A portfolio of academic, therapeutic practice and research work Including an investigation of psychotherapists’ and clients’ accounts of the integration of spirituality into psychotherapeutic practice

by

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INTRODUCTION TO PORTFOLIO

Introduction

This portfolio contains papers submitted as part of the Practitioner Doctorate (Psych. D) in Psychotherapeutic and Counselling Psychology. The three dossiers contained cover the academic, therapeutic and research aspects of the course. The Academic Dossier contains three essays on different theoretical models of therapy. The Therapeutic Practice Dossier contains short descriptions of my five placements as well as a personal account of integrating theory, research and practice. The Research Dossier contains one literature review and two research projects. Each of these dossiers will be considered in more detail in the sections below. Counselling psychology acknowledges that an individual’s own experiences, conceptions and theoretical frameworks influence their therapeutic practice and research. Therefore, I will start by providing the reader with some information about my reasons for training and my stance with regard to counselling psychology as these have inevitably influenced my research and practice interests.

Background

I became interested in psychology during my previous career in Information Technology (IT) where I received training in various interpersonal skills (for example, team building, leadership and influencing skills). My growing interest in psychology coincided with my search for a career that I could find more personally meaningful and fulfilling than IT. In reviewing the popular press and some psychological literature, it seems that to some extent I was following a common cultural and developmental trend (especially among the ageing ‘baby boom’ generation) of seeking a new sense of meaning in life and a deeper purpose beyond the enjoyment of consumerism and the pursuit of health, wealth and the self (Chambliss, 2001; Jung, 1973; Miller, 1999a; Steere, 1997). On a more personal level, I feel that approaching the age my father was when he died brought me face to face with my own mortality and with that came an urgent review and some clarity of what was truly important and what was trivial in my life.
I became specifically interested in therapy, whilst receiving relationship counselling which I found very useful in helping me understand and clarify my thoughts, feelings and patterns in relationships. My degree in Psychology and Counselling was the first tentative step towards changing careers. I thoroughly enjoyed my degree course, which gave me the experience of therapy from both a top down models' approach and a bottom up learning through experience approach.

As part of the top down models' approach, I explored a range of theoretical approaches to therapy, for example, psychodynamic, cognitive, humanistic, behavioural, existential, transpersonal and body therapies. I also investigated the dangers and opportunities of integrating the different schools and of eclectic therapy. I found that comparisons between each models' view of people, psychopathology and 'cure' through therapy developed my analytical and critical skills. It also helped me gain an appreciation of the strengths and limitations of each model.

I found the practice therapy sessions on my degree course particularly challenging, as there were so many different aspects to actually practising therapy. These practice sessions gave me an opportunity to try out various therapeutic skills (for example, active listening, reflection of feelings, application of 'advanced empathy' and identifying core messages) and to reflect on how therapy operated. The practical element of my degree course also helped me develop my skills in communicating with people, and in understanding and dealing with shifting and ambiguous problems in therapy sessions.

This bottom up learning also helped me learn to tolerate not knowing and not controlling as, unlike the experimental situation, the client is not a passive object that can be predicted and controlled. This led me to appreciate that therapeutic practice is not just a mechanical application of theory and skills. Thus, the therapy practice sessions helped me learn to adapt and cope with the unexpected and recover from mistakes. They also helped reveal my potential and develop humility about the limits of my abilities.
Furthermore, throughout the course I kept a journal on my experiences and thoughts as a session by session record of what happened in practice sessions. Analysing my overt responses, specific difficulties and own internal responses (feeling, thoughts, assumptions) toward the situation, the client and their material has helped me to be more aware of my specific difficulties and obstacles which might get in the way of my better understanding and responding to clients (such as my own memories, my fear of intruding, my fear of evoking strong emotions). Thus, the analysis of my practice sessions helped me develop self-awareness and the ability to reflect critically on my own experience. It also enabled me to examine the complex range of choices open to the practising therapist. The tools of journalling, reflection and analysis were used to describe the learning, which accompanied such choices.

Therefore, my degree course encouraged a more exploratory attitude to learning through ‘situated action’. It taught me the importance in being open to and learning from situations and helped me realise that mistakes and failures are as vital to the learning process as successes. It also made me realise that theory is not always superior to practice.

My degree also gave me the opportunity to explore the factors that effect the process of therapy. For example, the relationship, setting, work, journey of change, therapist and client variables. I also developed an appreciation of the difficulties in assessing the effectiveness of counselling/therapy as these factors overlap and interact and thus are difficult to disentangle and measure for research purposes. I also explored the issues in managing the counselling process, for example, ethics, power boundaries. My varied life experiences especially being exposed to many different cultures and ways of thinking (I have lived in Africa, travelled widely and my father’s family comes from India) have made me more aware of cultural factors within therapy.

After my degree I considered various post graduate courses. I was drawn to the Practitioner Doctorate in Psychotherapeutic and Counselling Psychology as it recognised and incorporated the aspects of training I had explored in my degree, namely personal development, theory, practice, professional/ethical and research components. I believe that all these aspects are essential to becoming an effective
therapist as each element guides and informs the others. My postgraduate training experience is explored in more detail in my clinical paper in the therapeutic dossier.

**Academic Dossier**

My own struggle to find meaning in my life and my practice, in my first year, within the existential approach, which prioritises meaning making in therapy, led me to focus in my first academic essay on examining the existential model's contribution to therapists' understanding of meaning in the context of human distress. While meaning making in therapy appealed to me in theory, in practice I found reflecting with my clients on the meaning of their distress problematic. In part, this may be because the existential stance seemed incongruent with the context of a National Health Service (NHS) clinic with the expected medical model of diagnosis and prescriptive solutions.

However, in part I also felt that my first year of practice with 'real' clients raised strong feelings within myself (for example, anxiety, guilt, responsibility, the pressure to make things better) which contributed to the difficulties I had in practising within the existential model with its emphasis on facing the 'givens' of life like meaninglessness, isolation, anxiety and death. Initially I put down my strong feelings to my inexperience and incompetence as a trainee. Theoretical training and practice within the psychodynamic model led me to also construct my feelings as countertransference. Personal therapy and intensive verbatim supervision helped me with the very difficult task trying to identify which feelings may belong to me and which feelings may belong to my clients and/or both. My second essay on psychoanalytic ideas of countertransference was my attempt to further develop my understanding of countertransference and of how I could use it in my practice with clients. I felt that being able to think about my countertransference and being able to sometimes use it in my practice enhanced the therapeutic relationship I had with my clients in my psychodynamic placement.

However, in my next placement, which was within the cognitive behavioural therapeutic (CBT) approach, I noticed a deterioration in my therapeutic relationship
with some of my clients. One of the reasons for this was that I found it difficult to maintain an empathic, accepting, reflecting stance within the CBT model with its focus on changing symptoms, behaviours and cognitions within a very limited number of sessions (6-8). My third academic essay on how cognitive therapy conceptualises and works with difficulties that arise in the therapeutic relationship was my attempt to try and understand and mitigate some of the difficulties I was having with my clients.

**Therapeutic Practice Dossier**

The therapeutic practice dossier relates to clinical practice and provides the reader with a brief overview of my placements and the client populations I have worked with. It also contains a ‘Final Clinical Paper’ discussing my development as an integrative practitioner.

**Research Dossier**

The Research Dossier contains one literature review and two qualitative research projects all focussing on the integration of spirituality into therapy. Spirituality has been a major part of my culture. I was born and brought up in Africa within a practising Catholic family of Indian origin and I attended a convent school where prayer and mass were part of daily life.

On the first step of my therapy training, I was very fortunate to enrol onto a degree programme where the role of spirituality in the process of therapy was given some attention as one of my lecturers, who was an existential therapist, had a deep interest in spirituality. Also, while on my undergraduate degree, I developed a keen interest in meditation, which I still practice regularly. I have attended lectures and retreats on Christian and Buddhist meditation. I have also read widely about shamanic, Buddhist, Zen and Quaker traditions.

Despite my interest in spirituality, I did not initially consider it as a suitable subject for my doctoral research. I initially felt that spirituality was not ‘respectable’ or ‘scientific’ and would have an adverse affect on how I was perceived on the course. After much discussion with my supervisor, I eventually ‘owned up’ to spirituality but
not before attempting to research bereavement and ‘meaning in life’ which seemed to incorporate some spiritual elements but did not seem such risky topics. I was surprised by my supervisor’s encouragement about exploring spirituality as part of the research component of my course.

In my first placement, I felt reluctant to reveal my subject to my fellow trainees or to present my topic to my colleagues in my placement, who were mainly clinical psychologists. In both cases, other therapists’ interest in and openness towards spirituality was surprising, given that spirituality is a topic that is rarely discussed in practice or training. In reading some of the unexpected volume of literature on spirituality, I found other therapists had experiences similar to mine. For instance, some studies have found that therapists were interested in spirituality but were pursuing their interest privately. They felt constrained in discussing spirituality in their professional community, which they suspected might not accept spirituality as ‘respectable’ psychology (Bergin, 1980; Claxton, 1996; Prest and Keller, 1993; Prest et al., 1999; Schultz and Gutheil, 1997; Sims, 1994) – something that seems a little ironic, given that much of the psychology of therapy often struggles to find a place of ‘respectability’ and legitimacy within mainstream academic psychology anyway.

My personal stance on spirituality and religion (for example, the belief in God/transcendence and a view of all existence being in relationship to this transcendent reality and a higher purpose) led me to attend particularly to the literature that framed spirituality in these terms and downgrade the literature that framed spirituality in functional or psychological terms. Also, my personal experience with meditation and mild mystical experiences have led me to attend more to the experiential rather than the intellectual (for example, in the form of values and beliefs) aspects of the literature. Undertaking the literature review deepened my understanding of these aspects of spirituality and clarified my own particular stance on spirituality.

However, even after basing my literature review on the integration of spirituality into therapy, I still struggled with how to utilise spirituality to the benefit of my clients within the National Health Service therapeutic setting. In an attempt to mitigate my
difficulties in my second year, I chose to interview experienced therapists on how they integrate spirituality into their therapeutic practice.

I was much more interested in participants' experiential accounts of integration and this was the first category I defined and wrote on - some 30 odd pages. However, I had to cut this down considerably in order to give the other approaches to integration equal space. Nevertheless, I feel that this category has had the greatest impact on my therapeutic practice in that it has helped reinforce my faithfulness to my spiritual discipline of meditation, in order to actively connect to God/the spiritual realm. I also more regularly pray for my clients in order to seek a connection for them to God/the Spirit. However, like some of my participants, I found these aspects of integration very difficult to talk about in supervision even though both my supervisors were very interested, encouraging and helpful in my research. Some of my participants linked their reluctance to talk about spirituality in supervision to the idea that, despite the literature that suggests a rapprochement between the two areas, in some settings, especially the NHS, they felt that taboo of spirituality was alive and well.

In my third year, I investigated clients' experiences of integration as exploring clients' views on the integration of spirituality and therapy seemed like the next logical step in my research. I hoped that exploring clients' perspectives on integration would enable me to build an increasingly comprehensive picture of spiritual integration and help me extend the insights gained from my previous research with therapists.

Concluding comments

In conclusions, this portfolio is the culmination of five years of a part time doctoral study. As stated previously, the papers included reflect both my personal and professional experiences during my training.

NB. Details of individual clients have been changed and pseudonyms have been employed throughout this portfolio in order to protect client confidentiality
References


INTRODUCTION TO THE ACADEMIC DOSSIER

The academic dossier contains three essays. The first essay examines the existential model of therapy and the contribution it makes to therapists' understanding of meaning in the context of human distress. The second essay discusses psychoanalytic ideas on countertransference and how these can be used to inform practice. The third essay discusses how cognitive therapists conceptualise and work with difficulties that may arise in the therapeutic relationship.
THE EXISTENTIAL MODEL OF THERAPY MAKES A UNIQUE CONTRIBUTION TO OUR UNDERSTANDING OF MEANING IN THE CONTEXT OF HUMAN DISTRESS

Introduction

Until modern times a firm belief in God provided people with day-to-day meaning and also carried them through the greatest tragedies. The replacement of religious ideology with a scientific one has meant individuals have lost this sense of ultimate meaning from their relationship to God or other essential beliefs. Moreover, we are living in a turbulent world of ever changing jobs, careers, technology, residents and relationships. All these factors have drawn modern men, searching for new meaning, to the existential model which, with its primary focus on what can make life meaningful, seems more able to address their concerns (Van Deurzen-Smith, 1977b). This essay will start by describing the existential model of therapy and its therapeutic technique demonstrating how meaning is particularly relevant to our understanding of human distress. It will then go on to examine how individuals find meaning in their way of being-in-the-world and finally, this essay will examine the limitations of this approach.

What is the existential model?

The existential approach is unique in that it is primarily concerned with “making sense of human existence in general and of [an individual’s][1] personal predicament in particular” (Van Deurzen-Smith, 1997a, p.166). Also, the existential approach has a unique view of human distress. It perceives distress as caused by problems of living and not to pathology. Distress is part of human existence as problems of living hit everyone sooner or later; for example, illness, ageing, bereavement, job and/or relationship losses. These changes in personal circumstances may lead individuals to question their old meanings and to look for new meanings in their life. These changes may also force individuals to “put aside the everyday concerns with which [they] ordinarily fill [their] lives” and confront the ‘givens’ of existence; namely meaninglessness, isolation death and freedom (the price for freedom is responsibility and anxiety) (Corsini and Wedding, 1989, p.376).
Focussing on meaninglessness, some existential authors have argued that one of the
distressing 'givens' of existence is that there is no clearly defined meaning to life and
yet human beings cannot accept a life without meaning. In order to avoid the distress
of the ‘given’ of meaninglessness, clients may live as if their lives have a
predetermined meaning. In other words, clients may conduct their lives as if they have
no choices and no freedom. For instance, a client may spend 30 years working long
hours in the city to provide for his wife and children without much consideration for
the different options available to him. His last child leaving home may contribute to
the client realising that his old meaning is no longer working for him and may force
him to realise that he has constructed himself in a narrow and limiting way. In other
words, the client may start to question the way he used to make sense of his life as this
may no longer seem valid in the face of a new development or crisis (Van Deurzen-
Smith, 1988).

New developments or crisis may also lead the client to realise that meaning cannot be
fixed, as life is ever changing and unstable. Thus, the meaning we give to our
existence is found by facing each moment with awareness, responsibility and courage
and attempting to find meaning that is not only unique to us but that is also unique to
this moment (Prochaska and Norcross, 1994). Facing that life and the meaning of life
is an ongoing, ever shifting process can be distressing and anxiety provoking as it can
leave some clients (and therapists) feeling groundless and unable to choose between
different and sometimes conflicting meanings and actions.

The existential model is unique in that it does not help clients to remove or evade their
anxiety. Instead, existential therapists attempt to help clients come to terms with the
idea that a certain degree of anxiety is normal and even an essential part of living and
therefore trying to control or eliminate anxiety is futile. In addition, existential
therapists attempt to help clients to expand their acceptance of changing meanings and
of the clients' own contradictions and paradoxes by helping clients realise that
meanings are no longer either/or they can be both/and or rather neither/nor. Van
Deurzen-Smith (1977b, p.85) states that “keeping in mind the client's struggle with
changing meaning [and] learning to capitalise on these shifts of meaning, instead of being victimised by them, must be one of the secrets of effective psychotherapy”.

However, some clients may want their therapists’ ‘expert’ opinion of what is wrong with them and may prefer symptom relief to the search for meaning as thinking about the ever changing meaning of their lives may seem like too much effort. This may result in a battle in therapy with clients wanting to reduce their anxiety and therapists trying to convince them to live positively with their anxiety. Van Deurzen-Smith (1988) states that clients will only gain from the existential approach if they come to therapy with the goal of sorting out vital issues and coming to terms with life. However, if they want to be ‘cured’ of specific symptoms or solve particular problems without effecting the rest of their existence, clients may not be well served by an existential approach.

Moreover, clients can only create or re-create meaning to the extent that they believe in their own ability to do so. Van Deurzen-Smith (1988, p.7) states that the existential belief is not in chaos or in order but in “people’s ability to create meaning and order, in spite of seeming chaos and absurdity”. However, clients do not have unlimited choice and furthermore, clients cannot choose all available possibilities; for example, choosing to be a therapist means saying no to becoming as architect. Thus, existential therapists help clients identify the areas of lives which they can and those which they cannot influence in order to help clients seek out and expand opportunities for positive freedom and choice while accepting and working within the limits imposed by existing in the world (Corrie and Milton, 2000).

For clients who are willing to face their anxiety, Strasser and Strasser (1997) recommend distinguishing between existential anxiety and neurotic anxiety. Existential anxiety is a response to the existential ‘givens’ of existence and therefore is a normal part of living in the world whereas neurotic anxiety is a defence and avoidance of the problem. A client may experience a combination of both neurotic and existential anxiety. For instance, a client in her 50s may experience neurotic anxiety because she perceives the short-term work offered on the NHS as meaning that her therapist, like her parents and ex-partner, was unavailable to her. However,
she may also experience existential anxiety because the biological changes of mid life may force her to face her own mortality. Facing the temporality of her existence can give the client a sense of urgency for accomplishments and thus help her recognise the tasks she needs to do in order to make life more meaningful in the restricted time she has remaining (Spinelli, 1996).

**Therapeutic technique**

The existential therapist attempts to provide the clarity and support to help clients discover meaning in the face of meaninglessness, freedom, anxiety and death. This is done through the phenomenological approach, which is central to existential psychotherapy and is characterised by the ‘rules’ of description, bracketing and horizontilisation (Milton, 1997).

**Description**

Initially, the therapist attempts to describe what they have just heard and not try and explain it theoretically. By “remaining faithful as possible to the data of experience, [the therapist] ... seeks to understand rather than explain and searches for meaning rather than seeks to collect facts” (Spinelli, 1996, p.196). This can help both the client and therapist clarify the clients’ situation. In addition, challenging clients’ discrepancies through this method can help clients experience insights and discover new meanings (Strasser and Strasser, 1997). For example, the discrepancy for a client who says that she wants to get close to people but is disparaging about people may suggest conflicting meanings. On the one hand the client may want to build a more meaningful life through more intimate relationships, however in reality the client may avoid all relationships because that may mean that she can continue to perceive herself as special and superior and not dependent and needy like others. Making these conflicting meanings explicit may help the client realise that in the past she has made an unconscious choice to avoid relationships and may help the client make more conscious choices in the present and the future. Thus, the existential model is unique in that by attending to clients “descriptively focussed interpretations the therapist attempts to clarify the clients’ meaning world with them” rather than to fit them into models of health and illness (Spinelli, 1996, p.188).
**Bracketing**

In order to actually hear what the client is expressing, the therapist attempts to bracket her own models, views, biases and assumptions regarding meaning (as far as possible) and meet the client with an “attitude of open mindedness and wonder” (Van Deurzen-Smith, 1997a, p.166). However, this is challenging for therapists, as they must first become aware of their own views, biases and assumptions. Even then the therapist may find it difficult to bracket her views. For example, a client may have the fixed or sedimented view that depression was an illness that must be ‘cured’, whereas the therapist may have an equally sedimented view that depression is an opportunity for the client to re-evaluate what makes his life meaningful. All the therapist can do is invite the client to construct different meanings of his depression by offering the client other possible meanings, which may be less distressing than the sedimented meaning the client has chosen. However, the client may reject or accept these alternative meanings. Spinelli (1996) states that by taking a neutral, non-judgmental and accepting stance existential therapists can increase clients’ willingness to confront the fixed, sedimented biases and assumptions they hold about themselves, others and their world with greater courage.

**Horizontilisation**

By getting a full description of as much of the situation as possible and bracketing their assumptions (as much as they can) the therapist initially attempts to treat all material as being potentially relevant (i.e. horizontilisation) before allowing importance to be attributed to any aspect of the clients’ experience (Milton, 1997). This stance lessens the danger of therapists labelling their clients prematurely and then ignoring anything that does not fit into that label. For instance, the therapist who links all her client’s obsessive worry about her children to an incident in her childhood may miss that worrying to the client means that she cares deeply about her children and therefore giving up worrying may mean giving up caring. Thus, the advantage of this approach is that exploring many possible meanings and making them explicit to the client can promote individual autonomy by encouraging clients to recognise and question their taken for granted meanings and to encourage them to create their own new meaning rather than leave meaning-making to the ‘experts’. However, a client
who wants an 'expert' answer and wants to be 'cured' may find the existential approach frustrating.

**Ways of being-in-the-world**

Existential therapists argue that human meaning does not just lie within individuals, it comes about to a large extent because of individuals interrelations with the world and with others. In other words, the existential approach does not view clients as individuals, but rather views people in relation to the world or Dasein which, means 'being-in-the-world'. Existential therapists hypothesise that clients inhabit and can find meaning in their way of relating in four main worlds, namely their:

- **Physical world:** Their environment and how they perceive their physical body.
- **Social World:** Clients' interpersonal relationships, i.e. the way clients interact socially with others.
- **Intimate world:** Clients' intrapersonal worlds, i.e. the relationship clients have with themselves.
- **Spiritual world:** Clients' relationship to the ideal world which is not necessarily about religion but about personal beliefs and the purpose of life.

Meaning can be found on all four dimensions but its shadow side threatens each possible meaning (Van Deurzen-Smith, 1988). For instance, a client may be musically talented and want to strive for success but may be frozen by the fear of failure in his public, social world. Another cause of feelings of meaninglessness and human distress may be 'imbalances' in clients' ways of 'being-in-the-world' (Strasser and Strasser, 1997). It is possible for clients to live with a sense of meaning on only one dimension. However, “getting stuck on any one of the four will be experienced as a nagging dissatisfaction at the background of one's experience and clients may not know in any articulate explicit manner what it is that bothers them, but they do sense something is wrong” (Van Deurzen-Smith, 1988, p.157). For example, clients may be so preoccupied with their physical world that they may pursue anything that leads to safety and security, thus, neglecting their social, personal and spiritual worlds. However, realising this imbalance and trying to address it may lead to some meaning
in these other worlds but may not necessarily lead to the most meaningful encounters. The stance clients take in their different worlds also contributes to the meaning in their lives. For example, in order to cultivate their neglected social world clients may pursue simple contact leading to contractual rather than intimate relationships. Thus, the meaning clients give to their relationships may serve to keep others at a distance, as clients may end up being with others in a using way rather than a caring/loving way. The therapist uses their encounter with the client to clarify the client’s way of ‘being-in-the-world’ and offers insight and openness into alternative ways of being (Corrie and Milton, 2000).

