selected who regularly worked with religious themes in psychosis, expressed familiarity with related literature, and also advocated reflection in this area. This interview also further substantiated the sub-category of *exploring*. In addition to participant selection, the researcher also became more sensitive to emerging themes within the interviews. This allowed for probing questions in the interviews to check for exceptions, or to obtain elaboration of concepts. This served to further refine and broaden categories in the developing model. According to this level of theoretical sampling, the interview guide did not remain static, but developed and changed in its focus of questions.

2.3.5. Quality

The researcher used a variety of methods to help create an awareness of the influence of personal perspectives and to manage this. Memos, constant comparison of the data, a reflexive journal and the frequent use of academic and field supervision facilitated the researcher in identifying and monitoring assumptions and biases. In addition, peer supervision with a trainee and a qualitative support group were each accessed on a monthly basis to discuss coding and to gain alternative perspectives on the analysis.

3) RESULTS

3.1. Introduction

A model has been generated, with a central core category called **UNRAVELLING,** which represents the processes that clinical psychologists described in working with religious themes (see Figure 1, pg 73). The three main categories of this model represent positions that the participants found themselves in during their clinical work, which they described in their interviews. The main categories within the model are found in rectangular boxes with bold edges, i.e. **defining roles, unpicking cases** and **interacting with religious themes**. These main categories are further divided into sub-categories and are typed in bold italics, i.e. ***A defined boundary*** and ***Individual repertoires***. Further sub-categories are typed in italics only. Links between categories and sub-categories are indicated by lines connecting the boxes in the model.[3]

Each of the categories and sub-categories are explained in this section together with supporting quotes. Due to the word limit, some quotes are not produced in this section of the report, however references[4] are given for these additional supporting quotes in Appendix I.[5]

[3] Links denoted in the model do not indicate causal relationships.
[4] For example the quote reference 5:344 refers to the relevant passage located in transcript five from line 344 onwards.
[5] Please note that names and identifying information have been changed in the interview transcripts for anonymity. Transcript conventions can be found in Appendix I.

3.2. Core category: UNRAVELLING

The core category of **UNRAVELLING** captures the ongoing theme that follows through all the main categories – that is of participants trying to unravel both religious themes and the role that they have in working with them. **UNRAVELLING** is an important feature throughout the proposed model. Although participants are engaged in **UNRAVELLING** there also seem to be difficulties involved in this process.

Defining roles is the first main category discussed. This is concerned with how participants unravel and understand their role (4:357, 9:29) in working with religious themes. The role was understood as essentially *improving* the clients' mental health and *reducing distress.*

We have to work out when we would intervene with religious themes in psychosis. But yeah I think probably it would be in order to improve mental health and reduce distress. (6:389)

Participants drew upon their *professional training* and *personal experience* in determining their stance, yet most participants also commented on the ***limited guidance*** available within the profession to guide this process. Most participants noted that they felt that they were *not reflecting enough* on religious themes at an individual level or as part of a team.

The second main category is **unpicking cases.** This captures the way in which participants try to unravel cases to determine the types of religious themes emerging and therefore determine which might need attention.

...It's important that I take time to unravel what the case is about to know what form the religious themes are coming out and how I might work with that. (3:120)

The most commonly cited presenting issue was when religious themes were ***entwined*** in the psychosis and participants described trying to distinguish delusions from conventional religious beliefs.

The final main category outlines the process in which participants were actually **interacting with religious themes**, thereby engaging in a process of not only **UNRAVELLING** how to intervene, but also in helping the client to unravel their concerns (1:69).

So it's important to work with the client and think and reflect on how you are doing that - the religious stuff may be really important and you need to think carefully about how you are working with that to help the client reach their goals. (9:212)

There was a consensual view on certain principles and techniques that should be used at the level of building the therapeutic relationship. Yet alongside this there were **differing levels of interaction** with religious themes which existed as separate, but

related, forms of intervention. ***Interacting with religious themes*** was perceived as ***Hard work*** due to several challenges in the work, such as the difficulties in permeating something that clients associated with a higher power.

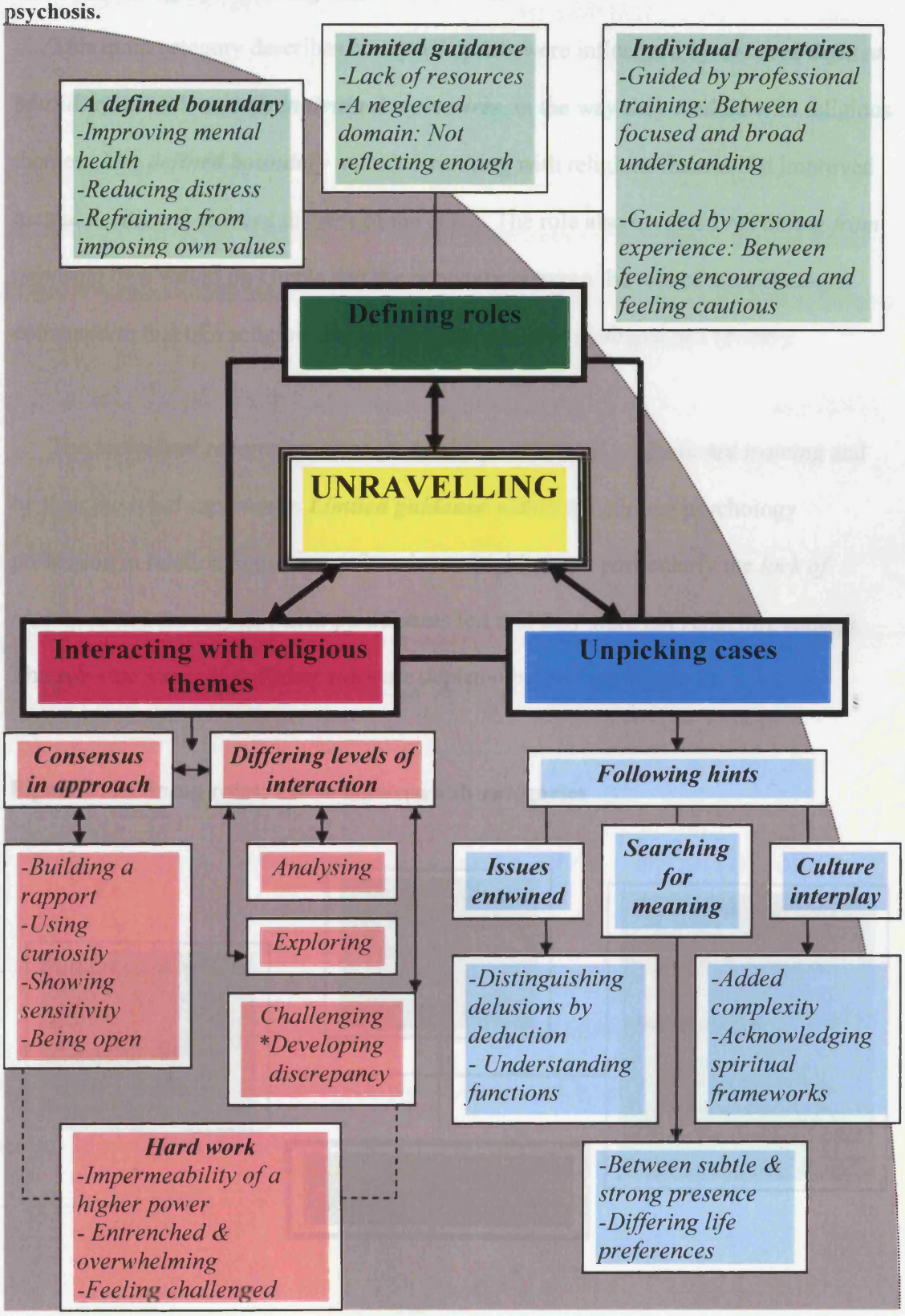
UNRAVELLING served to enrich participants' understanding of their cases and of their role, and further helped to move them through the process of working with religious themes. There seemed to be two factors, however, that contributed to the stresses and strains that some participants encountered in the process of **UNRAVELLING**. The first factor was the ***limited guidance*** available in equipping participants to reflect and to work with unfamiliar religious, spiritual and existential issues competently. The second factor related to limited reflection. Participants had a tendency to actively start **UNRAVELLING** when triggered or prompted by a challenge or unfamiliar demand. This led to brief and inconsistent exposure to reflecting on religious, spiritual and existential issues. This seemed to be influenced by participants' typically limited experience of working within a proactive reflective culture concerning religious, spiritual and existential themes.

The hypothesised order of categories was arranged as such because it seemed that each category had a potential influence on the other. This was primarily in the direction depicted in the model, although many other interactions could occur between the categories and subcategories. For example, the way in which participants understood their role in working with religious themes influenced the manner in which cases were

unpicked and categorized, which in turn influenced the way in which participants interacted with the religious themes identified[6].

[6] See Appendix J for additional notes.

Figure 1: A process model of how clinical psychologists work with religious themes in psychosis.

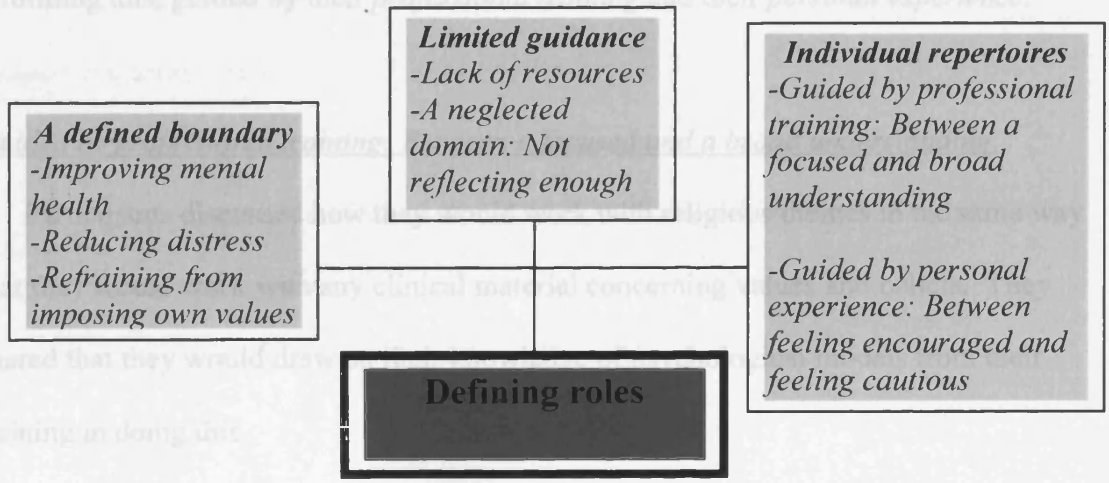


3.3. Main category: Defining roles

This main category describes how participants were influenced by a shared ***defined boundary***, as well as their ***individual repertoires***, in the way they worked with religious themes. The ***defined boundary*** included working with religious themes if it improved mental health and reduced distress of the client. The role also involved *refraining from imposing own values* on clients and the boundary between the role of a psychologist compared to that of a religious leader, for example, was distinguished (8:205).

The ***individual repertoires*** were guided by participants' *professional training* and by their *personal experience*. ***Limited guidance*** within the clinical psychology profession in relation to this area of work was highlighted, particularly the *lack of resources* and the way in which participants felt that they were *not reflecting enough.* The sub-categories of **defining roles** are depicted below (see Figure 2).

Figure 2. Defining roles: Links between sub-categories



3.3.1. *A defined boundary*

A shared boundary was emphasised involving work with religious themes primarily for *improving mental health* and *reducing distress* (5:726), whilst *refraining from imposing own values* (8:594). This differentiated the role of a psychologist and that of a religious worker or professional. Reducing distress was often in the context of client's having a religious delusion.

I suppose we would only want to intervene with it, the religious delusional beliefs, erm, if it was causing distress – you know to try and manage that and help the client with that. (7:95)

3.3.2. *Individual repertoires*

The boundary within which the role of a psychologist was perceived led to various ideas on how far the remit of a psychologist could extend in undertaking work to address religious themes with clients. Participants held ***individual repertoires*** informing this, guided by their *professional training* and their *personal experience*.

Guided by professional training: Between a focused and a broad understanding.

Participants discussed how they would work with religious themes in the same way that they would work with any clinical material concerning values and beliefs. They shared that they would draw on their knowledge of psychological models from their training in doing this.

Well religious beliefs are beliefs and psychological models that I would draw on work with beliefs. So I don't think I would be doing anything really different to what I would normally do. (8:119)

The variety of training experiences of psychological models lent itself to a spectrum of possible ways in which to understand religious themes. For example, at times participants would understand the religious themes more from a *focused* or problem orientated stance, with the view that the religious themes would be worked with if they were related to the presenting problems.

I suppose I use predominantly CBT... So I tend to work with the presenting problems you know, so that if the distortions or cognitive sort of errors involved kind of religious content – then I would work with that. (4: 328)

At other times participants were also aware of the wider connections that the religious themes could have on the client's life and thus understood the religious themes in a *broad* sense.

So it is important to understand the wider issues as well... systemic type of training might make you more attuned to thinking about cultural values and this can pick up the wider theme of religion. (3:109)

Therefore, training seemed to inform participants' ***individual repertoires*** and was a factor that could influence the breadth of their approach to working with religious themes.

Guided by personal experience: Between feeling encouraged and feeling cautious.

Differing positions also existed between *feeling encouraged and cautious* in working with religious themes. Some participants who had positive or interesting religious, spiritual or existential personal experiences tended to describe *feeling encouraged* to actively explore religious themes. For example religious themes were incorporated into assessment (9:100); faith was used as a tool for engagement (3:166); there was an active attempt to make spiritual connections; a general exploration of faith and the provision of supervision to a chaplain who was exploring faith with a client.

