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How clients with religious or spiritual beliefs experience psychological help-seeking and
therapy: a qualitative study

Claire Mayers

Adolescent Forensic Health Service, Parkville, Australia

Gerard Leavey

Barnet, Enfield & Haringey Mental Health Trust

Christina Vallianatou

Barnet, Enfield & Haringey Mental Health Trust

Chris Barker

University College London

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This paper is based on the first author's dissertation for the Doctorate in Clinical Psychology at University College London. Address correspondence to Dr Chris Barker, Sub-Department of Clinical Health Psychology, University College London, Gower Street, London WC1E 6BT, England. Email: c.barker@ucl.ac.uk

Abstract

This qualitative study explores the process of help-seeking and therapy among clients with religious or spiritual beliefs. Ten clients who were currently in, or had recently finished, therapy were interviewed. Participants reported using their religious or spiritual beliefs to cope with their psychological problems before and during therapy. Prior to therapy, they worried that secular-based help might weaken their faith. However, the experience of having psychological distress and the process of receiving therapy were both perceived as strengthening to faith and ultimately part of a spiritual journey. Contrary to expectations, a match between the spirituality or religious affiliation of the therapist and client was not considered important. This implies that the ‘spirituality gap’ between secular therapists and clients with religious/spiritual beliefs is bridgeable.

How clients with religious or spiritual beliefs experience psychological help-seeking and therapy: a qualitative study

Despite over 75% of the UK population specifying that they hold religious and spiritual beliefs (ONS, 2003), clinical training, practice and research have generally neglected the impact that such beliefs have on seeking and receiving help for psychological problems (Cinnirella & Loewenthal, 1999; Copsey, 1997; Friedli, 2000a; Friedli, 2000b; Hill & Pargament, 2003). In a UK nationwide survey, 17% of respondents said that they would seek a religious leader for help with personal difficulties or emotional problems compared with 16% who said they would go to a ‘mental health worker’ (Barker, Pistrang, Shapiro, & Shaw, 1990). In the USA the proportion of people who seek help from clergy for psychological problems is considerably greater (Greenley & Mullen, 1990; Veroff, Kulka, & Douvan, 1981; Weaver, 1995).

However, some commentators describe a ‘religiosity gap’ between clients and therapists, exemplified by the view among some mental health professionals that religious beliefs and behaviour are symptomatic of psychological disorder (Larson, Hohmann, & Kessler, 1988; Shafranske & Gorsuch, 1984). Clients with spiritual or religious beliefs may experience a dilemma between self-censoring these beliefs or risking further pathologisation by mental health staff (Leavey, 2004). Likewise, some mental health professionals may recognise religion and spirituality as integral to the patient’s healing process but nevertheless, for a variety of reasons, feel uncomfortable with raising such issues (Knox, Lynn, Casper, & Schlosser, 2005; Rose, Westefeld, & Ansley, 2001). However, the religiosity gap between mental health professionals and their clients is rarely examined. Two related questions seem pertinent. First, do people with spiritual beliefs necessarily maintain religious or spiritual conceptualisations of their problems which preclude or limit secular help? Second, although

religious clients may fear a cultural clash with therapists within a secular setting, do their fears match the reality of their experiences?

There is growing evidence that religious-based beliefs may influence help-seeking and adherence to treatment (Chadda, Agarwal, Singh, & Raheja, 2001; Cinnirella & Loewenthal, 1999). Thus, many people perceive their problems to be spiritual rather than psychological or look to religion as a means of understanding suffering (theodicy) and also as a beneficial way of coping with it (Barbarin & Chesler, 1986; Maton, 1989; Pargament, 1997; Zuckerman, Kasl, & Osfield, 1984). Furthermore, how clients conceptualise their problems is likely to influence the therapeutic relationship, raising possible concerns about respect, trust, shared meanings, acceptance and cultural competency. It is important for clinicians to understand the client's implicit models and beliefs in order to improve therapy outcomes and satisfaction with services (Bhui & Bhugra, 2002; Pistrang & Barker, 1992). However, previous qualitative research exploring religiously-minded people's help-seeking attitudes in a non-clinical sample indicate fairly negative views of secular mental health services (Mitchell & Baker, 2000): seeking professional help was seen as conflicting with religious beliefs and was considered a last resort.

