The influence of spiritual beliefs on seeking and receiving help for psychological problems

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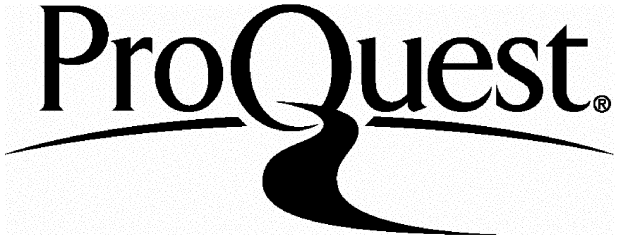

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ABSTRACT

This qualitative study explored how people with spiritual beliefs experienced seeking and receiving help for mental health problems. Ten people who were currently engaged in, or had recently finished therapy, with a clinical psychologist in the NHS were interviewed. The interview inquired about the type of help they encountered, before and during therapy, and what was helpful or unhelpful from each person's perspective. The resultant transcripts were analysed according to the principles of Interpretative Phenomenological Analysis.

Seven themes captured the key elements of the participants' experiences; these were organised into two higher order domains. The first domain, 'Dilemmas of help-seeking' represented the process that led up to the participant's inception into therapy with a clinical psychologist. The second domain, 'Process of therapy' encompassed the experience of therapy and the interface between the participants' religious/spiritual beliefs and the theories, models and ideas provided by the therapist.

Many people used their spirituality to help them to cope with their mental health problems, before and during their therapy. Contrary to expectations, a match between the spiritual affiliation of the therapist and service user was, overall, not judged to be important. Some of the service users found that the clinical psychologist was able to provide an intervention that was inclusive of their religious/spiritual beliefs, which was experienced as helpful. The implications of these findings for researchers, mental health professionals and services are discussed.

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CHAPTER 1: INTRODUCTION

OVERVIEW

Despite over 75% of the general population in the UK specifying that they hold religious beliefs (Office for National Statistics, 2001), training, clinical practice and research have generally neglected the impact that people's religious and/or spiritual beliefs have on seeking and receiving help for mental health problems (e.g. Cinnirella & Lowenthal, 1999; Copsey, 1997; Hill & Pargament, 2003; Mitchell & Romans, 2002). Such an oversight seems odd in the light of mental health care professionals struggling to provide help to such a diverse population. We must not underestimate the importance, for both clinicians and service users, of understanding how people's religious/spiritual beliefs may impact on their experience and understanding of mental health problems and the help they seek and receive.

So, how do people choose who to turn to for help and why is this an important question to ask? The understanding that people have of their problems affects what they think needs to happen in order to solve their problems, and who they think is most likely to provide effective help. It is important for clinicians to understand a service user's own beliefs, as they have been found to desire congruence between their understanding of their problems and needs and that of the helper (Delin, Delin & Bassett, 1996) and it is likely that people do better in therapy that is congruent to their own beliefs (Pistrang & Barker, 1992). However, mental health professionals are trained in a model that does not consider how people's religious/spiritual beliefs influence how they understand what the psychiatric model would term as mental health problems.

This chapter is divided into four main sections. The first, will focus on spiritual issues; the second will introduce and discuss help-seeking; the third will examine the interface between spirituality and coping, and the final section will review the current literature about the relationship between spirituality and mental health.

FOCUS ON SPIRITUAL ISSUES

This section will commence by considering the definition and concept of spiritual beliefs. It will then ask why this area is pertinent for consideration by mental health professionals and researchers. It will finish by examining the history of the relationship between clinical psychology and religiosity, and the impact of the different conceptualisations utilised by each.

Definition of terms

Spiritual and religious

In a recent review of the literature, Mitchell & Romans (2002) observed that the words 'religion' and 'spirituality' are often used interchangeably, being regarded as distinguishable yet overlapping constructs. For most of the studies of religion, spirituality and health, religion has a narrower definition, encompassing the outward practice of spiritual beliefs and has been the focus of most research to date. This field was broadened by King, Speck & Thomas (1994) to investigate the link between spirituality and health. Spirituality is defined as a metaphysical concept representing the belief in a power outside of a person's existence (Mitchell & Romans, 2002). The present study uses the definition provided by The Royal Free Interview for Spiritual and Religious Beliefs (King et al., 2001), which defined religion as "the actual practice of a recognised faith". Spiritual beliefs were defined as not belonging to a specific religion,

but the "belief in a power or force, other than themselves that might influence their life. Some people think of this as their God or gods, others do not", and may or may not include ritual or practice.

For the purpose of this study, the term 'spiritual beliefs' will be used broadly to encompass spiritual and religious ideologies. When referring specifically to the participants in this study, the term 'religious/spiritual beliefs' (and derivations of) will be used when talking about people who have religious beliefs *and* those who have purely spiritual beliefs. The term 'religious beliefs' (and derivations of) will be used only for those who practice a recognised religion.

Mental health

In terms of mental health terminology, 'bio-psycho-social model' will be used to describe the ideas and theories that are commonly taught and widely used in practice by clinical psychologists and other mental health professionals in the UK and other 'Western' societies. The bio-psycho-social model is understood to have been strongly informed by the medical model at the outset, and they still share a scientific and secular basis.

Why focus on spiritual issues in mental health?

The importance of the recognition and appreciation of diversity, and the ability to work effectively with difference, by clinical psychologists has been argued from an ethical perspective (Sue, 1999). The BPS's Committee for Training in Clinical Psychology (BPS, 1995) and the BPS Equal Opportunities Statement have confirmed the responsibility of post-graduate training courses and qualified clinicians to appropriately meet the needs of all clients. Futhermore, the report 'Health of the Nation: Ethnicity

and Health' (Department of Health, 1993) states that service provision should be tailored to meet the specific needs of individual groups of people. The Patient's Charter (DoH, 1995), clearly states that clients should expect the NHS to respect and address their religious and cultural beliefs. The inability to work effectively with diverse backgrounds has been characterised as 'cultural malpractice' (Hall, 1997).

In terms of research, it has been widely argued that the notion of objectivity is unhelpful as it masks the reality that the researcher's viewpoint and the theories that influence their work will fundamentally shape the process of research and the interpretation of their findings (e.g. Willig, 2002, p.7). In pragmatic terms, these epistemologies fundamentally determine research agendas, study designs, data interpretation and clinical practice. This is significant, because the growing body of literature concerning spiritual beliefs and mental health recognises that this area of investigation has been largely ignored or at best given cursory and over-simplistic consideration (Pargament, 1997) and there has been some speculation as to why clinical psychologists and other mental health professionals have, so far, paid little attention to this area.

The concept of religious and spiritual beliefs

Pargament, Sullivan, Balzar and Van Haitsma (1995), reported how a group of students, who were of the same religion, either Protestant or Catholic, defined religion very differently. The researchers speculated that these differences may be due to the immaturity of the participants, who had not yet refined their understanding of religion. When their study was duplicated with more mature participants – members of the Protestant and Catholic clergy - the findings were replicated, the differences in definitions were striking. They concluded that the term "religion" has come to mean very different things to different people (or even seemingly similar people). These

findings may help to explain why it can be so hard to *talk* about religion, as it has been found to be such a nebulous concept.

Pargament (1997) talks about "religious pathways" – meaning that religious/spiritual beliefs and practice are not static, but a dynamic process, unique to each individual. He argues that emotions, thoughts, actions and relationships are all parts of the paths that people take in their search for meanings and understanding. The implication of this conceptualisation is that knowing someone's religious orientation alone tells us very little about how spiritual/religious beliefs influence their thoughts and subsequent behaviour. Therefore, as mental health professionals, we need to ask when, why and how religion/spirituality interacts with the process of coping with mental health problems.

Alongside the influence of spiritual beliefs on the process of coping, it is acknowledged that cultural factors will also impact on this process. Although cultural factors are not the main focus of this thesis, it is important to note and that for many people, their spiritual beliefs will form an intrinsic part of their cultural identity.

The history of clinical psychology and religion

Clinical psychology is a new discipline, having emerged during the last century, whereas religion has been concerned with struggle and suffering and its amelioration for thousands of years (Pargament, 1997). The relationship between the two has been tense, with psychology having accused religion of dogmatism, intolerance, social repression and mental illness (Ellis, 1986). Freud (1961) viewed religious faith as an immature response, an illusion created as a way of coping with the uncertainties of life. It is clear that such a hypothesis, which influenced modern psychiatry, was unlikely to

encourage a harmonious relationship, and in turn, the mental health professions, including of course psychology, have been accused of arrogance, elitism, amorality and selfishness (Vitz, 1977; cited in Pargament, 1997).

Pargament (1997), who has been a prolific commentator and researcher in this area, asks why there is so much tension between psychology and religion/spirituality when they both share a common concern, that of the human condition? He suggests that the most compelling explanation is that psychology and religion have become, for many, competitors. Phenomena once commonly understood as religious have been redefined as naturalistic (e.g. eclipses, disasters & illness). Religion has lost some of its authority as a source of absolute and indisputable meaning. With the rise of capitalism and the increasing focus on individuality during the course of the twentieth century, reality has become more of a subjective, personal concern, more of a concern for psychology. Pargament pushes the point even further by noting how psychology parallels religion in its rituals, use of symbols and charismatic leaders. He suggests that psychology offers another way of looking at the world and has its own mechanisms for solving problems, for instance, that the alternative to confession is counselling. He explains that he is not trying to say that psychology is a religion, but in its theories and practices, psychology functions *like* a religion. Perhaps this may help to explain why psychologists tend to be less religious than the general population (Shafranske & Gorsuch, 1984; Ragan, Maloney, & Beit-Hallahmi, 1980); they utilise psychological theories and ideas for understanding the world, instead of religion.

Clinical psychologists and people with religious/spiritual beliefs often live in different cultures, operate within different belief systems, speak different languages and follow different customs. As such, it has been recognised that service users and professionals

each bring with them a set of beliefs about the helping process that can have a significant influence on outcome (Reder & Fredman, 1996). Indeed, whilst on the clinical psychology training course, we would be lectured by clinicians who used different models. There would often be a noticeable tension if a student asked how, for instance, the lecturer, as a cognitive behavioural therapist would work with 'transference', as conceptualised by psychodynamic theory. Although the jibes were all good-natured, a tension was evident. This tension arose because of the competing ways of conceptualising a problem. And this from *within* a profession. The differences between people who utilise different belief systems can be great, and between those who possess different world-views, greater still.

The impact of differences between conceptualisations

Leavey (2004) argues that mental health professionals tend to see religious belief as part of the service user's problem, either as cause or in presentation, and suggests this mutual suspicion strains the relationship. If so, this could present a problem, as we know from many research studies, the therapeutic relationship between service user and provider that is an important factor in the outcome of therapy (e.g. Safran & Muran, 2000). This gulf between cultures has led to the recognition that clinical psychologists and other professionals in the mental health services may sometimes be unaware of the way in which their culture constrains the way they interpret, interact with and, in essence, judge what their clients bring to therapy. The clinician's views are based on a set of assumptions, from a belief system, heavily influenced by various different ideas within the bio-psycho-social model, which may lead the clinician to be unwittingly insensitive to the religious/spiritual beliefs and understandings held by others (Pedersen, Draguns, Lonner & Trimble 2002). This idea can be applied to all potential helpers and help-seekers, whether professional or informal.

Psychology and religion have much in common, as they are both fundamentally concerned with the problem of personal control. However, psychology helps people extend their personal control, while religion/spirituality helps people face their personal limitations and go beyond themselves for solutions. There is much to be gained from bridging the world-views and practices embedded in psychological and religious/spiritual perspectives. The notions of human capacities, from a psychological viewpoint, and human limitations, from a religious/spiritual perspective, compliment rather than contradict each other (Pargament, 1997). Religion and spirituality add a unique dimension to the coping process, one that cannot be described simply, as good or bad. Like a bio-psycho-social understanding and intervention for a person's problems has its strengths and limitations, we find religion/spirituality has the potential both to help people through their hardest times and to make matters worse (Carey, Archbishop of Canterbury, 1997).

HELP-SEEKING

This section will discuss the concept of pathways to help and the importance of cultural factors and similarity. It will then describe psychiatric and lay models for understanding mental health problems and influence of these models on people's help-seeking behaviour.

Help-seeking pathways

The concept of help-seeking pathways is used to describe and explain why some people, and not others, turn to professional mental health care. Help-seeking is conceptualised as the sequence of contacts with individuals and organisations prompted by the distressed person's efforts and/or those of their significant others, to

seek help, as well as help that is supplied in response to such efforts (Rogler & Cortes, 1993). How a person experiences their problem will have a profound influence on their help-seeking behaviour. This experience is shaped by many factors, including their world-view and belief systems. To illustrate this point, it can be seen that a person who perceives their problems as arising from stress, resultant from a negative life event will experience and deal with their problem very differently from someone who perceives their problems as arising from demonic possession.

Rogler and Cortes (1993) emphasise that pathways function in the context of social networks. The process of help-seeking involves a network of potential consultants, from those with which the person has an intimate relationship and the wider family, to their wider social network, through successively more distant figures until they reach the mental health professional. They suggest that the closer the fit between the explanations of the problem between the professional system and the person in distress and their immediate family, the quicker they will access that professional system. All of the potential consultants in a person's network, including religious/spiritual peers and organisations, can play a mediating or obstructive role in people accessing mental health services (Leavey, 2004). For example Diakonia, (2003, cited in Leavey, 2004) alleged that some Pentecostal groups in the UK discourage people with mental health problems to seek help from mental health services. Gater et al. (1991) found that pathways into psychiatric care differ internationally, depending on the country's level of resources; in well-resourced countries the pathway was via GPs and to a lesser extent, hospital doctors. Less well resourced centres showed a wide variety of pathways, with native or religious healers often playing an important part. However, delays on the pathway were found to be remarkably short, regardless of level of resources, although in some centres, longer delays were found related to native healers. Foskett (2001), in

a study of religious leaders in Somerset found that of the small sample he questioned, 40% had actually referred numerous people to GPs and counsellors. The research in this area is contradictory and more studies need to be conducted before we can understand the factors that influence this mediating role.

It is widely recognised that the majority of mental health problems that register on community surveys are not seen by mental health services. Angst and Dobler-Mikola (1985) found that only 20% of people with anxiety or phobias had discussed their problems with a GP, although nearly all had discussed them with a friend or relative. Research conducted in the UK by Bebbington et al. (2000) found that only a third of people with psychiatric symptoms consult their GP regarding their mental health problems and that less than 14% of people with neurotic disorders were receiving treatment for them. A major epidemiological study conducted in the U.S. also found that only a minority of people with psychiatric problems ever obtain professional treatment (Kessler, 1994).

In a large nationwide sample of the UK population, Barker, Pistrang, Shapiro and Shaw (1990) found that 17% said they would go to a religious leader for help with emotional problems compared with 16% who said they would go to a 'mental health worker'. In addition, Sorgaard, Sorensen, Sandanger and Ingebrigsten (1996) found that a 'substantial proportion' of participants opted to contact priests. This was not because of dissatisfaction with secular mental health services, nor simply by religiosity on its own, but by a combination of religious commitment, particular type of problem (involving personal loss) and greater openness to help-seeking generally.

Goldberg and Huxley (1992) proposed a model which describes a series of filters at each stage up the pathway to more specialised help for mental health problems, so that only a small minority will be seen by mental health professionals. The first filter incorporates 'illness behaviour' (Mechanic, 1968), where a person adopts a 'sick role' in order to receive 'provisional validation' that they have a problem from someone close to them; a family member or friend. During this initial help-seeking encounter, some sort of meaning is co-constructed and advice maybe given or a course of action decided upon. Goldberg and Huxley (1992) suggest that cultural influences have a decisive effect in this process. Studies have found that many people who perceive their mental health problems as being spiritual or religious in origin will tend to seek out religious/spiritual support prior to and often in place of seeking help from NHS mental health services (Narrow, Reiger & Rae, 1993; Cole, Leavey & King, 1995). Many people find that their problems can be dealt with and contained by this process and do not progress past this filter. A person will pass through the second filter when their helper is unable or unwilling to detect the problem. Goldberg and Huxley (1992) explain that the inability or unwillingness on the part of the helper to acknowledge psychological distress is a major reason why many people go on to seek help from other sources.

Focus on demographic variables

In trying to understand how cultural factors effect people's perceptions and help-seeking behaviour, Berry, Poortinga, Segall and Dasen (1992) defined culture as the shared group beliefs, attitudes, values, behaviour patterns and modes of communication that govern the way the environment is perceived and responded to. They expected culture to effect personality, interpersonal dynamics and the meanings attributed to behaviours. Therefore it has been argued that it is important to consider

cultural factors in the development of psychological intervention for minority ethnic groups (Sue & Zane, 1987).

Factors such as gender, ethnicity, cultural factors, religious spiritual beliefs and social class, have been investigated to ascertain their influence on people's help-seeking behaviour and uptake of mental health services for psychological problems (e.g. Barker et al., 1990; Chadda, Agarwal, Singh & Raheja, 2001; Cinnirella & Lowenthal, 1999; Deane & Chamberlain, 1994; Goldberg & Huxley, 1992). These studies found that all of the listed demographics influenced how people understand and seek help for their mental health problems and have highlighted the importance of cultural factors.

The importance of similarity

It has been suggested that the more congruence between the models of mental health used by a service user and therapist, the better the outcome of therapy (Pistrang & Barker, 1992). Therefore it is important to ask service users how they understand their problems and how they might be overcome; their responses may give important clues as to what approaches may or may not help this person. When thinking about who we would choose to help us, Smail (2001) suggests we would like to be seen by people we could identify as being like how we like to think of ourselves. However, a person could focus on many different aspects when looking for similarities between themselves and a potential helper. Cinnirella and Lowenthal (1999) emphasised the importance of a shared frame of reference after finding that 92% of their sample felt it could be beneficial to seek help from a professional of the same ethnicity and/or religion.