When I was younger I kind of spent some time thinking about it all, and I did find it really interesting even though I don't believe... So I don't mind at all to think about this with clients. And I supervise a chaplain who directly works with a client for example... (5:675)

Some participants also described *feeling cautious* about exploring religious themes unless there was an explicit reason for them to do so. This was related to varying fears, including the risky task of finding a religious leader or chaplain to co-work with who could potentially sabotage, rather than complement, the psychological work being done (1:356). Some participants also had the perception that most people were not religious and that raising religious themes may present unnecessary barriers (8:562). Some

participants also felt that they needed to work primarily as a psychologist, drawing on psychological models, so as to not fall out of the ***defined boundary*** (4:360). Having religious beliefs did not necessarily correspond with feeling encouraged to proactively work with religious themes, as the latter two examples were of participants who had a personal faith. For some participants being aware of the 'damaging effects' of religion also led to them feeling cautious (7:556). Some participants fluctuated between feeling encouraged and cautious.

Why shouldn't we address these issues. You know I think it is a part of my work and it is important. But as well, yeah – there is something about, well you do need to think carefully about who you will co-work with from the religious community if you do want to go down that route. (5:721)

3.3.3. ***Limited guidance***

The issue of there being ***limited guidance*** available for this topic area was raised by many participants. In particular it was recognised that there were limited resources that addressed this area, such as the lack of guidance in clinical text books or the lack of teaching on training courses (5:347). Furthermore participants shared that they and the teams that they were working in were *not reflecting enough* on religious themes in psychosis.

I don't think it's something that we reflect on enough – I mean individually but within teams as well. (7:606)

A few participants who were more familiar with the topic area, due to some personal experience and/or academic pursuit, and who felt encouraged with working with religious or spiritual themes, tried to independently integrate spiritual ideas in conceptualisation of cases. However they felt that this effort was deficient and that reflecting on this topic area should be supported more within teams (10: 704). However one participant was successfully able to make his work culture more reflective on these issues. He made his interest in this area known and prompted others in his team to send him referrals specifically related to religious themes. This illustrated that a suitable level of reflecting can occur in contexts where teams are prompted by a motivated individual.

In my team people know me and that I have an interest in this area. I am open about my knowledge and experience and often they will refer people to me with religious themes. (9:550)

Although participants described being involved in the process of **UNRAVELLING** in their work, they also recognised certain limitations that could in effect hinder the depth of reflections reached within this process. For example, being part of a predominantly white middle class team limited the direct experience of cultural and spiritual issues that could be contributed in reflective discussions.

I am aware that teams are not really that diverse though... You know there are limited diversity perspectives, if you like, that can be drawn on... if you haven't had much experience in working with more diverse sort of groups then you might be more likely to miss things. (10:724)

Participants also occupied different positions on how much prompting they felt was required to move them into a reflective position concerning this topic area. The majority felt that it was a topic that they had not previously articulated their thoughts on (6:443). For these participants some prompt, such as encountering an unfamiliar religious belief that placed a demand on their usual conceptualizations, was required to move them into a position of **UNRAVELLING** (5:75). A few who felt familiar and encouraged with the area described requiring less prompting to actively start **UNRAVELLING** religious themes. The interview process itself was a prompt and was used by participants to unravel their own practice. Within this some started to reconsider some of their views, such as those relating to routine assessment of religious themes.

You've got me thinking now – and perhaps it would be a good idea to include it in assessment. (6:372)

3.4. Main category: Unpicking cases

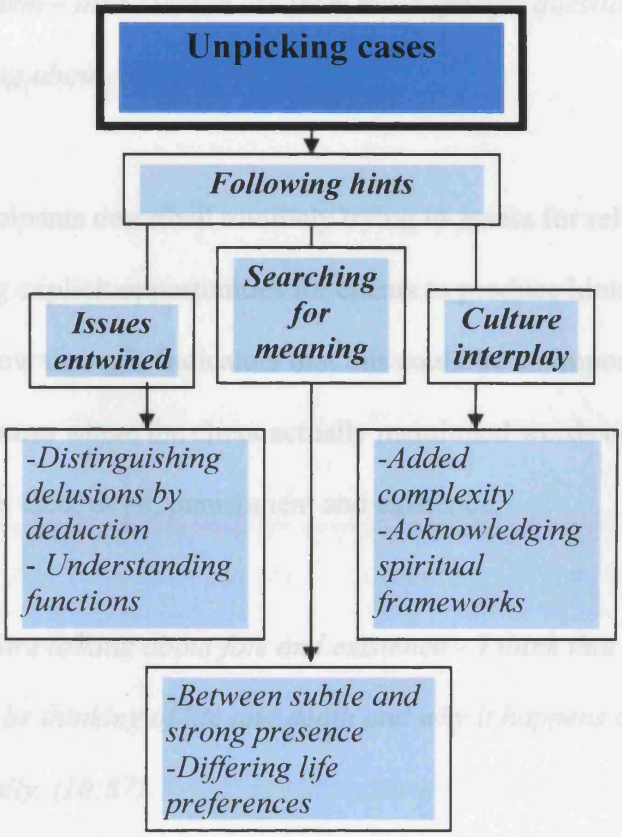
This category related to the process in which participants described **Unpicking cases** where there were religious themes present. While **UNRAVELLING** represents a

general over-arching process that occurs over a length of time, **Unpicking** relates to a specific process concerning the categorization of cases. This often occurred as an active process when participants felt unclear about where to intervene. Cases were often categorized according to the nature of the presenting problem or the way in which the religious themes came to the fore. This process began by participants ***following hints*** from clients and from referral information to ascertain whether or not to enquire about, and to formally assess, religious themes further. Cases were largely categorised into three groups. The main group identified involved religious ***issues entwined*** in the case. This was when religious themes formed a central feature of the psychosis and participants described being involved in a process of *distinguishing delusions by deduction* and comparison to conventional religious beliefs. Religious themes were linked to psychotic symptomology in these cases and participants were involved in a process of *understanding functions* of such religious themes. The second category of cases was ***searching for meaning.*** This was described on a continuum *between subtle and strong presence* in how much clients brought these issues to therapy. This also involved *differing life preferences* for some clients which related to their religious values. Finally, cases with a ***culture interplay*** were also described and were perceived as having a layer of *added complexity*. Participants recognised the importance of *acknowledging spiritual frameworks* of clients from different cultures.

This main category is linked to the next main category called **Interacting with religious themes**. The manner in which cases were unravelled linked to the levels of

interaction that participants chose to engage with when working with the religious themes.

Figure 3. Unpicking cases: Links between sub-categories



3.4.1. Following hints

This sub-category is concerned with how participants understood the religious themes. This occurred through the process of being aware of hints or religious overtones that were present in the referral information about clients, and in conversations with clients themselves (2:176). The majority of participants described ***following hints*** from clients in a discrete manner to determine whether or not a follow

up of this topic area would be useful (5:124). If judged to be an important area, the topic would then be followed up through assessment by the participant.

But if the client kind of said something that made me think oh this could be important for them – then I would ask them more specific questions on what I thought they were hinting about. (8:126)

A few participants described routinely trying to assess for religious themes (9:83), thereby creating explicit opportunities for clients to produce hints on religious themes for them to follow through. Indicators that this could be an important area for the client included incidences where the client actually mentioned words or phrases related to concepts of fate, God, devil, punishment and existence.

...If clients are talking about fate and existence – I think that can be a strong hint that they might be thinking of life and death and why it happens and whose in charge of this process really. (10:87)

Once perceiving that religious themes were present and important to pursue, the participant embarked on the task of ***unpicking*** and **UNRAVELLING** the cases further. Three categories of religious themes were identified which could arise in isolation or alongside each other for clients. These were ***issues entwined***, ***searching for meaning*** and ***culture interplay.***

3.4.2. Issues entwined

This sub-category refers to cases where religious themes were central to the psychosis (3:80). Participants were involved in a process of *distinguishing delusions by deduction* from conventional religious beliefs to ascertain whether or not the religious themes were acceptable within the religious organisation to which the client related, or whether the religious themes were delusional.

The issues can be centrally entwined in the case and you have to kind of look at the conventional religious beliefs held by that church or whatever to work out if the religious themes are normal or could be delusional. (2:211)

Deduction was used by carrying out a comparison between the religious themes brought by the client, that were potentially delusional, and the norms of that religious belief system. This was conducted in various ways, such as learning from the client about other peoples' religious views in their church (2:227), reading about the religion to learn what the norms were, and consulting colleagues or religious chaplains (6:335). This process was described as challenging by some participants as it was sometimes difficult to distinguish between delusions and accepted beliefs. This was particularly when the religious ideas were more likely to be perceived as a potential delusion in some religious spheres but not in others.

...what we found difficult is that his mum to some extent has not been a good measure... they're both very heavily involved in the Church ...when he became high he

became very confident and mum actually perceived that, as he did, as a healing from how he had been and therefore was delighted that he had the confidence to go out on the streets and preach. (3:132)

Participants were also engaged in a process of *understanding functions* of the religious themes to determine whether the delusional religious themes were serving a functional or dysfunctional purpose in the wellbeing of the client. Dysfunctional religious delusions were identified as those that caused distress or were impacting on the quality of life of the client. Functional religious delusions were those that were actually serving a useful purpose in maintaining some aspect of the client's health. The latter would not always be the focus of intervention for this reason (6:125).

3.4.3. Searching for meaning

These religious themes often came up during assessment and referred to a general sense of ***searching for meaning*** (10:91). The search for meaning could take the form of questioning about existence and purpose in life, to being curious about some aspect of God and the devil.

They might have questions like who is God, why is the devil evil and you know what is life about. (9:65)

Participants described varying levels of themes relating to a search for meaning. For example, these themes could present as *subtle* issues for some clients. However for

other clients these issues could actually form a *strong presence* in the therapeutic encounter. *Subtle presence* represented issues in the background to a case with clients hinting occasionally at the area but not necessarily wanting to fully explore it (5:132). For other clients, ***searching for meaning*** was more overt in their conversations within therapy. Furthermore, for some clients the need to discuss religious themes in their search for meaning was a significant factor determining whether or not they engaged with services.

...he actually would not engage with any therapist that dismissed his religion or didn't want to hear about it. (9:134)

Clients who were ***searching for meaning*** could also hold *differing life preferences.* At times these were unfamiliar and unexpected by participants.

It wasn't what I usually would expect that you know - clients usually don't say that they want to only mix with other people of their religion and not others. (2:90)

This illustrated how certain clients' religious themes impacted on their way of life and on their day to day activities. This was a challenge when not anticipated by the participant and required the participant to expand their ***individual repertoire*** of how to work with religious themes creatively, whilst respecting the *life preferences* of the client.

Her religious preferences, I mean they were different to what I would expect so that did challenge me and I had to think creatively to work with that...(2:95)

3.4.4. Culture Interplay

Religious themes were also raised in relation to clients from different cultural backgrounds. In such cases it was deemed to be important to understand these themes within the cultural context of the client. Therefore cultural factors were recognised as important contributors in a formulation (1:382). Participants described a layer of *added complexity* with clients from differing cultures, especially if unfamiliar to the participant.

Clients from other cultures, erm, there is more complexity to untangle. You know what is from the religion, what is from the culture and what is coming from the psychosis. (6:302)

Cultural factors were recognised as sometimes contributing to difficulties, for example when clients were trying to negotiate living in two cultures that did not place religious beliefs at the same level of importance in day to day living (3: 104). This was recognised as complicated to work with at times and would require extra effort by the service in order to engage the client (6:309).

Another dimension of *added complexity* was the awareness of spiritual frameworks within certain cultures. It was recognised that clients from different cultures could hold

spiritual models of illness and that *acknowledging spiritual frameworks* would be beneficial for the client (4:42). Participants acknowledged that clients could hold western psychological models of psychosis and spiritual models of illness simultaneously. The complexity arose for participants in knowing how to integrate both models into understanding rather than them opposing each other.

Some clients hold both spiritual and sort of bio-psycho-social models together and they don't have a problem with that. But it can also be complicated at times when both seem opposed. It can be tricky to know how to integrate the perspectives. (4:57)

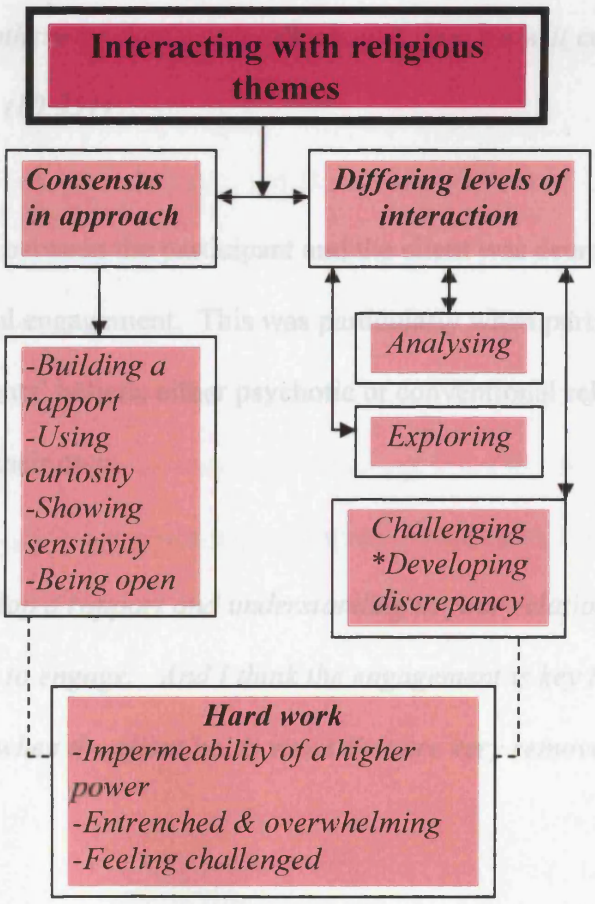
3.5. Main category: Interacting with religious themes

This main category outlines the way in which participants interacted with religious themes in their clinical work (and tried to unravel how to intervene) in order to help the client in **UNRAVELLING** the themes. There seemed to be a consensual stance amongst participants in approaching such cases with abstract techniques and principles such as; *building a rapport, using curiosity, showing sensitivity* and *being open.* A dynamic process alongside this consensual approach involved ***differing levels of interaction*** with religious themes. For example, participants who were concerned with religious themes at the level of *analysing* the origins of such themes engaged in building a formulation which could be shared with the client. The most common level of interaction occurred at the level of *challenging* some aspect of the religious theme, usually in the context of *reducing distress. Challenging* occurred largely through *developing discrepancy* between the clients' distressing or unhelpful delusional beliefs and a religious source to which the client attributed authority and meaning. Some

approaches also facilitated the client in *exploring* wider religious or spiritual issues of concern within their own frame of reference, although this was less common. These levels of interaction could occur individually or simultaneously.