The present study aimed to explore how clients with religious/spiritual beliefs conceptualised their psychological problems, and how their beliefs influenced the help and resources they sought. In addition, it explored their experiences of disclosing their religious beliefs within a therapeutic relationship in a secular setting.

An exploratory, qualitative approach was used. Qualitative methods have been recommended for research in areas where little is known, particularly where the study is exploring complex, little understood personal and interpersonal processes, and where it is important to preserve the subtlety and ambiguity of the phenomena under study (Elliott, Fischer, & Rennie, 1999).

Method

Participants

Clients who were currently receiving, or had recently finished, therapy were recruited from National Health Service (NHS) Clinical Psychology services in London. The main inclusion criterion was that participants defined themselves as having strong religious/spiritual beliefs, as assessed by quantitative and qualitative information on The Royal Free Interview for Spiritual and Religious Beliefs (King, Speck, & Thomas, 1995; King, Speck, & Thomas, 2001). Ten participants (seven women and three men) had a mean age of 42 (range: 32-52). Seven described themselves as white English, two as mixed ethnic origin, and one as black Caribbean. Six were married, four were single. Most were educated beyond secondary education, four possessing university degrees. All had a profession, but five were not working due to long term sick leave for their psychological problem at the time of the interview.

All participants said that their religious/spiritual beliefs were crucial to their worldviews and way of life. Four described themselves as evangelical Christians within the Church of England, two as Evangelical/Pentecostal Christians within black congregations; one as Greek Orthodox and one as Sunni Moslem. Of the two who described themselves as having no affiliation with organised religion, but having purely spiritual beliefs, one made reference to the New Testament, suggesting a Christian background, and the other described pagan beliefs.

Six participants described themselves as having depression, one of whom also had a diagnosis of personality disorder, two people had bipolar disorder, one of whom also had a diagnosis of personality disorder, and two people had an eating disorder. Many found it difficult to state exactly when their difficulties began, but their first contact with mental

health services ranged from within the last six months to 13 years ago (mean was 3.2 years, mode was one year). Two of the participants had past in-patient admissions.

Interview

The study was conceptualised with the framework of Interpretive Phenomenological Analysis (IPA), which is a systematic method for conducting qualitative research in health psychology and related areas (Smith & Osborn, 2003). The term itself signifies the duality of the approach. It is phenomenological, in that it is concerned with individuals' perceptions. However, IPA acknowledges the influence of the researcher's own conceptions in making sense of the other's personal world, and in this sense it is also interpretative.

The semi-structured interview schedule was designed to explore people's experiences of seeking and receiving help and how their religious/spiritual beliefs interacted with this process. It was constructed using guidelines set out by Smith, Jarman and Osborn (1999). The schedule was used as a flexible guide: the aim was to follow what the participants themselves brought to the interview. In this way it was hoped to balance an exploration of how their religious/spiritual beliefs impacted on the process of help-seeking and the process of therapy with "allowing the interviewee the space to re-define the topic under investigation and thus to generate novel insights for the researcher" (Willig, 2001, p 22). Interviews were conducted in a respectful and empathic manner, adopting a 'not knowing' position (Anderson & Goolishian, 1999), in which the researcher's assumptions are laid aside and the researcher is actively curious about what the participants are saying. It was thought this stance might be especially helpful as it was anticipated that the participants may find it difficult to talk to the interviewer, as someone from a secular profession. The interviews, which lasted around an hour, were all conducted by the first author [CM]; they were audio-taped and transcribed for later analysis.

The schedule was organised into five main areas: (1) *Background context*, which covered participants' opinion of the service they had most recently received, what they were hoping for, and what they saw as their main problems, (2) *Religious/spiritual beliefs*, covering the impact of the participants' religious/spiritual beliefs on how they understood their problems, how they coped, how they felt they could best be helped, and by whom. They were asked if they had talked about their religious/spiritual beliefs while receiving help from statutory services and what this experience had been like, (3) *Help-seeking*, which covered their experience of seeking help in a chronological order, from when they first realised they had a problem, through to their decision to utilise NHS mental health services, and (4) *Intervention*, which addressed the most helpful and unhelpful aspects of their therapy with a clinical psychologist.