However, can it be assumed that two people, who share the same ethnicity and/or religion, share the same beliefs about how a problem can best be solved? There is

evidence to show that this is indeed an assumption used by many when searching for a suitable helper. Mitchell and Baker (2000), who investigated healthy Christian's expectations of the experience of psychological help found that their participants expected that a Christian helper would acknowledge and address their spirituality, that the helping episode would be characterised by warmth, understanding, safety and a non-judgemental stance and that answers would be found and the problem would be 'dealt with properly'. Whereas a clinical psychologist, as a member of the mental health profession, would neglect and reject their spirituality and their interaction would be characterised by a cold, impersonal style, with misunderstandings and uncertainty. Any positive outcome will be short term only as it is resultant from 'mind manipulation'.

The question has been asked as to whether these assumptions around similarity are borne out by the outcome of helping encounters between service users and providers who are matched for certain cultural variables. At present there is no data available on the efficacy of matching service user and therapist for religious beliefs. However, Sue, Fujino, Hu, Takeuchi and Zane (1991) carried out a study in the US that matched people for ethnicity, gender and language, and found more sessions were attended and better outcomes, for some minority ethnic groups. Alternatively, a review of research did not show support concerning matching service user and therapist for the same three factors: ethnicity, language or gender (Flaskerud, 1990). The results seem inconclusive and the literature does not reflect general agreement on the effects of these variables (Pedersen et al., 2002).

In summary, it seems that demographic factors can only tell us a limited amount about a person's experience of psychological help-seeking. It has been argued that it is crucial to understand how these demographic factors interact with all the other aspects

of a person (e.g. specific religious/spiritual beliefs) in order to understand their impact. (Copsey, 1997; Pargament, 1997).

Models for mental health problems

This section will commence by describing the bio-psycho-social model, and outline some of the 'sub' models that conceptualise help-seeking behaviour and the factors that they determine as influential. It will then move on to consider lay models and the points of similarity and divergence when compared to the bio-psycho-social model, and then present a conceptualisation by which society can judge as to whether someone's behaviour is culturally appropriate.

The bio-psycho-social model

The current model took shape from the psychobiological school of Adolf Meyer, which was formulated in the first half of the 20th century as an attempt to persuade psychiatrists to pay attention to both the physiological and psychological aspects of disorders. Following this, George Engel's (1977) bio-psycho-social model was another step in this direction to the conceptualisation that underlies the many different models used in practice today.

Goldberg and Huxley (1992) spoke about two perspectives which need to be used by mental health professionals when trying to understand mental health problems: the first perspective considers the brain (using molecular biology, neuropharmacology, immunochemistry); and the second considers the mind (epidemiology and the social sciences). Goldberg and Huxley suggest that neither brainlessness nor mindlessness can be tolerated in psychiatry or medicine. And indeed, although there is a lot of

variation in how the bio-psycho-social model is practiced between and within the mental health professions, it commonly incorporates these two perspectives.

There are many 'sub' models that are incorporated into the bio-psycho-social model. For instance, there are three dominant theories that guide research into help-seeking and the utilisation of mental health services: the sociobehavioural model (Anderson and Newman, 1973), cited in Pescosolido & Boyer, 1999), the health belief model (Rosenstock, 1966, cited in Pescosolido & Boyer, 1999) and the theory of reasoned action (Ajzen & Fishbein, 1980, cited in Pescosolido & Boyer, 1999). However, none of these perspectives make specific mention about religious beliefs or spirituality; these perspectives to understanding mental health have, so far, not been incorporated into the psychiatric model. Despite the growing importance of 'cross-cultural psychiatry', 'ethnic diversity' and about being 'culturally sensitive', there still seems little desire to consider the importance of 'Faith Communities' and religious/spiritual beliefs systems and how these factors impact on people's models for understanding what the psychiatric model terms mental health problems.

Lay models

Helman (1990) described 'lay models' as having 'an internal logic and consistency' which helps people to understand what is happening and why. Lay models are dynamic, often consisting of complex inherited folklore, which is influenced in an ongoing way by concepts disseminated in the media and from the medical model. Helman goes on to describe four factors which explain the aetiology of ill health. Common to all models are explanations that include the individual (e.g. heredity, lifestyle, behaviour) and natural world (climate, viruses, pollens, pollution) causes. The remaining two, the social (witchcraft, attachment theory) and supernatural (gods, spirits)

feature less strongly or not at all in the medical model, although many people all over the world, from all sections of society will draw on explanations from these two sites, including many people in the UK who hold religious/spiritual beliefs. Supernatural aetiologies do not fit a bio-psycho-social model, which is derived from a positivist paradigm and is therefore concerned with the observable and testable, which is in contrast to spirituality. Therefore, religious/spiritual beliefs are largely seen as irrelevant, at present, and are not included in training and consequently in clinical practice. This is an example where the clinician's model is privileged to the exclusion of the service user's.

Problems have arisen when there has been confusion over whether someone's behaviour has an aetiology of mental illness or whether it is a 'healthy' expression of spiritual beliefs. As clinicians we need to know what may be pathological and what is a legitimate belief or practice according to the service user's culture. In order for mental health professionals to make such a decision, Helman (2000) suggests we look to the *appropriateness* of behaviour within certain contexts and social relationships.

To illustrate this idea Helman described a society where the belief in spirits, and in possession by them, is considered normal and accepted. The reality of possession by spirits and witchcraft forms an integral part of their belief system of religious ideas and assumptions. Where this belief system is held, disbelief in the spirits or witches as the aetiology of the problem would be a striking abnormality, a bizarre and eccentric rejection of normal values. Helman goes on to outline that the consequences for the dissenter would be the cultural and mental alienation that would be roughly equivalent to that of those who in our secular society today believe themselves to be possessed or bewitched.

So how can a mental health professional judge whether or not any given behaviour is appropriate? Helman suggests four possible zones of social behaviour (see Figure 1). He goes on to explain that there are strict guidelines within every society, which determine what is 'normal'. The context in which the behaviour is carried out is also an important determinant of its 'normality' and appropriateness. The zones are not static, but a fluid spectrum of possibilities, that are likely to change with time and circumstance. For instance, speaking in tongues is regarded as desirable, and people who do it are seen as better adjusted in certain religious denominations, but people who are unable to *control* the ritual, as mentally ill. It is the distinction between controlled and uncontrolled that distinguishes between people practicing religion from people with psychosis. In every society there is a spectrum between what people regard as normal and abnormal, controlled and uncontrolled.

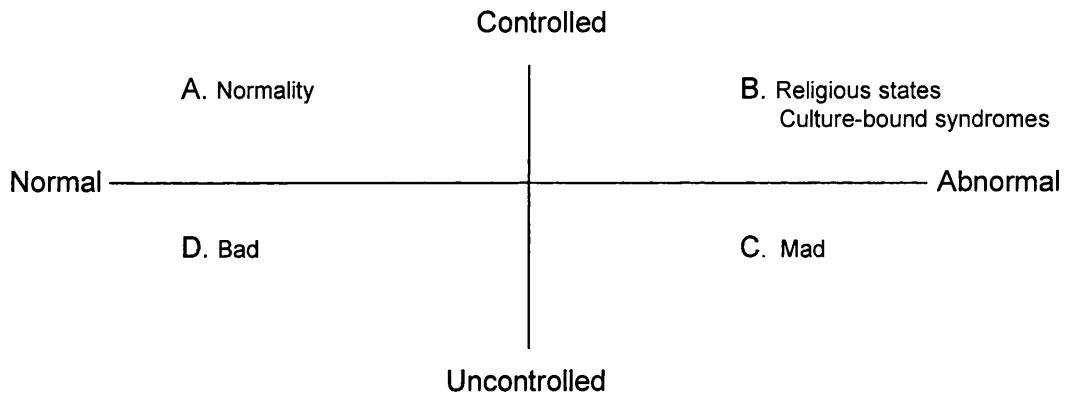

Figure 1. Zones of social behaviour

Helman explains that behaviour is labeled as 'mad' if it is abnormal, not controlled by social norms and has no discernible cause or purpose. 'Bad' or criminal behaviours are regarded as normal and uncontrolled – a person is regarded as guilty but normal.

Helman suggests that when trying to distinguish whether someone is mentally ill, the perception of their behaviour by their cultural group is crucial, alongside a psychiatric evaluation. For instance it might be acceptable to accuse someone of sorcery, but these accusations might be followed up by maladaptive behaviours, rather than the accepted communal technique for dealing with sorcery. Helman goes on to recognise that each culture provides its members with ways of becoming 'ill', of shaping their suffering into a recognizable illness entity, of explaining its cause, and of getting some treatment for it. Culture bound disorders can only be fully understood by looking at the wider context in which they appear – which may include political, economic, social and gender issues in the wider society.

COPING

This section will first consider the concept of coping and that many factors can influence how a person will cope with any given situation or problem. It will then focus on the role of religion/spirituality in people's efforts to cope with their psychological problems.

The concept of coping

Coping can simply be viewed as an encounter between person and situation. The theme of the individual confronted with difficulty runs consistently through the many definitions of coping that have been introduced over the past 40 years. For example, Friedman, Chodoff, Mason and Hamburg (1963) describe coping in terms of mechanisms for meeting threat. Menninger (1963) sees it as devices for regulating everyday emergencies. Pearlin and Schooler (1978) speak of responses to strains or potentially harmful outcomes. Lazarus and Folkman (1984) talk about efforts to

manage taxing internal and/or external demands. Aldwin (1994) speaks of coping as the use of strategies for dealing with situations and the emotions they elicit.

Although the specific focus and language varies, each conceptualisation concerns itself with the interface between individual and situation, within a broader context. In line with the descriptions above, coping is not restricted to one dimension of functioning; it involves the cognitive, affective, behavioural and physiological. Also, it is not limited to what goes on within the individual; it occurs within the layers of social context; of relationships and settings – family, organisational, community, societal and cultural. These systems may assist in the coping process and may create obstacles.

Pargament (1997) has highlighted that coping theory rests on a broader set of assumptions, that acknowledge the potency of internal and external forces, but one that also recognises the potential to transcend our personal and social circumstances. He argues that this is a way of thinking that is compatible with religious/spiritual conceptualisations. Coping theory assumes people develop their own perceptions of the world, but that there is a real world to be perceived.

Coping and spirituality

The proportion of people who hold religious/spiritual beliefs and involve religion/spirituality in coping with stressful experiences has been found to vary dramatically; some studies have found that only a minority of people made use of religion in dealing with their stressful events, from as low as 4% to 35% (Bowker, 1988; Gurin, Veroff & Feld, 1960; LeGrand, 1985). Others (Gilbert, 1989; Greil, Porter, Leitko & Riscilli, 1989; Pargament et al., 1990) have found that religion is used in coping by the large majority of their participants, with figures indicating as high as 91%. Part of

the reason for this wide variance may be explained by differences in methodologies, but the conclusions drawn from the studies may reflect the point that religious coping is variable, within and between cultures. So what can we conclude? Two contrasting points stand out. That a substantial number of people will employ their religious/spiritual beliefs and/or practice to help them cope in critical times in their life, and also that many people will deal with their problems without turning to religion/spiritual beliefs.

THE CURRENT STUDY

Summary and rationale

The first section of the literature review outlined the need, as set out by the government and the BPS, for mental health research, training and practice to focus on spiritual issues. It then defined the concept of religious/spiritual beliefs and described the contentious history between the mental health profession and religion. The second section focussed on help-seeking pathways and the influence of demographic factors throughout the process of seeking and receiving help, including how to gauge the appropriateness of someone's behaviour within the context of their own culture. Finally it considered the concept of coping and how people use their religion/spirituality to cope with mental health problems.

Psychological research so far has paid relatively little attention to religion and spirituality. When they are included in empirical studies, they are typically add-on variables, assessed by relatively crude measures, such as frequency of church attendance or denominational affiliation. In a systematic review of the evidence for a relationship between religion and health, Levin (1994) found a definite association. Hill

and Pargament (2003) note that even in these studies, with insubstantial measures, religion and spirituality have consistently emerged as significant predictors for physical and mental health. However, there has been growing interest in the relationship between religion/spirituality and physical health (e.g. Seeman, Dubin & Seeman, 2003, Powell, Shahabi & Thorensen, 2003), mental health (e.g. see Hill & Pargament, 2003), coping (e.g. see Pargament, 1997) and help-seeking (e.g. Cinerella & Lowenthal, 1999).

However, the question still remains of what accounts for this link. The earlier literature (e.g. Levin & Vanderpool, 1987) seemed to focus on the possibility that frequent religious attendance may be conducive. More recently the research (e.g. Levin, 1994) has considered social and psychological elements associated with religiosity/spirituality. Maybe it is felt that these questions need to be answered before the mental health profession considers how to alter the current paradigm, and therefore clinical psychology training and practice in order to consider and utilise people's religious/spiritual beliefs to optimise the effectiveness of psychological interventions.

In a review of religion/spirituality and health, Miller & Thorensen (2003) concluded that the study of religious/spiritual factors and health is a true frontier for psychology, and one with high public interest and that investigation is clearly warranted and clinically relevant. Traditionally, when undertaking research, psychologists try to control for complicating factors and try to make their sample as homogenous as possible. When it comes to religion/spirituality and coping it is these complicating factors that are often the variables of greatest interest. The study of religion, within context, can be complex and messy, and yet it may hold the key to understanding. Capps (1977, cited in

Pargament, 1997) suggested "the religious is not elusive because it lurks behind ordinary phenomena but because it is woven into the phenomena".

To summarise, religion/spirituality is a very complex, multi-dimensional phenomena. Thoughts, feelings, actions and relationships are all part of religious experience. A similar complexity is found with the concepts of coping and help-seeking. Additionally, underpinning all of these factors, there is an individual, with a unique personality, who, ultimately, can choose. Combine these phenomena together and the subject becomes very complex and intertwined. No wonder practitioners and researchers alike have had difficulty getting to grips with it.

Cinnirella and Lowenthal (1999), explored the influence of religion and ethnicity on beliefs about mental illness, and information about religiously based beliefs and practices which may complement or conflict with the bio-psycho-social model. They concluded that relatively little is known, by mental health professionals and researchers, about religious variations in beliefs about mental health and its causes and cures, or the relationships of such beliefs to help-seeking and coping.

There is a need to comprehensively describe the experience of people with religious/spiritual beliefs who have sought and received help for their mental health problems. Previous literature has started to consider the impact of religious/spiritual beliefs on help-seeking and the experience of help from informal helpers. Although some research has asked people about what they *anticipate* therapy would be like for them as a person with religious/spiritual beliefs, there has been no investigation into people's actual experience of therapy with a clinical psychologist and exploration of the

interface between people's religious/spiritual beliefs and the theories and ideas utilised during therapy.

Methodological approach

Both qualitative and quantitative methodologies have their strengths. However, within the context of this study, qualitative approaches have a number of distinct advantages. As this chapter has described, there has been some research conducted into the interface between religious/spiritual beliefs and mental health, but how people reconcile their religious/spiritual beliefs with the process of therapy with a clinical psychologist has received relatively little attention. Qualitative approaches have been recommended for exploratory research in areas where little is known (Barker, Pistrang & Elliott, 2002). They are particularly useful where the study is trying to seek knowledge concerning complex, little understood, personal, interpersonal and social processes (Ridgeway, 2001). Qualitative methodology is advantageous for this study because it allows the "meaning, subtlety or ambiguity" of the phenomena under study to be preserved and explored (Barker, Pistrang & Elliott, 1994, p. 81), aspects which are anticipated to characterise religious/spiritual people's experiences of seeking help from informal sources and the NHS as a secular service. Moreover they allow the participant greater freedom to express the issues important to them, and as they see them (Barker et al., 2002) with less imposition from the researcher's assumptions.

Aims and research questions

This qualitative study explores how service users with religious/spiritual beliefs understand their psychological problems and the types of help and support they sought

and how they experienced it. It examines both the informal and formal helping relationships from their perspective.

By increasing our understanding of the factors associated with how people cope with their mental health problems, this research may suggest ways to improve the match between what people with religious/spiritual beliefs are offered in therapy with a clinical psychologist and what they would actually find helpful. Specifically this study will address the following research questions:

1. What types of help and support do people with religious/spiritual beliefs seek and receive?
2. What kinds of help and support do they perceive and experience as helpful or unhelpful?
3. How were their religious/spiritual beliefs incorporated into therapy and what was their experience of this?

CHAPTER 2: METHOD

OVERVIEW

This was a descriptive, qualitative study. Ten participants were interviewed about their respective experiences of help-seeking and receiving therapy from a clinical psychologist for their various mental health problems. The interviews were tape-recorded, transcribed and analysed using Interpretive Phenomenological Analysis (IPA: Smith & Osborn, 2003).

ETHICAL APPROVAL

Ethical approval was granted from Barnet, Enfield and Haringey Local Research Ethics Committee (Appendix 1).

RECRUITMENT

Rationale for criteria

The aim was to interview people with religious/spiritual beliefs who had experienced therapy with a clinical psychologist. It became clear as a result of pilot interviews that, although participants may identify themselves as belonging to the same religious group, their beliefs and practice could vary considerably. Therefore it was decided to include participants according to their strength of religious/spiritual belief, as opposed to their denomination or a measure of their formal religious/spiritual practice.