**Criticisms and limitations of the existential model**

The existential approach to therapy has been criticised for being a philosophy rather than a theory. Moreover, there seems to be a lack of controlled research evaluating the effectiveness of existential therapy. This may be related to existentialists distaste for ‘scientific’ research which they argue cannot do justice to study of humanness as it “dehumanises, objectifies and reduces clients to test scores” (Prochaska and Norcross, 1994, p.118). However, the danger of having no procedures and research is that existential therapy can “degenerate into anything-goes anarchy [where] ... therapists feel no responsibility to evaluate the effectiveness of their work [or evaluate] ... which approaches are most effective with which types of client problems” (Prochaska and Norcross, 1994, p.121).

**Conclusion**

Despite these criticisms, the existential model of therapy makes a unique contribution in that it seems to meet the “pressing need for meaning and purpose in our society which is facing unprecedented change and disintegration of traditional values” (Wong, 1998, p.429). Prochaska and Norcross (1994) state that more and more individuals’ lives are becoming existential vacuums where they doubt the meaning of work, love, life and death. Chen (1996, p.7) states that once a client’s “existential meaning is gone ... they have little desire left for living. [They] ... may physically still be alive but psychologically they are trapped in an existential vacuum”. Existential therapists make a unique contribution in that they encourage the client to step out of this
meaning vacuum in order for them to regain the appreciation for life, even though life is not without conflicts and struggles. Thus the existential model is unique in that it encourages clients to accept responsibility for their choices, accepting that meaning is fluid and not frozen and encouraging them to have the “courage to act in the face of limited information” (Prochaska and Norcross, 1994, p.113).


DISCUSS COUNTERTRANSFERENCE IN RELATION TO PSYCHOANALYTIC IDEAS

Introduction

Since Freud first ‘discovered’ countertransference in 1910 there has been a growing volume of diverse psychoanalytic literature on the subject. There is a broad consensus that countertransference exists and that it refers to the therapist’s response to her client. However, there is some debate concerning the content of this response. It can be argued that different psychoanalysts have highlighted different aspects of countertransference. For instance, Freud (1910) highlighted ‘abnormal’ countertransference, which is the therapist’s transference of her own unresolved conflicts onto her client. In contrast, Heimann (1950) emphasised reactive countertransference, which is the therapist’s reaction to her client’s transference. Klein (1952) more specifically linked this reactive countertransference to projective identification, in other words, the countertransference that arose out of the client’s treatment of the therapist as an internal object which the therapist identified with. Winnicott (1949), on the other hand, underlined objective countertransference which he defined as the “analyst’s love and hate in reaction to the actual personality and behaviour of the patient” (p.70). Winnicott (1949) together with Stern (1985) also stressed ‘normal’ countertransference, which is akin to affective attunement and empathy.

It is beyond the scope of this essay to discuss the many different psychoanalytic ideas on countertransference, therefore this essay will focus on Klein’s intrapsychic countertransference as, arguably, this type of countertransference is most useful in understanding what goes on in our clients’ minds. Intrapsychic countertransference arises from the client projecting into the therapist the experiences that they do not have words or thoughts to describe and/or elements that they are trying to get rid of in themselves. Consequently, intrapsychic countertransference can be seen as unconscious communication between the therapist and the client and therefore a unique opportunity to understand the client’s unconscious needs, expectations, fantasies, impulses, defences, conflicts, fears and their relationships with their internal
figures (Casement, 1990; Bateman and Holmes, 1995; Gill, 1997; Hinshelwood, 1994; Hughes, 1997; Joseph, 1985; Klein, 1952; Little, 1986; Steiner, 1992). However, there are many difficulties in using intrapsychic countertransference in practice.

**Lack of countertransference**

One difficulty is that there may be instances in therapy where the therapist feels no emotional response to her client. Most contemporary therapists reject Freud’s original idea that countertransference can be eliminated or minimised by thorough analysis of the therapist and view the idea of the therapist as a blank or neutral screen as a myth. Joseph (1975) states that there is always something going on in therapy which is based on the client’s past relationships with his internal objects and/or his beliefs about them. Therefore, it is important for the therapist to think about what is going on between the client and herself even when it seems like nothing is going on.

A lack of countertransference may indicate that the client is not using the therapist properly and may not be projecting his experiences into her. For example, the client may be convinced that the therapist like his mother, would not be able to bear his grief, shock, fear and rage and therefore he may protect both his mother and therapist from his distress (Hinshelwood, 1994). Alternatively, the client may have deadened his feelings in an attempt to prevent the pain of living (Hughes, 1997; Joseph, 1975; Suman and Brignone, 2001). Using clinical examples, psychoanalytic ideas have highlighted how in some cases, a lack of countertransference can be an active communication from the client.

On the other hand, a lack of feelings on the part of the therapist may not be solely down to the client, but may instead or as well be due to the therapist repressing her feelings. Therapists’ counter-resistance may be particularly prevalent with feelings that carry pejorative connotations, for example, envy, boredom, sexual arousal, aggression, hate or confusion (Casement, 1990; Flannery, 1995; Hughes, 1997; Joseph, 1985; Little, 1986; Winnicott, 1949). These worrying feeling may be especially difficult for new or inexperienced therapists (Flannery, 1995; Little, 1986; Suman and Brignone, 2001). Various therapists have used case examples to illustrate
how, by exploring the possible meanings of pejorative countertransference feelings, they were alerted to clients' conflict which they might have otherwise missed and thus achieved progress which might otherwise have remained impossible. In this way, psychoanalytic ideas have illustrated the importance of therapists and their supervisors viewing all feeling with a non-judgmental, non-defensive and curious attitude and have to some extent reduced the pejorative, guilt inducing aspect of some countertransference (for instance Casement (1990) with sexual arousal, Winnicott (1949) with hate).

A lack of countertransference may also indicate that the therapist has closed herself off from the client's projections. For instance, if the client's internal objects, client's defences or areas of conflict are too similar to the therapist's or important transferential objects in therapist's past, the therapist may find it difficult to accept the client's projections (Flannery, 1995; Hinshelwood, 1994). Psychoanalytic ideas have highlighted that many important countertransference reactions may remain unconscious because of the therapist's own defensive needs.

**Overwhelming countertransference**

Even if the therapist is able and willing to become conscious of her countertransference reactions, there is a danger that they may overwhelm her. For instance, when the client's disturbance resonates with the therapist's difficulties, the therapist's mind may become overrun by this disturbance making it very difficult for her to think about her countertransference (Hinshelwood, 1994). Psychoanalytic ideas have stressed the need for the therapist to be well analysed so that conflicts in client's material will have quality of pastness rather presentness or immediacy for the therapist, thus better enabling the therapist to be more open and receptive to the client's projections and also more able to contain them (Freud, 1910; Hinshelwood, 1994; Little, 1986; Winnicott, 1949).

However, even the most well analysed therapist may be overwhelmed by the disturbing and severe countertransference responses elicited by challenging client groups such as those labelled schizoid, psychotic, borderline and anorexic. Therapists
caught in the painful grip of acute anxiety, frustration, helplessness, sense of responsibility, anger, hatred, fear for/of the client may find it very difficult to stand back from these powerful emotions and try and understand what is being enacted (Bateman and Holmes, 1995; Hughes, 1997; Winnicott, 1949). Different psychoanalysts have understood these powerful emotional responses in various ways. They have been viewed as a ‘normal’ reaction to provocative and intolerable behaviour (Winnicott’s (1949) objective countertransference). In addition, the therapist’s intense and disturbing feelings have been seen as a reaction to client’s intense, crude, premature and chaotic projections, which stimulate the most defended and primitive aspects of therapist’s personality (Bateman and Holmes, 1995; Little, 1986; Steiner, 1992; Winnicott, 1949).

Psychoanalytic ideas have alerted therapist to the extremely difficult countertransference they can expect from working with extensively disintegrated clients. By forewarning therapists, it can be argued that psychoanalytic ideas have better enabled therapists not only to tolerate and survive these feelings but also helped therapists to resist using these feelings as motives for what they do to their clients (Winnicott, 1949). In addition, the ability to reflect upon and use difficult countertransference feelings may be essential with disturbed clients as some of these clients may “not respond [to therapy] ... in the ordinary way, by developing a transference, which can be interpreted and resolved. [Therefore], countertransference has to do the whole of the work” (Little, 1986, p.42).

**Overly positive countertransference**

At the opposite end of the continuum away from overwhelming negative countertransference is countertransference that seems to be overly positive. Even in this case it is important for the therapist to consider what this gratifying countertransference may mean. For instance, likeable and co-operative clients may be keeping their infantile feelings such as rivalry, envy, aggressiveness, dependency and neediness out of reach of the therapist (Joseph, 1975). By colluding with these clients the therapist may be drawn into a pseudo analysis which addresses the adult part of the client whereas the split off deeper unconscious convictions which really need to be
understood remain unexamined (Joseph, 1975; 1985). Thus, psychoanalytic ideas have alerted therapists to reflect on all countertransference even countertransference reactions that seem uncomplicated and pleasant, as positive (as well as negative) countertransference can be obstacles to successful therapy.

**Understanding the cause and meaning of the countertransference**

Even if a therapist is able to recognise and cope with her countertransference, understanding the cause and meaning of it is very difficult. For one, feelings are not simple emotional responses. Some feelings may not be distinct phenomena, for instance boredom may be connected to emptiness (Flannery, 1995). Also, conscious feelings may be a defence against unconscious feelings, for example, boredom may be a defence against sexual arousal or aggression towards the client (Casement, 1990; Flannery, 1995). Also, countertransference may be a complex communication from the client. Joseph (1975) states that it is important to locate the splitting in the ego, understand the process being acted out by the conflicting parts of client and the motive and anxiety associated with these activities. For instance, Joseph, (1975) uses a clinical example to illustrate how a client was difficult to reach because her enviously watchful part was splitting off the more needy and potentially more responsive and receptive part of herself.

The use of countertransference is further complicated by the fact that both therapist and client share conscious and unconscious expectations, desires, needs, fantasies, anxieties, internal objects and defence mechanisms and it is difficult to differentiate what belongs to whom (Bateman and Holmes, 1995; Casement, 1990; Hinshelwood, 1994; Steiner, 1992; Suman and Brignone, 2001). For example, a countertransference feeling of incompetence may, in part, be related to a trainee therapist’s inexperience and, in part, be relevant to the client’s contempt for his impotent self. It is crucial for therapist to be able to discriminate between the two things, which may feel very similar. However, disentangling her own stuff from what has been received from the client can be a difficult process (Hinshelwood, 1994). Psychoanalytic ideas have emphasised the importance of in-depth clinical consultation and supervision to help therapists with this process (O’Neill, 2001; Steiner, 1992).
Even with active and careful consideration and exploration, self-awareness may only occur after the therapist has reacted inappropriately (Bateman and Holmes, 1995; Steiner, 1992). For example, a feeling of incompetence may mobilise the therapist’s defences against the loss of her idealised role of ‘good’ therapist or her omnipotent phantasy of self as ‘healer’ and may lead to overzealous attempts to help the client (Bateman and Holmes, 1995). As well as her own unconscious needs, a therapist may also be induced to enact something by pressure from her client to meet his unconscious needs. Various psychoanalysts have argued that clients are so skilled in unconsciously manipulating the therapist to create a particular situation in the therapy that they do get therapist to co-operate unwittingly (Gill, 1997; Hinshelwood, 1994; Joseph, 1975; Steiner, 1992). However, in order to enable the client to take back disavowed aspects of himself, the therapist needs to understand and interpret their countertransference rather than repeat the client’s past patterns (Hinshelwood, 1994). Being vigilant especially when they find themselves acting unusually can help therapists to better utilise their countertransference responses.

On the other hand, the therapist’s usual way of acting may also hinder the process of treatment. This is especially so when parts of the therapist’s personality match with the client’s unconscious needs. For instance, the client’s projection of a perfect mother may mate with the therapist’s wish to be one (Hinshelwood, 1994). To avoid this trap, psychoanalytic ideas have stressed the importance of therapists “knowing which parts of [themselves] are vulnerable and available to be projected into” (Hinshelwood, 1994, p.168). Hinshelwood (1994) identifies therapists’ superegos and their motherliness as two obvious possibilities. Conversely, the therapist may be so frightened of acting out that she might freeze and not get in touch with the client’s deeper unconscious convictions (Hinshelwood, 1994). Therapists have to walk the thin line between being involved enough to experience the projected part of client and detached enough to extricate themselves from the expected roles (Bateman and Holmes, 1995; Casement, 1990).

Further complication is introduced by the fact that countertransference is a dynamic process that is constantly moving and changing. Also, the therapist’s and client’s
countertransference and transference, conscious and unconscious interact and influence each other making it difficult to isolate countertransference (Clarkson, 1991; Gill, 1997; Joseph, 1985; Little, 1986). Case illustrations by experienced psychoanalysts are helpful in teaching therapists how to deal with some countertransference. However, the four way matrix between client and therapist, conscious and unconscious make each analysis unique (Bateman and Holmes, 1995).

All these factors make it extremely difficult for therapists to understand how their countertransference might be connected to the client’s internal world and internal objects. Hinshelwood (1994) states that therapists’ understanding of what is going on, what is the client’s contribution and what is the therapist’s contribution is only partially known by even the most insightful therapists. Therefore, psychoanalytic ideas have stressed the importance of the therapist not basing her understanding of what is going on solely on her countertransference. It is important the therapist uses the actual data in the therapy session to steady, direct and support her understanding of her countertransference (Casement, 1990; Heinmann, 1959; Hinshelwood, 1994; Joseph, 1975).

In addition, psychoanalytic ideas have generally become less authoritarian and encouraged therapists to be willing to consider clients’ interpretations. The client is always listening for information about the therapist’s state of mind and therefore may be aware of the therapist’s real feelings before the therapist herself is fully aware of them (Little, 1986; Steiner, 1992). Gill (1997) states that it is important to give clients ample opportunity to tell us what they see as “patients may have much to teach us about how we may be colluding in acting out old patterns, both theirs and ours “(p.82). In addition, clients may never have experienced a relationship where the other person is willing to discuss their feelings and impulses with interest, objectivity and without defensiveness. If the therapist is able to do this then therapy may become truly therapeutic (Gill, 1997).
Sharing the understanding of countertransference with the client

If the therapist is able to use her countertransference to gain some understanding of the client’s experience, his way of functioning and the process that is taking place in therapy, the next difficulty is when and how she shares this understanding with the client. The aim of the therapist is to reproject the reworked/modified client’s projection by putting into words what the client is feeling, especially his unconscious experiences and/or phantasies (Hinshelwood, 1994). If the therapist is able to reflect on the client’s experience the therapist may model to the client that his experiences are bearable and can be thought about. This may increase the client’s own capacity to think about his experiences and may also help the client reintegrate previously disowned elements of himself (Hinshelwood, 1994; Steiner, 1992).

However, a difficulty with this is that the client may not hear the countertransference interpretations in the way the therapist intended. Joseph (1985, p.453) states that “interpretations are rarely heard purely as interpretations unless the patient is near the depressive position”. Clients operating at the paranoid-schizoid position may be unable to tolerate interpretations and may experience them as the therapist blaming them and pushing the anxiety back into them (Steiner, 1992). In these cases, containment may take priority over insight and the therapist may need to be able to carry the client’s projections and refrain from returning feelings prematurely to the client (Bion, 1963; Casement, 1990; Steiner, 1992).

Knowing when the client is ready to hear an interpretation is difficult to judge. Casement (1990) suggests that therapists use trial interpretations with the client to monitor the affect on the client of each possible interpretation. Steiner (1992), on the other hand, differentiates between therapist/analyst-centred and client/patient-centred interpretations which focus on the client’s view of the therapist or what is going on in the client’s mind respectively. Steiner (1992) recommends that therapists use therapist-centred interpretations when the client is in the paranoid-schizoid position and client-centred interpretations when the client temporarily shifts to the depressive position. However, it is a challenge to find the balance between client and therapist...
centred interpretations. Also both can be experienced as anxiety provoking by the client (Steiner, 1992).

It is also a challenge for therapists to find the right balance between returning clients’ projections prematurely and interpreting too far from the actual experience. Psychoanalytic ideas have stressed that it important for the therapist to keep interpretations in constant contact with what going on in the session. Otherwise there is a danger that interpretations will lead to intellectual discussions, which can be used as a defence, rather than leading to real contact and understanding (Hinshelwood, 1994; Joseph, 1975). Another difficulty is when to link countertransference interpretations to the client’s past. Gill (1997) states that it is tempting for both therapist and client to flee from the more stressful examination of the present to an exploration of the past. However, psychoanalytic ideas stress that for interpretations to be useful the therapist needs to bias her attention to the present and avoid linking her interpretations to the past until the “heat no longer on” (Joseph, 1985, p.452).

**Conclusion**

Thus in conclusion, psychoanalytical ideas have alerted therapists to the real value of countertransference in the work of therapy. Through clinical examples, various psychoanalysts have illustrated how the understanding of intrapsychic countertransference can enrich, support and sustain therapy by illuminating parts of our clients’ situation that may not have been accessible otherwise. However, there are many problems with how and when to use countertransference. Countertransference is an extremely complex, entangled, dynamic phenomena which arises from various sources. This makes it extremely difficult for the therapist to tease out whose feelings are whose and how they have come about. Therapists need considerable emotional resilience, skill, experience, intuition and patience in order to simultaneously engage with their countertransference and put it to use in the session. If cautiously and responsibly introduced, the use of countertransference can be an indispensable therapeutic tool in treatment.
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IN COGNITIVE THERAPY, HOW WOULD THE THERAPIST UNDERSTAND AND WORK WITH DIFFICULTIES IN THE THERAPEUTIC RELATIONSHIP?

Introduction

Some schools of therapy (for example, psychodynamic, person centred) see the therapeutic relationship as the cornerstone of therapy. In contrast, classical or traditional cognitive therapists seem to take the view that while a good therapeutic relationship is necessary; it is not the active ingredient of therapy. Instead traditional cognitive therapists focus on the arsenal of cognitive techniques and tools (for example, guided discovery, problem solving, cognitive restructuring, Socratic questioning, identifying and challenging unhelpful thinking, developing coping strategies, teaching anxiety/anger management, assertiveness skills) to resolve clients’ problems (Bannan and Malone, 2002; Corrie, 2002; Morse, 1996; Sanders and Wills, 1996, Williams and Garland, 2002). Typically traditional cognitive therapists focus on clients’ cognitions and take a structured, systematic, directive, active, non neutral, supportive stance in therapy in an attempt to appeal to the clients’ rationality, reason and good sense; to instil hope in client for their capacity to change and to minimise transference and other interpersonal complications (Bannan and Malone, 2002; Corrie, 2002, March, 1997).

Ideally the cognitive therapist hopes to establishes a positive, collaborative, straightforward, business like therapeutic relationship, within which the therapist and client can work together to identify and resolve the client’s current difficulties in the most effective and efficient way (Bannan and Malone, 2002; Beck and Freeman, 1990). In theory, classical cognitive therapists assume that developing this kind of collaborative working alliance is relatively easy. However, in practice more contemporary cognitive therapists have found that there are many difficulties that prevent the establishment of this ‘ideal’ therapeutic relationship. Some of these therapists have offered a variety of frameworks to help cognitive therapists understand and work with these difficulties (Beck, 1995; Newman, 1994; Rudd and Joiner, 1997; Young and Klosko, 1993).
Difficulties related to the way cognitive therapy is implemented

Some of the cognitive literature understands difficulties in the therapeutic relationship as due, in part, to the way the therapist applies cognitive therapy. Judith Beck (1995) states that difficulties in the therapeutic relationship can be as a result of therapists’ difficulties in several categories; namely diagnosis, conceptualisation, treatment planning, therapeutic alliance, structure and pace of sessions, socialisation of patient to the cognitive way of working, dealing with automatic thoughts and accomplishing therapeutic goals.

In my practice with my first few patients I felt that problems in many of the areas above contributed to the difficulties in the therapeutic relationship with my clients. For example, as an inexperienced cognitive therapist I struggled with explaining and selling the cognitive model to clients and with mastering the numerous cognitive techniques (for example, guided discovery, problem solving, cognitive restructuring, and Socratic questioning). Also, as I worked in a service that offered a maximum of six sessions, I felt pressurised to provide a ‘quick fix’. As a result, I focused on the clients’ current symptoms rather than their developmental history and rushed into using the standard cognitive techniques without fully conceptualising or empathising with my clients’ difficulties. For instance with one client (Mr E) who’s core belief was “I have no control” I jumped straight into trying to get the client to list evidence for and against his belief in each period of his life and into using continuum technique to try and shift the client’s polarised belief to a more balanced midpoint on the continuum (Padesky, 1994). Neither this client nor any of other first few patients seem to respond to my interventions or do their homework.

Difficulties related to the nature of traditional cognitive therapy

It seems that some of the literatures on relationship difficulties have understood the difficulties I experienced with my clients not just as a result how therapists practised cognitive therapy but also as a result of the nature of classical cognitive therapy. Some of this literature argues the traditional cognitive approach with it short-term, goal orientated therapy which focuses on the ‘here and now’ rather than past is bound to raise difficulties in the therapeutic relationship, in the form of resistance on the part
of clients and lack of empathy on the part of the therapist, as this type of therapy makes concerted efforts to change symptoms, behaviours and cognition without addressing or understanding the anxieties that motivate them (Bannan and Malone, 2002; March, 1997; Morse, 1996; Newman, 1994).