Some participants described working with religious themes in psychosis as ***hard work.*** This seemed to be related to the difficulty in working with the *impermeability of a higher power* for some participants. Other participants felt that the cases with religious themes were more likely to be *entrenched and overwhelming,* which could leave them *feeling challenged* in their clinical work.

Figure 4. Interacting with religious themes: Links between sub-categories



3.5.1. Consensus in approach

This sub-category describes the view of participants that in order to work effectively there were certain agreed principles that ought to be applied, especially in the initial approach of the therapeutic contact. These were described as common skills and principles that psychologists would use with any client group or problem area (8:349). However these were especially important for psychosis and religious issues, due to the highly personal and sensitive nature of these areas, which could therefore be threatening to discuss due to a fear of being negatively judged.

...If you think about it religion and psychosis are both highly personal issues and you have to work with the person using all your skills really to make them feel comfortable with you otherwise they won't talk about it, you know it could feel threatening otherwise. (10:351)

Building a rapport between the participant and the client was deemed to be imperative to successful engagement. This was particularly when participants recognised that the clients' beliefs, either psychotic or conventional religious beliefs, were very different to their own.

...you have to develop a rapport and understanding in your relationship with the client if you want them to engage. And I think the engagement is key to successful outcomes – especially when the client holds views that are very removed from your own. (8:271)

Participants explored a variety of ways of doing this. For example; 'suspending' their own disbelief of the clients' views and to temporarily let go of their own certainty, to 'walk in the shoes' of the client and to recognise the 'psychotic' in themselves as ways of understanding the clients' world (10:38). Sometimes participants would disclose their own position on religion, if asked by the client, and used this as a tool for engagement. However this did not always have a positive outcome if the client considered the participant to have a position on religion that was too different from their own religious stance.

I had one client say that to me, that I wouldn't understand her anyway because I wasn't Christian. (7:144)

Using curiosity was advocated as an important and effective way to continue with the process of ***following hints*** in judging how much to work with religious themes. This was useful in reaching a deeper understanding of the religious frame of reference that the client was using, or the meaning that the religious themes had for them (2:105). Curiosity was also used as a way to learn from the client about the aspects of their religious belief that the participant was unaware of or did not have a full understanding of.

...If there was something I didn't know or understand then I would ask the client to explain that, you know so showing I'm curious really and trying to learn from them about it. (5:296)

Throughout the consensual approach of *building a rapport* and strengthening engagement, participants were acutely aware of the importance of *showing sensitivity* and were mindful that they did not want to make the client feel attacked or undermined when working with religious themes *entwined* in psychotic symptoms (7:566). They described *showing sensitivity* by trying to be respectful in the way that they disagreed with religious themes that were related to psychotic symptoms. This was often by implicitly conveying a different point of view rather than being explicitly confrontational (2:373). This process was described as a delicate balance between *showing sensitivity* and not colluding.

I think it can be hard to get the balance as well. You know trying to be sensitive ... The delicate side to that is not to collude whilst doing that. (5:263)

Being open was another principle that participants felt was important to allow the client to feel comfortable in talking about their religious beliefs and ideas (8:322). Although participants were striving towards *being open* and non-judgemental through utilising the above processes, there was a limit to how far it was possible for them to 'suspend their disbelief' or to refrain from judging negatively at times. For example if the clients' cultural or religious beliefs seemed unfair (7:398). In instances where there

were value clashes participants described trying to process these by **UNRAVELLING** their own values and prejudices. This would be facilitated through the use of peer or formal supervision.

But I think I would take it to supervision and talk it through, to see where my prejudices are and understand a bit more. (7:407)

3.5.2. Differing levels of interaction

Participants' accounts described different levels at which the religious theme could be interacted with in the therapeutic encounter. Participants' accounts indicated that some interacted through all these levels at times, whereas others remained predominately within one or two of the levels. This may have been influenced by the participants' ***individual repertoires*** of professional training and personal experience (7:371).

Analysing

Analysing religious themes took the form of mentally making connections and links between religious themes and the clients' early history. This would enable the participant to hypothesise about the origins of the religious themes (10:220) – and then lead to sharing an interpretation about this at times if appropriate. The decision to share an interpretation with the client would depend on the strength of the therapeutic relationship, the appropriateness of timing and the readiness of the client to reflect and to be open to possible interpretations.

...and I try to connect what they are saying and you know I will try and relate it to what they have just said about God or something and see if that makes sense to them, for example that people let you down when you were growing up and if also they feel God has let them down now. (10:382)

The understanding gained from *analysing* was also used to develop formulations to link together previously established connections and the possible origin of distressing emotions (10:545). Sometimes participants would try to trace significant emotions of concern through religious themes (5:248). Sometimes the formulation itself was seen as the intervention, either in helping the client to understand their difficulties or in helping other professionals involved in the client's care (2:255).

Exploring

Although *Analysing* could form an intervention in itself, it could also lead into another level of interacting with the religious theme such as helping the client in *exploring* further their general religious and existential concerns that were not necessarily linked to psychotic symptoms. This was to enhance mental health or alleviate the internal turmoil felt by the client who was struggling with particular religious themes. Examples of themes included a desire to understand God, a preoccupation with the meaning of life or other religious concepts which were troubling the client.

This person had issues he needed to explore and he wanted to know what life was about and I allowed him to do that exploring in therapy because I felt this is fundamental to his mental well-being. (9:152)

One example of *exploring* involved offering supervision to a chaplain who worked directly with the client in *exploring* general religious themes (5:367). Some participants felt comfortable in exploring religious themes with the clients directly themselves, although this was not a common practice. Competency in exploring religious issues was raised as an important factor that would determine how comfortable participants felt in facilitating clients to think about religious concerns. In particular it was felt that, in order to do this effectively, it was important to have a thorough grasp of the client's religious beliefs.

I will explore religious themes with clients but I will only do that if I think it will benefit the client and if I have a good enough grasp of their beliefs to do it competently. I would not feel comfortable otherwise. (9:250)

When the frame of reference of clients was unfamiliar and not fully understood, it was thought to hinder how helpful the participant could be to the client.

...I wouldn't want to be working with a client outside my level of competency if their beliefs were unfamiliar to me. I think I would not be useful then, in fact that could actually have a detrimental effect on a client. (5:412)

It was deemed important to be aware of the limits of being able to fully explore religious themes with clients and the option of referring on to someone more competent, if possible, was advocated if the participant could not meet the client's needs (9:256).

This level of intervention tried to incorporate a holistic approach in understanding the overall context of the client's struggle. In particular, how different parts of the client's life interacted with and impacted on improving their mental health (9:146).

Challenging

Challenging religious themes in order to reduce distress or to enhance quality of life was carried out when it was felt that an aspect of a religious theme was a misinterpretation. This would also occur when participants felt that clients held an unhelpful interpretation of conventional religious perspectives. Examples included beliefs about constantly being punished by the devil or God, beliefs about Jinn[7] possession to the exclusion of a psychosis explanation of illness (2:245), beliefs about the need to constantly meditate, and beliefs about being Jesus.

...his sort of beliefs were around Buddhism that I thought were directly causing problems for him in terms of his mental health problems, so I did actually try to challenge those... he was using meditation in order to block out psychotic thoughts and voices, but he was kind of over-using it. (4:236)

[7] According to Islamic beliefs, a Jinn is an unseen being originally created from fire.

The most common way in which delusional religious themes were challenged was to use some form of religious authority that the client attributed to be an important source of information. This was in order to start *developing discrepancy* between this source of information and the client's misinterpreted beliefs[8]. This facilitated the client to see the mis-interpretations held in their dysfunctional delusions and to re-evaluate their beliefs relating to the religious themes in question.

So if the client has misinterpreted their religious beliefs, then I would use a sort of gentle challenging approach to help them re-evaluate that using some form of evidence in the process. (1:199)

Examples of the sources of religious authority that were used included religious texts (3:171), religious leaders, as well as accessing other religious people's stories on the internet. These were sometimes used as behavioural experiments with the clients (1:197) during which they were encouraged to look for evidence that supported the beliefs that were felt to have been misinterpreted. Some of these methods did not always work, for example if the religious leader chosen was not from the same Church and therefore was not trusted by the client (7:119). The pace of challenging, if too rapid, could also leave the client feeling defensive or not heard (2:330). There were many other challenges such as trying to understand religious sources from an

[8] Occasionally participants also perceived functional delusional beliefs as a useful tool to assist in *developing discrepancy* to reduce distress. An example of this is where delusional beliefs about angels offering protection were used to counter the distress from delusional beliefs about being tormented by the devil (8:400).

unfamiliar religion, or if religious norms seemed to overlap or to be similar to what could also be perceived as delusional[9].

3.5.3. Hard work

Some participants felt that working with religious themes in psychosis was ***hard work.*** This was due to the sense of *impermeability of a higher power* that often featured in delusions with religious themes. This was described as difficult to penetrate at times as clients perceived the higher power as omnipotent and the distress therefore as irremovable (10:172). At times the higher power within the client's religious themes was felt to penetrate therapy, rather than to engage with the therapy and move towards a dialogue about the parameters of power it had for the client (10:212). This struggle was perceived as qualitatively unique by some participants and added ***hard work*** to what was already perceived as a challenging area to work in (10:186).

Maybe it's something about it being a powerful being. I suppose it would be different if it was the voice of an uncle or a friend or something, maybe they could be challenged a bit easier. (7:479)

Cases with religious themes were also perceived as more *entrenched and overwhelming,* with the effect of leaving some participants feeling deskilled. Furthermore, it was hypothesized that other professions could also be struggling with this area of work (6:540).

[9] As already discussed in the previous main category '**Unpicking cases**'.

...I think it can feel quite de-skilling ... I suppose my experience is that when religion is tied up with psychosis it can prove more problematic. It can be potentially more difficult to help somebody in terms of - it can prove to be a more entrenched difficulty. (6:427)

There were particular struggles highlighted by participants, such as distinguishing delusions from conventional beliefs, as already mentioned; not knowing enough about different cultural and religious belief systems, such as ideas like Jinn possession; and the potential for personal value clashes surrounding this sensitive topic. All of these factors contributed to the participant *feeling challenged* at times when working with religious themes in psychosis.

4) Discussion

The current study aimed to investigate how clinical psychologists work with religious themes that emerge in the therapeutic encounter with clients who experience psychosis. The aims of the study to gain insight into how clinical psychologists address religious themes, and of their views on the impact of values on practice, were achieved. The results suggest that clinical psychologists engage in a process of **UNRAVELLING** when thinking about how to work with religious themes. However, the accounts also draw attention to the difficulties in doing this. The proposed process model provides valuable insight into some of the details of the **UNRAVELLING** process.

According to this study, religious themes that were an important part of the client's way of life, tended to be responded to with a combination of *sensitivity*, *exploring*, *analysing* and *curiosity*. However, *challenging* was the most frequent level of interaction discussed by participants, which was predominantly used to work with delusional religious themes rather than general religious themes that might be raised by clients. There seemed to be a complex interplay of several factors in understanding the impact that participants' values had on their practice. A mixture of experiences, feelings and thoughts about religion impacted on them in feeling *encouraged* or *cautious*, or both, in working with religious themes. Value clashes with clients were acknowledged and were said to be managed through the use of supervision. Participants were also aware to not impose their own values on clients in the therapeutic encounter but acknowledged that their values could influence the encounter in some implicit form.

This section will discuss the process model and its four categories; **UNRAVELLING**, **defining roles**, **unpicking cases** and **Interacting with religious themes,** in relation to previous research. Key findings, recommendations, methodological issues and suggestions for future research will also be explored.

4.1. The core category: UNRAVELLING

The core category is consistent with findings that most clinical psychologists and therapists consider religious themes a relevant area in clinical practice (Hathaway et al. 2004; Shafranske & Malony, 1990b; Smiley, 2001). The current findings are also consistent with the suggestion from previous studies that there is ***limited guidance*** in

this area. This has been previously mentioned as a factor contributing to the neglect of therapists working with religious and spiritual themes (e.g. Shafranske & Malony, 1990a, and b).

The results suggest that most participants were reactively inclined towards initiating a process of **UNRAVELLING**. This is suggested as **UNRAVELLING** often occurred as an active process when participants were trying to manage unfamiliar or challenging material as it was encountered. A proactive process of integration of religious themes was not found, except for one participant who had an informal arrangement with colleagues who would refer to him clients who were concerned with religious themes. In contrast, it is suggested that clients do not readily raise religious themes, but test therapists first (Suarez, 2005), and that the routine incorporation of spiritual themes in assessment would be beneficial to clients (Crossley & Salter, 2005). Therefore, reactive **UNRAVELLING** may not be the most effective way to capture clients' needs.