Inclusion and exclusion criteria

Inclusion criteria were: (1) self-definition of having strong religious/spiritual beliefs; (2) current or recent experience of a mental health problem; (3) currently receiving, or

recently finished, therapy with a clinical psychologist; (4) stable and well enough to undergo an hour-long interview; (5) age 18-65 years; (6) any spoken language, as there was funding available for an interpreter.

Exclusion criteria were: (1) the mental health problem related to substance misuse; (2) self harming behaviour; (3) currently experiencing a major life event (including relapse) which was perceived as stressful.

Procedure

Clinical psychologists in the region were approached and requested to review their caseloads and identify service users who matched the research criteria. At this point, some of the clinical psychologists indicated that they would not be able to identify potential participants, as they did not know about their clients' religious/spiritual beliefs. When a potential participant was identified they were then told of the study and given an information sheet (Appendix 2) by their clinical psychologist, either at the end of a session, or if therapy had finished, by letter. Once people had received the information sheet from their clinical psychologist - whether by post or in person - the procedure was identical. If they had not declined the option to discuss participation, this introduction to the study was followed up by a telephone call by the researcher. The researcher waited at least two weeks before telephoning the potential participants to answer any questions and to reiterate that their decision whether or not to take part would not affect their contact with formal services. Interviews were then arranged.

PARTICIPANTS

In total, 12 service users were given information sheets and contacted by the researcher. Of these, one person had just suffered a bereavement, and another was to shortly spend an extended period of time outside the UK. Therefore, ten people were interviewed, all of whom had received a short term intervention, mostly Cognitive Behavioural Therapy (CBT). Potential participants spoke English as a first language and interpreting services were not utilised.

Characteristics

Participant characteristics are set out in Table 1. Of the ten participants, seven were female and three were male. Their mean age was 42 (range: 32-52). Seven described themselves as white English, two as mixed ethnic origin, born in the UK, and one person as black Caribbean. Two people had been born outside the UK, but had emigrated to England as children. Two people who described themselves as white English explained that their parents had emigrated to the UK as adults and had strongly retained their cultural and religious identities from their countries of origin.

To gauge religious/spiritual beliefs, the participants filled out The Royal Free Interview for Spiritual and Religious Beliefs (King, Speck & Thomas, 1995 & 2001; Appendix 3). The quantitative and qualitative information on the questionnaires was used to get a sense of how fundamental and influential their beliefs were. All of the participants who were recruited indicated their religious/spiritual beliefs fundamentally impacted on how they understood and functioned in the world.

In terms of religious/spiritual beliefs, four people described themselves as Evangelical Christians within the Church of England; two described themselves as Evangelical/Pentecostal Christians within black congregations; one was Christian Greek Orthodox; one was Sunni Moslem; and of the two who described themselves as having purely spiritual beliefs, one of those people made reference to the New Testament of the Bible. Six people were married and living with their partner, four were single and living alone. Regarding educational attainment: one left school at 16, two left at 17 and one at 18, two undertook further education qualifications following A-levels and four had university degrees. All had a profession, but five were not working due to long term sick leave for their mental health problem at the time of the interview.

Regarding their mental health problems, six people described themselves as having depression, one of whom also had a diagnosis of personality disorder, two people had bi-polar disorder, one of whom also had a diagnosis of personality disorder and two people had an eating disorder. Many found it difficult to pin-point 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.

Table 1 Participant characteristics

	Gender	Age	Ethnicity	Religion/spirituality	Living situation	Education	Work status	Main problems	Duration (years)
P1	Female	35	White English Born in the UK	Evangelical Christian C of E	Married With partner	School: 18 & further education	Not working	Eating disorder	1
P2	Male	46	Mixed: White Other – African ancestry Born in the UK	Evangelical, Pentecostal Christian	Single Independent	School: 18 & further education	Not working	Depression	2
P3	Female	52	White English Born in Africa, emigrated to UK as a child	Spiritual beliefs	Married With partner	School: 16	Working	Depression	1
P4	Female	32	White English Born in the UK	Spiritual beliefs	Single Independent	School: 17 Currently studying	Working	Bi-polar disorder & Personality disorder	13
P5	Female	45	Black Caribbean Emigrated to UK as a child	Evangelical, Pentecostal Christian	Single Independent	School: 17	Working	Depression	1
P6	Female	39	White English Born in the UK	Evangelical Christian C of E	Married With partner	University	Working	Eating disorder	1
P7	Female	32	Mixed : Pakistani & Iranian Born in the UK	Sunni Moslem	Single Independent	University	Not working	Depression & personality disorder	7
P8	Male	48	White English Born in the UK Both parents Cypriot	Christian Greek Orthodox	Married With partner	University	Not working	Depression	0.5
P9	Male	46	White English Born in the UK	Evangelical Christian C of E	Married With partner	University	Not working	Bi-polar depression	4
P10	Female	45	White English Born in the UK	Evangelical Christian C of E	Married With partner	School: 18	Working	Depression	1

PROCEDURE

Participants were offered a choice of location for the interview: at their home, in the research department on a hospital site, or at the same location as their NHS therapy. Wherever the location, all of the participants were interviewed in privacy, as it was felt this would allow them more freedom to discuss the difficulties they encountered, or the unhelpful aspects of support.

Opening the interview

Before the start of the interview, the key aims of the study were reiterated. It was emphasised to the participants that there were no right or wrong answers and the researcher was hoping to understand their personal experience of seeking and receiving help; therefore I did not need them to share their personal experiences of their difficulties, but more about how they understood their difficulties and what led them to decide what might help them. It was also emphasised that we would meet just once and they were encouraged to think about the type of information they would like to share within this context. It was made clear that their boundaries would be respected and supported by the researcher if they decided not to share information, especially if it were of a very personal or upsetting nature. The confidential and anonymous nature of the research was reiterated and the participants were reminded that they could withdraw their consent and terminate the interview at any point.

Participants were given a consent form relating to their participation in the study and the audio taping of the interview (Appendix 4).

Interview schedule

The interviews were based around a purposely designed, semi-structured interview schedule (Appendix 5). This helped the researcher explore people's experiences of seeking and receiving help and how their religious/spiritual beliefs interacted with this process. The interview schedule was constructed using guidelines set out by Smith, Jarman and Osborn (1999). The questions were informed by the issues that have been discussed in previous literature about help-seeking, and adapted to focus on the impact that the participants' religious/spiritual beliefs may have had on the process.

The schedule was used as a flexible guide. The aim was to follow what the participants themselves brought to the interview and only use the questions to guide them back to the main focus of the study should this be necessary. 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 (Barker et al., 2002; Burman, 1994), adopting a 'not knowing' position (Anderson & Goolishan, 1999), in which the researcher's assumptions are laid aside and the researcher is actively curious about what the participants are telling them. 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. Interviews were audio-taped and lasted between 50 and 70 minutes.

The schedule was organised as a series of open questions arranged around five main areas, some followed by potential prompts. These are outlined next.

Getting to know the participant

Participants were asked their opinion of the service they had most recently received, what they were hoping for, and what they saw as their main problems. This enabled the participant to focus on their experience of therapy with a clinical psychologist and also gave the researcher some contextual information about their difficulties.

Religious/spiritual beliefs

The next section covered the impact of the participants' religious/spiritual beliefs on how they cope, how they feel they could best be helped, and by whom. This was to gain knowledge of the participants' model for understanding and alleviating their mental health problems. 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.

Help-seeking

This section encouraged the participant to talk about their experience of seeking help in a chronological order, from when they first realised they had a problem, through to their decision to utilise mental health services in the NHS. It paid attention to whom they did and did not turn to and why, and if any help they received was particularly useful or unhelpful.

Intervention

The participants were asked about the most helpful and unhelpful aspects of their therapy with a clinical psychologist.

Closing the interview

The researcher asked if there was anything that had not been covered during the interview that the participant felt would give useful or important information. They were also invited to reiterate anything that they felt was important or that they felt the interviewer had not properly understood. They were then asked how it had felt to discuss these issues, as a person with religious/spiritual beliefs, with someone from the NHS, which was seen as a secular organisation, as it was anticipated that the participants may have found it difficult to talk about their religiosity/spirituality within the context of secular research. Finally they were thanked for their time and for discussing their personal experiences with the researcher.

After the interview

Any issues that had arisen from the interview were addressed and the participants were given the researcher's telephone number at the research department should they wish to contact her later - no participants subsequently did so. A copy of their consent form, along with a copy of the information sheet, was sent to their clinical psychologist to act as a record that they had taken part in the study. Finally, the participants were offered a summary of the research. Those who wanted to receive this gave their contact details to the researcher.

ANALYSIS

Each of the interview tapes was transcribed verbatim. Any identifying features, such as names or locations, were removed. The transcripts were then analysed using Interpretive Phenomenological Analysis (Smith & Osborn, 2003).

Rationale

IPA is a relatively new approach to qualitative analysis and was specifically designed to enable insight into people's psychological worlds (Willig, 2001). It was chosen as the mode of analysis for a number of reasons. The nature of this study did not lend itself to a discursive analysis, since the aim was to explore how the participants themselves experienced help-seeking and therapy, rather than to account for the historical, cultural, social and linguistic influences upon their constructions of help and support. It was also felt that the aim of the study was more aligned to that of IPA than grounded theory, as it was not the aim of this study to produce a theory accounting for the phenomena in question. In contrast, IPA is concerned with *describing* the nature or essence of people's experiences (Willig, 2001, p. 69).

IPA aims to explore "how particular individuals attempt to make sense of, or find meaning in, their [experiences]" (Smith, 1996, p. 266). The term itself signifies the duality of the approach. It is phenomenological, in that it is concerned with individuals' personal perceptions of a phenomenon, such as an event or experience, rather than aiming to produce an objective statement regarding the phenomenon itself. However, in doing so, IPA acknowledges the influence of the researcher's own conceptions in making sense of the other's personal world. In this sense it is also interpretative. The outcome of IPA is therefore recognised as "a co-construction between participant and analyst in that it emerges from the analyst's engagement with the...participant's account" (Osborn & Smith, 1998, p. 67)

Process

Smith and colleagues have published many clear and systematic guidelines on the process of IPA (e.g. Smith, 1996; Smith et al., 1999; Smith & Osborn, 2003). The analysis in this study was loosely based upon the outline described by Smith et al. (1999) with reference to Willig (2001). Smith et al. emphasise that "there is no single definitive way to do qualitative analysis" (p. 220) and that most researchers will find themselves adapting the method to their own way of working.

The analysis began by selecting one interview and reading it several times until the researcher was thoroughly familiar with the transcript. In doing so, anything of significance or interest was highlighted (stage 1, Appendix 6). These initial quotes were then entered onto a computer table, noting the line numbers (stage 2). The next step entailed identifying tentative theme titles, which seemed to capture the essence of what was being expressed by the participant – these were added to the computer table. Once all the themes had been noted from this transcript, the complete list was grouped into a tentative framework of themes and superordinate themes (stage 4, Appendix 7). The researcher continually checked back to the original transcript to ensure that the emergent structure actually reflected the participant's account. At this stage, some themes seemed specifically relevant to the phenomena under investigation and some related more generally to issues around help seeking and therapy. These themes were processed in the same manner but placed in a second section of the table.

The table of themes produced for the first transcript were used to process the second transcript. Stage 1 was repeated, then the highlighted quotes were slotted into the theme table, or new theme titles were created. This process was repeated for each transcript in turn until a superordinate table of themes from all participants was constructed (stage 5, Appendix 8). 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. A final table was constructed with the complete list of domains, themes and sub-themes together with participant quotes.

Credibility checks

An initial credibility check was provided by one of the participants. We met to read over the transcript of our interview and to check that the quotes and themes had accurately represented the participants experiences and ideas. Further credibility checks on the emerging themes and framework were provided by a second researcher, with extensive experience in research on pathways into care, religiosity and mental health, and qualitative methodology. He independently analysed two transcripts and read five others. Following this, the two researchers discussed their respective themes and frameworks before arriving at a tentative consensus. This was further checked by a third researcher, who has experience of research into informal helping and IPA, who had read three of the transcripts. They discussed its reflection of the original material, and from there, the final framework was constructed.

RESEARCHER'S PERSPECTIVE

Guidelines to good practice in qualitative research encourage "owning one's perspective" (Elliot, Fischer & Rennie, 1999) or "reflexivity" (Henwood & Pidgeon, 1992; Willig, 2001). This involves explicit consideration of the researcher's values, assumptions and interests, in order to make apparent how these may have influenced the study direction and findings.

My interest in this area of study has many origins - professional, therapeutic and personal. My earliest interest was personal. I was raised in a secular family, who were open and positive about religious and spiritual beliefs, but clearly did not believe themselves. I was fascinated by people who did have beliefs; this ranged from people immediately in my social network, to items on the news about conflict and war in the name of religion. I found it quite confusing to witness how much strength and comfort some people derived from their spirituality, and how much pain and conflict it caused others.

I remember clearly, when I was eight years old, feeling I needed something to happen in my life. Looking back, I think I needed more ways to understand the world and hoped God would provide that understanding and containment. I remember looking forward to my Christening and, naively, fully expected my life to change from the moment the holy water hit my head. I was thoroughly disappointed and felt somewhat adrift. I now believe this may be where my path to becoming a clinical psychologist began. In my need to understand the social world I started to look for further explanations for people's behaviour. I now realise I was drawing on all sorts of psychological constructs (e.g. personality, motivation) – my own 'model' for understanding the world was becoming furnished with all of these concepts, as each 'psychological' explanation helped me to understand and function within the social world. So, for me, I believe psychology did indeed function like a religion. One could say God's loss was clinical psychology's gain!

As a trainee clinical psychologist I watched as a succession of lecturers 'evangelised' their particular theory or model of working. They used phrases like 'you need to *believe* in [this model] yourself, so you can help your client to *believe* – they need to *believe*, or

else it won't work'. It struck me how similar their charismatic approach was to that of preachers, and how having *faith*, whether that be in God or in CBT, was important in order to reach a common goal – to be more fulfilled and happier in your life.

Then I noticed how negative some clinical psychologists and other mental health workers were towards people's religious/spiritual beliefs. I went onto some psychiatric in-patient wards and noticed how dismissive a majority of the staff were to people's religious/spiritual beliefs and perspectives, mostly seeing how they undermined their efforts to help the person get better. I asked the question of why one belief system should be privileged over another; why, for instance, was one woman laughed at when she asked to see a vicar, and told that her only hope was to 'keep taking the tablets'. The psychiatric model of care seemed to be privileged to the exclusion, and even derision, of the service user's model of understanding or easing their discomfort. I wondered if there was really a need for this exclusivity, and if the two could work together to further optimise a person's recovery. It certainly seemed common sense to me that if, as a potential helper, you ignore someone's perspective they will feel disrespected, and even alienated, by the person offering help and therefore less likely to engage with anything that is offered, whether this may be helpful to them or not.

These experiences and ideas led to the conception of this research. My experiences as an undergraduate led to the recognition of the strengths and limitations of quantitative approaches. My studies of both psychology and the philosophy of literature ignited an interest in feminist psychology and post-modern concepts about multiple and subjugated narratives. I have since carried out both quantitative and qualitative research and found the method and the discoveries from the qualitative studies more interesting, respectful and clinically influential.

These experiences and interests led me to hold certain expectations while I was developing the ideas and protocol for this study. I anticipated some people may have a different understanding of their problems to those that would be put forward by a clinical psychologist and that their peers may discourage them to seek help from the NHS as a secular service. I also expected that people would find conflict between their beliefs and the psychological theories and ideas, which they may not be able to voice and which may have impacted negatively on the therapy. I thought the effect of suffering with mental health problems would have weakened the faith of many of the participants. Finally, I was apprehensive that my lack of understanding about religious/spiritual ideas and practices may lead me to unintentionally cause offence. Further reflection on how my personal interests, expectations and biases may have influenced the course of the study will be discussed in Chapter Four.

CHAPTER 3: RESULTS

The analysis led to the generation of a number of themes and sub-themes, which have been clustered into two broad domains (Table 2). The first, 'Dilemmas of help-seeking' represents the process that led up to the participant's inception into therapy with a clinical psychologist. The second 'The process of therapy' encompasses the experience of therapy and the interface between the participants' religious/spiritual beliefs and the secular theories, models and ideas. The themes within each domain are not mutually exclusive; some overlap exists between them.

Note on terminology and notation

This section presents each theme in turn, illustrated by excerpts from the interviews. Quotations from the participants are indicated by 'P' followed by their research identification number (for example, 'P1' refers to participant 1). The extracts from transcripts have been edited for readability. An edited omission in the text is indicated by three dots (...), long pauses are indicated using five dots (.....). Words that were spoken with special emphasis by the participant are in **bold**. All identifiable information has been removed and replaced by a descriptor in square brackets, for example [husband]. Editorial clarifications are also placed in square brackets.

Table 2: Domains, themes and sub-themes

DOMAINS	THEMES	SUB-THEMES
Dilemmas of help-seeking	1. Understanding the problem	How I understand my problem
		How others view and react to my problem
	2. Help from religious/spiritual sources is variable	Peers attitudes to seeking secular help
		Searching for a therapist with religious/spiritual beliefs
		"Church counselling can be more detrimental than helpful"
		Faith: a consistent source of help
	3. Fears about turning to secular services	To turn to secular services is to turn away from God?
		Help from a secular source will not consider my religious/spiritual beliefs/practices
	4. Needing a secular understanding of the problem	Needing another perspective
		Needing to do things differently
The process of therapy	5. Reluctance to disclose religious/spiritual beliefs	They'll think I'm mad
		Language as a barrier
	6. Secular perspectives and religious/spiritual beliefs can be integrated	Respect and acceptance
		"I went to the ungodly and found God there"
		Similarities between the underlying principles
		When religious/spiritual beliefs have and have not been considered
	7. The reciprocal influence of therapy and religious/spiritual beliefs	"Knock-on effect"
		His hand was upon it
		"My faith is stronger now"

DOMAIN ONE: DILEMMAS OF HELP-SEEKING

The first domain covers the time leading up to the participant starting therapy with a clinical psychologist. The themes address the dilemmas the participants faced, from first realising that they had problems they felt they could not cope with on their own, through a process of trying to gain a fuller understanding of the nature of their problems, and subsequently, the issues and conflicts that surrounded turning to the NHS, as a secular service, for help.

