A Portfolio of Academic, Therapeutic Practice & Research Work

Including an investigation of the role of religious and spiritual beliefs in the search for meaning after bereavement

By

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Introduction to the Portfolio

This portfolio represents a selection of work carried out in fulfilment of the PsychD in Psychotherapeutic & Counselling Psychology at the University of Surrey. It is divided into three dossiers representing the core areas of training: academic papers, therapeutic practice and research. A range of topics from my work has been included, with an emphasis on links between theory and therapeutic practice and the development of the discipline of Counselling Psychology.

Due to the confidential nature of therapeutic work, practice-related reports take the form of edited summaries. Full reports are located in the Confidential Appendix, submitted separately and not publicly available. Throughout the portfolio, where personal material is cited or referred to, the names of individuals have been changed, and any identifying information altered or omitted in order to preserve confidentiality.
Academic Dossier
Academic Dossier

This dossier contains a selection of papers and reports submitted over the duration of the course. Two ‘Advanced Theory and Therapy’ papers are included which address issues relating to the integration of theory and practice. These explore psychodynamic conceptualisations of the therapeutic frame, and the role of the therapeutic alliance in cognitive therapy. A paper from the final year options course discusses the relevance and implications of the scientist-practitioner model for the profession of counselling psychology. Finally two reports on ‘Issues in Counselling Psychology’ are submitted. The first compares perceptions of counselling psychology with the experience of doctoral training, and the second discusses the implications of clients’ religious and spiritual beliefs for ethical practice in psychological therapy.
Psychoanalytic practitioners place a lot of emphasis on the therapeutic frame. Describe its core components and discuss the psychological reasons for its importance.

N.B. Throughout this paper the terms 'analyst' and 'therapist' are used interchangeably to refer to psychoanalytic practitioners.

Freud (1912) first set out what he saw as the core conditions of psychoanalysis, and many therapists since have outlined what they consider to be the prerequisites that constitute the frame of psychoanalytic practice, and the reasons for adhering to such a framework. In examining the sorts of conditions that are commonly described, it becomes clear that there are two distinct aspects of the frame referred to: firstly there are the overt, external prerequisites for therapy. These usually include confidentiality, timing and length of sessions, the physical therapeutic environment and the fee. Secondly, there are the often more covert assumptions about the therapeutic encounter that may be thought of under the label of 'therapeutic responsibilities of the therapist and client'. These will include for example, the neutrality and relative anonymity of the therapist and assumptions about the importance of free association. I intend here to focus primarily on the more covert aspects of the frame, since these tend to be grounded in particular theoretical constructs, and on general themes of the frame. The overt aspects, while arguably of equal importance, are mainly concerned with creating a reliable, safe environment, that is conducive to introspective work. The foundation for these aspects has been expounded in depth elsewhere (e.g., Smith, 1991) and I shall not repeat it in the limited space available here.
The term 'frame' was first used by Milner (1952) who, in making a comparison with the frame of a painting, indicated that 'the frame marks off the different kind of reality that is within it from that which is outside it' (p. 183). Adherence to basic rules of the analytic situation therefore delineates the therapy from other areas of the client's life. Why this should be necessary or important is a question that has been addressed in several different ways. Milner continues by concluding: '...in psycho-analysis it is the existence of this frame that makes possible the full development of that creative illusion that analysts call transference' (p. 183). In contrast, Winnicott (1954) emphasised the reliability of the analytic setting as one that invited regression - a feature that he presumably felt was a critical element of the analysis.

The development of the transference phenomena referred to by Milner is considered a fundamental element of therapy by the vast majority of psychoanalysts, and central to this are the principles of abstinence, anonymity and neutrality which make up a critical part of the therapeutic frame. I shall briefly describe these elements and the traditional reasons for their importance.

Abstinence refers to the refusal of the analyst to 'act out' with or at the expense of the client. It is considered fundamental to the therapeutic relationship since it allows for deep exploration precisely because nothing can be acted upon. It is also hoped that reactions of the analyst to transference phenomena, which could lead to heightened resistance or the breakdown of treatment, are avoided. Anonymity of the analyst ensures that attention is kept focused on the client and is intended to allow for the full spectrum of transference responses to the analyst, which may be restricted if specific knowledge about his or her personal life is disclosed. The neutrality of the analyst implies refraining from giving personal opinion or judgements and is again intended to safeguard the development of transference reactions.
However, as well as such classical reasons for the importance of these aspects of the frame, they also have other meanings, both for the client and the therapist. For the client, adherence to the rules of abstinence and neutrality allows the development of trust: the consistency of the analyst may reassure the client that he or she has no hidden agendas. Also the anonymity or the therapist reminds clients that the space and focus within the therapeutic session is theirs: no one else will be the centre of attention. Breaking such ground rules may have severe consequences on several different levels. These may be thought of in terms of disruption to the transference, but this has the danger of putting the emphasis onto the client, and not looking at the possible neglect by the therapist of the real person-to-person relationship. The principles of abstinence, anonymity and neutrality are thus important from a humanistic point of view as well as from the classical perspective of safeguarding transference phenomena.

Cherry and Gold (1989) note that despite prolific discussion in psychoanalytic literature regarding the frame, this has focused primarily on three areas:

1. Unusual circumstances (almost always severe psychopathology) that may justify modifications in the frame;
2. Problems created when the therapist introduces or permits alterations in the frame;
3. The meaning of the frame to the client.

(Cherry & Gold, 1989, p. 163)

What has been neglected, they consider, is the importance of the frame to the therapist; at the simplest level they regard it as creating an environment that fosters comprehension of the client through the limits placed on the therapist's activity:

Bound by the needs to remain nonjudgemental and to avoid unnecessary self-disclosure, ( ) the therapist remains free to monitor personal inner emotional response and imagery. There is no agenda ( ). The commitment
to neutrality means that the therapist has no vested interest in the choices that are to be made by the client (Cherry & Gold, 1989, p. 164).

The frame thus assists the therapist in consistently placing the client's interests foremost. Noting the fact that the structure is there for both therapist and client helps the therapist to avoid imposing the rules that comprise the frame in an unduly rigid or authoritarian manner.

The rules of the analytic frame are mainly directed at the conduct of the analyst. While it may be thought that the client has at least some basic responsibilities, such as attending sessions regularly, and refraining from violence or physical contact, a framework for the analyst's behaviours serve both as protection for the client and as a guide for the analyst. A principal exception to this focus on the analyst derives from the classical psychoanalytic framework, and is the 'requirement' for free association.

When Freud originally proposed the basic prerequisites for an analytic relationship he emphasised the 'fundamental rule' of free association which: 'is the hallmark of psychoanalytic treatment conducted by analysts of every stripe' (Kris, 1990, p. 26). Busch (1995) stresses the importance of the patient's free associations as the primary data of the analysis, and considers that in delineating an analytic frame upon commencing therapy, it should be clear to both participants what the data of analysis will be. He states that this is critical because, while empathic understanding or appreciation by the therapist may be important for the patient, it is the ability for self-analysis that is the aim of therapy, and 'there can be no self-analysis without the nature of the analytic data being clear' (p. 454). Thus Busch states that the therapist should outline to patients the necessity for free association.

Two questions are raised by such an approach: firstly, why is free association so important that it is apparently necessary to instruct clients to behave in accordance with it, and secondly, what happens when clients do not comply? Busch attempts
to answer the first of these questions, as has been outlined above, in terms of the need for an ability to self-analyse, and this would seem to be a valuable goal of therapy, both for the client and analyst. In particular, it may help to guard against the component of the analyst's stance that Stone (1961) refers to as the 'patient as cadaver' paradigm; that is, the reliance on elements of the traditional physician-patient relationship, with the analyst as the expert and conveyer of understanding. However, is it possible or desirable to force free association upon clients? While Freud, in advocating free association, apparently regarded any departure from it as resistance, this can be seen as exerting undue pressure upon the client, which may be counterproductive as far as the therapeutic alliance is concerned. A change from the original psychoanalytic stance was put forward by Little in 1951: 'We no longer 'require' our patients to tell us everything that is on their minds. On the contrary, we give them permission to do so' (p. 39).

While an emphasis on free association and the developing ability for self-analysis would seem to be important parts of psychoanalysis, these are high level elements of the therapeutic relationship, and assume a certain level of understanding and willingness on the part of the client. There are also more basic aspects of the therapeutic frame that may be essential as a prerequisite for free association, or else as therapeutic elements in themselves. The notion of analytic space (e.g., Casement, 1990) is one that underlies some ideas about the importance of the frame. This may derive from overt boundaries established in the therapy, such as regularity and timing of sessions, and consistency of the environment, or from more subtle behaviour of the therapist:

Rivers silences are not manipulative.... He's not trying to make you say more than you want, he's trying to create a safe space round what you've said already, so you can think about it without shitting yourself.

The Ghost Road, Pat Barker, 1995.
This description of a psychiatrist in Pat Barker's novel illustrates this aspect of the therapeutic frame - the importance of a secure place within which to explore difficult or traumatic feelings. In this instance, there was no concrete signal of what the frame consisted of, but it is obvious that what was important to the patient was the sense of a safe space - something that was experienced as different from everyday reality.

Winnicott considered the frame from this perspective, viewing it as fulfilling a 'maternal' function: 'the setting of analysis reproduces the early and earliest mothering techniques. It invites regression by reason of its reliability' (1954, p. 286). Winnicott emphasises the importance of the frame as a provider of the experience of an inner sense of security that facilitates growth and development. Additionally he considered that the frame increases in importance when working with severely disturbed patients, at which time the setting itself becomes paramount, outweighing the therapist's interpretations in importance. Since such patients did not experience reliability in the maternal care of infancy, the reliability of the therapist becomes the critical factor, and deviations in the frame can create periods of stalemate and resistance (Winnicott, 1956). This suggests that provision of a secure, invariable therapeutic frame is particularly essential for severely disturbed clients, and indeed it has been argued that where adequate maternal provision can be assumed and there is an intact ego the therapeutic frame is relatively unimportant (Kernberg, 1976). However, discussions in the analytic literature concerning unusual circumstances that may justify modifications in the frame almost invariably focus on situations where there is severe psychopathology. Despite his emphasis on the frame in such situations, Winnicott (1954) also suggests that the desires of more disturbed patients represent 'ego needs', and not instinctual wishes that would be observed in patients who possess an intact ego. He felt that unlike the instinctual wishes, ego needs must be met before further progress can be made. At first sight this seems to be an impossible position for the therapist. On the one hand a rigid frame is considered vital, but gratification of a client's wishes (that may entail alterations of the frame) may at the same time be considered essential for progress.
Deciding whether for an individual client, an alteration in the frame will be the one thing that helps, or a devastating return to the unreliability they experienced as a child is not an easy position for a therapist to negotiate. Perhaps a middle path here is that the perceived 'ego needs' in disturbed patients may usefully shape certain analyst responses, yet the critical elements of the therapeutic frame will remain intact. For example, it can be observed that with some very disturbed patients, silence may be unhelpful and perceived as punitive. Gratifying this need for not having prolonged silences need not endanger the critical elements of the frame.

Even in situations where an element of the frame is the issue, the most important feature may be how the situation is dealt with - the process of negotiation - rather than whether gratification or frustration of the client's wish is the outcome (Mitchell, 1991). Taking a request seriously and being able to look into the meanings within it together with the client convey a sense that the client is important and that the therapist is prepared to make an effort for him or her. A parallel may be drawn with parental responses to a teenager wanting to stay out later than usual to go to a party. Instant responses, for example, 'no, of course you can't' or 'yes, come back anytime', require little effort from the parent, and thus do not convey any sense that the son or daughter is valuable enough for them to give thought to the problem. If after deliberating, a new limit is set, or the old limit is kept to, the position of this limit may be less important than message conveyed that the request is taken seriously, and implicitly, the individual is respected.

Several reasons have so far been mentioned for the perceived importance of the therapeutic frame: classical psychoanalysis views it as a mechanism for safeguarding the appearance of transference reactions; a later view, deriving from Winnicott, emphasises the reliability of the setting as critical. Linked to this is the concept of the analytic space, where the everyday rules of interaction can be put aside, allowing different and perhaps usually impermissible thoughts and feelings to emerge. What these approaches have in common is their adherence to a particular theoretical stance, which, at least in theory, is non-negotiable; i.e., if regression or
transference are necessary for analysis, and if the frame is integral to this, it follows that the frame must always be kept intact. This however provides no guidance to therapists in negotiating unusual circumstances where frame alterations may be necessary and fails to take into account what is important for different individuals. Such concerns have led many contemporary therapists to take a more open approach to the frame, based on humanistic concerns to prevent unnecessary suffering (e.g., Langs & Stone, 1980; Lomas, 1987). Such approaches often rely on a grounding of common sense, and on refraining from behaviours that may be seen as absurd and unnecessary by the client.

The communicative paradigm in psychoanalysis, pioneered by Langs, takes a somewhat different perspective on the frame (Langs, 1975, 1977; Smith, 1991). Whereas those therapists who argue for a loosely structured frame note the variability in conscious responses of clients to the frame and alterations to it, Langs' perspective focuses on the importance of clients' unconscious communications regarding the frame. These, he suggests, unlike conscious attitudes, are notably consistent and point towards upholding a strict approach towards the analytic frame. The reasons for this, however, stem from very different premises than the classical orthodoxy. Smith (1991) outlines the nature of Langs' 'secure frame' in some detail. Despite the emphasis on basic ground rules, the importance of these being upheld is not determined by the clinical judgement of the analyst - such as whether for this client, a frame alteration represents a 'basic need' and therefore should be met - but by what is referred to as the derivative unconscious communication of the client. Thus, Smith argues that the communicative psychoanalyst, rather than adhering to the principles of the secure frame because of his or her belief in their therapeutic importance, will wait for unconscious feedback from the client regarding any alteration in the frame. He goes on to suggest that:

(The analyst) is fully prepared to conform with the patients unconscious recommendations. Unconsciously, patients virtually always urge analysts to
maintain a secure frame with strictly defined ground rules and clear interpersonal boundaries (Smith, 1991, p. 170).

Similarly, the communicative paradigm proposes that when the analyst violates the therapeutic frame, patients' concerns regarding this may be communicated through either direct or derivative means. Direct communications tend to be clear and unambiguous in nature, but the derivative disclosures will tend to describe situations outside the therapy that present the same themes as those the patient is experiencing within the analytic situation (Watkins, 1985).

Langs' communicative paradigm appears to provide a more responsive approach to structuring the frame compared with other theoretical models. It regards a structured frame as important, but bases this on what clients communicate unconsciously to their therapists concerning their requirements about the frame. It therefore seems to go beyond a dogmatic adherence to a framework on the basis of a theoretical principle, for example transference or regression, and also provides a means to find direction in those cases where a break from the secure frame might be appropriate. In addition, monitoring of clients' derivative communications can alert the analyst to unnoticed deviations in the frame on his or her part. The difficulty in such an approach however seems to be in ascertaining the validity of unconscious communications in individual cases. Although there are times when the themes in clients' accounts seem beyond doubt to point towards some aspect within the therapeutic situation, there are many other moments when the analyst may be left in doubt, or else attach a derivative interpretation to the client's communication for which there was no basis in reality. Smith (1991) argues that interpretations based on derivative communications will be validated or refuted by further unconscious responses from the client, and the analyst can thus be guided in his or her responses. However while this is an appealing notion, to validate something in terms of itself may be a flawed way to build scientific hypotheses. In the absence of any other confirmation, it is questionable whether the analyst should be using only derivative communication to confirm or deny previous derivative communication, where the
validity of that communication is in doubt. It is obvious that when there is uncertainty, it is better to err on the side of caution. Despite this, there are many cases where the therapist can be confident in seeing what a derivative communication is referring to, and can use this knowledge both in interpretative work and in monitoring the frame.

In conclusion, it appears that most analytic models continue to attach considerable importance to the therapeutic frame, despite this often being for very different reasons, each of which may seem important in particular situations. It is the communicative approach however which appears to offer the most potentially useful and approach to the structuring of the frame. It builds on psychoanalytic theory of unconscious communication to arrive through observation at the same conclusion as previous theorists - i.e., that a secure frame is critical. However, unlike previous theories, it does this in a way that can allow the therapist guidance in difficult situations regarding the frame, and can alert him or her to unintended frame alterations.

References


_Psychoanalytic Inquiry, 11_, 147-170.


What role does an effective therapeutic alliance play in the use of cognitive approaches in therapy?

Cognitive approaches to therapy are often portrayed as neglecting the relational elements within therapy. In this regard they have been contrasted with the humanistic and psychodynamic traditions which view the therapeutic relationship as a central mechanism of change in therapy. Historically, this attitude can be traced to the behavioural roots of cognitive approaches, which had little to say about the significance of the therapeutic relationship, the emphasis being placed on the development of specific techniques and standard protocols for treatment. Krasner (1962) described the therapist as a social reinforcement machine, and this mechanistic view was inherent in attempts to automate the situation of therapy, for example through the use of tape-recorded instructions for systematic desensitisation (Lang, Melamed & Hart, 1970).

In the cognitive tradition however, many authors go to some lengths to point out the importance that this approach gives to the therapeutic alliance and relationship (e.g., Gluhoski, 1994; Wills & Sanders, 1997). However, this appears to ignore much of the emphasis of the early cognitive formulation, which, like the earlier behavioural tradition, saw the therapy as using the cognitive tools to resolve problems. A good relationship was deemed necessary in order to facilitate important aspects of change, but this was not seen as involved in the process of therapy, being insufficient in itself for therapeutic change (Beck et al., 1979). Relationship issues in cognitive therapy have thus tended to be thought of as comprising the 'nonspecifics' of the change process (Raue & Goldfried, 1994). It appears that in its initial formulation, cognitive therapy paid lip-service to the idea of the therapeutic relationship or alliance, borrowing the Rogerian 'core conditions' as forming the basis for therapy, but giving these little importance other than as a
platform upon which the 'real work' could be carried out. Problems that occurred in
the relationship could be seen as obstacles that would have to be addressed and
solved, before returning to the therapy.

While this approach to cognitive therapy may now be seen as outmoded in the light
of more recent developments (e.g., Beck et al., 1990; Persons, 1989; Wright &
Davis, 1994), it emphasizes the fact that there are several different aspects within
the relational aspect of therapy, not all of which are necessarily covered by the term
'therapeutic alliance'. Gelso & Carter (1985) refer to three components that
comprise all therapeutic relationships, regardless of the orientation of the therapist.
These are the working alliance, the transference relationship, and the real
relationship. Hence when something called the 'therapeutic alliance' is discussed, it
is important to consider what this really refers to. Is it the first of these components
alone, or does it contain the other aspects of the relationship? Within the
psychoanalytic tradition a distinction has always been made between transference
and another aspect of the relationship, variously referred to as the 'therapeutic
alliance', 'working alliance' or 'treatment alliance' (Sandler et al., 1992). Zetzell
(1958) has stated that:

It is also generally recognised that, over and above the transference
neurosis, successful analysis demands at its nucleus a consistent, stable
relationship which will enable the patient to maintain an essentially positive
attitude towards the analytic task (p. 182).

There are distinctions to be made here between what may be thought of as the
contractual elements for therapy, rapport with the therapist, and the transferential
aspects of the relationship. The contractual elements of the alliance, such as
agreement on therapeutic goals and the degree to which client and therapist agree
on the means towards achieving those goals (Bordin, 1979), are seen as important
across the different therapies. They foster a sense of stability within the relationship
where the client knows what he or she can expect from therapy and the therapist.
Such issues, referred to within the psychodynamic tradition as concerning the 'analytic frame' are also one step towards building a rapport with clients that can facilitate therapeutic work. The manner in which the therapist conveys information about the nature of the therapy will provide many clues for clients about the security of the therapeutic environment, and the extent to which they will feel able to work constructively with the therapist.

Creating strong therapeutic rapport within sessions is accomplished within cognitive therapy, as in other therapies, through attention to the core conditions of empathy, understanding, genuineness, respect and unconditional positive regard (Rogers, 1957). However the role and purpose of creating such a 'therapeutic alliance' has been discussed as differing in a number of ways from other therapies. Raue & Goldfried (1994) mention several specific functions of the alliance within cognitive therapy, which derive from social learning theory. Firstly, strong rapport with the therapist increases the 'reinforcement value' of therapists. It provides for a greater ability to influence clients' behaviour and ensure they engage with the work of therapy. Secondly, therapists can model alternative or more adaptive behaviours, for example in assertiveness training or problem solving within sessions (Goldfried & Davison, 1976). Finally the alliance is seen as a key factor in overcoming resistance to any aspect of the therapy. In this respect, Raue & Goldfried (1994) compare therapy to a surgical procedure under anaesthetic. The primary concern of the operation is the surgical procedures, but, if any problems should occur in the anaesthesia, this would rightly become the focus of attention. The therapeutic alliance therefore needs to be monitored during therapy, and attended to particularly at the times when resistance is encountered.

There are however a number of problems associated with such perceptions of the alliance within cognitive therapy. A major element of the cognitive approach is the emphasis laid on therapy as a collaborative endeavour between therapist and client. That is, they attempt to work as a team to explore the belief structures of the client, evaluate the evidence for and against these beliefs, and decide on future ways of
behaving (Beck et al., 1979). Co-existing with this however is the assumption of the therapist as 'expert', and most cognitive approaches put considerable emphasis on the didactic role of the therapist, especially in the early stages of therapy. This appears to undermine to some extent the claim that the therapy is a collaborative enterprise. It also raises the question of how the therapist responds to the client who is antagonistic to the didactic or expert role of the therapist. This situation may cause a severe rupture to the therapeutic alliance, or else not allow it to develop. This may be conceptualised in terms of resistance, yet there seems to be little in the original cognitive model, or in alternative models such as Ellis's Rational Emotive Behaviour Therapy (REBT) that provides a framework for managing such situations.

Despite these drawbacks, there may also be considerable positive impact of the alliance as it is thought to develop in cognitive approaches. For example, Beck et al., (1985) state two implications of the collaborative nature of the work. First, that the relationship develops on a reciprocal basis, with both therapist and client working together to observe what is happening and offer solutions. While the therapist may have more input towards the start of the therapy, there should be considerable encouragement for clients to take on the role of therapist for themselves. This may provide a sense of empowerment and ability which can usefully undermine the idea of the therapist as 'expert' and client as being helpless and in need. This is an aspect of the therapeutic alliance which is particular to the cognitive approaches, at least in such an explicit form. The second implication of collaboration is also one that can have an impact on the therapeutic alliance, since there is an aim to avoid hidden agendas, for example of the therapist keeping interpretations to him or herself, but allowing these to influence the direction in which the therapy goes. There is therefore an aim to have an open-minded therapy in which 'the therapist admits mistakes, is open to suggestions, and willing to go where the client wants to go, without colluding with his difficulties' (Wills & Sanders, 1997, p. 59). While this sounds laudable, in practice, as with other therapies, individual therapists will have their own areas of difficulty which make
such an open stance difficult to achieve at all times. It is also not only in the
cognitive therapies that collaboration and openness are valued. It is possible to go
back as far as Freud to find a concern with the pact between therapist and patient,
and with making the patient a collaborator (1895). The issue of going 'where the
client wants to go, without colluding with his difficulties' also creates problems
within the original cognitive framework since there is little mention of how to deal
with differences of opinion in what needs to be explored other than through taking a
didactic role.

Outcome research has demonstrated the significant contribution of the alliance to
therapeutic outcome (e.g., Horvath & Symonds, 1991; Krupnick et al., 1996).
However, in addition, some studies have suggested that some cognitive therapists
attempt to deal with problems in the alliance through increasing attempts to
persuade clients of the usefulness of the cognitive rationale (Castonguay, 1996).
Similar findings have been observed in psychodynamic outcome research, in which
an increase in technical competence was often accompanied by neglect of the
alliance, with detrimental consequences for therapeutic outcomes (Henry et al.,
1993). It appears that there often remains a separation between technique, seen as
valuable and necessary, and the alliance, seen as less important and to be attended
to when difficulties with the cognitive model arise. However, a different
perspective has seen the techniques of cognitive therapy as embedded within an
effective interpersonal relationship. This has been a focus of recent research and
development of the cognitive model (e.g., Safran, 1990; Safran & Segal, 1990),
concerning the use of the therapeutic relationship as an integral part of the
therapeutic process. Whether such an role is in fact part of the therapeutic alliance
is open to question. The focus within this paper so far has been on how therapists
may form an alliance with clients that creates an environment in which useful work
can be done. The transferential elements of the relationship have been excluded, as
well as any discussion of the relevance of how the client behaves within sessions
towards the therapist. It is possible that such elements are not, strictly speaking, a
part of the therapeutic alliance, and yet it can also be argued that through the use of
interpersonal information within sessions, rapport with the therapist, and hence the therapeutic alliance can be significantly strengthened. These new developments of the cognitive approach, which borrow ideas from other models of therapy but mould them into a cognitive framework will therefore be explored in some detail.

There are several aspects of the therapeutic relationship which may have a role in cognitive approaches to therapy. Despite cognitive therapists generally discouraging the use of transference, it has also been argued that the behaviour of a client within the therapy can provide useful information about difficulties in the ways he or she interacts with others (Goldfried & Castonguay, 1993). Safran (1990) refers to the concept of an interpersonal schema which will be activated in relationships with others, and then maintained by behaviours that evoke responses from others that are consistent with the schema. Hence understanding about clients' schemas or core beliefs can be gained both from client's reactions to the therapist or aspects of the therapy ('transference'), as well as from the feelings of the therapist towards the client both at such key times and in general ('countertransference').

What is important in the new developments of the cognitive model is that these relationship aspects can represent a critical part of the therapeutic work, rather than an obstacle to progress. Safran (1990) notes that specific client behaviours and communications may be pinpointed through reference to the therapist's feelings or cognitions about a repeating pattern of the client's. Such instances may be thought of as 'interpersonal markers', indicating a useful point for further cognitive exploration. For example, the therapist may become aware of a client changing subjects whenever particular feelings seem to be under discussion. Noticing this repeating pattern can enable the therapist to point out to the client the change of subject and ask what was happening for them at that time. Alternatively, the therapist may be more aware of his or her own feelings with such a client - perhaps frustration because deeper feelings never seem to be accessed within the therapy. This provides a clue for conceptualisation for the therapist: it is likely that the client has a similar pattern in relationships with others which will have an effect on the
quality and nature of their interactions with others. Safran is quick to point out that locating the interpersonal markers only represents starting points for investigation, while further collaborative exploration is needed to clarify how relevant the interpersonal pattern in question is to the client's everyday life and problems (Safran & Segal, 1990). However, in addition to the interpersonal markers, focusing on the interpersonal dimension provides a means for the client to encounter new interpersonal experiences - i.e., if the therapist refrains from acting in such a way that maintains the client's schema, this provides a new experience for the client as well as eliciting new behaviours from them in response to the novel situation. This appears to be a similar process to that described in psychodynamic therapy as a 'corrective emotional experience', since, whether or not the therapist refers directly to the in-session behaviour of the client, there is a response which challenges their existing schema and encourages exploration of new ways of viewing the world. As Carson (1982) suggests, such interactions provide opportunities for 'generating perturbations in extant, maladaptive cognitive schemata and restructuring them into a more functional processing system' (p. 78).