Analysis

The analysis was conducted in accordance with the recommendations of Smith and his colleagues on the process of IPA (e.g., Smith, Jarman & Osborn, 1999; Smith & Osborn, 2003) and other general good practice guidelines for qualitative research (Elliott et al., 1999). The initial analysis was conducted by the first author [CM]. Each transcript was re-read until the researcher was thoroughly familiar with it. Quotations corresponding to significant meanings were highlighted and entered onto a table. Tentative theme titles were then added to the table. Once all the themes had been noted from a transcript, the complete list was grouped into a tentative framework. The researcher continually checked back to the original transcript to ensure that the structure actually reflected the participant's account. The emerging analysis was audited by the other members of the research team. This process was repeated for each transcript in turn until a table of themes from all participants was constructed. At this stage, the themes that seemed less central to the participants' accounts, and those which were not directly relevant to the phenomena in question, were omitted.

Finally, a superordinate table was constructed with the complete themes and corresponding participant quotes. This process was again audited by the other members of the research team until a consensus was reached.

Background of researchers

All four researchers were white professionals, three clinical psychologists and one medical sociologist. They held a range of personal beliefs about spirituality/religion incorporating belief in a God, atheism and agnosticism. None had strong preconceptions about the phenomena under study.

Results

The themes emerging from the analysis were clustered into two broad domains: (1) spiritual and secular help-seeking and (2) receiving secular help. The first domain encompasses problem recognition, the process of identifying appropriate help and the management of ambivalent attitudes towards secular resources; the second encompasses the clients' resolution of spiritual and secular psychological models within the context of the therapeutic relationship. The following extracts from transcripts have been edited for readability. All identifying information has been removed.

Spiritual and Secular Help-seeking

Participants faced a number of issues in the period leading up starting therapy with the clinical psychologist, from first trying to understand their problems within both secular and spiritual explanatory frameworks, to then realising that they could not cope without professional help, to finally struggling with the dilemmas and conflicts that surrounded turning to the NHS, as a secular service, for help.

Understanding the problem

In general, participants' understanding of their problems was fairly congruent with biomedical or psychological explanatory models: most offered a stress-illness explanation for

their psychological distress, such as work, family stress or relationship difficulties. The following comment was typical:

I think it's mainly life events...it's mainly my childhood. (P7)

Despite participants' strong religious beliefs, none offered spiritual explanations of distress as primary causes. However, some integrated biopsychosocial and spiritual explanations:

...they're partly social, cultural things, the problems that I've had, but I also do believe that I was born with some of them...also I think, it is again a Buddhist belief...I'm experiencing the karma perhaps for my family going back perhaps generations and therefore that can kind of link in with it being a genetic or a biological thing...I don't feel they necessarily need to exclude each other. (P4)

I know how it happened, it was a direct result of too much work, and it was a result of bullying by my superior and it was the result of being made to lie by my superior to higher superiors, which I couldn't take. But I also think it was perhaps that God wanted to teach me a lesson as well, because I was getting too high and mighty and I was forgetting my humility. So I think it might have been a little bit of that as well.

(P8)

Some felt that their problems were exacerbated by 'fundamentalist' views held by their church peers. One gay man, while maintaining his allegiance to Christian teachings, spoke about the negative and selective abuse of scriptural authority, which he believed could lead to depression and suicide

Religious Support

Almost all participants described their faith or their relationship with God as a consistent source of strength that underpinned coping. (Only one did not employ religious coping: her deity was particularly punitive, and therefore was of no support to her.) Religious belief and commitment were understood to fortify the individual with direction, purpose, self-esteem and courage. One expressed the healing power of faith in the following way:

... if you remain true to what you believe in as a person that has a tremendous power to heal you of...depression and mental illnesses and physical illnesses... if I hadn't had a religious faith I would have just given up. (P2)

Participants typically had a long-standing connection with their faith community, and anticipated the reaction of fellow congregationalists to their illness. This tended to fall into either supportive or reproachful responses. Thus, at the onset of distress, fellow church members and clergy, regarded as trustworthy, understanding and kind, were sought as important sources of advice and support.

My minister's wife came and spent an evening with me, she's a very good listener and a very wise woman, sensible and practical and then at the end of the evening we spent time praying together. I approached her; no one sort of forced themselves on me at all. (P6)

People in the faith communities were considered as helpful and supportive, with some recommending secular help but generally also emphasising the continued need for religious connection through prayer and church support. Three participants tried to access formal therapy via a Christian counselling organisation. One was upset by the lack of specialist resources (eating disorders) and another was offended by the expectation of payment. The third was pleased at the help offered by a Christian counsellor, viewing this therapy as equally professional but with the added value of having a level of shared understanding.