4.2. Main category: Defining roles

The three elements of *improving mental health, reducing distress* and *refraining from imposing values* are consistent with the British Psychological Society's professional practice guidelines for clinical psychology (Division of Clinical Psychology, 2005). The idea of a boundary has also been raised in previous studies, for example where therapists with spiritual beliefs have felt cautious in self disclosure of faith during work with spiritual themes due to a fear of overstepping the therapy boundary (Baker & Wang, 2004; Suarez, 2005).

According to authors and studies which suggest that the notion of value-neutral psychological theories and clinical practice is questionable (e.g. Bergin, 1980; Jones & Wilcox, 1993; Richards & Bergin, 1997; Lewis & Lewis, 1985; Kelly & Strupp, 1992), it may also be useful to consider that the imposition of values may to some extent be an inevitable process. In light of this it is important for clinical psychologists to be aware of values and endeavor to manage and unravel the impact they have, rather than understanding it as a process that can be avoided. This could prove a useful reframing which, if fully explained and acknowledged within the BPS guidelines, could avoid confusion over the role of values. In particular it could serve to clarify what would constitute an inevitable interplay of values in comparison to what would constitute abuse of power.

Participants discussed personal experiences and feelings relating to religious themes in their own lives, and the way this influenced how they felt about working with religious themes. It seemed that a positive encounter with religious, spiritual or existential themes, in their own personal growth or professional development, was an important factor in feeling encouraged in working with religious themes. In light of this it might be useful to consider that a positive training experience could be important in helping clinical psychologists to feel encouraged, as well as competent, in exploring religious themes. It was also possible for participants to feel encouraged and cautious at the same time. This suggests that there may be a complex dynamic involved and that negative experiences of religion may not be the only factor leading to cautious feelings

about incorporating religious themes in clinical work, as some participants held faith beliefs yet still expressed caution.

It seemed that this topic area was a struggle to discuss for most participants who said they were discovering and formulating thoughts as they spoke. It can be assumed from this that articulating their thoughts on this subject was an infrequent event. Some participants raised the issue of not feeling adequately equipped to work with religious themes. There was recognition that it was not reflected on enough at times, or that reflecting within a dominant white middle class context had limitations in thinking about religious themes of an unfamiliar minority culture. This has implications concerning the adequacy of reflective practice in place to facilitate the **UNRAVELLING** process. Participants may have been trying to reflect within a professional culture which does not routinely reflect on these issues, and in which religious themes still remains a relatively neglected domain of clinical practice.

4.3. Main category: Unpicking cases

This category is consistent with studies that indicate that therapists and clinical psychologists have a tendency to follow hints from clients from which they judge whether or not to follow up religious themes (Crossley & Salter, 2005; Smiley, 2000). The idea that cases require **UNRAVELLING** is also consistent with previous studies that have eluded to religious themes in psychosis as one of the potentially complicated areas that therapists struggle with (Smiley, 2001; Suarez, 2005).

Although participants were articulate in describing how they would work with distressing religious delusions, it seemed that they were less fluent about cases which involved *culture interplay* or different life preferences. So although religion as a concept was not perceived as vague, like spirituality (Crossley & Salter, 2005), there may be an obscurity about the way in which to address it in clinical practice. For example, participants were less expressive of ways in which to work with spiritual frameworks, even though they felt it was important to acknowledge them with clients.

Religious themes were also largely associated with positive psychotic symptoms within the ***issues entwined*** category of cases. *Searching for meaning* was also described as a common theme. This is consistent with previous research of clients who felt that religious themes and religious beliefs were important in making meaning (Mohr, et al.2007; Sullivan, 1993). Therefore, it would be important to consider that religious themes may be highly significant in the process of making meaning, which could be just as important as working with religious themes in symptomology.

4.4. Main category: Interacting with religious themes

This main category describes a dynamic process through which participants interacted with religious themes. According to Tan's (1996) conceptualisation of implicit and explicit techniques of integration, some participants used methods that could be considered towards the explicitly religious end of the spectrum. Examples of this were practices that incorporated a specifically religious aspect, such as referring on to religious leaders or religious therapists, disclosing faith for engagement and

discussing scripture interpretations. However, these practices were infrequent. This is consistent with findings that techniques which are specifically religious in content are less likely to be used by psychologists and therapists (Shafranske & Gorsuch, 1984; Shafranske & Malony, 1990b). In comparison, the ***consensus in approach*** sub-category illustrates the frequent use of generic psychological techniques and principles to help engagement and to create a safe environment in therapy.

Although many of the participants discussed interacting with religious themes in order to reduce distress, fewer participants discussed examples of exploring religious themes and concepts at a general level to enhance mental health. As mentioned above however, religion can be very important in meaning making and can be an important resource in coping for clients with psychosis (Mohr, et al.2007; Sullivan, 1993). Therefore, the level of *exploring* general concerns and religious concepts could actually help to consolidate a useful coping mechanism.

The level of *Analysing* corresponded to the use of formulation, which is a general requirement in clinical psychology training and practice. *Analysing* sought to make connections between the religious themes and the client's past and present history. Previous research indicates however, that some clients fear that their religious beliefs will be dissected and rationalised (Suarez, 2005) which could potentially be perceived to occur if clinical psychologists are clumsily engaged in *analysing*.

Exploring occasionally involved referring the client on to a religious leader, or to a religious psychologist, to facilitate exploration within the client's frame of reference. This type of facilitated *exploring* was infrequent as also suggested in a review of studies concerned with referrals to religious professionals (Worthington et al. 1996). On the contrary, this seems to be the level of interaction that could best suit highly religious clients and those *searching for meaning* and this approach may also be less threatening than *analysing* and *challenging*. The level of *challenging* is consonant with the current psychosis evidence base, which advocates CBT as a method of *challenging* distorted beliefs (Division of Clinical Psychology, 2000).

4.5. Key findings and recommendations

This study has contributed an understanding of some of the religious themes that emerge in psychosis specialties, and of the potential difficulties that may be encountered in working with them. For example, the *impermeability of a higher power* highlights that the power to which the source of voices and hallucinations is attributed can be an important factor in how receptive clients are to *challenging* the relationship they have with their voices. Therefore, therapy that is focused on reducing distress may struggle if the client attributes the origins of their voices to a belief in a higher power, such as God or the devil - which is unrivalled by anything else. This can leave psychologists *feeling challenged* and deskilled, especially if they do not have an adequate grasp of the religious themes and beliefs of the client.

Although participants interacted with religious themes at different levels as mentioned above, the most commonly cited level of interaction discussed was at the level of *challenging*. This implies that participants were simply more familiar with this level of interaction, or that these examples were the most striking for participants when asked about religious themes that they had worked with. The most common reason for interacting at the level of *challenging* seemed to be the therapeutic goal of reducing distress.

If the indication that participants are most likely to work with religious themes at the level of *challenging* is correct, this finding suggests that clinical psychologists may have a tendency to work with religious themes in relation to psychopathology. Conversely, it is suggested that many clients with a diagnosis of schizophrenia hold religious themes as an area of importance often not related to delusional content (Huguelet, et al. 2006; Mohr, et al., 2007). Further, *exploring* existential themes and processes of constructing meaning within the client's religious framework may be important in capturing the context of the client's distress. This could help clients to utilise their religious framework as a resource in coping (Koenig, McCullough, & Larson, 2001). This implies that the level of *exploring* may be just as important if clients' needs are to be more fully addressed. A study looking at clients' experiences of receiving spiritually integrated therapy has also hinted that some clients found Cognitive Behavioural Therapy too pragmatic and psychoanalytic approaches too antagonistic to their beliefs, but they did not mind existential or transpersonal approaches (Suarez, 2005). In light of this, it may be useful for clinical psychologists to

consider the use of therapeutic models that are more exploratory in nature or that could draw more readily on the religious or spiritual resources of the client. Examples might include solution focused, existential and transpersonal approaches. This would encourage a move away from a problem focused style, which could potentially focus on pathology and miss other issues related to meaning-making or the usefulness of religious resources in coping.

The above is also important to consider as some clients may benefit from explicit discussions on how they could draw on their religious coping strategies effectively with their clinical psychologist. Such clients may not be satisfied with receiving guidance from their religious community alone, which could also be problematic for those who do not have a good relationship with their religious community. This is important to reflect on as research suggests that clients would prefer more integrated care concerning their mental wellbeing and spirituality (Little & Baker, 2007; Quackenbos, Privette & Klent, 1985; Quackenbos, Privette, & Klent, 1986; Wyatt & Johnson, 1990).

In the process of unpicking cases it was identified that the presence of cultural factors could add complexity in understanding religious themes. Further struggles were evident in the process of **UNRAVELLING** along with a possible lack of competence in the area. The above can lead to a possibility of misunderstandings in the process of *distinguishing delusions,* where minority groups' beliefs could be misunderstood for psychopathology. This is relevant as one of the factors in identifying a delusion is that the belief should be culturally unacceptable (Morrison, 2001). However psychologists

may not be adequately informed through training about cultural factors, and may not be adequately aware of sub-groups within minority cultural groups. For example, it is common for Pakistani families to ascribe negative events such as mental health problems, to black magic and curses (Karim, Saeed, Rana, Mubbashar, & Jenkins, 2004; Malik, 2000). This explanation could easily be understood in a Western mental health setting as a delusional belief. This danger is further confounded by the Western context of training and an increasingly secular society which influences assumed norms. It is important that psychologists have a good understanding of cultures in order to determine whether or not religious beliefs are culturally acceptable. There is a danger that areas of importance for others could be overlooked if not part of the dominant Western Middle Class culture which characterises the profession. At times, this can misrepresent the increasingly diverse population of Britain. Current topics in the media, such as religion and terrorism, and the irrationality of religion as deemed by Dawkin's (2006) latest 'God delusion' discourse, are strong messages to which psychologists are also exposed. This further highlights the importance of psychologists being aware of their assumptions and how these cultural discourses may influence them, or how they may impact upon clients with strong religious beliefs. Thus, an improved system of training and professional practice is important in order to increase competence in gaining awareness of cultural contexts. This study indicates that teams are not always equipped to support this and that psychologists approach other people or learn individually in different ways. A more organised and systematic approach within teams may be more efficient and would allow consistency in building cultural competence to serve clients.

Finally, it is clear that clinical psychologists need to be reflecting more in order to facilitate **UNRAVELLING**. However, an important requirement for this would be to nurture a reflecting culture regarding religious themes. It is of note that issues relating to respect, competence and reflective practice in working with difference are general principles that have been rehearsed in the British Psychological Society's code of ethics and conduct (e.g. The British Psychological Society, 2006). These are general principles that form part of the foundation of clinical psychology practice. However they appear to be applied with difficulty in relation to working with religious or spiritual issues in the context of this study. It is important to reflect upon, therefore, what exactly constitutes the difficulty in applying these principles to this topic area. It seems that this topic area would benefit from being included more specifically as a diversity domain along with other areas of diversity such as gender, race, culture and sexuality. Inclusion within training, supervision and reflective practice should also be accommodated and integrated as a regular item. Specific inclusion may help to prevent religious and spiritual issues from being routinely overlooked. Additionally, as this topic area relates to existential concerns, such as the meaning of life and ideas about what occurs after death, it is important that psychologists are offered a safe reflecting space within which to discuss this. It is advocated that clinical psychologists should also aim to understand their own personal relationship to these ideas. The above may help to unravel, in part, where some of the difficulty with this subject matter may be arising.

4. 6. Conclusion

This study is an important contribution to the development of specialty specific literature that has been advocated (Smiley, 2001). The study has highlighted a model of working with religious themes that includes a dynamic process of interaction at varying levels. This model has been developed through an exploration of the views and practice of clinical psychologists and has been used in offering a theory of clinical practice. The consensus approach is primarily concerned with engagement, developing trust and enabling the client to feel heard; whereas ***differing levels of interaction*** takes the therapy to another level in which the clinical psychologist can start to facilitate a process that involves reframing and the developing of ideas. The therapist is facilitating the client in *exploring*, *analysing* and *challenging*. However, a careful balance is important between allowing the client to feel heard and respected alongside a delicate process helping the client explore, analyse and challenge. It is recommended that the degree to which these levels are indulged could be informed by a careful holistic assessment and agreed goals. The use of reflexivity and supervision can help to unravel and monitor that the appropriateness of concentrating on one area, such as *challenging*, is not at the expense of neglecting other areas that could also be important for the client. This research has also highlighted that in order for religious themes to be addressed effectively it is important that the issue of ***limited guidance*** is addressed by the profession to guide clinical psychologists – especially those who offer supervision.

4.7. Methodological critique and research limitations

The findings represent a good level of conceptual density and are a useful contribution to the field of working with religious themes and psychosis. However it is also important to consider the factors that influenced the research. For example, the results were influenced by the interview context in which a trainee was questioning qualified psychologists about their clinical work. This context would have influenced what was felt safe to share, especially as the researcher was also from an ethnic minority background and could have been perceived in an expert role[10]. The researcher's Islamic dress also provides insight into her position on faith, which could have influenced participants in terms of them feeling that they could not share negative views on the topic, or believing they would be judged negatively if they portrayed themselves as unknowledgeable on the subject. It was important for reflexivity to be present throughout the research and this was achieved through the use of a reflexive journal, regular academic and peer supervision as well as attendance at a qualitative support group.

The study was conducted within a tight time frame and therefore yielded a small sample of participants. However the recruitment of participants from different teams and regions across the Midlands allowed perspectives from participants in different contexts, and thus findings may be more transferable. Theoretical sampling was used in this study. However further theoretical sampling and deviant case analysis would have

[10] See critical appraisal for more discussion.

been beneficial in considering further perspectives, such as from psychologists who have no interest in this topic area.

