Religion, spirituality and therapeutic practice

Adrian Coyle and Jenny Lochner

Abstract
Increasing attention has been paid to how therapists might respond respectfully and usefully to clients’ religious and spiritual beliefs and commitments. Although recommendations overlap with principles of good clinical practice, some specific themes have emerged in the literature. Three of these are briefly examined in this article: the assessment process; responding to problematic religious and spiritual material; and training and supervision. Contextual constraints within public sector service provision are also noted. Mindful of these, therapists are encouraged to engage constructively with clients’ religious and spiritual material to enrich therapeutic experience and effectiveness.

Question
How can clinical, counselling and psychotherapeutic psychologists work with clients’ religious and spiritual material in respectful, constructive ways?

Resources


Over the last couple of decades, a substantial literature has developed that considers how mental health practitioners might respond respectfully and constructively to clients’ religious and spiritual issues. Some psychologists might wonder why we would want to do this. Within Western liberal social discourse, religion has often been associated with negative qualities such as conflict, control, judgmentalism and anti-intellectualism. In this light, would it not make more sense for practitioners to help clients deconstruct religious or spiritual commitments?

It is clearly important that mental health practitioners do not collude with their clients’ dysfunctional religious beliefs and spiritual practices. However, there is a general consensus that practitioners should engage with their clients’ meaning-making systems and life worlds. To ignore or attempt to deconstruct the religious and spiritual aspects of these could carry major adverse implications. As Bergin and Payne (1991: 201) put it, ‘Ignorance of spiritual constructs and experience predispose a therapist to misjudge, misinterpret, misunderstand, mismanage, or neglect important segments of a client’s life which may impact significantly on adjustment or growth.’

**Therapeutic approaches to religion and spirituality**

In the past, mental health practitioners have not always engaged with their clients’ religious and spiritual commitments in useful or respectful ways. Instead they have tended to regard religious beliefs and practices as lying outside the remit of the clinical encounter or as part of pathology when these are implicated in clients’ problems (King-Spooner, 2001). Historically, this has been especially so within psychoanalysis. Here, religion and spirituality have been seen as neurotic, regressive and comforting illusions that people use to defend themselves against the reality of human vulnerability, limitations and hopelessness (for example, see Freud, 1927). Yet scholars and practitioners have also applied psychodynamic ideas to religion and spirituality in constructive, insightful ways (for example, see Rizzuto, 1979).
Indeed, some hold out hope of meaningful, concerted integration between these domains (Strawn, 2007).

In recent years, a version of cognitive behaviour therapy (CBT) that seems to incorporate an openness to spirituality has become increasingly popular. Mindfulness-based cognitive therapy was developed with the aim of reducing relapse among clients who are vulnerable to depression (Segal et al., 2002). Drawing upon the principles of mindfulness meditation (Kabat-Zinn, 1994), it usually includes educating clients about depression; training clients to understand and manage the connection between their depressive thoughts, emotions and behaviours; simple breathing meditations and yoga. Here, mindfulness is used as a technique directed towards therapeutic outcomes rather than as a spiritual practice or a means of orienting to clients’ spiritual concerns.

What, then, is involved in orienting meaningfully to clients’ religious and spiritual material? There have been attempts to specify competencies for this work (Young et al., 2007). However, what seems to be required is the implementation of standard principles of good clinical practice in this particular context. For example, some writers have considered how best to create a therapeutic space in which practitioners and clients can feel comfortable in raising and exploring religious and spiritual issues (Clarkson, 2002; King-Spooner, 2001; Purton, 1998). These therapeutic relationships have been described in terms that strongly echo the qualities of any good therapeutic relationship.

Nevertheless, some more specific themes and issues can be discerned in the literature on religion, spirituality and therapy. These include assessment, responding to problematic religious and spiritual material, and training and supervision.

**Assessment**
It is important to include clients’ religious and spiritual perspectives and experiences in the initial assessment. This can usefully convey to the client that it is permissible to discuss these aspects of their life world in therapy.

Pargament (2007) recommends using a few basic questions to explore the salience of spirituality and religious affiliation for the client (for example, ‘Do you see yourself as a religious or spiritual person? If so, in what way?’) and the salience of spirituality for the problem and potentially for any resolution (for example, ‘Has your problem affected you religiously or spiritually? If so, in what way?’). Yet, clients may be unwilling to disclose such potentially intimate material during assessment, especially if they fear that this might be evaluated negatively. There is evidence that clients with strong religious beliefs may be wary of seeking therapy in non-religious settings due to such fears (Mayers et al., 2007).

Hence an assessment of clients’ religious and spiritual beliefs and experiences may need to unfold progressively within the context of a secure therapeutic relationship. This unfolding assessment may cover clients’ religious or spiritual background, family beliefs, important spiritual events, current religious and spiritual beliefs and practices, involvement in religious and spiritual communities, how they make sense of the issues that have brought them to therapy, images of and perceived relationship to higher power(s), and ideas about the meaning of their life (Gorsuch & Miller, 1999). Some of these areas may be relevant to all clients and others may be more salient for clients with expressed religious or spiritual commitments. Sometimes it may be valuable explicitly to elicit a client’s ‘spiritual story’, especially if their past or present religious or spiritual path is deemed relevant for their presenting problems or as a source of potential resources for resolving difficulties (Pargament, 2007).