However, several participants described a less helpful aspect of their religious communities. One suggested that her crisis provided an opportunity for other church members to present a religious superiority or, through projection, avoid their own problems by challenging her strength of faith.

...while I was coming to them and pouring my problems to them, they made me feel like as if it was something wrong in my life - why I wasn't getting healed; it was my faith that wasn't strong enough, that's why I had problems in my life. But as I got to know them, I got to know they had problems in their own life also. (P5)

Some of the Christian participants had encountered people with evangelical beliefs, usually from a Pentecostal background, who provided a spiritual understanding of mental health problems as an “evil, satanic attack” and this was recognised by them as harmful. Others resisted advice from within the church.

...my Pastor...referred (me) to this same organisation...which claims to cure you from being gay... but because I'd seen a documentary about it I just told him point blank that I was not going to go. Of course he didn't like that. (P2)

One friend in particular has actually said there are a lot of good secular counsellors out there, but really you should be thinking about would you want to come to some of these meetings [charismatic healing]. And I've backed away from doing that, it's been my choice. (P6)

Significantly, there was broad agreement that counselling from within the church could be harmful because this often meant having an exclusively spiritual explanation and thus an exclusively spiritual solution imposed upon them.

...spiritual counselling about a mental problem, I think that's actually quite a destructive thing potentially, because it all gets spiritualised and I think you actually have to understand it as a mental thing. (P9)

It looks at things from a purely Christian perspective and didn't take on board all the other things, which is why I've probably come on further here because it hasn't been so much about my faith, but it's been about things in my mind that have needed to be adjusted. (P1)

Dilemmas about Contacting Secular Services

Whatever their reservations about seeking help within the church, participants did not, on the other hand, easily embrace seeking help from the NHS. Even those who were relatively comfortable in consulting mental health services anticipated possible secular conflicts with their spiritual beliefs and practices. They felt that seeking secular help may have been seen by God, others and themselves as a rejection of God's healing, and this led them to profound introspection as to their strength of faith. Such conflicts were described as uncomfortable and guilt-inducing and also as a weakness.

I guess a part of it is a sense of by doing that I wasn't relying on God, that having to seek secular help was a weakness on my part. (P6)

...there is always the guilt factor (about turning to secular help)... the church, sometimes more than they should I feel, preach of faith. (P5)

Others felt initially that it would be impossible to discuss spiritual concepts with non-religious therapists or that their spiritual and religious beliefs would be minimized or neglected within secular therapy. Another fear was that of contamination where they would

be exposed to conflicting or anti-religious beliefs or that their therapists would attempt a ‘conversion’ in behaviour that would conflict with religious or spiritual beliefs and values.

When I decided that I needed some help, other than just medical help, my first reaction was to look for a Christian organisation where I could get that from. I really didn't want to go down the secular counselling road because I assumed that it would be in conflict with what I believed. (P6)

Concerns about secular psychological help were generally resolved through a reconceptualisation of the problem, in two main ways. In the first, after much deliberation, the distress was reconsidered as unrelated to religion or spirituality; in the second, both the problem and the solution were viewed as part of a ‘divine plan’ that could not be understood, at least initially. Moreover, God’s goodness was considered as encompassing secular care. One person indicated the need for a different viewpoint to that offered by some people within the church.

I prayed and I believed God wanted me to go and seek help, secular help. I needed to hear somebody else's voice, somebody who was objective, somebody who wasn't necessarily religious, for them to tell me the truth of what I was facing (P5)

Indeed, some participants felt that religion or faith, although valuable, can sometimes block access to the insights required for changing painful or problematic aspects of their lives; this required a non-religious perspective.

If I had just sought help within the church, through just sort of prayer or through counselling, it wouldn't have actually dealt with some of the things that I needed to deal with or look at them in that sort of way (P1)

I haven't sort of been out so much for prayer to be healed. I suppose it's because it almost feels too much to hope for, as it were, and that I kind of don't want to build my hopes up (P9)

By not relying entirely on a miracle, the locus of control shifted for another participant, and she was then able to move from her a feeling of being 'stuck' and to reclaim a sense of autonomy and control.