4.8. Future research

A parallel study has been undertaken focusing on carers (Longbotham, 2007) of people with psychosis and their use of religious or spiritual coping. It would be interesting to compare findings to elucidate the needs and experiences of carers in relation to the current study. It may also be useful to extend this research to elaborate on the factors that may contribute to the experience of ***hard work.*** Research could also focus on Black Minority Ethnic clinical psychologists' experiences of working with religion in psychosis, in order to investigate if they draw on different spiritual models. The current findings suggest that ***differing levels of interaction*** may correspond to the three dominant models taught in clinical psychology training e.g. Systemic, Psychoanalytic and Cognitive Behavioural Therapy. It would be interesting for future studies to compare clinical psychologists with psychologists and therapists from other training programmes, e.g. counselling psychology, to further investigate the link between psychological models and what leads psychologists to feel encouraged to work with religious themes. Another area of research could involve investigating the views of religious leaders about how they would perceive a formalised integration process with mental health services for people experiencing psychosis. If a formal collaboration was being sought by the profession, this could instill confidence amongst psychologists.

5) References

Baker, M. & Wang, M. (2004). Examining connections between values and practice in religiously committed U.K. clinical psychologists. *Journal of Psychology and Theology, 32*(2), 126-136.

Bergin, A. (1980). Behaviour therapy and ethical relativism: time for clarity. *Journal of Consulting and Clinical Psychology, 48*, 11-13.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis.* London: SAGE Publications.

Clarke, I. (2001). Psychosis and spirituality: The discontinuity model. In I. Clarke. (Ed). *Psychosis and spirituality: Exploring the new frontier.* (pp.191-207). London: Whurr.

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*, 295-313.

Davies, M. F., Griffin, M. & Vice, S. (2001). Affective reactions to auditory hallucinations in psychotic, evangelical and control groups. *British Journal of Clinical Psychology, 40,* 361-370.

Dawkins, R. (2006). *The God delusion.* London: Bantam Press.

Department of Health (2003). *'Inside Outside': Improving Mental Health Services for Black and Minority Ethnic Communities in England.* London: Stationary Office.

Department of Health (2005). *Delivering race equality in mental health care, an action plan for reform inside and outside services; and an independent inquiry into the death of David Bennett.* London: The Stationary Office.

Division of Clinical Psychology. (1995). *Professional practice guidelines.* Leicester: British Psychological Society.

Division of Clinical Psychology. (2000). *Recent advances in understanding mental illness and psychotic experiences.* Leicester: British Psychological Society.

Drinnan, A. & Lavender, T. (2006) Deconstructing delusions: A qualitative study examining the relationship between religious beliefs and religious delusions. *Mental Health, Religion & Culture, 9*(4), 317-331.

Elam, J. (2000). Psychosis and spirituality – exploring the new frontier. Conference report. Unpublished manuscript. Retrieved 7th May 2007 from http://www.psyspiritstory.co.uk/report2000.htm

Ensworth, H.M. (1984). A phenomenological and content analysis of religious ideation among schizophrenics. *Dissertation Abstracts International, 44*(8-B), 2553.

Getz, G.E., Fleck, D.E. & Strakowski, S.M. (2001). Frequency and severity of religious delusions in Christian patients with psychosis. *Psychiatry Research, 103,* 87-91.

Golsworthy, R. & Coyle, A. (2001). Practitioners' accounts of religious and spiritual dimensions in bereavement therapy. *Counselling Psychology Quarterly, 14*(3), 183-202.

Hathaway, W.L., Scott, S.Y. & Garver, S.A. (2004). Assessing religious/ spiritual functioning: A neglected domain in clinical practice? *Professional Psychology: Research and Practice, 35*(1), 97-104.

Huguelet, P., Mohr, S., Borras, L., Gillieron, C. & Brandt, P-Y. (2006). Spirituality and religious practices among outpatients with schizophrenia and their clinicians. *Psychiatric Services. 57(*3), 366-372.

Jackson, M.C. & Fulford, K.W.M. (1997). Spiritual experience and psychopathology. *Philosophy, Psychiatry and Psychology, 1,* 41-65.

Jones, S. & Wilcox, B. (1993). Religious values in secular theories of psychotherapy. In E. Worthington (Ed.). *Psychotherapy and religious values* (pp.101-117). Grand Rapids: Baker.

Karim, S., Saeed, K., Rana, M.H., Mubbashar, M.H. & Jenkins, R. (2004). Pakistan mental health country profile. *International review of Psychiatry, 16* (1-2), 83-92.

Kelly, T. & Strupp, H. (1992). Patient and therapist values in psychotherapy: perceived changes, assimilation, similarity, and outcome. *Journal of Consulting and Clinical Psychology, 60*, 34-40.

Koenig, H.G., McCullough, M.E. & Larson, D.B. (2001). *Handbook of Religion and Health.* New York: Oxford University Press.

Lambert, M.J. (Ed.). (2004). *Bergin and Garfield's handbook of psychotherapy and behaviour change.* Hoboken, NJ: Wiley.

Lewis, K. & Lewis, D. (1985). Impact of religious affiliation on therapists' judgements of patients. *Journal of Consulting and Clinical Psychology, 53*, 926-932.

Little, J. & Baker, M. (2007, March). *'Understanding my mental health problem': How religious service-users experienced the views of their local faith community, and those of the NHS mental health staff caring for them.* Unpublished paper presented at the

British Association of Christians in Psychology (BACIP) 17th Annual Conference, St Albans, UK.

Longbotham, S. (2007, March). *An exploration of how carers of people with a diagnosis of psychosis interact with their religious beliefs and communities in relation to coping with their role as a carer.* Unpublished paper presented at the British Association of Christians in Psychology (BACIP) 17th Annual Conference, St Albans, UK.

MacCarthy, B. (1998). Clinical work with ethnic minorities. In Watts, F. (Ed.). *New Developments in Clinical Psychology.* (Vol. 11, pp. 122-139). Chichester: John Wiley and Sons.

Madill, A., Jordan, A. & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies. *British Journal of Psychology, 91*, 1-20.

Malik, R. (2000). Culture and emotions: Depression among Pakistanis. In: C.Squire (Ed.), *Culture in Psychology.* (pp147-162). London: Routledge.

McCabe, R. and Priebe, S. (2004). Explanatory models of illness in schizophrenia: Comparison of four ethnic groups. *The British Journal of Psychiatry, 185*, 25-30.

Mohr, S., Gillieron, C., Borras, L., Brandt, P-Y. & Huguelet, P. (2007). The assessment of spirituality and religiousness in schizophrenia. *Journal of Nervous and Mental Disease. 195*(3), 247-253.

Morrison, A. P. (2001). The interpretation of intrusions in psychosis: An integrative cognitive approach to hallucinations and delusions. *Behavioural and Cognitive Psychotherapy, 29*, 257-276.

National Institute of Mental Health in England. (2003). *Inspiring hope: Recognising the importance of spirituality in a whole person approach to mental health.* London office: Mental health stationary.

Peters, E., Day, S., McKenna, J. & Orbach, G. (1999). Delusional ideation in religious and psychotic populations. *British Journal of Clinical Psychology, 38*, 83-96.

Quackenbos, S., Privette, G. & Klent, B (1985). Psychotherapy: Sacred or secular? *Journal of Counseling and Development, 63*, 290-293.

Quackenbos, S., Privette, G. & Klent, B (1986). Psychotherapy and religion: rapproachment or antithesis? *Journal of Counseling and Development, 65,* 82-85.

Richards, P. & Bergin, A. (1997). *A spiritual strategy for counselling and psychotherapy.* Washington: American Psychological Association.

Shafranske, E. & Malony, H. (1990a). California Psychologists' religiosity and psychotherapy. *Journal of Religion and Health, 29*, 219-231.

Shafranske, E. & Malony, H. (1990b). Clinical Psychologists' religious and spiritual orientations and their practice of psychotherapy. *Psychotherapy, 27*, 72-78.

Shafranske, E., & Gorsuch, R. (1984). Factors associated with the perception of spirituality in psychotherapy. *Journal of Transpersonal Psychology, 16*, 231-41.

Sheridon, M. J., Bullis, R. K., Adcock, C. R., Berlin, S. D. & Miller, P.C. (1992). Practioners' personal and professional attitudes and behaviours toward religion and spirituality: Issues for education and practice. *Journal of Social Work Education, 28*,190 –203.

Siddle, R., Haddock, G., Tarrier, N. & Faragher, E.B. (2002). Religious delusions in patients admitted to hospital with schizophrenia. *Social Psychiatry and Psychiatric Epidemiology, 37* (3), 130-138.

Siddle, R., Haddock, G., Tarrier, N. & Faragher, E.B. (2004). Religious beliefs and religious delusions: Response to treatment in schizophrenia. *Mental Health, Religion & Culture, 7* (3), 211-223.

Smiley, T. (2000). *Non-religious psychologists talking: What happens when a psychologist who is not committed to any religion encounters religious beliefs from clients?* Unpublished doctoral coursework, University of Surrey, UK.

Smiley, T. (2001). *Clinical psychology and religion: A survey of the attitudes and practices of clinical psychologists in south east England.* Unpublished doctoral thesis, University of Surrey, UK.

Stompe, T., Bauer, S., Ortwein-Swoboda, G., Schanda, H. & Karakula, H. (2006). Delusions of guilt: The attitude of Christian and Muslim Schizophrenic patients toward good and evil and the responsibility of men. *Journal of Muslim Mental Health, 1,* 43-56.

Strauss, A. & Corbin, J. (1994). Grounded theory methodology: An overview. In N.K. Denzin, & Y. S. Lincoln, (Eds). *Handbook of qualitative research.* (pp. 273-285). London: SAGE Publications.

Strauss, A. & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (2nd edn). London: SAGE Publications.

Suarez, V.B. (2005). *A portfolio of academic, therapeutic practice and research work including an investigation of psychotherapists' and clients' accounts of the integration*

of spirituality into psychotherapeutic practice. Unpublished doctoral thesis, University of Surrey, UK.

Sullivan, W.P. (1993). 'It helps me to be a whole person': The role of spirituality among the mentally challenged. *Psychosocial Rehabilitation Journal, 16,* 125-134.

Tan, S. (1996). Religion in clinical practice: implicit and explicit integration. In E.P. Shafranske (Ed.). *Religion and the clinical practice of psychology* (pp.365-387). Washington: American Psychological Association.

The British Psychological Society. (2006). *Code of ethics and conduct.* Leicester: British Psychological Society.

Turpin, G., Barley, V., Beail, N., Saige, J., Slade, P. & Walsh, S. (1997). Standards for research projects and theses involving qualitative methods: Suggested guidelines for trainees and courses. *Clinical Psychology Forum, 108*, 3-7.

Walsh, J. (1995). The impact of schizophrenia on clients' religious beliefs: Implications for families. *Families in Society: The Journal of Contemporary Human Services. 76*(9), 551-558.

Worthington, E., Kurusu, T., McCullough, M. & Sandage, S. (1996). Emprical research on religion and psychotherapeutic processes and outcomes: A 10-year review and research prospectus. *Psychological Bulletin, 119,* 448-487.

Wyatt, D. & Johnson, R. (1990). The influence of counsellor's values on clients' perceptions of the counsellor. *Journal of Psychology & Theology, 18*, 158-65.

Yarhouse, M.A. & Fisher, W. (2002). Levels of training to address religion in clinical practice. *Psychotherapy: Theory, Research, Practice and Training, 39*(2), 171-176.

SECTION C: Critical Appraisal

This section details my reflections on the research process taken from entries in my reflexive journal, notes from supervision and memos from interviews. It explores the reasons why I became interested in this topic area and the influence of my own beliefs. This discussion includes how the research was planned, what it was like to do qualitative research, reflections on recruiting participants and on conducting the analysis. Issues of confidentiality and the experience of interviewing clinical psychologists are also reflected on, along with learning points gained from this research.

1) Origins and Planning

This research area appealed to me for several reasons. Firstly, I perceived that there had not been sufficient research concerning the intricacies of what occurs in practice when therapists work with religious themes. I was very curious about this and I felt that I wanted to give to clinical psychologists an explicit opportunity to share what they do in practice concerning this research question. This felt important as other studies had indicated that religious themes are a neglected domain (e.g. Hathaway, Scott & Garver, 2004). I wanted to provide an opportunity for clinical psychologists to respond to this or at least to provide insight into the complexity of why it may be a neglected area if I found this to be the case.

On a personal level this topic area has been intriguing to me because of my own dilemmas about how to work with religious themes in practice. I have also been aware of the informal debates via internet mental health forums that have started to develop amongst Muslim mental health workers and therapists, such as in America, Australia and the UK. These debates have included topics such as whether Islam should be interpreted from a Western psychological perspective and developed into a useable psychological model for Muslim clients living in secular societies. The alternate view is that such a process would degrade the work of theologians who have taken Islam as a holistic system of beliefs and practice, which does not need to be re-interpreted by a secular and Western perspective. These issues have sparked an interest in me regarding how clinical psychologists in the NHS actually work with religious themes, especially when working with clients from minority ethnic backgrounds. I became interested and eager to hear how issues might emerge in the therapeutic encounter and the possible ways of working with them that would be accepted and respected in an NHS setting. I became interested to investigate this specifically in the specialty concerned with psychosis as I felt that clinical psychologists were certain to come across religious themes when working with delusions, and that this would be rich material to draw on in the analysis. My experience in reviewing the literature also highlighted that although psychosis and religion has been studied in the context of religious delusions (e.g. Drinnan & Lavender, 2006; Peters, Day, McKenna & Orbach, 1999), a gap was apparent in addressing the topic area from the perspective of other types of religious themes.