Theme 1: Understanding the problem

All participants seemed to go through a phase where, although they had accepted that they had a problem and needed help, they were still searching for further definition of their problem that made sense to them. Other people's explanations needed to fit coherently into their own model for understanding their problem, otherwise it would be seen as unhelpful or be rejected.

How I understand my problem

All of the participants described the aetiology of their problems with an explanation that was broadly congruent with a bio-psycho-social model, synonymous with the psychiatric model. Most of the participants emphasised the role that 'life-events' played in their problems.

> *I think with me it was stress at work which brought it on, but then the main trigger with me at work was something that went wrong and I felt I was taking the responsibility on myself. (P9)*

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

Two of the ten participants also incorporated spiritual beliefs into their explanatory model of their illness. Interestingly, Participant 4 had reconciled the bio-psycho-social model of understanding with the spiritual, and suggested that these seemingly different perspectives of understanding the aetiology of mental illnesses need not be seen to be conflicting.

…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)

How others view and react to my problem

Some of the participants found people in their church very helpful. Most felt that the most useful forms of help were being listened to and not being told what to do or having advice or views thrust upon them.

Firstly, spoke to a friend from the church, to pray and to sort out what was going on in my head. She said it would be ok to pray about it. (P1)

When I first acknowledged that I really did have a problem, 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)

Some found other people's attitudes to their problems unhelpful. In particular, many of the participants expressed that it was unhelpful to be told that their problems had arisen because they were acting in a manner that went against their faith, or that their faith in God may not be strong enough.

*I found out there was a kind of two-tier hypocrisy, because 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. And I felt to myself well you've got problems in your life, that you can preach to me and tell me that my faith isn't strong enough, but then it seems to me that they were not addressing their own problems either. (P5)*

A few of the participants in this study said that they had encountered some Christian helpers, particularly those from a Pentecostal background, who offered a spiritual

understanding of their problems. The spiritualisation of what the participants themselves regarded as mental health problems was seen as most unhelpful.

> *I think from those, that type of background there tends to be quite a lot of misunderstanding about mental illness…I think it's almost seen as an evil….. satanic… attack….. I did have that from one or two people, um, and I just tried to shut that out because that's actually very hard, and hurtful thing. (P9)*

Some of the participants felt their problems actually arose because of the views their church or their religious peers held and broadcast, which they felt were not necessarily true to the intended meaning of their religious texts. They spoke about the difficulties that can occur when certain personalities use parts of scripture as a tool for social control.

> *The church preaching isolated lines of scripture telling you if you're gay you go to hell for example. And it's something that any person of any faith would experience, whether Christian or Muslim or whatever, they've all got lines in there that they can use to judge you by, on sexuality and a whole range of other issues… This is where religion does cause an awful lot of suicides and depression and a whole load of problems for Christians, Muslims, whatever; because, and I am sure it is true throughout history, it's used as an element of control you see, that's the bad part of it…. they use whatever they feel like to control and manipulate you to a certain pattern of behaviour that* ***they*** *want, which when you analyse it in a more free thinking sort of way, has nothing to do with the real teaching of the scripture at all. (P2)*

I've seen religious people, I've watched the wickedness that they do…under religious pretences. (P3)

Following on from receiving explanations that were unhelpful to them, some participants found that they did not agree with the advice they were given as to how to get better.

…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)

Theme 2: Help from religious/spiritual sources is variable

The participants all had an idea of how people in their church would understand and react to their problems from their own previous experiences, or those of others, which they had observed. They used this information to anticipate how much or little help they anticipated they would receive, and how useful the help would be. This seemed to influence how much or little they shared their problems and sought help from within the church.

Peers attitudes to seeking secular help

Most participants found that their peers were supportive of secular therapy. Some actively encouraged the participant to take up services offered by the secular service.

> *The majority of my Christian friends have been very supportive in this and have been very pleased that I've had such good help offered to me and that I've been willing to take it as well. (P6)*

> *In the early times when we didn't know it was bipolar depression…I was talking with another Pastor and his wife in their house…the Pastor, he was upstairs, [my husband] wasn't well at that time and [the Pastor] phoned me up and says get [husband] to the doctor quickly I've seen this before, this is bipolar depression he's on a high if you don't get him to the doctor quickly he's going to go shooting right down and he'll be worse than he was before. So he gave me advice to get him to the doctor. (P10)*

Many of the peers who supported secular therapy felt that this should be undertaken in tandem with religious practice, such as prayer. One person offered to try and increase the effectiveness of the secular intervention for the participant by praying at the same time.

> *One of the leaders …church wardens and he's told me that every day he prays for me, he prays for our family and he knows we're going to couple therapy and he (asks) "what time's your couple therapy you're going to because I'm going to pray for you", so he's always praying for us. So I know there's that prayer support, I know that people are talking with us (the therapy), and someone's praying that God will help at the same time. (P10)*

They would qualify that [support of secular services] with also spending time with me praying and praying for me…which was very helpful. (P6)

Searching for a therapist with religious/spiritual beliefs

Three of the participants tried to access formal therapy via a Christian counselling organisation. Two found difficulties with accessing the therapy and seemed disillusioned about finding a dearth of help from a Christian organisation.

Their initial response was well we don't really deal with eating disorders. No one seemed to be able to offer, or if they did have some sort of specialist treatment they were a long way away. (P6)

It seems that they were expecting very large donations… in money terms and I felt a little bit annoyed with that because I felt if they are doing God's work. I know nobody works for free but…I believe that anything you do for the church has got to be done freely…I give my time to the church freely. So Christian organisations who are counselling and then charging for it, I couldn't reconcile the two, so I didn't feel very confident with that kind of arrangement. (P5)

It seemed ironic that for Participant 5, it was the Christian organisation that offended her Christian values to the extent that she did not feel she could seek help there. However, the one person that did access therapy through a Christian organisation found it very useful.

…I felt it's actually quite important to have somebody who might actually understand a Christian in those sort of circumstances…I think the conventional therapy but done by somebody who has the same faith as you is a very good thing…I think you actually have to understand it as a mental thing, but then apply spirituality into that mental issue, as opposed to seeing it as the opposite way round. (P9)

"Church counselling can be more detrimental than helpful"

The view that counselling from within the church can be detrimental was universally supported by all of the participants who were connected to a church. They seemed to be saying that church counsellors can be very useful, but that they found it unhelpful to be restricted to having a purely spiritual explanation for their problems, and therefore, exclusively spiritual intervention (e.g. prayer, fasting) when trying to address their problems.

…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)

Not that I'm against church counselling… I suppose there's a difference between actual mental health issues and things which people are just struggling with in their life. 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)

I could talk my heart out to them (Christian Counsellors) but I don't feel as if my basic issues were being addressed for me to deal with them. (P5)

Faith: a consistent source of help

For all of the participants, no matter how positive or negative their experiences with people or formal organisations, they described their faith, and/or their relationship with God, as a consistent source of tremendous strength.

*...from the personal faith point of view if you forget about the church, if you remain true to what **you** believe in as a person that has a tremendous power to heal you of, you know, depression and mental illnesses and physical illnesses... if I hadn't had a religious faith I would have just given up. (P2)*

My strength and courage comes from my relationship with God. (P5)

People will go up and down but I know God is constant and I can always depend on God. (P10)

Theme 3: Fears about turning to secular services for help

Many of the participants talked about their concerns around seeking help from the NHS, which they regarded as a secular organisation. Some of those who were very comfortable with taking their mental health problems to mental health services still had concerns that they would be required to do something that conflicted with their religious/spiritual beliefs/practices. Some felt that a secular therapy would mean that their religiosity/spirituality - a large and important part of themselves - would be

neglected in a secular therapy. Others were reluctant to turn to secular services at all because they felt that this action may be to turn away from God, and led them to question if this move represented a lack of faith in God, which they described as uncomfortable and distressing.

To turn to secular services is to turn away from God?

Some were worried that their utilisation of secular help would demonstrate that their commitment to God was diminished.

> *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)*

Help from a secular source will not consider my religious beliefs/practices

The people who feared that they would not be able to talk about their religious beliefs in a secular therapy seemed to feel that it would be difficult to tell the therapist if the therapy, or aspects of it, conflicted with their religious/spiritual beliefs.

Several people spoke about getting better in terms of becoming 'whole', and that this is what God wants for them. It seemed to be a term that, although in usage in everyday society, took on an important religious significance for some of the participants. It seemed to some that a secular therapy would be incomplete, and therefore unsatisfactory, because it would ignore the religious aspects of themselves.

...also a feeling that going to a secular counsellor, I could only talk to them at a certain level...I felt they wouldn't see the whole picture of me. (P6)

Some of the participants feared that secular therapy would expose them to ideas that conflicted with their beliefs, or try to get them to behave in a way that would be in conflict with how they lived their life, according to their religious or spiritual beliefs.

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)

Theme 4: Needing a secular understanding of the problem

All of the participants felt it would be helpful to get another perspective on their difficulties, that gave an alternative to their problems being rooted in their spirituality. It seemed that people wanted another means of arriving at an understanding of their problems, as so far the spiritual explanations that had been offered did not ring true for them. Following this, it seemed they were searching for advice about extra ways to help with their difficulties, ways that were not based in religious or spiritual beliefs or practice.

Needing another perspective

The seeking of another perspective from secular sources was conceptualised as either part of God's portfolio of help available to them, or as seeking help for something that

had nothing to do with their spirituality. Both of these perspectives seemed to help people move forward in their search for help from secular services.

> *I prayed and I believed God wanted me to go and seek help, secular help. I needed to hear somebody's 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)*

> *I really needed something that was secular, even though I had such strong beliefs and faith. It was easier in that you were just looking at it from one level (P1)*

Some of the participants outlined some specific benefits of seeing a secular therapist.

> *It was good to be more open and honest about my religion (P7)*

> *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)*

> *People in that field are supposed to have an expertise in that area and are more able to hear what you are saying from a different perspective (P1)*

Needing to do things differently

Some people seemed to be saying that the belief expressed by those around them, that they would get better through being granted a miracle, was not entirely helpful. This

was possibly because they didn't want to hold a belief that they felt was likely to lead them to feel let down by God or the strength of their faith.

> *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 seemed to shift for another participant, and she was then able to move from her stuck position, and started to look at what she could do to help herself with her problems.

> *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)*

DOMAIN TWO : THE PROCESS OF THERAPY

This second domain is concerned with the issues encountered by the participants once they started to see a clinical psychologist. The themes are presented in chronological order, from initial reluctance to disclose religious beliefs because of their assumptions about how this information would be heard and acted upon by a secular therapist, through a realisation, as therapy continued, about how their religious or spiritual beliefs could be integrated with ideas from psychological models.

Theme 5: Reluctance to disclose religious/spiritual beliefs

People were reluctant to disclose their religious/spiritual beliefs to the clinical psychologist at the beginning of their therapy. This was characterised by a general feeling that religious/spiritual 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)*

They'll think I'm mad

Many people expressed the fear that if they spoke openly about their religious/spiritual beliefs or ideas, and how they conducted their relationship with God, that they might be misunderstood, seen as mad, or even sectioned.

> *It was a bit scary (about sharing her beliefs), I thought I've got to be careful in case I find myself sectioned (P3)*

> *…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)*

> *Initially, before I knew [clinical psychologist] I would have been very reluctant [to discuss my religious beliefs]…[later on] I felt confident that he wasn't going to just listen to it and think oh this guy's a lunatic (P8)*

> *It's assumed your whole personality is somewhat adrift…if you express spiritual or religious ideas. I mean I've met a few people over the years who have been admitted purely for being overly religious, which is very, very strange (P4)*

Language as a barrier

Some people expressed a fear that what they were saying from a religious or spiritual point of view, might be misunderstood by a clinical psychologist, because of subtle differences in the meanings of words when they are used in different contexts.

> *I think everybody has their own individual version of language we all sort of – if I say bird then 10 people in the room will each have a different image in their mind. When you start talking about things that don't even exist in a physical sense it's inevitably much more complex (P4)*

> *[about being misunderstood because of differences in language] I think a good balance would be to have Christians going on psychotherapy training (P10)*

One person spoke about how our perspectives, and how we think and conceptualise ideas, can pit us against each other. She observed that people often argue the same point, but because they express themselves using different words and ideas, can seem in conflict when actually they are not.

> *I don't feel they [medical and spiritual conceptualisations] necessarily need to exclude each other. A lot of stuff I read... it seems there has to be a choice between one thing and another and quite often you know, I've listened to people having really very philosophical arguments about stuff...but actually they...both agree with each other, they are saying the same thing. The essence of the idea is exactly the same, you know, they each want the same thing, same outcome perhaps. They just order their own view with different words and they put themselves in conflict. Quite a lot of stuff needn't be in conflict that is. (P4)*

Theme 6: Secular perspectives and religious/spiritual beliefs can be integrated

As time went on in therapy, many of the participants started to 'test the water' by referring to their beliefs and observing the reaction of their therapist. All of them had experiences where they felt their beliefs were respected and accepted and the fears they held about being dismissed or misunderstood were not borne out. In addition to this, the participants found that their therapy, far from conflicting, actually supported their spiritual beliefs and religious practice.

Respect and acceptance

It seemed that the respect and acceptance shown by the therapist allowed the participant to share their beliefs around their religion and spirituality, and also to feel that they could reject any of the secular ideas that may be discordant with their beliefs. This seemed to shift the power balance between the therapist and participant to one that was more egalitarian, which seemed to help the participant feel a higher level of safety about being exposed to secular ideas that may conflict with their belief systems.

> *It was the feeling I had first of all when I met her, and then speaking to her I gradually brought it in [my beliefs] 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 "nutter", 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)*

She [clinical psychologist] made it very clear that I took what I could cope with out of it…and if I couldn't relate to it fine, that was alright…I didn't feel then that I was doing the wrong thing because I knew I didn't have to do the wrong thing, there was no pressure on me to go along with any theories or practices or whatever that I didn't feel comfortable with. (P6)

"I went to the ungodly and found God there"

Many expressed, with joy and enthusiasm, that they had found a soft landing at the bottom of their 'leap of faith' into secular therapy. It seemed that it had been very helpful to them to find that they were able to bring religious/spiritual aspect of themselves into therapy.

…because I think I went to a secular healing session with [clinical psychologist] I think it's made me even more aware… by going to the social services by going to the national services…..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)*

I think there was a fear in me that I was being very un-spiritual in doing this, but I don't feel that now, I feel it's been very helpful, very helpful. (P6)

Similarities between the underlying principles

Some of the participants spoke about the connections they were able to make between the secular ideas in therapy and their spiritual beliefs.

During the interviews, some people quoted parts of the Bible that they had found useful. These passages expressed principles that are very similar to some models and ideas used in clinical psychology. For example, the quote below seemed analogous to the principles of narrative therapy, which suggests that the dominant narrative a person uses to guide their thinking and actions is keeping the person 'stuck' in a situation. Therapy aims to explore their subjugated narratives, with the aim that if new or different ideas and understandings are brought to the forefront, this may help someone to move forward from their stuck position.

> *...there is a psalm in the Bible that says open up my heart that I may sing you a new song; and when you're having problems .....it feels as if you are singing the same old song all the time...I wanted to say something new because I needed to get to that point, to open up and do it, I needed to sing a new song. (P5)*

Some of the participants described a similar process that happened during their therapy. The theories and ideas brought in by the therapist would resonate with their spiritual beliefs.

> *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)*

One of the participants described her experience of using some ideas from a different religion to her own.

The little things like books that [clinical psychologist] lent me… was written by someone in a Zen monastery, which you know, isn't anything I do myself, but I could take it on board and it actually made a huge difference to me. But I could view it, a lot of those things could still be from a Christian perspective as well, so it's taking what things are helpful and not taking the things that weren't. But generally they intertwined and I could work out which things were helpful (P1)

When religious/spiritual beliefs have and have not been considered

Looking back to the third theme in the first domain, 'Fears about turning to secular services', many of the participants described that their reluctance to seek therapy from a secular organisation stemmed from the fear that they would be exposed to ideas that conflicted with their beliefs. All the people who had expressed this initial fear found that the conflict they had anticipated did not become an issue.

So I've been able to interact with [the psychologist] not only on a secular level but also on a religious level, which has been really amazing. (P8)

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)

I can't think of anything that has come into conflict. (P5)

The importance of being seen as 'whole' and the fear that a secular therapy would not be able to do this was revisited.

> *I feel I'm being honest with her and she's seeing the whole picture of where I'm coming from. (P6)*

However, one person, who had two sets of therapy with different clinical psychologists in the NHS, had a less satisfactory experience with the therapist who did not consider religious 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, whereas I suppose at least if you're talking to a Christian therapist, then at least, I suppose they might see it as more of part of it… because an issue came up the other week…..I didn't want to take the discussion any further because I didn't know to what extent there would be any understanding… (P9)*

Theme 7: Reciprocal influence of therapy and religious/spiritual beliefs

As described in the previous section, most people had an experience where they 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 actually had a reciprocal influence on each other.