The therapeutic relationship has thus shifted from being a 'necessary condition' for change, to a principle mechanism of that change. But in what way is the use of the relationship in this way connected with the therapeutic alliance? Perhaps they can both be thought as comprising the similar elements, but this is not the way that the alliance has traditionally been viewed, as Greenson (1967) states:

(It is) the relatively non-neurotic, rational, and realistic attitudes of the patient towards the analyst.... It is this part of the patient-analyst relationship that enables the patient to identify with the analyst's point of view and to work with the analyst despite the neurotic transference reactions (p. 29).

It would seem difficult therefore for a client to hold onto both the realistic and the transferential aspects of the relationship at the same time, but in this case what stops
him or her from terminating therapy when transference reactions towards the therapist are strong? There would seem to be an interaction between the two forms of relationship in which the therapeutic alliance is both necessary for and maintained by attention to interpersonal and transference issues within therapy. If the therapist is going to explore interpersonal areas with the client, this entails work on a different level from, for example, working to identify and modify negative automatic thoughts. A good rapport will therefore need to be in place between therapist and client for this to occur, otherwise the interventions may have a counterproductive effect. However, such interventions can also have the effect of increasing rapport, if framed appropriately for the client, since they are likely to be at the core of the problems brought to therapy. What is also important to note is that an effective therapeutic alliance does not necessarily imply that rapport between therapist and client must be good at all times. A willingness to explore ruptures in the therapeutic alliance in a collaborative way with the client may strengthen rapport in a way that concern not to disrupt the alliance will not. Such breaks in rapport also offer unique opportunities for clarifying clients' underlying beliefs, whether they are a result of technique-driven or interpersonal cognitive work (Safran & Segal, 1990).

In conclusion, this paper has explored several different aspects of the therapeutic alliance and relationship, the roles of which can be seen to have changed to a considerable degree since the initial conceptualizations of the cognitive model. The need for an alliance, when thought of as the structural elements and rapport within therapy, have been important across therapeutic traditions, and cognitive approaches are no different in this. But a useful addition of the cognitive model has been the explicitness with which the structure is set out for the client, and this may be a factor in the high ratings of therapeutic alliance in some research on cognitive approaches (Raue, Castonguay & Goldfried, 1993). Cognitive therapy also appears to have shifted considerably in the extent to which it views the therapeutic relationship as important. This has meant that there has been considerable expansion of the cognitive framework in dealing with particular issues that previously were not well conceptualised. Thus, in the original approach, while
resistance or ruptures to the alliance were thought to necessitate a shift from technique-driven work to strengthening the alliance, there was no framework within the cognitive model to specify how this might be done. The more recent developments provide much more thorough theoretical and practical means by which both the relationship and alliance can be attended to, and, most critically, used as mechanisms for therapeutic change, rather than just a necessary prerequisite.

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Who's afraid of scientist-practitioners? A discussion of the relevance and implications of the scientist-practitioner model for the profession of counselling psychology.

The scientist-practitioner model is generally regarded as a fundamental basis of counselling psychology. Indeed, since counselling psychology can be thought of as the application of scientific psychological knowledge to counselling and therapeutic practice (Woolfe, 1996), part of the momentum behind the development of the discipline has come from the perceived lack of a scientific basis within counselling. On the other hand, it can also be seen that the profession developed as an endeavour to bring a more humanistic philosophy base into psychology. However, in using the term 'scientist-practitioner' counselling psychology borrows the language and inherent meanings associated with a different area of the profession - that of clinical psychology. While it may be argued that these two sub-groups have more in common than separates them, it is important to examine closely what is taken on when such labels are accepted. The scientist-practitioner model was created and developed within a profession which, according to the literature of counselling psychology, has a substantially different value base (Duffy, 1990; Elton Wilson, 1995; Woolfe, 1990). In this paper, I therefore wish to explore some of the background and meanings of the term scientist-practitioner, since if counselling psychologists are to accept the model as a central creed, they need to be aware of the difficulties that may exist in applying it.

The Division of Counselling Psychology (DCoP) 'Guidelines for Professional Practice' (1995) state that:

(Counselling Psychology) continues to develop models of practice and research which marry the scientific demand for rigorous empirical enquiry
with a firm value base grounded in the primacy of the counseling/psychotherapeutic relationship.

An immediate problem with such a guideline is the tension between traditional psychology, with its dominant paradigm of logical positivism, and the idea of a profession based on a value system which gives centrality to the therapeutic relationship, and hence the subjective person of the therapist, as an active ingredient. Mainstream psychology, despite the changes brought about by the shift of emphasis from behavioural to cognitive models, nevertheless maintains the position of the psychologist as an external observer, necessarily taking a mechanistic view of human processes: that there are discoverable, generalizeable laws that can allow the prediction and control of human behaviour.

The development of counselling psychology as a discipline has been largely separate from this scientific tradition, since it questioned the appropriateness of the natural science model as a basis for human science. Counselling psychology was therefore influenced both by the existing practice of counselling and psychotherapy, and by research grounded in humanistic and phenomenological traditions (Strawbridge & Woolfe, 1996).

In contrast, clinical psychology's early development owed much to the logical positivist framework, and also to the dominant medical model of care, originating as it did in psychiatric institutions such as the Maudsley Hospital. Working with clients from a psychotherapeutic model was commonly seen as outside the remit of clinical psychology:

Therapy is something essentially alien to clinical psychology and....if it is considered desirable on practical grounds that psychologists perform therapy, a separate discipline of Psychotherapist should be built up to take its place beside that of Clinical Psychology (Eysenck, 1949).
The basis for such a stance was the perceived importance of clinical psychologists being objective, and not subject to the same interpersonal effects (e.g., transference and countertransference) as those carrying out the 'treatment' of individuals - psychiatrists. Hence early training in clinical psychology emphasised the skills of assessment and formulation, giving advice about the types of treatment that were likely to be effective. Despite the later focus on management and therapeutic work, the skills of assessment and formulation were maintained together with their integral link with the experimental paradigm. It is these concerns which have continued to define the contribution of clinical psychology as a profession.

For counselling psychology, it may be asked if the qualities associated with the profession are the same as those which are said to underpin clinical psychology. The BPS Diploma in Counselling Psychology requires skills in assessment and formulation, but does this have the same meaning as it does in clinical psychology? It appears that we have borrowed the language of a profession that is wedded to a positivist scientific model and which, in its early development, endeavoured put such a model into practice through the emphasis on psychological testing. But this is not the aim of counselling psychology. When we think about assessment and formulation, it is not, on the whole, in the rigorous standardized manner envisaged by the early proponents of clinical psychology. On the contrary, our assessments tend to be a more subjective and practitioner-based phenomenon, as are, notably, many of those of clinical psychologists. Even by adopting the term assessment as an integral part of our profession we find conflict between the value base of counselling psychology - concern with the individual and their experience - and the positivist assumptions upon which the notions of assessment and formulation rest (Crellin, 1998). Formulating the problems of a client at an assessment stage may fit well within a model of 'objective' administered tests, but is at odds with humanistic and phenomenological approaches to therapy which allow the problem to unfold over the course of therapy. As Crellin (1998) states:
If the task we are engaged in is that of helping the client to arrive at a meaningful narrative, and to make sense of things over time, then no formulation is possible until the end of therapy, and logically, it would be the client and not the therapist who would need to be satisfied with (it).

As a counterpoint to this view, I would offer the observation that, just as value-free practice is now mainly accepted as a fiction, so practice without some form of (at least) intuitive assessment and formulation must necessarily be a myth. Were this not the case, I am doubtful of the ability of therapists to be of use to clients. Without some organising of the client's world and experiences in the mind of the therapist there would be no basis for any intervention except perhaps literal reflection. But the tension between formulating and not-knowing in therapy is in my view, the point of maximum impact of therapists. We cannot escape trying to organise experiences, but we can at the same time be aware of this, and its function as filling the vacuum of unknowing in the therapeutic situation. If we can sustain this tension we are best placed to hear what our clients are saying to us, without rushing to 'solve' the problems that our own anxiety as practitioners will not allow us to listen to in full.

Counselling psychology thus sits at a crossroads between conflicting paradigms. Much of the impetus behind its creation, and the strengths that distinguish it from other forms of psychology come from a value base that is only marginally recognised by mainstream psychology, despite the prevalence of post-modernist ideology in other disciplines. However, the difficulty for counselling psychology has been increased by the concern for power and acceptance both among peer groups and within a competitive marketplace. Firstly, in gaining recognition and chartered status within the British Psychological Society (BPS) it has been necessary to endorse the positivist model. Secondly, many counselling psychologists work alongside psychologist colleagues from other divisions, such as clinical psychology, and rightly assume parity of status at chartered level. However,
due to the prevailing ethos of positivist science, the only way that counselling psychology has been able to prove itself as worthy of this parity is by emphasising the similarities with clinical psychology. Status and acceptability has therefore come at the expense of marketing the profession within a traditional scientific tradition, while in reality practising something somewhat different. Counselling psychology is thus in danger of trying to be all things to all people, a situation created by the understandable urge to gain the power and respectability of accepted institutions when the cutting edge of counselling psychology has always emphasised its differences from such institutions.

The mere fact of calling ourselves scientist-practitioners draws us towards the principles of clinical psychology. Hence problems that may be faced in a practitioner context can be thought of from an external 'scientific' perspective, i.e., diagnostically. Reports of individual problems and suffering may be categorised, for example as PTSD or depression, and this may lead to the carrying out of a protocol for treatment of such a problem. But, as counselling psychologists, we are concerned with a more phenomenological perspective in interacting with our clients - the meaning and experience of their difficulties in the client's own terms (Williams & Irving, 1996). These two perspectives do not mix well together, and while we, as a new profession, seek to underline our authority and status through subscribing to the models of an established profession, it is important to recognise that within clinical psychology, there is widespread dissatisfaction and unease with the scientist-practitioner model, since it is widely seen as having marginal relevance to the practice of clinical psychology (Jones, 1998).

Counselling psychology therefore seems to use terminology and approaches deriving from very different value bases, depending on the demands of the moment. We may be seen to be scientists when we engage in academic research or conducting service evaluation, but practitioners when we are applying our therapeutic skills, a distinction which is fostered by the presence within the Division of Counselling Psychology of separate sub-committees for professional and
scientific affairs. One way of resolving what it means to be a scientist-practitioner is to separate the two:

We belong to both the practitioner and the scientist community. This does not mean that we need to perform both these roles at once (O'Brien, 1996).

However, an alternative to this stance, or perhaps an addition, is to make use of the new-paradigm research that is now available to give meaning to the term scientist-practitioner. This is not a new idea. Kiesler (1979) stated:

It's time... to get on... with increasingly creative efforts to implement the model. The unfortunate historic fact is that we started to throw out the model at the very time in our development when we were acquiring new perspectives and learnings that could permit us to apply the model in truly meaningful ways.

More recently Coyle (1998) has described some similarities between qualitative research and counselling psychology, particularly in its concern with 'viewing experiences from the perspectives of those under study in an unprescriptive way'. This is a very different approach from the traditional quantitative methods in psychology which have viewed psychological phenomena as object-like, omitting or distorting conceptions of meaning that are central to qualitative research.

It may be that it is both the fate and the strength of counselling psychology that it dwells in the uncomfortable divide between the new and old paradigm research, and between scientific psychology and the 'art' of therapy. Woolfe (1996) notes 'a developing awareness of the need for a more articulated 'scientific' basis for counselling (sic) and in refining what is meant by the term scientific.' It is therefore the role of counselling psychology to straddle this divide between paradigms and make it a valuable and productive place to be, both for ourselves and for other professions.
To call ourselves scientist-practitioners can, as I have shown, mean a number of things. As counselling psychologists, I think it is essential for us to be aware and take account of the differences in the value systems underpinning various aspects of our profession. But we should be aware at the same time that it is inevitable that there will be confusion regarding the value base of the profession when it draws upon such different traditions. We cannot easily reconcile the traditions, but we can hopefully ensure that we are aware of what model we are drawing on in a given situation, be it research or practice, and aim for consistency within it. If however our profession does not foster a questioning climate in training and professional debate regarding the different aspects of science and practice, we may expect confusion within both research and therapy. The danger is that through maintaining a stake in each paradigm, and in using terms such as scientist-practitioner that have a history distinct from that of counselling psychology, others may misunderstand what we represent. Counselling psychologists themselves may also make assumptions about links between values and practice that in reality are tenuous or non-existent. Hence both clients and practitioners would be wise to be cautious about those calling themselves scientist-practitioners until they are clear about what such individuals mean by the term.

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Religion and ethical practice in psychological therapy

Introduction

The place of religious and spiritual considerations within psychology and the psychological therapies has been the subject of much contention. This paper aims to explore some of the issues that have made the area problematic, particularly in terms of whether and how religious and spiritual beliefs enter into therapeutic practice. The paper will therefore address three main themes. Firstly, the attitudes that are to be found within psychology towards religion; secondly, practical and ethical grounds for attending to religious issues; and thirdly, the implications of bringing religion and psychological therapy together.

Initially however it is necessary to clarify the concepts that are being discussed since the terms 'religion' and 'spirituality' can be used to mean many different things. For the purposes of this paper, unless otherwise stated, the term 'religion' is used inclusively to refer both to systems of traditional religious belief and practice as well as personal orientations that are considered 'spiritual' in nature by individuals, but may or may not be associated with traditional religions. In discussing these concepts together it is not intended to imply that there are no differences between them, and the following definitions indicate the kind of difference that is generally noted:

(Religiøsity is) adherence to the beliefs and practices of an organized church or religious institution (Shafranske & Maloney, 1990, p. 72).

Spirituality is the courage to look within and to trust. What is seen and what is trusted appears to be a deep sense of belonging, of wholeness, of connectedness, and of openness to the infinite. (California State

The differences inherent in these definitions are clearly important in considering the ways in which religious and spiritual concerns are handled in therapy. However, such a level of detail is beyond the scope of the present paper which seeks to address the issues in more general terms.

Attitudes towards religion

Attitudes within psychology towards religion have often been negative, perhaps in some degree due to a perceived gulf between the scientific endeavour and questions that involve religious behaviour or experience:

Religion is the most important social force in the history of man (sic)... But in psychology, anyone who gets involved in or tries to talk in an analytic, careful way about religion is immediately branded a meathead; a mystic; an intuitive, touchy-feely sort of moron (Hogan, 1979, p. 4).

Although there is now a considerable literature devoted to religion and psychology, there has been a bias in both research and practice towards the view that religiosity is at odds with emotional health and rationality (Bergin, 1980; Lannert, 1991). This has been attributed to two sources (Spilka, 1986). Firstly, the parallels drawn between religion and neurosis in psychoanalytic thought (Freud, 1927); and secondly, the positivistic assumptions within psychology that reject subjective and mentalistic accounts. In the therapeutic context there still appears to be a widespread avoidance of religious considerations and negative attitudes towards religion despite the considerable literature documenting the complexity of the relationship between religion and mental health (see Lowenthal, 1995 for a review).
Albert Ellis, a highly influential figure within the development of psychological therapy considers that:

Religiosity is in many respects equivalent to irrational thinking and emotional disturbance... The elegant therapeutic solution to emotional problems is (to be) quite unreligious... The less religious they are, the more emotionally healthy they will tend to be (Ellis, 1980, p. 637).

The prevalence of such rigid thinking within psychology has been a limiting factor in research. It is equally important in therapeutic practice where the consideration of how religious issues may be handled in therapy raises a number of practical and ethical questions.

Throughout the history of counselling psychology, there has been particular attention paid to groups that constitute substantial minorities within the population. Sensitivity in the practitioner is needed to respond to the needs of people with diverse understandings of the world. But as far as religion is concerned, there is a widespread perception that therapists are unconcerned with the religious or spiritual orientations and values of clients. A number of research studies support this view (e.g., Purpura, 1985; Fenchel, 1986), for example reporting the ignorance of psychotherapists about Catholic practices and values, as well as negative attitudes to religion and religious people.

Information about the religiosity of a client has been found to have a profound effect on the clinical judgement of therapists. One study (Gartner et al., 1990) asked clinical psychologists to rate and diagnose two patients on the basis of case histories, with one case including information about beliefs. Religiously committed clients were more likely to be judged in negative clinical terms. Specifically, they were more likely to be judged as obsessive-compulsive and less likely to be judged as anxious.
Other authors however point to a range of accommodation to religious values in psychotherapy (e.g., Quackenbos, Privette and Klenz (1986). But many psychotherapeutic systems seem to lack a conceptual framework to deal with the profound existential-religious issues of clients, raising the suspicion that such accommodation may be predominantly due to the personal leanings of therapists, rather than therapeutic models which assist exploration of religious issues and experience. Even existential therapies, with their focus on personal explorations of inner experience and world-view sometimes appear to undervalue religious ways of being in the world. Spinelli (1989) suggests that the searching for meaning through philosophical texts or religious pronouncements of faith is a path to inauthenticity. While adherence to religious beliefs is not of course inevitably healthy, such pronouncements do not allow for the interaction between experiential forms of knowledge and religious practices that is widespread within all religions.

Taking a historical perspective on psychotherapy, Benner (1989) has cited a view first argued in the early 1900's that psychotherapy involves healing through the use of mental, moral and spiritual methods. This is explained through examining the literal meaning of psychotherapy, 'psyche' meaning soul, and 'therapist' being defined at that time as servant. The psychotherapist is thus described as a servant of the soul. The movement from the cure of souls to the cure of minds can be seen as a result of the growth of science and subsequent decline of religion. The social sciences hoped for new solutions to old problems - to address the same life issues and emotional and behavioural problems, but without reference to religion. Benner (1989) suggests that perhaps therapists have been asked to perform the impossible: the cure and care of the soul, or psyche, without reference to spiritual aspects of being.

Awareness and sensitivity towards religious concerns does however appear to be growing among mental health professionals (Prasinos, 1992). Despite this, there remains a lack of attention given to the area in training courses in counselling,
psychotherapy and psychology which may be a factor in the continued undervaluing of religious issues.

Practical and ethical considerations

Considering religious issues in the therapeutic context can be seen as important simply due to the fact that for large numbers of people, religious beliefs are highly influential value systems and creators of meaning. It is therefore necessary for therapists to be aware of and sensitive to the needs of clients whose religious beliefs may enter into the therapeutic encounter. Some authors (e.g., Humphries, 1982) have suggested that there is a lack of awareness of the harm that can occur through insensitivity to religious concerns. This includes the countertransference of therapists concerning religion, or the conveying (consciously or unconsciously) of personal attitudes towards religion as though they were matters of scientific fact.

Ethical considerations may also contribute towards reluctance by therapists to address religious concerns. Henning and Tirrell (1982) note that therapists are ethically prohibited from operating outside the boundaries of their competence. However, despite most therapists receiving little or no training on religious issues, a survey found that significant numbers (72%) address such issues, at least occasionally, in their practice (Lannert, 1991).

It is generally considered bad practice to inject religion into therapy where it is counter to the client's belief system, or to attempt to discredit the client's beliefs (Peck, 1993), and of course these are useful basic assumptions. But avoidance of religious content can also violate both clinical and objective psychological goals and principles (Spilka, 1986). In trying to ensure the avoidance of behaviour that impinges on clients' beliefs, it is usual for therapists to fall back on another belief system - that of secular humanism. This therefore raises the question of whether it is really any more acceptable that, for example, secular humanist beliefs should be
imposed upon a religious client, which seems almost a standard procedure in many therapeutic orientations.

It is part of the ethics of the profession of counselling psychology to respect individual dignity, uniqueness and freedom of choice, and on this basis, it would be wrong to impose therapist's values on clients. But it is also well established that in 'successful' therapy, clients often change their values to approximate more closely to those of their therapist (Beutler, 1979), and that values are therefore a constant feature of therapy (Bergin, 1980, London, 1986). The important point must therefore be not how to be neutral, but whether values can be used to therapeutic advantage without abusing the therapist's power or the client's vulnerability (Thompson, 1990). The strategy of trying to be non-committal is likely to fail either due to silence being seen as agreement with the client's view, or else through therapist inclinations being indicated involuntarily at critical points. This has been underlined by the observational studies of Carl Rogers' work in the 1960's (Truax, 1966; Bergin, 1991). If it is impossible for a therapist renowned for his non-directive approach to be objective or neutral, it seems unlikely that others will succeed.

Implications for psychological therapy

Having noted that bringing values into therapeutic practice cannot be avoided, it may be useful to explore how religious issues can be incorporated into therapy in an acceptable way. At the most elementary level, this must entail giving these aspects of human experience the same respect that therapists (hopefully) accord to other dimensions of life. This respect appears to have been missing from several frameworks of therapeutic practice.

Exploring religious issues in therapy is seen to be complex partly because of the ease within which situations can be thought of in which bringing in a religious or
spiritual dimension would be inappropriate. In contrast, secular humanist responses tend to be seen more often as within an acceptable range of therapist behaviour. As an example, in a recent session with a client, it was noted that some of the client's material might concern a spiritual dimension. However, comment on this was avoided, with a focus instead on the fact that a set of experiences seemed to have particular meaning for her. This uncovered further information, in which the meaning became apparent as connected to past history, and feelings of security. Had an interpretation been made regarding a spiritual dimension, this important information could easily have been missed. Although existential or spiritual concerns may frequently be in evidence, it is critical that these are not exclusively focused on to the detriment of more down-to-earth psychological processes. In taking religious concerns seriously in therapy it is not necessary or desirable to exchange secular dogma for religious dogma.

However, providing space for a client's religious value system does not necessarily mean that such values should never be challenged, and this is another aspect of religious belief that creates difficulties for therapists in knowing how to work within this area. Religious practices can be used as instruments of denial or repression on an internal level, just as they can be used for emotional or spiritual development. For example, Theravada Buddhism teaches that freedom from suffering can be gained through non-attachment and acceptance, removing the cycle of craving and aversion that creates misery - a theory that has similarities to the cognitive model of therapy. The emphasis is on our evaluation of an event as what makes us feel happy or sad - it is not within the event itself, but in what we construe as meaningful in it. If the evaluation is altered the emotional response will also change. But non-attachment may also be a very appealing philosophy to those for whom difficulty with, or denial of particular emotional responses is evident. A problem in coping with angry and negative feelings for example may be helped in the short-term by a philosophy that can be interpreted as being about cultivating peacefulness. From this perspective Buddhism can be seen as route through an emotional minefield which allows a non-reactive response to difficult events. But where such non-
reaction has been a difficulty in the past, for example, through not being able to understand or express particular emotions, Buddhist philosophy is likely to simply strengthen the defences that keep these emotions in check. It will be a coping strategy, possibly a very effective one, but not perhaps ultimately very rewarding, since the emotions are simply being denied. Such instances may be areas for probing within therapy, but it also highlights the value assumptions made by most therapist regarding what is 'healthy' and 'unhealthy' behaviour as far as the expression and awareness of emotional responses are concerned.

That religion can have positive and negative effects on mental health is confirmed by the large number of research studies over recent years which have challenged the traditionally negative bias (e.g., Spilka et al., 1985a). There is now more recognition of the complexity of the phenomenon. However, differentiating the positive and negative therapeutically is not straightforward, so it is not surprising that the area is often avoided. But does this mean that therapists are unable to question or confront aspects of a belief system that form a defence against some other psychological difficulty? It would appear that therapists of all orientations do this without difficulty in secular areas, perhaps challenging perceptions or worldviews that are seen as psychologically damaging. This is, after all, the basis of cognitive therapy, despite its recognition of the phenomenon of depressive realism (Taylor, 1983). Substantial research findings indicate that depressed people tend to form more accurate assessments of events than the non-depressed, and yet their perceptions are challenged in the interests of taking what is supposed to be a more 'realistic' view of the world.

**Conclusion**

In dealing with the area of religious beliefs, therapists need, as in other areas, to guard against conveying judgmental attitudes, exploring instead the meaning of clients' values and experiences. As well as having a role in relation to particular
psychological problems, for example as a protection from life's stresses, religious explanations and practices have the potential to meet some basic human needs: creating meaning from what is confusing or unclear; giving a sense of personal control in situations which appear hopeless; and maintaining or enhancing self-esteem (Spilka et al., 1985b). As such, religious beliefs may constitute a powerful force for therapeutic change. Conversely, if a therapist remains unaware of religious beliefs, therapeutic work may in some cases be futile, for example when it contravenes some of the client's basic assumptions for living. Therapists also need to be keenly aware of their own attitudes towards the various religions and towards religious questions in general. This is vital in being able to help religious clients make informed choices about the direction of therapy in a way that is both congruent and non-defensive.

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Do clinical psychologists' perceptions of counselling psychology and the views expressed in counselling psychology literature correspond with the experience of training?

Introduction:

The catalyst for writing this paper was a qualitative pilot research project exploring clinical psychologists' perceptions of counselling psychology. This was carried out by four clinical and two counselling psychology trainees, and consisted of semi-structured interviews with six chartered clinical psychologists. The research particularly focused my thoughts on the apparent discrepancy between current definitions of counselling psychology and what trainees are actually being trained to do. Through highlighting some of the important issues currently facing the profession, such as the overlapping roles of psychologists, their breadth of training, and the confusion surrounding the contribution that counselling psychology has to make, the research gave momentum to my own further reflection on the nature of counselling psychology. While I would not wish to draw any generalized conclusions about the views of clinical psychologists on the basis of such a small-scale study, the themes identified in analysing the data are ones which also occur in discussions within counselling psychology literature and in the context of training. I have therefore adopted these themes as a focus for discussion about discrepancies between perceptions of counselling psychology and the experience of training.

Two major themes emerged from the interviews with the clinical psychologists. I shall briefly describe these before going on to compare the views expressed with perspectives found in the BPS and counselling psychology literature and with my experience of what, in practice, a doctoral level training appears to be providing. I shall also address the issue of research in counselling psychology, reference to
which was notable by its absence in the interviews, in spite of the fact that research forms a substantial part of my training.

The first theme arising from the research interviews concerned the client group with which counselling psychologists are seen to be involved. Within the field of adult mental health this was thought to be fairly limited, the emphasis being on those with life-span problems or developmental issues as opposed to those with more severe symptomatology, although several interviewees did note that counselling psychologists may be suited to work in a number of specialities, such as child or elderly services, as well as in adult mental health. The second theme concerned the form of interventions provided by counselling psychologists. This was generally thought of as a limiting factor; counselling psychologists were seen as providing a specific form of treatment, identified as 'counselling' or 'therapy'. Structured psychological programmes, behavioural treatments and mental health and risk assessments are examples of areas that were felt by individual respondents to be outside the remit of counselling psychology.

Theme 1: The client group of counselling psychology

Although several clinical psychologists interviewed acknowledged the potential roles of counselling psychologist in different specialities, I will confine my observations here to the field of Adult Mental Health. The limited range of clients considered suitable for interventions by a counselling psychologist may be readily understood when we look at how the profession has presented itself through the BPS definition, which states that the counselling psychologist will be working with people facing 'normal life-cycle developmental issues' (BPS, 1994). Furthermore, Woolfe (1990) states that one of the motivating forces behind the discipline of counselling psychology has been an 'emphasis in the work of helpers on well-being rather than sickness'. However, in a study investigating the employment of counselling psychologists within a clinical psychology service, Collins and Murray
(1995) noted that the implication that the profession is concerned with people facing less complex, severe or intractable problems is not necessarily held by counselling psychologists themselves.

As far as my own training is concerned, and the psychotherapeutic work that trainees are expected to do on placement, these definitions with the emphasis on well-being rather than sickness are somewhat limited, given the actual working environments of many counselling psychologists, and undervalue the wide applicability of the skills that are learnt during a three year full-time training. The experience of trainees on the Surrey course demonstrates that from an early stage of training, we are expected to work with people who may have persistent mental health problems which cannot be seen simply as 'normal life-cycle' issues. Accordingly, the approaches that we use with our clients may sometimes come from a psychological knowledge base rooted in concepts of disorder or illness as well as from well-being and health.