I have also become aware that I have received different reactions from my colleagues, supervisors and fellow trainees concerning the importance I attach to this area of diversity. This experience has generally been one of acknowledgement that it is an important area for practice, however often the discourse would not venture beyond this, for example in my experience of clinical supervision. This left me feeling frustrated at times. It increased my desire to research this area in order to add to the literature in a meaningful way and to substantiate that this is a legitimate area of importance for clinical practice. I was unsure about whether my research interest would be supported, however I was pleased to find a supervisor who was interested in the area and who agreed to supervise me.

My personal spirituality has influenced this choice of topic. I am a practising Muslim woman from a working class Pakistani family. I grew up adopting many Western and secular views in the way I lived my life. My belief in God and the existence of an afterlife were important, but felt disconnected from the way in which I was living my life. I attempted to integrate my religious and spiritual views and experienced changes in my spirituality throughout adolescence and adulthood as a consequence. At times I felt I was quite religious, and other times I felt I was more disillusioned. Along with my personal experience, I was also aware of the experiences of others within the Pakistani and Muslim community who were also struggling to make sense of their beliefs within the secular society in which they lived. I noticed throughout this spiritual journey that I, and others, did not have an appropriate outlet for our concerns. Different avenues were tried but quickly rejected due to a lack of

middle ground. My parents, for example, carried the values of their traditional village life in Pakistan, whilst school teachers and work colleagues held secular views. Although cultural differences were inherent in this search for peace, the nature of the search that I and my peers were experiencing related broadly to existential matters, captured by the notion of religious faith. These early experiences increased the significance of this topic area for me. I was aware that I hoped to be able to offer something to communities who may benefit from acknowledgement of the challenge of aligning secular and spiritual values, and the impact that this can have on mental well-being.

2) Qualitative Methodology

Grounded Theory (GT) was a methodology that seemed well suited to my research question as my research topic involved exploration of views about how a phenomenon is worked with. In this case the phenomenon in question was the presence of religious themes in the therapeutic encounter. I felt GT had a strength which was that the researcher would be able to develop a theory and model from the interview data. I felt that this approach would, therefore, allow communication of findings in a creative way. The development of a model could also potentially move the research a step forward in that it could inspire further research and discussion on practical issues of therapy in this area. Thus, GT was utilized in the research, informed by a critical realist epistemological position. Critical realism centres itself between a pure 'realist' position and a social constructionist standpoint. This is because it acknowledges the interplay of values, expectations and experiences of the participant and researcher, yet

it also considers that 'real' experiences are being shared (Madill, Hordan & Shirley, 2000). This also seemed to complement my personal perspective of a 'reality', but that our experiences, expectations and beliefs have an influence on what we perceive.

Applying GT was not as straight forward as I had imagined it to be as I quickly found myself immersed in data. I struggled at times to cope with the numerous possible avenues that I could take with the data. The generation of a theory felt like a daunting task and far from reach in the beginning stages of the research process. Regular supervision and a 'breathing' space at frequent intervals between interviews helped me to feel in control of the process.

3) Participants and Recruitment

I was surprised by the number of clinical psychologists who opted into the study across the three Trusts. I received a total of fourteen responses opting into the study. I was disappointed that I was unable to interview all fourteen participants but as the research process went on, it became apparent that it was a very time consuming process. Transcribing and analysing additional interviews would have compromised the time for writing up the research. I also received interest from a counselling psychologist who was eager to take part in the study. I was not able to pursue this due to the ethical approval procedures that would have needed to be revised. This led me to realise that theoretical sampling could have potentially involved looking at training differences, which could have added an additional perspective to enrich the model.

I was pleased that my participant sample reflected a variety of experience, a range of years in practice, an equal gender balance and a broad age range. The main difficulty in recruitment was in obtaining participants from minority ethnic backgrounds, reflecting the low number of individuals from minority ethnic backgrounds within this profession. The participants held a broad spectrum of beliefs including those who were atheist and agnostic, to those who identified with Christianity but were not practising religious activities, and finally those who strongly identified with Christian beliefs and practices.

4) Interviewing Clinical Psychologists

Initially I allowed 60 minutes for the interviews, but this felt rushed and so I allowed more flexibility with the timing of subsequent interviews which lasted between 60-90 minutes. To begin with I noticed that I was following the interview guide closely, which at times felt constraining. As I became more familiar with the guide I felt more comfortable to move away from it and I started to focus on participants' examples of case material rather than on questions structured around the phases of intervention. This felt easier for participants and these interviews seemed to flow better.

Some of the participants struggled to think of case material and spoke hypothetically about how they would work with religious themes in psychosis. However other participants had spent time before the interview considering what to discuss and had specific examples in mind. One participant brought some notes she had made to the interview and went through case examples she had jotted down in

preparation for the interview. This interested me and made me think about what may have led some to prepare for the interview whilst others did not. Although I was initially touched that such efforts were made I also wondered if some participants were anxious about being asked about their practice.

It became apparent from the first stage of interviewing that some interviews felt more comfortable than others. This was something I reflected on with my supervisor, at the qualitative support group and with a fellow trainee in peer supervision. I was very conscious of the assumptions that participants may have held about me and I felt an urge to reassure them. On reflection some interviews may have felt uncomfortable for me due to non verbal signals, which I interpreted as signs that the participant was feeling uncomfortable. For example, there were some silences, blank facial expressions and deep breaths, which were not captured in the transcripts as is appropriate with GT methodology. I tried to unravel what was creating the uncomfortable atmosphere for me, and possibly for the participant in some interviews. I wondered if it was my colour, my hijab - headscarf and long dress, the topic area or transference issues relating to how I experience gender roles. Eventually I concluded that it could be a combination of all these factors. I was aware that this discomfort did not occur in other interviews, which made me wonder about the impact of the participant's confidence on the subject, their anxieties about what the interview could lead to, or their uncertainty about their own views. I was aware that at times I would hesitate during questioning in the interview because I did not want the participant to feel awkward and I began to feel apologetic for digging deep with my questions. I discussed this in supervision and

decided I would try to spend more time explaining the purpose of the research and my role prior to the interview in the hope that this would help to allay any anxieties.

Interviewer: *Just before we begin I just wanted to say that, erm, this is a new area for me as well. I haven't worked in psychosis before – I am just starting a placement and really this topic area is something I would really like to learn about from all your experience. And also that I'm aware that I am from a faith background as you can gauge from my dress, but I would really like to hope that this does not influence how open you feel you can be. I am really interested in your experiences and views on this area, so please don't hesitate to express your opinions. (8:3)*

However one participant verified some of my suspicions:

...It's quite threatening to be asked about this, but I think importantly so - I think if one didn't feel threatened there would be a problem because I certainly cant be complacent about this and I would hope others aren't. I certainly recognize that there are areas of practice in this arena which I could improve on, erm and that's difficult to confront, in a way because that then induces a degree of guilt that one hasn't done something about it already...I'd be interested in the reasons why people didn't volunteer for you, that would be another study ((laughs)) because I was aware that I hesitated. Part of the reason I hesitated was because I've got confused feelings about religion and because I suppose to be perfectly blunt - you're putting yourself on the line, and you could well be judged as not being good enough...This kind of felt like a role reversal - you know,

you're the expert - that's how I see it, I mean I'm probably wrong but that's how I see it - I see you as the expert and me as someone whose probably thought less and knows less on this particular topic - so its a role reversal and one may or may not feel – there's degrees of discomfort that go with that. It's a discomfort that I obviously felt I could tolerate otherwise I wouldn't have engaged with it, but it would have been an easy thing to have avoided. (6:555)

This interview was a turning point for me. I felt that finally I could stop guessing about where the awkwardness was coming from. I became more explicitly aware of the potential 'role reversal' experience for participants who could be feeling tested like a trainee and the way in which the interview could feel deskilling for participants. I struggled to know how to respond to this and wondered how I could make it more comfortable for participants. However, I reached a point at which I accepted that I should just trust in the process and accept that I could only try and reassure participants at the start of the interview and use my listening skills throughout to adopt a sensitive and curious style of questioning. After all, there were many interviews that did not feel awkward and many participants were interested and keen to be informed of the findings of the study.

Before embarking on this research process I was unaware that the interviews would evoke a number of different feelings in me. I felt inspired from learning from the wealth of clinical experience of participants, and I felt humbled at participants' willingness to share, and there were even times when I felt attacked. For example, I can

recall an interview during which the participant suggested that religious psychologists needed to be particularly aware of their agendas in clinical work with clients. This felt like a personal attack on me as a Muslim psychologist researching this topic area. I interpreted it as an accusation that I was trying to convert clients and I used my reflexive journal to work through and manage the feelings, which I promptly discussed in supervision.

Participant: *...be sure not to become some kind of crusader in some way - sort of banner carrier for whatever cause, be that religion or not.*

Interviewer: *Are you referring to a clinical psychologist who might have a personal faith system?*

Participant: *Yeah, yes I am (.) It should not be used for, I mean the psychologists should not use it as an opportunity to talk about their own religious views and we should not be imposing our own views onto our clients. (8:588)*

5) Approaches to Interviews and Confidentiality

Confidentiality was vital as clinical psychologists within a shared specialty could have been familiar with each other across the country through sharing practice, regional and national meetings or forums and conferences. Equally, specific departments and their psychologists could be identifiable as teams usually have low numbers of psychologists. Every effort was made to keep transcripts anonymous and to omit or alter identifiable information. I also became aware that some participants may have chosen to disclose their participation in the study to colleagues in their teams. They

may have discussed the process, which could have influenced the ideas shared by participants who were interviewed at a later date.

6) The Reflective Process

Throughout the long journey of the research I felt that I was also involved in a process of **UNRAVELLING** like the participants of this study. I experienced this at many levels; the research findings slowly coming together into a theory from a collection of codes, the development of my understanding of the process issues within the interviews where I sensed an awkward atmosphere, and finally in my understanding of how to approach work with clients I was working with on placement. As all of these involved religion and psychosis there was no surprise, on reflection, that actually I would also be engaged in **UNRAVELLING** as the researcher!

As well as reflections on my own **UNRAVELLING**, my reflexive journal was used to document and to reflect upon my assumptions, for example the possibility that this area would not be valued by potential participants. Indeed my assumptions were challenged as I interviewed an atheist who felt it was an important area to address and who supervised a chaplain, compared to a participant with faith beliefs who was more cautious in his approach. I tried to make sense of how and why this was, and developed a view that it was not as simple as having a faith and therefore feeling encouraged. There was a complex interplay of many factors, not just about having a personal faith, although this factor was an important one.

Interestingly I noticed how people around me also held assumptions about this topic area. I recall an incident where I brought a transcript extract along to a qualitative support group for coding only to find the group split in their reflections and codes. Half of the group was negative and critical of the transcript and I noticed that others in the group were less forthcoming with their codes. This was until I shared that in the interview I did not feel that the participant was being dismissive of religious themes. At this point others shared their codes and other interpretations were shared and the group members who offered their negative interpretations reflected on the assumptions that they had made. A useful discussion followed about the role of interpretation and the importance of reflexivity. I felt quite shocked at the time as I did not anticipate such a split in views, and I wondered if this reflected a split of feelings and opinions on this area within the profession. This incident certainly highlighted the different feelings that could be evoked by the topic area and how this could bias interpretations made.

This incident prompted me to check my own assumptions such as those from my personal experience of spirituality being infrequently considered in clinical work on placements. This was reflected on in supervision which helped me to re-evaluate codes to ensure that they did not depart from the transcript. I purposely brought such transcripts to supervision to allow a discussion of my own assumptions in order to recode extracts whilst understanding my own position better in terms of how I may be inclined to interpret participants' comments.

Further, I was aware that my own biases would have influenced my interest in some themes more than others, and I may have unwittingly glossed over some themes. However I used certain methods to try and manage this and create suitable credibility of my findings. As well as the steps taken that I have described above, I used a set of self-reflection questions after interviews and my reflexive journal regularly to monitor assumptions, ideas and feelings on the research. I also provided quotes from transcripts for readers to consider along with the final model. This was used in order for the findings to be grounded in examples (Elliott, Rischer & Rennie, 1999) and, to an extent, allow readers to judge credibility of the findings for themselves. I discussed ideas within academic supervision, peer supervision and a qualitative support group to obtain others perspectives on extracts and to obtain feedback on the developing model. Two independent clinical psychologists also provided feedback on the final model. This helped me to be aware of my perspective and of areas that I may not have fully considered previously.

7) Analysis and Writing Up

I found the process of writing up challenging due to the short word limit. A substantial number of supporting quotes could not be inserted into the results section, and were referenced in the appendices instead. This was frustrating but reflected the future process of writing up my research for publication, which I am keen to pursue, where short word limits are usual. I felt anxious that I may not be able to represent all participants' perspectives fully in my write up. These issues were discussed in supervision and I was able to appreciate that the findings were my account and that

other interpretations are possible, as long as they suitably represent and account for the data.

The development of the theory was a long process involving many revisions of the diagrams and drafts of writing. The initial model consisted of four main categories. Later one of the main categories formed the core category, which was later dropped as a separate category and dispersed within the remaining three main categories instead. The concept of **UNRAVELLING** was taken as the core category from being a main category. Through supervision and further analysis, there were indications that this process was an overarching theme that was relevant to all the main categories. Initially I felt that this was a *never ending* process and that I could spend *my whole life* revising the model, therefore reaching a stage at which I felt satisfied with the model was very gratifying.