"Knock-on effect"

This sub-theme describes the participants' experience of the therapy having an impact on the religious/spiritual beliefs/practice, and vice versa, which seemed an unexpected bonus for them, especially 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)

A lot of the [psychological] principles about how I manage myself and deal with myself have a knock-on effect to those (the spiritual) areas of my life as well. (P6)

It seemed that for some people, therapy got them to a point, or they hope will get them to a point, where they could then ask God for help.

…and I got to the point whereby 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)

…[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)

Another participant described how she uses CBT techniques discussed in therapy to help her to more effectively achieve her spiritual goals in life.

I know by putting into practice the things I talk about with [clinical psychologist], they will actually help in that (the things I strive for), even though those things come from a Christian faith…We've talked about attention training and how that can actually have beneficial effects on praying. (P6)

His hand was upon it

A theme common to many people was that they looked back on events to make sense of them, and it was at this point that they recognised the impact that God had on their situation.

In terms of prayer, then maybe retrospectively when I look back, then you see the influence of it all. Although I wouldn't have said this at the beginning (of treatment), I've looked back and felt it was very much part of God's plan. (P1)

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

It was at this point, when the participants had come through the worst, that they were able to reconceptualise their difficulties into challenges that have had some positive outcomes.

…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…..I didn't realise that until later on. (P8)

…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 or better person or something. That belief is absolutely fundamental. (P2)

…I began to view them [mental health problems]…as a training ground to make me a better person…I have been blessed for my struggles (P5)

"My faith is stronger now"

All of the participants had been through very difficult experiences while struggling to cope with their mental health problems. The question was asked as to 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)

…[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. There's been no story in there where evil overcame good. (P2)

Some people made links between their faith strengthening and to the process of therapy.

…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)*

My faith is stronger now, through the process [therapy] I am going through now. (P1)

CHAPTER 4: DISCUSSION

OVERVIEW

This qualitative study explored how people with religious or spiritual beliefs experienced seeking and receiving help for mental health problems. Ten people who were currently engaged in, or had recently finished, therapy with a clinical psychologist in the NHS were interviewed. The interview inquired about the type of help they encountered, before and during therapy, and what was helpful or unhelpful from each person's perspective. Transcripts were analysed according to the principles of Interpretative Phenomenological Analysis.

Seven themes captured the key elements of the participants' experiences; these were organised into two higher order domains. The first domain, 'Dilemmas of help-seeking', represented the process that led up to the participant's inception into therapy with a clinical psychologist. It consisted of four main themes: 'Understanding the problem', 'Help from religious/spiritual sources is variable', 'Fears about turning to secular services for help' and 'Needing a secular understanding of the problem'. The second domain, 'Process of therapy', encompassed the experience of therapy and the interface between the participants' religious/spiritual beliefs and the theories, models and ideas provided by the therapist. This domain incorporated three main themes: 'Reluctance to disclose religious/spiritual beliefs', 'Secular perspectives and religious/spiritual beliefs can be integrated' and 'Reciprocal influence of therapy and religious/spiritual beliefs'.

This chapter will first review the findings of the study and discuss them in the wider context of the existing literature. This will be followed by a section which will identify the

key methodological issues, which must be considered when interpreting and drawing conclusions from the study. The chapter will conclude with an exploration of the potential implications this study holds for future research and clinical practice.

FINDINGS AND LITERATURE

Summary of findings

This study set out to explore the help sought and received by people with religious/spiritual beliefs who had mental health problems. It retrospectively tracked their experiences from their first experience of help-seeking, from informal helpers, through to their experience of therapy with a clinical psychologist in the NHS. The study focused exclusively on issues relating specifically to the interface between their religious/spiritual beliefs and their experience of seeking and receiving help. I will draw out aspects that appear to be significant for our understanding of how to approach clinical work under two broad headings: 'Searching for similarity and anxieties about difference' and 'Working with people's religious/spiritual beliefs.

Searching for similarity and anxieties about difference

Informal help

In line with previous research (e.g. Barker et al., 1990), this study found that when embarking on help-seeking, people first take their problems to informal helpers. Most of the participants in this study first turned to peers who shared their religious/spiritual beliefs. In addition, for some of the participants, their informal helpers continued to be a great source of help and support throughout the process of help-seeking and during therapy also, a finding which is consistent with studies which have found informal

helpers to be very effective (Smail, 2001). For the people whose mental health problems had resulted in them feeling alienated from their religious/spiritual peers, they continued their path to recovery without drawing on their peer group for help and support. This resulted in some rejecting the idea of organised religion altogether. For most of the participants, however positive or negative their experiences with peers, their faith provided a consistent source of strength and comfort and they employed religious/spiritual coping behaviours throughout.

Religious coping

Previous studies have disagreed about the proportion of people who make use of their religious/spiritual beliefs when dealing with stressful events, with some finding religious/spiritual coping employed by the minority (Bowker, 1988; Gurin et al.,1960; LeGrand, 1985) and some studies by the majority (Gilbert, 1989; Greil et al., 1989; Pargament et al., 1990). This study found that nine of the ten participants employed religious/spiritual coping strategies to deal with their mental health problems. Even people who were very clear about their mental health problems having a purely bio-psycho-social aetiology, still employed religious/spiritual coping strategies. Strategies employed by the individual were characterised by asking for or relying on God to give them the strength to be able to cope with their problems and holding the belief that God would not allow the "bad" (the problem) triumph over the "good" (themselves and their efforts to conquer the problem). Some of the participants described that their peers would help in this process by praying for the same things, sometimes timed to coincide with the time when they were attending therapy. This fusion of psychological and spiritual helping was described as particularly helpful.

Hoping for a miracle or praying for a cure was seen as unhelpful. One person felt this was too much to ask for and another had felt a sense of guilt when issues she had prayed about had not been resolved. In general, the participants wanted to avoid making such a request from God, in case it was not granted. It seemed that if the request was not met, this would not reflect on the power or compassion of God, but the strength and quality of the participant's faith, a finding consistent with previous literature (Cinerella & Lowenthal, 1999). There was only one person who did not employ religious coping strategies. She was unique in the group, as her deity was particularly punitive and punishing, and therefore was of no support or help to her. It is interesting to note that the participants who employed religious coping strategies also reported that their faith remained as strong as ever or increased. This lends support to the study by Rogers, Maloney, Coleman and Tepper (2002) who found that positive changes in faith were related to more religious coping and that religious attitudes are dynamic and a part of the experience of coping with mental health problems.

Demographic similarities

Mostly, the participants were not looking for a clinical psychologist who was similar to them when they were asked to consider a list of demographics like gender, ethnicity and religion. This finding contradicts the findings of several studies (e.g. Chadda et al., 2001; Cinerella & Lowenthal, 1999) that found evidence to support the hypothesis that congruence between socio-cultural factors is important and appears to influence help-seeking behaviour. Smail (2001) suggests we would like to be seen by people we could identify as being how we like to think of ourselves. This idea is possibly more pertinent to the participants of this study, as they wanted someone who they could 'connect' with - someone who would listen to their point of view and would respect and understand their viewpoint, on the participant's terms, even if they did not share it.

Some of the participants said it was helpful that the clinical psychologist did *not* share their viewpoint, as this gave them a new perspective. One person found that it helped that the therapist was not of the same religion, as she felt a therapist of the same religion may be offended by her views of her religion and in turn, having a secular therapist meant she did not expect to feel scorned for holding such views. It seemed that acceptance and understanding, and then a willingness to work with, and not against, the participant's way of viewing the problem and ideas about a solution was considered a lot more helpful than demographic similarities.

Perhaps people seeking help state that a congruence between demographics is important because they hope that these similarities may increase the chances that they will experience acceptance, understanding and a willingness on the part of the helper, informal or professional, to engage with their own model and understandings about their problems. This idea is possibly reflected in the surprising finding that many people expressed, some in very strong terms, that church counselling can be unhelpful, even detrimental to the individual. Although, seemingly, they share religion as an important demographic, but also the counsellors were located within their church, so therefore they were of the same denomination and congregation, but they were still found to be unhelpful, because they 'spiritualised' what the participants regarded as a mental health problem. It seems this represented a clash between the seekers' and the helpers' understandings about the aetiology of the problems, where neither party were able to reconcile the other's view with their own.

This contradicts the findings of Mitchell and Baker (2000) who investigated healthy Christians' expectations of the experience of psychological help from different sources. They found their participants expected that a Christian helper would acknowledge and

address their spirituality and that the helping episode would be characterised by warmth, understanding, safety and a non-judgemental stance. They also expected that answers would be found and the problem 'dealt with properly'. On the other hand, the participants expected that a clinical psychologist would neglect and reject their spirituality, and the features of their interaction would be characterised by a cold, impersonal style, with misunderstandings and uncertainty. Any positive outcome would be short term only as it was resultant from 'mind manipulation'. It is interesting to note a similarity between the studies that claim a match between demographic variables as important factors in the process of help-seeking and the experience of help (Cinerella & Lowenthal, 1999; Mitchell & Baker, 2000). Both studies have drawn their sample from people with religious beliefs who are *not* experiencing mental health problems. They required the participants to *anticipate* what they would do if faced with having to cope with mental health problems. Their findings are consistent with some of the fears held by the participants of this study when they were embarking on seeking help from a clinical psychologist. However, this study has shown that the fears, which the participants grounded in dissimilarity between demographic factors, did not become evident during their actual experience of therapy with a clinical psychologist. Therefore the findings from this study seem to suggest that it is unhelpful to conclude that help-seekers' negative assumptions about the experience of therapy, based on difference between demographic variables, such as religion, will be proven accurate.

Ambivalence towards using non-religious/spiritual methods of coping

All of the participants in this study emphasised a bio-psycho-social model when explaining the aetiology of their problems. This could influence why they sought help from NHS mental health services and found it to be helpful, as they anticipated that their model for their problems would be largely congruent with that of a clinical

psychologist. However, despite this similarity, many remained ambivalent, because they felt the spiritual part of themselves would be neglected and therefore disrespected, by the clinical psychologist. This led the participants to worry that there would be conflict between themselves and their religious/spiritual ideologies and the clinical psychologist and their theories and suggestions. In support of the findings of Mitchell and Baker (2000) this study also found that some people experienced guilt about utilising something other than their faith to cope with their problems.

This study posed the question: Can people who do not have religious/spiritual beliefs help those who do? As previous research has found clinical psychologists to be a group of people in society who are amongst those least likely to have religious/spiritual beliefs (Shafranske & Gorsuch, 1984; Ragan et al., 1980), this is a pertinent question.

The dearth of research concerning people with religious/spiritual beliefs, and their experience of therapy with a clinical psychologist, has led to speculation on how people would experience therapy using the literature around the importance of socio-cultural factors on help-seeking behaviour (e.g. Chadda et al., 2001; Cinnirella & Lowenthal, 1999). It was thought that the mis-match between participant and clinician regarding their religious/spiritual beliefs would impede therapy to the extent that therapy would be experienced as unsatisfactory. Of the participants in this study, some but not all, would have welcomed a therapist of the same religion as themselves. However, there was a recognition that even a therapist of the same denomination would likely still hold and practice their beliefs differently, so it was felt unrealistic to expect that a match between the religious/spiritual beliefs of the service user and therapist could ever routinely occur.

Consistent with previous literature (Cinnirella & Lowenthal, 1999; Copsey, 1997), the participants all feared being misunderstood and subsequently judged by mental health professionals to be "mad" and potentially sectioned. The participants in the study by Cinerella and Lowenthal who were non-white explained that this fear stemmed from the mental health professional being white and misunderstanding culture based problems, such as the impact of family conflict. In the present study, all participants, regardless of ethnicity, feared that a secular helper would misunderstand the nature of their religious/spiritual beliefs.

Two points emerged from the data that the participants found useful in their therapy. The first was that many found it *was* possible to talk about their fears around, for example, their guilt at using non-religious coping methods, and the issue of anticipated conflict between their spiritual beliefs and the ideas and theories in therapy, and subsequently felt able to voice such issues should they have arisen. This seemed to help the participants explore the secular ideas presented by the therapist. The second is that in exploring the secular ideas, not one person found any point of conflict with their religious/spiritual beliefs. In fact, some people described how the ideas expressed by the clinical psychologist fitted with, and even reinforced, their beliefs. There was a general feeling that their therapy and their religious/spiritual beliefs and practice strengthened each other in a reciprocal manner, with one person describing that their religious beliefs had 'come alive again' through the process of therapy.

What seemed most important to the participants was that their belief system could be voiced and would be heard in a respectful manner. Therefore, this study has found that a mental health professional does not need to hold religious/spiritual beliefs in order to help a person who does. The participants found it most helpful when the clinical

psychologist could be open to the idea that there are other ways of conceptualising and coping with problems. This is a finding that seems to contradict the ideas expressed in the existing literature. From this small sample of people, it seemed not only *possible* for a clinical psychologist to provide an intervention that was inclusive of perspectives that are different to those in the traditional mental health models, it was actually *happening*, and that the service users were finding this approach helpful.

Limitations of language

A theme that was woven throughout the main findings was about how language can be a source of confusion, and not clarity. This seemed to occur because people who do not share the same world-view and/or belief system, use a common language. It became clear that words and phrases can have different meanings when removed from the context in which they were originally spoken.

For instance, one participant said how she avoided using the term "God speaks to me" in therapy, for fear that she would be considered to be suffering from a psychotic illness. It is thought this is because the concept of hearing voices has become so solidly identified with the explanation afforded by the psychiatric model; that a person is suffering from a psychotic illness, and that any other explanation occupies a subjugated position. This is an example of the apparent dominance of the Western psychiatric model manifested through language and concepts that pathologise hearing or talking to an intangible entity, e.g. God or gods.

We communicate our religious/spiritual beliefs in words, which Bateson (1972) described as "abstractions" that we use for convenience, but that there is often so much more, or at least a lot of room for interpretation, of what is actually meant by those

words. Bateson emphasises that words will only be an approximation of the concept that is actually being described. Therefore, there is lots of room for different meanings to be taken from a single word or phrase. Sheldrake (1990) suggested that the increasing dominance of the scientific world view over the last three or so centuries has significantly impacted on our understanding of the religious/spiritual dimension of life. Common discourse has shifted from the construction of meaning using a religious/spiritual rationale, therefore the language of spirituality has been used less and less. Douglas-Klotz (2001) elaborates on this point to say that western culture fails to support people experiencing 'abnormal' states of consciousness e.g. psychotic or spiritual, with a viable cultural language. Clarke (2001) suggests that this has resulted in a loss of appreciation that there are different ways to encounter reality. She highlights that spiritual experiences are, by their nature, individual, subjective, and difficult to communicate because the language that exists to discuss these issues is inadequate and assuming.

Clarke (2001) argues that our society's particular illiteracy in the area of spiritual experience contributes to greater isolation of the person with religious/spiritual beliefs. Like Hannah (1994) and Copsey (1997), this study similarly concludes 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.

Words need to be understood *within* their context, not by transporting them to an alien frame of reference, with the assumptions that will bring with it. During the interviews, when the participants could trust that the researcher was able to step outside the parameters of the psychiatric model, and was genuinely interested to understand them

from *their* perspective, they reported feeling more comfortable and appeared more willing to discuss their spirituality openly. If potential service users could trust that would happen, maybe they would no longer fear that mental health professionals will regard them as mad.

Expectations

This section considers the assumptions that clinical psychologists may bring with them to working with people with religious/spiritual beliefs. It underlines that people's spiritual beliefs, even if they are part of a well established and widely recognised religion, will be personalised and idiosyncratically applied to their daily living.

Discussions with some of my colleagues about working with people's religious/spiritual beliefs in therapy highlighted the assumption held by many that they should know, in advance of meeting the service user, about their religious beliefs, if for example they are Moslem, and that the service user will be offended by their ignorance if they do not. Similar to a study carried out by Copsey (1997), the current research found much diversity and unique personal aspects to people's religious/spiritual beliefs. Participants who described themselves as belonging to the same faith group had very different ways of conceptualising and practising their beliefs. The description label of e.g. Christian, can encompass a whole continuum of beliefs and practice. It seems that although there may be some broad or fundamental aspects that are common to all Christians, there are also a lot of differences too. This is in fact where clinical psychology may well have its expertise, given that clinicians are trained in formulation, which is very suited to working with unique aspects of a person, such as religious/spiritual beliefs. The current study found that it is not an expectation of the service user that the clinician should

know about their religious/spiritual beliefs, and that the only way anyone can find out is to ask.

It may help to know a little about a person's religious beliefs, but I found that when I prefaced my ignorance with the participants this helped our conversations, and my lack of knowledge did not seem to impede the interviewing process at all. In fact, people liked to tell me about their religious/spiritual beliefs, from their own point of view - especially as some had turned their backs on organised religion because of how their religious peers had reacted to their mental health problems. Similar to the findings of Rose, Westfeld and Ansley (2001), the participants believed religious concerns were appropriate for discussion in therapy, and *preferred* that they were able to discuss them.

This sort of knowledge about religious/spiritual beliefs, as with many other issues, can be acquired with exposure to working with people's religious/spiritual beliefs. However, it seems difficult for many to start this process. I found, like Copsey (1997), that people were very willing to talk openly and freely about their religiosity/spirituality. The factors that helped them to do this have already been highlighted by the sub-theme 'respect and acceptance'.

The issues of religious/spiritual beliefs and mental illness are a concern for mental health professionals and the clergy alike. This section will conclude with a plea from a lecture given by Sims, quoted by Carey, Archbishop of Canterbury (1997, p. 397)

> *For too long psychiatry has avoided the spiritual realm, perhaps out of ignorance, for fear of trampling on patient's sensibilities. This is understandable,*

but psychiatrists have neglected it at their patients' peril. We need to evaluate the religious and spiritual experience of our patients in aetiology, diagnosis, prognosis and treatment.