Schema focused cognitive therapy

Schema focused cognitive therapists have attempted to broaden classical cognitive therapy by focusing attention, not just on changing clients' current maladaptive thoughts and beliefs but also on understanding how clients' came to develop these thoughts and beliefs. Helping clients understand not just their belief systems but also the origins of their core beliefs/schema and the compensatory emotional and behavioural strategies they use to cope with these beliefs may help clients feel that their therapist is willing to understand and validate their experience and not just force them change. This may alleviate problems in the therapeutic relationship caused by client resistance (Corrie, 2002; Eckhardt, 1999; Morse, 1996; Young and Klosko, 1993).

Difficulties related to clients' schemas

Using the insights from schema focused therapy, I tried to moderate my clients' 'resistance', by revising my conceptualisation of their problem to include how their childhood experiences may have contributed to their core beliefs. I also attempted to conceptualise how they have used maintenance, avoidance or compensation to cope with these beliefs (Young and Klosko, 1993). I used Beck's (1995, p. 139) cognitive conceptualisation diagram to share this understanding with my clients. For instance, with Mr E, I hypothesised that his childhood experience of his father as overbearing and controlling and his perception of his mother as passive had contributed to his belief that he had no control. I further hypothesised that his coping strategy was to surrender to his schema and passively accept everything that happened to him (for example, jobs below his ability, car accident, unemployment, wife leaving him, illness). This passive acceptance maintained his feeling of having no control to change anything as it did not give him any opportunities to disprove his schema.
Schema focussed cognitive therapy has also brought attention to how difficulties in the therapeutic relationship may be understood as mirroring the clients' core schema and coping strategies (Sanders and Wills, 1996). In the case of client resistance, Newman (1994) suggest that therapists try and understand how the clients' resistance fit into their developmental/historical patterns. For example, the difficulties Mr E had in finding evidence against his schema could also be understood as reflecting that one way he maintained his schema was through the process of distorting or not noticing and discounting information that contradicted his schema (Padesky, 1994; Young and Klosko, 1993). In addition, as Mr E's belief was that he "had no control so what was the use in trying", it seems understandable that he would not even attempt to do his homework.

Broadening my conceptualisation of Mr E’s difficulties to include how he may have constructed his maladaptive schema and how his schema and compensatory strategies played out in his life and in our sessions and sharing this understanding with the client did seem to have some impact on him in that the client seemed to at least try to do his homework.

However, our session seemed dead and lifeless and I continued to have a nagging feeling of uneasiness and irritation with Mr E that was difficult to pin down. Some of the literature on breakdown in the therapeutic relationship does recognise that in some cases a breakdown in the relationship can be difficult to understand, as the indications of the breakdown may be subtle and intangible. Also, as therapists are participants in the therapeutic relationship it may be difficult for them to ‘unhook’ from their interaction with the client and reflect on what is going on. These cognitive therapists suggest that therapists use thought diaries, downward arrow techniques, role plays in supervision and therapy tapes to monitor their own reaction to themselves, their clients and the therapeutic process in an attempt to step back and try and understand the difficulties in the therapeutic relationship (Beck and Freeman, 1990; Corrie, 2002; Bannan and Malone, 2002; Sanders and Wills, 1996). However, despite the use of these cognitive techniques strains in the therapeutic relationship may still be hard to describe and understand as interpersonal engagement is largely at an emotional and non-verbal level and therefore therapists (and clients) may recognise difficulties in the
therapeutic relationship emotionally long before they are able to understand them intellectually (Bannan and Malone, 2002; Sanders and Wills, 1996).

Some cognitive therapists have borrowed the concepts of transference and countertransference from psychodynamic theory in an attempt to mitigate some of the difficulties in recognising, describing and understanding some of the more subtle breakdowns in the therapeutic relationship (March, 1997; Newman, 1994; Sanders and Wills, 1996). However, the use of psychodynamic theory within cognitive therapy is controversial.

Some cognitive therapists argue that paying attention to transference and countertransference can provide cognitive therapists with invaluable information which may help them understand more shadowy factors that may be undermining the therapeutic relationship (Beck and Freeman, 1990; Hoch-Espada and Lippmann, 2000; March, 1997; Sanders and Wills, 1996). On the other hand, Rudd and Joiner (1997) argue that the psychodynamic constructs of transference and countertransference are inconsistent with the fundamental principles of cognitive therapy, which emphasises knowable and accessible cognitions rather than the potentially inaccessible unconscious.

Nevertheless, despite these misgivings, schema focussed therapy has incorporated the constructs of transference and countertransference into cognitive therapy under the guise of interpersonal schemas (Young and Klosko, 1993). In accordance with psychodynamic theory, schema therapy hypothesises that difficulties in clients' early relationship are likely to surface in the therapeutic relationship as clients pull, from their therapists, responses that match the patterns of their past relationships and their own schema patterns. Therapists can get sucked into the client's way of being leading to a re-enactment of clients' dysfunctional cognitive interpersonal cycles in therapy rather than a different healing experience (Hoch-Espada and Lippmann, 2000; Newman, 1994; Sanders and Wills, 1996).

Trying to understand how the issue of control was surfacing in the therapeutic relationship with Mr E, I hypothesised that my earlier attempts to try to persuade the
client that he did have some control through searching for evidence to disprove his schema and through using continuum technique could have been misconstrued by Mr E as me trying to control him. In addition, I realised that I was behaving in a controlling way in that I did not collaborate with the client in setting his homework or his goals for therapy. I attempted to remedy this difficulty by giving the client a range of homework assignments that he could choose from. The client chose to monitor his activities and try and gain some control over his life by increasing the activities that he found pleasurable and/or that gave him a sense of achievement. However, I felt that the client was contemptuous towards me for negotiating with him.

Although, Mr E was able to monitor his activities between session, he had been unable to change any of his activities and I continued to feel irritated towards the client. I pondered with the client about what might be getting in the way of doing his homework. We explored together the short term and long term cost of staying the same and what he feared might happen if he did change.

In addition, I hypothesised that the client may experience my trying to help him as me trying to control him. Although the client denied this, the next thing Mr E talked about was how his father had wanted him to be an academic and gleefully informed me that, when he deliberately failed his 11-plus, his father had mourned for a week. Looking back at our sessions realised that I had missed the clues of Mr E’s history of opposition against authority figures.

In my conceptualisation of Mr. E’s compensatory emotional and behavioural strategies, I had picked up how Mr. E maintained his schema through lack of motivation and passive acceptance of his lot in life. However, I missed that sometimes Mr E also actively rejected all my efforts to help. Although, my irritation with Mr E may indicate that emotionally, if not intellectually, I did have some recognition of his defiance towards me and his delight at thwarting me.

I hypothesised with Mr E that the difficulties in our relationship could be understood as he experiencing me at times as his overbearing, controlling father who he had to defy to maintain his autonomy. On the other hand when I became more collaborative,
I hypothesised that Mr E experienced me as his passive mother who could not help him. Thus, leaving both Mr E and myself in a no win situation. Sharing my revised conceptualisation of the clients compensatory strategies and my understanding of what was going on between us did change the dead feeling in our sessions (which I had understood as Mr E’s depression) to a more engaged, alive therapeutic relationship. Thus, it can be argued that understanding the difficulties in the therapeutic relationship as reflecting the essence of Mr E’s problems and trying to weave my understanding of these difficulties into my conceptualisation of Mr E’s core conflict had given Mr E an opportunity to experience himself and me in a new way.

**Difficulties related to therapists’ schemas**

As well as clients’ characteristics, cognitive therapists have also looked at the ways in which therapists’ characteristics can contribute to difficulties in the therapeutic relationship. As discussed earlier I felt that in my practice I struggled with many of difficulties that the literature lists as common with beginner cognitive therapist (Bannan and Malone, 2002; Corrie, 2002; Sanders and Wills, 1996). For example, I found it difficult to socialise my clients to cognitive therapy, to vary therapy in accordance with the needs of the individual patient, to decide on the appropriate level of intervention or to agree with clients an appropriate goal for therapy that was both important for them and achievable in the time allocated. In addition, I found it difficult to interweave the relationship and cognitive techniques and in focusing on trying to learn the many cognitive techniques, maintaining the therapeutic relationship and Roger’s core conditions got lost.

In addition, cognitive therapists have understood difficulties in the therapeutic relationship as in part due to the triggering of not just the clients but also the therapists’ schema (Hoch-Espada and Lippmann, 2000). For example, it can be hypothesised that another reason I felt irritated with Mr E was that his ‘resistance’ and initial lack of progress triggered my own schema of defectiveness/failure. I tried to work with this difficulty by monitoring my reactions, both inside and outside our therapy sessions, with my supervisor to try and differentiate between responses to my
clients that were based their needs and ones that were base on the conditional belief that I was not a good cognitive therapist unless I could cure the patient in six sessions.

**Difficulties related to environmental factors**

On the other hand, difficulties in the therapeutic relationship can also be understood as due to factors outside the therapy, the client and/or the therapist. For example, it could be argued that Mr E’s illness, unemployment, desertion by his wife, car accident and financial difficulties had meant that he did have little control over his life. I worked with these difficulties by identifying these variables and empathising (belatedly) with how difficult things were for Mr E. I also tried to empower Mr E by pointing out his continuing humour and resilience in the face of very difficult real life problems.

Another outside factor that contributed to the difficulties in my relationship with Mr E was that I worked in a service where the number of session allocated per client was determined by the limited resources and long waiting lists rather than by the needs of the client. So even thought we were able to identify Mr E’s core schema and maybe cast some doubt on the validity of this schema, we were unable to modify Mr E’s schema. Cognitive therapists hypothesis that schemas are stable, long-term cognitive patterns that are extremely resistant to change. I worked with this difficulty by discussing with Mr E various options for future work. For instance, Mr E could be referred to longer term therapy, try reduced-fee, private therapy and/or he could buy Young and Klosko’s (1993) self-help schema based book and work through the exercises of imagery, psychodrama, evidence logs, thought diaries and thought challenging to try and continue the work we had begun in therapy. I also offered Mr E a couple of follow up sessions to help him think about his options.

**Conclusion**

Thus in conclusion, traditional cognitive therapists paid little attention to the therapeutic relationship and focussed instead on the therapeutic techniques. However, contemporary cognitive therapists have expanded and modified the traditional approach by bringing the therapeutic relationship more centre stage. Difficulties in
the therapeutic relationship can vary widely and can be obvious and specific (for example, lack of experience of the therapist) as well as more subtle (for example, clients' and therapists' unique combination of schemas and compensatory strategies). In addition, contextual factors related to the type and duration of the therapy and the client's real life circumstances can all contribute to these difficulties. To complicate matters further these factors interact and effect each other making it very difficult for therapist to disentangle, identify, assess and work with all aspects of difficulties in the therapeutic relationship, some of which may be outside the therapists' control. Instead of ignoring or understanding difficulties in the therapeutic relationships as obstacles to be resolved before the 'real' work can begin, contemporary cognitive therapists have brought these difficulties more the fore and tried, where possible, to make greater use of difficulties in the therapeutic relationship to help understand and work with clients' more complex problems.
References


INTRODUCTION TO THE THERAPEUTIC PRACTICE DOSSIER

The therapeutic practice dossier relates to clinical practice. It contains descriptions of each of my placements including type and duration, client population and types of supervision and brief account of other appropriate therapeutic work and professional activities. As I undertook year 2 and 3 part time, I had five placements, all of which were within the National Health Service (NHS).

This section also contains my 'Final Clinical Paper' which provides an overview of my current approach to the integration of theory, research and practice.

In order to preserve confidentiality, details of individual clients have been changed and pseudonyms have been employed and placement locations have been omitted.
DESCRIPTION OF CLINICAL PLACEMENTS

Placement 1: Secondary Care Adult Psychology Clinic

My first placement was in a secondary care, adult psychology clinic in a suburb of a large city. The clinic was staffed by twenty clinical psychologists, who worked mainly within the cognitive behavioural and systemic approaches. In addition, there was also one psychodynamic counsellor and an existential counselling psychologist who supervised the therapeutic work I undertook. Supervision mainly involved a verbal presentation of client material but also included going through tapes of some of my client sessions.

A demographic breakdown of the area suggested a socio-economically-diverse population with clients ranging from higher socio-economic groups to those whose families had endured generations of council housing and unemployment. Almost all clients were referred by their General Practitioners (GPs). The most common presenting problems, as defined by the GPs, were depression, anxiety and relationship problems.

Practising mainly within the existential model, I provided one to one therapy for clients. I worked with two clients for the duration of my placement (10 months) and with my other clients I worked within the 12 sessions existential time-limited model with up to 2 review sessions. I was also part of the family therapy team.

I attended weekly team meetings, regular joint psychotherapy and psychology meetings and departmental seminars most of which included case discussions. I presented my research on spirituality and therapy at one of these departmental seminars. I also sat in on assessment sessions and had meetings with a number of clinical and counselling psychologists, specialising in various areas, for example, child and adolescents, eating disorders and neuro-psychology. Some of these meeting involved visiting GPs surgeries and Community Mental Health Teams (CMHT). I found all these experiences invaluable in demonstrating different ways of thinking about and working with clients.
Placement 2 (a): Secondary Care Adult Psychology Clinic

My second placement was in a secondary care, adult psychology clinic in an inner city area. The clinic consisted of a multi-disciplinary team of counsellors, psychotherapists and psychologists who worked in both group and individual settings, using a variety of models, namely cognitive-analytic, psychodynamic and/or cognitive behavioural. Therapists also worked in various modes; for example, art, body and/or drama as well as talking therapies. I received supervision from a psychotherapist who worked mainly within the Cognitive-analytic therapeutic (CAT) model.

The clinic served a multicultural community. A great majority of clients were of lower socio-economic status (for example, poor education, inferior housing and high unemployment). Community Mental Health Teams (CMHTs), GPs and/or psychiatrists referred clients with a variety of what they defined as severe or enduring mental health difficulties, such as depression, anxiety, personality disorders and/or psychosis.

I provided individual therapy mainly within the CAT model, in which clients were offered an average of 16 sessions. The CAT discipline of writing reformulation letters to clients after four sessions helped to develop my case conceptualisation skills. Writing goodbye letters to clients helped focus my attention on the difficult and conflicting feelings that may be raised by endings.

Supervision mainly took the form of role-playing, which was very helpful, as it enabled my supervisor to model a variety of interventions and stances (for example, calm curiosity, challenge). I found role playing the client helpful in enabling me to get more into my clients’ shoes and in enabling me to feel the effects of my supervisor’s interventions and stances. I also had the opportunity to receive a few sessions of supervision from an art therapist. I found these experientially based supervision sessions powerful learning experiences which gave me access to insights into my clients, our relationship and myself which I might otherwise have missed.
**Placement 2 (b): Tertiary care Psychotherapy department**

This placement was in a psychotherapy department within a psychiatric hospital in the suburb of a large city. The department consisted of a team of psychotherapists and psychiatrists who worked mainly within the psychodynamic and/or systemic paradigms. The service offered individual, couple and family therapy to people diagnosed with a variety of severe or enduring mental health difficulties, such as depression, anxiety, personality disorders, obsessive compulsive disorders, alcohol abuse and/or psychosis. The department served a predominantly white community, a great majority of who were of higher socio-economic status. Clients were referred to the service by Community mental health teams (CMHTs), General Practitioners (GPs) or psychiatrists.

In this placement I provided individual longer term psychodynamic therapy and I was also part of the family therapy team. For my individual work, I received both individual and group supervision from two psychotherapists who worked primarily within the psychoanalytic model. For my family therapy work, I received supervision from the family therapy team, which consisted of two systemic family therapists and a consultant psychiatrist. Individual supervision took the form of verbatim reports of sessions, which focussed on the minute by minute process of each session. This helped me focus on the client's intrapsychic reality, the relationship between the client and myself and also helped me to link my practice to psychodynamic theory. Group supervision gave me an opportunity to see how trainees from different disciplines (for example, psychiatry, psychotherapy) worked with their clients. As my supervisor was also group analyst, group supervision also raised my awareness of group dynamics and the possible effects these could have on clients.

The family therapy sessions gave me an opportunity to work with couples and families and provided me with an invaluable opportunity to watch and learn from a variety of therapists at work. Family therapy also enabled me to experience 'live' supervision and feedback on my actual practice. In addition the videotapes of my family therapy sessions enabled me to review my own work in greater detail.
**Placement 3 (a): Primary Care General Practitioners' (GPs') surgery**

This placement was in a primary care general practitioners' (GPs) surgery in an inner city area. The department consisted of 13 GPs, various administration staff, two consultant clinical psychologists and five trainee counselling psychologists. The psychologists worked mainly within the cognitive behavioural and/or systemic paradigms, with both couples and individuals. I received individual integrative supervision from a consultant psychologist and group supervision from another consultant psychologist who worked mainly within the CBT model.

The clinic served a multicultural community with a wide range of socio-economic status (clients range from poorly educated and unemployed to very highly educated and affluent). Clients were referred by their GPs with a variety of difficulties; for example, physical health problems, depression, anxiety, relationship problems, poor self-esteem, alcohol misuse and anger control.

I provided individual short term (6-8 sessions) therapy mainly within the traditional CBT model and the schema focussed approach. The very short term nature of the work in this placement helped me further develop my assessment skills and also helped me become a more active and practical therapist.
Placement 3 (b): Tertiary care specialist service

This placement was a tertiary service in an inner city area, which specialised in treating clients with a diagnosis of Borderline Personality Disorder (BPD). The service was run by a multi-disciplinary team of clinical and counselling psychologists and a community psychiatric nurse. Clients were referred to the service by their CMHT or psychiatrist.

I provided weekly individual therapy, mainly within the Dialectical Behavioural therapy (DBT) approach. This approach involved carrying out a period of contracting and motivational work with each client prior to them entering the therapy. This pre-commitment phase was used to ensure that clients knew what they were signing up to and to increase their commitment to working on the behaviours DBT targets, namely life-threatening behaviours (suicide and self harm), therapy interfering behaviours (for example, non/late session attendance) and quality of life interfering behaviours in that order.

I also co-facilitated a weekly, skills training psycho-educational group which focused on teaching clients emotional regulation, distress tolerance and interpersonal effectiveness skills. The core skill underlying all DBT skills training was what DBT calls “mindfulness” which was based on Buddhist meditative practices.

As most clients were cared for by a multi-disciplinary team, my work also involved liaison with other mental health professionals, mainly psychiatrists and key workers. I attended regular Care Programme Approach (CPA) meetings to assess the needs of my clients and carried out joint risk assessments. In addition, I have carried out joint assessments with my supervisor to assess if clients met the diagnostic criteria for BPD. Assessments involved using the structured clinical interview for DSM-IV Axis II personality disorders (SCID-II questionnaire). I received weekly individual supervision and some team supervision at the weekly case consultation meetings I attended.
**Introduction**

In this paper I attempt to provide an overview of my journey towards becoming a counselling psychologist and of how I engage with the process of integrating theory, research and practice. I also attempt to provide an account of how integration has been influenced and guided by the ethos of counselling psychology, my research, my personal therapy and my experiences of supervision.

**Ethos of counselling psychology**

I was drawn to counselling psychology because of its focus on 'being with' the client in a way that facilitated their personal growth and well-being rather than 'doing something to' the client to cure their pathology (Woolfe, 1996). Also, having explored some of the many different psychological theories in my undergraduate studies the integrative approach of counselling psychology appealed to me. I agreed with the counselling psychology position that a single model approach was limited as no one theory captured the entire complexity of our clients. Instead each theoretical approach seemed to shine a light on different aspect of the human experience (for example, childhood traumas, cognitions, painful emotions, family systems, existential struggles). By taking into account more than one theory counselling psychologists seemed better able to construct a more complex, holistic view of their clients. A multi-model approach also enabled counselling psychologists to be more flexible in selecting and/or tailoring the theories, techniques and relationship styles to best meet the diverse needs of their clients rather than trying to fit all clients into the same model (Clarkson, 1996; Stricker, 1993; Woolfe, 1996).

**Research Based Practice**

While in theory, I agreed that integration based purely on my clients' diverse needs was exemplary, in practice I found many difficulties with this ideal. For one, evidence based practice requires that therapists select well established proven or
effective treatments so that the needs of clients can be met in the most efficient and
effective manner possible (Hooper, 1996; Stricker, 1993; Wampold, 2001). However,
there are enormous difficulties in evaluating the efficacy of therapy and much debate
over the evidence base. For instance, in the evidence base there seems to be a bias
towards short term behavioural and CBT therapies which are seen as more ‘scientific’
as behavioural therapeutic interventions and behavioural client change are more easily
defined and measured (Wampold, 2001). However, some counselling psychologists
argue that narrow, objective, scientific methods cannot capture the subtlety and
complexity of our clients or what happens in the therapeutic encounter and have
moved towards more qualitative research methods (for example, grounded theory and
interpretative phenomenological analysis (IPA)) in an attempt to redress this balance
(Wampold, 2001; Woolfe, 1996).

**Common factor approach to integration**

Despite many conflicts in the current research, one consistent finding is that there are
negligible differences in efficacy between the different therapies (Wampold, 2001).
This finding has contributed to some therapists arguing that the potent ingredients in
therapy are ones that underlie all psychotherapy orientations and that integration
should focus on these common elements (Clarkson, 1996; Hooper, 1996; Lazarus,
1995; Martin, 1997).

**The therapeutic relationship**

Of the common therapeutic elements identified so far it is generally accepted among
therapists from a variety of approaches that the therapeutic relationship is the most
important in creating positive change (Gold, 1993; Linehan, 1993; Wampold, 2001;
Woolfe, 1996). In many perspectives the therapeutic relationship is constructed as
“providing an arena for understanding, reparation, healing or learning” (Clarkson,
1996, p.265). Cottone (1988) states that “we are all born of relationship, nurtured in
relationship, educated in relationships” and maybe also damaged and healed in
relationships. In accordance with these findings my training as a counselling
psychologist put great emphasis on developing a good therapeutic relationship as
characterised by Rogers' (1951) core person centred qualities of empathy, acceptance and genuineness.