8) Conclusion and Learning Points

I enjoyed conducting this research, something that I did not expect to feel after such a long process, and I am keen to follow up this research area, given the opportunity. I have found this research both satisfying and personally enriching. I feel I have gained a wealth of knowledge from talking to clinical psychologists about a very important subject. I have learned a lot and developed my ideas, and feel I have a greater appreciation of the complex interplay of models, training and personal experiences that can impact upon how clinical psychologists approach this area of work.

I hope to disseminate my findings to participants and to present the findings at a regional psychosis special interest group meeting in the Midlands later this summer. I also hope to publish the findings in order to contribute to the literature base in this area.

9) REFERENCES

Drinnan, A., Lavender, T. (2006) Deconstructing delusions: A qualitative study examining the relationship between religious beliefs and religious delusions. *Mental Health, Religion & Culture, 9*(4), 317-331.

Elliott, R., Rischer, C.T. & Rennie, D.L. (1999). Evolving guidelines for the publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology, 38,* 215-229.

Hathaway, W.L., Scott, S.Y., & Garver, S.A. (2004). Assessing religious/ spiritual functioning: A neglected domain in clinical practice? *Professional Psychology: Research and Practice, 35*(1), 97-104.

Madill, A., Jordan, A. & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies. *British Journal of Psychology, 91*, 1-20.

Peters, E., Day, S., McKenna, J. & Orbach, G. (1999). Delusional ideation in religious and psychotic populations. *British Journal of Clinical Psychology, 38*, 83-96.

SECTION D: Appendices

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Appendix A: Publishing guidelines for the British Journal of Clinical Psychology

Notes for Contributors

The British Journal of Clinical Psychology publishes original contributions to scientific knowledge in clinical psychology. This includes descriptive comparisons, as well as studies of the assessment, aetiology and treatment of people with a wide range of psychological problems in all age groups and settings. The level of analysis of studies ranges from biological influences on individual behaviour through to studies of psychological interventions and treatments on individuals, dyads, families and groups, to investigations of the relationships between explicitly social and psychological levels of analysis.

The following types of paper are invited:

- Papers reporting original empirical investigations;
- Theoretical papers, provided that these are sufficiently related to the empirical data;
- Review articles which need not be exhaustive but which should give an interpretation of the state of the research in a given field and, where appropriate, identify its clinical implications;
- Brief reports and comments.

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length

Papers should normally be no more than 5,000 words, although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.

3. Reviewing

The journal operates a policy of anonymous peer review. Papers will normally be scrutinised and commented on by at least two independent expert referees (in addition to the Editor) although the Editor may process a paper at his or her discretion. The referees will not be aware of the identity of the author. All information about authorship including personal acknowledgements and institutional affiliations should be confined to the title page (and the text should be free of such clues as identifiable self-citations e.g. 'In our earlier work...').

4. Online submission process

1) All manuscripts must be submitted online at http://bjcp.edmgr.com .

First-time users: click the REGISTER button from the menu and enter in your details as instructed. On successful registration, an email will be sent informing you of your user name and password. Please keep this email for future reference and proceed to LOGIN. (You do not need to re-register if your status changes e.g. author, reviewer or editor).
Registered users: click the LOGIN button from the menu and enter your user name and password for immediate access. Click 'Author Login'.

2) Follow the step-by-step instructions to submit your manuscript.

3) The submission must include the following as separate files:
- Title page consisting of manuscript title, authors' full names and affiliations, name and address for corresponding author -
- Abstract
- Full manuscript omitting authors' names and affiliations. Figures and tables can be attached separately if necessary.

4) If you require further help in submitting your manuscript, please consult the Tutorial for Authors -
Authors can log on at any time to check the status of the manuscript.

5. Manuscript requirements

- Contributions must be typed in double spacing with wide margins. All sheets must be numbered.
- Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text.
- Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate page. The resolution of digital images must be at least 300 dpi.
- For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: Objectives, Design, Methods, results, Conclusions. Review articles should use these headings: Purpose, Methods, Results, Conclusions: British Journal of Clinical Psychology - Structured Abstracts Information
- For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full.
- SI units must be used for all measurements, rounded off to practical values if appropriate, with the Imperial equivalent in parentheses.
- In normal circumstances, effect size should be incorporated.
- Authors are requested to avoid the use of sexist language.
- Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations etc for which they do not own copyright.

For Guidelines on editorial style, please consult the *APA Publication Manual* published by the American Psychological Association, Washington DC, USA(http://www.apastyle.org).

6. Brief reports and comments

These allow publication of research studies and theoretical, critical or review comments with an essential contribution to make. They should be limited to 2000 words, including references. The abstract should not exceed 120 words and should be structured under these headings: Objective, Method, Results, Conclusions. There should be no more than one table or figure, which should only be included if it

conveys information more efficiently than the text. Title, author and name and address are not included in the word limit.

7. Publication ethics

Code of Conduct - Code of Conduct, Ethical Principles and Guidelines
Principles of Publishing - Principles of Publishing

8. Supplementary data

Supplementary data too extensive for publication may be deposited with the British Library Document Supply Centre. Such material includes numerical data, computer programs, fuller details of case studies and experimental techniques. The material should be submitted to the Editor together with the article, for simultaneous refereeing.

9. Post acceptance

PDF page proofs are sent to authors via email for correction of print but not for rewriting or the introduction of new material. Authors will be provided with a PDF file of their article prior to publication.

10. Copyright

To protect authors and journals against unauthorised reproduction of articles, The British Psychological Society requires copyright to be assigned to itself as publisher, on the express condition that authors may use their own material at any time without permission. On acceptance of a paper submitted to a journal, authors will be requested to sign an appropriate assignment of copyright form.

11. Checklist of requirements

- Abstract (100-200 words)
- Title page (include title, authors' names, affiliations, full contact details)
- Full article text (double-spaced with numbered pages and anonymised)
- References (APA style). Authors are responsible for bibliographic accuracy and must check every reference in the manuscript and proofread again in the page proofs.
- Tables, figures, captions placed at the end of the article or attached as separate files.

Appendix B: Ethical approval letter

Leicestershire, Northamptonshire & Rutland Research Ethics Committee 2
Research Ethics Office
Derwent Shared Services
Laurie House
Colyear Street
DERBY
DE1 1LJ
Telephone: 01332 868842
22 February 2006

Ms Rukhsana Ali
Trainee Clinical Psychologist
Leicestershire Partnership NHS Trust
School of Clinical Psychology
University of Leicester, 104 Regent Road
Leicester
LE1 7LT

Dear Ms Ali

Full title of study: **A qualitative study of how clinical psychologists address religious issues when working with clients experiencing psychosis.**
REC reference number: **06/Q2502/1**

Thank you for your letter of 15 February 2006, responding to the Committee's request for further information on the above research and submitting revised documentation.
The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion
On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites
The Committee has designated this study as exempt from site-specific assessment (SSA). There is no requirement for other Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Conditions of approval
The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents
The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Application	Version 5.0	12 December 2005
Investigator CV		12 December 2005
Protocol	V2 15.2.06	15 February 2006
Covering Letter		07 December 2005
Peer Review		26 September 2005
Interview Schedules/Topic Guides	Appendix A, Interview Schedule including prompts - Version 1(April 2005)	
Interview Schedules/Topic Guides	Appendix B, Interview Schedule Summary - Version 1(April 2005)	
Letter of invitation to participant	Appendix C - Version 1	16 April 2005
Participant Information Sheet	Appendix D Version 2	15 February 2006
Participant Consent Form	Appendix E - Version 1	16 April 2005
Response to Request for Further Information	Email dated 15.2.06	15 February 2006
Other	Appendix F, Diagram of Research Procedure (Flow Chart) - Version 1 (April 2005)	

Research governance approval
You should arrange for the R&D department at all relevant NHS care organisations to be notified that the research will be taking place, and provide a copy of the REC application, the protocol and this letter.
All researchers and research collaborators who will be participating in the research must obtain final research governance approval before commencing any research procedures. Where a substantive contract is not held with the

care organisation, it may be necessary for an honorary contract to be issued before approval for the research can be given.

Statement of compliance
The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

06/Q2502/1	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project
Yours sincerely

Chair

Email: sarah.gill@derwentsharedservices.nhs.uk

Appendix C: Participant information and consent form

University *of* Leicester

School of Psychology

Clinical Section

104 Regent Road
Leicester LE1 7LT · UK
Tel: + 44 (0) 116 223 1639
Fax: + 44 (0) 116 223 1650

A study looking at how clinical psychologists in psychosis services work with religious themes in therapy.

Purpose of the study.

There is little research looking at how clinical psychologists, or therapists in general, work with religious issues in the therapeutic context with clients experiencing psychosis. This is interesting as religious themes have been found to be prevalent in this client group. The purpose of this study is to investigate how clinical psychologists actually work with religious themes in the therapeutic context in order to disseminate good practice and highlight further research questions. It is envisaged that this study will contribute towards enhancing clinical practice in meeting individual needs in this important client group.

Participant involvement

Participation will involve a single semi-structured interview lasting 45-60 minutes which will be audio-taped and transcribed for analysis. Themes covered in the interview will involve:

-Practical examples of how participants address religious themes when they are both present prior to or occur after the onset of a psychotic episode.

-Examples will be discussed in relation to the different stages of therapy including assessment and intervention.

-Discussion will also involve reflection on the participants' beliefs and values, and how they may influence the participants' approach to clinical work.

Inclusion criteria

- Participants must be qualified clinical psychologists employed by the NHS (Birmingham, Leicestershire or Worcestershire).
- Participants must have worked in a Psychosis related service for a minimum of 6 months.
- Participants must have access to formal or informal support through their employing NHS trust.
- Participants must have understood what the study is about and what their participation will involve. Participants must have provided informed consent based on this.

Confidentiality and anonymity

Every effort will be made to ensure that identity of participants will be anonymised throughout the research process. Any identifying information will be excluded from transcripts. Tapes will be stored securely and wiped after successful completion of the study or upon participant withdrawal. A copy of the tape will be available to you upon request. The chief investigator will use funding to pay for transcription to be done, however, confidentiality will be maintained throughout the process.

The chief investigator is under an obligation to report to a supervisor any information that may arise from the interviews that suggests poor practice or breach of clinical governance.

Consent

The interview will involve some potentially sensitive questions related to personal values and beliefs and how this may influence your practice. For this reason it is important that you have access to formal or informal support through your employing NHS trust should you feel you need to access support after the interview. Participation is voluntary in this study and you are free to withdraw at any point in the duration of the research process.

If you require further information, please contact me at the following address:

Ms Rukhsana Ali
Trainee Clinical Psychologist
School of Clinical Psychology
University of Leicester
104 Regent Road
Leicester
LE1 7LT

Phone: 0116 223 1639
Email: ra31@le.ac.uk

CONSENT FORM

University of Leicester

School of Psychology

Clinical Section

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A study of the way in which clinical psychologists (working in psychosis services) address religious issues in therapy.

- I have read the participant information sheet and understand that this research may involve potentially sensitive questions relating to my values and beliefs.
- I confirm that I do have access to formal or informal support through my NHS employing Trust should I require it.
- I have had the nature of the research explained to me, and have had the opportunity to ask questions and discuss the study.
- I understand that participation will consist of a single semi-structured interview, which will be audio-taped. I understand that transcription will occur through an employed individual other than the chief investigator and that the individuals handling raw data will respect anonymity and confidentiality.
- I understand that I may withdraw from the study at any time without justification.
- I understand that all information will be treated confidentially and that tapes will be wiped upon successful completion of the study or upon my withdrawal from the study.
- I understand that all information relating to the interview conducted will be stored securely.
- I agree to take part in this study, as laid out in the participant information sheet.
- I agree to be interviewed and for the interview to be audio-taped and transcribed.

Participant Name (BLOCK CAPITALS).....

Participant Signature.....Date.....

Chief Investigator Name.....

Signature.....Date.....

Appendix D: Interview guide

1. Introduction

- Personal introductions/ Outline of research/ Consent and confidentiality.

2. About them

- How long worked? / Client types? / Settings?
- Case load with religious themes?
- Theoretical orientation?

3. How do you work in assessment & formulation (when case involves religious themes)?

- A) When working with pre-morbidly religious clients? (Give examples).
- B) When religious themes emerge for clients after the onset of psychosis?
- C) If there are no religious themes in caseload – why might this be? (What would you do in the future if it did come up?)

4. How do you work in intervention (when religious themes are involved in the case?)

- A) With pre-morbid clients?
- B) When religious themes appear to emerge after on-set of psychosis.
- C) With other client categories?
- What methods did/would you use in addressing religious issues?
- Do you have any idea why religious themes were not addressed in intervention?

- What are the dilemma's you have faced?

5. About participant's beliefs

- How would you describe your own value system?
- How does your value system influence your work as a clinical psychologist?
- Can you give examples of how you may have managed any differences?
- How has clinical practice affected your belief system?
- What do you see as the value model in psychology and in clinical psychology training?

6. Tips on intervention

- What advice would you give to others working with cases where religious themes may be prevalent?

7. Ending

- Review consent.
- How has the interview seemed?
- Anything to add that has not been covered?

Appendix E: Example of open coding

A: Yeah and I mean I do I do ask about people's erm spirituality and their beliefs or like their framework for looking at the world or understanding the world. You see it's difficult because my case load is very small. so I'd say probably any one time it's been one out of nine where it is a feature but that doesn't mean that in those nine – there might be others who may have you know they may have a faith background.

I: Right.

A: Erm, I could think of several people now where their faith beliefs are more than just stuff on the ground - it is bigger because it's sort of features in their their psychosis.

I: So sort of you're saying that faith can feature as a person's sort of background? But it also can be in the actual psychosis itself?

A: Yeah.

I: Would you say those are the main areas in which you encounter religious beliefs? Or are there other ways as well?