Working with people's religious/spiritual beliefs

The previous section considered the findings of this study within the context of the previous research literature. The aim of this section is to have more of a clinical focus, which will aim to reframe religion/spirituality from a taboo subject, that is largely seen as irrelevant, to one that clinical psychologists can feel more confident about exploring with the service user.

A clinical psychologist, like any helper or healer, will come to the helping relationship grounded by a set of basic assumptions about people, life and helping. Drawing on this model or orientating system (Pargament, 1997), the clinician tries to assist others who have become disorientated and are unable to cope effectively. Helman (2000) categorises psychological interventions alongside folk or religious healing. He describes these interventions as 'symbolic healing', as they do not rely on any physical or pharmacological interventions for their efficacy, but rather on language, ritual and the manipulation of powerful cultural symbols; further details are given in Appendix 10.

All helping involves an interaction between the seeker's and the helper's orientating systems. This meeting is far from a value-free encounter. Embedded in the helper's orientation system are assumptions about what is of ultimate significance and what are the most appropriate methods for obtaining that significance. Formal theories rest on values, which are more often implicit than explicit. The idea that helpers, formal or informal, can set aside their own values and enter into the relationship as "blank slates"

does not stand up well to empirical scrutiny. Counsellors affect the goals for therapy (Worthington & Scott, 1983), influence their client's values over the course of counselling (Kelly, 1990) and selectively attend to and overlook what their clients are saying. However, the problem is not that we hold these assumptions and values, indeed we need them, as a 'road map' for helping, without which we may get lost ourselves. The problem lies in how we deal with them during the course of a therapeutic intervention (Bergin, 1980). The danger is to fail to recognise the impact of your own orientation system on others. However, clinical psychologists, as with other mental health professionals, receive little training on religious issues, including the potential impact of their own religious/spiritual/secular orientations on the helping process. Thus, many helpers may be at least somewhat disorientated themselves when it comes to religion, which may impact on their ability to work most effectively with people who have religious/spiritual beliefs.

This section will discuss the need for a new paradigm and underlines the need for change, in order to enhance clinical effectiveness and research endeavors. It focuses on an approach to enable the clinician to take into account cultural factors within the context of the individual. It is hoped this may describe a way to understand cultural influences in a more comprehensive way than merely a consideration of difference in demographic factors.

The need for a new paradigm

O'Connor (2002) has suggested that we are at the beginning of exploring the spiritual in mental health research and practice and need a new scientific/theological paradigm that integrates, not separates, science and theology. 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 *function* of religious/spiritual beliefs, rather than their epistemological status as truths (Carone & Barone, 2001).

Copsey (1997) observed that presently it seems important and acceptable to talk about 'cross-cultural psychiatry', 'ethnic diversity' and about being 'culturally sensitive', but there seems little desire to consider the importance of religious/spiritual beliefs systems, which are central to many individuals who come to therapy with a clinical psychologist. The factors listed above are important; they are a layer of context that needs to be included if you want to understand a person's problems. However, it seems that understanding a person's cultural background is not enough. There needs to be an understanding of how these factors *interact* with other contextual and personal factors.

The increased prominence of cross-cultural psychiatry has been very useful; it has highlighted important factors that were previously ignored. However, this approach, as it has been largely employed so far, has its limitations. The next section will explain the concepts and significance of 'world-view' and 'belief system'. This is with the aim of understanding how cultural factors interact with individual factors, in order to promote the efficacy of clinicians work with all people, whatever their culture, who understand or operate in the world in a different way to that assumed by the psychiatric model. It is thought that these concepts provide a useful theoretical framework within which to conceptualise the findings of this study.

World-view and belief systems

To know someone's religion is not enough; it tells us very little about how the individual employs their beliefs to help them to cope with their mental health problems. There are

two things that are particularly important: people's world-view, and their belief system (Pargament, 1997). These concepts allow the clinician to examine culture within the context of the individual. World-view refers to a general way of viewing and dealing with the world. Our worldview is shaped by our culture, ethnicity and the society within which we live and the values we learn. Our belief system exists within the context of our world-view and is further influenced by individual factors such as personality, experiences, family, schooling and social network.

These conceptualisations are useful as they can be applied to any individual or group, not just to minority ethnic groups. The concepts can be applied to anyone who conceptualises and/or copes with their problems with reference to belief systems that are outside the ideology of the psychiatric model. These concepts are helpful to a study such as this one, as many of the participants described themselves as white British and conceptualised their problems in a manner that was congruent with the psychiatric model. However, many still had reservations about therapy, as they felt that the psychiatric model would not attend to their religious/spiritual needs because it would privilege narratives based in a scientific ideology, over, and to the exclusion of, the metaphysical.

Beliefs systems need to be placed firmly on the agenda (Copsey, 1997). Clinical psychologists and the mental health profession in general, need to acknowledge that the world-view and belief systems that underpin their practice are just that; a belief system, which is no better or worse, no more 'true' or 'untrue', than any other belief system. Service users need to feel that if they want to talk about their beliefs, they can do so with confidence and that they will find respect for, and curiosity about, these

beliefs, which, just like the psychiatric model, provide order and understanding to an otherwise chaotic and unpredictable world (Carone & Barone, 2001).

The next section will explore the concept of the Explanatory Model as a clinical tool for understanding and working with people's world-views and belief systems.

Explanatory models

Throughout the eighties, Arthur Kleinman introduced the idea of an explanotory model and how this concept can be utilised in therapy (e.g. Kleinman, 1980; 1988). Kleinman described the importance for understanding the 'meaning' of illness or mental health problems, and views healthcare as the interaction between the explanatory models of the providers and the service users. It was proposed that the greater the 'fit' between the explanatory model of the provider and the service user, the more successful the intervention will be. This may help to explain the conclusions of various studies (e.g. Barker et al., 1990) who have found that people are most likely to take their problems to those closest to them before seeking more formal help. An important factor in this decision could be because of the congruence between their explanatory models. What is more, it has been found that 'informal' help can be very effective, again perhaps because of the fit between the explanatory models of the help-seeker and the helper. The effectiveness of informal helping was explored when Cowen (1982) carried out a study that assessed the types of help given by four groups of informal helpers: hairdressers, family lawyers, industrial supervisors and bartenders. The types of problems raised with these informal helpers were similar to those brought to mental health professionals. The informal helpers used a variety of approaches to help, some of which were similar to those used by mental health professionals. Most of the participants felt good about providing interpersonal help and believed they did so

moderately well. It was concluded that a precise knowledge of society's own help-giving mechanisms is essential knowledge for mental health professionals. Therefore, it is suggested that the idea of 'fit' can be applied to all potential helpers, from those closest to the person with problems (spouse, family, peers) to mental health professionals. Kleinman suggests that explanatory models are a useful way to look at the process by which an illness is interpreted and treated, and that the contextual factors of the service user will have a major impact on their explanatory model. Therefore, the service user's world-view and belief system is incorporated by this approach.

Kleinman devised five major components to 'illness episodes', which construct the framework of the explanatory model. These are aetiology, time and mode of onset of symptoms, physiological pathology, course of illness and treatment. Helman (1990) suggests that service users and their families are often hesitant to volunteer their own explanatory model to a service provider, for fear of ridicule or even intimidation. Therefore the mental health professional may know very little about the explanatory model that a service user utilises in order to understand their problems and what they understand the best intervention to be; be that taking tablets, counselling or prayer.

Kleinman (1980) suggested a list of questions to elicit a person's understanding of their problems (Appendix 9). He suggested that providers, as well as service users, respond to these questions, revealing their explanatory model as part of the process. The areas of non-congruence can then be identified, as this is where misunderstandings and disagreement are most likely to arise. These areas can be addressed as part of the intervention, with the hope that their amelioration will enhance the efficacy of the intervention.

Kleinman conceptualises consultations between service users and mental health workers as 'transactions' between explanatory models. However, it needs to be acknowledged that each person's perspective may not carry the same weight, and within the healthcare system, the clinician's beliefs are privileged. The growing prominence of 'cross cultural psychiatry' has started to make health care professionals aware of factors that may impact on the therapeutic encounter, apart from an awareness that these differences exist, and may impact on the service user's adherence to treatment regimes.

However, there is still very little in training programs about how, as a clinician, you can actually work *with* people's beliefs that differ from those provided by the clinician's own explanatory model. Kleinman suggests clinicians may gather information from the service user that will 'fit' a psychiatric model of illness, rather than allowing the service user's own perspective of the problem to emerge. With little training on how to assimilate and use this information, it is unsurprising that this is common. Added to the tendency within the scientific community to invalidate world-views and beliefs systems incongruent to the psychiatric model, by referring to them as "beliefs", while simultaneously, Western beliefs about science and medicine are referred to as "knowledge" (Gaines, 1998).

METHODOLOGICAL ISSUES

In evaluating this study and reflecting on its implications, several methodological issues need to be considered. These include sample characteristics such as

representativeness and heterogeneity, as well as issues relating to quality, validity and reflexivity.

Recruitment source

Potential participants were approached through clinical psychologists working in the NHS. This restricted the pool of potential participants to those who were willing to engage with statutory services. Therefore, the participants in this study can be considered to be a very small sub-group from within the pool of people with religious/spiritual beliefs who have mental health problems.

Recruitment to the study was hard, as most of the psychologists approached did not refer on any potential participants. There could be numerous reasons for this, from being too busy, to not wanting to 'disrupt' the process of therapy, to the service user not meeting the criteria for the study. In one meeting I attended, someone commented that they had no one with religious/spiritual beliefs on their caseload, which seems, perhaps on reflection, unlikely as a majority of the general population has religious/spiritual beliefs (Office for National Statistics, 2001). I believe I may have found the key to my problems with recruitment when another clinical psychologist commented that they 'wouldn't have a clue' whether or not someone held religious/spiritual beliefs. It seems possible that the clinicians who did pass on potential participants may have formed a small minority who did ask about, and work with, people's religious/spiritual beliefs in therapy, leaving a majority of clinicians who do not. This may mean that the positive experiences that most of the participants in this study experienced regarding their religious/spiritual beliefs in therapy, were reflective only of a minority of people with religious/spiritual beliefs who undergo therapy with a clinical psychologist.

Nature of religious/spiritual belief

With most of the participants practicing Christianity or referring to the Bible, it is suggested that this study reflected a sub-section of religious/spiritual beliefs, within the context of beliefs and religions that are held and practiced across the UK and the world. As mentioned previously, the recruitment process limited the pool of potential participants to those willing to engage with statutory services. Employing the current methodology around recruitment, this study did not access people with religious/spiritual beliefs who were unwilling to engage with statutory services. Therefore, the generalisability of the findings of this study are limited. However, Henwood and Pidgeon (1996) suggested that when sampling decisions have not been made on statistical grounds, it is more appropriate to think in terms of *transferability* of findings. This refers to 'applying the findings of a study to context similar to the context in which they were first derived (Henwood & Pidgeon, 1996, pp. 108). This suggests the possibility that the issues highlighted in the analysis of these data may apply in an amplified form to people whose world-view, and/or belief system, mean it is less likely that they will engage with statutory services.

Quality of interview data

A majority of the participants communicated their experiences in clear, rich articulate detail. One of the participants was closer in time to the onset of his problems, and therefore, was less advanced in his course of therapy, and another was preoccupied by her imminent transfer to another therapist, which influenced either the quantity of their account or it's focus. This may have biased the analysis such that the contributions of these participants were underrepresented.

With each interview, new themes would emerge that then inevitably influenced how I conducted the next interview. Therefore, some of the later participants were asked to consider points that the earlier ones were not. This too may have led to an under-representation of some of the earlier participants views.

All of the participants were interviewed in private and a good rapport was achieved with all. It is thought that all of the participants were able to be open about their experiences and views. Many of the participants commented that they had not thought about their experiences of help-seeking and therapy and their religious/spiritual beliefs in this manner before. It was interesting to note that when the participants were expressing new thoughts and ideas about the interface between their beliefs and their experiences of help, their grammar would break down, and it was at these points that they would struggle to express or articulate their views. It was at these times that we would work together to make sure that we constructed an accurate shared understanding.

Validity

The criteria used to evaluate quantitative research cannot be applied to qualitative research in a meaningful way (Willig, 2001). This has led to the publication of a number of good practice guidelines to ensure qualitative research is rigorously conducted, and that the interpretations and conclusions from such studies are "internally consistent, useful, robust, generalisable or fruitful" (Stiles, 1993, p.607; see also Elliott et al., 1999; Henwood & Pigeon, 1992; Spencer, Ritchie, Lewis & Dillon, 2003).

There are many fundamental commonalities between these guidelines, most of which have already been addressed by this study. Thus the sample was situated (Elliott et al., 1999) by description of the recruitment process and participant characteristics. In

addition, the process of analysis has been detailed in Chapter Two, and the interpretation and understanding developed from the analysis has been 'grounded in examples' (Elliott et al., 1999). Credibility checks on the preliminary codings were provided by a participant, who was asked to gauge whether the quotes reflected the meaning that she was trying to communicate and whether the themes identified adequately reflected her experience (e.g. Willig, 2001). Credibility checks for the preliminary codings and final framework were conducted by second and third researchers, as described in Chapter Two.

Reflexivity

The process of research is inevitably influenced by the researcher's own preconceptions, beliefs, values, experiences and interests. Since it is not possible to fully set aside one's own perspective, issues of reflexivity have therefore been emphasised within guidelines for qualitative research (e.g. Elliott et al., 1999; Willig, 2001).

Within the interviews, I was aware of the possibility of interview bias and tried to be mindful of my own expectations and beliefs. To minimise the risk of imposing these upon the participants' accounts, I intervened as little as possible and adopted a 'not knowing' position (Anderson & Goolishan, 1999), where I acknowledged and laid my ideas and assumptions aside, and took a stance of naivety, and was respectful and actively curious. However, it is likely that my interests and beliefs did influence the direction and content of the interviews. For example, my choice of what to follow-up and when to summarise or empathise.

To return to my initial worries about conducting the interviews, I was concerned that as a mental health professional, I may be viewed with suspicion, and that I would inadvertently cause offence by using the wrong term or expressing myself in an offensive way. However, I found people were very eager to express their views to me as a secular practitioner, and to have their perspective heard, as someone with religious/spiritual beliefs.

It is difficult to gauge how much these factors affected the direction of the interview and subsequent analysis and interpretation. However, their influence is likely to have been limited, to some extent, by the credibility checks provided by the other researchers and a participant. In addition, there were several unanticipated findings, which ran counter to my initial position and expectations. For example, I had expected to find that more people had been *unable* to bring their religious/spiritual beliefs into the therapeutic encounter. Additionally, the extent to which the participants could reconcile their religious/spiritual beliefs with therapy and the positive reciprocal influence they had on each other was unanticipated. I was also surprised so many of the participants had experienced counsellors within their church to be unhelpful.

FURTHER RESEARCH

Studies on how people's religious/spiritual beliefs affect the course and outcome of therapy seem to be absent from the literature. Yet this study showed it to be a potentially rich avenue for understanding people's experiences, and it could well be informative to follow up on some of the tentative findings.

Some of the methodological considerations that limited the scope of this study could be overcome by specific research into these areas. This could help to tease apart some of the heterogeneity. For example, the study could be replicated for people from other ethnic backgrounds; with different religious/spiritual beliefs. The development of some of these themes through time could be explored by specifically focusing on people with different durations of experience. An improvement on the current study would be to ascertain the religious/spiritual beliefs of the therapist and explore whether a greater match between religious/spiritual beliefs of therapist and service user impacts positively on the experience and outcome of therapy.

As noted under the methodological considerations, the exclusive use of clinical psychologists for recruitment greatly reduced the pool from which potential participants were taken. The sub-group of people who have strongly held religious/spiritual beliefs, but who do not voluntarily engage with NHS services, could be recruited via faith communities and churches, to further explore the interface between people's religious/spiritual beliefs and their mental health problems, and how these factors impact on people accessing services.

It may be interesting to replicate this research with people who have strong religious/spiritual beliefs, but to include people who were unable to bring their beliefs into the process of therapy with a clinical psychologist. This may help us to understand more about helpful and unhelpful aspects of secular therapy for people with religious/spiritual beliefs, and may also allow a tentative exploration of outcome between the group of services users whose religious/spiritual beliefs are taken into consideration, and those whose are not.

CLINICAL IMPLICATIONS

Direct work

The data provides support for the idea that religious/spiritual beliefs are tailor made by the individual, who will employ them in an idiosyncratic way, and cope differently with different problems in their lives. Therefore, it is suggested to occupy a naïve position and meet the service user with respect and curiosity for the factors which influence how they cope with their problems. A conceptual framework which may help with the formulation and intervention of how people's religious/spiritual beliefs interact with their efforts to understand and cope with their mental health problems may be supplied by Co-ordinated Management of Meaning (CMM; Cronen, 1994; Pearce, 1994). The central idea behind this conceptualisation is that different layers of context influence how we make sense of the world and behave. They describe CMM as a tool that can be employed by the therapist to explore social interaction with the service user to explore the meanings they attach to events and behaviours. More detail of CMM, together with a suggestion regarding its application to religious/spiritual beliefs is given in Appendix 11. It is thought that an approach, such as CMM, which may help the clinician to integrate the dimensions that constitute their coping effort, as it has been suggested by Pargament (1997) that when religion/spirituality, or any other method, fails to help people cope with a situation, it is not necessarily the belief, practice or strategy that is harmful, instead the problem is with the *integration* among the dimensions of coping. From this perspective there is no single road, but many potentially worthwhile destinations and pathways to reach them. People run into trouble in coping not *when* they have failed to discover the 'right' solution, but because the process itself is incoherent. This lends all the more support to the idea that to be most effective, clinical psychologists need to work with the person *in their entirety*, this

includes their religious/spiritual beliefs and how these affect their understanding of, and coping with, their mental health problems. It seems it was this issue that was raised by the participants of this study, when they were concerned that the secular therapy might encourage the use of understandings or strategies that may have conflicted with their religious/spiritual beliefs.