Clarkson (1996) identified 5 major kinds of therapeutic relationship and suggested that one way of integrating the different theoretical paradigms is by constructing them as focussing on different types of relationships. Following Clarkson's (1996) guidelines, I conceptualised my practice within the existential model as focussing on the 'real' person to person relationship, my psychodynamic practice as focussing on the transferential-countertransference and reparative/developmentally needed relationship, my CBT practice as focussing mainly on the working alliance and spiritually orientated therapies as focussing on the transpersonal relationship.

**Mindfulness**

My DBT practice (in my last year of training) and my research on spirituality and therapy has led me to also focus on 'mindfulness' which Martin (1997) proposes as another common factor in therapy. I have linked 'mindfulness' with the integration of spiritual techniques into therapy as in the DBT approach a western version of Buddhist meditative practice was used to enhance both clients' and therapists' mindfulness (Linehan, 1993).

Martin (1997, p.291) defines mindfulness as “a state of psychological freedom that occurs when attention remains quiet and limber, without attachment to any particular point of view”. Although there are considerable similarities between Martin's (1997) and Linehan's (1993) definition of mindfulness, Martin (1997) does not seem to relate mindfulness to meditative practice. Instead, Martin (1997) argues that “mindfulness” is one of the core elements in all therapies as all approaches attempt to increase clients' conscious awareness of various aspects of themselves (for example, their automatic thoughts, their patterns in relationships) and in this way enable clients to disengage from their mindless, reactive and compulsive patterns and open up to new possibilities. In other words, all therapies help clients to detach or step back from their habitual patterns and consider alternative ways of behaving, thinking, feeling and relating.
Martin (1997) also suggests that mindfulness can help integrative therapists step back from their habitual ways of practising and scan the landscape of possible therapeutic options and in this way enable therapists to make optimum choices among different orientations. From the therapist’s perspective, mindfulness has been likened to Freud’s (1910) concept of free floating/evenly hovering attention.

**Technical eclecticism**

As well as the common factor approach to integration, different models can be integrated in practice on the level of therapeutic techniques. In other words, therapists can select techniques (for example, the gestalt chair, CBT thought diaries) which they feel may be helpful to their clients without necessarily adopting the theory underlying the technique. However, the difficulty with technical eclecticism is that it could degenerate into haphazard sampling of techniques (Halgin and McEntee, 1993).

**Theoretical integration**

This concern has contributed to therapists largely favouring integration at the theoretical rather than technical level as they argue that it is important in practice to have a consistent and integrated theoretical base (Gold, 1993). However, theoretical integration comes with its own set of difficulties.

Firstly, there are a bewildering number (over 400) of therapeutic approaches and techniques, which have the potential for engendering much confusion in both therapist and client (Halgin and McEntee, 1993; Hooper, 1996; Walder, 1993). Secondly, whereas it can be argued that some of these 400+ approaches are complementary others seem theoretically and clinically incompatible with conflicting explanations on personal distress and how this can be worked with in therapy.

These obstacles have lead some psychologists to state that “integration is often honoured more in rhetoric than in performance” (Stricker, 1993, p.545). However, other therapists have offered ways to ameliorate some of these difficulties. For instance, instead of seeing theories as truth or facts, theories can be understood as stories or metaphors used to help clients make sense of their experiences. Integration
can be conceived of as open, creative and constructive synthesis between apparently opposing theoretical systems; for example, ‘being with’ versus ‘doing to’, acceptance versus change (Clarkson, 1996; Halgin and McEntee, 1993; Hooper, 1996; Linehan, 1993). In the section on my practice I will discuss some of the struggles I had trying to synthesise some apparently conflicting theories and/or stances.

**My research on integrating spirituality into therapy**

As well as the ethos of counselling psychology, my practice has also been influenced by my research on the integration of spirituality and therapy. For example, my research has reinforced, for me, the importance of nurturing my own spiritual life. My daily meditative practice and using meditation to prepare for my clients before each session has helped me become more able to disengage from my own concerns and from my previous clients in order to clear a space in my mind for my next client. In addition, in accord with some of the psychological literature I felt that meditation helped me become more able to get into a particular frame of mind which some literature describes as enhanced feelings of mindfulness (discussed earlier), spaciousness, groundedness, openness and compassion which I felt helped improve the quality of ‘contact’ or ‘presence’ between my clients and myself (Kornfield, 1994; Nanda, 2005; Martin, 1997).

**Personal Therapy**

As well as my research, personal therapy has also contributed to my practice. Throughout my training I have undergone psychoanalytic psychotherapy. My therapy has had a profound effect on my practice. Like most of my supervisors my therapist modelled prioritising effectiveness over sticking rigidly to a particular approach. For example, she has behaved in a very directive CBT manner at some times when insight did not seem to enable me to move forward in areas of my life where I felt stuck.

My feelings about personal therapy have fluctuated over my training. There were times when I found therapy very containing and supportive in helping me untangle my issues from those of my clients and help me identified to what extent shared
difficulties with my clients (for example, the sudden loss of parent in childhood) may be helping or hindering the therapeutic process.

However, there were other times when I have found therapy extremely challenging and distressing, for example, when coming face to face with aspects of myself or my experience which I found frightening, painful or distasteful. These times have reinforced for me the important of a strong therapeutic relationship before confrontation and challenge can occur. My experience of personal therapy has enabled me to be more empathic and accepting of my clients’ ambivalence, defensiveness and resistance towards therapy.

**Supervision**

As I have undertaken the 2nd and 3rd year of my training part time, I have had the opportunity over my 5 years of training to experience various forms of group and individual supervision, involving role playing, art work, verbatim reports of sessions, listening to audio tapes of sessions, watching video tapes of sessions and/or live supervision (as part of the family therapy team).

Supervision has provided a space for me to reflect on my practice. It has helped me make sense of my clients’ difficulties within different theoretical frameworks, discuss the rationale for my interventions, evaluate my effectiveness with clients and identify blocks or resistances in both my clients and myself that may be interfering with the process of therapy.

I found role-play where I played the client particularly useful in enabling me to get into my clients’ shoes and experience the effects of my supervisor’s interventions. Verbatim reporting of sessions, listening to audio tapes and/or watching video tapes of sessions helped me become more aware of the moment by moment process of the therapy session. Live supervision helped me vary my interventions in the heat of the moment.
Most of my supervisors have been very experienced practitioners and even though most seem to describe themselves as working within one model all had been open to different ways of conceptualising clients. My supervisors' flexibility and group supervision within the course has helped me develop the capacity to hold more than one theoretical perspective of my clients. It has also helped me identify areas of compatibility and conflict, strengths and limitations between different theoretical approaches.

**My personal account of integrative practice**

Undertaking my 2nd and 3rd year part time also gave me the opportunity to work within 7 different models. Experience in so many different models raised many problems for me. I have felt at times ambivalent, anxious, confused and overwhelmed by the complexity of trying to personally integrate my varied practice experience. Thinking about integrating the various approaches along the common therapeutic factors of the therapeutic relationship and of mindfulness was one way I was able to construct some structure around my varied experience.

Because of the word limit in this paper I will very briefly describe my experience of working within single models (namely Existential, family therapy, psychodynamic and cognitive behavioural therapy). I will focus on how each model increased my mindfulness/awareness of different aspects of the person and how I attempted to increase the clients mindfulness/awareness of these aspects, the benefits of each model and the difficulties I struggled with. I will focus the bulk of this section on the integrative models I worked with (namely Cognitive Analytic Therapy, Schema Focussed Therapy and Dialectical Behavioural therapy) using vignettes of clinical work with clients to demonstrate integration issues.

**Individual therapeutic models**

**Existential therapy (Year 1)**

In my first placement I adopted an existential approach, which was mainly informed by Strasser and Strasser's (1997) Existential Time-Limited Therapy. Existential
theory conceptualises personal distress as mainly linked to “problems of living” and not by pathology (Dryden, 1995, p. 158). Thus, distress is part of human existence as problems of living (for example, bereavement, relationship/job loss and/or biological changes of middle age) hit everyone sooner or later. These changes in personal circumstances force the individual to put aside their everyday concerns and confront the ‘big’ concerns/“givens” of existence, namely meaninglessness, isolation death and freedom (which brings with it responsibility and anxiety) (Corsini and Wedding, 1989; Yalom, 1980).

Existential therapists focus predominantly on building a ‘real’ person to person relationship with the client within which they attempt to help the client become more mindful/aware of how s/he lives their live in the hope of enabling the client to lead a more authentic and meaningful life. Particular attention is paid to the way clients relate in their intimate (self-to-self), interpersonal (self-to-other), physical (self-to-nature/biology) and spiritual (self-to-ideal) worlds (Strasser and Strasser, 1997).

Thus in practice, I used techniques of reflecting, paraphrasing, mirroring and clarifying to encourage clients to explore their way of being-in-the-world and attempted to help them become more mindful of:

- the imbalances in their world (for example, a client who is “so preoccupied with their interpersonal world … that they do not have time to cultivate their other three worlds” (Strasser and Strasser, 1997))
- the choices they make and how they make these choices (for example, trying to avoid responsibility and anxiety by getting others to make their choices for them).
- their polarised and/or rigid beliefs that restricted their possible choices (for example, having to be completely dependent or completely self-sufficient in relation to others).

The existential model most appealed to me in theory as it focussed on the ‘big’ concerns/questions in life. However, I found it extremely challenging in practice. With time I learned to become more comfortable with exploring the painful ‘givens’
of existence with my clients despite my fear of making them worse. However, I had
difficulties synthesising some clients' and the NHS medical culture's view of anxiety
and depression as illnesses that could be cured and the existential view of using
distress constructively to help patients reconsider how they live their lives within the
limitations of human existence.

**Systemic therapy (Year 1 and 2b)**

In my first and one of my second year placements I also worked as part of the family
therapy team whose practice was mainly informed by the systemic-social construction
model (Napier and Whitaker, 1987; Tomm, 1987a ; 1987b,1988). Within the sytemic
approach, personal distress is seen as mainly related to destructive family dynamics.

In practice, I attempted to take the position of non expert, non knowing and non
pathologising and attempt to create a space where all voices were represented and all
possibilities were explored (Korner,1986; Napier and Whitaker, 1987; Tomm, 1987a ;
1987b,1988). This was done by focussing on the whole family rather than the
'identified patient' and asking mainly questions to enhance family members
mindfulness of:

- their dilemmas (for example, togetherness versus separateness, talking about
  problems versus fear of talking about problems)
- the circular relational patterns and the benefits and costs each party derived
  from these patterns,
- the possible functions of the illness (for example, protect the patient’s spouse’s
  self esteem by giving him the role of caregiver)
- the polarised roles each member of the family took up (for example, the
  depressed one, the happy go lucky one)
- other possible scenarios (for example, what would happen if the patient got
  better or if the children moved out of home)

Family therapy helped me develop more tolerance for multiple perspectives and
positions and develop an appreciation of the complexity of family systems. However,
as the systemic approach was not one of the main models I worked in, it is the model I felt least competent in. My inexperience was mitigated in part by the invaluable and rare opportunity to watch a variety of therapists in actual sessions through a one way mirror and the opportunity to receive live supervision on my work from very experienced therapists.

Psychodynamic therapy (Year 2b)

In one of my second year placements in a psychiatric hospital I adopted a predominantly psychodynamic approach which was mainly informed by self-psychology and object relations developmental theory (Hinshelwood, 1995; Kohut, 1977; Ryle, 1999). Psychodynamic theory hypothesises that personal distress is linked to the patient responding on an unconsciously level to a current event/relationship as if it were the same as an original childhood trauma/relationship.

Using techniques such as empathic mirroring, interpretations and confrontation I attempted to make patients more mindful of:

their early object relationships and/or trauma
the defence mechanisms they used to cope with this
the consequences of these defence mechanism
how these intrapsychic dynamics are replayed in the client's current interpersonal life and in the therapeutic relationship

I felt most comfortable with the psychodynamic approach as it corresponded to my personal therapy. Intensive verbatim supervision was very challenging and invaluable in helping me become more self-reflective about my work. Supervision helped increase my mindfulness of:

the ways I collude with clients to recreate their past in therapy
how I could utilise my subjective experience of the patient (i.e. countertransference) as a source of potential knowledge about the patient. (Supervision and personal therapy helped with trying to judge the extent to which my reactions came from within myself and/or from the client).
the unconscious communication between the client and myself
the extent my interventions may be serving my needs rather than the needs of
the client (for example, containing my anxiety rather than the client's)
the conflicting, unacceptable parts of the client and myself that we both
defended against

*Cognitive Behavioural (Year 3a)*

In one of my third year placements in primary care my practice was mainly informed
by Cognitive Behavioural Therapy (CBT) (Beck, 1995; Greenberger and Padesky,
1995a, 1995b). CBT hypothesises that personal distress is related to faulty learning
and/or thinking. Practicing within the CBT model I tried to build a collaborative
working alliance with the client by attempting to engage their rational, adult part.

I used techniques such as guided discovery, problem solving, cognitive restructuring,
identifying and challenging unhelpful thinking, and psycho-education to help patients
become more mindful of:

- how their thoughts, emotions, behaviours and body sensations were related
- their self-defeating patterns of thinking and behaving
- any skills deficits they may have (for example, social skills, anxiety
  management skills)

I also agreed self-help homework assignments with clients (for example, self-help
literature, thought diaries, activity monitoring and scheduling, experimenting with
new behaviours).

I found the traditional CBT model the most challenging model to work within. I
found it very difficult to switch from the very reflective stance taken in my previous
psychodynamic placement to the more active, agenda based, directive stance of the
CBT model. Also I was afraid that focusing on changing symptoms, behaviours and
cognitions without a deeper understanding of the client's difficulties would feel
superficial and have a distancing effect on the therapeutic relationship.
Despite my misgiving I found that with some of my patients the CBT emphasis on ‘doing’ was extremely helpful. For example, with one client who was extremely agitated at our first session, using relaxation technique seemed to help build her trust in my competence. Also I found that thought diaries enabled some clients to communicate sensitive issues which they found very difficult to talk about face to face (for example, sexual difficulties).

In addition, with one highly emotive client just recording her thoughts was helpful in regulating the client’s emotions as it seemed to help her slow down her thinking and reacting. However, with very intellectual clients I felt that CBT reinforced their defences of using thinking to limit feeling. This may in part explain Padesky’s finding (workshop, 2004) that people with higher IQ do less well in CBT.

**Integrative models**

*Cognitive Analytic Therapy (Year 2a) & Schema Focussed Therapy (Year 3a)*

Because of the limited word count in this paper and because of the considerable similarly between the Cognitive Analytic (CAT) and Schema Focussed (SFT) therapy I will discuss them together and use a vignette from my third year using SFT to illustrate some of the integration issues. My Cognitive Analytic placement in my second year was mainly informed by Ryle (1999) and my Schema Focussed practice in my third year was mainly informed by Young and Klosko (1993, 2003).

Young and Klosko (1993) found that patients who experienced psychodynamic therapy felt accepted and understood by their therapist and received insight into their difficulties but did not know how to change, whereas patients who received CBT felt their therapist was trying to change them without understanding their difficulties. Both CAT and SFT try to counteract these limitations by integrating the psychodynamic and CBT approaches. Ryle (1999) and Young and Klosko (1993, 2003) hope that adding CBT to psychodynamic therapy will assist patients in translating their insight into change or action.
In both models, the therapist and client negotiate an explicit written conceptualisation of the clients difficulties in an attempt to help patients achieve a more rapid awareness/mindfulness of:

- how their past may be contributing to their current problems
- their core pain or schema and how this is triggered in their current life
- how the way they defend against this may be reinforcing their schema/pain
- strategies for breaking out these vicious cycles

Miss L is a 28-year-old woman who I saw while working in a GPs surgery where most patients were offered 6-8 sessions of CBT. Miss L was referred for therapy for what her GP described as a “first severe depressive episode”. Miss L felt she was being “pathetic” and had “no reason to be depressed”. She described her symptoms as a “out of control crying that seemed unstoppable”. Miss L wanted to “get back to normal” and get back to her very busy life, which included a demanding job and an active social life.

As CBT was treatment for choice for depression (Roth and Fonagy, 1996) I started my work with Miss L in the standard CBT format by explaining the model and agreeing with Miss L that she would keep a thought diary recording her thoughts whenever her emotions shifted. I also gave Miss L some self-help literature on depression (Greenberger and Padesky, 1995).

However, while reviewing Miss L’s thought diary in our next session, it became evident that Miss L’s difficulties were relational and long standing. This led me to wonder if a schema focussed approach (SFT) would be more helpful as Young and Klosko (1993) state that traditional Cognitive behavioural therapy (CBT) is not sufficient to change lifelong patterns. However, my dilemma was that SFT was a much longer-term therapy and I had only 6-8 session with Miss L. My supervisor and I agreed that giving Miss L an understanding of her difficulties in relationships with the option of being referred on for further therapy may be more helpful for Miss L than focussing on her immediate “negative automatic thoughts”.

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In my next session with Miss L I attempted to explain the rationale for changing from present focussed therapy to exploring her past by sharing the hypothesis with Miss L that her early experiences may have contributed to her developing a strong belief that “no one wanted to be with her” and this may be triggered by the end of her last relationship but also may be contributing to her difficulties in having a “proper relationship”.

Miss L became distressed as she interpreted this as confirmation that there was something wrong with her. Realising that what was missing from the practical, business like and change focussed CBT stance I had taken with Miss L was how painful it must be for her to believe that there must be something wrong with her, I empathised with Miss L’s distress. Miss L seemed very irritated at this intervention. Halgin and McEntee (1993) talk about the potential jarring effects on clients when therapist shift stances, models or techniques in sessions and this may in part explain Miss L’s response. However, in our work together I noticed that Miss L continually rejected my attempts at emphatic understanding.

An exploration of Miss L’s early experiences revealed that both her mother and father were unavailable to her. Miss L reported that her father worked long hours and her mother was an alcoholic. I hypothesised with Miss L that the unavailability of her parents to comfort her as a child may have taught her to develop a detached protective side which rejected her own feelings of distress as “pathetic” and rejected my and others attempts to offer her comfort. While this strategy was useful in childhood as it enabled her to survive, in her current life it seemed to prevent her from getting comfort and closeness she craved from others and reinforced her schema or belief that “no one wanted to be with her”.

Miss L did not seem to get much relief from our joint conceptualisation of her difficulties. It may be that this formulation and my interventions triggered Miss L other core schema of being defective. It seemed that what Miss L most needed was what Clarkson (1996) describes as the developmentally needed therapeutic relationship to provide her with the corrective emotional experience she lacked as a
child. I felt that even though I had tried at times to provide Miss L with an experience of an empathic soothing parental mode, 6 sessions and 2 review sessions were not enough time for Miss L to internalise this.

However, just talking about her patterns in relationships seemed to shift, in some ways, how Miss L related to others. By the end of therapy, Miss L had to some extent been able to accept comfort from her father, mother and flatmate. Both parents may have been more available to Miss L than they were when she was a child as her father was retired and her mother had got her drinking under some control. Also it seemed Miss L was more able to express her distress openly.

Dialectical Behavioural Therapy (Year 3b)

In my last year of training, my practice was mainly informed by Linehan’s (1993) Dialectical Behavioural Therapy (DBT) which specialises in working with patients diagnosed with Borderline Personality Disorder (BPD). I was very interested in this placement because it seemed in line with my interest in integrating spirituality into therapeutic practice. Linehan (1993) describes DBT as an integration of Eastern (Zen Buddhist) practice with Western (CBT) psychological practice.

As it is common for BPD patients to vacillate between rigidly held yet contradictory points of view (for example, completely self sufficient versus completely helpless) DBT emphasises ‘dialectics’ which Linehan (1993, p.19) describes as a “reconciliation of opposites in continual process of synthesis”.

Linehan (1993) views one of the most challenging dialectic dilemmas for the therapist as the synthesis of “acceptance versus change”. This synthesis is something I had struggled with in my CBT, CAT and SFT placements. Linehan (1993) states that with BPD patients if the therapist uses acceptance orientated tactic of listening and empathetically validating the patients’ experiences and difficulties, patients panic at the prospect that their life will never improve. However if therapists take the opposite change orientated stance, they risk invalidating their patients’ experience. Either stance increases patients’ vulnerability to self-harm.
Thus, the main aim of DBT is to assist patient towards behaviour change (prioritising self destructive behaviour) but at the same time understand and validate the reasons for this behaviour (Linehan, 1993).

A combination of individual and group training sessions are used to attempt to provide patients with a validating environment as well as to help them build emotional coping, distress tolerance and interpersonal skills. The core skill underlying all other skills is mindfulness, which is based on Buddhist meditative practice (Linehan, 1993). Mindfulness is used to help patients increase their ability to experience rather than avoid emotion. It is also used to help patients inhibit impulsive self-destructive mood dependent action. In clinical trials in the US, Linehan (1993) found that patients randomly assigned to DBT had fewer para-suicide episodes and fewer inpatient admissions during therapy than a treatment-as-usual control group.

Miss S is a 20-year-old university student who met the diagnostic criteria for BPD as defined in DSM-IV1, namely:

- a pattern of unstable and intense relationships characterised by alternating between extremes of idealisation and devaluation
- frantic attempts to avoid real or imagined abandonment
- identity disturbance; markedly and persistently unstable self-image or sense of self
- self-damaging impulsiveness in at least two areas (alcohol use and sexual behaviour)
- recurrent suicidal threats, gestures or behaviour or acts of self-harming
- affective instability due to marked reactivity of mood
- chronic feelings of emptiness or boredom
- transient, stress related paranoid ideas or severe dissociative symptoms

Miss S is the youngest of three children and described her mother as always stressed and her father as an alcoholic with a diagnosis of manic depression who singled her out for verbal and physical abuse.