In one sense it [secular help] made me realise that there was more to it, and that I did need help, and that there wasn't going to be some sort of miraculous cure (P1)

Integration of Beliefs within the Therapeutic Relationship

The second domain encompasses the issues participants encountered once they started to see a clinical psychologist. The themes are again presented in chronological order, from initial reluctance to disclose religious beliefs because of assumptions about how a secular therapist would react, through a realisation, as therapy continued, about how their beliefs could be integrated with ideas from psychological models.

Disclosing Beliefs in Therapy

At the beginning of therapy, clients were reluctant to disclose their religious/spiritual beliefs, feeling that such issues could not be discussed within a secular model.

...it's scientific and it's not holistic and it doesn't really allow for a spiritual approach (P4)

Many feared that if they spoke openly, that they might be misunderstood or seen as mad.

...when you start off you think - be very careful [when talking about hearing the voice of God], you know cos you could be totally misunderstood (P10)

It was a bit scary [sharing her belief], I thought 'I've got to be careful in case I find myself sectioned' [detained under the Mental Health Act] (P3)

Over time participants started to test the water by introducing their beliefs and observing the reaction of their therapist. Most felt, to their surprise, that their beliefs were respected and accepted.

It was the feeling I had first of all when I met her, and then speaking to her I gradually brought it [my beliefs] in and watched her face. And I watched her face and her face didn't change, a good poker player [laughs]. And I thought well she hasn't looked at me as if to say "mutter", so then I carried on and I brought bits in and she respected the way I, even if she thought I was a dope, but she respected it was part of me and she didn't say anything, which made me more able to be more open with her.

(P3)

However, one participant, who underwent therapy with a different clinical psychologist, reported that the therapist's attitudes to religion were sometimes unsatisfactory. In these sessions beliefs or feelings of a spiritual nature were ignored by the therapist, which in turn made the participant reluctant to talk further about their spiritual beliefs.

I think it's put to one side...I might talk about it but they don't bring it in...I suppose the faith is not seen as part of it ... I didn't want to take the discussion any further because I didn't know to what extent there would be any understanding... (P9)

Some participants reported that they were able to talk about religion within the context of an empathic and accepting therapeutic relationship. Although these qualities are arguably important in all therapeutic relationships, their significance was heightened when it came to disclosing religious issues. The importance of a warm and caring therapeutic relationship was clearly expressed by most of the participants.

Yeah, from a personal point of view that always made an awful lot of difference. If I felt that, not that somebody had to be my friend or be personally involved much more with my case than with anybody else's but if there wasn't some kind of warmth and compassion and empathy there then I would just feel quite resentful at having to share with them (P4)

Participants' opinions differed about what would help them develop a trusting relationship with the therapist, and they expressed mixed views about being matched with a religious psychologist. Some said it was helpful that the clinical psychologist did *not* share their viewpoint, as this provided fresh insights. One found this cultural distance helpful in that a therapist of the same religion might have been offended by some of her views. It seemed that acceptance, respect, understanding, and then a willingness to work with, and not against, the participant's way of viewing the problem and ideas about a solution enhanced the development of a sound therapeutic relationship.

It's not particularly important about [therapist's] gender or religion or ethnicity or anything like that, ... it was her respect. (P3)

Others felt that knowing the therapist's religious background facilitated the discussion of religious issues. For these clients, the therapist's disclosing this information contributed to a sense of feeling understood and the development of trust.

I wasn't sure how [the therapist] would take the religious aspect of it so I avoided it until last week when I was quite sure myself that he had some religious background himself ... so I felt confident that he wasn't just going to listen to it and think 'oh this guy's just a lunatic' ... so I've been able to interact with [him] on a, not only on a secular level but also on a religious level, which has been really amazing. (P2)

Integration

Participants spoke about the connections they perceived between the secular concepts in therapy and beliefs found within a religious framework. Some reflected that occasionally during therapy, passages from the Bible occurred to them which they had found meaningful, and resonated with ideas used in clinical psychology.

A lot of the principles we've talked about, you know I sit there sometimes and Bible references come into my mind...the counselling has reiterated what is said in the Bible. (P6)

This integration allowed for a reconceptualisation of therapy whereby psychological and religious insights were increasingly regarded as complementary.