These suggestions about proactively including religion and spirituality in assessment do not accord with reports of standard practice, however. Crossley and Salter (2005) carried out a study of clinical psychologists’ experience of addressing spiritual beliefs in therapy. They
found that, while some practitioners reported a proactive approach, others waited for clients to raise spiritual issues on the assumption that if these were significant, the client would mention them without prompting. As has been noted, there are reasons why this assumption may not always be justified.

**Problematic material**

The literature on religion, spirituality and therapy varies in the extent to which it engages with religious and spiritual material that may be deemed problematic. Despite a generally positive association between religion and good mental health, some clients’ psychological and life problems and difficulties may be expressed in religious or spiritual language or may be directly related to their religious beliefs (such as problems in reconciling sexuality with religious beliefs: see Jaspal & Cinnirella, in press).

There is also the issue of ‘anomalous experiences’. The nature and location of the border between mystical and psychotic experiences are blurred (see article by Loewenthal and Lewis, this issue). While some writers have offered clarification (see Clarke, 2001), this is an area of continuing debate.

The question then arises of whether and how to challenge religious or spiritual material that is problematic for clients. In Crossley and Salter’s (2005) study, clinical psychologists reported responding to such situations in various ways. One unsatisfactory response was to withdraw from an examination of this client material. An alternative response, when clients were experiencing distress while questioning the validity of their religious or spiritual beliefs, was to refer them to a relevant religious or spiritual practitioner, such as a priest, rabbi or imam. In such cases it seems advisable for the mental health practitioner to liaise with the religious/spiritual practitioner to ascertain his/her perspective before referring the client. This could also ensure that both practitioners are engaged in a
trusting, collaborative endeavour, with each knowing what his/her role is, and how that contributes to the care of the client (McMinn et al., 1998).

A more complex response reported in Crossley and Salter’s (2005) study was to explore the scope for clients and practitioners to work on re-framing problematic spiritual or religious material in ways that are helpful but still consistent with client beliefs. This requires the practitioner to have considerable knowledge of the client’s religious or spiritual tradition if lines of exploration are to be seen as credible and to prove workable outside the clinical context. In this, clients might usefully draw upon relevant self-help books and websites from their own faith traditions (see, for example, Williams et al., 2002). These could also constitute informational resources for practitioners.

Contextual constraints

Much of the literature on religion, spirituality and therapy comes from the USA (for example, Aten & Leach, 2009; Miller, 1999). This is different from the UK, both with respect to its religious landscape and its provision of public therapy services. Hence some of the recommendations offered may not transfer readily to a British context. This is especially the case for practitioners working in settings where they are limited in the number of sessions they can provide to clients and where they are expected to adhere to a specified way of working.

Take the example of a psychological therapist providing the standard four sessions of low intensity treatment in primary care under the ‘Increasing Access to Psychological Therapies’ (IAPT) programme (Clark & Turpin, 2008). This practitioner is unlikely to have scope for developing a fully contextualised understanding of clients’ religious and spiritual beliefs and commitments unless these play an explicit, central role within the formulation of the presenting problem. Yet, even in time-limited therapeutic work, there is scope for
acknowledging religion and spirituality in ways that are experienced by clients as productive, as the following case scenario reveals:

A client with anxiety and substance misuse problems was referred by his GP to a short-term CBT-focused service. As part of the assessment, he was asked whether religious or spiritual beliefs had ever been important to him. He said they had, and that he used to gain a sense of peace and identity from his religious beliefs, but that he hadn’t felt welcome in his local place of worship due to his sexual orientation. However, he continued his own private spiritual practices, which helped him feel calmer and gain a broader perspective around his anxieties. Although the therapeutic relationship spanned only four sessions before referral to a specialist substance misuse service, one part of the work that the client identified as having been important was the opportunity to acknowledge his dilemma about his faith. Through this, he had begun to explore and challenge his assumption that he would never find a community within which he could practise his faith and be fully accepted.

Training and supervision

Inevitably when examining an emerging practice concern, commentators call for increased attention to be paid to the issue in the training of practitioners. The area of religion, spirituality and therapeutic practice is no exception. The literature from which training could be crafted is readily available, although more subject-specific expertise among training teams may need to be developed. The question of how practitioners might respond effectively to clients’ religious and spiritual material is gradually finding its place alongside other aspects of clients’ life worlds (such as gender, ethnicity, culture and sexuality) in clinical and counselling psychology training. This needs to be accompanied by training for supervisors so that practitioners can feel comfortable and confident in exploring religious and spiritual issues within supervision (Aten & Hernandez, 2004).
Respectful and constructive engagement with clients’ religious and spiritual material carries much potential for enriching therapeutic experience and effectiveness. The challenge now is to ensure that this potential is realised for the benefit of clients.

References


Biographical information

Adrian Coyle is in the Department of Psychology at the University of Surrey.
A.Coyle@surrey.ac.uk

Jenny Lochner is a Counselling Psychologist working in an IAPT service in Surrey.
jennifer.lochner@sabp.nhs.uk