In accordance with the DBT protocol I offered Miss S an initial 4-6 sessions to see if we could work together. This “pre-commitment phase” is used to strengthen the working alliance and ameliorate some of the problems with engaging BPD clients into therapy (Linehan, 1993). In this phase I attempt to orient the patient to the therapy and agree on written treatment goals.

In theory, it seems highly ethical to put aside time to prepare clients for therapy and to enable them to give informed consent before participating in the process of therapy. However, in practice I felt very uncomfortable in the pre-commitment phase with Miss S. This in part may be due to me trying to learn yet another model and my anxiety about working with high-risk clients. However, in part my unease seems related to me experiencing Miss S as desperately trying to please me and me feeling cruel for not offering her therapy straight away. Because of my psychoanalytic personal therapy and because my experience of conceptualising clients within the psychodynamic model in three of my five placements (namely, psychodynamic, CAT and SFT approaches) I conceptualised my subjective experience in terms of the transferential-countertransferential relationship and hypothesised that in the transference I represented Miss S’s father and Miss S was demonstrating how helpless she felt in the face of a cruel, authoritarian figure who had such power over her.

To give Miss S a flavour of our therapy, I attempted to do a behavioural chain analysis of Miss S last self-harming incident. This technique is used to help both the therapist and client become more mindful:

- of the client’s vulnerable factors,
- the internal or external triggering events,
- their unmanageable feelings,
- the self-harming behaviour and both its positive and negative consequences and
other coping strategies.

Miss S described her last self-harming incident as "coming out of nowhere". She remembered laughing in the pub with her friends one minute and the next thing she remembered is being found by one of her fellow students in the toilets having cut her arms. Although in theory I knew that it was a common pattern for BPD clients to oscillate between inhibiting all feeling and being overwhelmed by feelings, in practice I felt disturbed by Miss S’s level of dissociation. I found myself worrying that while she seemed competent and cheerful in our sessions she could walk out and self harm in the next minute.

Again integrating my learning from my psychodynamic placement, my anxiety about Miss S’s unpredictability could be viewed as Miss S unconsciously communicating to me what it was like relating to her unpredictable father. Using my countertransference helped me to validate how disturbed, anxious and helpless Miss S must have felt growing up with a violent and unpredictable father and validate her worries about what I might be like.

In addition, I hypothesised with Miss S that the erratic and extreme responses she received as a child may have taught her that negative emotions were dangerous and contributed to her inhibiting her negative emotions. However, when these emotions got too overwhelming to avoid maybe the only way she could cope with them was by self-harming. BPD clients are difficult to engage in therapy (Linehan, 1993) and I feel that paying attention to my countertransference and the ways Miss S’s past may be recreated in our therapy helped me identify and address potential problems in our therapeutic relationship.

Realising that I was too much on the acceptance end of the continuum, I attempted to balance my validation with some change orientated techniques and offered Miss S an opportunity to try the DBT skill of mindfulness in our sessions as a way of helping her to check in with herself and to learn notice in a non-judgmental way her thoughts, feelings and body sensations. Miss S agreed to try mindfulness exercise in our session and also to practice this at home.
Although mindfulness seemed to help Miss S identify her thoughts more accurately she not surprisingly still had trouble identifying any feelings. The CBT technique of keeping a diary card with a list of ‘typical’ BPD emotions seemed more useful in helping Miss S identify possible emotions. In time we were able to customise the standardised diary card to match Miss S problematic behaviours, thoughts and feelings (for example, suicidal ideation, anxiety, paranoia, guilt, loneliness, depression, anger, self-invalidation/ rumination, difficulties with assertiveness, cutting).

Miss S remained understandably fearful of ‘negative’ emotion. However, she seemed more able to recognise the triggers and signs of an oncoming crisis and ask for help at these times and although her urges to self harm fluctuated she had not self-harmed during our therapy.

*Concluding Remarks*

What stood out for me in my training was that models, which seemed so persuasive and understandable in theory raised such difficult and complex choices and dilemmas in practice. I have particularly struggled to integrate acceptance versus change which seems similar to ‘being with’ versus ‘doing to’ or insight versus action. Finding the middle way or balance between these conflicting stances in practice was a process of constant adjustment being mindful of how my clients were responding to my interventions and also being mindful of how my limitations and the limitations placed on me by the NHS contributed to my ability to flexibly respond to the needs of my clients. My experience has taught me that, even when practising within an integrative model, integration is more of a process that is done continuously rather than product or orientation (Clarkson, 1996; Stricker, 1993).
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INTRODUCTION TO RESEARCH DOSSIER

This dossier consists of a literature review and two pieces of original research. The literature review examines the psychological literature relating to the integration of spirituality into therapy. The second paper explores psychotherapists' accounts of the integration of spirituality into their psychotherapeutic practice. The third paper explores the experience of clients who are in receipt of what they perceive as spiritually integrated therapy.
INTEGRATION OF SPIRITUALITY INTO THERAPY - A REVIEW OF THE LITERATURE

**Summary**

Despite substantial literature on the integration of spirituality into therapy, spirituality is virtually ignored by mainstream therapists. This paper explores possible reasons for this neglect.
**Introduction**

Over the last century many influential psychologists have written widely on spirituality and religion (for example, Allport, 1950; Erikson, 1950; Freud, 1918, 1927; James, 1902; Jung, 1973; Loewenthal, 2000; Maslow, 1970; Miller, 1999a; Shafranske and Malony, 1996; Skinner, 1953). Traditionally, therapists have largely pathologised and distanced themselves from these domains (for example, Freud, 1918, 1927; Skinner, 1953). However, recent literature suggests that contemporary therapists from a range of backgrounds are becoming more interested in the beneficial effects of spirituality and religion and are investigating ways to integrate them into therapy (for example, Clarkson, 2000; Kurtz, 1999; Miller, 1999a; Rowan, 1993; Spooner, 2001; West, 2002; Wulff, 1996).

Nevertheless, despite therapists’ increasing openness to spirituality and the growing psychological literature on the subject, it seems that clients’ spirituality is rarely understood or even asked about in therapy (Butler, 1990; Miller and Thoresen, 1999; Spooner, 2001). Therefore, this review aims to explore the barriers or difficulties that may be impeding the integration of spirituality into therapy. These include; difficulties in defining what ‘spirituality’ is (and isn’t), the ongoing debate about whether spirituality (however defined) should be integrated into therapy at all or whether it refers to a domain that is entirely separate from and incompatible with therapy and the practical ways spirituality can be addressed and incorporated into the process of therapy.

**What is spirituality?**

A significant difficulty with the integration of spirituality into therapy is that the voluminous psychological literature on spirituality and religion, over the last hundred or so years, has conceptualised these domains in a wide variety of ways. Traditionally, the terms ‘spirituality’ and ‘religion’ have often been used interchangeably (for example, Allport, 1950; Erikson, 1950; Freud, 1918, 1927; James, 1902). Recently, however, therapists seem to be increasingly differentiating
between the two (Carroll, 2001; Miller, 1999a; Rowan, 1993; Spooner, 2001; West, 2002).

There seem to be many reasons for this distinction. Firstly, the current sociological literature shows that in Western cultures there is a increasing tendency for people to move away from institutional religion towards a more informal, personal form of spiritual practice (Butler, 1990; Clarkson, 2000; Shafmanske, 1996; West, 2000a). Also, traditionally the psychological literature on religion has mainly focused on Christianity and Judaism and neglected other religions. Therefore, contemporary therapists may be adopting a new language of "spirituality" in an attempt to be inclusive and respectful of all cultural and religious traditions (Loewenthal, 2001; Miller, 1999; Wulff, 1996).

In addition, 'religion' has been increasingly associated with prejudicial attitudes, violence, power, prestige, restricted dogmatic beliefs and narrow political, economic and social agendas. 'Spirituality', on the other hand, invokes synonyms like 'holy', 'numinous', 'divine' and 'sacred'. Thus, it seems that in defining spirituality as distinct from religion therapists may also be attempting to avoid the pejorative connotations of religion whilst still retaining some of its core qualities (Clarkson, 2000; Kurtz, 1999; Miller, 1999; Wulff, 1996).

This paper will also use the term 'spirituality' rather than 'religion' in order to point to a larger construct that may involve organised religion but which is meaningful in its own right. The various definitions of 'spirituality' that have been advanced in writings by therapists and on therapy seem to fall into three major categories: explanatory definitions, descriptive definitions and multidimensional definitions (Miller, 1999a; Wulff, 1996).

**Explanatory definitions of spirituality**

Some explanatory definitions have conceptualised spirituality as neurotic, regressive and a comforting illusion used to defend against the reality of human vulnerability, limitations and helplessness. Moreover, it has been argued that spirituality is a
dangerous illusion for both individuals and society as it prevents problem solving (Ellis, 1980; Freud, 1918, 1927; Rowe, 2001; Yalom, 1980).

Other therapists have challenged this pathologising of spirituality and have instead defined it in more functional terms. These definitions can be located on a continuum. At the most basic level, spirituality has been defined as a coping mechanism in response to stressful, unpredictable and uncontrollable situations (such as ageing, illness, death, evil, persecution, atrocities) (Cole and Pargament, 1999; Frankl, 1973; Golsworthy and Coyle, 2001; Yahne and Miller, 1999). At the other end of the continuum, spirituality has been defined as a way of attaining (under favourable conditions) human excellence by calling forth qualities of reason, compassion, love, wholeness, integrity, goodness, vitality, serenity, confidence, courage, hope, wisdom, creativity and a need to contribute to others (Clarkson, 2000; Duffy, 1998; Elkins et al., 1988; Erickson, 1963; Frankl, 1973; James, 1902; Jung, 1973; Kohut, 1977).

However, a number of therapists argue that the difficulty with the above definitions is that they speak of spirituality as a whole and make sweeping generalisations about it and, as a result, they fail to take into account that spirituality is a “complex and ever changing dynamic that waxes and wanes both within individuals and within cultures” (Shafranske, 1996, p.2). For instance, spirituality can change depending upon individuals’ life events, spiritual practice, biological maturation, emotional and cognitive development and cultural influences (Fowler, 1996; Schultz and Gutheil, 1997; Shafranske, 1996).

Various therapists have attempted to model some aspects of this changing dynamic by incorporating spiritual development into their stages of human development. Some have even delineated the various ways in which spirituality can go awry; for instance, whereas spirituality can offer support for the attainment of qualities like integrity, wisdom, hope and a sense of wholeness, these qualities can be vulnerable to pathological distortions such as self-righteousness, elitism, grandiosity, pride and narcissism (Allport, 1950; Erikson, 1950; Jung, 1973; Kohut, 1977; Wilber, 1979).
However, one difficulty with defining spirituality as a developmental process is that differentiating ‘normal’ development from ‘abnormal’ or ‘pathological’ development is incredibly problematic as spiritual development is a life long process that undergoes repeated revisions and is highly personal (Belzen, 2001; Duffy, 1998; Miller and Thoresen, 1999; Wulff, 1996). Also, ‘normal’ development may involve transient ‘pathological’ stages such as instability, disequilibrium, depression, uncertainty and doubt (Coe, 2000; Fowler, 1996; Nino, 1997). For example, Coe (2000) describes the ‘dark night of the soul’ where periods of depression, emptiness and disconnection precede opening up to higher levels of spiritual awakening.

**Descriptive definitions of spirituality**

Phenomenological therapists have argued that a fundamental difficulty with all explanatory definitions of spirituality is that they secularise spirituality by reducing it to nothing more than the psychological functions it serves; for example, a coping resource or a human urge towards perfection (Clarkson, 2000; Maslow, 1970; Miller and Thoresen, 1999; Spooner, 2000a; West, 2000a). In contrast, some phenomenological therapists have stated that at the heart of what many would call “spiritual” are mystical experiences, as these experiences enable individuals to transcend ordinary sense experience and develop an awareness of the presence of something greater. Therefore, instead of the above explanatory definitions, phenomenological therapists have put forward more descriptive definitions of spirituality such as an altered state of consciousness, enlarged sense of existence or enhanced state of being (Agosian, 1992; Allman, et al., 1992; Argyle and Hills, 2000; Cole and Pargament, 1999; Duffy, 1998; Kurtz, 1999; Maslow, 1970).

However, one difficulty with defining spirituality as mystical experiences is that these experiences vary greatly. They range from mild mystical experiences to dramatic ecstasies like those described by great religious mystics (such as, within Christianity, St Teresa of Avila and St John of the Cross). Another difficulty is that the interpretation of mystical experiences as spiritual requires a particular socialisation (Argyle and Hills, 2000). In addition, even the most careful description risks being misunderstood especially by those who have not had recognisable mystical
experiences themselves. Wulff (1996) even argues that “those who are not spiritual or religious are destined to remain incomprehensive outsiders” (p.66).

Furthermore, certain therapists argue that a key difficulty with definitions that seek spirituality in exotic mystical experiences is that they treat spirituality as an abstracted mode of experience with a life of its own. As a result, these definitions fail to take into account that spirituality pervades the whole of life and as well as sometimes seeing different things, it also involves seeing everything differently (Butler, 1990; Kurtz, 1999; Nino, 1997; Spooner, 2001; Still, 2000).

Instead of mystical experiences, some therapists state that the heart of spirituality is a feeling of interconnectedness with everything in existence - for example, with oneself, others, nature and God or a higher power - as we are not isolated entities but rather a unique part of the whole created order (Clarkson, 2000; Miller and Thoresen, 1999; Thorne, 1998, West 2000). However, Argyle and Hills’ (2000) study of ‘milder’, less dramatic mystical experiences suggests that mystical experiences can open one up to this feeling of interconnectedness. Argyle and Hills (2000) found that ‘ordinary’ mystical experiences contained three factors, which were social (being united with other people), immanent (awareness of the spiritual unity of all things) and transcendent (contact with some higher power outside the self).

A principle difficulty with the above factors is that the divisions between them seems to be blurred in the psychological literature. Some therapists have collapsed Argyle and Hills’ (2000) ‘social’ and ‘immanent’ factors and labelled them as ‘transcendence’, arguing that transcendence does not necessarily involve contact with some otherworldly power. Transcendence may also centre on more earthly aesthetic experiences such as a reflection on the direction and purpose of one’s life, feelings of intimate connection with others, quiet contemplation of nature and/or ‘higher’ values like love, truth and justice (Cole and Pargament, 1999; Miller, 1999a; Miller and Thoresen, 1999; Peck, 1993; Spooner, 2001).

However, this has been hotly debated by theistic therapists who state that there is a spiritual dimension to reality and human nature beyond the material world that we
know through our senses. Moreover, they argue that a fundamental difficulty with definitions of spirituality that deny the existence of this spiritual reality (for example, in the form of an eternal human spirit, God/Allah or a supreme being or universal order) is that they rob spirituality of its essential component (Nino, 1997; Norman, 2001; Rowan, 1993). Theists argue that conceptualising spirituality in material terms is more about human vanity than authentic spirituality as it allows people to interpose their desires in place of divine will and play at God rather than seek God. As a result, spirituality without reference to the divine loses its sense of seriousness, commitment, awe and sacredness (Cole and Pargament, 1999; Norman, 2001).

**Multidimensional definitions of spirituality**

A number of therapists have argued that the diversity of conceptions of spirituality may reflect the fact that the expression of spirituality in today’s pluralistic world, both within and outside organised religion, is a matter of great complexity. In other words, spirituality it is too large and complex a phenomenon to submit to any single, simplistic definition. Instead, these therapists suggest that spirituality be viewed as a multidimensional space with the various definitions reflecting different dimensions of spirituality (Elkins et al., 1988; Gorsuch and Miller, 1999; Nino, 1997; Peck, 1993; West, 2000b).

However, one difficulty with defining spirituality as a multidimensional space is that therapists are still debating over what these dimensions are. Drawing upon the reviews offered by Argyle (2002), Loewenthal (2000) and Miller (1999a), the most commonly proposed spiritual dimensions in the literature are practice / behaviour, experience / emotion, belief / faith, intellectual / cognitive and application (how the first four are applied in daily life). Swinton (2001), on the other hand, suggests three dimensions intrapersonal (quest for inner connectivity), interpersonal (relationships between people) and transcendent (connection to something beyond self and others).

Defining spirituality as a multidimensional space does seem capable of capturing some of the breadth, depth and complexity of spirituality. It also endorses the idea of spirituality as interwoven into all areas of life. However, there are many difficulties
with this approach, which seem to reflect the difficulties with defining spirituality in general. Firstly, each dimension encompasses a wide range of constructs and variables; for example, Fowler (1996) states that the belief/faith dimension consists of personal, cultural, social and perhaps archetypal components. Secondly, a source of confusion in the literature is that spirituality is a common thread running through many other psychological constructs; for example, relationships and meaning in life (Yahne and Miller, 1999). In addition, dimensions cannot be separated into neat categories as they can and do interact with one another (for example, the belief dimension affects behaviour and experiences and vice versa) (Argyle, 2002; Gorsuch and Miller, 1999).

All these difficulties have led some therapists to argue that spirituality is indefinable, intangible, irreducible and infinite, and therefore cannot be caught in a net of categories or pinned down in language (Clarkson, 2000; Len, 2001; Smail, 2000; Still, 2000). It does seem that most attempts to describe spirituality fall into clumsiness and banality with very few writers managing to get across the numinous, rare, sublime, healing qualities of spirituality (some exceptions being provided by Gibran, 1923; Merton, 1974; O’Donohue, 1997). O’Donohue (1997), while agreeing that there will always be some aspects of spirituality that remain mysterious and beyond our grasp, argues that the main difficulty with therapeutic definitions of spirituality is that they use scientific, psychological and/or conventional language for something that can only be expressed in poetic, symbolic, metaphorical and/or mystical language.

**Difficulty choosing which spirituality to integrate into which therapy**

Thus, in reviewing the literature, it seems that one of the biggest impediments to the integration of spirituality into therapy is that therapists are still struggling to find common ground for their understanding of spirituality. Another difficulty is that definitions or theories of spirituality are rarely accepted or rejected on the basis of formal empirical evidence. Instead, the appeal of certain definitions seems to correspond to therapists’ own personal experience of spirituality (Wulff, 1996). Wulff (1996) states that explanatory definitions are posited mainly by non-believers in a spirituality reality who have attempted to explain (or, in most cases, explain away)
spirituality on the basis of psychological, biological, social and cultural constituents. On the other hand, phenomenological therapists (typically believers in a spirituality reality) identify spirituality with its experiential core and have put forward primarily descriptive definitions, which focus on the subjective human experience of spirituality. These therapists argue that explanatory definitions are reductionist and are inherently misleading as they strip spirituality of its subtleties and mysteries.

Another difficulty is that therapists' cultural and historical contexts and their personal and professional agendas have also influenced the definitions of spirituality they have chosen. Traditionally, therapists have attacked spirituality in an attempt to distance themselves from it and sell psychology as a science (Freud, 1918, 1927; Skinner, 1953). Modern therapists have become more interested in spirituality's potential. However, most mainstream therapists, whilst affirming the human urge towards perfection, have tended to disavow, omit, gloss over or reinterpret the transcendent realm. This view may reflect the dominance of the positivistic, materialistic and scientific paradigms of the 19th century. It also reflects the medical, technological model which has been the dominant paradigm in psychology and which has treated human beings as part of a mechanistic, molecular world (Clarke, 2000; Kurtz, 1999; Miller and Thoresen, 1999; Still, 2000; Wulff, 1996). However, a number of contemporary mainstream therapists are becoming more open to the theistic hypothesis1. Typically, these therapists have talked about their personal moments of transcendence and provided more personal descriptions of spirituality (for example, Duffy, 1998; Spooner, 2001; West, 2002).

Therefore, it seems important that therapists are aware of their personal, cultural and professional biases and "of what spirituality means to them, both in positive, negative and indifferent ways" (West, 2002, p.87). Also, considering the diverse cultural and spiritual traditions in our pluralistic society, Wulff (1996) cautions against the use of a simple formula or typology to sum up spirituality. Instead he suggests that therapists regard the diverse conceptualisations of spirituality in the same way as some therapists

1 A theistic viewpoint assumes God or some kind of transcendent organising influence exists and that humans have an eternal spiritual identity.
are beginning to view the 450 (or so) theories of psychotherapy - specifically, that no
type is absolute and that each one shines light on a different aspect of experience.

Thus, in the same ways that counselling psychologists develop an appreciation for
more than one psychotherapeutic model, a number of therapists recommend that
therapists develop the broadest and deepest acquaintance possible with the various
perspectives on spirituality. For example, West (2000b, 2002) recommends therapists
have some working knowledge of the main religions in Britain (namely Islam,
Hinduism, Sikhism, Judaism, Christianity and New Age spirituality) and knowledge
of some psycho-spiritual developmental models (for example, Allport, 1950; Erikson,
1950; Jung, 1973; Kohut, 1977; Wilber, 1979). In this way, therapists can “relativise
the field [of spirituality and religion] for themselves” and use each definition, practice
or model of spirituality to “qualify or contextualise the others” (Wulff, 1996, p.67).

**Why include spirituality in psychotherapy?**

Despite the difficulties with defining spirituality, some therapists argue that there are
compelling reasons to support the integration of spirituality into therapy. These are
that spirituality has the potential to be a significant influence in the mental health of
individuals; spirituality is relevant to and can have a significant influence on the
process of therapy; there is growing public interest in spirituality; and this may partly
account for the research that suggests that there is an increasing incidence of spiritual
experiences and problems. However, there are many difficulties with all these
arguments.