The participants' assumption that they would not be able to discuss their religious/spiritual beliefs, and particularly the issue of possible conflict between their beliefs and the ideas used in therapy, and the guilt at turning to the secular services for healing, were obstacles for people to use secular services. It seemed they had to take a leap of faith, and hope that they were doing the right thing by God and their faith, in utilising secular therapy. For some, it seemed to have taken a lot of courage to come for therapy, especially to over come the fear that if they were to discuss their religious/spiritual beliefs with the clinical psychologist, they would be perceived as mad. It was helpful for them to be able to discuss their worries and have some control over what they were comfortable to utilise from therapy, and to feel reassured that they needn't accept anything that conflicted with their beliefs.

A theme that was woven throughout the main findings was about how language can be a source of confusion, not clarity, and that words and phrases can have different meanings if they are understood within a context alien to that in which they were originally spoken. Therefore, it is suggested that the clinical psychologist co-construct a shared understanding and language with the service user about their spirituality, seeking to improve the therapeutic alliance, and thereby hoping to enhance the experience and effectiveness of therapeutic interventions for people with religious/spiritual beliefs.

The recognition of the interaction between cultural and individual factors, and the impact this has on how people understand and cope with their problems was explored by this study. It is suggested that an understanding of a service user's world-view and belief system, using the conceptual framework provided by Kleinman's (1980; 1988) explanatory model, can help the clinician and service user to recognise and address the areas of non-congruence between their understandings of the problem. It is thought that this approach, to openly understand and acknowledge the areas of similarity and difference between the conceptualisations held by service user and clinician, may help to improve the efficacy of psychotherapeutic interventions.

Training and service provision

As previously discussed, training programs for all mental health professionals have not typically provided much practical guidance about religious/spiritual topics. It is suggested that training courses and service providers address this gap, and include practical guidance for how to work with service users' religious/spiritual beliefs. It has been suggested that such training should include self analysis, to help the clinician develop an appreciation for the power of the helper's own orientation to religion (Copsey, 1997).

With the aim to improve access, services could draw on models provided by community psychology, and make links with faith organisations, especially those that contain people who are routinely under-represented in the uptake of service provision.

CONCLUSION

This study set out to explore the experience of help-seeking and therapy for people with religious/spiritual beliefs. It identified a number of ways in which people with religious/spiritual beliefs felt helped and supported by formal and informal helpers. In addition, it highlighted some of the issues and dilemmas involved in seeking and receiving such help. This complemented and expanded the existing literature on the interaction between the cultural and individual factors that impact on people's help-seeking and pathways into and through therapy with a clinical psychologist. The study demonstrated that people's conceptualisations of their religious/spiritual beliefs, and subsequent coping efforts, are unique to each situation and idiosyncratic to each individual. It was suggested that clinical psychologists already have the tools at their disposal, in formulation, and the concept of the explanatory model (Kleinman, 1980; 1988) to work with the intricacies and uniqueness that people's world-views and belief systems present. However, the reluctance of the mental health professions, so far, to acknowledge the impact and utility of beliefs outside of those provided by the current paradigm , has led to the absence of the consideration of religious/spiritual issues on the training curriculum, including clarity around how to incorporate people's religious/spiritual beliefs into assessment and intervention.

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APPENDICES

APPENDIX 1

Ethical approval

Barnet, Enfield and Haringey Local Research Ethics Committee.

North Central London NHS
Strategic Health Authority
Victory House
170 Tottenham Court Road
London
W1T 7HA

Chair: Mercia Saunders
Chief Executive: Christine Outram

13th November 2002

Ms Claire Mayers
Trainee Clinical Psychologist

Dear Ms Mayers

60/02: Religious help-seeking and pathways into care

Acting under delegated authority I write to acknowledge receipt of your letter dated 2nd November 2002 and the enclosed clarification requested by the LREC in our letter to you dated 7th June 2002. There is now no objection on ethical grounds to the proposed study. I am therefore happy to give you the favourable opinion of the LREC on the understanding that you will follow the conditions set out below:

Conditions

- You do not undertake this research in a NHS organisation until the relevant NHS management approval has been gained as set out in the Framework for Research Governance in Health and Social Care.
- You do not deviate from, or make changes to, the protocol without prior written approval of the LREC except where this is necessary to eliminate immediate hazards to research participants, or when the change involves only logistical or administrative aspects of the research.
- You send an interim report to this LREC in one year's time or when you have completed your research or if you decide to terminate it prematurely.
- You advise this LREC of any unusual or unexpected results that raise questions about the safety of patients taking part in the research.

I confirm that LRECs are fully compliant with the International Committee on Harmonisation/Good Clinical Practice (ICH) guidelines as they relate to the responsibilities, composition, function operations and records of an Independent Ethics Committee/Independent Review Board.

Your application has been given a unique reference number 60/02 please use it on all correspondence with the LREC.

Yours sincerely

C Hamilton

Christine Hamilton
LREC Co-ordinator
Barnet Enfield & Haringey

APPENDIX 2

Participant information sheet

For participants recruited through the NHS under the Barnet, Enfield and Haringey Local Research Ethics Committee.

Barnet, Enfield and Haringey NHS
Mental Health NHS Trust

INFORMATION SHEET

Version 2
January 2003

Hello, I'm Claire Mayers, a trainee clinical psychologist. I am doing a piece of research as part of my training and would like to invite you to participate. I have put together some information, which might help you to decide whether or not you would like to be part of this project. If you have any questions I would be happy to talk with you. My contact details are at the bottom of this page.

Study title
How a person's religion or spiritual beliefs affect the type of help they seek out and find useful.

What is the purpose of this study?
It has been found that people seek help for all types of problems from people they already know before getting more help from professionals. Furthermore, it is thought that this help, from friends, family, church etc. can be very useful. This study is particularly interested in how people with religious or spiritual beliefs use those beliefs to help them cope with problems and if those beliefs affect who people seek help from and what has been their experience of the help they have received.

Why have I been chosen?
Mental health professionals have been asked to identify service users who have indicated they hold religious or spiritual beliefs. As one of those people you are invited to take part. If you decide you might like to participate, you will be invited to meet with the researcher.

Who is organising the study?
University College London is funding the researcher, who is studying for a doctorate in clinical psychology.

What will happen to me if I take part?
At first, you will be asked to answer a short questionnaire about your beliefs. After this, you will be invited to take part in a longer interview, which will last for about one hour. Everyone who takes part will receive a small fee for their time and any travel expenses incurred. The interview will be conducted by the researcher and will be quite informal. A few questions will be asked to encourage you to talk freely about different aspects of your experience of seeking help for your problems. For ease, and so the researcher doesn't miss anything, this conversation will be tape-recorded. The tape will be kept

securely, just like any other medical record. At the end of the study, the tape will be erased.

Are there any disadvantages in taking part in the study?
This study hopes to enrich our understanding of the type of help people find most useful. Any information we find may benefit people in the future, but is unlikely to benefit the care you receive.

Are there any risks?
No. The aim of the questions is not to probe about any problems or difficulties that you may have experienced, but how you made sense of these and how you coped.
Your care will not be affected by your decision to participate or not. The study is self contained, meaning that any information you choose to share will not be passed on to anyone involved in your care. When the study is written up, care will be taken so that no-one will be able to identify you.

Consent
It is your right to withdraw from the study at any point before during or after our meeting. If, during the taped conversation, you were to decide that you do not wish to disclose any type of information for any reason you would be supported in that decision.

Is the researcher being paid for including me in the study?
No

Confidentiality – who will know I am taking part in the study?
All information which is collected about you during the course of the research will be kept strictly confidential. Any information about you will be made anonymous, so that you cannot be recognised from it.

Will my GP be notified about my participation in the research?
No, there are no drugs involved, so therefore no need.

Who has officially approved the research?
The Local Research Ethics Committee for Barnet, Enfield and Haringey Authority.

What will happen to the results of the study?
They will be published. If you would like to obtain a copy of the published results you can let the researcher know.

Who can I contact for further information?
You can contact the researcher, Claire Mayers through Gerry Leavey at the R&D Department, St Ann's Hospital, telephone 020 8442 6503. If I am not there you can leave a message and I will get back to you.

Thank you for your time.

APPENDIX 3

Questionnaire for spiritual and religious and beliefs

Barnet, Enfield and Haringey NHS
Mental Health NHS Trust

Doctoral Thesis

Claire Mayers, Trainee Clinical Psychologist, UCL.

Mental Health & Spirituality / Religiosity

Understanding how religious and spiritual beliefs influence how people perceive and cope with 'mental health issues'.

Date : Participant ID no.:

Medical Information

Date of birth: Gender:

Previous referrals/admissions*:
☐ no ☐ yes
if yes, date of previous referrals/admissions (year and month if possible)

.....

if yes, ever been under section ☐ no ☐ yes
information:

.....

Present referral/admission*:
Date (year and month if possible)

.....

☐ voluntarily ☐ under section (specify) .....

Diagnosis:
☐ Bi-polar disorder ☐ Depression ☐ Depression with psychotic features

☐ Personality Disorder ☐ Psychosis ☐ (probable) Schizophrenia ☐ Self harm

☐ Other .....

* delete as appropriate

Barnet, Enfield and Haringey NHS
Mental Health NHS Trust

Questionnaire for Spiritual and Religious Beliefs

This questionnaire concerns your beliefs and your views about life.

How would you like to describe yourself? (tick one or more):

Relationship status:
☐ Divorced ☐ Living with partner ☐ Married ☐ Separated ☐ Single ☐ Widowed

Ethnicity:
☐ Bangladeshi ☐ Black African ☐ Black British ☐ Black Caribbean ☐ Chinese
☐ Indian ☐ Pakistani ☐ White English ☐ White Other.....
☐ Mixed .....
☐ Other .....

Place of birth .....
If born outside England, age arrived in this country .....

Occupation:
How old were you when you left school/education?

Occupation? .....

I am now going to ask you some questions about religious and spiritual beliefs. Please try to answer them even if you have little interest in religion.

In using the word *religion*, we mean the actual practice of a faith, e.g. going to a temple, mosque, church, or synagogue. Some people do not follow a specific religion but do have *spiritual* beliefs. For example, they may believe that there is some power or force other than themselves that might influence their life. Some people think of this as their God or gods, others do not. Some people make sense of their lives without any religious or spiritual belief.

1. Therefore, would you say that you have a *religious* or *spiritual* understanding of your life? (please tick one or more):

☐ Religious
☐ Spiritual
☐ Religious and spiritual
☐ Neither religious or spiritual

If you have NEVER had a RELIGIOUS or SPIRITUAL BELIEF, please go to question 13. Otherwise, PLEASE TRY TO ANSWER THE FOLLOWING QUESTIONS:

2. Can you briefly explain what form your religious/spiritual belief has taken?

.....

.....

3. Some people hold strongly to their views and others do not. How strongly do you hold your religious/spiritual view of life? Circle the number that best describes your view.

Weakly held view 0 1 2 3 4 5 6 7 8 9 10 Strongly held view

4. Do you have a specific religion?
☐ I do not observe a religion (go to question 8) ☐ Buddhist
☐ Church of England/Anglican ☐ Roman Catholic ☐ Other Protestant
☐ Evangelical Christian ☐ Other Christian ☐ Hindu ☐ Jain ☐ Jew ☐ Shi'ite Moslem
☐ Sunni Moslem ☐ Other .....

5. Can you give more detail? (e.g. denomination, sect)

.....

.....

6. Do the following play a part in your belief? For example. you might pray or meditate alone or with other people. (Tick as many choices as apply to you.)

Prayer	☐ Alone	☐ With other people
Ceremony (e.g. washing before prayer, a religious service)	☐ Alone	☐ With other people
Meditation	☐ Alone	☐ With other people
Reading and study	☐ Alone	☐ With other people
Contact with religious leader	☐ Alone	☐ With other people
None of the above	☐	

7. How important is the practice of your belief (e.g. private meditation, religious services) in your day to day life? Please circle the number on the scale which best describes your view.

Not necessary 0 1 2 3 4 5 6 7 8 9 10 Essential

You can explain further if you would like to:

.....

8. Do you believe in a spiritual power or force other than yourself that can *influence* what happens to you in our day-to-day life? Please circle the number on the scale which best describes your view.

No influence 0 1 2 3 4 5 6 7 8 9 10 Strong influence

9. Do you believe in a spiritual power or force other than yourself that enables you to *cope* personally with events in your life? Please circle the number on the scale which best describes your view.

No help 0 1 2 3 4 5 6 7 8 9 10 A great help

10. Do you believe in a spiritual power or force other than yourself that influences world affairs, e.g. wars? Please circle the number on the scale which best describes your view.

No influence 0 1 2 3 4 5 6 7 8 9 10 Strong influence

11. Do you believe in a spiritual power or force other than yourself which influences natural disasters, like earthquakes and floods? Please circle the number on the scale which best describes your view.

No influence 0 1 2 3 4 5 6 7 8 9 10 Strong influence

12. Do you communicate in any way with a spiritual power, for example by prayer or contact via a medium?

□ No □ Unsure □ Yes (describe)

.....

.....

13. Do you think that we exist in some form after our death?

□ No □ Unsure □ Yes (describe)

.....

.....

14. Have you ever had an *intense experience* (unrelated to drugs or alcohol) in which you felt some deep new meaning in life, felt at one with the world or universe? (If you believe in God it may have felt like an experience of God). It might have been for a few moments, hours or even days.

□ Yes □ No □ Unsure

If you answered No to this question, go onto question 18. If Yes or Unsure, please continue:

15. If yes, how often has this happened to you? .....

16. How long did the experience last (or usually last)? .....

17. Can you describe it?

.....

.....

18. Some people have described intense experiences at a time when they almost died but were eventually revived. Has this ever happened to you?

□ Yes □ No □ Unsure If **Yes** or **Unsure**, please describe the experience

.....

.....

.....

If **Yes** or **Unsure**, how much has this near death experience changed your life? Please circle the number on the scale which best describes your view.

Not at all 0 1 2 3 4 5 6 7 8 9 10 Extremely

THANK YOU VERY MUCH FOR TAKING PART IN THIS QUESTIONNAIRE

APPENDIX 4

Study consent form

Barnet, Enfield and Haringey NHS
Mental Health NHS Trust

CONSENT FORM

Patient Information number for this trial:

Title of Project:

Name of Researcher:

Please initial box

1.	I confirm that I have read and understand the information sheet dated January 2003	
2.	I understand that my participation is voluntary and that I am free to withdraw at any time without my medical care or legal rights being affected.	
3.	I am willing to allow access to my medical records but understand that strict confidentiality will be maintained. The purpose of this is to check that the study is being carried out correctly.	
4.	I agree to take part in the above study	
5.	I give consent that my interview can be recorded. I understand that it will be kept securely, like a medical record and erased once the study is complete.	

Name of participant (block capitals) Date Signature

I have explained the nature, demands and foreseeable risks of the above research to the subject.

Name of Person (block capitals) Taking consent if different from Researcher (status/relationship) Date Signature

Name of Researcher (block capitals) Date Signature

1 for participant; 1 for researcher; 1 to be kept with hospital notes

Barnet, Enfield and Haringey NHS
Mental Health NHS Trust

TAKING PART IN RESEARCH

You are being invited to take part in a research project. Here is some information to help you decide whether or not to take part. Please take time to read the following information carefully and discuss it with friends, relatives and your doctor if you wish. Ask me if there is anything you do not understand or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

1. You may not receive any direct benefit from taking part in the study. However, information obtained during the course of the study may improve our understanding and help future patients.

2. It is up to you to decide whether to take part or not. If you decide to take part you will be given an information sheet and a consent form. Even if you decide to take part, you are free to withdraw at any time and without giving a reason. This will not affect the standard of care you will receive. Your doctor will not be upset if you decide not to take part.

3. You may be paid travelling expenses for taking part in this study. The study may require you to attend after you have been discharged. You should ask the researcher about this.

4. All the information collected about you during the course of the research will be kept strictly confidential. Any report of the research, published or not, will not identify you.

5. Consumers for ethics in research (CERES) publish a leaflet entitled 'Medical Research and You'. This leaflet gives more information about medical research and looks at some questions you may want to ask. (Please supply leaflets, copies may be obtained from CERES, PO Box 1365, London N16 0BW.

APPENDIX 5

Interview schedule

Semi-Structured Interview Protocol on Help-Seeking

A. Getting to know the participant

I'm going to be talking to you about how you see your difficulties and what help you have tried to get in the last year or so, leading up to your work with a psychologist.
- The information you give to me today will be kept confidential and anonymous
- You can withdraw your consent at any time
- Only meet one time, think about information you are comfortable sharing within that context

1 What has it been like for you [here]
2 How did you come to be referred to [here]
Prompt - status on entry if in-patient admission? Under section?
Prompt- how was the decision made, who made them, what were they hoping for?
3 What do you see as your main problems? How do you understand they came about?