To see counselling psychology as operating within a particular set of boundaries, such as which clients should be seen by a counselling psychologist, is understandable, since it is a straightforward way that other professions can differentiate it from themselves. However, the discrepancy between perceptions of counselling psychologists in relation to the client population with whom they work would seem to stem from a difference in conceptualization of distress and disorder, rather than a difference in the actual clients themselves. Whilst I do not suggest that client difficulties should be conceptualized in terms of psychopathology and psychiatric diagnosis, the idea that counselling psychologists should work only with people facing normal life-span problems does seem to impose an inappropriate limit on their work.
Theme 2: Therapeutic interventions in counselling psychology

The limited form of intervention noted by clinical psychologist interviewees is difficult to reconcile with the experience of training in counselling psychology. Trainees on the Surrey course spend a substantial part of training in adult mental health settings, where assessments, therapeutic skills and structured psychological interventions form an integral part of their work. The problem may be that counselling psychology is seen with the emphasis on 'counselling', which neglects the importance of a training rooted in psychology. This may be a consequence of uncertainties concerning the level of training in counselling psychology, but it also highlights the drawbacks of the title, and the profession may be better served by adopting a name which does not have such connotations. Although this may seem unrealistic, given that the profession exists in a more developed capacity in Australia and the United States, it is important to draw attention to the point that we may be misperceived in this country due to assumptions or preconceptions derived from the title of the profession.

In reality, individuals, once qualified, will follow their particular areas of interest in their work, and the title of their profession may be less important than their experience both during and after training. Thus, there are many clinical psychologists who focus on the process and relationship issues that we consider to be critical from a counselling psychology perspective. Similarly, a counselling psychologist may have a particular interest in people with psychotic disorders, and choose to work, for example, primarily cognitive-behaviourally with such a client group in a psychiatric setting. This may not fit with some of our ideas about what counselling psychology is, but the important point is that my training provides skills and knowledge that would be a basis for such work.
Reflections on the roles and boundaries of counselling psychology

The research and the themes discussed above highlighted considerable uncertainty among the clinical psychologists interviewed about the nature of counselling psychology. The escalation of qualifications to doctoral level created difficulties in reconciling what was perceived as the rather restricted working range of counselling psychology, and the fact that the training is to an equivalent level as clinical training. Thus although the need for 'people doing counselling' was appreciated by respondents, this was seen as a limited role, and in some cases there was uncertainty about whether it would be any more useful to employ a counselling psychologist rather than a BAC accredited counsellor, for example in a CMHT.

The Collins and Murray (1995) study, noted above, looking at the employment of counselling psychologists in a clinical psychology service, exemplifies the confusion of roles that can occur; in this case through the selection of 'counselling psychologists' for employment. The research took place before the formation of the Division of Counselling Psychology and the employees had been trained in counselling and also held first degrees in psychology. However as the authors are aware, these criteria would not satisfy divisional requirements for chartered status, and did not involve any training at a postgraduate level. Uncertainty about the profession is also exacerbated by use of the term 'counselling psychologist' by those who are not chartered or eligible for chartering by the BPS and by job advertisements for counselling psychologists which do not require chartered status.

The 1989 study of clinical psychology services in the NHS by the Management Advisory Service (MAS) may help to clarify the position of counselling psychologists in relation to other professional groups. It delineated a framework for describing psychological knowledge and competencies, identifying three levels as follows:
Level 1 - basic 'psychology' such as establishing relationships with patients and relatives, maintaining and supporting a relationship, interviewing and using some simple (sic), often intuitive techniques, such as counselling and stress management.

Level 2 - undertaking circumscribed psychological activities, such as behaviour modification. These activities may be described by a protocol. At this level there should be awareness of the criteria for referral to a psychologist.

Level 3 - A thorough understanding of varied and complex psychological theories and their application.

Almost all healthcare workers use level 1 and 2 skills...Some have well developed specialist training in level 2 activities. Healthcare psychologists possess skills and knowledge at all three levels. Their particular contributions in their rounded knowledge of psychological theories and their application (MAS, 1989).

Leaving aside the issue of the 'simplicity' or otherwise of some 'Level 1' skills centred on the therapeutic relationship, which many psychologists might question, it seems clear to me that that 'level 3' skills of understanding and linking theory and practice is a critical element of counselling psychology. The emphasis on this in my training, and the use such a knowledge base to inform therapeutic practice would seem to be a major difference between training in counselling psychology and training in counselling.

In attempting to define counselling psychology it is easy to overlook the fact that there will always be exceptions to our definitions when we look at what counselling psychologists are actually doing. Perhaps it is experience after qualification that may be the most important in developing roles, since this builds on the broad
training we have towards specific areas of interest. There will have been a breadth of training that provides a basis of skills applicable in a wide range of situations and populations. Post qualification training and experience is, as in clinical psychology, of vital importance for developing specific qualities necessary for work in particular situations.

This however does not help to clarify where the limits of professional activities might lie. While it is essential to avoid restricting the profession through rigid definitions, it may be equally damaging to give the impression that counselling psychology has universal applicability; this tells others little about us, and may suggest that we wish to devalue the skills of other professional groups. However, the range of types of placement that occur on the Surrey course, and the areas in which counselling psychologists work are very wide. We may find in many cases that individual clinical and counselling psychologists are doing much the same kind of work. However, it seems to me that it is the emphasis on the relationship- and process-oriented paradigm within our profession that is important for counselling psychologists in different fields to remember. As has been discussed in other papers, (Woolfe, 1990, Collins and Murray, 1995) the distinctiveness of a counselling psychology approach may be more in what we *are* rather than what we *do*. Woolfe (1990) discusses the humanistic values underlying the profession through which process issues and the therapeutic relationship are considered to be central. Such values remain important for counselling psychologists whatever their theoretical orientation or client group.

**Counselling psychology and research**

This discussion so far has emphasised the therapist-practitioner aspect of the profession, which is the focus implicit in past definitions from the BPS and in our interviews with clinical psychologists. However, this does not take into account the important role that counselling psychologists play, as generators and consumers of
research, in forging stronger links between theory and practice. This is an area that is much emphasised in current training, both by accredited courses and the independent route. The importance of the integration of practice and research is also widely recognised in the counselling psychology literature:

(Counselling psychology) must see research as crucial and instigate original research rather than just note the research of others. The counselling psychologist has thus to be a critical analyst of his or her own and others' work, as well as a pioneer and original thinker (Breese, 1985).

There has been considerable debate within counselling psychology of the relevance of the scientist-practitioner model to the profession. Heppner and Anderson (1985) noted the tendency to emphasise the practice and experiential elements apart from a scientific basis, which is a problem for a profession claiming to espouse this model. However, a reconciliation between research and practice has been greatly assisted by the new perspectives brought by the qualitative paradigm. Kiesler (1979) defends the scientist-practitioner model by endorsing original efforts to apply it:

It's time for us ( ) to get on ( ) with increasingly creative efforts to implement the model. The unfortunate historic fact is that we started to throw out the model at the very time ( ) when we were acquiring new perspectives and learnings that could permit us to apply the model in truly meaningful ways.

A qualitative approach allows for greater integration of ideas about research and therapeutic practice than has been the case from the quantitative perspective. The two-way criticisms of, firstly, therapy not being sufficiently scientific or research based, and secondly that research is not sufficiently relevant to practice are now beginning to be addressed.
Conclusion

This paper has examined three different perspectives on counselling psychology: from clinical psychologists, from within counselling psychology and the BPS, and from my own experience on a doctoral training programme. These have been discussed in relation to both therapeutic practice and research in counselling psychology. Although valid conclusions about the perspective of clinical psychology cannot be made on the basis of the few interviews carried out, I hope it is clear that the themes I have reported exemplify important questions that face counselling psychology, regardless of their origin.

I have aimed to respond to these questions from a trainee's perspective, as well as suggesting what my training appears to be actually providing in practice. While counselling psychologists have been concerned with differentiation from other branches of psychology, we must also recognise the overlapping roles that exist, a situation exemplified by the increasing number of departments for 'Psychological Therapies' within the NHS. Whatever criteria are used to define our profession, counselling psychologists will inevitably, like other therapists, find their own individual directions and ways of working.

References


Therapeutic Practice Dossier
Therapeutic Practice Dossier

The contents of this dossier address issues relating to the practice of counselling psychology as developed over the three year-long placements. The nature and experiences of therapeutic training on placements in the National Health Service are discussed, addressing the various aspects of my role as a psychologist, which entailed organisational and educational activities in addition to direct therapeutic practice. Summaries of four client studies describe some of my individual client work, utilising humanistic, psychodynamic and cognitive-behavioural perspectives. A discussion of issues arising from three process reports expands on my client work, addressing the role of the therapeutic relationship and a process-oriented approach to my therapeutic practice.
Placement Reports

This section comprises a description of the three PsychD placements followed by an overview of experiences and development within each placement.
First Year Placement: An NHS Community Mental Health Team and Primary Care

October 1995 - August 1996

For this placement I was based in a Community Mental Health Team (CMHT) and also working for one session each week in a General Practice (GP) Medical Centre. I saw clients from a range of social backgrounds, although the cultural diversity was limited. Presenting problems included depression, anxiety and phobias, obsessive-compulsive disorder, bereavement, relationship issues, post-traumatic stress disorder and disfigurement issues. At the GP Medical Centre I also ran a stress-management group together with a Practice nurse.

My supervisor at this placement was a clinical psychologist within the CMHT. Client issues were formulated primarily from a psychodynamic perspective with particular attention to process issues within the therapeutic relationships. However, the style of intervention with clients varied, depending on individual needs, and included humanistic, cognitive behavioural, problem-solving and psychodynamic perspectives.

The placement also provided opportunities for further involvement with the CMHT through team meetings, making presentations, and attending training days. These included a team 'Awayday' and conferences on 'Working in Multi-disciplinary Teams' and 'Death, Dying and Bereavement'.
Second Year Placement: An NHS Psychoanalytic Psychotherapy Department and Acute Psychiatric Unit.

*September 1996 - August 1997*

My clients within the psychotherapy department were seen for the duration of this placement, providing experience of relatively long-term work. From January 1997 I was a co-therapist in an analytic group, and this part of the placement continued until December 1997. In addition to the work within the psychotherapy department, I also provided psychological input to an inpatient ward team which met weekly. Occasional consultative assessments were provided for the team, and I saw one patient referred by the team for longer-term work.

Presenting problems of clients seen at this placement included depression, anxiety, bulimia nervosa, manic-depression, complex loss and bereavement issues and sexual abuse.

Supervision for individual work at this placement was provided by a psychoanalytic psychotherapist who is also a clinical psychologist. This consisted of joint supervision with another trainee, in which process notes from one client were discussed each week within the psychoanalytic framework. Additional individual supervision was also provided for discussion of other issues, including the supervision for clients referred from the ward team, with whom a psychoanalytic approach was not taken. My group work was supervised by an IGA (Institute of Group Analysis) and SAP (Society of Analytical Psychology) trained psychotherapist.
Third Year Placement: An NHS Adult Psychology Service

*September 1997 - August 1998*

This placement had a primarily cognitive-behavioural orientation with clients being seen for short-term contracts (ranging from 4 to 16 sessions). Client referrals were taken from a CMHT, Primary Care and Health Psychology. Presenting problems of clients included the following: depression, anxiety and panic disorder, manic-depression, management of severe atopic eczema, coping with delusional and intrusive thoughts, childhood sexual abuse, post-traumatic stress disorder, binge eating, codeine addiction and bereavement issues. In addition to the individual client work, in the latter part of the placement I set up and led a group on an acute psychiatric inpatient unit. This was run together with an Assistant Psychologist, with an emphasis on structure and using exercises designed to foster communication between individuals.

Supervision in this placement was provided by a clinical psychologist with further training in schema-focused cognitive therapy and in body-oriented approaches to therapy. Hence although the predominant mode of formulating and working with clients' problems was cognitive-behavioural, this was embellished by theory which emphasised a more holistic and multi-modal approach.
An Overview of Placement Experiences

The three work placements extending throughout the PsychD course have provided a wide range of experience both in terms of the therapeutic orientation and the context of psychotherapeutic and counselling psychology practice. This experience has also been informed by and reflected upon through the university-based parts of the course, and by my own personal therapy, psychoanalytic in nature, which I have continued throughout the duration of the course.

The initial induction into therapeutic practice emphasised the humanistic tradition and values, and in practical terms the fundamental skills relating to the 'core conditions' (Rogers, 1957) provided the foundation for the first year of therapeutic practice. On my placement however, there was also the opportunity for exposure to other models. With a supervisor who worked primarily within a psychodynamic framework, this formed the basis for much of my thinking about clients, particularly since concurrent seminars at the university also focused on the theoretical basis of psychodynamic therapy. Hence there was the opportunity to begin to apply psychodynamic concepts within my work, albeit at a fairly basic level. This was invaluable however, particularly in learning the importance of the therapeutic process, and in taking account of my own emotional responses in sessions. I consider that I was therefore beginning to develop self-monitoring skills and 'free-floating attention' (Casement, 1985) although at this stage I had difficulties in translating internal awareness into practical interventions.

There was also the opportunity in this first placement for some work within a cognitive-behavioural (CBT) framework. The contrast of this with the other approaches I was using could be confusing at times, but was also helpful in developing my thinking about what form of intervention would be most useful for individual clients. In retrospect I can see that the therapy I was engaged in from the cognitive behavioural perspective was somewhat technique-oriented, but this was
nevertheless an important basis for generating a greater integration of my therapeutic abilities.

The context of the placement also had considerable influence on my experiences, and I was able to benefit from learning about the operation of a Community Mental Health Team (CMHT), and the role of a psychologist within that team. This was very different from later experiences, since contact with a departmental base, and therefore other psychologists, was limited, which emphasised the importance for a CMHT psychologist to have a well-established concept of their identity and role within the setting. In contrast, my later placements were within departmental settings, firstly a psychotherapy department and later a psychology department. In the second placement, with longer-term therapy being offered within a psychoanalytic framework, I found that my style of working and thinking within a psychoanalytic framework were able to be greatly developed. Despite a grounding in these ideas during my first year, I found that the greater complexity of cases and emphasis on staying within the analytic model meant that for some time I had a sense of having lost abilities that I thought I had mastered by the end of the previous placement. In retrospect this can be seen as a refining and sharpening of my practice, which necessarily included some questioning of previous assumptions and a realisation of the need to make use of my intuitive reactions more fully. After the initial difficulties this enabled me to make much better use of transference and countertransference phenomena, using these to inform interpretation. This was also assisted by my increasing awareness of the importance of other aspects of therapy, such as the analytic frame and unconscious or derivative communication (e.g. Casement, 1985; Smith, 1991), which theoretical workshops and my own reading had highlighted. At the same time, the benefits of engaging in my own therapy for a prolonged duration was clear, both in helping to clarify my own 'blind spots', and in developing further an intuitive understanding of the various theoretical concepts I have mentioned, based on my experiences as a client.
In addition to the individual psychoanalytic work on this placement other activities also made a valuable contribution to my development as a practitioner. As a member of an acute inpatient ward team I attended weekly meetings, and took a small proportion of my caseload from this source. This work with people who had more severe or enduring mental health problems provided a very different perspective from the rest of my work on the placement. Being involved with the co-ordination of services in order to meet the needs of individuals on the ward and after discharge was an important part of this, and over the course of the year I gained considerable confidence in terms of my role as a psychologist within the ward team. In seeing clients referred by the ward team for individual work, the importance of liaising with other staff groups was also emphasised, both with the inpatient ward team, and the day hospital. However, the effects of this on clients was also an area that needed close monitoring and discussion within therapeutic sessions. Working in such a way creates a very different frame of practice, particularly regarding confidentiality, which is clearly apparent to the client and can create conflicting feelings of loyalty in the therapist. In my situation, the fact that I was on the ward team as well as being an individual therapist seeing clients away from the ward led to concerns for clients about trust and the extent to which their communications would be reported to the ward or day hospital staff. Such issues clearly needed to be addressed in a straightforward and open manner within the therapeutic encounter.

Also within this placement, I was the co-therapist within an analytic group for one year. This provided an excellent opportunity to broaden the psychoanalytic skills that I was developing, particularly in awareness of the process within the group that formed an integral part of interventions. It was also very useful in helping me to develop trust in my own intuitive responses, since I found early on in the group that I tended to think too long about a possible intervention, with the result that the group would move on and it would become redundant. This work was thus a challenge that was an invaluable part of building my confidence in making more spontaneous interventions. Being with an IGA (Institute of Group Analysis) trained co-therapist
also enabled me to learn considerably from her experience, both within sessions and in the debriefing discussions after the group meetings.

My final placement was of a very different nature from the first two, being within a psychology department and with a focus on cognitive-behavioural work. Coming into this style of working was initially very difficult, both in terms of the change of models and the change in the duration of therapy to short-term work. This led to considerable feelings of confusion initially, and the notable recollection that it seemed (subjectively) as though I had been practising CBT more effectively in my first year than in the third. However, despite such feelings, it was obvious that I was now approaching CBT and therapy in general from a very different perspective - as a practitioner with knowledge and experience rather than as a beginner. Hence, while I may have been attending quite effectively to the technique-driven aspects of CBT in my first year, I was later able to take a more comprehensive overview of my practice. Of particular importance was attention given to the more recent developments of CBT, centring on the therapeutic relationship and interpersonal theory (e.g., Safran, 1990; Wills & Sanders, 1997). These approaches make use of the interpersonal and unconscious processes that have not traditionally been the domain of cognitive orientations. My training, which had, up to this point, had a strong emphasis on these processes as important aspects of the therapy, therefore put me in a strong position to make use of the recent developments of cognitive-behavioural theory. I was able to begin to integrate my knowledge from psychoanalytic models with a style of working that builds on such knowledge, but employs it in a more concrete and problem-focused manner than tends to be the case within most psychoanalytic approaches. Providing cognitive-behavioural supervision to a CPN in the later stages of this placement also helped to develop my clarity of thinking about this model and its integration with other approaches.

The integrative theme of my final placement was also emphasised through having a supervisor who specialised in body-oriented therapy as well as schema-focused cognitive work. This aided in the development of a more 'multi-modal' approach to
my work (Lazarus, 1981) and in increasing awareness of the systems both within individuals and of which they form a part. Also of importance as this placement continued was the awareness of the importance of acceptance of the client, not only by the therapist, but by the client themselves. In this regard it can be seen that very many clients come to therapy with schemata and experiences of 'not getting anything right'). Cognitive therapy (and indeed many other therapies) can appear quite punitive due to the emphasis on the dysfunctional nature of an individual's thinking and as such may confirm fears about low self-efficacy. The idea of compassion for and acceptance of the self may therefore be seen as an important aspect of the therapeutic process, and one that may often be neglected. However, with the humanistic value base of counselling psychology, working with such concepts may be seen to be an integral part of therapeutic work.

I also had the opportunity on this final placement to be part of a 'reflecting team' for a consultancy model approach to assessment. This involved a video link-up to assessment sessions for CMHT clients, and aimed to pool the resources of different team members in formulating problems and deciding on therapeutic options for the clients. As well as being helpful to hear the range of opinions of different team members, it was useful to observe the what could be done with the reflections of the team, since the therapist would take some of these back to the client in the second half of the assessment.

Finally, throughout the three years I have made a number of presentations on placement. These have been to team or department members as well as to other professionals or client groups. For example in my first year I presented a seminar on bereavement issues to CMHT members. I also ran three workshops on psychological factors in diabetes, two of these to general practice nurses, and one to a parent support group. On my final placement, I made presentations on my research, and also on the use of the therapeutic relationship in cognitive therapy. My ability in making presentations has grown considerably over the duration of the course, and I now feel considerably more confident about this aspect of my role.
In conclusion I can see a gradual development in my confidence and competence as a
counselling psychology practitioner over the three years of the course. This has been
greatly assisted by the variety of experiences on the different placements, and by the
range of expertise that has been offered by my supervisors. The order of placements
has also been influential, with the psychoanalytic placement coming before the
cognitive-behavioural one. Although the traditional CBT model might have been an
easier approach to learn first, initial exposure to the humanistic and psychoanalytic
models created a much greater ability to use the cognitive-behavioural models
effectively and to integrate what has been learned over the three years, both on
placements and within the University study programme.

References


Client Report Summaries

Four client reports are summarized, one from the first and third year placements, and two from the second year placement.
Client Report 1

The following client report is from my first year placement and took place within a primary care setting.

The client and presenting problems

Miss S was a 28 year old, heterosexual woman who reported experiencing severe anxiety from her early teenage years, and at the age of 22 developed Irritable Bowel Syndrome (IBS). She found great difficulty in forming relationships with men, and said that she had never had a close or sexual relationship with a man. Although she had been on a number of initial dates, Miss S felt she did not know how to behave and hence finished the relationships as a consequence of the stress evoked in such situations.

Personal history

Miss S lived with her parents and reported a close relationship with them, although she remembered her father being angry and unpredictable when she was a child. She had recently begun to feel restricted at home, and aware that her parents discouraged her from taking any risks. Miss S had been employed in temporary work for some years, moving from one job to another.

Formulation

Miss S was very concerned about others people’s opinion of her, and feared that she would be judged and criticised in social situations. This appeared to be a
consequence of a highly dependent relationship with dominating parents, for example, the influence of her mother whom she reported as always looking for the negative aspect of any situation and hence discouraging Miss S. In addition, the unpredictability and fear of rejection in her early relationship with her father had assisted the development of a 'false self' in order to protect herself in this situation. Miss S had coped with early conflict in her family through taking on a peacemaking role. In social situations she therefore tended to be concerned with presenting an image of how she thought other people wanted her to be rather than how she was.

As a consequence of these developmental factors, Miss S had a very poor self-image and invested considerable energy in ensuring that others did not get to know her well. She would stop dating men after one or two meetings, and would also change employment frequently, since she felt uncomfortable if she thought others were getting to know her too well. Miss S's beliefs about herself and relationships she had with others were also maintained by her anxiety and IBS reinforcing each other, and by her negative beliefs and behaviours which served to confirm her beliefs. Hence her belief that she could not trust men with her true feelings was sustained by giving important information in a very light-hearted manner. When this generated a light-hearted response, Miss S would take this as confirmation of her belief.

The therapeutic relationship and interventions

Miss S's problems in social situations were strongly evident in the therapeutic relationship and this constituted an important mechanism for progress, through making explicit the nature of interactions in therapy. Miss S commonly tried to minimize the extent of her difficulties through laughing about them and we discussed the way that her assumptions would have been confirmed had I colluded with her laughter. In addition some cognitive techniques that were used to help Miss S cope with her anxiety became anxiety-inducing in one session. This led to the exploration of her feelings that she must have others' approval. Silences were also experienced as
tension-inducing, and associated with uncomfortable childhood memories and the feeling that it is her responsibility to fill the silence.

**Outcome of therapy**

The therapy was characterized by dramatic shifts and insights balanced by retreats into pre-existing defences. Later sessions focused on the importance of Miss S making changes for herself rather than waiting for something to happen to her. While she appeared to have gained significant insights from therapy and had made changes in her relationships at work, other areas of her life appeared to remain unchanged, although she was able to use some behavioural strategies to manage her anxiety symptoms more effectively. However, it is likely that significant changes would have been very difficult to achieve while she remained in the family home and Miss S was hoping to move within the following few months.
Client Report 2

This client report, from my second placement, relates to long-term (11 months duration) work within a psychoanalytic psychotherapy department.

The client and presenting problems

Mrs J was aged 54 and had been married for 30 years. At the time of the therapy she worked in an administrative post. She had been depressed for the past 2 years, and had previously taken part in a short-term cognitive therapy group, which she felt had had little effect. She also reported feeling increasingly anxious, which she linked to low self-esteem and an inability to 'stand up' for herself. On commencing therapy, Mrs J separated from her husband, having discovered that he was having an affair.

Mrs J reported having a difficult childhood and being the youngest of six children. She was quite solitary, to avoid teasing by her siblings, and recalls her father having a violent temper and her mother being self-centred and critical of her.

Formulation

Mrs J appeared to have taken a passive, submissive role in many relationships, with particular difficulties occurring with dominant individuals. This resulted in feelings that no one took account of her viewpoint. In her marriage this was particularly evident and Mrs J considered her husband to be very self-centred and uncaring, while at the same time holding a powerful position over her. However, her passivity concealed considerable covert power, exemplified by an almost mother-child relationship that had also existed between her and Mr J.
In Mrs J's early family history, expressing her own needs and feelings seems to have been met with disapproval and considered selfish. As the youngest child, she felt she was of least importance and picked on by her siblings and parents. Her father's critical nature was a source of fear to her since he could be violent, and she felt she always had to 'get things right' and would be made to feel stupid if she said the wrong thing. Mrs J's dominant side was therefore suppressed, since expressing it meant being met with anger or ridicule. It appeared later to only surface in moments of great stress or tension. She was highly self-critical of such times, believing herself to be acting in a vicious or sadistic way. Her own memories of such treatment led her to wish to avoid inflicting this on others, despite some positive feelings when she has taken a powerful position. More usually her tendency to be submissive created in others the lack of interest in her feelings that she finds so difficult. Mrs J's depression could therefore be seen as a reaction to feeling unable to express her true feelings and needs in an overt way, and not having these taken into account by significant others.

The therapeutic relationship and interventions

The therapeutic rapport was slow to develop in depth, which appeared to be due to Mrs J's anticipation of being judged or criticised. She gave many clues about transference feelings in her manner of speaking and through voicing opinions in a way that anticipated potential criticism. This was clearly useful material that could generate insight-oriented interventions. However, there was also considerable frustration on my part in the therapy, which seemed to stem from Mrs J's tendency to devalue her own thoughts and feelings, encouraging others to think for her. When this happened in therapy, I would feel a strong desire to tell her what to do, an impulse which clearly needed to be avoided to prevent repeating a pattern which she had experienced in previous relationships. Not reacting to such situations in the ways that Mrs J was used to resulted in considerable deepening of the therapeutic rapport and increasing emotional expression, notably that of anger.
Outcome of therapy

Mrs J became much more confident and less passive during the therapy. The separation from her husband, which was very painful for her, meant that she had to confront new situations and discover new ways of relating to others. This enhanced her self-perception, and much of the therapy concerned exploring the blocks that sustained the assumptions that she had to hide her real self. Although she thought of the future with some uncertainly, Mrs J was very positive in her outlook, especially since her relationships with close friends and her children had deepened significantly in the past months.
Client Report 3

This report relates to work with a client referred from an inpatient ward team, of which I was a member during my second placement.

The client and presenting problems

Mrs S was 38 years old, married, and, prior to her hospital admission, had been working in a professional capacity. Her admission was due to the recurrence of the symptoms of a manic-depressive disorder and Mrs S had begun to have mental health problems 5 years previously. Mrs S appeared to have some degree of insight into her difficulties at the time of assessment, which she acknowledged had not been the case previously. She was concerned to explore her feelings of low self-worth, particularly negative thoughts about underachievement.

Personal history

Mrs S was one of three children and recalled being the least favoured by her mother, while her father was often violent, although apparently not directly abusive towards herself or her sisters. As a teenager she felt in competition with her 'more talented' older sister. Despite initially not doing well in examinations, Mrs S continued studying as an adult, gaining several qualifications.