I thought I'd have to keep it separate. That there would be part of me that could be dealt with on a secular basis, and then I had my friends at church and other Christian friends who would be praying with me...and that the two wouldn't sort of come together. But I've found it's actually been easier to dovetail the two together than I actually imagined it would be. (P6)

Reciprocal influence of therapy and religious/spiritual beliefs

As described under the previous heading, most participants found commonalities between the basic principles of therapy and their religious/spiritual beliefs. They then went on to describe how the secular and spiritual did more than just lie comfortably side by side, but had a reciprocal influence on each other. This seemed an unexpected bonus, as many had feared a secular therapy would somehow take away from their religious/spiritual self.

I think the two sort of helped each other really. (P1)

I don't see a dividing point. I think I'm using one to help the other, I'm using my faith, my spirituality to help heal the problems that I have (P5)

One person described herself as both “emotionally and spiritually troubled” found that therapy was helpful in breaking through what she perceived as a spiritual barrier and helped her to “reach a point”, where God’s help could be called upon.

... visiting [clinical psychologist] and talking about the abuse, I started to pray and I says “Lord something’s got to be done and I don’t know what, show me the way”.

(P5)

Similarly, another person described how therapy was seen as a stepping-stone towards a more complete, i.e. spiritual, healing.

...[clinical psychologist] appreciated that I’ve deliberately not used my religion to help me with my difficulty at the moment because as I said I’m not ready yet...But I know that as soon as I ask God for forgiveness, he’ll make me better but in the meantime I’m relying on my psychologist, psychiatrist and social worker. (P8)

To bring these beliefs full circle, therapy enabled participants retrospectively to consider a ‘greater meaning’ to their difficulties and attributed their life events and subsequent quest for healing as “*very much part of God’s plan*”. (P1)

One person felt that she was directed by God to her therapist

I can even say I was sent to the right person, I felt I was sent to the right person [by God]. (P5)

Moreover, participants’ psychological problems were reframed as something positive, a way of reshaping their lives and supporting their spiritual growth.

...so the belief in my mind about what’s happened to me that none of it’s accident but perhaps to go through all these things to somehow become closer to God ... (P2)

Participants were asked how their faith had changed, if at all, during this time.

Without exception, all of them said their faith had become stronger.

No, definitely not challenged, my faith is always strong, definitely not challenged.

(P8)

My faith stayed still strong my faith in God I just know whatever any human person does I just know that God doesn't change and his love for me is the same.

(P10)

The narratives suggest something of the redemptive aspect of illness where the participants endure suffering but ultimately triumph.

...[my faith] increased I believe, what your faith is telling you is that although you suffer tremendous hardship, that good will always triumph over evil. (P2)

Some people made links between their faith strengthening and the process of therapy, and especially to the unexpected understanding of the therapists.

...you're not expecting to find any favours, any favouritism but you find the kindest thing happens to you in a place where you're not expecting anybody to know about God or anybody to talk to you about God or anybody to have the time, you know where you see yourself as one of the crowd and yet still you find that your treatment has been one of complete individuality. So for me that strengthens my faith. (P5)

...because I think I went to a secular healing session with [clinical psychologist] I think it's made me even more aware... I went to the ungodly but I still found God there...that made my faith so much stronger... where I went, He came with me...it doesn't matter, the secular is there for us to use and get healing. (P5)

Discussion

This study examined the relationship between clients' spiritual beliefs and their experience of help-seeking and contact with secular psychological therapy services. We

found that participants' preconceptions about therapy as antagonistic to religious/spiritual beliefs and sensitivities may provoke reticence but not deter help-seeking from secular therapy. However, it is important to note that the sample consisted of people who had received therapy; those who had avoided NHS services were not interviewed. Nevertheless, our findings tend to support the argument that explanatory models of illness need not be considered as inflexible or mechanical conceptualisations that directly dictate specific and obvious courses of action. Rather, they are often idiosyncratic and fragmentary, containing contradictory aspects, contingent on the availability and access to various personal and social resources (Kleinman, 1981; Pelto & Pelto, 1997)).