A: Well the other the other aspect is really understanding, say for example from the context that might influence cultural aspects. Like say in terms of with the Asian population or sometimes the Afro Caribbean population where you're aware, for example the religious context actually affecting the cultural in terms of maybe seeing a woman or those kinds of things so it's not affecting their psychosis but it does affect how you work with them or how they might work with you or things that you might be asking them to do or say. sometimes where it might actually be contributing maybe to some of their difficulties where it raises attention and maybe a cultural dilemma really in terms of maybe two different cultures meeting and people finding themselves caught between that.

Asking about Spir/beliefs & frameworks

Spir/beliefs to understand the world

1/9 cases = relig themes

faith background might be more common

faith beliefs more than background for some

faith beliefs perceived as bigger when feature in the psychosis.

Interviewer Summarising & Seeking clarification

Understanding Context & Cultural aspects

Specific Cultural/Asian populations identified

Religion impacting on Culture.

Status of women.

Relig + Culture Interaction = impacts on work.

Impacts on what is said or done.

Relig/Culture impacting on difficulties

Cultural dilemma.

Being Caught between two Cultures

Appendix F: Example of focused coding

M: I'm not sure but certainly we formulated that and I did a formulation with him and he kind of accepted some of it but not all of it. You know that maybe some of the delusional ideas about being tormented and being persecuted by the devil were a way of him kind of expressing how little he thought about himself and how unimportant he was and how kind of crap some of his life experiences had been. And that led him to actually not really think very much of himself and that he didn't deserve anything better. There was a real thing about you know not being worthy, not being deserving anything other than torture by the devil (.). So I guess it was, there were difficult conversations to have with him cos he felt he was condemned for all time so that led on to discussions about kind of would he still be tortured and persecuted after his death. That led on to discussions about what did he think would happen to him after he died, which I think kind of fairly directly opens up a conversation about what your kind of spiritual or religious beliefs are. Erm and he just felt that he was really into Buddhism and he was very knowledgeable about it actually he read an awful lot of Buddhism text, like original, like really old Buddhist text.

Negotiating a formulation

Experience Shaping Schema

Difficult Conversations

Naturally exploring religious beliefs

knowledge of Buddhism

Appendix G: Example of Memo

There seems to be a theme about competence and knowledge. And how therapy can feel difficult if the participant has a lack of knowledge of the area. Possibly feels deskilling? This comes under the wider issue of lack of guidance and the general sense of not discussing religious beliefs routinely. Also the way the religious themes were being interpreted by the participant seemed psychological. There was use of a psychological theory – it reminded me of schema and the connections with early experiences almost relates to psychodynamic theory and how defenses are formed? Religious themes seemed to naturally spring into the conversation as the feelings were explored – almost like it slowly unravelled itself through their conversation?

In the next few interviews I will look out for themes relating to feeling deskilled, the ways in which religious themes are interpreted and if certain topics naturally lead into discussing religious themes more than others.

Appendix H: Notes on theoretical sampling

A participant who predominantly worked from a psychodynamic perspective, along with a participant who described being familiar with literature on the research area and who regularly reflected on religious themes in psychosis, were selected. This was in order to refine and broaden the emerging themes of *challenging* and *not reflecting enough*. For example, the sub-category *challenging* was tested with the participant informed by a psychodynamic theoretical orientation in order to check whether this process would still be pertinent according to theoretical models other than CBT.

The researcher presented initial findings of this study at the British Association of Christians in Psychology (BACIP) 17th annual conference in March 2007. This was based on the analysis of seven interviews. This presentation was followed by a discussion, which further provided an opportunity to discuss the developing theory with Christian clinical psychologists and other presenters. This led to further revision of the developing model's main categories. This was implicitly tested in the final two interviews and the subcategories of *exploring* and *analysing* were further substantiated.

Appendix I: Transcript conventions and supporting quotes

Transcript conventions

...	Text omitted (e.g. identifiable information)
( )	Interview recording too inaudible to transcribe
(.)	Pause
=	No silence between words
((word))	Transcriber's comments

Adapted from:
Silverman, D.(2003). *Qualitative research: Theory, method and practice.* London: Sage Publications.

Supporting quotes

Category	Quote reference	Quote
Core category: **UNRAVELLING**		
	4:357	*But it is necessary to kind of think about where you're starting from I suppose – you know I'm a professional and what is it that I can do to work with the religious ideas.*
	9:29	*I always try to think about what it is I'm doing and what my role is in this, it's really important that we work as reflective practitioners in thinking about religious themes as well as sort of thinking about the evidence base for this or that.*
	1:69	*…you do always have to stop and just check whether what you're doing is what is most suited to the client you know, and when its not really working or it feels that you're stuck – erm its important to reflect on that to help in moving forward again.*
Main category: **Defining roles**		
	8:205	*I think our role as psychologists, I mean a religious worker may want to make the client more religious and try to make them believe more in what they themselves believe. You know that's a different kind of role to what psychologists do.*
	5:726	*Because I do think It would be important to intervene, and you know actually work with religious themes, to help the client manage distress. Also to enhance their mental health in some way, you know.*
	8:594	*It should not be used for, I mean the psychologists should not use it as an opportunity to talk about their own religious views and we should not be imposing our own views onto our clients.*
	9:100	*But I do think it's really important to assess for religious themes and I do it…My personal experience tells me it can be so important.*
	3:166	*You know faith can actually be used as a tool to engage someone – you know if you have beliefs that are similar – you can say yes I do know what you believe in and that way they might let you in. And in fact I have got a faith background myself - I declared it…*

	1:356	*…if your gona get a religious leader …If you get someone who's got a radical view of something that goes completely against what you want to achieve, you can actually end up making it worse.*
	8:562	*But yes, it may actually be an unnecessary barrier for clients if it was routinely introduced.*
	4:360	*But I see my role as a psychologist and that's how I would work, I would be expected to work psychologically. So I don't work from a faith perspective.*
	7:556	*I mean if clients would benefit from talking about religion then yeah I would; but maybe at the same time inside I am a little bit cautious just cos I know that for some it can kind of have damaging effects as well.*
	5:347	*I've not kind of had a teaching experience about that or I've not read in a book kind of how to think about working with that. It felt that there was kind of less out there to guide me in these kinds of conversation.*
	10:704	*So independently I try to incorporate a spiritual level of thinking as well as all the other things we think about – the bio-psycho-social. I think this is limited in clinical psychology, and I think that there should be a culture where it was discussed more.*
	6:443	*I'm just thinking about this as I talk really, erm and I suppose I've not really talked about this before.*
	5:75	*Usually something kind of prompts, or you know makes you think oh that's something I don't know much about. And then if it becomes something quite big and needs kind of unpicking –I would then try and think about it and take it to supervision*
Main category: **unpicking cases**		
	2:176	*So yeah I was following hints, you know. I tried to register in my mind things that indicated that religious themes were important, so from the conversation with clients and from referral information.*

	5:124	*So if they hinted something, you know like life is controlled by fate or something – I would maybe see if that came up again or if other stuff they said kind of followed on from that. If it did, then I might think oh this is important. So yeah, I am much more kind of discreetly following it with the client and that's how I try and determine if you know I need to kind of follow it up more explicitly.*
	9:83	*I always ask about it and I think it gives them a chance then to talk about it, it gives that space for them to use ...so yeah I think its important to allow a more explicit opportunity for all that to happen*
	3:80	*Yes, So there are those cases where the religious themes are kind of centrally entwined, they are central to the psychosis.*
	2:227	*So sometimes I ask clients about what others in their Church believe and what the Church thought of his beliefs.*
	6:335	*So if there are things I'm not sure about I would try and find out about it by reading about the religion, if time permits that. Or I would consult others on it – if a colleague knew more about it then I would ask them.*
	6:125	*So yeah sometime the religious beliefs are actually quite functional for the client. So for him it actually helped to stop him from committing suicide. And so the religious themes were not causing distress and did not really need addressing. But if it was a serving a dysfunctional purpose, then the delusional religious beliefs would need addressing.*
	10:91	*With some clients you can kind of get a sense that they are searching, not satisfied with things and generally searching for some meaning.*
	5:132	*Sometimes there can be subtle themes in the background, there was one client who would hint about fate or other things kind of relating to faith beliefs. But we never actually explored it – I got the sense that the client did not really want to and other things would be the focus of therapy.*
	1:382	*So yeah cultural factors can be quite important in understanding the formulation.*

	3:104	*...it might actually be contributing maybe to some of their difficulties where it raises attention and maybe a cultural dilemma really, in terms of maybe two different cultures meeting and people finding themselves caught between that. So their culture might advocate more religious ways of doing things but the society they live in is quite secular.*
	6:309	*So it can be quite complicated to work with clients from different cultures, particularly unpacking their problems and knowing the place of their culture. And I think my experience is probably that one has to make extra effort in engaging clients from different cultural backgrounds –certainly more sensitivity is required by services. Things like appropriate awareness and sometimes interpreter availability are important for services to engage clients.*
	4:42	*Sometimes clients have their own spiritual frameworks and you know they might have their own way of understanding things. So it would be important to be aware of that with clients and acknowledge that with them.*
Main category: **Interacting with religious themes**		
	8:349	*...there are certain skills and principles that would be used - as with any client and situation really. As a psychologist the engagement is really important and through our training we are taught sort of general principles for this.*
	10:38	*I think I have started to in a way recognises the psychotic in me – you know sometimes when things feel unpredictable you know that we do have a side of us that can feel psychotic. So I think that helps me to understand where the client is coming from.*
	2:105	*I would try and be curious and ask questions to try and develop a deeper understanding of what this means for them and to try and get a grasp of their beliefs.*
	7:566	*You know I think as psychologists we try to be sensitive and I really don't want to come across as undermining the clients' beliefs or that I'm attacking their faith. That's what I'm aware of when I'm working with someone whose got religious ideas in their delusions, so I try to be sensitive really*

	2:373	*You know I will kind of really subtly say that oh I see it a bit differently, you know in a way that isn't head on confrontational – its more implicitly kind of saying oh I respect you see it that way, but I think of it a bit differently and is it ok if I share that with you too.*
	8:322	*I try to be open and not judge people. That's important so they feel able to share their beliefs.*
	7:398	*I might think looking at porn, you know it's a normal thing whereas for him it's a sin. You know to me, I would think there's nothing wrong with that. But I suppose someone from a Christian background might say well actually it is wrong and it is sinful. But to me that might seem a bit unfair.*
	7:371	*I suppose the CBT model that I've been trained in is about challenging, and that's the model I use. It's about reducing distress so I suppose a lot of what I might do with clients is kind of look at challenging the sort of religious psychotic beliefs.*
	10:220	*But for some clients who have been rejected in life, and religion, and having religious experiences makes them feel special which is what they have always missed out on.*
	10:545	*So when I make links and kind of analyse or make analytic links– really that's about building a formulation which will include everything talked about. And this helps to make sense of where distressing emotions have come from and how religion plays an important part in the client's world.*
	5:248	*...I tried to look for the feelings behind the religious themes that he was talking about, like the anxiety and how he was feeling scared of something which kind of was coming through those religious themes...*
	2:255	*My main objective in getting involved was to try and provide the team with some kind of formulation about what was going on with him. That was an intervention in itself to kind of help clarify ideas for those involved in the case.*
	5:367	*...I actually supervise the Chaplain who works with this client... the chaplain is involved with helping the client to explore stuff.*

	9:256	*If I feel I cant help the client I think its important to refer them on if possible to someone who would be able to understand that frame of reference and religion better than me.*
	9:146	*When you're exploring their frame of reference you are taking into account everything and that includes things which may not necessarily be the actual presenting difficulty. But it's about knowing the context of the person and how they derive meaning - so it's trying to have a holistic outlook in helping them.*
	2:245	*...he feels that he is possessed by his Jinn... He was pretty unwilling to accept any kind of medication from us because he just didn't feel he had a problem really ...our doctor and our nurses were trying to talk to the family about psychosis really and tell them a bit about that and the fact that actually they thought that was probably what was going on for this lad...*
	3:171	*I wanted to highlight areas from the Bible which they frequently quoted to basically suggest that also there was a personal responsibility that you couldn't just leave everything up to God... there is something you would be expected to also take some personal responsibility ...*
	1:197	*I used it as a behavioural experiment really. I just got hold of one and found a relevant passage... we just used the Bible, so that's sort of an evidence for testing thoughts really* .
	7:119	*It didn't work because she said that even if we get this chaplain in she wouldn't go along with what they were saying because he wasn't from the same Church as the one she'd been to. So she wasn't going to trust him.*
	2:330	*And maybe I was moving in too quickly with the suggestion of self monitoring and that made him all defensive.*
	10:172	*You know sometimes the religious themes in the delusions - the devil or God - can be so powerful for the client, it's like it can't be shifted in any way sometimes. You know the source of their concerns is coming from something so powerful that nothing is able to compete with it and they feel that their distress is almost irremovable.*

	10:212	*It's like it can be hard to penetrate this higher power, and its almost as though at times the religious themes are penetrating the whole space in therapy and not the other way.*
	10:186	*Psychosis is possibly one of the most challenging areas to work in anyway and added factors like this – you know this is different I think in some way, I think it can really add to the challenge.*
	6:540	*...if we're struggling with this, which I think to some extent we are as a profession because I think it is difficult. You can bet your bottom dollar that the nursing staff are struggling...*

Appendix J: Notes on the Core Category

- **UNRAVELLING** could alter the initial understanding of the participant's role, by expanding the ***repertoire*** of how to approach religious themes. This could in turn alter the way in which religious themes were **unpicked** or **interacted** with in the future.

- It is important to note that the categories may not occur as processes in complete succession one after the other but may also occur simultaneously whilst interacting through the central core category. Participants may also move along a spectrum of how much they interacted with the core category of **UNRAVELLING.**