Formulation

The violence of Mrs S's father together with disapproval from her mother appeared to have created severe difficulties in trusting others. In addition, the sense of
competition and being seen as the 'bad' daughter fuelled Mrs S's need to excel at whatever she did in order to compensate for her feelings of inadequacy. When events did not go exactly as planned, Mrs S tended to catastrophize the situation, creating a cycle of negative thinking. Her underlying schema of worthlessness was triggered through any indications that she was performing less well than she had done previously. Such unrealistic expectations fuelled her manic episodes and the negative thinking was clearly linked to her depressed states. An additional factor was Mrs S's concern for self-reliance which tended to isolate her from others at times when she needed support. Her strong wish to be taken care of, which she felt put her in a vulnerable position, conflicted with her wish to be independent, not giving others any power over her. Her experiences of such situations in the past had been that her vulnerability would be abused.

The therapeutic relationship and interventions

The development of trust was a key factor in the therapy, and although a cognitive-behavioural approach had been taken, much of the work focused on trust within the therapeutic relationship. This was made particularly important as a consequence of my dual role as therapist and a member of the ward team. Interpretative work relating to the problems of trust and the therapeutic boundaries was therefore a critical tool for therapeutic movement, and it was vital that the implications of my dual role were discussed openly and clearly. The therapy was marked by long periods of silence, and these were of great value to the developing relationship. It is possible that through my ensuring that Mrs S took her own time within the sessions, she was able to gain a sense of trust and being trusted that she felt was so lacking in other relationships.

Cognitive-behavioural strategies were also used in order to enhance Mrs S's ability to monitor her mood changes and behaviours and allow her to take action when she observed greater than usual fluctuations. Specific negative thoughts and assumptions
centring on needing to excel were also explored and challenged, and alternative more realistic assumptions discussed.

**Outcome of therapy**

The development of a trusting relationship appeared to be a valuable part of this therapy, providing a different experience from other relationships. There was some success in addressing the monitoring of mood and in exploring the consequences of Mrs S's manic periods and her negative thinking, which had a positive impact on her self-monitoring. However, during the course of the therapy, severe strains in Mrs S's marriage became apparent and it was clear that this was a major factor in precipitating episodes of illness. The ending of therapy coincided with some major stresses connected with her husband and family. Although Mrs S appeared to be coping well with these difficulties, the ending of therapy was very hard for her as it had been an important source of support. I suspect that Mrs S remained vulnerable to further episodes of illness due to the continued instability in her personal relationships.
Client Report 4

This report relates to a client seen during my third placement in an NHS Adult Psychology Department. A cognitive-behavioural framework was used.

The client and presenting problems

Mr P was a 30 year old man who had been diagnosed with schizophrenia 7 years previously. He was single and lived alone, and despite several acute episodes of illness over the past few years had managed to continue working during most of that time. Mr P reported having unpleasant intrusive thoughts, often racist or homophobic in nature, which he tried to block out. He distinguished these thoughts clearly from hearing voices, which he also experienced, but found he could cope with. However he was much more concerned by the thoughts, particularly since he also believed that others must know he is racist or homophobic, despite the fact that his thoughts were never translated in words or actions. He suspected that others must be aware of what he was thinking, and had consequent feelings of shame and exposure. He also felt 'attacked' by others, thinking that comments were being made about him, or seeing derogatory meanings in language that was not apparent in their surface content. Such events were sometimes seen by him as reprimands for having his intrusive thoughts.

Personal history

Mr P had been a single child who was shy and with few friends. He recalled considerable tension between his parents, and when he was a teenager his mother was diagnosed with schizophrenia. He felt very negative and critical towards her at this time. Mr P later lived with his father after his parents separated, with whom he
reported having a good and supportive relationship, particularly in terms of practical help.

**Formulation**

Mr P's intrusive thoughts appeared to serve a number of functions, particularly a defensive one against the perceived intrusions of being 'attacked' by others. Hence when he felt that he was being referred to by others negatively, he would have a reactive thought to that perceived comment. The likelihood of such events was greatly increased by the selective attention that Mr P paid to the conversations of others, associating common everyday language with particular references to himself.

Another aspect of the problem was Mr P's perception of himself as a 'bad' person, linked consciously to the fact that he had such 'bad' thoughts. His efforts not to have the thoughts led to an increase in their incidence and intensity. However, the image of himself as a bad person appeared to predate the thoughts, and seemed to concern Mr P's image of himself as a person with schizophrenia. He thought others would not like him because of this, which was grounded in the relationship with his mother and his strongly negative feelings towards her. His concern that others would not like him was greatly exacerbated by his belief that they were able to know what he was thinking. In practice it may be that such concern led to changes in Mr P's behaviour towards others, resulting in turn in behaviour that he interpreted as evidence for them knowing his thoughts.

**The therapeutic relationship and interventions**

An important milestone in the development of the relationship was when Mr P felt able to voice his concerns about intrusive thoughts he was having about me. This
was helpful in developing trust, as well as assisting access and exploration to internal cognitions due to the immediacy of the event. This led to Mr P engaging more fully with the cognitive-behavioural model, for example in challenging his thinking, looking for alternative thoughts, and testing out his assumptions.

**Outcome of therapy**

Despite considerable improvement over the course of therapy in Mr P's ability to cope with his intrusive thoughts, his use of the strategies explored was also affected by other factors. These included stresses at work and a cycle of change associated with having his depot medication. Hence while he tended to be able to use the strategies well for some time after the depot, in the days before the next one was due, this ability lessened, and he become more vulnerable to his thoughts and delusions about others knowing what he was thinking. A number of follow-up sessions were arranged after the therapy to maintain changes, and while Mr P still had the intrusive thoughts, most of the time he was able to manage these more effectively than had previously been the case.
Process Reports

Process issues

This paper consists of a discussion of process issues arising from previous reports of therapeutic sessions. Three process reports will be referred to. The first two reports were written from sessions occurring during relatively long-term (one year) psychoanalytically-oriented therapy. The third took place during short-term cognitively oriented therapy, with a consequent difference in the nature of the session and the style of interventions made.

Discussion of the process issues will take the form of an examination of developments in the therapeutic relationship, particularly in relation to the awareness of and expression of anger. I will discuss a number of processes that occur as part of the therapeutic relationship, including transference, countertransference, derivative communication and meta-communications of the therapist. These have been examined as they naturally occur within the relationship rather than extracting each phenomenon for individual examination. This allows a greater sense of understanding and intimacy with the actual process of the therapy, in which the various phenomena may occur together, and overlap with each other.

In the first report, which took place after approximately 10 months of weekly sessions, the client, Mrs K, initially started to talk about some disturbing dreams that she had been having. The session occurred at a time when there had been several disruptions to the therapy. Having been prompt and regular in attending the sessions over nine months, five weeks before the reported session, Mrs K forgot to come to therapy. Exploring this the following week led to Mrs K having a feeling of being 'told off', and this transference was linked to significant others in her life. In the following weeks Mrs K was often late for the sessions, varying between five minutes
and half an hour, and was ten minutes late for the reported session. Although I had connected this with Mrs K's difficulties in exploring certain feelings in the therapy, particularly those of anger, she had not accepted in previous sessions that this was the case. I was aware of the possibility of anger towards me being expressed indirectly through Mrs K's recent lateness, but this was not something that was easy for her to accept.

By commencing the session with a discussion of her recent dreams, Mrs K introduced the strength of her anger towards others in her life although she appeared to distance herself from these feelings, for example by focusing on the fact that she would never carry out the actions that were in the dream. When she continued to discuss her dreams, but in a rather vague and unspecific manner, I noticed myself starting to feel some irritation. This may have been both my own countertransference, due to thoughts about Mrs K's apparent avoidance of feelings, and also a connection with her underlying feelings of anger. I was aware of the possibility of the dream material being associated with the therapeutic situation, and initially made an interpretation that compared the dream material with the relentless nature of the therapy - that it seemed to Mrs K that I was pushing through barriers that she had thought were safely closed. I also contrasted themes within two of the dreams - anxiety and the need to keep hidden in one, and the very expressive anger in another, commenting on how the anger may be something that Mrs K feels she must hide. This second interpretation appeared to lead onto a significant movement in the session, as Mrs K began to talk about never having felt that she was allowed to say what she really felt.

At this point within the session, I noted further countertransference feelings that were used to help guide the progress of the session. These centred on my feeling of wanting to tell Mrs K what to do. Such feelings had occurred before in the therapy. Although my own needs, stemming from personal history, for example in wanting to be 'helpful' and 'useful' to clients, are clearly implicated here, my experiences in the therapy could also be thought of as a response to projections of helplessness from Mrs K, and there was evidence of this in her other relationships. This tended to lead
to directive responses from others that Mrs K felt did not value her own thoughts and feelings. Mindful of this, in the following interactions I stayed very close to Mrs K's feelings in my responses, emphasising the difficulties of holding on to such angry emotions when feeling that it is not acceptable to even to have them, much less express them. Mrs K noted at this point how positive it was to be understood, and this was followed by a long pause - approximately two minutes. This was very unusual and seemed to me to be a particularly profound and comfortable silence. It emphasised to me the importance in the previous dialogue of having stayed close to Mrs K's feelings. This was confirmed by her next comment, in which she referred to a prior conversation with a family member as comforting and helpful. The critical aspect of this was that there had been no pressure put on her and he had been prepared to listen to her with no ulterior purpose in mind. This appeared to represent a 'derivative communication', as described by Smith (1991):

Unconscious communications, expressed in an encoded fashion through derivatives, primarily express the real implications of the therapists' behaviour (p. 136).

Hence Mrs K was using a different situation to demonstrate the meaning to her of the interaction in the session, emphasising to me the importance to her of feeling valued and listened to in the therapy. It is possible that the communication also served as a direct warning against any impulses to be directive since this created feelings of expectation for Mrs K.

The therapeutic rapport within this session seemed to be considerably greater than in other recent sessions, enabling considerable movement towards the acknowledgement of feelings of anger. This was particularly emphasized towards the end of the session. Mrs K again began to deny the existence of angry impulses when she had made a comment to someone that she immediately regretted. My response to this ('Because really you meant it exactly like that'), was a challenge that I thought would previously have been rejected by Mrs K. However, the quality of rapport that
was apparent in the session as a result of paying close attention to the underlying process meant that Mrs K was able to accept the validity of the challenge, acknowledging the expression of angry aspects of herself.

In the second report, which occurred at the 14th session, it can be seen that rapport within the therapeutic relationship deepened and then lessened with interventions that consisted of meta-communication and interpretation about the nature of anger within the session. I had been aware for some time in the therapy of a tendency for the client (Mrs A) to talk about feelings of anger or irritation, but then to deny such feelings when I reflected them back to her. This was a source of considerable frustration for me over much of the therapy. In the reported session, the same process appeared to be happening with anger being attributed to others around Mrs A but a logical standpoint being adhered to for her, for example that it would not have been right to have been angry. At one point although Mrs A seemed to have acknowledged angry feelings concerning the childhood relationship with her father, she then began to retreat from this and I commented on the process:

We have talked a lot about anger in recent sessions and you have expressed here your own anger about things in the past, sometimes very forcibly, and yet when I comment on or note this anger you seem to minimize it. It's hard to accept from me.

This seemed to prompt Mrs A to become more thoughtful. Her voice lowered and she acknowledged that this process does happen, because, she thought, of her fear of the uncontrollable nature of her anger. I noticed a change in my feelings in the session, from frustration towards Mrs A for again minimizing her very powerful feelings of anger, to a more empathic response. Because this breakthrough seemed an important one, it would have been advisable not to push Mrs A too far in this direction, since in previous similar situations, denial of the feelings had quickly followed. My next comment was therefore cautious, but linked Mrs A fear of overwhelming anger to the anger in her father. Mrs A appeared to accept this, but I
then went on to make a further interpretation concerning the perceived danger of being angry in the therapy due to a fear of either overwhelming me, or receiving a punitive response from me, as she would have done from her father. This was clearly going to far for Mrs A at this time. It possibly stemmed from my own frustration and anger about Mrs A's denial of feelings, resulting in an attempt to move faster therapeutically than she was able to cope with. The intervention caused an immediate retreat from the emotions that Mrs A was allowing awareness of in herself to a more logical standpoint. She appeared startled, laughed and then continued to emphasise the feelings of upset that predominate for her, again negating any angry emotions. In retrospect it can be seen not only that the direct comparison of myself with her father was not acceptable to Mrs A but that there was an insufficient basis in her material for such an interpretation at that time, and it would have been more helpful to have stayed with the immediate content of the session in my responses.

A contrast to the above sessions can be seen in the third process report. Here the therapy is of a short-term duration, and the session reported is the fifth. The therapy took place near the beginning of a cognitive placement, a time of considerable uncertainly due to the change in therapeutic models. These factors had a considerable impact on the process of the therapy, notable in the reported session, in which there is little attention paid to potential derivative communication, and I do not refer explicitly in the session to the therapeutic relationship or process. This is not due to any incongruence of such issues with the cognitive framework. Although initial conceptualizations of this model did not focus on the relationship or process aspects as an important element of the therapy, more recent approaches have integrated such factors within a cognitive model. Transference and countertransference phenomena are thus seen as important identifiers of cognitive distortions or assumptions, and ruptures in the therapeutic relationship are viewed as opportunities to assess the client's beliefs (Beck et al., 1990; Safran, 1990; Wills & Sanders, 1997).
Hence in the third report, while I was aware of particular countertransference feelings within the session, I did not make use of these at the time. I consider that this was mainly due to the short duration of my exposure to cognitive work at that time, which resulted in doubts about my therapeutic style. Feelings that I should somehow be working more 'cognitively' took on an implicit meaning of taking a more directive and solution focused approach. As has already been mentioned this is something that my personal history can influence me towards doing, perhaps more with some clients than others, and such feelings are something about which I try to maintain a high level of awareness. The neglect of the therapeutic process at this stage however had important consequences for the therapy, resulting in feelings of confusion where a focus on what was happening within the therapeutic relationship may have clarified the situation both for myself and the client.

In the reported session therefore, my predominant feeling was of confusion. Mrs V talked very quickly, telling long and complicated stories about current or past situations which reflected her need to ensure that she was clear and precise about everything that she was saying. Paradoxically, the reverse seemed to be true: since she said so much, the point of what she was saying often became lost in the quantity of information. Although it seemed that Mrs V was avoiding her feelings, it was also apparent that she did usually come back to herself and her feelings eventually. However, the result in terms of the effect on me was a sense of impatience, and I was aware afterwards that this was likely to be an important element in Mrs V's feeling that others are not interested in her. In this respect there is some similarity with the first process report, and again discussion of anger was a major element of the session. My comments about this however differed in that they were all concerned with Mrs V and other people in her life. Although there appeared to be movement in the session as a result of this, again with a long and very unusual silence after an interchange about anger, it was striking that in this session, rather than leaving Mrs V to develop the theme, I interrupted the silence with an unrelated directive statement. This seemed to be reactive to the countertransference feelings of impatience with Mrs V's style of communication. It had the effect I think of repeating the pattern that Mrs
V had been used to with others in her life, i.e., I was discounting her feelings, and sending a signal that I was not really interested in her. Hence in this example, despite an awareness of the process elements within the therapy, my own perceived needs as a trainee therapist had an impact on the therapy. My concern at that time for becoming acquainted with a new therapeutic model resulted in less attention being paid to the process within the session.

I have aimed to highlight some of the major processes that occur within the development of the therapeutic relationship, and the importance of attention to such issues regardless of the nature of the theoretical approach. I think that these issues have been and continue to be central my development as a practitioner, with a gradual development in my ability to use the therapeutic relationship and process within sessions. Most importantly, the emphasis on the interpersonal relationship and the process of therapy has allowed an integration of ideas that previously had been separated in my thinking about therapeutic practice. Hence the relevance of the psychodynamic and cognitive models to each other, rather than as separate unreconcilable theories, has become central to my working style.

References


Research
Dossier
Research Dossier

Three research reports are included within this dossier, one from each year of the PsychD course. Together they constitute a single research programme which investigated the role of religious and spiritual beliefs after bereavement. The initial research paper reviewed the area and used a theoretical framework of meaning-making to address the role of such beliefs after bereavement. This theme was taken up empirically in the second research project which explored ways in which bereaved older adults utilised their religious or spiritual beliefs to create meaning after the death of a partner. The final research project built on the previous findings to extend the research directly into therapeutic work. Therapists working in bereavement were interviewed in an investigation of the ways in which religious and spiritual dimensions emerge and are addressed therapeutically.
Religion, spiritual beliefs and the search for meaning in bereavement

Abbreviated title: Religion and bereavement

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Religion, spiritual beliefs and the search for meaning in bereavement

ABSTRACT    Theory on bereavement has begun to address issues of meaning. However, models of loss that focus on descriptions of overt aspects of the bereavement process remain influential in therapeutic practice. Religious and spiritual beliefs are not represented in such models. Evidence for religion as a moderator of bereavement outcome is reviewed. The narrow focus of such research is discussed together with the attempts of research on the psychology of religion to describe the multi-dimensional nature of the phenomenon. The relationship between religious and spiritual beliefs and meaning construction in bereavement is explored and the concept of 'grief-work' re-examined in the light of an approach that takes into account the search for meaning. This is drawn upon in discussing some theoretical and therapeutic implications of the search for meaning in loss.
Religion, spiritual beliefs and the search for meaning in bereavement

Introduction

This paper focuses on the role of religious and spiritual beliefs in bereavement, particularly in terms of their impact on meaning-making processes. Although the concept of meaning is multidimensional, a full exploration of this is not within the scope of the present paper. However, the idea of meaning-making may be an important one for exploring the role of spiritual beliefs in bereavement. Although spiritual beliefs and practices are not the only way of creating meaning, they are influential factors for many people. A review of the literature on this issue identified three research domains and perspectives which seemed particularly informative; mainstream bereavement research; research on psychology and religion; and an existential approach that engages with the issue of meaning-making as a primary motivating factor for individuals.

There has, however, been little overlap between these fields of research. The literature on psychology and religion appears to have largely ignored approaches that take meaning-making into account. Research on bereavement has also been slow to address issues of meaning within bereavement, something that is particularly important within a practitioner context. Theoretical models have mainly focused on describing overt aspects of the bereavement process, e.g., the classic task or stage models, or more recently The Dual Process Model of Coping with Loss (Stroebe & Schut, 1995), which postulates an oscillation between the approach and avoidance of grief and coping behaviours. These descriptive models have provided a theoretical basis for therapeutic interventions, although recent research suggests that the personal meaning of loss is an important variable in determining the course of grief (Wortman et al., 1993). The descriptive theories appear limited in their ability to...
assist therapists in understanding the processes involved in adaptation to loss for individual clients. Therapeutic interventions may therefore be enriched by a theoretical framework which focuses on exploration of the personal meanings arising through the experience of loss rather than a facilitation of different phases of grief.

As the terms 'religion' and 'spirituality' are not used interchangeably in this paper, clarification of their definitions is necessary. 'Religion' is defined as referring both to systems of beliefs and practices and to their social or community aspects. This means that there is at least some degree of consensus over core beliefs and practices in particular religious contexts. The terms 'spirituality' and 'spiritual belief' are used when focusing on the first of these factors, the direct personal beliefs and experiences as opposed to those with a social aspect. These may or may not be within a religious framework, but are plainly concerned with meanings that transcend the self and material reality.

Bereavement research: religion as a moderator of bereavement outcome

In reviewing bereavement research that has included the effects of religion and spiritual beliefs, the dominant research question concerned whether religion can be considered a moderator of bereavement outcome (Stroebe & Stroebe, 1987; Smith et al., 1992; Austin & Lennings, 1993). In this work moderating effects are hypothesized to arise from two sources: the tendency of religious participation to enhance social support, and the psychological resource which religious ideology provides when people confront stressful life events (Sherkat & Reed, 1992). Research on these process questions has produced mixed conclusions (e.g., Maton, 1989; Sherkat & Reed, 1992). Stroebe & Stroebe (1987) considered that it is unclear whether findings that religious widowed individuals demonstrate enhanced adjustment to bereavement can be attributed to the spiritual or social support offered
by religions. Sherkat & Reed (1992) examined the effects of religious behaviours and social support on self-esteem and depression among the suddenly bereaved. Self-esteem was found to be enhanced by religious participation, but depression was not significantly affected by church attendance once social support indicators were taken into account. However there is an assumption in such research that the social support gained through religious participation can be differentiated from religious or spiritual aspects and hence operates in the same ways as social support in any context. Yet it seems clear that if religious individuals are able to adjust more easily than those who have non-religious social support, there must be an additional element to the religious social support - perhaps an element of spiritual meaning which is not gained otherwise.

A considerable body of research has examined links between religion and bereavement. However, a review of empirical research (Stroebe & Stroebe, 1987) was unable to draw any clear conclusions about the effects of religion and spiritual belief on bereavement. A number of studies have found no association between religion and bereavement outcome, using measures such as church attendance, self-rated religiosity, and belief in an afterlife (e.g., Stroebe et al., 1985). Stroebe & Stroebe (1993) assessed the impact of religious beliefs and habits on coping with loss, finding no evidence for an association between religiosity and health. However other research has found religion to be a source of emotional strength and comfort (Glick et al., 1974; Gilbert, 1992) with belief in an afterlife also associated with recovery from bereavement. One study observed that those with a high level of belief in an afterlife were 'less likely to actively avoid thinking about the death, which perhaps enabled them to have more time and energy to deal with the death, find some meaning in it, and ultimately recover' (Smith et al., 1992, p. 222). Findings such as these have been criticized as reporting 'only' subjective feelings (Stroebe & Stroebe, 1987), and not investigating specifically the relationship between religion and outcome in bereavement. This assumes that religion and spiritual beliefs should be investigated in terms of whether or not they are predictors of bereavement outcome, which has provided a narrow focus for research. Investigating the hypothesis that
religion is a moderator of bereavement outcome neglects the fact that religion is a complex concept: different components and different individual approaches may have positive or negative effects on outcome. These effects may depend, at least partly, on the meanings and worldview that are held within an individual's religious belief system. Using measures of religion such as church attendance or belief in an afterlife does not tap into these meanings, or take into account the context of beliefs.

The subjective importance of religion and spiritual support in coping is a consistent finding in the research literature (e.g., Austin & Lennings, 1993). Differences in actual (rather than perceived) helpfulness may be explained by factors such as how actively religion is used and the way that beliefs have come to be held. The reason why the subjective importance of religion has not been found to be a good predictor of adaptation to bereavement may be related to the ways in which it has been measured and assessed. The complexity of the concept needs to be explored, taking account of the contextual factors that shape it. Beyond the research setting it is evident that subjective experience cannot be dismissed in the context of therapeutic interventions.

When considering areas of religious research other than bereavement, there does not appear to be the same simplistic assessment of the role of religion. A review of the impact of religion on mental health (Mickley et al., 1995) emphasised the multidimensional nature of religion and explored some of the ways in which both positive and negative influences on mental health were apparent. A meta-analysis found that, of 30 effects included, 23% showed a negative relationship between religion and mental health, 47% indicated a positive relationship, and 30% zero relationship (Bergin, 1983). While the present review is not concerned with general issues of mental health and religion, such research indicates the self-imposed limitations of much research on bereavement and religion.
The psychology of religion

Research on the psychology of religion has also paid closer attention to different dimensions of religion and spiritual belief than is apparent within bereavement research. Lowenthal (1995) discusses five aspects of religiosity outlined by Glock and Stark (1965), all of which could, in theory, be independent of one another. These five dimensions are:

- Experiential (to what extent the person has religious experiences);
- Ritual (what religious practices the person actually engages in);
- Belief (what the person actually believes in);
- Intellectual (what the person actually knows about the teachings of their religion);
- A fifth dimension reflecting the extent to which the first four are actually applied in life (p. 9).

Lowenthal goes on to suggest that in practice, three popular measures of religiosity are:

- Affiliation: whether the person belongs to a religious organisation;
- Self-definition: whether the person defines themselves as religious, or Christian, or Jewish, or belonging to whatever categories the researcher is interested in;
- Belief in God (p. 9).

These measures of religiosity self-evidently fail to cover many aspects of the dimensions presented above, and yet have continued to be influential in research designs.

Religious involvement can stem from several sources, for example, from subjective experience, from a leap of faith, or from being in a culture that provides an
involvement that is not questioned. Of these possibilities (which are not mutually exclusive) it would be expected that the interpretation of experience as spiritual would have the greatest impact upon the orientation towards significance and meaning, since belief would then become a subjective 'fact'. The way in which a spiritual belief comes to be held may therefore have an influence on how that belief may help or hinder an individual after a traumatic life event.

A popular means of categorising religious beliefs and behaviours has been Allport's (1966) measures of intrinsic and extrinsic religiosity. This conceptualization has highlighted some of the different dimensions of religion, and led to research based on the hypothesis that intrinsic religious orientation is more adaptive and healthy than an extrinsic orientation (e.g., Rosik, 1989). A meta-analysis of studies employing the intrinsic-extrinsic (I-E) orientations (Donahue, 1985) indicated a pattern of positive association between extrinsicness and several discrete variables, including prejudice, dogmatism, fear of death and perceived powerlessness, although some correlations, for example on prejudice, were not as strong as Allport would have predicted. Measures of intrinsicness were found generally to be uncorrelated with variables such as prejudice and dogmatism, contrary to Allport's expectation of a negative correlation.

The usefulness of the I-E concepts has been much disputed. Kirkpatrick and Hood (1989) address several conceptual and methodological limitations, questioning the definition of 'religious orientation', and asking whether the scales are measuring religion or simply some differences in pervasive personality or motivational characteristics. The concept of religious orientation is 'content free', meaning that it is independent of specific belief content. While this can be seen to have some theoretical advantages, considering the 'how' of belief makes it easy to overlook the importance of what is believed. In practice, it can be seen that studies employing different measures of religion frequently do better at predicting other variables than the I-E measures. For example, fundamentalism/orthodoxy is a better predictor of
prejudice than either I or E (McFarland, 1989), indicating the need to consider belief content as well as 'orientation.'

Empirical evidence suggests that people look to religion for different things in coping with negative events, which are insufficiently addressed by the I-E conceptualization. Pargament et al., (1990) investigated what people sought from religion in coping with negative events, and found five purposes: spiritual, self-development, resolution of the problem, sharing with others, and emotional and behavioural restraint. Pargament (1992) argued that the focus on means (extrinsic) and ends (intrinsic) detracts from the more critical question of how religion is involved in the search for significance. He recommended a reconceptualization of the theoretical approach, suggesting that concepts of means and ends have become synonymous with the good and bad of religion, whereas in fact both are central, interrelated parts of religious life. In dichotomising the means and ends of religion, he is concerned that the nature of each is overlooked together with the ways that they come together in religious experience. This seems particularly relevant to coping with stressful life events such as bereavement, since a motivation to consider religion as an end (as measured by the intrinsicness scale) does not mean that it will never be used as a means, or that such use will not constitute a viable way of coping with a stressful event. Pargament (1992) observes that even 'people who 'live' their religion use it, and that even those who 'use' it may seek ends with some religious value' (p. 211).

The I-E religious orientations can be seen as a measure of motivation for religious behaviour rather than the behaviour itself (Kirkpatrick & Hood, 1990). Thus, although they access a finer grain of information than, for example, church attendance, they do not explore the dimensions of religious involvement and beliefs such as those outlined by Glock and Stark (1965), presented above. If, as Pargament (1992) suggested, religion is considered in terms of a search for significance, these dimensions may be of use in delineating different means and ends of religious involvement, since, for example, an individual with a high level of 'experiential'
religiousness is likely to view their religion and make use of it very differently from someone whose involvement is primarily intellectual.