Importantly, participants realised that their religious or spiritual beliefs do not have to be concealed or sidelined within the process of therapy, but rather can used complementarily and integral to a positive outcome. Here too, people tend to be judicious in their expectations of religion in that spirituality is used for guidance and coping rather than in hope of a miraculous cure. Moreover, it is interesting that those participants who employed religious coping strategies also reported that their faith was undiminished and often, reinvigorated. Previous studies indicate that psychological distress can often provoke a reassessment of belief (Kirov, Kemp, Kirov, & David, 1998; Rogers, Maloney, Coleman, & Tepper, 2002). It may be that for clients with such problems, religion and spirituality provides meaning and a sense of control; faith may be strengthened in relation to the crisis faced (Pargament, 1997). Rogers et al. (2002) suggest that the primary function of religion among people with mental health problems is for the purposes of coping and alleviating distress but that the success or failure of this coping impacts on the person's relationship with religion. However, they conclude that people are unlikely to reject religion or convert to another faith group. What may be important to stress is that religion is rarely static and is flexibly reviewed and utilised by clients.

In this study, we found that clients rejected a '*spiritualisation*' of their problems (e.g., "God is punishing me"). Moreover, we were surprised to find that many people expressed, some in very strong terms, that church counselling may be unhelpful, even detrimental to the individual. This contrasts strongly with the findings of previous studies (Cinnirella & Loewenthal, 1999; Mitchell & Baker, 2000) whose non-service-user participants placed higher value on faith-based psychological support, compared to mental health professionals, in that such help would explicitly address and acknowledge spirituality and that the helping episode would be characterised by warmth, understanding, safety and a non-judgemental stance. Clinical psychologists, by contrast, were envisaged as dismissive or neglectful of spirituality, and the features of their interaction would be burdened by misunderstandings and uncertainty. Any positive outcome would be short term only as it was resultant from 'mind manipulation'. In contrast, while our findings confirm the existence of similar fears prior to therapy, they may not be borne out in real therapeutic encounters.

It may be that psychological concepts and ideas are incorporated and reinforce existing religious beliefs. Thus despite any matching of client-therapist beliefs or drive for a spiritual agenda, the religious/spiritual needs of clients appear to be managed adequately without consciously placing these on the therapeutic agenda. Why might this happen? In common with previous research we suggest that participants believed religious/spiritual concerns were appropriate for discussion in therapy, and preferred that they were able to discuss them (Rose, Westefeld, & Ansley, 2001). It may be that as long as the therapist is perceived to be open, and that a respectful, comfortable relationship exists, the exploration of spirituality will happen as for any other core issues.

Our findings pose two questions; why do many people with spiritual/religious beliefs hold negative views of secular counselling? What can be done to change this?

Clarke (2001) makes the point that spiritual experiences are, by their nature, individual, subjective and often ineffable. Thus, communicating these beliefs and experiences to the therapist outsider is likely to be problematic. The posited steady erosion of a spiritual literacy in modern discourse may contribute to the increased isolation in a secular environment of the person with religious/spiritual beliefs. This study concurs with other work that it is the job of the clinical psychologist to co-construct a shared understanding and language with the service user about their spirituality, which can then be used to enhance the experience and effectiveness of therapeutic interventions (Hannah, 1994). Rather than being biased for or against religion or trying to debate religion, therapists need to engage in problem solving with clients in the context of sociocultural factors; they need to become interested in the meanings and function of religious/spiritual beliefs, rather than their epistemological status as truths (Carone & Barone, 2001). However, few mental health professionals, receive training on religious or spiritual issues (Culliford, 2002) and although cultural competency has become an important issue in the provision of psychological therapy, discussion of the effects of religious/spiritual beliefs on the course and outcome of therapy, in the UK at least, may be less common (Sue, Arredondo, & McDavis, 1992).)

One limitation of this study was that the sample was restricted to those clients who were still in receipt of treatment or had completed therapy. Dissatisfied clients who discontinue psychological services may present very different perspectives about the ability or willingness of therapists to discuss spiritual issues. Furthermore, this study was limited to a treatment-seeking population: it would be valuable in future work to examine the experiences of people who did not choose to seek professional, secular help for their difficulties. Nevertheless, this study indicates that the secular-spiritual divide may not be as severe or as problematic as previously envisaged. However, more studies are needed which look at the

effects of ‘matching’ client and therapist beliefs and secondly, whether the explicit examination of religious/spiritual beliefs influences therapy process and outcome.

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