**Spirituality and health**

Over the last 30 years, a large body of research has explored the relationship between
spirituality (mainly within the context of religion) and health. However, this research
has been contradictory and ambiguous. Spirituality and religion have been positively
associated with physical health, longevity, well being, a more secure sense of self,
optimism about the future, less fear about death, existential certainty and more
satisfactory and harmonious relationships. Spirituality and religion have also been
found to be inversely related to suicide, substance abuse, divorce, stress and
depression (Argyle, 2002; Gorsuch, 1994b; Joseph, 1998; King and Bushwick, 1994; Len, 2001; Levin, 1994; Marwick, 1995; Maugans and Wadland, 1991; Miller and Thoresen, 1999; Nino, 1997; Richards et al., 1999). On the other hand, other studies have suggested that spirituality and religion are not invariably beneficial. They have also been associated with various forms of psychopathology; such as guilt, prejudice, anxiety, obsessiveness, authoritarianism, dogmatism, rigidity, dependency and suggestibility (Argyle, 2000; Gartner, 1996; Gartner et al., 1991).

Various explanations have been suggested for these conflicting findings. One possible explanation is that there may be different forms of spirituality or religiosity. Some of the literature has attempted to separate ways of ‘being spiritual’ that are regarded as ‘intrinsic’, ‘authentic’ and ‘desirable’ from ways of being spiritual that are seen as less genuine and less constructive (Allman et al., 1992; Allport, 1950; Argyle, 2000; Gartner et al., 1991). These distinctions do explain some of the inconsistent findings. For example, Batson et al (1993), in their meta analysis of 115 studies, found intrinsic religiosity correlated with lower anxiety, whereas extrinsic religiosity was associated with higher levels of anxiety. However, there is considerable controversy about how therapists differentiate between healthy and harmful spirituality, as this can be as difficult to define as spirituality itself (Bergin, 1980; Gorsuch and Miller, 1999).

Another possible explanation for the ambiguous findings is the wide variety of discrepant ways in which spirituality/religion and health have been assessed. Gartner et al. (1991), in their review of more than 200 studies, found that the ways spirituality/religion and mental health were measured “had a dramatic impact on the pattern of relationships” observed between them (p.202). Studies that linked spirituality to positive health generally used real-life behavioural measures such as church attendance, suicidal behaviours, drug use, alcohol abuse and divorce, while studies linking spirituality and psychopathology almost exclusively employed questionnaires to measure hypothetical, theoretical constructs such as religious/spiritual commitment, self-actualisation, tolerance of ambiguity and flexibility (Gartner et al., 1991).

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2 Extrinsic spirituality is where spirituality is used as a means to an end (e.g. social or personal benefits) whereas intrinsic spirituality is valued for itself.
Gartner et al. (1991) argue that measures of actual behaviour are value neutral and therefore more valid, whereas questionnaires have limited reliability and validity. In the case of mental health, questionnaires are sometimes biased in that they reflect the "non-theistic" orientation of authors, who define mental health in their own image. Thus, health questionnaires may penalise subjects holding spiritual values; for instance, traits such as self-discipline, altruism and humility may be weighted negatively, whereas traits like personal freedom, assertiveness and a high opinion of oneself may be weighted positively (Bergin, 1983; Gartner, 1996; Gartner et al., 1991).

Conversely, Miller and Thoresen (1999) argue that behavioural measures generally have a narrow vision of the nature of spirituality and health, as spirituality and religion cover more than church attendance and health is more than a lack of disease. This has led some therapists to posit an alternative explanation for the confusing results on the relationship between spirituality/religion and health – namely that, while spirituality and religion are protective factors in that they are a restriction to every form of acting out, at the same time spirituality and religion may also limit the development of more autonomous forms of higher personality development (Gartner, 1996).

Carroll (2001) argues that, while the above criticism can be lodged against traditional religion (which is well mapped and calls for obedience to one truth), the same cannot be said for spirituality outside religion (which is uncharted and therefore is about many truths, questions and openness). However, research on non-institutionalised spirituality and health has barely begun (Miller and Thoresen, 1999). This may be due to the difficulties therapists are having in defining spiritual constructs, as we have seen in the previous section. Also, unlike religion, there seems to be no convenient behavioural measure for spirituality. Some therapists have even argued that spirituality by its nature defies material limits and therefore eludes operational definition and measurement (Allman et al., 1992; Gorsuch and Miller, 1999; Kurtz, 1999). In other words, a major difficulty with justifying the integration of spirituality into therapy is that "spiritual experiences exist in a different category than 'proof'" (Kurtz, 1999, p.39).
Nevertheless, even if therapists cannot prove that there is a link between spirituality and health, many have argued that spirituality, in the form of values or beliefs, is already part of therapy as every client and therapist has a stance on spirituality. As well as traditional religiosity and non-traditional spirituality, atheism, agnosticism and secular humanism can also be viewed as forms of spiritual values or beliefs. Moreover, these values or beliefs influence every area of life. For instance, they profoundly affect how clients and therapists perceive and understand the nature of the universe, human beings, mental health, life, suffering, God, ethics and death. Thus, they argue that therapy, like life, cannot help but be immersed in spirituality (Aponte, 1996; Belzen, 200; Bergin, 1981, 1991; Bergin and Jensen, 1990; Bergin et al., 1997; Brodley, 2001; Clarkson, 2000; Gorsuch and Miller, 1999; Kurtz, 1999; Loewenthal, 2000; Lukoff et al., 1998; Nino, 1997; Richards et al., 1999; Schultz and Gutheil, 1997; Shafranske, 1996; Spooner, 2000b; Williams and Irving, 2001; Yahne and Miller, 1999).

In other words, the above therapists question the notion that therapists practise or could ever practise with a degree of neutrality or objectivity, not just in relation to therapy and spirituality but, in any context. Some therapists have even likened therapy to religion and therapists to secular priests, arguing that clients are considered cured when they are converted to the therapist’s way of thinking (Butler, 1990; Clarkson, 2000; Len, 2001; Newnes, 2001; Williams and Irving, 2001). As a result, some therapists argue that the question is not whether to include the consideration of spiritual beliefs in therapy but what form this consideration should take. These therapists call for an acknowledgement of the implicit values (spiritual, cultural and personal) inherent in the provision of psychotherapy and an appreciation of quasi-religious aspects of psychological treatment.

Other therapists go even further and call not just for acknowledgement of the implicit (Western) values of therapy but for a transformation of these values. Eisenberg (1998, p.101) states that most models of therapy have an “isolated view of the self”, which has contributed to our sense of emptiness and meaninglessness and encouraged
"individuals and families to maximise their personal gain and well being [and] ... allowed us to commit acts of terrifying violence on others and nature". In contrast, spiritual values advocate the idea of interdependence and interconnectedness with each other and with nature. Thus, an increasing number of therapists are arguing that it is crucial for our healing and for the survival of our planet that therapists and society as a whole shift away from the contemporary hegemonic Western morality of hedonism, individualism, materialism, competition and greed towards spirituality which encompasses social responsibility, community, compassion, co-operation and altruism (Argyle, 2000; Bergin, 1980; Bergin and Jensen, 1990; Butler, 1990; Clarkson, 2000; Duffy, 1998; Kurtz, 1999; Loewenthal, 2000; Nino, 1997; Thorne, 1998, West 2000b; Williams and Irving, 2001).

However, there are many difficulties with these arguments. Firstly, even though new physics and post modernism have suggested that an objective or value-free scientific approach is untenable and that all ‘truth’ rests upon non empirical, subjective and emotion-laden choices, some mainstream therapists still tend to “ignore, downplay or resist acknowledgement of the role their own belief systems play in their work” (Schultz and Gutheil, 1997, p.131). Secondly, many therapists feel uncomfortable exploring their clients’ spirituality as they feel that this area is risky and sacred and outside the scope of therapy (Bergin and Jensen, 1990; Butler, 1990; Hopkins, 1995; Miller and Thoresen, 1999; Schultz and Gutheil, 1997; Shafraanske, 1996).

Even if therapists did acknowledge the influence that their beliefs and their clients’ beliefs had on therapy, another difficulty is that therapists and clients may have a wide spectrum of beliefs, which may be disavowed, unstated, unacknowledged, unconscious and/or inconsistent (Schultz and Gutheil, 1997). An additional difficulty is that therapists may feel that the integration of spirituality into therapy is beyond their competence level as therapists rarely – if ever – receive education and training in this area (Hopkins, 1995; Miller and Thoresen, 1999; Prest et al., 1999; Schultz and Gutheil, 1997; Shafraanske, 1996).
Despite all these difficulties, some research suggests that therapists may be encouraged to try to bridge the gap between the psychological and spiritual realms by the recent resurgence of public interest in spirituality. This is evidenced by the growing number of best selling books on psycho-spiritual topics (for example, Burton, 1992; Moore, 1994; O’Donohue, 1997; Peck, 1993). Also, numerous surveys in Britain and the USA state that the number of individuals who report that they personally believe in God or some spiritual force is on the increase (Bergin and Jensen, 1990; Duffy, 1998; Greeley, 1992; Miller and Thoresen, 1999; Shafranske, 1996; Woodward, 1994). In addition, there seems to be an explosion of interest in eastern, mystical, esoteric, shamanic and pagan traditions, with a significant increase in people participating in spiritual practices such as meditation, yoga, martial arts, tai chi, special retreats, vision quests and sweat lodges (Clarkson, 2000; Duffy, 1998; Kurtz, 1999; Lewis and Melton, 1992; Lukoff et al., 1998; Spooner, 2000b), although sometimes in the West these practices are stripped of their spiritual elements.

Moreover, clients often say that spirituality is the most important aspect of their lives in that it is central to their meaning, identity and well-being and that they would like their spirituality to be incorporated into the realm of psychotherapy (Butler, 1990; Gorsuch and Miller, 1999; Miller and Thoresen, 1999; Steere, 1997). In addition, many therapists argue that our understanding of what means to be human cannot be contained solely within narrowly defined psychological models. They argue that spirituality is as much a part of human existence as emotionality and mentality and therefore therapists’ understanding of their clients is incomplete without knowing about their spirituality (Butler, 1990; Duffy, 1998; Kurtz, 1999; Newnes, 2001; Schultz and Gutheil, 1997; Spooner, 2001; West, 2000a). Some therapists go even further and argue that therapists’ current ways of understanding their clients in terms of parts of their being (for example, as depression or as a personality disorder) further compound clients’ possible sense of fragmentation and only a holistic understanding of clients can enable them to become whole (and holy) (Miller and Thoresen, 1999; Nino, 1997).
Despite all the above arguments for the inclusion of spirituality within therapy, it seems that the integration of spirituality into therapy still remains the exception rather than the rule (Butler, 1990; Miller and Thoresen, 1999; Spooner, 2001). Some possible explanations for this neglect have been discussed in the previous sections. However, there may also be other reasons why spirituality is overlooked in therapy.

Some research suggests that one of the difficulties with integrating spirituality into therapy is that therapists are generally less interested and less involved in spirituality than their clients (Miller and Thoresen, 1999; Newnes, 2001; Shafranske, 1996). On the other hand, in their survey of psychotherapists, Bergin and Jensen (1991) found that, although some therapists are hostile to organised religion, a sizeable majority are deeply interested in vaguely defined non-institutionalised spirituality. This has led a number of studies to suggest that a major difficulty with integrating spirituality and therapy may be that both therapists and clients are reluctant to reveal their deeply held beliefs within the secular framework of therapeutic practice, for fear that their mental health or competence will be questioned (Bergin and Jensen, 1990; Claxton, 1996; Prest and Keller, 1993; Prest et al., 1999; Schultz and Gutheil, 1997; Sims, 1994). This seems a valid fear considering the long history of pathologising spirituality and religion with therapeutic contexts.

In addition, with the growing diversity of unorthodox and non-western spiritualities in our modern pluralistic society, there seems to be an increasing danger that therapists’ cultural and spiritual bias may lead them to misconstrue uncommon beliefs as pathological. As well as more orthodox beliefs in God and life after death, a number of clients may also believe in spirits, psychic phenomena, parapsychology, past lives, spiritual healing, spiritual helpers, angels and demons, (Argyle, 2000; Brodley, 2001; Clarkson, 2000; Duffy, 1998; Schultz and Gutheil, 1997; Shafranske, 1996; Still, 2000; Thompson, 2001). However, the difficulty for therapists is that there is a paucity of empirical research concerning the spirituality of many ethnic groups (Shafranske, 1996).
Reports of increasing incidence of spiritual experiences and problems

Another reason for attending to spirituality in therapy is that there is some evidence that the growth of public interest in spirituality is mirrored by an increasing incidence of spiritual experiences and problems. For instance, in his review of 15 years of survey research on extra sensory perception, visions, near death, mystical and other unusual experiences, Greeley (1987, p.49) concluded that "What has been 'paranormal' is ... becoming normal in our time".

Since James (1902), therapists and psychologists have been particularly interested in mystical experiences. Various surveys in the UK and the USA report that one-third of the population have had at least one mystical or religious experience (Allman et al., 1992; Argyle, 2000; Hay 1990). The most common triggers for these experiences are music, prayer, nature, distress, meditation and religious ceremony (Argyle and Hills, 2000; Rowan, 1993; Maslow, 1970; Spooner, 2000b).

Some traditional therapists have viewed mystical experiences as clearly pathological (Ellis, 1980; Freud, 1918, 1927). However, an increasing number of therapists are arguing that mystical experiences are powerful psychological events that have the capacity to revolutionise lives. Some even argue that mystical experiences should be a goal for therapy, education and society (Agosian, 1992; Allman et al., 1992; Argyle and Hills, 2000; Clarkson, 2000; Cole and Pargament, 1999; Duffy, 1998; James, 1902; Jung, 1973; Maslow, 1970). Possible positive effects have been described as feelings of profound peace, ecstasy, wonder, awe and gratitude; a sense of coherence and security; non-rational intuitive insights; feelings of being in harmonious relationship with the divine and everything in existence and an opening to the realm of absolute values like love, truth and justice, (Agosian, 1992; Allman, et al., 1992; Argyle and Hills, 2000; Cole and Pargament, 1999; Duffy, 1998; Kurtz, 1999; Maslow, 1970; Peck, 1993; Wulff, 1996).

However, one difficulty with the literature is that there is considerable conceptual variability among researchers concerning mystical experiences (Allman et al., 1992). Also, a problem with trying to integrate mystical experiences into therapy is that they
“come unannounced and unsought and cannot be induced or orchestrated” (Duffy, 1998, p.315). In addition, mystical experiences are mostly fleeting (although the great mystics have had more prolonged experiences) and their benefits are easily lost, romanticised, diluted and/or rejected (Nino, 1997; Spooner, 2001).

A difficulty that has received particular attention from therapists is the difficulty in distinguishing between genuine experiences of self-transcendence and psychosis. The effects of more dramatic mystical experiences (described as spiritual emergencies3) and psychosis may appear to be similar or even identical; for example, euphoria, dissolution of normal boundaries, bewilderment, delusions, loosening of associations, markedly illogical thinking, grossly disorganised behaviour and/or jumbled speech (Allman et al., 1992; Clarke, 2001; Lukoff et al., 1998).

Allman et al. (1992), in their survey of 285 American therapists, found that a significant difficulty when distinguishing between mystical experiences and psychosis was therapists’ limited interpretative frameworks. Allman et al. (1992) found that therapists’ attitudes towards clients reporting mystical experiences were influenced more by their theoretical orientations, whether or not they valued spirituality in their lives and the extent to which they had been exposed to mystical literature and traditions rather than on the client information presented. For instance, some therapists in Allman et al.’s (1992) survey diagnosed clients as possibly psychotic even when told that the “client made several positive life changes as a result of the experience” (p.565). Conversely, other therapists diagnosed clients as non-pathological regardless of how clear the psychotic behaviour and cognitions were. It seems that one way to alleviate this difficulty is for therapists’ to familiarise themselves with the literature specifying criteria to distinguish mystical experiences from psychotic experiences (for example, Clarke, 2001; Lukoff, 1985; Lukoff et al., 1998).

3 “In spiritual emergence ... there is a gradual unfoldment of spiritual potential with minimal disruption in psychological, social and occupational functioning, whereas in spiritual emergency there is a significant, abrupt disruption in psychological, social and occupational functioning”. Meditation, mystical experiences, near-death experiences, etc can bring about both (Lukoff et al., 1998, p. 38).
How to integrate spirituality into practice?

Despite all the difficulties with defining spirituality and the debates on the inclusion of spirituality into therapy, therapists from a range of backgrounds have been investigating how to make room for religion and spirituality in their therapy, including cognitive behavioural (Propst, 1996), psychodynamic (Healey 1993; Northcut, 2000; Randour, 1993; Spero, 1996), existential (Mahrer, 1996) and marriage, family and systemic therapists (Abbott et al., 1990; Adams, 1995; Anderson et al., 1997; Patterson et al., 2000; Prest et al., 1999; Sperry and Giblin, 1996). These investigations have been categorised into two major approaches which have been differentiated according to the degree of implicit and explicit integration of religious and spiritual beliefs, values, themes, practices and resources within therapy (Tan, 1996). However, one difficulty in this area is that there are myriad variations within these implicit and explicit approaches. It is beyond the scope of this paper to review all possible variations of spiritual integration; instead this section will select the variations that best illustrate the range within these approaches.

Implicit approaches

Most implicit approaches to spiritual integration focus predominantly on the spirituality of the therapist – in the form of values, beliefs, practices and attitudes – and the effect these have on the therapeutic process. A number of therapists have put forward a form of implicit spiritual integration which is mainly concerned with creating a particular environment in therapy – one which enables both therapists and their clients to be open to the transcendent dimension and/or a special quality of human relatedness. This has been likened to Rogers’ (1980) way of being with clients or his later concept of ‘presence’ (Rogers, 1985), Buber’s (1970) I-Thou relationship and/or Clarkson’s (2000) transpersonal relationship. These special relationships have been described in a variety of ways; for example, empathic, unconditional, loving, compassionate, authentic, energising, healing, non-objectifying, open, non-judgemental, absorbing, reflective and non-goal-directed (Belzen, 2001; Buber, 1970; Clarkson, 2000; Duffy, 1998; Miller and Thoresen, 1999; Purton, 1998; Rogers, 1980; Spooner, 2001; Still, 2000; Thorne, 1998; Yahne and Miller, 1999).
However, one difficulty is that these relationships are impossible to describe fully (Buber, 1970; Clarkson, 2000; Newnes, 2001; Spooner, 2001). Also, some of the characteristics of these special relationships (for example, love and compassion) are given little or no emphasis in mainstream training and research (Miller and Thoresen, 1999). Another difficulty is that, due to limited resources and long waiting lists, the National Health Service is increasingly favouring short-term therapy with small measurable outcomes and this may conflict with some of the above descriptions (for example, a non-goal-oriented approach) of spiritual therapy (West, 2000b).

Explicit approaches

In contrast to implicit approaches, explicit approaches to integrating spirituality into therapy focus predominantly on the spirituality of the client. These approaches can be placed on a continuum and can involve one or more of the following:

- respecting clients' spiritual diversity
- dealing with spiritually-related themes and issues brought up in therapy (for example, meaning and purpose in life, loss or questioning of faith)
- matching therapists' and clients' religious and spiritual values
- assessment of clients' spirituality
- using spirituality as a resource in therapy to promote psychological coping, healing and/or growth
- integrating spiritual goals into therapy

This section will explore the assessment of spirituality as many therapists argue that, as a minimum, therapists need at least a basic understanding of their clients' spirituality. This section will also investigate the use of spirituality both as a therapeutic resource and as a therapeutic goal as these are more ambitious forms of integration and also more problematic.

Assessment of Spirituality

There is a large literature on the assessment of spirituality and religiosity. A number of therapists advocate the inclusion of spirituality into client assessments as they argue
that spirituality is as important as other areas (for example, family history, social support or stress). Also, asking about clients' spirituality can show respect for their spirituality, may identify spirituality as a potential coping resource, can indicate to clients that spirituality is a subject that is 'allowed' in therapy and enables therapists to determine with their clients whether spirituality will have an overt role in treatment. Assessment can include clients' ideas about the meaning of their life, their religious or spiritual background, family beliefs, pivotal spiritual events (in terms of persons, places, experiences or ideas), current practices (such as prayer, meditation, rituals), the nature of their spiritual communities, how they make sense of what has happened to them, images of and relationship to transcendence, God, higher entities or powers and/or ways they think their spirituality might help them with their problems (Belzen, 2001; Clarkson, 2000; Cole and Pargament, 1999; Gorsuch and Miller, 1999; Hall and Hall, 1997; Hodge, 2000; Miller and Thoresen, 1999; Nino, 1997; Northcut, 2000; Richards et al., 1999; Schultz and Gutheil, 1997; Sims, 1994; Sperry and Giblin, 1996; West, 2000b).

Assessments can be in the form of questionnaires (for example, Hall and Edwards' (1996) Spiritual Assessment Inventory or Malony's (1988) Religious Status Interview); graphic representations (for example, spiritual genograms and timelines which have the advantage of depicting a long-term perspective (Hodge, 2000; Northcut, 2000)); and/or clinical interviews. Hall and Hall (1997) recommend that therapists also use these tools to assess their own attitudes, beliefs and personal biases about spirituality.

However, a difficulty with spiritual assessment is that clients' and therapists' spirituality may be informal, unreflected, unconscious and different from that which they readily disclose (Fowler, 1996; Gorsuch and Miller, 1999; Kurtz, 1999; Schultz and Gutheil, 1997). Also, as discussed earlier, there are diverse forms of spirituality and therapists can have difficulty differentiating between spirituality that enhances mental health and that which impedes or undermines it.
Spirituality as a resource in the psychotherapeutic task

Nevertheless, there is some empirical evidence that spirituality may promote physical and psychological healing and adjustment and that incorporating spirituality into secular treatments can improve outcomes for spiritually-oriented clients. Some research has focused on specific client groups (for example, those that were bereaved, elderly, terminally ill or had suffered violence) and have suggested that the integration of spirituality into therapy may be especially helpful with these clients as spirituality may instil a sense of meaning, strength, freedom, coherence and/or courage in the face of uncontrollable, unmanageable or otherwise difficult situations (Golsworthy and Coyle, 2001; Koenig et al., 1996; Ryan, 1998; Shafranske, 1996; Simoni et al., 2002). However, other therapists argue that spirituality is relevant for all client groups as we all face the ultimate loss of control in the form of ageing, illness and the death of loved others and ourselves (Cole and Pargament, 1999; Nino, 1997).