B. Religious beliefs

You indicated on the questionnaire that you have strong religious/spiritual beliefs,

4 Does your religion have any influence on -
- how you cope with problems and difficulties?
- how you feel you can best be helped?
5 Do you think it would make any difference to you if you were treated by a person who is similar to you in some ways e.g. same gender, religion, age.....?
6 Did talk about your religious beliefs while receiving help from any part of the health service?
Prompt- what was that like?/ I wonder why not?

C. Help seeking

7 Before you came here, to health services, did you go to anyone, maybe to talk about what you were going through or to help you to cope?
Prompt- GP, friend, relative, religious figure, spouse, psychiatrist/mental health professional.
8 What was it about that person/those people that helped you to decide that they might be able to help you?
9 What was your experience of help from each of these/this people/person?
10 Was there anything that turned out to be particularly helpful?
11 Was there anything that turned out to be unhelpful or any suggestions from your helper that you felt wouldn't work or that you couldn't do?
12 Were there people you avoided seeing? [who]
13 What sort of 'help' do you think they would have offered? And what is it about that help that feel would actually be unhelpful?

D. Intervention

14 Since you have been getting help from [here], what has been most helpful?
15 Has there been anything that has been unhelpful or any suggestions that you felt would not work or that you could not do? why?

E. Closing the interview

16 Is there anything else I should have asked you or anything that you said that you feel didn't quite understand?
17 How has it felt discussing these things?
18 Thank you for talking to me

APPENDIX 6

IPA Stage 1: highlighting the text

IPA Stage 1: highlighting the text (P6)

P: Um, oh, I'm not really sure, I guess part of it is um, I'm not sure how to put it into words, I guess part of it is a sense of by doing that I wasn't relying on God, that having to seek secular help was almost a weakness on my part and also a feeling that going to a secular counselor I could only talk to them at a certain level, that there would be parts of me that... I don't think I so much feared conflict, but I just felt they wouldn't see the whole picture of me. And in fact by the time I started seeing [clinical psychologist] here, within a couple of sessions I felt comfortable enough with her to actually say that to her, look I'm going to be completely honest with you, you know, there are going to be certain things that maybe I don't agree with and that did bother me initially, it worried me. But as soon as I had said that to her she was great. She turned to me and said I've been waiting for us to have this conversation, but I thought I'd let you initiate it, you know, and she said – I got from the first session that your faith was important to you, but it needed to come from you, rather than me delving into it and she said that's fine, she said I'm here, you take what is helpful to you and if you don't agree with anything – shelve it, you take... and a lot of things that we have actually discussed, I haven't found to be in conflict at all with what I believe. There hasn't really been a big issue that we've disagreed over, and in fact a lot of the principles that we've talked about, you know I sit there sometimes and bible references come into my mind, you know a lot of it is, there is a spiritual element in it, which she would agree with as well, even though she says herself, she hasn't got any strong spiritual belief, but she could see how there could be parallels. But the big thing was the guilt factor that I wasn't relying on God, that I was drawing on something else, and it took me a while to accept that that was actually alright to, that these things could be of help to me.

I: Right, so are you saying that you still feel that you are drawing on something else, but that's ok now, you've reconciled //

P: Yes, yeah, I don't feel that what I'm drawing on is actually compromising what I believe. I've been able to be honest with [clinical psychologist], and I feel that she sees... I talk quite openly now about my faith and about praying and things like that with her and I think as long as she's seeing the whole picture then that's fine. I feel I'm being honest with her and she's seeing the whole picture of where I'm coming from.

I: Yeah, I'm just trying to think, and let me check this out with you, is it that almost by coming to a secular service that you might have to almost hide a part of yourself that's very important?

P: Yes

I: But actually in practice you have been able to talk about it and that's why it's felt//

P: Yes, yes, yeah, I thought I'd have to keep it separate, that there would be so much 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 would be one ... and that the two wouldn't sort of come together, but I've found that it's actually been easier to dovetail the two together than I actually imagined it would be.

APPENDIX 7

IPA Stage 4: Preliminary coding

IPA Stage 4: Preliminary coding – excerpt from table (P6)

Main or sub title	Quote	Line no
3. seeking help		
3.1 encouragement from friends and family	(went to GP) under pressure from other people at the time I didn't take it (pressure to seek help) too kindly That (physical symptoms) combined with everyone else hammering it home to me, I needed to do something. So I went to my GP. The majority of my Christian friends have been very supportive in this and have been very pleased that I've had such good help offered to me and that I've been willing to take it as well. They would qualify that (support of secular services) with also spending time with me praying and praying for me...which was very helpful.	11 32 45 344 384
3.3 help from friends (spiritual)	Someone gave me the telephone number of an organization called Exodus, which is a Christian counselling organization Friends helped me in very practical ways too	192 390
3.5 who I do and don't turn to	When I decided that I needed some help, other than just medical help, my first reaction was to look for a Christian organization 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. But I couldn't find anywhere to get that help. [If that organization (Kanos Trust) were up here] I would have gone to them, yes. The Christian counsellor actually said to me it doesn't work to be trying to see two people at the same time (a Christian and a secular counselor), it's important that you only see one counselor at a time.	187 617 625
3.6 fears about turning to secular help	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. Also a feeling that going to a secular counselor, I could only talk to them at a certain level... but I felt they wouldn't see the whole picture of me. The big thing was the guilt factor that I wasn't relying on God, that I was drawing on something else. I've always felt they (counselling and charismatic healing) were all about focusing on yourself and that's not a good thing, quite self indulgent, and I guess that was also part of my reluctance in getting involved in counselling. Dilemma that it wasn't the right thing to do, to go into the secular. And also the stigma attached to seeing a psychologist.	221 223 246 360 693

APPENDIX 8

IPA Stage 5: Extract from master table of quotations

IPA Stage 5: Extract from master table of quotations

Domain	Theme & subthemes	Quotes
Therapy	**Reluctance to disclose religiosity** 1- what helped people disclose (or not) 2- surprise that beliefs are respected 3- language as a barrier	**1. communication with God/ideas-a sign of madness?** Pp3 1047 It was a bit scary really (sharing about her beliefs), I thought I've got to be careful in case I find myself sectioned. Pp8 218-238 Initially, before I knew [clinical psychologist] I would have been very reluctant (to discuss my religious beliefs)... I felt confident that he wasn't going to just listen to it and think, oh this guy's just a lunatic Pp4 898-901 there's a lot of room for misunderstanding Pp10 846 You've got to be sort of careful what you say **1a. Acceptance:** Pp3 1008 Accepted the way that I perceive things and accepted me the way I am. Pp3 1035-43 It was the feeling I had first of all when I met her, and then speaking to her I gradually brought it in (her beliefs) 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, nutter, 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. Pp6 257 I feel I'm being honest with her and she's seeing the whole picture of where I'm coming from. **2. Surprise that beliefs are respected** Pp6 227-38 Within a couple of sessions (with clinical psychologist) I felt comfortable enough with her to actually say to her look, I'm going to be completely honest with you, you know, there are going to be certain things that maybe I don't agree with...as soon as I said that to her she was great...she said I got from the first session that your faith was important to you, but it needed to come from you, rather than me delving into it and she said that's fine, she said I'm here, you take what is helpful to you and if you don't agree with anything – shelve it **3. language as barrier** Pp4 83-4 language is a huge barrier, especially when it comes to discussing something like spirituality Pp4 886-91 I think everybody has their own individual version of language we all sort of – if I say bird then 10 people in the room will each have a different image in their mind. When you start talking about things that don't even exist in a physical sense it's inevitably much more complex Pp9 857-98 Problem with 'training people in spirituality': you've got so many different types of churches haven't you, (laughs) you've got some churches go right over the top in their phraseology ..... (and some are) totally different, you know same thing but saying it simply .....if you try to find a church well which one would you go to?

APPENDIX 9

Kleinman's list of questions to illicit a person's explanatory model (Kleinman, 1980)

1. **What has happened?**
(organises symptoms and gives it a name)

2. **Why has it happened?**
(aetiology)

3. **Why has it happened to you?**
(This relates the problem to aspects of the service user, such as behaviour, diet, personality, heredity.)

4. **Why now?**
(timing and mode of onset - sudden or slow)

5. **What would happen to you if nothing were done about it?**
(likely course and prognosis)

6. **What are the likely effects on others** (family, friends, employers, workmates) **if nothing were done about it?** (loss of income, strain in relationships)

7. **What do you think you should do about it - or to whom do you turn for further help?** (how to deal with it using the resources from self, family, peers, professionals)

APPENDIX 10

The process of helping and healing

The process of helping and healing

When Helman (2000) set out the requirements for being a 'healer' he put 'talk therapies' in a category along with folk or religious healing. Although 'healer' is not a term used by the psychiatric model, the concept seems pertinent, as one of the participants referred to therapy with a clinical psychologist as her 'secular healing sessions'.

Helman describes these interventions as 'symbolic healing', as they do not rely on any physical or pharmacological interventions for its efficacy. But rather on language, ritual and the manipulation of powerful cultural symbols. Helman goes on to explain that before this type of healing can take place, involving a particular healer and client, within the context of a community and culture, six conditions, common to all forms of healing, must be fulfilled:

1.The healer must have a coherent system of explanation, or frame of reference for the origin and nature of the problem and how it can be dealt with. Dow (1986) proposed a model of experiential reality, whose elements represent solutions to problems and which is composed of culturally specific beliefs, metaphors and idioms. For example, the cause of mental illness may lie with 'spirits' for one model or 'intrapsychic conflicts' with another. Such a belief can be shared by the society as a whole, or by a sub-group and may take supernatural or secular forms.

2. The model must include a symbolic bridge (Kleinman, 1988) between personal experience, social relations and cultural meanings. The individual, within their cultural context, must be able to understand their situation and its resolution in terms of the imagery and symbols provided by the healer (e.g. spiritual possession or intrapsychic conflict). In many cases these symbols are already familiar to the individual as they

represent the 'cultural grammar' (Finkler, 1985), which governs how that individual within that society orientates themselves to the world around them and to their inner world, and serves to link the individual to the social world, a world which may encompass the supernatural world as well.

3. When an individual consults a healer, the healer aims to activate this symbolic bridge by convincing the client that their problem is explicable in terms of the symbols provided by the model. This may be done using a range of techniques.

4. Once the healer and client have reached a consensus, the healer needs to get the client emotionally, as well as intellectually, 'attached' to the symbols of the model. The aim is to not only relate the client's emotions, including their hopes and fears, to the symbols of the model, but also to link the individual to wider social, cultural and, in some cases, cosmological concerns.

5. The healer now begins to guide therapeutic change by manipulating the symbols of the model. For example, having identified the spirit possessing the client, there is a complex ritual of exorcism and the client is reassured that the spirit has left them and they are free to resume a normal life. Or they may be reassured by a psychotherapist that they have at last 'worked through' their inner conflicts. Healing, whether sacred or secular, achieves its efficacy through the transformation of experience. The client learns to re-evaluate or re-frame their past and present experiences. This process, and the symbols used within it, link the client's 'self' to the social and cultural concerns of the wider society. Thus a successful transformation will affect not only their emotional state, but also their physiology, relationships with others and relationship to the culture at large.

6. The 'healed' client has acquired a new way of conceptualising their experiences in symbolic terms and a new way of functioning, both of which are confirmed by the healer. In the process they have acquired, or brought to the fore, a new or different narrative of their past and present and of their likely future. Whether this narrative is short (exorcism) or lengthy (psychoanalysis) it summarises what happened to them and why, and how the healer was able to restore them to happiness and health.

Proliferating Western therapies, can be understood as the expression of certain core Western cultural values: self-awareness, insight, personal growth, individualism, privacy, confidentiality, the high value being placed on language and the ability to verbalise one's distress and the location of conflicts deep within the psyche, rather than in the social world outside. In many cases a service user may learn about the model provided by Western therapies, but this understanding is often inaccessible to their family or community, who are usually excluded from the consultation. There are radical differences between ego-centric Western culture and sociocentric non-Western cultures, and culture has been shown to exert a powerful effect on care (Helman, 2000).

APPENDIX 11

Addressing spirituality using Co-ordinated Management of Meaning

Addressing spirituality using Co-ordinated Management of Meaning

Cronen and Pearce developed a way of organising and thinking about the way in which different contexts influence our interpretations – the way we make sense of the world, interactions and actions (e.g. Cronen, 1994; Pearce, 1994). They called this model Co-ordinated Management of Meaning (CMM, see Figure 2). They describe it as a tool that can be employed by the therapist to explore social interaction with the service user. They suggest that this process of making meaning can provoke action (Tomm, 1987) and in this sense has a therapeutic effect. They describe that there are a number of levels of context that are influential in a person's life. The number of levels is indeterminate, but they suggest one way in which different levels of context can be organised.

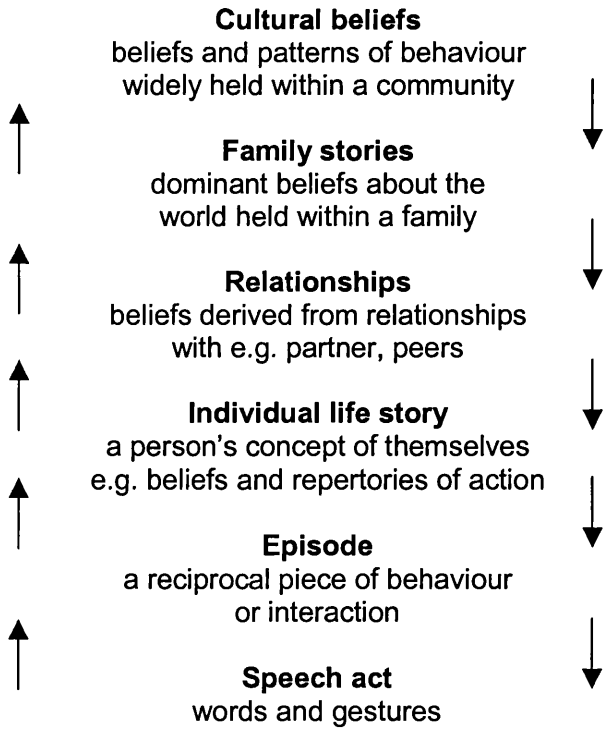


Figure 2 CMM Model

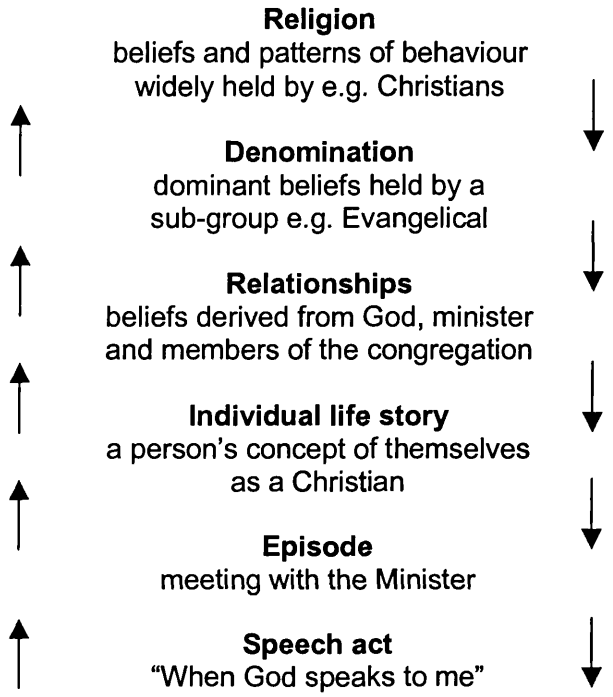
In this model, beliefs at one level, e.g. culture, form the context for understanding beliefs at any other, e.g. family beliefs or speech act. This model can provide a starting place for the therapist to explore the service user's beliefs and to help them to make sense of their situation (Ekadawi et al, 2000).

Although the levels are depicted in the diagram as one above another in a hierarchy, which implies more importance attached to the higher levels, these levels of context are seen as heterarchically organised (Burnham, 1992). That is, the position which each occupies can change around, so that at one point culture may be the most significant context for determining meaning, and at another, individual life story may have the most influence on how to make sense of things.

Hannah (1994, p.69) demonstrated the "essential importance of viewing what is experienced in therapy through the lens of culture" through the analysis of a piece of clinical work that employed CMM to address the meanings that informed the actions of a service user. He concluded that a failure to address the cultural dimension would have resulted in continued confusion for the service user. Similar to Hannah (1994) I propose that CMM could be usefully employed by the clinician when working with a service user to focus specifically on their religious/spiritual beliefs.

This final section will present a CMM diagram of the contextual levels for religious beliefs (Figure 3). Questions that the therapist can use to elicit information about the contextual layers that influence how people make meaning have been adapted from Ekdawi et al (2000). The questions aim to assist in the process of understanding the impact of the different levels of context that constitute a service user's religious beliefs. This process may enable the therapist to identify areas of conflict or difficulty within the

service user's lived experience of their spirituality, which may impact on the efficacy of their coping efforts. If a CMM diagram were constructed to map the contextual levels for religious beliefs it may look like this:



Questions

- What beliefs are there in your religion about psychological problems?
- What might your minister/members of your congregation say about how to cope with psychological problems?
- What does that tell you about their beliefs about psychological problems?
- What does that tell you about yourself?
- What do you tell other people about your psychological problems?

Figure 3 CMM for religious beliefs

This diagram would constitute a small part of the usual CMM diagram, that would include the layers of context already outlined, like culture, family stories etc. As can be seen, it is only 'religion' and 'denomination' that refer to a context that is wider than the service user, all of the other layers of context are unique. This is where naivety and the 'not knowing position' (Anderson & Goolishan, 1999) could be employed as helpful tool, as the information which is of most importance is how that faith works for the individual, and that simply cannot be known without asking.