Bereavement and the search for meaning

Research that links spiritual beliefs to the search for meaning in events may help to elucidate the complex role of religion and spiritual beliefs in bereavement. Despite the observation that bereavement theory has not taken existential issues into account, a number of empirical studies have reported that meaning is often sought from negative life experiences, including bereavement (Sanders, 1980; Dollinger, 1986; Schwartzberg & Janoff-Bulman, 1991; Braun & Berg, 1994). A frequent response of bereaved individuals, especially when the death is a sudden one, is to ask 'why?' (Craig, 1977). As Frankl (1963) has observed, there is no reason to go on living without meaning.

Bereavement makes demands on individuals to revise their assumptions about the world and their place in it. Whether or not they are aware of it, people take decisions and act through a personal framework of meaning based on their experience (Barbato & Irwin, 1992). This constitutes a basis for giving meaning to new experiences. It has been hypothesized that this preserves continuity, providing a way to assimilate new realities into an existing mental structure and belief system (Benoliel, 1985). However, when one's interpretation of life is damaged by traumatic events, a significant difficulty encountered is the construction an adjusted framework which makes sense of the new experience. Development of the belief system is needed to accommodate the new information and create a new meaning structure. It may be that 'what makes significant loss a critical experience is the crisis of continuity it imposes' (Benoliel, 1985, p. 227). Making a life event meaningful therefore implies either integrating it into an existing belief system (assimilation) or undergoing a process of change and development in the belief system such that the event is able to be incorporated (accommodation). Not being able to assimilate or adjust to the new
situation results in a state of unresolved tension; this may be one reason for the higher rates of mortality and physical illness among the bereaved (Stroebe & Stroebe, 1987).

An analysis of meaning-making in bereaved mothers found the core variable to be the nature of the meaning structure held before the death, i.e., the collection of beliefs, assumptions and values making up the mothers' world views (Braun & Berg, 1994). Where this framework could account for and 'place' the death, development of its meaningfulness and acceptance of the loss were rapid and there was little discontinuity or disorientation. If an explanation of the death did not fit into the existing meaning structure, disorientation resulted as ideas about the way life should be were overturned. For example, the death of a child presented a threat to parents' views about the existence of order and control in life. One stated: 'I always thought that if you lived life properly, never hurt anyone else, that things would work out' (p. 116). Creating new meaning structures involved reinterpreting the event to restore a sense of meaning and purpose and three phases of meaning reconstruction were observed: discontinuity, disorientation and adjustment. The adjusted views were not necessarily fixed however. Parents described themselves as moving between an adjusted view and disorientation. But with this came an increased awareness of what was felt to be really important in life, namely relationships, especially within the family.

If a pre-existing meaning structure that can account for the death is helpful in the bereavement process, this is an area in which spiritual beliefs are likely be important. Religious or spiritual attributions of meaning which incorporate beliefs about death may make it seem less threatening. Most studies of religious individuals have demonstrated low levels of anxiety, fear and concern about death (see Spilka et al., 1985 for a review). Religious meaning structures may also facilitate the cognitive processing of a loss. McIntosh et al., (1993) investigated relationships between cognitive processing, finding meaning, religion and adjustment in parents who had lost a child. Religion was measured by two variables: participation in religious services and the importance of religion. Both greater religious participation and the
attachment of a high degree of importance to religion were found to be related to increased meaning-making around the loss. High ratings of the importance of religion were also found to be related to greater cognitive processing, which the authors construed as providing support for the view that being religious means having a more developed cognitive structure for religion. Hence the prior religious meaning structure may provide a basis for a greater degree of cognitive processing. In addition, increased cognitive processing shortly after the loss was associated both with short-term distress and with decreased distress over time. Such findings suggest one reason for the conflicting findings within the research literature on religion and bereavement (Stroebe & Stroebe, 1987). Looking at a loss within a personal framework of meaning may be expected to produce conflict and intense feelings that avoidance or denial of such issues will not produce. This may slow down the course of grief and entail feelings of anxiety or depression but does not provide grounds for considering it unhealthy (Gray, 1988). Gray considered that models of normal bereavement do not adequately account for such differences in meaning orientation between individuals, illustrating this with a hypothetical situation of two individuals suffering equivalent losses:

Person 1 resolves the task of mourning through bearing the pain of loss over time, readapting to the environment, and then reinvesting in other relationships. She goes through a period where she is unable to find a sense of meaning in life, but over time this lessens, and now she does not think much about the big questions of life and death. Rather, she tries to avoid thinking about them, because they remind her of her loss and the pain that remains. Person 2 goes through a similar process of letting go of her loved one. However, rather than transitory questioning of meaning, she finds that she is overwhelmed by the recognition of life's impermanence and of the...suffering that all...must experience. Long after the time when she has felt some completion about the loss...she continues to be absorbed in questioning what life is really about and why people must die (pp. 314-315).
Gray suggests that the second individual would be likely to show the most negative symptoms. However, it is possible therefore that through considering wider existential or spiritual aspects, there could be a healthier response over time than would be gained from avoidance of these issues. Bereavement theories have been slow to recognise that personal growth and change may be an integral component of the grief process, often prompted by being confronted by the power and immediacy of death.

Religious or spiritual beliefs may therefore provide an interpretative framework which creates the possibility of constructing meaning and purpose and allows people to make sense of their existence. Bereavement may be assimilated through such a framework. Yet not all those with religious beliefs will use them in this way. It has been suggested that deriving meaning and purpose from religious beliefs may depend on the salience of religion, defined as 'the extent to which people are committed to their faith, attach central importance to it, and are motivated to integrate it into a way of life' (Petersen & Roy, 1985, p. 51). Religious salience has been found to have a strong positive effect on attributions of meaning and purpose in life (Petersen and Roy, 1985). In contrast, simplistic behavioural measures such as church attendance have been found to have little effect on meaning and purpose. However, as has been discussed previously, spiritual beliefs and practices can be seen both as ends in themselves and as an resources which may or may not be taken up after a loss. Religious means of coping, such as prayer or church attendance, may be seen as helpful by those who do not use spiritual beliefs to create meaning. Pargament et al., (1988) investigated religious coping styles in problem-solving, finding that religion could guide the individual in the process of selecting solutions to problems. Additionally religion can provide emotional support throughout the problem-solving process, including rituals that can be helpful during stressful periods (Pargament & Hahn, 1986). Religion may thus be used as a distraction or comfort. From the social psychological literature on attitudes and behaviour, it is known that people may behave in a certain way and then change their attitudes in line with their behaviour (Eagly & Chaiken, 1993). Similarly, although religious practice may occur without
pre-existing spiritual beliefs, it could lead to the development of such beliefs or a renewed interest in them. People in this situation may find themselves with a new resource for meaning-making, although, because of its novelty and its association with a specific event, it may not prove terribly robust.

**Therapeutic interventions and 'grief work'**

In terms of therapeutic intervention, little research attention has been paid to the potential value of creating opportunities for bereaved clients to explore the meanings of their loss. Could difficulties in the grief process be attributed to an inability to find meaning? If so, can the process of finding meaning after a traumatic event be assisted through therapy? Smith *et al.* (1992) reported that finding meaning in bereavement was enhanced by counselling: all participants who reported having had some type of counselling said they had found some meaning in the death; less than half of those who had no counselling reported finding meaning. In Braun & Berg's (1994) study of bereaved mothers discussed earlier, all participants found that talking about their child and about the experience of the loss and being understood were helpful in adjusting to their new reality. This suggests that making the feelings and thoughts about the experience explicit and having these understood helps to create a new framework of meaning after loss. This process may be what underlies the concept of 'grief work' that has occupied such a central place in many theories of bereavement (Lindemann, 1944; Mawson *et al.*, 1981; Worden, 1991). However, there has been some movement away from the grief work hypothesis as a result of research attempting to explore the complexity of bereavement. The problem may lie with the prevalence of limiting definitions of 'grief work' which have focused on facing up to the emotions of grief as suggested by Stroebe and Schut (1996):

Basic to the formulation (of grief work) is the notion that one needs to confront, to work through, grief in order to gain detachment and re-establish ties with others (p. 4).
This concept of grief work has taken a central place in therapeutic programmes, and Stroebe & Schut discussed the range of applications that have been derived from it, such as 'forced mourning' (Lieberman, 1978) and 'confrontation with bereavement cues' (Mawson et al., 1981). Walter (1996) notes that although classic writings on bereavement outline complex ideas of grief work, (e.g., Bowlby, 1979, 1980) subsequent research has attended selectively to these. He suggests that there may be a cultural imperative to discount the possibility of a meaningful relationship between the living and the dead. This trend can also be seen in studies documenting the operation of bereavement groups and counselling which describe the process of moving clients through grief in order to put it behind them (Wambach, 1985; Broadbent et al., 1990). Bowlby (1980) discusses the need of the bereaved to try and regain the deceased, which gives rise to specific behaviours. Such yearning behaviour is noted in stage and task models, but the relevance of this to meaning-making has been neglected. The focus is on the emotions accompanying the yearning, and the hopelessness and helplessness experienced, with the function of the behaviour apparently being overlooked. Walter (1996) considered that it is partly through the search for the dead that a new perspective on meaning can be found. The deceased is eventually regained, although in a different kind of relationship with the living.

It has also been observed (Stroebe & Schut, 1996) that working through the emotions of grief is by no means universal. Beliefs about death and ways of grieving are highly variable across cultures. It is possible that in some cultures different attitudes and attributions about death mean that there is no break in continuity from previous structures of belief or meaning. Recovery is swift, since new structures do not need to be developed. Bereavement models which give priority to a concept of grief work that does not consider meaning seem therefore to be over-simplified.

However, some ideas about the nature of grief work do take the concept further. The view of bereavement as a developmental process, through which we are able to fulfil our growth potential (e.g., Frankl, 1963, 1969) has been influential and implies a
search for personal meaning. Leonard (1976) stressed that an essential task with clients is to help them understand their search for meaning in the experiences that threaten them, and May (1950) suggested that bereavement work is a programme with components of rediscovery, re-orientation and re-education. Grief work has also been thought of as an active coping strategy (Stroebe & Stroebe, 1987), an idea that derives from a theory of cognitive adaptation to threatening events (Taylor, 1983). This suggests that to be an effective means of coping, grief work must involve a search for meaning in the experience, an attempt to regain control over one's life, and an effort to enhance one's self-esteem. There is considerable difference between seeing grief work as experiencing the emotions of grief and viewing it as an active coping strategy involving a meaning-making process. Other research domains also indicate that emotional catharsis alone may not be a sufficient condition for therapeutic change (e.g., Ebbesen et al., 1975; Gevarter, 1982; Moyer, 1982).

Meaning can be sought both through an attributional search - 'what caused the event to happen?' - as well as through wider searching reflected by attempts to answer the question 'what does my life mean now?' In studies of cancer patients, Taylor (1983) found that over half the participants reported that the experience had caused them to reappraise their lives, often bringing a new attitude to life, and increased self-knowledge or self-change, although not all the participants were able to construe positive meanings from the experience. Within bereavement research, Edmonds & Hooker (1992) explored the idea that there are positive aspects of experiencing loss, particularly that a relationship might exist between the grieving process and existential meaning in life. The majority of the sample reported a positive change in life goals.

Such research provides support for the hypothesis that threatening events are opportunities for change and growth (Cassem, 1975; Schneider, 1989), as can be found in some existential and transpersonal psychology literature. However, the possibility of change is one which is often resisted since it is perceived as threatening. The internal maps of an individual's reality may need to be revised but there is often
an instinct to avoid this and to preserve the status quo. Contradictory forces operating within the individual have been hypothesized to explain this. On one side there is the impact of a death-denying culture (Gray, 1988) and hence an unwillingness to engage with existential issues. An opposing force is found in the impulse arising from what Jung referred to as the 'collective or impersonal aspects of the psyche' (in Brookes, 1991, p. 310) which is thought to propel the individual towards creativity and wholeness. Parkes (1975) noted the same ambivalence in his discussion of changing world models during psychosocial transitions such as bereavement. He suggests that 'by looking boldly at what has been lost, the demarcation between the world that is and the world that was becomes clearer' (p. 136). However, the tendency to maintain the status quo is strong, and this may serve to prevent the learning of skills appropriate to a new, unwanted world.

The most important aspect of interventions in bereavement may not therefore be about working through the emotions of grief, but concern the creation of an environment in which new 'maps' of the individual's reality can be constructed. In the process there may be considerable emotional expression, arising both from the grief and from the challenging nature of change, but this should not be mistaken for the means or end of therapeutic work. If this is the case, it can be seen that most theoretical literature on bereavement is very limited when applied to therapeutic practice. In particular, theoretical frameworks need to update the central principle of grief work to create space for a search for meaning and significance. In terms of therapeutic practice this may involve asking questions relating to religious or secular meaning structures and exploring what has happened to these after bereavement. Therapeutic interventions would then focus on the personal meanings arising through the experience of loss rather than a facilitation of different phases of grief.
Conclusion

In writing a paper which brings together different areas of research and theory it is notable that the discussion can take on a rather abstract quality. It is easy to lose a connection with the profound and personal nature of bereavement, the struggle with conflicting feelings and with religious or spiritual beliefs that may, at different times sustain or desert individuals. Creating meaning after significant loss has been neglected by many theorists, despite evidence that the process of meaning construction may be an integral part of the bereavement process. Theoretical speculation and research focused on outcome therefore seems to overlook a fundamental part of bereavement, centring on the question 'what does my life mean now?'. This may be answered in many different ways during bereavement and for many clients a religious or spiritual dimension will have a profound effect on how they interpret the meaning of events, the selection of coping resources and the difficulties experienced when beliefs once held cannot cope with the changed circumstances. For therapists, there is a need to be able to explore and validate the struggle about meaning and purpose with clients without being limited by models which simplify this process.

The complexity of the phenomenon of religion has also been a focus of this review, which has highlighted the inadequacy of many measures applied in empirical research on religion and bereavement. The prevalence of simplistic measures may be one factor behind the contradictory findings of much research, together with the assumption that religion can be investigated in terms of whether or not it is a predictor of bereavement outcome. One means of gaining further understanding of these conflicting findings would be to generate more in-depth data through the use of qualitative, phenomenological approaches. Such methods permit the description of how individuals structure meaning relative to their experience in the world (Luckman, 1978), for example through exploring the ways in which aspects of religion and spiritual beliefs are and are not found to be helpful after bereavement. This would illuminate some of the processes that have not been accessed through quantitative
approaches and indicate new avenues for research that takes into account the complexity of the phenomena of religion and spiritual beliefs.
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Appendix

Notes for contributors to ‘Mortality’.

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References should follow the style of the *American Psychological Association*. All publications cited in the text should be listed following the text; similarly, all references listed must be mentioned in the text. Within the text references should be indicated by the author’s name and year of publication in parentheses, e.g. (Sloane or Howarth & Jupp, 1995), or if there are more than two authors, (Gallico et al., 1985). Where references are quoted consecutively within the text the order should be chronological, e.g. (Sloane Dickenson & Johnson, 1993), or within a single year, alphabetical (Dinnage, 1990; Kelleher, 1990; Walter, 1990). If more than one paper from the same author(s) and year are listed, the date should be followed by (b), etc., e.g. (Walter, 1991a). References should be listed alphabetically by author on a separate sheet (double spaced) in the following standard form, capitalization and punctuation:

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(b) for books:


(c) for chapters within multi-authored books:


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All illustrations (including photographs, graphs and diagrams) should be referred to as Figures at position indicated in the text (e.g. Fig. 3). Each should be submitted on a separate sheet of paper, numbered with the back with Figure number (Arabic numerals) and the title of the paper. The captions of all figures should be submitted on a separate sheet, should include keys to symbols, and should make interpretation possible reference to the text. Figures should ideally be professionally drawn and designed with the format of the page (175×248 mm) in mind and should be capable of reduction.

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Tables should be submitted on separate sheets, numbered in Arabic numerals, and their position indicate text (e.g. Table 1). Each table should have a short, self-explanatory title. Vertical rules should not be separate columns. Units should appear in parentheses in the column heading but not in the body of the table. Any explanatory notes should be given as a footnote at the bottom of the table.

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Spiritual beliefs and the search for meaning following partner loss among older adults

Abbreviated title: Spiritual beliefs and bereavement

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Spiritual beliefs and the search for meaning following partner loss among older adults

ABSTRACT  This study explores the role played by spiritual beliefs in the process of meaning-making among older adults following the death of a partner. In-depth interviews were carried out with nine participants who held Christian beliefs. Data were analyzed using Interpretative Phenomenological Analysis to highlight both commonality and diversity within the association between spiritual beliefs and structures of meaning. Participants' beliefs were diversely related to the creation of meaning for the loss and for the survivor's ongoing life. In more specific terms, these beliefs were implicated in discussions of support, ongoing relationships with the deceased, attributions of responsibility, the creation of explanations for the death and hope for the future. Findings are considered in terms of existing bereavement literature and implications for therapeutic practice are examined.
Spiritual beliefs and the search for meaning following partner loss among older adults

Introduction

The death of a partner is a traumatic experience that has a profound impact on the survivor's ongoing life. Older adults may experience partner loss differently from younger people (Brock & O'Sullivan, 1985; Greenblatt, 1987) and have been found to have higher subsequent morbidity rates (Thompson et al., 1984; Valanis & Yeaworth, 1982). These may be associated with a more extended bereavement period in older adults (Ben-Sira, 1983; Zisook & Schuchter, 1985) and the high prevalence of mental health problems in the elderly (Fink et al., 1987).

In recent bereavement research, which has highlighted the importance of issues of meaning, it is clear that the experience of loss makes demands on people to revise their assumptions about the world and their place within it (Barbato & Irwin, 1992). Such assumptions, founded on experience, form the basis for giving meaning to new experiences. This preserves continuity, providing a way to assimilate new realities into an existing mental structure and belief system (Benoliel, 1985). However, when traumatic events cause damage to personal interpretations of reality, the belief system may be required to develop in order to accommodate the new information and create a new meaning structure (Braun & Berg, 1994; Janoff-Bulman, 1992). Not being able to assimilate or adjust to the new situation results in a state of unresolved tension. As Frankl (1964) observed, there is no reason to go on living in a world in which there is no meaning. This may be one reason for the high rates of mortality and physical illness among the bereaved (Stroebe & Stroebe, 1987).

Religious and spiritual beliefs represent one way in which human beings create a structure of meaning that gives a sense of order and purpose to their existence and to death.
However, research into the role of religion in bereavement appears to have been restricted by a focus on religious behaviours and beliefs as moderators of bereavement outcome. This does not take account of the complexity of the phenomenon as the simple measures of religion often used - such as church attendance or belief in an afterlife - do not explore the interactions between an individual's belief system and their responses to loss. Looking at areas of religious research other than bereavement, the multi-dimensional nature of the phenomenon is more frequently emphasized. For example, positive and negative influences are apparent in the association between mental health and religion (Bergin, 1983; Mickley et al., 1995), and the role of belief systems in meaning-making has been considered (Hall, 1985; Reed, 1991a; Tellis-Nayak, 1982).

Rosik (1989) concurs with the idea of locating loss within a framework of meaning, such as a religious or spiritual context. He suggests, however, that this process occurs some time into the bereavement because immediately after the death, the individual is 'reacting to the fact of the loss...experiencing the emotional pain...(and) not...attempting to make sense of the situation' (p. 252). However this assumes a limitation on what religious or spiritual belief offers to individuals. The loss may be containable within an existing meaning structure - for example, a religious framework (Braun & Berg, 1994) - resulting in an immediate impact on how the death is experienced. It can also be asked whether spiritual beliefs are only relevant in their capacity to make sense of the loss, as implied by Rosik (1989). They may still be seen as important to the bereaved individual for other reasons, even if they are inadequate in easing suffering.

Exploration of the meaning-making process may also have considerable impact on therapeutic intervention in bereavement. Little research attention has been given to the potential value of an opportunity to explore the meanings of loss. The spiritual aspects of this may be particularly relevant to older adults where a lack of meaning seems to impact negatively on mental health (Reed, 1991b). Religion and spiritual beliefs appear to play an increasing role for a large number of individuals as they become older (Ainlay & Smith, 1984; Hunsberger, 1985) and high salience of religion has been found to have a strong positive effect on attributions of meaning and purpose in life (Petersen & Roy, 1985).
Reed (1991a, 1991b) suggests that spirituality - defined as the human propensity to find meaning in life through self-transcendence - is a potential developmental resource and one that often becomes particularly salient as people age and move closer to death. Meaning can be sought after bereavement through asking 'why did this happen?' as well as through wider searching reflected by attempts to answer the question 'what does my life mean now?'. Rubin (1985) argues that the bereavement process is usually complete when levels of functioning and personality characteristics are the same as prior to the loss. However, phenomenological theory suggests that there cannot be a return to a pretraumatic state (Braun & Berg, 1994). This is supported by findings that bereavement and other threatening events can be catalysts for substantive changes within the individual (Cassem, 1975; Schneider, 1989; Taylor, 1983). The most important aspects of therapeutic interventions may not therefore be about 'working through the emotions of grief' (Worden, 1991), but creating an environment in which a new representation of the individual's reality can be worked out.

The present study explores the multi-dimensional nature of religion and spiritual beliefs and their interaction with meaning-making processes which are widely regarded as being linked with spiritual experience (Reed, 1991a). A qualitative perspective was used since, given the conflicting findings of quantitative research, an exploration of the diversity of the area may assist theoretical development.

Method

Participants

The ministers of five Surrey churches of different Christian denominations were contacted and asked to pass information about the research to members of their congregations who
might meet the study's eligibility criteria; i.e., people who were aged over 50, who had experienced the death of their partner between one and three years previously and whose religious/spiritual beliefs were important to them. The ministers approached nine individuals, all of whom met these criteria and agreed to participate. The sensitive nature of the interview was made clear to participants in advance. Follow-up sessions were also offered, to provide participants with an opportunity to discuss any difficulties that had arisen as a result of talking about their experiences.

Procedure

Participants were interviewed in their homes. All signed a consent form which provided details of confidentiality and completed a brief background information questionnaire. A semi-structured interview schedule was then administered, consisting of open-ended questions supplemented by reflections on the emotion or content of responses, requests for clarification and probes (e.g., 'can you tell me more about that?'). The main content areas of the schedule were as follows: the 'story' and context of the loss; social support; spiritual beliefs; life changes following the loss; asking 'why?'; evaluation of the experience; hope; and therapeutic issues. However, there was also considerable scope for the participant to influence the direction of the interview. Interviews lasted between 1 and 1½ hours and were recorded on audiotape.

Analytic procedure

Interviews were transcribed and subjected to Interpretative Phenomenological Analysis (IPA), a procedure which has been used to analyze qualitative data on a range of health and well-being issues (for example, see Flowers et al., 1997; Jarman et al., 1997; Holmes et al., 1997; Osborn & Smith, 1998). IPA emphasizes the importance of engaging with the way participants think and attempting to adopt an 'insider' perspective on participants' experiences (Smith, 1996a; Smith et al., 1997). It is strongly influenced by symbolic
interactionism (Denzin, 1995) which argues that the meanings individuals ascribe to events are of central concern to the researcher and can only be arrived at through a process of interpretation. Thus IPA, while seeking to elucidate individual perceptions of meaning, recognizes that this process is influenced by and dependent on the interpretative framework of the researcher who must try to make sense of such perceptions. The idea that verbal reports are reflective of underlying cognitions is by no means universally accepted (Coyle, 1995). While IPA does not claim that the thoughts of an individual are transparent within verbal reports, analysis is undertaken with the assumption that meaningful interpretations can be made about that thinking (Smith et al., 1997).

Good qualitative research should be open about its process of analysis (Smith, 1996b). It is therefore useful to outline the analytic procedure systematically. The first step involved repeated reading of the transcripts which resulted in notes being made on each transcript regarding key phrases and processes. The notes included attempts at summarizing, making connections with other aspects of the transcript or initial interpretations. Within each transcript, such notes were then condensed as similarities (and differences) in the meaning of various aspects of the transcript were identified. The resulting key words or phrases represented the initial themes for that transcript. Particular attention was paid to examining each transcript as an individual and separate case. For this study, as well as looking for overall shared themes, elucidation of the complexity of the phenomenon under investigation meant that individual variation was an important element. The initial list of emergent themes for each transcript was then analyzed alongside themes from other transcripts, producing a consolidated list of themes, with extracts from the transcripts grouped under the theme headings. Individual experiences were not jettisoned, however, as these often extended understanding of the complexity of the common themes and the processes that underpinned them. Indeed, attempts to account for variability within the data often led to the creation of new themes. A concern with discerning process led to a particularly sensitivity for the connections that participants made between different aspects of their experiences. This enabled links between themes to be made, although unambiguous lines of causation were not frequently discerned.
Inevitably such an analysis is a subjective process, raising questions about the issue of reliability. IPA explicitly uses the researcher's frame of reference to arrive at interpretations and conclusions. Different researchers may foreground different aspects of a data set. However, issues of truth and accuracy are best understood in qualitative research as relating to evidence and credibility (Chenitz & Swanson, 1986). Although one researcher was responsible for the analytic and interpretative work, the development of themes was closely monitored at each stage through research supervision, which enabled verification that emergent themes and interpretations were grounded in and supported by the data. This process - which sometimes resulted in the modification of the analysis - was designed to reduce the risk of the final analysis arising from an idiosyncratic interpretative framework. In this paper, through ensuring that interpretations are accompanied by quotations from the data set the basis for these interpretations has been conveyed. This represents a further attempt to increase transparency and to render the analysis open to evaluation by readers.

Throughout the analysis, the frequency of occurrence of particular themes is indicated using adjectival phrases (e.g., a few, many), as discussed by Krueger (1994), who advocated the exclusion of quantitative indices in the analysis of purely qualitative data. The introduction of a quantitative element to this study would have been problematic and possibly misleading, given the small number of participants. No pre-defined criteria exist for determining the extent to which themes must recur within responses before they merit citation. In addition, in analyzing diverse qualitative data, quantification may undervalue the significance of themes that are identified, especially where, as in this research, attention to the diversity of responses was a key element.

In the quotations throughout the analysis, empty brackets indicate the omission of material. Information that appears within brackets has been added for clarificatory purposes. Ellipsis points (…) indicate a pause in the flow of participants' speech. Note that the names of the participants, the people they refer to and place names have been changed to preserve confidentiality.
Analysis

Background information

There were six female and three male participants, with a mean age of 67.2 years (range 53-78; SD=7.2). Two had been educated to degree level, three had undertaken vocational training, two held school certificates and two had no educational qualifications. All but two reported that they were now retired.

The participants had all been married to their partners and the mean length of marriage was 37.3 years (range 17-52; SD =10.2). The time between the loss of the partner and the research interview ranged from 1 year to 2 years 10 months. The suddenness of death was variable. Of the nine participants, three experienced a sudden unexpected loss, with death occurring within 24 hours of the onset of illness. For other participants, death was due to illnesses of a duration ranging from a few months to 4½ years.

All participants defined themselves as Christian. Three belonged to the Church of England, three to the United Reformed Church, two to the Baptist Church and one to the Roman Catholic Church. Eight participants rated their religious beliefs as very important to them and one assessed their beliefs as quite important.