Some of the literature has framed explicit spiritual integration in terms of utilising and even evoking powerful affects associated with spirituality such as faith, hope, serenity, grace, control, acceptance and/or forgiveness. Therapists have argued that these affects can influence the course of therapy and that some of them may even be vital elements in healing (Argyle, 2000; Clarkson, 2000; Cole and Pargament, 1999; Connors et al., 1999; Fowler, 1996; Frankl, 1973; Gorsuch and Miller, 1999; Kurtz, 1999; Miller and Thoresen, 1999; Richards et al., 1999; Ryan, 1998; Sanderson and Linehan, 1999; Shafranske, 1996; West, 2002; Yahne and Miller, 1999). However, one difficulty is that some aspects of these affects may also hinder the treatment process (for example, they could encourage passivity, avoidance, irresponsibility and over-reliance on spiritual systems to the exclusion of other resources). Also, therapists are not clear what conditions determine what outcome (Cole and Pargament, 1999; Miller and Thoresen, 1999; Ryan, 1998; Wulff, 1996).

In order to draw on spiritual resources in the process of healing, some therapists frame explicit spiritual integration in terms of employing practices borrowed from spiritual/religious traditions (such as Christian, eastern and/or shamanic traditions). These include techniques such as prayer, meditation and mindfulness, the use of
scripture and sacred texts, active imagination, visualisation, guided fantasy and dreams (Bergin and Payne, 1991; Butler, 1990; Clarkson, 2000; Hall and Hall, 1997; Kelly, 1994; Kurtz, 1999; Lukoff et al., 1998; Marlatt and Kristeller, 1999; McCullough and Larson, 1999; Miller and Thoresen, 1999; Northcut, 2000; Rowan, 1993; Shapiro, 1992; Sims, 1994; Spooner, 2001; Still, 2000; Tan, 1996; Walsh, 1992; West, 2000b; Wulff, 1996). Prayer and meditation are the most researched of these techniques in both psychological and medical treatments. A growing body of literature suggests that prayer and meditation reduce heart rate, distress, depression and anxiety (Argyle, 2000; Byrd, 1991; Clarkson, 2000; Davies, 1992; Dossey, 1993; Kurtz, 1999; Hall and Hall, 1997; McCullough and Larson, 1999; Nino, 1997; Northcut, 2000; Shapiro, 1992; Sims, 1994 Walsh, 1992; West, 2000b).

However, a difficulty with all these practices is that they are multi-layered and complex; for example, in the case of prayer, McCullough and Larson (1999) found that there are up to 21 different types of prayer some being contemplative, ritual, petitionary, conversational and intercessory. Therefore, a difficulty with using these practices is that therapists may take ones that are alien to their culture, misunderstand them and/or apply them in a superficial manner. Another difficulty is that these techniques can be used in a defensive manner to avoid dealing with the interpersonal process between the therapist and the client, probing client issues in more depth and/or struggling with the complexity of clients’ problems. Therefore, the use of these techniques needs to be informed and handled in a sensitive and aware manner (Shafranske, 1996; Tan 1996).

**Spirituality as a Goal**

On the other hand, therapists who take transcendence as the essential mark of the spiritual argue that ‘spiritual’ affects and/or ready-made practices cannot be used intentionally as a way of helping clients cope with and/or gain relief from difficulties. They state that the divine cannot be controlled or manipulated. Instead, clients and therapists need a degree of sincerity, devotion, attentiveness, patience, trust, faithfulness, commitment, humility, awe, devotion, obedience, respect, surrender and submission to the divine before they can experience the beneficial effects of spirituality (Belzen, 2001; Bergin and Jensen, 1990; Butler, 1990; Cole and

However, the difficulty with this is that many of these themes are directly contrary to much psychological therapy, which values personal control, individual freedom, self fulfilment and self-reliance (Bergin, 1980; Cole and Pargament, 1999; Kurtz, 1999). Therefore, it seems that, to accommodate this version of integration, what is required is a willingness by therapists to think creatively about and, if necessary, expand some fundamental ways in which they conceptualise therapy. From the literature on integration, it seems that it is primarily the spiritual domain that is critically interrogated in order to ensure that it can be fitted into the therapeutic domain. Some therapists are also calling for some concomitant critical interrogation of the therapeutic domain (Argyle, 2000; Bergin, 1980; Bergin and Jensen, 1990; Butler, 1990; Clarkson, 2000; Duffy, 1998; Kurtz, 1999; Loewenthal, 2000; Nino, 1997; Thorne, 1998, West 2000b; Williams and Irving, 2001).

A number of therapists cite the Alcoholic Anonymous (AA) 12-step program as a pragmatic and useful example of explicit integration, which has managed to resolve many of the difficulties of integration that contemporary therapists are wrestling with. These therapists argue that the 12-step program uses common-sense language to bridge the gap between the spiritual domain and the practical difficulties that clients present with. In addition, the 12-step program attends to both psychological and spiritual transformation and it also resolves, to some extent, the quandary between divine intervention and human free will.

The constituent elements of the 12-step program involve giving up control or surrendering to a loosely defined 'higher power'; daily prayer and meditation in order to develop a personal relationship with this 'higher power'; admissions of one's wrongdoing in a way that restores empathy and forgiveness between self and others; and increased self awareness and active problem solving (Butler, 1990; Cole and Pargament, 1999; Gorsuch and Miller, 1999; Shafranske, 1996; Tonigan et al., 1999). In their meta-analysis of the AA literature, Tonigan et al. (1996) found the 12-step
program was associated with reduced addictive behaviours and improved psychosocial functioning but in some cases it was also associated with learned helplessness and poor self-esteem. Further work may need to be done to determine what factors lead to what outcomes.

**Conclusion**

There is a growing body of psychological research that advocates the integration of psychotherapy and spirituality. Some reasons for integration are that spirituality is common and important in our clients' lives and can have a significant effect on their health and well being and on societal integrity. Spirituality may also hold important keys in understanding healing and change within the process of therapy.

However, the integration of spirituality into therapy is fraught with difficulties. A major difficulty is that both psychotherapy and spirituality are complex, diverse and imprecise domains with both benevolent and detrimental effects, which are difficult to distinguish between. Another major difficulty is that spirituality (both clients' and therapists') has long been a taboo in therapists' rooms. Also, therapists' lack of training in this area makes them ill prepared to deal with their clients' spirituality. In addition, therapists' limited cultural, religious and spiritual perspective may lead them to view diverse expressions and experiences of spirituality as indicative of psychopathology or psychosis. Finally, in some areas (such as, divine will, human freedom and human limitation) therapeutic and spiritual insight diverge significantly.

To mitigate these problems, some literature suggests that therapists take a relativistic stance on spirituality by familiarising themselves with the different (and sometimes conflicting) definitions of spirituality, the basic information about the major faiths within their society, various ways of mapping individuals' spiritual development and the literature around spiritual emergence. Therapists also need to develop a deep sense of their own relationship with spirituality and openness to self-criticism and new ideas.
As well as education and training, further research on the major issues emerging in the area of spirituality and the therapeutic process are also required to ensure competent integration of these two domains; for example, there have been few systematic studies on multicultural approaches to integration, the negative effects of spirituality (for example, cults and evil) and why some clients and therapists reach a level of connection with transcendence while others do not and what difference that makes to therapeutic intervention. Thus, although there is a substantial amount of literature on spirituality and therapy, there are still many unanswered questions within this domain.


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ABSTRACT

Traditionally, psychotherapists have often pathologised spirituality and religion and have distanced themselves from this domain. However, there is evidence to suggest that contemporary psychotherapists from a range of theoretical backgrounds are becoming more interested in incorporating spirituality (both their clients' and their own) within their practice. This poses many challenges because of lack of training and because sometimes spiritual and psychotherapeutic discourses diverge significantly. The study that will be described in this presentation aimed to produce an account of practice possibilities in this domain using a 'key informant' approach and to develop a localised theory of the assumptions, meanings and challenges associated with the integration of spirituality and psychotherapy. Interviews were conducted with 10 psychotherapists who described themselves as having a 'deep interest' in spirituality and who reported having at least sometimes integrated spirituality into their practice. Data were subjected to grounded theory analysis and a theory of the integration process was produced. At the heart of this lay five categories which related to discerning the border between spirituality and psychotherapy, seeing psychotherapy as intrinsically spiritual and integrating spirituality at discursive, theoretical and experiential levels. The implications of this study for psychotherapeutic practice and training will be considered.
INTRODUCTION

The voluminous psychological literature on spirituality and religion, over the last hundred or so years, has conceptualised spirituality and religion in a wide variety of ways (Suarez, 2002). Traditionally, the terms 'spirituality' and 'religion' have often been used interchangeably (for example, Allport, 1950; Erikson, 1950; Freud, 1918, 1927; James, 1902). Recently, however, therapists seem to be increasingly differentiating between the two (Miller, 1999; Rowan, 1993; Spooner, 2001; West, 2002). This seems to reflect the current cultural move away from institutional religion towards a more informal, personal form of spiritual practice (Butler, 1990; Clarkson, 2000; Shafranske, 1996; West, 2000a, 2000b) and may be an attempt by therapists to be inclusive and respectful of all cultural and religious traditions (Loewenthal, 2000; Miller, 1999; Wulff, 1996). In addition, adopting the term 'spiritual' may also be an attempt to avoid the pejorative connotations of 'religion' whilst still retaining some of its core 'holy', 'numinous', 'divine' and 'sacred' qualities (Clarkson, 2000; Kurtz, 1999; Miller, 1999; Wulff, 1996). This paper will also use the term 'spirituality' rather than 'religion' in order to point to a larger construct that may involve organised religion but which is meaningful in its own right.

Despite much debate around integration, therapists from a range of backgrounds have been investigating how to accommodate spirituality (and also religion) into their therapy (Suarez, 2002). However, a major difficulty in the area of practice is that there is a confusing and sometimes contradictory range of variations within these approaches. Also, probably because of the complexity of this domain, the trend in the literature has been to focus on a specific aspect of integration - for example, the implicit use of the therapist's spirituality or the explicit use of prayer. This piecemeal way of dealing with spiritual integration seems to leave the 'ordinary' therapist who would like to integrate spirituality and/or religion into their practice unsure about how best to achieve this. Thus, it seems that, despite the voluminous literature on the subject, many contemporary therapists are still grappling with the complexities and difficulties of integrating spirituality into therapeutic practice and an important element that seems absent from the current literature is in-depth, detailed accounts of
how therapists attempt this integration in practice and how they deal with the many choices and challenges involved in the process.

Therefore, as the integration of spirituality into therapy is still at an exploratory stage, investigation into this domain appears ideally suited to an open, qualitative research approach. Of the qualitative methods available, grounded theory – with its aim of generating new localised theorising on topics on which theorising is absent or incomplete – appears most relevant due to the relatively uncharted nature of the research topic and the lack of any theory which might shed light on how the various factors involved in the integration of spirituality and therapy might be related (Charmaz, 2003; Glaser & Strauss, 1967; Henwood & Pidgeon, 1992; Pidgeon, 1996; Pidgeon & Henwood, 1996). Thus, the study presented in this paper uses the principles of grounded theory to analyse qualitative data provided by experienced therapists who have a deep interest in spirituality and who had at least sometimes integrated this into their practice, with the aim capturing and theorising the assumptions, meanings and challenges that enter into the process of integrating spirituality and therapy.

The idea of drawing on experienced therapists fits, at least in part, with Gilchrist’s (1991) notion of ‘key informants’ in ethnographic research. Gilchrist (1991) defines ethnography as learning from rather than studying groups of people and, drawing upon Goetz and LeCompte (1982), she defines key informants as ‘individuals who possess special knowledge, status, or communication skills, who are willing to share their knowledge and skills with the researcher and who have access to perspectives or observations denied the researcher’ (p.75). By adopting a key informant approach in this study, it was hoped that the knowledge and opinions of therapists – who could draw upon their experience of having explored this issue and, at least sometimes, having integrated spirituality into their therapeutic practice – could be harnessed for the benefit of therapists who might be interested in integrating spirituality into their practice but who currently lack any credible ‘road maps’ to guide this process.
METHOD

PARTICIPANTS

Eligibility for participation required therapists who defined themselves as deeply interested in spirituality, who had been involved in therapeutic practice for at least 5 years and who had attempted to integrate spirituality into their therapeutic practice at least sometimes. Participants were recruited through professional contacts of the researcher and her supervisor and through contacting therapists who had written on the integration of spirituality and therapy. Further attempts to recruit participants were made by ‘snowballing’ from therapists who had been contacted though the above channels.

An attempt was made to recruit a heterogeneous sample and capture a diversity of perspectives (for example varied ages, religious orientations, client groups and settings). Ten therapists were eventually interviewed by the researcher at either their home or place of work.

INTERVIEW GUIDE

The interview guide (see Appendix F) was based on the research aims which emerged from issues identified in the researcher’s literature review (Suarez, 2002) outlined earlier. The main content areas of the interview guide were participants’ personal definition of spirituality and their own practice experiences and the processes by which they have sought to achieve the integration of spirituality and therapy.

Two pilot interviews were conducted to assess the suitability of the interview guide. As only minor adjustments were made to the guide, these pilot interviews were included in the study.
PROCEDURE

Ethical approval was obtained from the University of Surrey's Advisory Committee on Ethics (see Appendix A).

The interview began with the completion of the consent form (see Appendix D) which outlined details of confidentiality and the collection of demographic information (see Appendix E) followed by the main interview (see Appendix F for interview guide). Despite the linear format of the interview guide, the participants influenced the flow and direction of the discussion. The guide was used as a checklist to ensure the research aims were met.

Each interview lasted between one and two hours. All interviews were audio taped and transcribed (see Appendix H for sample interview transcript).

ANALYTIC STRATEGY

The data were analysed using grounded theory (Glaser & Strauss, 1967; Henwood & Pidgeon, 1992; Pidgeon, 1996; Pidgeon & Henwood, 1996; Charmaz, 2003). Each transcript was labelled with an interview number and the interview date and was entered into Windmax, a software program for computer-assisted analysis of text-based data. Starting with one transcript, an indexing system was initiated by taking each unit of meaning in turn (that is, a phrase, sentence or longer extract that was seen as constituting a discrete point) and giving this a category name which captured its essence. As this analytic process unfolded, the number of index categories grew, although when data were considered examples of existing categories, they were simply added to those categories (with the category name being altered if necessary to accommodate the new data). As the categories developed, they were constantly compared (Glaser & Strauss, 1967) so that links could be made and recorded which would be vital at a later stage of analysis. At the same time, the researcher created ‘theoretical memos’ to record any changes in category names, any splitting or amalgamation of categories, any thoughts that the researcher had about possible connections with existing literatures or any hunches or reflections concerning the
emerging theory. The analytic process is thus a creative one that both uses the interpretative powers of the researcher but also stays closely grounded in the data.

As the categories developed, the researcher eventually found that no more new examples were being produced that could add more richness or diversity to the category. At this point, the category was said to be saturated. When a final set of saturated categories was produced, a detailed definition of each category was written, which summarised the commonalities between the data extracts that constitute the category. At this point, a diagrammatic representation of the categories was created which included the links between the categories (see Figure 5, Appendix J).

Since such a methodology relies upon the subjective interpretations of the researcher, the traditional methods of evaluating research which concentrate on checking for researcher objectivity and disengagement are inappropriate for assessing this study (Henwood & Pidgeon, 1992). Instead, alternative evaluative criteria have been suggested by qualitative researchers and these include the criterion of persuasiveness by grounding in examples (Elliott, Fischer, & Rennie, 1999). Meeting this criterion involves illustrating the analysis with extracts from the data set so that the reader can evaluate the interpretations in light of the data. Finally, the work as a whole should be transparent so that readers may understand the motives and interpretations of the researcher as well as be able to follow arguments clearly (Yardley, 2000).

**ANALYSIS**

**DEMOGRAPHIC INFORMATION**

Three female and seven male therapists participated in the study. They ranged in age from 34-77 years (mean = 57.1; SD = 13.9).

One participant belonged to the Russian Orthodox Church, two described themselves as Quakers, one did not belong to any religious group, and six described themselves as Anglican Christians or Church of England. Many participants had changed religious
denomination/outlook; for example, from Baptist to Quaker, Atheist to Church of England, none to Russian Orthodox. In addition some participants were very interested in more than one spiritual group and saw themselves as trying to ‘bridge’ the gap between groups; for example, Shamanism and Eastern Christianity, Western and Eastern Christianity. Two participants had switched from explicitly spiritual/religious roles as clerics to therapeutic roles. Two had concurrent therapeutic and spiritual roles.

Participants practised within a variety of models (see Figure 1) and had diverse training (see Figure 2).

Only one participant’s initial therapeutic training included the spiritual dimension. Other participants had developed their practice and understanding of spiritual integration into therapy over many years through research, attending workshops, reading, writing and teaching about spirituality and therapy.

The length of time participants had been a therapist ranged from 6-40 years (mean = 21; SD = 11.6). Most participants had worked in a variety of settings (see Figure 3) and roles (see Figure 4).
Some currently worked in more than one setting; for example, private practice and student counselling. At the time of the interview two participants had recently retired and one was taking a sabbatical to rethink his practice.

PRESENTATION OF FINDINGS

The analysis of the data yielded an extensive diagrammatical representation of all inter-linking categories, which are summarised in Table 1 (see Appendix I). Figure 5 (see Appendix J) suggests how the categories that arose during the analysis might be related to one another. Connecting lines indicated participants' expression, within interviews, that the categories were related in some way. A line with an arrow indicates a reported directional causative relationship; a line with an arrow at either end indicates a mutual causative relationship and a line with no arrows indicates a non-causative association.

Although all categories are reported in Table 1 (see Appendix I) and in Figure 5 (see Appendix J), due to space limitations only the categories most directly related to therapists' current experiences of integration will be discussed in detail in the next section i.e. categories encompassed within the inner circle of 'therapists' experiences of integrating spirituality and therapy'. These categories seem to be five overlapping but distinct forms of participants' experiences of integration, namely, discerning the border between spirituality and therapy, seeing therapy as intrinsically spiritual and integrating spirituality at a discursive, theoretical and experiential level. These central
categories will be elaborated and associations between them will be explained; any overlap between them will be noted.

The categories in the outer circle represent various background categories. Specifically

- the 'contextual factors' participants perceived as having an influence on their experiences of integration i.e. their therapeutic development, therapeutic setting, personal spirituality and surrounding culture
- participants' descriptions of the 'impact of integration' on the therapeutic relationship, their client and themselves
- participants conceptions of 'ideal integration' which, in the main, they described in terms of the pitfalls of integration and the possible ways to mitigate these pitfalls

Some of these background categories will be discussed when they seem particularly relevant to the central categories.

In the quotations from the data set, empty square brackets are used to indicate where material has been omitted; material within square brackets is clarificatory; and ellipsis points indicate a pause in participants' speech. Pseudonyms indicate the various sources of the quotations.

**BORDER BETWEEN SPIRITUALITY AND THERAPY**

The elaboration of the central themes within Figure 5 (see Appendix J) is initiated with the category the 'border between spirituality and therapy' as participants perceived discerning the border between spirituality and therapy as a core process in integration. In other words, this category is strongly associated with the four other categories within the inner circle of 'therapists' experiences of integrating spirituality and therapy'.

**OVERLAP/SHARED TERRITORY**
Most participants talked about the many different types of spirituality and many different types of therapy. Although they could imagine some models of therapy (which they described as scientific, medical, symptom focused and/or manipulative) and some forms of religion/spirituality (which they depicted as institutionalised, judgmental, evangelical, 'nailed down' and/or rigid) where spirituality and therapy could be seen as totally separate, most participants felt that their version of spirituality (which they variously represented as flexible, open, broad, non orthodox, nebulous, non-judgmental, loving God and/or humanistic) and their model of therapy (which they described as flexible, open, broad, insight orientated and/or relationship focussed) overlapped:

"there is an overlap... or there is shared territory" (Paul)

Despite this overlap, it seemed that most participants were also saying that there was a border beyond which therapy should not go.

**DEFINITE BORDER**

In some cases, participants had a very clear idea about where this border was. For instance, some participants who were or had been part of the clergy stated that even though their spirituality was alive in their therapeutic practice in an implicit way, their explicit practice as therapists and as priests was very different:

I would use other resources as a chaplain, I would pray with people for example [] or I refer them to passages from the Bible which I thought might be helpful for them [] ... which I wouldn't as an analyst. (Michael)

**VAGUE BORDER**

In contrast, other participants felt that:

where therapy ended and spirituality began was a bit vague (Paul)
These participants described the integration of spirituality and therapy involving ongoing monitoring of their practice, both with themselves and their clients, to check that they had not slipped into the ‘pitfall’ of going too far into the spiritual territory. A few participants talked about, at times, feeling close to the edge between therapy and spirituality and fearing that this may not be ‘acceptable’ to mainstream psychology, which to some extent still regards spirituality as a taboo. For instance, Paul describes:

An experience of going into a very deep meditative place with [a client] in the session [] It's like we knew what we were doing was a bit different from what therapy could be like... maybe even what therapy should be like. (Paul)

Other participants expressed the opposite fear - that some forms of integration of spirituality and therapy may slide into the ‘pitfall’ of not going far enough into the spiritual territory and that spirituality may be integrated into therapy in a “weak” form without “commitment”, “dedication”, “seriousness” and “responsibility” (Matthew):

The way [explicit integration] is being done now, I think, is relatively weak. [] So, I am not saying that I am sceptical of the aspiration but I think how it is done really matters and I think it has been done too quickly and too facilely [] The challenge to do it is much more difficult than [therapists] have appreciated. (Matthew)

It seemed that at the heart of participants’ dilemma about going too far or not going far enough lay the difficulty in trying to define with any certainty both the spiritual and the therapeutic domains. Some participants felt that spirituality and therapy were difficult to define because the overlap between them was too strong to be able to split them:

It is difficult to disentangle. It is certainly not ‘this is the therapy and this is the spiritual thing’. (Peter)

Another reason for the difficulty in discerning the border between spirituality and therapy seems to be that some participants felt that the parameters of these categories
shifted depending on their surrounding culture, work contexts, client groups, therapeutic models, spiritual development and/or therapeutic development:

My thinking evolves all the time and I expect it to. [] My psychological theory is only provisional. Similarly my own theological understanding is [] evolving. (Mark)

Some participants talked about experiencing “huge tension and crisis and change and shift” (Paul) within this evolving process which included points where participants “knew what [they] didn't want to do but […] didn't know what [they] wanted to do” (Paul) and/or points where participants “knew what they wanted to do but not how to do it” (Matthew) and even times when participants felt that they “couldn't even put a name to what [they were] doing” (Matthew).