Faith and spiritual support

The data provided a wide range of information on the nature of bereavement and the processes associated with it but issues of faith and spiritual support were foregrounded by participants and appeared to influence many of the other processes of grief. Most of the participants referred to not understanding how 'if you haven't got a belief ( ), how you'd cope' (Marjorie).
'Importance of faith' was therefore a primary theme relating to coping with the loss. This reaffirms the findings from quantitative studies in the bereavement literature concerning the subjectively perceived importance of faith. However what is not examined in such research, which questions the actual as opposed to perceived helpfulness of faith, is the variability in conceptions of faith. Several different approaches could be seen within the data in this study. A key element of faith was the nature of relationship or connection with God. For several participants this was an intensely personal and trusting connection:

Any time I got down or felt low, I just turned to the Lord and just prayed about it, ( ) I'd just talk it over with the Lord. (Marion)

This sense of a personal and trusting link to God was, for such people, a vital part of feeling supported through their grief:

My faith has been very strong for a long while, but now it's almost as though it's like...the Lord and myself. (Betty)

A high value was placed on spiritual support, which was prioritized by several participants partly because of the sense of permanence they attributed to it:

There is also that spiritual support ( ). You've got a feeling that God is with you all the time. (Tony)

For some participants there was more uncertainty evident in their faith and relationship with God. Their experience of bereavement appeared to shake their faith, leading to questioning and doubt:

Well, I was just trying to hang on to it (my belief) and I managed. And I was helped you know. I think we all have our doubts sometimes. (Elizabeth)
However, these participants also placed a high value on spiritual support, evident in reported feelings of 'having been helped'. Thus for most participants, there was an underlying sense of 'being in God's hands', which, even for those experiencing doubts concerning their faith, seemed to recur and provide a sense of spiritual support:

I was really more than lucky, it's really God looking after me. (Jan)

Although participants could make a distinction between spiritual and other support (e.g., personal or practical), the majority connected the spiritual with other forms of support. This may help to explain conflicting findings in the bereavement literature. Attempts to evaluate whether positive effects attributed to church attendance after bereavement are a result of spiritual or social support have led to some researchers emphasizing the social component as being helpful (e.g., Lund et al., 1993; Sherkat & Reed, 1992). Most participants in the present study acknowledged the importance of social support, with support gained from talking to others who had also experienced the loss of a partner being highlighted by some:

Somebody I've known casually for years, ( ) she understood exactly what I was feeling and it makes such a difference. (Jennifer)

However, in addition, the majority of participants talked about the link between personal support and feeling spiritually supported. This was evident in several different sorts of relationships. For Elizabeth, talking with a geriatric specialist was found to be beneficial:

The fact that she put me on my feet physically helped me spiritually.

Elizabeth also reported that her relationships with her children, whom she had found closely supportive although they were 'not especially religious', had changed:

The family have all grown together a lot ( ) and that is also a very positive experience of my spiritual life.
For some others, the link between spiritual and personal support was clear because personal support was received within a religious context. A few of the participants talked about being able to sense the prayers of others for them. A shared faith therefore resulted in personal support, which was also experienced by the bereaved as spiritual support:

I could feel ( ) the power of the prayer, I could feel that people were praying for me. (Betty)

The relationship between personal and spiritual support was also evident in the importance attached by participants to the shared faith of themselves and their partners. All referred to having had a shared faith and this was one aspect of a theme concerning the relationship with the deceased.

**Relationship with the deceased**

Throughout the interviews, there were repeated references to the relationship with the partner, both in terms of the relationship while he or she was alive and an ongoing relationship after the death. The participants can be divided into those who had some warning of the impending death and those for whom the death was sudden and unexpected. The value of preparation appeared evident among those who felt they had been forewarned. The relationship with the partner took on a particular significance for several participants, who felt that this had enabled them to prepare for their life ahead. This occurred in ways ranging from the highly practical to the development of a deeper connection resulting from their shared faith or gaining strength from the strength and faith of the partner. For example, Elizabeth reported:

He was a very positive person and right to the end of his days he had a smile and a sparkle and he wasn't bogged down by death, he wasn't frightened, he accepted it peacefully and that gave me strength. ( ) There was no reason for me to be depressed about that.
In one instance the shared belief in an afterlife meant that Betty had 'a feeling of elation because we were both very strong believers and I felt that I knew where he had gone to'. A shared faith meant that for several participants, their spiritual beliefs had an immediate impact upon their experience of loss. Betty suggested that she would have been much more upset had this shared faith not provided the certainty of knowing where her husband was. Hence the presence of a framework of meaning appeared to have a potential impact throughout the bereavement process. This contrasts with Rosik's (1989) assumption that spiritual beliefs are not relevant or helpful in the immediate aftermath of the loss.

For most participants, there was a sense of continuity arising through an experience of an ongoing relationship with their partner after death. For example, Elizabeth said:

One thing I don't mind is being alone ( ), it doesn't worry me because I feel he is with me.

However the meanings attached to this relationship differed, particularly in the extent to which there was a feeling of spiritual support gained from the sense of ongoing connection. In most of the interviews, feelings of being helped by the partner were an important feature:

I kind of talk to her as though she's here, I ( ) look to her for guidance. (Tony)

At the simplest level this seemed to be a coping strategy that was generally found useful and Marion pointed out how 'you have become such a part of each other over the years you automatically sort of talk'. For her, continuity was thus an important factor but she did not appear to attach a spiritual meaning to the ongoing connection with her husband:

It's just an automatic reaction ( ). It's not that I think he's there to hear. And in a way it helps the loss because you are still doing what you used to do anyway.
For many others, however, the continuing relationship with their partner had other connotations, implying a sense of support, which, since it could not be said to be of a social kind, may at least in some sense be interpreted as spiritual in nature:

In the summer I felt very very low, I suddenly thought, I've lost him, you know, ( ) and I feel (now) that he's with me again. (Elizabeth)

Such feelings were sometimes connected with spiritual experiences involving the deceased, and feelings of being helped by them:

I think Pam is here ( ) with us now. ( ) I talk to her frequently, discuss things, and I truly believe that when I've got problems here ( ) that Pam helps me to solve these problems. (Charles)

But despite this sense of continuity in the relationship with the deceased, the sense of loss was not easily overcome for any of the participants. Betty's feelings were shared by many:

I was just hit by this overwhelming sense of sadness and separation, you know, the fact that he wasn't there any more to talk to. ( ) Just somebody of your own.

Spiritual support therefore - either from feelings of connection with God or the deceased - did not appear to act as a buffer against feelings of loss and grief, contrasting with findings in the research literature concerning the 'stress-buffering' role of spiritual support (e.g., Maton, 1989). However this may highlight a differentiation between feelings of loss that may be inevitable and a separate issue of feeling that there is support of a spiritual nature present that helps in living with the grief - i.e., not necessarily reducing it. Indeed in most interviews, feelings of loss were thought to be permanent, although for some there was an acceptance that this was how it should be:
It's literally half of you has gone and that feeling I don't think one will ever work out. I don't think it's meant to be. (Elizabeth)

The interviews thus suggest that there may be a permanent change after the loss among older adults.

'Locus of control'

Taking control of one's lifestyle and situation has been highlighted in bereavement research on older adults as a predictor of adjustment (Lund et al., 1989; Lund et al., 1993), for example, through the use of personal resources and skills. While there was a strong sense for most participants of being in God's hands, this co-existed with attitudes of self-reliance, which together made up the theme of 'locus of control'. There seemed to be an inherent paradox to this theme. Many of the statements made by participants seemed fatalistic:

Hand of God...whatever He wants I'll have to accept it, there is no other way, eh?
Day after day, what else can you do, you've got no choice really. (Jan)

However, in contrast to this apparent external locus of control, in the actions and plans of all the participants there emerged a robust self-reliance and internal control, exemplified by statements such as 'I felt that it was up to me to do it' (Jennifer) and 'Positive because I make it positive myself' (Jan). Paul summed up one way in which the paradox of control can be resolved, in stating that through doing something about a problem yourself, 'that is the way the spirit or force works. If you fail ( ) I genuinely believe you'll get strength from elsewhere, but you've got to try that first'.

The issue of locus of control also had other aspects associated with it, particularly in the apportioning of blame or thanks. Many participants interpreted events in their lives as being due to the help of God or the spirit of the deceased:
I was so aware of how fantastically good God had planned everything so far. ( )
The Lord wasn't going to let me down now. (Marion)

However, personal difficulties that occurred after the bereavement - such as feelings of depression - were attributed firmly to the self and in many cases were said to have resulted in feelings of shame or self-criticism and a consequent reluctance to talk to others about difficulties. As Marjorie put it:

There are times when I feel I'm not coping very well but how do you go and say to someone I'm not coping very well? That's a very weak thing to say. I jolly well should be coping.

It was clear that in some cases the feelings of shame were connected with spiritual beliefs - a sense of 'letting down' both God and the deceased. Elizabeth seemed to construe her depression as her own fault and as something which was not reasonable, given the positive way she perceived the circumstances of her husband's death:

(My husband) died so much at peace that I felt God with us, you know, so I felt a little bit ashamed that I got so depressed.

Elizabeth's feelings resulted in doubts concerning her spiritual life but not in the form of questioning her faith or asking why the death had occurred. Instead it was an uncertainty as to whether she was 'getting it right' in terms of her spiritual practice:

You begin to get a few doubts, you know, ( ) wondering whether I was praying enough, whether I was really looking at my spiritual life in the right way.

In contrast, some other participants, notably those whose partners had died suddenly or with considerable suffering, reported greater oscillations around locus of control, which centered on thinking why the death and/or suffering had occurred. This was associated with the theme of creating meaning around the loss.
Making sense of the loss: the meaning-making process

Asking or thinking about why the death happened was a consistent theme associated with creating meaning from the loss. Participants varied in their views as to the validity, inevitability or irrelevance of asking 'why?'. For most, it was explicitly connected with their ideas of spiritual support and the nature of their relationship with God:

I think your life is planned out for you by the Lord and He has some reason for this (loss) ( ) and it's not a bad reason. (Charles)

Therefore for Charles, understanding the loss and answering the question 'why?' was assisted by his prior beliefs and assumptions about meaningfulness. Although he did not know a precise reason for his loss, he was able to trust that God had a reason and that the death was therefore meaningful. Others also had such a 'prior meaning structure' (Braun & Berg, 1994) which seemed to enable them to place the loss effectively within their system of beliefs:

It never entered my mind to ask why because it all was so patently obvious that it was perfectly planned. (Marion)

Such a strong meaning structure gave a pre-defined understanding of the loss, with the result that 'trying to make sense of the death' seemed irrelevant; it already made sense to the survivor and could be contained within the existing belief structure. Braun & Berg (1994) discuss a dichotomy between having a meaning structure that can place the death versus not having such a structure, which is said to lead to a period of discontinuity and disorientation before a new meaning structure is created. In the present analysis, there appears to be some continuity between these two extremes. A prior meaning structure may sometimes be able to place some but not all aspects of the loss. For the majority of participants, doubts and questions that involved their faith appeared to result in an oscillation between the support gained from their prior meaning structure and a sense of
uncertainty. For Marjoram this centered on the understanding of her husband's suffering in his long period of illness rather than the fact of the death:

I know there's suffering in the world. I believe that God ( ) suffered on the cross ( ) so there's an answer in there somewhere ( ). It seems to me that ( ) an all-loving God could have brought it to an end sooner. I believe in an all-loving God but why that had to go on and on, ( ) that's the hardest thing to understand.

This concurs with recent bereavement theory (e.g., Stroebe & Schut, 1996) which focuses on an oscillation between the approach and avoidance of grief. In the interviews this was more commonly referred to as feeling that 'It goes in waves you know' (Elizabeth) or 'You think, ah, I've turned a corner, and something happens, and wham' (Charles).

The sense of separation and resulting grief was difficult for some participants to reconcile with their faith, although despite this, it did not lead any to abandon it. The process of oscillation seemed for many to be a constructive process which led to a reintegrated religious meaning structure. For example, Jennifer initially found the very sudden loss of her husband impossible to accept and asked 'why it had happened the way it did. I thought it was such a cruel way'. The discontinuity felt at this point was reflected in difficulties with her spiritual practice:

I found it a bit hard to pray. ( ) I tried but I didn't feel as if I was getting anywhere.

However, over time, the perception of this sudden death changed so that Jennifer no longer felt that the loss was 'cruel':

It wasn't until quite a long time later that I began to see that it was a very kind way for Joe to go. ( ) I'm not angry any more.
It seems that there may be an interaction between a prior meaning structure and the sense of discontinuity which can produce a reassessment of the meaning of the death. Such a process that can make sense of the loss is one important aspect of the overall meaning-making process. However, of equal importance is the survivor's capacity to find meaning and purpose in their ongoing life. For one participant, Paul, the loss seemed to have pushed into the foreground issues of his faith and whether he truly believed in an existence after death:

> It is just that fundamental point where I still have the belief that there was something before and there will be something afterwards but ( ) that question has become ( ) more real as a question.

This highlights an issue that has been discussed by Gray (1988) in his critique of models of bereavement. Paul found that issues of the meaningfulness of life had become more important through the experience of loss. Gray (1988) suggests that 'negative' symptoms (e.g., depression) may be greater or more prolonged in those who look beyond the loss to wider issues of existential and spiritual meaning. Thinking about such issues may be expected to bring out intense feelings that avoidance or denial may not produce. Yet it would be unjustified to characterize such responses as necessarily unhealthy and Gray argues that such searching may in fact be a healthy response in the long term. This is supported by research findings that long-term well being is indirectly associated with the importance attached to religion, despite increased distress in the short-term (McIntosh et al., 1993).

In a minority of cases, there remained a sense of pointlessness about life that seemed to indicate the lack of a meaning structure to account for or aid with the ongoing life of the individual. Such feelings did not appear to affect spiritual beliefs but there was an apparent lack of connection between such beliefs and a continued existence in the world. For example, Jennifer said:
I'm living, but, um, no, I'm not, I'm existing. There doesn't seem much point to anything.

In contrast, others felt a consistent connection between their spiritual beliefs and their continuing life in the world. Despite sometimes feeling hopeless, their beliefs helped make sense of their ongoing life. For example, Marion reported:

There was only once when I really felt 'what's the point of living?' ( ) It brought to mind a verse from the Bible that says: if we live, we live for the Lord and if we die, we die for the Lord. ( ) I have no doubt that Alan's death was for the Lord ( ). So many ( ) were really touched through hearing what had happened. I thought, yes if we die, we die for the Lord and if I live, I live for the Lord, okay, I'll go on living.

Hence the meaningfulness of the death was one part of creating a sense of meaning in Marion's ongoing life and suggests a purpose to the death - affecting others spiritually - that also made her life meaningful.

In addition to the spiritual dimension associated with asking 'why?', there was also a rational mechanism for making sense of the loss, focusing on the non-validity of asking 'why?'. This often involved comparisons with others, especially with the sudden loss of a young person which was felt by several participants to be much more difficult to accept. For example, Jan said of her husband 'he had his life', which made his death 'acceptable' in her eyes. This suggests that there may be differences in the grieving process and 'acceptability' of partner loss for different age groups. However, this remains an empirical question requiring investigation with groups of young people who have lost partners.
**Spiritual experiences and the sense of self**

A further aspect of the meaning-making process was the impact of the loss on life outlook and self-concept, which seemed in many cases to arise out of the oscillation between prior beliefs and uncertainty. The significance of certain experiences or events - often construed as spiritual in nature - seemed for most participants to confirm a sense of purpose or give rise to new meaning which assisted in coping with the existence of doubts and uncertainty. Elizabeth said that she experienced such a sense of peace and tranquillity while sitting with her husband after he had died that this acquired a spiritually supportive meaning for her:

> I remind myself of that when I feel a bit down, you know. It was definitely a God-given moment.

Similarly, events around the time of the death of Marion's husband confirmed her sense of connection with God:

> Everything had just dovetailed and it was perhaps the most healing thing of all. ( ) Instead of being the saddest day, in a way it's the most precious day. ( ) I couldn't have any doubt that this was God's timing.

It is notable that uncertainties were not said to have disappeared but they seemed to be contained within a spiritual framework that acknowledged the influence of God in the ongoing life of the individual. This could be through unusual experiences that were thought of in spiritual terms, as with Paul, who reported the occasional awareness of his wife's 'presence' with him.Alternatively, there was a more pervasive acknowledgment of God's hand in everyday life. Betty spoke of feeling 'the nearness of God much more' and related how she had been helped by God even in small ways:

> I've said 'Oh Lord, I can't open this' and then I've just got it and it's as if it's never been tight, you know.
As has already been suggested, the change in role brought on by bereavement can have detrimental consequences for the sense of self but, perhaps more surprisingly, there was a consensus throughout the interviews about the loss having had some positive implications. This may be part of what Reed (1991b) has called self-transcendence. In the interviews, this was referred to in terms of an enhanced capacity for empathy and understanding of others and an increased sense of the importance of and involvement with relationships and human life. For example, Betty said:

I think when you suffer you're changed by it. ( ) You (can) have more understanding and more compassion for other people who are suffering.

In most interviews, such feelings were associated with representing the loss as part of God's purpose. There was a strong desire to be able to help others and for several participants, an awareness of what was felt to be God's plan for them:

So I could get involved with people with cancer, which I am doing. ( ) So this is the way the Lord wanted me to go, to provide, sort of, help in another direction. (Charles)

Helping others was highlighted by most participants as important and appeared both to create a sense of purpose and have a function as a positive way of helping oneself. There were also some references to a process of change from an internal to external focus:

Little by little everything restarts. Then you find that you are not completely useless, you can help others and you can do things. That is important. (Jan)

While helping others was thought to be a significant way of creating meaning in the survivor's ongoing life, for many, being helped was more difficult. As Elizabeth put it:

When you feel so low, you begin to feel that you will be a burden and that causes anxiety.
This reticence about seeking help may be linked to the perceived importance of self-reliance. Some participants suggested that there might be a generational influence operating here. For example, Jennifer said:

We were taught that it was up to yourself to pull yourself out of these things.

Such feelings were an important element of the participants' attitudes towards psychological therapy, which most did not feel was appropriate for them. With self-reliance being a highly valued mode of coping, for some there were feelings of shame associated with asking for help. A few acknowledged, however, that had they thought they were really not managing to cope, they would have considered asking for therapeutic intervention.

**Hope**

Hope is a construct that has been little explored in bereavement research, although in one study it was found to have accounted for 79% of the variance in 'grief resolution' (Herth, 1990). Participants talked about hope both in terms of the future in this world and in the afterlife. For most, meeting their partner again in the next world was a significant aspect of hope:

To know that you will meet again eventually, that's very very important to me.
(Charles)

However the certainty with which hope was experienced varied, the idea of hope meaning different things to different people. One perspective was:

Hope is a very positive thing in a Christian's life. Hope is a...it's a sure and certain hope. My hope is that one day I'll be with the Lord. ( ) That is my hope, that I know I will. (Betty)
Although the hope of some others seemed less certain, there was throughout the interviews a theme of positivity regarding the future after this life. For example, Marion looked upon her death as 'going through the front door into life'. Even for those who seemed to feel a sense of pointlessness about their continued existence, there was a stronger optimism about the afterlife:

Joe always used to say that we'd meet up again, you know, that whoever went first, it would only be a brief parting. And I think he's right. (Jennifer)

Optimism and hope even in the face of despair were apparent in all the interviews, although with differences in the extent to which they were generalized within an individual's life or remained somewhat abstract. For a few participants, the co-existence of despair and optimism or joy seemed especially significant. This was marked in some cases by statements such as 'So it was a happy day, although it was a sad day' (Marion) and by reported feelings of joy alongside grief. For example, Betty reported that:

At his service I felt joy in my heart, ( ) joy that we'd had a good life together ( ) and joy that he was at peace at last.

Thus in some interviews, hope and optimism seemed to pervade the life of individuals, giving them an attitude to their situation that seemed 'alive'. For others optimism was present but did not appear to be 'lived' in the same way, being demonstrated by a more rational internal attitude rather than in connection with the world and life. An example of this is the meaning found by Marjorie in a quotation of William Berkeley, which she read to convey her own feelings:

'If in the darkest hour we believe that somehow there is a purpose in life and that purpose is love, even the unbearable becomes bearable, and even in the darkness there is a glimmer of light.' That puts it better than I can.
Overview

The picture conveyed by the findings in this study is not complete because certain realms of experience were omitted. For example, the recruitment strategy may have been biased towards attracting people who felt they had been helped by their faith and/or those whom the ministers thought would be 'good' interviewees. This may have resulted in the exclusion of the experiences of those who did not find their spiritual beliefs helpful. Those who were finding their loss particularly difficult to deal with may also have been overlooked by ministers, perhaps because of a desire not to risk causing them further pain through the interview process (although some participants did report continued difficulties). The experiences of people who hold non-Christian religious beliefs are also not represented. Had the research taken other faiths into account, different results may have been obtained. For example, Jewish ideas about death and the afterlife are very different from those of Christianity (Jacobs, 1984; Neuberger, 1995). However, the findings do provide tentative insights into the meaning-making experiences of people with salient Christian beliefs following partner loss, reflecting considerable variability in meaning-making. Knowledge derived from qualitative research proceeds through a series of studies on related issues with different groups, with each study providing another aspect of the overall picture as part of a cumulative process. Other researchers may wish to advance this process by conducting similar studies with some of the groups whose experiences are not reflected in this research.

The meaning-making process among participants was evident in diverse ways with considerable variation in the nature of the meaning structure that was challenged by bereavement. For some, uncertainty was felt about the entirety of their beliefs, while for others, fundamental beliefs remained certain but there was a questioning of their purpose in being alive in the absence of their partner. Such differences were associated with widely varying timescales over which oscillation between doubts and prior spiritual beliefs occurred. The questioning of one's belief system seemed to be associated with a longer period of disorientation. However, even for some whose basic spiritual beliefs remained
unquestioned, if they did not gain a sense of meaning and purpose for their continued existence, disorientation could also occur over an extended period. In contrast, it could be seen that two participants were able to find meaning for the death within an existing belief system and answer questions about the purpose of continued life very rapidly. It could be hypothesized that this would have enhanced their ability to reconnect with life, while at the same time maintaining a link with the deceased.

A commonality among these different responses was the idea of the permanence of feelings of loss. The existence of a religious meaning structure did not appear to lessen feelings of grief, although participants did not seem to think of this as indicating that their beliefs were not helpful. On the contrary, they recognized what they perceived as inevitable feelings of grief but distinguished this from finding support and/or meaning in the loss and in their ongoing life through their spiritual beliefs. The consensus on positive aspects arising from suffering and loss also concurs with research that has highlighted such events as opportunities for change and growth (Cassem, 1975; Schneider, 1989). Linked with this is the emphasis on self-transcendence through being able to help others (Reed, 1991b). While helping others is not unique to older adults or those with spiritual beliefs, it may be an important source of purpose in life for such people, as well as affecting the sense of self. Helping others, for example through voluntary work, may be ascribed a spiritual value. Where this occurs, the salience of spiritual belief would be high, due to the motivation 'to integrate it into a way of life' (Petersen & Roy, 1985) and this could be hypothesized to exert a positive effect on attributions of meaning and purpose.

A consistent finding within the study was the emphasis participants placed on the connection between spiritual and other forms of support. The research literature tends to view spiritual support as conceptually distinct from practical issues or relationships with friends and family (see Stroebe & Stroebe, 1987, for a review). The analysis presented here suggest that attempts within research to determine which form of support is 'useful' for the bereaved are misplaced since for most participants the spiritual dimension was clearly seen as an inherent part of other forms of support.
In terms of therapeutic interventions, the findings suggest a concern with self-reliance which could lead to a reluctance to engage in psychological therapy. This may in part be a generational effect, as some participants suggested. Yet participants reported that shame and self-criticism were prominent reactions to depression or other personal difficulties after the loss, with a widespread sense that because of their faith, they should have been able cope effectively. It is possible that such feelings may have a negative impact on the bereavement process since research has suggested that those who communicate with others about their thoughts and feelings during bereavement are more likely to have a positive adjustment (Lund et al., 1985). An important aspect of therapy may therefore be to explore such feelings that could hinder the course of grief. This may entail looking at the assumptions made about the contribution and personal meaning of spiritual beliefs. In addition, there are questions concerning the ongoing purpose of the individual's life which may be associated with spiritual beliefs. Therapeutic interventions need to take account of religious and spiritual factors as a potential resource for meaning-making if the bereaved are to be helped to gain new perspectives or assimilate a loss into an existing framework.
References


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Appendices

1. Information sheet for participants

2. Research consent form

3. Demographic questionnaire

4. Interview schedule

5. Notes for contributors to 'Mortality'
COPING WITH THE LOSS OF A PARTNER: THE ROLE OF SPIRITUAL BELIEFS

I am a trainee Counselling Psychologist at the University of Surrey, conducting a research study which looks at how people cope after the death of a partner and how their spiritual and religious beliefs might help them to cope.

After losing a partner, most people go through a difficult period of adjustment which often involves trying to find some meaning in the death and trying to make their own lives meaningful after the death. Although people's spiritual and religious beliefs may be helpful in these tasks, there has been little research done to investigate the ways in which such beliefs might influence how people cope with bereavement. That is why I am undertaking this research.

I am seeking people who have lost a partner between one and three years ago and who consider that spiritual or religious beliefs are or have been very important in their life. Those who volunteer for the research will be interviewed about their experiences for approximately one hour. At the end of the interview, if an interviewee wishes to talk further, I will be happy to arrange another meeting. Interviews will take place at a location that is convenient for you.

I hope that this research will help counsellors, psychologists and therapists in working with bereaved people. I also hope that those who take part in the research will find it helpful to talk about their experiences.

If you would like to take part in this research or find out more about it, please ring me on 01483 259176.

Richard Golsworthy
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Guildford GU2 5XH
RESEARCH CONSENT FORM

The aim of this research is to explore how people cope after bereavement through the loss of a partner, and to look at how their spiritual beliefs might affect their experiences and ability to cope.

You will be asked to take part in an informal interview about your experiences of bereavement. The interview will be recorded on audio-tape so that, in writing up the research, I can cite people's experiences directly. Naturally, to protect confidentiality, I will not quote any identifying information such as names and locations. In making the transcriptions, therefore, your name will be replaced by a letter, and I will not record the names of other people or places that may arise in the interview. Once transcribed, the audio-tape recordings will be destroyed.

If you have any questions so far, or feel you would like further information about this research, please ask the researcher before reading on.

Please read the following paragraph and, if you are in agreement, sign where indicated.

I agree that the purposes of this research and what my participation in it would entail have been clearly explained to me in a manner that I understand. I therefore consent to be interviewed about my experiences of bereavement. I also consent to an audio-tape being made of this discussion and to all or parts of this recording being transcribed for the purposes of research.

Signed.......................................................... Date..............................................

On behalf of those involved with this research project, I undertake that, in respect of the audio-tape(s) made with the above participant, professional confidentiality will be ensured, and that any use of audio-tapes or transcribed material from audio-tapes will be for the purposes of research only. The anonymity of the above participant will be protected.

Signed.......................................................... Date..............................................
Coping with the loss of a partner: the role of spiritual beliefs

Thank you for participating in this research study. It would be very useful if you would read and complete this information sheet about your beliefs and your relationship with your partner.

Quite often in the interview we will talk about spiritual beliefs. Such beliefs may be highly individual, for example involving a personal relationship with God. They may also be beliefs associated with a religion and involve particular practices. All these different aspects, together with any others that you feel are important for you, are valuable to this research.

Please fill in the following brief questionnaire:

Age:

Highest educational qualification:

Occupation:

What was the relationship you had with the person who died?

How long were you in this relationship?

How long is it since he or she died?

What is your religious denomination (if any)?

How important are your spiritual beliefs to you?

Very important
Quite important
Not very important
Not at all important
INTERVIEW SCHEDULE

Note that some of the questions listed below may elicit material that renders later questions redundant. In this case, the interviewer will either ignore the redundant questions or will ask truncated versions to check whether further information can be elicited on the topic.

Preliminaries
Introduction of the researcher and the nature and aims of the research project. Explain the confidentiality procedures and obtain consent to tape record the interview. Address any questions which the interviewee may wish to ask.

Have the interviewee complete the demographic information questionnaire (age; highest educational qualification; occupation; definition of difference between religious and spiritual beliefs; religiosity; religious denomination; importance of religious beliefs; spirituality; importance of spiritual beliefs; nature of relationship with person who has died; duration of relationship; length of time since death).

The Story of the Loss
I'd like to start by getting a sense of how things have been for you and how you've coped from around the time your partner [use whichever term the interviewee seems most comfortable with] died until the present day. To begin, could you tell me what happened in the days immediately before and after your partner died?

[Elicit contextual information about this period, asking how the interviewee felt (where appropriate)]

What role, if any, did your spiritual beliefs have at that time?

Thinking of how you have experienced your loss since those early days, what would you say have been the milestones or turning points for you? What have been the major events - good or bad - in the [specify the relevant time period] that you've been dealing with your loss?

[Elicit information about these milestones, including what happened, how they made the interviewee feel, (in the case of negative events) how they coped with them and why they consider these to be milestones]

What helped you to cope in those situations?

[Where appropriate, ask:] Did that event/experience affect how you thought of your loss in any way? [If yes:] In what way?
Social Support
It seems that from all that has been written on grief and bereavement, that coming to terms with losing a partner is often a difficult and painful experience. People going through a bereavement often look to others around them for help. Where has your support come from? Who has supported you?

[Identify sources of support, including the timing of their support in the grief process]
What did they say or do that was supportive?
How helpful did you find that?
What was it that made that helpful?

Can you think of anything which other people said or did which you did not find helpful? [If yes:] What was it about that that made it unhelpful?

Is there anyone whom you would have expected to have been more supportive than they have been? [If yes:] Why would you have expected them to have been more supportive? What, if anything, did they do?
How did that make you feel?

Spiritual Beliefs
I’d like to focus now on your spiritual beliefs. Thinking of what your spiritual beliefs were like before your bereavement and what they are like now, would you say that they have changed in any way?

[Elicit information about the nature and strength/importance of the interviewee’s spiritual beliefs and religious practices before the bereavement and currently. If there has been a change, encourage them to describe the nature of this change themselves and ask them whether they think this change was caused by the bereavement or by other factors or by the bereavement and other factors. If other factors are implicated, elicit information about these other factors and the ways they have influenced the process of change]

In what ways, if any, have your spiritual beliefs affected your experience of the loss?
Did they help you to make sense of your loss?
Did you find that helpful? [If yes:] In what ways do you think it was helpful?

Have there been any ways in which your spiritual beliefs made it more difficult to deal with your loss? [If yes:] In what ways?

Have you had any specific spiritual experiences that have affected how you think about your loss? [If yes:] Can you tell me more about this/these? In what ways did this affect how you think about your loss?
Other Life Changes Following Bereavement
Looking back on your experiences over the past [specify time period], what have been the most important ways in which the loss of your partner has affected your life?
[Elicit information on the nature, implications and evaluation of these changes]

Has your experience of losing your partner had any effect on the way you think of yourself, your sense of who you are?
[If yes:] What sort of effects has it had?
[Elicit information on the evaluation of these effects]

Has your experience of losing your partner had any effect on your assessment of life's meaning?
[If yes:] What sort of effects has it had?
[Elicit information on the evaluation of these effects]

Asking "Why?"
One of the most common questions that people ask when they are confronted by the loss of someone close to them is "Why?". Have you ever asked that?
[If yes:] Have there been particular times over the past [specify time period] when you asked "Why?" or have you done so all the time or regularly?
[If "Why?" is asked at particular times, elicit information about the nature of these situations and the feelings associated with them]
When you ask "Why?", who or what do you direct the question to?
Have you found any answers to this question?
[If yes:] What answers have you found?
[Explore the process by which the interviewee arrived at these answers]

Evaluation of the Bereavement Experience
While for some people, bereavement is an entirely negative experience, others say that their experience of bereavement has had some positive effects in their lives. Do you think anything positive has come out of your experience of bereavement or has it all been a negative experience?

Hope in the Future
Hope in the future is sometimes suggested as something that helps people to cope after a bereavement.
Looking ahead, what do you think the future holds for you?
How does that make you feel?
What role, if any, do your spiritual beliefs have in this?
What is it that keeps you going from day to day?
[If appropriate:] Again, what role, if any, do your spiritual beliefs have in this?

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Therapeutic Issues
As I mentioned at the start, I am doing this research as part of my doctoral course in Psychotherapeutic & Counselling Psychology. I’d therefore like to look at some issues around counselling. To begin then, have you received any sort of formal counselling to help you deal with your loss?
["Formal counselling" includes counselling provided on a one-to-one basis by a member of a voluntary organisation]

Questions for those who received bereavement counselling
If yes:
Could you tell me a little about that?
If appropriate, elicit information on the specific reasons for entering therapy. Elicit information on how they arranged to see a counsellor, whether the counsellor belonged to a particular organisation, how long they saw them and how often]

Before you began, what were hoping that you would be able to achieve through counselling?

Did you find the counselling helpful?
If yes:
What was it about it that you found most helpful?
Regardless of whether or not they found it helpful, ask: Is there anything the counsellor could have done to have made it (even) more helpful?
If yes:
What could they have done? How do you think that might have helped?
If no:
What makes you say that?

Were your spiritual beliefs talked about during the counselling?
In what way were they raised?
How helpful did you find that?
What do you think the counsellor's attitude was towards your spiritual beliefs?

Do you think that you achieved the aims that you talked about earlier?
If yes:
Do you think this was due to the counselling or was it because of other factors?
If other factors:
What other factors?

Questions for those who did not receive bereavement counselling
Did you ever think of seeking counselling to help you deal with your loss?

If no:
Is that because you felt you were coping OK or was it because there’s something about counselling that you feel wary about or is there some other reason?
If either of the latter two responses:
Could you say something more about that?
Can you think of anything which would have made you consider seeking counselling?

If yes:
What made you think of seeking counselling?
Why, in the end, did you decide not to?
Prompts and Probes
Could you tell me more about that?
What makes you say that?
What happened then/after that?
Why do you think that happened? Why do you think he/she said/did that?
How did that make you feel? How did you feel about that?
Notes for contributors to ‘Mortality’

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Manuscripts may be in the form of: (1) research papers (not exceeding 8,000 words); or, (2) reviews; (3) reports for rapid publication (not exceeding 2,000 words); or (4) letters to the Editors. Four complete manuscripts should be submitted to the Editors, Mortality, School of Cultural and Community Studies, University of Falmer, Brighton BN1 9QN, United Kingdom. All submissions should be in the style of the American Psychological Association (Publication Manual, Fourth edition, 1994). Papers should be typed on one side of the paper, double spaced (including the references), with margins of at least 2.5 cm (1 inch). All pages are numbered. The first page should include the title of the paper, name(s) of the author(s), and for each a short institutional address, and an abbreviated title (for running headlines within the article). At the bottom of the page give the full name and address (including telephone and fax numbers and Email address) of the author to whom all correspondence (including proofs) should be sent. The second page should repeat the title and contain an abstract of not more than 200 words. The third page should repeat the heading to the main body of the text. Within the text section headings and subheadings should be typed on a separate line without numbering, indentation or bold or italic typeface.

References
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(a) for periodical articles (titles of journals should not be abbreviated):

(b) for books:

(c) for chapters within multi-authored books:

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All illustrations (including photographs, graphs and diagrams) should be referred to as Figures or position indicated in the text (e.g. Fig. 3). Each should be submitted on a separate sheet of paper, numbered with Figure number (Arabic numerals) and the title of the paper. The captions of all figures should be submitted on a separate sheet, should include keys to symbols, and should make possible reference to the text. Figures should ideally be professionally drawn and designed with the format of the page (175x248 mm) in mind and should be capable of reduction.

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Tables should be submitted on separate sheets, numbered in Arabic numerals, and their position indicate text (e.g. Table 1). Each table should have a short, self-explanatory title. Vertical rules should not be in separate columns. Units should appear in parentheses in the column heading but not in the body of the table. Any explanatory notes should be given as a footnote at the bottom of the table.

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Religious and spiritual dimensions in bereavement therapy: a qualitative study of practitioners' accounts.

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Religious and spiritual dimensions in bereavement therapy: a qualitative study of practitioners' accounts.

ABSTRACT  This study explores religious and spiritual dimensions in bereavement therapy through in-depth qualitative interviews of the perceptions and experiences of 12 therapists. Information was gathered on the conceptualisation of religious and spiritual issues, the perceived influence of therapists' beliefs on their practice and the therapeutic processes that occur in work with religious or spiritual issues. Interpretative Phenomenological Analysis was used to analyse the data, examining associations between these areas as well as highlighting the diversity of experiences and viewpoints. The multi-dimensional role of the therapeutic relationship was highlighted by participants as well as the perceived limitations of many theoretical models of therapy and bereavement in working with religious or spiritual issues. Some therapeutic processes are described in terms of the exploration of belief systems that have been challenged by bereavement and the re-creation of personal meaning. Implications for therapeutic practice and further research are discussed.
Religious and spiritual dimensions in bereavement therapy: a qualitative study of practitioners' accounts.

Introduction

There is an enduring perception that practitioners of psychological therapies are insensitive to the religious or spiritual values of clients (Fenchel, 1986; Purpura, 1985; West, 1997). However, there is also evidence to the contrary (e.g., Quackenbos et al., 1986) and a considerable body of literature has attempted to address the perceived neglect of religious and spiritual issues in therapy and provide conceptual definitions (see Hall & Hall, 1997, for a review). Preliminary definitions are given here to orient the reader to the terms used. The religious dimension refers to 'adherence to the beliefs and practices of an organised church or religious institution' (Shafranske & Maloney, 1990, p. 72). The spiritual dimension refers to personal beliefs and experiences that may or may not be contained within a religious framework, but are concerned with meanings that transcend the self and material reality.

It is evident that many psychotherapeutic systems lack a conceptual framework to deal with religious or spiritual issues, despite some exceptions (e.g., Assagioli, 1975; Jung, 1978). The topic also appears to remain taboo on training courses in the psychological therapies. This may lead to the avoidance of religious and spiritual issues by practitioners and a lack of knowledge and ethical guidelines for work in these areas. However, this is not necessarily a consequence of irreligious attitudes: surveys of mental health practitioners in the USA indicate high levels of religious or spiritual belief, albeit to a slightly lesser degree than among the general population (e.g., Bergin & Jensen, 1990). In addition, the extent of personal
relevance of spirituality has been found to have a direct effect on how psychologists perceive its relevance in therapy (Shafranske & Gorsuch, 1984; Shafranske & Maloney, 1990). The perceived neglect of religious and spiritual issues may therefore be a result of therapists utilizing therapeutic frameworks that do not easily incorporate such work, rather than from an intrinsic bias. Where therapists do incorporate religious or spiritual dimensions, this has been found to be shaped by their personal orientations rather than by therapeutic models or training which provide guidance (Shafranske & Maloney, 1990).

Counselling psychology has paid particular attention to groups that constitute substantial minorities within the population. This is grounded in multicultural research which has suggested that therapists need to seek an understanding of clients' worldviews to avoid cultural insensitivity and bias (Ibrahim, 1985; Sue & Sue, 1990). Such concerns are of equal value with religious and spiritual worldviews, and the domains are clearly not mutually exclusive. Higher levels of religious belief and observance are reported among some ethnic minority communities than among the dominant culture and the misrepresentation of these issues by mental health professionals is reported as widespread (Littlewood & Lipsedge, 1989; Lowenthal, 1995). Richards and Bergin (1997) suggest that assessment of spiritual worldviews is essential with religious clients if therapists are to gain empathic understanding and avoid bias.

Within the field of bereavement, theoretical models have not addressed the roles of religion or spirituality, despite research which has highlighted the importance of meaning-making processes after traumatic events (e.g., Janoff-Bulman, 1992) and the salience of religious or spiritual world views to such processes. Wortman et al., (1993) have applied the framework of meaning-making to bereavement, suggesting that the impact of loss may be determined by the extent to which it can be understood within an individual's system of beliefs, assumptions and expectations relating to the self, others and the world. Religious and spiritual beliefs represent one way of creating a meaning structure that provides a sense of order and purpose
to existence and to death (Golsworthy, 1997). This may have an important impact on the therapeutic process for bereaved clients and the theoretical framework of meaning-making provides a useful basis from which to examine therapeutic work. Beliefs can have an adaptive and explanatory function, which clients may find helpful. They may also be perceived as unhelpful however, if, for example, bereavement causes disruption to the belief system or the death cannot be assimilated within it. Adaptation or reinterpretation of the belief system may be needed (Barbato & Irwin, 1992; Braun & Berg, 1994). Because of the previously supportive nature of the belief system, such change may be resisted, with the result that the death cannot be incorporated as a meaningful part of the survivor's ongoing life (Golsworthy, 1996, 1997). Such issues present a significant challenge to therapeutic practitioners in working with bereaved clients who have religious or spiritual concerns.

Therapists' values and belief systems also affect the way in which clients explore and create meaning structures in the therapeutic process (Bergin, 1991; Kelly & Strupp, 1992; London, 1986), influencing which meanings may or may not be developed within therapy. However, the extent to which these values are acknowledged, either to the client or to the self, is variable (Shultz-Ross & Gutheil, 1997). Conscious or unconscious attitudes may be conveyed to clients and affect judgements about them. For example, Gartner et al., (1990) found that information about religion led psychologists to rate religiously committed clients in more negative clinical terms than uncommitted clients. Hence in working with clients who bring religious or spiritual issues to therapy, attention needs to be given to the ways that therapists' values affect how and whether the issues can be explored.

This paper reports a qualitative study of therapists' perceptions and experiences of religious and spiritual dimensions in bereavement work. It will also have relevance for other domains of therapy since many clients seen by psychological services have difficulties related to bereavement or other losses. However, one reason for this focus was the relevance of religious or spiritual questions to issues of mortality and
loss, and their consequent salience for therapeutic practitioners working with bereaved clients. The study aimed to generate qualitative data of commonalities and divergence among therapists who frequently encounter religious or spiritual dimensions in their work. Specific research questions addressed conceptualization of 'religious' and 'spiritual' issues; the perceived influences of the therapeutic relationship and the therapists' value system on religious and spiritual aspects of therapy; and therapists' experience of the emergence and process of work with these issues.

Method

Participants

Eligibility for participation required involvement in therapeutic practice where bereavement formed a major part of the work for a minimum of one year. Only those accredited or eligible for accreditation (self-reported) with the United Kingdom Council for Psychotherapy (UKCP), the British Association for Counselling (BAC), or the Counselling Psychology or Clinical Psychology Divisions of the British Psychological Society (BPS) were considered for inclusion.

Twelve participants were recruited by contacting six hospices or bereavement services in London and South-East England. This sample size falls well within that recommended for qualitative research within doctoral training programmes (Turpin et al., 1997). A theoretical sampling strategy (Glaser and Strauss, 1967) was used to expand an initial core sample. The research questions suggested the need to attend to the diversity of religious/spiritual perspectives. Other dimensions considered important were gender, since this is seen to influence viewpoints on
many issues, and work setting, as this may affect how religious or spiritual
dimensions are considered in relation to practice. Having identified particular
viewpoints of the initial participants (e.g., religious orientation), further participants
were recruited who would provide insights from different perspectives (e.g., those
with atheist/agnostic orientations). The emerging analysis was thus subject to
challenge and revision by the need to incorporate diverse perspectives. A
'snowballing' procedure was used, asking participants to nominate individuals who
met the criteria for participation. Fifteen individuals were approached, all of whom
were willing to participate. However, three were not interviewed since their
viewpoints were already adequately represented. The names of participants have
been changed and identifying information has been altered or omitted to preserve
confidentiality.

Procedure

Participants were interviewed at their place of work or in their homes. Interviews
lasted between one and two hours and were recorded on audio-tape. All
participants signed a consent form (Appendix 1), which provided details of
confidentiality, and completed a background information questionnaire (Appendix
2). A semi-structured interview schedule (Appendix 3) was then administered,
consisting of open-ended questions supplemented by reflections on the responses,
requests for clarification and probes (e.g., Can you say more about that?).
Development of the interview schedule was assisted by the themes identified in an
earlier stage of this research programme (Golsworthy, 1997) and by the literature
outlined previously. Two pilot interviews were conducted to allow refinement of
the interview questions. Since only minor adjustments were made, these interviews
were included in the sample. The main content areas of the schedule were as
follows: therapists' background within bereavement work; personal values and
beliefs; conceptualization and emergence of religious and spiritual dimensions
within therapy; the role of the therapeutic relationship; and therapeutic processes
with religious and spiritual issues. The schedule served as a guide for investigation rather than a fixed questionnaire, providing considerable scope for the participant to influence the direction of the interview.

**Analytic procedure**

Interviews were transcribed and subjected to Interpretative Phenomenological Analysis (IPA) (Smith, 1996; Smith *et al.*, 1997). This approach has an emphasis on engaging with the way participants think and act (Flowers *et al.*, 1997) and attempts to adopt an 'insider' perspective (Smith, 1996; Smith *et al.*, 1997), being concerned with individuals' personal accounts or perceptions rather than producing objective statements. It is strongly influenced by symbolic interactionism (Denzin, 1995) which argues that the meanings individuals ascribe to events are of central concern to the researcher and can only be arrived at through a process of interpretation. Thus IPA, while seeking to elucidate individual perceptions of meaning, recognises that this process is influenced by and dependent on the interpretative framework of the researcher, who must try to make sense of such perceptions. While IPA does not claim that the thoughts of an individual are transparent in verbal reports, analysis is undertaken with the assumption that meaningful interpretations can be made about that thinking (Smith *et al.*, 1997).

The analytic procedure commenced with repeated reading of the transcripts resulting in notes being made on each transcript regarding key phrases and processes. The notes included attempts at summarizing, making connections with other aspects of the transcript, or initial interpretations. Within each transcript, such notes were then condensed, as similarities (and differences) in the meaning of various aspects of the transcript were identified. The resulting key words or phrases represented the initial themes for that transcript which were then consolidated with those of other transcripts to produce a list of common themes. Particular attention was paid, however, to examining each transcript as an individual
and separate case. As well as looking for shared themes, individual variations provided insights into the complexity of the phenomena under investigation and the processes operational within them. Extracts from the transcripts were grouped under the theme headings, and the analytic process repeated to establish connections between themes in the data. This created new 'cross-therapist' themes in the attempt to account for the variability within the data and bring together different themes in a meaningful way.

Evaluation

Inevitably such an analysis is a subjective process, raising questions about its reliability. However issues of truth and accuracy in qualitative research can be understood as relating to evidence and credibility (Chenitz & Swanson, 1986). IPA explicitly uses the researcher's frame of reference to arrive at interpretations and conclusions. Different researchers may foreground different aspects of a data set. The speaking position of the researcher is therefore relevant to the research enterprise. This has been shaped by factors such as my training and practice in Counselling Psychology, particularly in work with issues of bereavement; my personal experiences of loss; and a spiritual perspective consisting of a personal awareness of a spiritual dimension and belief in a higher 'reality' or order of things. While influenced by Christianity and Buddhism, this perspective does not have an explicit religious framework. Holding such a belief system will inevitably have influenced what I attended to in the interviews and the nature of supplementary questions. In the analysis it may also have fostered a tendency to note and prioritize certain themes over others through the extent to which they created a personal resonance and hence seemed 'true' or important. Such a bias may also have affected the extent to which a critical approach was taken with certain concepts that accorded with my personal beliefs. However awareness of these difficulties meant that there was an attempt to 'bracket' (Giorgi, 1985) these preconceived expectations and attributions. In addition, although my interpretative framework
shaped the analysis, the development of themes was closely monitored through research supervision. This process ensured that the emerging themes and interpretations were grounded in and supported by the data, reducing the risk of the final analysis arising from an idiosyncratic interpretative framework. Through ensuring that quotations from the data accompany interpretations, the transparency of the analysis permits the evaluation of the research by readers.

Throughout the analysis, the frequency of occurrence of particular themes is indicated using adjectival phrases (such as 'a few', 'many') as has been advocated by Krueger (1994). A concern to elucidate the complexity and breadth of experience within the sample meant that quantitative indices were not considered appropriate and could be misleading, given the relatively small number of participants. Quantification may also undervalue the significance of certain themes and no pre-defined criteria exist for determining the extent to which a theme must recur to merit citation.

In the quotations throughout the analysis, empty brackets indicate the omission of material. Information that appears within brackets has been added for clarificatory purposes. Ellipsis points (...) indicate a pause in the flow of participants' speech.

Analysis

Background information

There were 10 female and 2 male participants, with an age range of 40-64 years (mean = 51; SD = 7.8). Current work settings were hospices (6), bereavement services (2) and other settings, including private work (4). The length of time in
bereavement work ranged from 1.5 years to 15 years (mean = 9.6; SD = 3.1). There were 4 counsellors, 3 counselling psychologists, 3 social workers and 2 psychotherapists.

Brief preliminary information was obtained about religious affiliations and spiritual beliefs, although the data collection instrument was not sensitive to differences in how such concepts were perceived. A personal religious affiliation was described as being quite or very important by 8 participants and not very important or inapplicable by 4. Religious or spiritual beliefs were quite or very important for 11 participants, and inapplicable for 1. However the nature of such beliefs varied, with 2 participants also describing themselves as agnostic. Conceptualisation of religiosity and spirituality will be described below.

Conceptualizations of religious and spiritual dimensions

A range of descriptions of religious and spiritual concepts was offered by participants, which provided a background for the material associated with therapeutic practice. However, due to space limitations only a summary of conceptualizations will be given here.

The religious dimension

There was a consensus about the concept of religion, regardless of participants' personal value systems. It was seen as an external organisational structure involving affiliation to a group of people with particular beliefs. This aspect led many participants to discuss issues of authority and dogma which were seen by some as being limiting for or damaging to spirituality. Religion was also seen as a
framework for spiritual beliefs, although such beliefs could also be expressed through other frameworks, e.g., socially or culturally.

In addition to the idea of religion as a means of expression for internal spiritual beliefs, an opposite process was also discussed: the adherence to religious beliefs or practices without an internal spiritual basis. This was seen as potentially problematic by several participants since it was thought to be connected with beliefs that did not take into account the unpredictability of the world. Examples referred to the creation of a sense of 'safety' due to particular beliefs or practices:

Because they say they believe in God, or go to church and perform certain rituals, they will be safe. (Mary)

The spiritual dimension

Spirituality was portrayed by most participants as pervading other aspects of life. Although personal representations of spirituality varied, there was greater consensus about the elements that could make up a spiritual dimension. It was seen as potentially including religious belief, but would be a 'very individual thing ( ) ... what gives meaning to their life and what ways do they see a connection with a higher being of any sort or the purpose of our existence' (Catherine).

Hence while spiritual values could include belief in an external power or afterlife this was not seen as inevitable. Spiritual values were described by some as also referring to existential questions about the nature of existence, and deriving meaning and purpose from factors such as the natural cycle of life and death, human relationships and ongoing connections with others through memories and creative works.
A spiritual element often referred to was a sense of 'connection', used in referring to relationships with the self, with others, and with God or a higher power that could be seen as external and/or internal. It was often seen in terms of unconscious links and commonalities between people. In paradoxical contrast to this, spirituality was also seen in the uniqueness of individuals, often referred to as the 'soul' or 'essence'.

The therapeutic relationship

An awareness of religious and spiritual perspectives and openness to these in others was seen by participants as integral to therapy due to its influence on the development of the therapeutic relationship. However a distinction was made between explicit attention to religious or spiritual issues, and an implicit aspect of the therapeutic relationship commonly perceived as a spiritual dimension.

Explicit aspects

Entering the client's frame of reference is generally acknowledged as a vital part of developing trust and understanding within the therapeutic relationship, the quality of which has been closely linked to therapeutic outcome (Clarkson, 1997; Horvath et al., 1993; Norcross, 1997). Exploring religious and spiritual values has been described as an integral part of understanding clients' worldviews and avoiding insensitivity and bias (Richards & Bergin, 1997). Several participants viewed raising such issues in this way:

To some extent I can get into their religious and/or spiritual frame in the same way as I can get into any other part of their frame. ( ) I think it's important to do it. (Mary)
However, while participants shared a concern to understand and enter clients' frameworks, there were differences in how this occurred. It could form part of an assessment:

I will sometimes ask if they have a religious faith and if so if it is relevant and if they would want to go into it, and if so how is it relevant ( ), and likewise with what I regard as the personal spiritual. (Mary)

Alternatively it could be through acknowledging and responding to what were described as 'subtle cues' (Gillian) from the client, often seen as being covertly communicated due to anxiety or confusion about addressing such issues:

You've got to be very alert to the cue which often sounds like a standard phrase, to look behind it... ( ) 'I'm not sure what it's all about', 'Is it terrible to say that I don't miss him?'. (Gillian)

Responding to such cues explicitly was seen as an important part of developing the relationship, with hesitancy or avoidance by the therapist having a negative effect:

I think people are embarrassed and scared about this stuff and if you skirt off it once... you know (they think) 'I knew I was a freak'. (Gillian)

Implicit aspects

An implicit spiritual dimension within the therapeutic relationship has been referred to by Clarkson (1995) as 'impossible to describe' (p. 181), but alluding to the mysterious and inexplicable elements of a healing relationship. Some humanistic writers have also addressed this aspect (e.g., Rogers, 1980; Rowan, 1993; Thorne, 1991). Rogers (1980) discussed the concept of 'presence', which he viewed as being 'in touch with the unknown in me ( )... it seems that my inner spirit has
reached out and touched the inner spirit of the other' (in Kirschenbaum & Henderson, 1990, p. 137). Many participants saw a spiritual dimension as embedded within the therapeutic relationship, often representing it as something that either is not or cannot be spoken of:

There's something ( ) intrinsic and I hope covert in the way I work ( ). Because I don't believe it's right to verbalize it ( ). There's a meeting of souls or spirits, whatever you want to say. (David)

For other participants this spiritual dimension was experienced 'more strongly with some people than with others' (Suzie). Elizabeth noted that 'you could almost have therapy without saying anything'. One means of explaining such experiences is through the phenomenon of countertransference. The therapist may feel an empathic response to the client arising from a resonance with earlier relationships (Bateman & Holmes, 1995). However, this would not necessarily be helpful or meaningful for clients, whereas several participants considered that when they experienced such a spiritual dimension, it was linked to the quality and effectiveness of the therapeutic interaction:

It's a very animal thing, this sort of connection, a very deep thing ( ) that seems to be pretty central ( ) for things to happen. I know that when I do connect that we work at a far more deep and intense level. (Robert)

Such ideas of connection were likened to the concept of rapport, but seen as having a deeper meaning. Several participants referred to this inadequacy in language about the therapeutic relationship which was not seen to do justice to a spiritual dimension. For example, the concepts of empathy and genuineness were also seen as important but limited. Rowan (1986) refers to resonance as a form of temporary identification that goes beyond empathy. A similar concept is found in Kohut's 'empathic resonance' described as 'the recognition of the self in the other' (in
This was addressed by David, illustrating the role of the self of the therapist in a 'person-to-person' relationship (Clarkson, 1995):

I think there's a resonance whenever people are searching, there's something about my search, something on an unconscious level ( ). We use the word 'empathy' but I think it's stronger than that. ( ) I think the more I can own the conflicts in me, the more I can hear the conflicts in other people.

Whether there is a qualitative difference between the concept of a spiritual connection and more traditional ideas about emotional connections between individuals through rapport, empathy and transference is open to question. However, it is clear that such a difference was experienced by many participants. This may be an important element in sustaining and giving meaning to their therapeutic practice.

Unspoken elements of the therapeutic relationship were also represented in terms of unconscious communication between therapist and client about the nature of the relationship. The literature and research on the therapeutic relationship suggest that different clients require different kinds of relationships (Clarkson, 1995, 1998; Norcross, 1997). Participants discussed the provision or denial of a space for religious or spiritual dimensions through unconscious communication of the kinds of relationship in which therapists are prepared to participate:

Maybe my own barriers... maybe people pick up from me that I'm not religious, ( ) and they might not bring that because of... if they pick it up unconsciously, which I believe they can. (Amanda)

Hence therapists' ability to accept and address religious and spiritual dimensions was thought to be communicated covertly to clients through the nature of the therapist's presence and the setting of the therapy. For example, Val's psychodynamic training had highlighted the concept of neutrality and the
importance of therapeutic boundaries. While acknowledging their relevance, Val found that rigidity in these areas could be restrictive, communicating particular limits on what the therapeutic relationship could be:

The ambience for therapy, as to both how much of a blank screen you are and the setting, creates a context in which it is possible or impossible to do spiritual work.

**The role of therapists' personal beliefs and values**

The unconscious elements outlined above were seen by participants as emphasizing the importance of the therapist's beliefs in addressing religious and spiritual realms of experience.

**Personal development and therapeutic practice**

Implicit within therapy is the underlying belief system of the therapist, irrespective of whether this has a religious or spiritual basis (Kelly & Strupp, 1992; Shafranske & Gorsuch, 1984). This was seen by all participants as influencing the emergence of religious and spiritual issues, and how these were handled within therapy, for example:

It inevitably influences what I'm open to, the possibilities I'm open to. (Val)

As previously noted, the majority of participants reported holding religious or spiritual beliefs. Although several participants' belief systems did not include any reference to an external power or afterlife, they identified what were represented as spiritual components within their own values. This may explain the high ratings of
the importance of spiritual beliefs in the background questionnaire. Despite differences in participants' core beliefs, there were many shared values. Regard for religious or spiritual dimensions in therapy appeared to be based less on the kinds of beliefs held than on individual attempts to acknowledge and confront the existential, spiritual or religious questions posed by life. In his work on the evolution of adult consciousness, Gould (1980) discussed the mid-life period (35-50 years) as a time of increasing awareness of mortality with potential conflict between maintaining past illusions and a drive towards authenticity. It may be argued that it is with increasing age and experience that therapists become better able to incorporate and consider such issues in their work. Val referred to her own process of development as enhancing her ability to relate to the spiritual concerns of clients:

Perhaps that part of me was becoming more available because of my own journey in life, if that makes sense. (Val)

However, life events at any age can also impact on this process. For Catherine, who held what I have described as humanistic spiritual beliefs, engaging with personal issues of bereavement influenced the extent to which she felt able to address spiritual issues with others:

That's where my spiritual awareness has come around for me in my personal life, and therefore being more comfortable in talking about these things with ( ) clients.

This link between personal experiences and therapeutic work was seen by many participants as an important factor affecting their work with religious or spiritual issues. There was an inadequacy seen in many theoretical models or in training regarding exploration of these areas, with the result that personal approaches and experience were highlighted:
I think ( ) there could be a bit more emphasis in training on this type of thing because I do think that I have had to arrive at this aspect of things on my own (Mary).

The gap between theory and personal experience was also perceived by some as a difficulty or a limiting factor in their practice. For example Robert refers to theoretical models as not addressing some of his concerns in the spiritual dimension and the consequences of this:

Some of the models at the moment haven't completely answered this for me. ( ) I do recognise that there are limitations about some of the ways I work, and whether I will change them in the future, who knows?

Problems were also experienced in therapeutic work, particularly with religious issues, when there was a strong conflict in values or when clients wanted to address religious issues that the therapist did not feel qualified to explore. For example, Mary recognised her difficulties with extreme religious views and her own religious background was not seen as useful in such situations:

I suppose it's harder for me to get into that frame of reference, and I have an urge to change it, but at the same time I feel hesitant to challenge it, and so it does set up difficulties for me.

Many participants referred to the need to be aware of their own limitations. This was seen as important for acknowledging personal value conflicts that may entail referral to another therapist and in being aware of the limits of the therapists' role:

I think therapists sometimes get caught up doing stuff that is not our role to do. I think part of the therapy role is helping... 'where might you go, what might you do with this?'. (David)
Personal beliefs as a sustaining resource for therapists

There was evidence in participants' accounts that they found their beliefs and values personally sustaining and this was linked to their effectiveness as practitioners. For many, spiritual beliefs were associated with experiencing hope and optimism for the future. This was seen as vital to maintaining their will and ability to continue in demanding work:

I have a sense of hope and if I didn't have a sense of hope then I wouldn't be able to do the work. (Robert)

Helen emphasized the importance of her experience of hope, grounded in religious belief, in challenging perceptions of death as 'the end of hope'. Her hope was seen as something that helped clients to stay with their pain without giving up:

Hope ( ) is very important ( ). It gives courage to stay here, with the grief and the pain, without dropping into despair.

Hope was represented by participants as arising both from an external spiritual reference and from evidence derived from therapeutic practice and personal experience. Julie's spiritual beliefs meant that she had a sense of ultimate meaning and purpose that sustained her:

It enables me to know that... how things appear is not necessarily how they are and to know that at the bottom line things are okay. So in this kind of work that feels very, very significant, I suppose if you like I have an underlying kind of optimism.

Such convictions meant that there was support available for many participants that was seen as sustaining, even when more immediate personal experiences or evidence did not provide hope:
Sometimes I may feel hopeless, but beyond that, that's still... that glimmer (of hope) still holds on, and I ( ) hold onto the hope for the process that's going on between us which I don't think is just about this world here. (Amanda)

The spiritual journey

Individual development was seen by many participants in terms of a spiritual journey, and hence evidence from therapeutic practice gave hope that 'this journey that they are going through is worth going through, it will get them somewhere' (Julie). The concept of the spiritual journey is discussed within the transpersonal psychology literature (e.g., Assagioli, 1975; Gordon-Brown & Somers, 1988) This dimension of spirituality can be differentiated from external religious or spiritual references and experiences, although the concepts are not mutually exclusive:

She felt she had grown so hugely as a person and in her depth of understanding of herself and of people and of God from the inner journey she had been making. (Helen)

Hence participants represented the spiritual journey as a process of looking inward towards the depths of oneself, 'the journey to discover truth, your own truth' (Robert). Nino (1997) discussed this as 'a process of creating purpose, meaning and direction in life well beyond the givens of organised religion' (p. 196). He saw the process as being a part of the developing integration of an individual's 'life structure' (Levinson, 1986), and hence a basic criterion of psychological health since it is concerned with building internal coherence. For many participants the therapeutic process was seen as embedded within a framework of the spiritual journey. This was evident in concerns about authenticity and integrity, for example in Robert's discussion of a client's change in communication with his partner:
For me this was a hugely spiritual process, because he was starting to be truthful. He'd been totally dishonest with himself, and with her ( ). It's a great spiritual issue about authenticity ( ) and it gives great hope.

**Disclosure of therapists' beliefs**

The extent of disclosure of therapists' beliefs or values is an important issue of professional debate. However little research has examined the effects of disclosure on therapy despite Spero's (1981) finding that shared religious values actually hindered the provision of acceptance and sensitivity. One participant perceived the willingness to disclose the therapist's value base as essential, due to its potential effects on the therapy:

If I go and see a therapist I will want to know what spiritual base they are working out of ( ) and I sometimes shudder for a lot of the general public who are not able to do that, and have no idea that it can have an influence on what might happen for them. (Jennifer)

Other participants reported that they would at times disclose something about their beliefs, although the extent of this varied depending on the therapist, the individual situation and the setting. For example, Catherine recognised that on occasions being open about her religious background but lack of current religious affiliation 'could be quite freeing for clients, ( ) they can be free to say actually what they want'. A place was thereby provided for the questioning of religious values that may have been more difficult to address within a religious community. The dominant influence on disclosure, however, appeared to be the organisational context. Half of the participants worked within a hospice setting with those who were dying as well as the bereaved. In this work and also in the immediate pre and post-bereavement work with relatives, several participants saw disclosure as more
likely to occur. This was due to the short time framework and the need for rapid
development of the therapeutic relationship:

People need to very quickly establish security, they need to know who you are, they may have something very profound to do. (Gillian)

This context therefore seemed to demand different responses from therapists, suggesting that withholding disclosure, often used in the service of uncovering latent meanings and concerns of the client, became less relevant:

I feel sometimes that I'm working with people and in a classic framework I'd be there in three months time ( ), (and) we're into it 20 minutes into the first session, because there may not be another session. (David)

The therapeutic process

The data highlighted several elements of the therapeutic process related to religious and spiritual dimensions, although it was noted that these were not inevitable elements of therapy, with other aspects often being more prominent. However questions or concerns about meaning were perceived as an integral part of therapy, possibly representing clients' needs for religious or spiritual exploration.

The challenges of meaning-making

Many participants noted that bereavement can challenge frameworks of belief. This could result in questioning of the belief system and assimilation of new information or accommodation to new values (Golsworthy, 1997). Within therapeutic practice the potential need to question aspects of beliefs held by clients was discussed, for
example through exploring those aspects that were perceived as limiting or causing a client distress. This was referred to more often with regard to religious issues. Difficulties were thought to be experienced with beliefs that appeared at odds with the reality of the bereavement. The loss could lead to the questioning of a pre-existing belief system:

It's called into question their ( ) assumptions that God treats those who are good well and ( ) those who are bad not so well. (Julie)

Gould (1980) discusses similar assumptions in his model of adult development, although without a religious reference. He identifies beliefs in life being fair and that rewards will come from being 'good' as engendering unrealistic expectations. Such beliefs are represented by Gould as being part of the childhood consciousness that exists alongside an adult view of reality. They provide a sense of stability and safety, but also constrain the evolution of a life structure in which the individual is seen as creating his or her own life. Conflicts between these factors could occur directly in therapy, for example through the client expressing their confusion. They could also arise indirectly in the emotional responses of individuals such as anger, depression or guilt. Anger towards God was a commonly reported response:

There are some people who are really angry with God, because how can He have let this happen to them? (Suzie)

The potential for feelings of guilt was thought to increase when belief systems were not questioned, since if the prior assumptions are seen to remain valid, it may be asked 'why are we being punished?' (David) or 'what have I done wrong?' (Gillian). Such responses may stem from a belief that since God punishes those who are 'bad' this must be what is happening, as Amanda commented in reference to a religious client whose child had died:
She also felt a failure in some way, she felt if she had been a better person, good, her child wouldn't have died, which was connected with her religion, so this was punishment.

Alternatively, feelings of guilt or feelings about being punished were seen as stemming from a religious framework that may no longer be subscribed to, but which may have an ongoing influence from an earlier time. Participants often referred to links with clients' past relationships, especially with parental figures, and the importance of these in forming internal attributions. These could have a religious significance in contradiction to conscious beliefs:

The kind of parental voice about the finger-wagging God which has come from possibly parents or church. They may discover a very judgmental finger-wagging God, having been thinking that they believed in a loving God. (Helen)

This exploration of ‘why people feel judged or why they believe they have been found wanting’ (Gillian) was seen as particularly valuable within therapy. Participants saw the role of the therapist as assisting exploration of the sources of beliefs and the emotions being expressed, looking at ‘whether there is a framework, whether it's been lost or thrown out’ (David). For many this was clearly seen as connected to psychological conflicts as with Amanda's example, where she questioned her client's assumption that the punishment was coming from outside her:

What we were able to look at was actually it was coming from within, she had punished herself for years. It was being to some degree you might say projected onto God. Actually she was punishing herself because she believed it was her fault.
Ongoing processes of meaning-making

Many participants saw the process of creating meaning as one of expanding the framework of beliefs rather than refuting it. It was often portrayed as a transition from external religious values to internal spiritual ones, although this did not imply an abandonment of religion:

I think she moved then ( ) to a spiritual understanding of who God was in her life, rather than from the kind of template that if you do this ( ) then God will do that. ( ) I don't think her religious belief was upset in any way. (Helen)

Meaning-making was thus portrayed as the adaptation of existing beliefs in the light of new experiences. There was a contrast in participants' accounts between religion as a framework for spiritual values and the kind of template described by Helen:

The basic dogma may be okay as a pattern, but it needs to be filled with truth and integrated, and if it's not then it's just a plaster on the surface of things, it's not a depth of spirituality.

This implies some assumptions about what is beneficial or healthy for clients in terms of beliefs, with an integrated spiritual and religious framework being prioritized. But support in a religious context may also come from social contacts, religious practices or guidance. Hence aspects of religion may provide for many individual needs in bereavement without such an integration:

She felt a genuine sense of being cared about and being held by the people within her ( ) belief. (Amanda)

Several participants discussed their role in terms of assisting people to utilize the frameworks and support systems available to them, and hence saw religious
structures as potentially part of this. Often the process was the opposite of the external to internal transition described, although still seen as concerning the creation of meaning. The external dimension was conceptualized as a means of expression for emotions and spiritual experiences:

I would ( ) look at a number of avenues, including a religious possibility ( ). I would be thinking of how people needed to act out what was within them. (Val)

Rituals were discussed as part of this process, for example in providing a means of saying goodbye to the deceased in a meaningful way:

I think part of my role on a sort of spiritual dimension is how might you say goodbye to this person in a way that means something for you as opposed to what you see prescribed. (David)

The externalizing process exemplified by rituals may therefore create a sense of control and focus for the bereaved, making concrete what was intangible (Rando, 1985). It was also recognised however that a client's search for meaning may not fit within a framework. In such instances, the importance of the therapist being able to acknowledge and contain what is unknowable was emphasized:

For some people that's going to be very clearly helping them move towards a framework. For other people it's about helping them stay in... this void really... and ( ) allowing the void to be more comfortable ( ) and finding the spirituality which is in that vacuum. (David)
Overview

This research explored religious and spiritual dimensions of bereavement therapy through the analysis of practitioners' experiences, and the conceptualizations and processes that they perceived to be salient in their work. It provides an incomplete picture however, due to the under-representation or omission of certain perspectives. Examples of these are the viewpoints of therapists without religious or spiritual values or beliefs, those for whom religious values represent a solely cultural dimension and male therapists. Such biases may be a consequence of the characteristics of the population from which participants were recruited. It appears likely that therapists with religious or spiritual beliefs are strongly represented within bereavement and hospice work and male practitioners constitute a minority across the therapeutic professions. The experiences of those who hold non-Christian religious beliefs were unrepresented. Different perspectives on therapeutic practice may have been obtained from those of other faiths since ideas about death and the afterlife differ across faiths (for example, see Jacobs, 1984).

There was considerable variability in conceptualizations of the spiritual dimension. This revealed that spiritual values were not seen as inevitably entailing an external reference such as God or an afterlife. The perception of secular, anti-spiritual therapists (e.g., West, 1997) may therefore be misplaced, at least in the field of bereavement, suggesting that measures of personal beliefs of therapists need to take account of more than just religious affiliations, as has been found in a previous survey of psychologists (Shafranske & Maloney, 1990).

The study highlighted the two distinct, although not mutually exclusive, means in which religious and spiritual issues are evident in bereavement therapy. These were the beliefs and experiences of participants regarding a spiritual dimension in the therapeutic relationship, and the overt ways in which religious or spiritual concerns of clients may be worked with. Spiritual beliefs and values were implicit for many participants in the therapeutic relationship, which might be seen in the context of a
greater spiritual 'reality' and/or in terms of a spiritual or personal journey towards authenticity and individual 'truths'. Such values were experienced as sustaining therapeutic practice, fostering a sense of optimism that was seen as important for participants' own well-being as well as for assumptions of the potential for change and growth in their clients. In the personally demanding field of bereavement work, it may be hypothesized that such beliefs serve a protective function for therapists, energizing their work and decreasing the risk of burn-out. Bringing such personal values within the therapeutic context also indicated for participants the inadequacy of therapeutic language for the religious and spiritual dimensions of experience. This was exemplified by their representations of 'connection' and 'resonance' within the therapeutic relationship. It is unclear whether such qualities are objectively different from the therapeutic concept of emotional connection through rapport and empathy. However, the findings exemplify the problems inherent in an increasingly secular society of how to maintain a language which does justice to the transpersonal, further reaches of human experience.

Participants' work with religious and spiritual dimensions was seen as strongly influenced by personal approaches and experience since many found inadequacies in theoretical models or therapeutic training. The personal development and approach of the therapist are important concerns as they will impact on the kinds of relationship that can be offered to clients. Previous research has highlighted the centrality of the relationship to therapeutic outcome (Gaston 1990; Horvath et al., 1993) and the need for different therapeutic relationships with different clients (Clarkson, 1995; Jones et al., 1988; Norcross, 1997). However, the lack of a theoretical framework to guide intervention is problematic for professions such as counselling psychology which seek a theoretical basis for practice. Most theoretical models of therapy and of bereavement were seen by participants as not addressing religious or spiritual dimensions directly. It may be hypothesized that they therefore constrain therapists' practice through restricting the ways in which clients' experiences can be understood and the meaning frameworks they may be helped to develop. This may be a factor in leading some therapists to prioritize working from
a personal basis. A previous study of psychoanalytic practitioners (Cohen, 1994) noted the deliberate separation of psychoanalytic and religious understanding. In the present study, the prevalence of more integrated viewpoints may be explained by the increased exposure to religious and spiritual issues in work that is focused on bereavement.

Working overtly with the religious or spiritual issues of clients was represented by participants in two ways. Firstly they discussed the importance of entering the client's frame of reference, and the difficulties experienced with regard to some religious beliefs. Acknowledgement of therapists' limitations was seen as vital, especially where there are conflicting values between therapist and client. However, the concern with understanding personal frameworks highlighted the importance taking the cultural context of beliefs into account through responding directly to, and not avoiding, clients' cues about religious or spiritual concerns.

Secondly, work with religious or spiritual issues was seen as a consequence of existing beliefs being challenged by bereavement. Conflicts were noted, particularly with religious issues, as a result of clients being confronted with situations or emotions which did not accord with their religious beliefs. In such instances, the religious framework of meaning could also be challenged through exploration of its limitations in therapy and the role of the clients' personal history in its development. This was constructed by participants as a movement towards the internalization of beliefs, and often seen as part of a personal or spiritual journey. Gould (1978, 1980) discussed a similar process as moving away from the internal constraints created by assumptions based on childhood rules, developing personally chosen beliefs and assumptions. While this was seen by participants as particularly valuable for therapeutic exploration, such exploration could be perceived as threatening and resisted by clients, due to the support gained from pre-existing beliefs (Golsworthy, 1996). Hence attempts by therapists to encourage re-evaluation and development of aspects of the belief system could be perceived as undermining the entirety of beliefs. This may be particularly problematic in bereavement since it is a time of
increased vulnerability. The focus on creating a new meaning framework may be seen as important to therapists whose value systems include a concern with personal growth and development. However supportive work within the existing belief framework may be equally important. This framework could be used to assist the expression of internal values and emotions, for example through ritual, creating a sense of control and focus for the bereaved. The findings emphasize the need for therapists to consider which kinds of relationships their own beliefs and values permit them to form with clients and which are excluded.

The present study represents an initial and broad-based analysis of a little researched area. A particular contribution has been to identify and clarify the various religious and spiritual dimensions within bereavement therapy, shaping areas of focus for future research. For example, although the perceived implicit spiritual aspects of therapy are difficult to address directly, the hypothesized function of beliefs as sustaining and protecting bereavement therapists could be explored. This would also be informed by research that has investigated connections between religious beliefs and well-being in other populations (e.g., Ellison, 1991; Petersen & Roy, 1985). Research into therapeutic processes could also investigate the effects of therapist disclosure of personal values, an integral part of discovering how differences in values, and subsequent difficulties in therapy, may be addressed. It is possible, for example, that disclosure in such situations may sometimes enhance therapeutic rapport and enable clients to make informed choices about their therapy.

Bereavement work involving religious and spiritual dimensions needs to be able to create a safe environment in which frameworks of meaning and conflicts may be explored without creating a rupture in the therapeutic relationship or devaluing clients' beliefs. This study suggests some ways in which such issues are present and may be addressed in therapy. There remains a need for further exploration of how psychological therapies can attend to religious and spiritual issues since both research and training has continued to neglect this important area.
References


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


Appendices

1. Research consent form

2. Background information questionnaire

3. Interview schedule

4. Notes for contributors to ‘Counselling Psychology Quarterly’
RESEARCH CONSENT FORM

The aim of this research project is to explore the ways in which bereavement therapists conceptualise and work with the spiritual and religious issues of clients. Within this, the impact of therapists' own belief systems on their practice is also considered relevant.

You will be asked to take part in an informal interview about your therapeutic practice. This will include some questions about personal beliefs. The interview will be recorded on audio-tape so that, in writing up the research, I can cite participants' reports directly. Naturally, to protect confidentiality, I will not quote any identifying information such as names and locations. In making the transcriptions therefore, your name and the names of any other people or places referred to will not be recorded. Once transcribed, the audio-tape recordings will be destroyed.

If you have any questions so far or feel you would like further information about this research, please ask the researcher before reading on.

Please read the following paragraph, and if you are in agreement, sign where indicated.

I agree that the purposes of this research and what my participation in it would entail have been made clear to me. I therefore consent to be interviewed about my therapeutic practice and the influence of my personal beliefs. I also consent to an audio-tape being made of this discussion, and to all or parts of this recording being transcribed for the purposes of research.

Signed: .............................................. Date: ................................

On behalf of those involved with this research project, I undertake that, in respect of the audio-tapes made with the above participant, professional confidentiality will be ensured, and that any use of audio-tapes or transcribed material from audio-tapes will be for the purposes of research only. The anonymity of the above participant will be protected.

Signed: .............................................. Date: ................................
Thank you for participating in this research study. Before we go on to the interview, it would be helpful if you would fill in the following brief questionnaire.

Age:

Professional qualifications:

Present employment title:

Length of time in bereavement work:

What personal religious affiliations or spiritual beliefs do you hold, if any?

If applicable, how important are these affiliations/beliefs to you in your everyday life?

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INTERVIEW SCHEDULE

Religious and spiritual issues in bereavement therapy

Introduction

Introduction of the researcher and the nature and aims of the research project, specifying that responses are requested in terms of the participant's bereavement work. Explain confidentiality procedures and obtain signed consent to the tape recording of the interview. Bring attention to the personal nature of some of the interview material and address any questions of the interviewee.

Have the interviewee complete the demographic information questionnaire.

(Begin tape recording)

Background of the therapist

I'd like to begin by getting to know how you became involved in the field of bereavement and any particular influences on that. Can you tell me how you came to work in this area?

Personal values and beliefs of the therapist

A lot of psychological research suggests that the value systems of therapists have a considerable impact on the therapeutic process, so I am interested to hear about personal values. I notice that on the questionnaire you state that you have ...belief(s).
1. Could you say in what ways this is important to you?

2. In what ways, if any, do you feel that these beliefs influence your practice as a therapist?

3. Are there any other personal values or beliefs that you would consider important in your therapeutic practice? Could you say what these are? (Elicit information on the ways in which they may be different from religious or spiritual beliefs and the impact they have on therapeutic work)
Therapeutic issues

There is a considerable range of belief and behaviour implied by the terms "religious" and "spiritual".

4. Do you find that there are differences between the "religious" and "spiritual" issues that occur in therapy? What is the nature of this difference? (*Ensure that information is elicited concerning 'what is religion?' and 'what is spirituality?' as far as the participant is concerned.*)

(Depending on the answer to these questions it may be necessary to elicit dual responses to the remainder of the questions in this section since different answers may be provided depending on whether the interviewee is considering religious or spiritual dimensions.)

5. In what ways, if at all, do you find that religious or spiritual issues emerge within therapeutic practice? (*Elicit contextual information, including examples where appropriate*)

6. What, if anything, helps you to decide on the importance of attending to a religious or spiritual issue, as opposed to other concerns of the client?

7. Are there any substantial differences in the way you work with religious or spiritual issues compared with other areas? (*If yes*) What is the nature of this difference? How has the difference come about?

8. Are there any particular techniques or therapeutic styles that you find helpful in working with religious and spiritual issues? (*If yes*) What are they? In what ways do you find these helpful?

9. Are there any particular techniques or therapeutic styles that you find are unhelpful in working with religious and spiritual beliefs? (*If yes*) What are they? In what ways do you find these unhelpful?

We know that religious and spiritual beliefs can be important ways of creating meaning in people's lives. Some models of bereavement suggest that the impact of a loss may be determined by whether it can be accommodated within someone's belief system.

10. To what extent do you think that creating meaning is an important process in working with bereaved people?

11. What therapeutic models might you use in thinking about the link between a client's beliefs and the process of creating meaning?

12. Do you feel that the theoretical models or theories that you draw upon provide what you need in addressing issues of religion and spirituality? If not... ...What is missing from them? ...How do you address the gap between theory and your
personal therapeutic practice? (Use prompts to elicit information concerning any personal therapeutic framework, e.g., integration of different models and personal values, that is used, and how this has been developed.)

The therapeutic relationship

A lot of research findings suggest that the therapeutic relationship is one of the most influential factors on the outcome of therapy. There is considerable variability in descriptions of what this relationship consists of. For example some writers discuss the relationship in terms of transference and countertransference or the working alliance.

13. What does the term 'therapeutic relationship' mean to you?

14. Some authors have also written about a spiritual dimension of the therapeutic relationship. I wonder what that means, if anything, to you? (Use prompts if necessary to elicit further information regarding the usefulness or otherwise of this conceptualisation.)

Personal experiences in therapeutic work

15. I am interested to hear how the emergence of religious or spiritual issues impact on the process of therapy. Thinking about your own experiences, what positive effects on the process of therapy can arise from exploring these concerns?

16. Can you describe a particular occasion where you felt that the emergence of these issues had a positive impact on the process of the therapy?

17. What negative effects on the process of therapy can arise from exploring these concerns?

18. Can you describe a particular occasion when you felt discussion of these issues had a negative impact on the process of therapy?

19. Are there any implications for practice of having versus not having spiritual or religious beliefs in working with these issues?

Ending the interview

That's all the questions that I want to ask. Is there anything on this subject you would like to talk about which I haven't covered?
(Switch off tape recorder)

Thank the participant for their help. Remind the participant of the confidentiality of the interview.

**Prompts and probes to elicit further information**

Could you say more about that?
Can you give me an example of that/what you mean?
How do you feel about that?
Why do you think that is? What makes you say that?
How useful/helpful do you find that?