Many participants put part of this struggle and difficulty down to the inadequacy or lack of subtlety of language when talking about the domain of spirituality:

Language is a bit difficult. You get peak experiences that you can't really describe to somebody who hasn't had one. (Andrew)

Also, where spirituality was concerned, some participants argued that there was a danger of losing its essence by trying to reduce what was “holy, mysterious [and] indefinable” (Matthew) to psychological definition/s:

The Spirit [] is also going to be the most easily missed, the most overlooked. As soon as you make definitions, it is gone. (Matthew)

In the case of therapeutic practice, some participants stated that definitions were difficult because:

What [therapists] are conscious of and what they actually do is such a complex thing. (Alice)
The associations between this category and the categories of ‘therapy as intrinsically spiritual’, ‘integration at an experiential level’, ‘integration at a theoretical level’ and ‘integration at a discursive level’ will be addressed within discussion of these categories.

**INTEGRATION AT A THEORETICAL LEVEL**

Some participants talked about the integration of spirituality and therapy in terms of how their psychological and spiritual/theological theories, understandings, discourses and/or frameworks sat in relation to each other. Many participants described this level of integration as taking many years of reflection and ‘working through’, which involved many shifts in their ideas about where the ‘border between spirituality and therapy’ lay.

**FRAMEWORK/Discourse compatible**

Again participants reiterated that there were many different types of spirituality and many different types of therapy and, in some cases, they perceived their particular psychotherapeutic and their particular spiritual discourse as compatible. These participants argued that there were some features/processes in therapy and spirituality that were the similar/the same, even though different terms were applied to them in these different domains. For example participants hypothesised that what was seen as “a word from the Lord” when receiving insights into the clients’ issues/pain could also be interpreted psychologically as “good therapeutic attunement” or “unconscious processes” (Claire). Similarly another participant wondered if:

[This] inner core of meaning which [religious/spiritual people] called ‘God’, which [therapists] call ‘identity’ or ‘core self’ [] may be [] the same thing but using different words to describe it” (Peter)

However, a few participants expressed the concern that, in trying to reconcile their spiritual and psychological discourses, therapists may skate over important differences
between the two discourses. For example talking about "guilt" and "shame" Mark said:

It may mean [ ] quite importantly different things within the different discourses. [ ] You have got to be so careful, you can't just say "oh, it is the same thing". It is just not the same thing and yet there is something pointing in fairly the same direction (Mark)

Nevertheless, despite some differences, many participants argued that their psychological and theological understandings were compatible because both frameworks had similar values, goals and theories about the process of change/transformation. For example, participants saw both their therapeutic and spiritual models as:

- being non-judgmental:

There is a lot in the Bible [ ] about being judgmental. [ ] Various examples of people who were considered to be... [ ] beyond the pale. [ ] What Jesus was doing wasn't judging them [ ] but he was actually reaching out and touching them [ ] which to me is what I do when I am working as a psychotherapist. [ ] Often the people who come to see me are neurotics and borderline. They have already been labelled as outcasts and I try and say I am not going to judge you. (Peter)

- both having the goals of fostering better interpersonal relationships through self-awareness, self-realisation, self-acceptance:

Reflecting on the relationship between the kind of therapy I am involved in and the Bible. [ ] Approximately 50% of the teaching of Jesus [ ] arises from a context [ ] of controversy with the Pharisees [ ] and it seems to me that [ ] the Pharisees are essentially presented as the people who do not have insight, who do not know who they are and what they are doing and their lack of insight distorts and deforms themselves and their relationships and so looked at in that
way, the fundamental element, direction of the spirituality of Jesus, is about self-awareness. This illuminates for me what has become my understanding of spirituality and indeed of therapy. (Michael)

- and both perceiving change/transformation as coming through the individual feeling understood, valued, respected and loved:

  A large number [of clients] feel that they are not much good and, within the therapeutic process, there comes that magic moment when they begin to feel that perhaps after all they are worth something then I think you are well on the road to pretty important developments, transformational at times... which, of course, is akin to certain forms of Christian conversion. (David)

This sub-category also seems to fit into the category ‘therapy as intrinsically spiritual’.

**FRAMEWORK/DISCOURSE COMPLEMENTARY**

In other cases, participant felt that even though their psychological and spiritual frameworks were different, they were complementary as spirituality addressed the areas that their therapeutic orientation did not reach:

Psychology doesn't address really important issues like suffering and the meaning of life and how to behave morally and all those sort of things. For me those sorts of questions are addressed in theological discourse but not really in the psychological discourse. (Mark)

**FRAMEWORK/DISCOURSE CONFLICT**

As well as compatible and/or complementary areas, participants also perceived seeming incompatibilities both between and within their spiritual and theological understandings. Participants talked about particularly wrestling with the concepts like life after death, hell and evil. They felt that life after death conflicted with the idea of the importance of this life and could stumble into the ‘pitfall’ of using spirituality to
escape the struggles and difficulties of this life. In addition, some participants felt that concepts like hell/evil conflicted with the idea of a loving God and being non-judgmental:

I really struggle with the word evil, [] which I am not very comfortable with religiously. [] It doesn't fit with the idea that I have of trying to make sense of people's behaviour. It seems very judgmental. (Peter)

**RESOLUTION OF CONFLICTS WITHIN/BETWEEN SPIRITUAL AND THERAPEUTIC DISCOURSES**

Thus it seemed that participants were saying that both within and between their different versions of spirituality and therapy, there were some compatible and complementary elements but also areas of conflict. Participants had a variety of ways of resolving these conflicts. In some cases, participants described switching between the two discourses:

Sometimes one is working within a very psychological model and you are thinking psychologically [] working as a therapist and it is not necessary to think explicitly about a theological discourse but if it comes up or if there are questions about what I should be doing which aren't simply answered within the psychological discourse then the theological discourse is a sort of a priority. (Mark)

In other cases, it seemed participants dropped incompatible parts of either their psychological or spiritual theories:

The religious idea about evil, I suppose also I rather skate over the whole issue [] and in some ways it may be that I am not very religious at all. I skate over this business about life after death. (Peter)

However, in other cases participants attempted to reconcile what they saw as paradoxical and complex issues like evil vs. being non-judgmental. These participants
talked about how good and evil were woven together in the human heart and how various psychotherapists (for example, Jung’s concept of the ‘shadow’) and religions (for example, Buddhist concept of delusive cravings) had attempted to give an account of how of how good and evil are woven together. However, these participants felt that the ‘cross of Christ’ added a unique dimension to these accounts:

We all have areas of our heart which are given over perhaps potentially to evil. [] One of the ways evil operates [is] one becomes very evil in the very process of opposing evil. That is why it is so difficult. That is why the cross of Christ is such a shock and such a reversal of everything that we expect, because the Cross says 'give good for evil.' [] The good way of heart cannot be independent of the bad way of heart. In a sense the good way has to take on the bad way, in a battle, but the good way also has to suffer the bad way, like a wound that it does not resist or oppose.... This total paradox of taking it on, opposing it, and yet in another way bearing it and suffering it and even paying a cost for it, is the true way of heart in the world. (Matthew)

In some cases participants described clients’ questions/issues as forcing them to face and try and resolve some of these conflicts. Clients’ questions/issues also compelled therapists to look to their theological discourse for areas that their psychological theory left unanswered. Therefore, this category (‘integration at a theoretical level’) was associated with ‘integration at a discursive level’.

THERAPY AS INTRINSICALLY SPIRITUAL

‘Integration at a theoretical level’ was also associated with the category ‘therapy as intrinsically spiritual’ as some participant described having to work at ‘integration at a theoretical level’ for many years before they were able to articulate how their version of spirituality encompassed their version of therapy:

Well I think that the integration is a given. What I have had to do is to develop my understanding of it so that I can talk about it. (Michael)
These participants perceived their therapeutic practice as both a spiritual as well as a psychological journey as both their therapeutic practice and their spirituality had ‘similar values, goals and/or ideas about the process of change’. This sub-category also seems to fit into the category ‘integration at a theoretical level’ and was discussed in detail under that category.

**Therapy as a calling**

In addition, some participants argued that their therapy was intrinsically spiritual, as they perceived their therapeutic practice as a vocational calling. These participants felt that being with marginalised, lonely, bereft and frightened people was responding to the call of Christ:

> It is my job [] to reach out and try and touch these people when they are in this predicament [and the] call to vocation [] is not an easy road to travel, you are saying ‘yes’ to opening yourself up to people's pain [] and [] their pain has to get into you. (Claire)

**The religious roots of therapy**

Many participants hypothesised that not just their version of therapy but that all therapy was intrinsically spiritual. They pointed to therapy’s religious roots and the quasi-religious aspects of psychological treatment; for example, ritualistic elements and faith healing:

> The early therapists probably were priests and there is all this business about Shamanism and I [] am aware that you can use these very powerful... almost like laying on of hands... these are things which are [] part of the mystique of being a therapist. [] It is a very powerful relationship. (Peter)

**Scientific therapeutic models likened to religion**
Even in the case of scientific, medical models of therapy that distanced themselves from religion/spirituality, some participants wondered if these models had more in common with some versions of religion/spirituality than they would like to think. They described the parallels as conflicts between schools, institutionalised power, rigidity/narrowness, therapy and training as a conversion process and faith in a therapeutic model (for more on this see Butler, 1990; Clarkson, 2000; Len, 2001; Newnes, 2001; Williams and Irving, 2001):

[Psychoanalysts] treat their own theory as science but it is in fact a religion, the way they hold their beliefs. [] The researcher from Mars would categorise it as religious, rather than scientific. [] During my training analysis [] you could say that I worshipped my analyst and that I also worshipped Freud. [] (Alice)

INTEGRATION AT A DISCURSIVE LEVEL

Some participants talked about the integration of spirituality into therapy in terms of explicitly discussing clients’ spirituality/religion and/or disclosing their own spirituality/religion.

DISCUSS CLIENTS’ SPIRITUALITY

In the case of the clients’ spirituality, most participants reported being reluctant to raise the subject of spirituality or religion:

I don't bring it up. (Peter)

If clients do introduce the subject, many participants reported struggling with how to best respond to it. Some participants felt that it was up to the client to explicitly raise any issues or questions about their spirituality. However, many participants felt that most clients were uncomfortable and hesitant about talking about spirituality in therapy and only hinted at it. These participants felt that, rather than back off, ignore
it or change the subject, it was the therapists’ job to pick up the clients’ hints and to give the client explicit permission to talk about spirituality:

Me feeling my way round it and picking it up and saying "So what is this about forgiveness?" and that was like giving her permission to speak in that frame, to use that language which is identifiably spiritual... (Paul)

A few participants described going even further and using the clients’ introduction of spirituality into therapy as an opportunity to explore and assess their spirituality:

If people mention a religious practice, like for example students here, a lot of them would be Muslim, I would say "What do you understand by that?" and "Do you have a sense of God?" "When you pray what is that like?". And I would never have done that before but now I just feel that it is important and if they mention that they pray regularly, I don't know what that means to them. So I usually ask them what it means. (Elizabeth)

Even when clients did explicitly raise spiritual issues or difficulties without needing any prompting, therapists struggled with how best to respond to these. Some typical examples of issues raised by clients in therapy were:

- members of religious group (for example, nuns, priests) struggling with the nature of their vocation
- clients’ (usually evangelical) struggle/disillusionment with their religion/religious institution
- forgiveness
- ‘psychotic’ clients’ belief/experience of being possessed by demonic/evil forces
- ‘psychotic’ clients’ fear of going to hell
- search for meaning in life
- dying or bereaved clients’ feeling of being in a spiritual wilderness and disconnected from God
Most participants struggled with how ‘best’ to respond to all these spiritual difficulties. In the case of ‘psychotic’ clients’ experiences/beliefs/fear of devil/evil/hell, participants described feeling uneasy with these concepts. This seems related in part to participants’ theoretical conflicts discussed in ‘integration at a theoretical level’. Most participants reported usually responding to these concerns in a psychological way. However, some participants wondered if, in some cases, dealing only psychologically with these issues may be avoiding the issue and/or may still miss an aspect of the clients’ experience and may also compromise the therapeutic relationship:

People who are psychotic - often religious things are very important they want to talk about that and they want to be taken seriously about that. [] If you don't address those things with them, that compromises the whole therapeutic alliance. (Mark)

A few participants had a very different approach to clients who experienced/believed that they were possessed by evil spirits. These participants described:

[Asking] questions like "What were these spirits like? Did they have a name?" actually starting to get interested in the spirits instead of just dismissing them as some kind of aberration that wasn't worth paying attention to and you know traditionally if you know the name of a spirit you can control it or at least begin to and [] having a sense for other realms, other than the everyday, I think is very valuable. It just allows you to be where the client is rather than being forced to step back and be somewhere else. (Andrew)

In the case of clients who were searching for meaning in life, some participants described this as “challenging” (David):

I spent so much of my existence really wrestling with these issues [] that I have to be extremely careful [] that I don’t provide answers which are mine rather than the clients. (David)
With clients who were disillusioned with religion/religious institutions participants found it particularly difficult if clients rejected all spirituality:

My difficulty was that I wanted to say to him that "not all churches are like that, you don't have to totally reject God because of that experience with that church". [] I didn't but I wonder if that came out anyway in some form. (Elizabeth)

In addition, participants found it difficult when discussing spirituality with clients whose religion/spirituality was very different from theirs; for example, clients whose religion seemed extremely evangelical, limiting, oppressive and/or punishing:

From my religious and spiritual viewpoint [] I just find that ... quite intolerable that [clients] should feel cut-off from their families and unable to communicate with them and feel unloved for the sake of religion and that is hard for me. It is a dilemma that I have to sit with while I am with them. (Elizabeth)

**DILEMMA OF THERAPISTS' DISCLOSURE**

Many participants seem to be saying that at the heart of why they seemed generally unsure, uncomfortable and uneasy with discussing spirituality explicitly with their clients was that they felt they could not discuss the client's spirituality without something about their own spirituality leaking out:

It felt like I couldn't really discuss it with [the client] without telling him a bit about where I was coming from. So I told him [and] it allowed us to discuss some areas of his religious life that was quite helpful to him in a way that felt sort of reasonably honest because you can't avoid having views. You can't really discuss it without disclosing something. It doesn't feel like it. So I thought well it is better to let him know, then he can make his own mind up rather than to pretend that I am neutral, when I wasn't. (Peter)
However, participants also described worrying about falling into the ‘pitfall’ going too far over the ‘border between spirituality and therapy’ and becoming evangelical:

It does feel at times as if it would be nice to find a way of [my spirituality] being a bit more out in the open… not quite sure how I would go about that because it just feels like being evangelical. (Peter)

A few participants felt that some of their difficulty and discomfort with discussing spirituality explicitly was that it conflicted with their role as a secular therapist in a secular institution:

The NHS doesn't want me to sit around and talk about God to my patients. [] So I am limited by the institution. (Claire)

A few participants resolved this dilemma by moving out of their secular work settings into private practice, which they felt enabled them to be “up front” (Paul) with clients about the importance of spirituality to them. These participants described being “up front” as giving them permission to use their spirituality and spiritual language in therapy, putting them in a different space and also giving the client a chance to make an informed choice. Even then it seems that it was unusual for the clients’ spirituality to be an explicit part of the therapeutic process:

It is not quite so much about them wanting to work on their spirituality but when they first make contact with me [] I will say to them that spirituality is important to me. [] I need to be up front with my clients that spirituality is important to me and it is going to be part of what goes on between us. (Paul)

A few participants had this dilemma resolved for them as some of their clients were aware of the therapists’ spirituality either because participants were also clergy or because participants had written widely on the subject of spirituality and therapy. In some cases, clients were suspicious, sceptical and/or fearful of being judged but in other cases clients chose these participants because of they wanted “somebody who
took the spiritual world seriously” (David). Some participants perceived their clients’ awareness as an advantage:

I was saying earlier that there are clearly some disadvantages from having written things, but I think that is probably one advantage, because it gives me a good excuse for getting [spirituality] really out into the daylight rather than letting it be a kind of undertone. (David)

INTEGRATION AT AN EXPERIENTIAL LEVEL

BEING A WAKE/OPEN/CONNECTED TO SPIRITUAL REALITY

Many participants described the integration of spirituality into therapy in experiential terms. For instance, participants described being awake/open/aware/connected to the spiritual realm/reality while in the therapy room with their clients. This spiritual realm/reality was defined in many different ways; for example, ‘communion of Saints’, ‘energy’, ‘God’, ‘the (Holy) Spirit’, ‘loosely defined higher being’, ‘non-everyday realm’ and/or ‘the transpersonal’. These participants described:

[Being] open to the Spirit and [] constantly calling on the Spirit. (Matthew)

Experienc[ing] God or something that I regard as God or [] an intermediary between me and God. (Paul)

Therapists strengthened by their connection to spiritual realm

This connection to the spiritual realm in therapy was described as being mostly in the background. Nevertheless, many participants talked about the ‘impact’ of this connection. They described it as strengthening them in their sessions and enabling them to be more open to their clients’ pain and to “be with those who suffer” (David). More specifically, participants described being connected to the spiritual realm as having a direct effect on their levels of “anxiety”, “hope”, “courage” and “confidence” especially when working with clients where participants reported feeling despair, fear,
powerlessness, helplessness, anxiety and/or worry (for example, sexually abused, suicidal, socially deprived clients and/or clients labelled as 'personality disordered'). For example Matthew stated:

I think my spirituality affected my courage. I remember there were a few clients in particular where I was frightened of them, [] I think [] it is the perception of a person being in such a difficult, hard place that it actually requires such sacrifice, []... even to be with them in that hard place, [] I think I have seen a lot of therapists, including myself, sometimes wanting to funk that. (Matthew)

**Therapists illuminated/directed by the Spirit**

Some participants stated that at times this connection to the spiritual realm/reality had a more dramatic 'impact' on them, which they reported as being illuminated/directed by the Spirit within their therapy sessions. Participants described these moments of illumination/direction as moments of “psychic truth”, “healing”, “clarity”, “understanding”, “insight”, “spiritual intimacy” and/or “connection” with their clients, which were “intuitive” and “empathic” and where participants had revealed to them by the Spirit what was going on in the client’s heart, their core pain and/or what the client needed. For example Claire describes an incident which she perceived as a “word from the Lord”:

The image that came up for me was about her and a baby and it was completely unrelated to what she was talking about and I sort of thought about it for a long time and []... I went ahead and said "what comes up for me [] and then she sort of fell apart a little bit and it was all about an abortion [] and a baby that never was, [] and it was one of those things that just convinced me that if you are having a strong what I would call spiritual sense but equally called a psychological sense [] give it a shot and share it and preface it by saying "This seems to have nothing to do with what you are saying but ..." and the fact that it was such, it really went to the core of what was painful for her and what was hard for her. (Claire)
However, participants felt that it was difficult to separate out what was spiritual and what was psychological in these moments of illumination and that other therapists who were not spiritual might interpret the same phenomena in "normal therapeutic terms"; for example, "good therapeutic attunement" (Claire). Therefore, this category seems associated with both the difficulty discerning the 'border between spirituality and therapy' and 'integration at a theoretical level'.

**ACTIVELY SEEK CONNECTION TO SPIRITUAL REALM/INVITE THE SACRED INTO THERAPY**

Most participants perceived being faithful to their spiritual discipline as connected to how strengthened and illumined they felt by the Spirit. Participants described their various individual and/or communal spiritual disciplines such as prayer, mass, meditation and/or Quaker meetings.

As well as connecting to the spiritual realm through their own spiritual practice, many participants described actively seeking or calling on the spiritual realm for their clients both outside and within their therapy sessions through, prayer, meditation and/or visualisations. Prayer seemed to be the most common way in which participants sought a connection to the spiritual realm for their clients:

> I prayed for all my clients, I prayed for help whenever I saw them, before they came, even in a session, quietly. (Matthew)

However, participants' definitions of prayer varied:

> The notion of prayer [] is something to do with holding in deep attentiveness another human being lovingly in the presence of whatever we believe there might be to be present to. (David)

> Prayer is about stopping and trying to be quiet and empty yourself of your shit basically and then ask and allow for a sense of God within yourself. (Claire)
Only a few participants talked about explicitly helping clients to connect to the spiritual realm, if they felt that was appropriate. These participants described helping some clients to get into a particular “state of mind” (Andrew) while presenting their material:

Most people have got an example of [] some kind of peak experience where they felt they were in touch with something greater than themselves and [I] ask them to get in touch with that again. [] Some extraordinary insights and breakthroughs can happen which are quite remarkable. (Andrew)

OVERVIEW

This research aimed to develop a localised theory that explicated and explained the patterns and processes involved in the integration of spirituality and therapeutic practice by drawing on the knowledge of experienced therapists who were deeply interested in spirituality and who had at least sometimes integrated spirituality and therapy. Arising from the qualitative data at hand were five distinct but not mutually exclusive approaches to integrating spirituality and therapy. A conceptual map of the phenomenon was produced, which highlighted the links participants made between these different approaches. The map also highlighted participants’ views of the conceptual factors that affect their integration, their perceived impact of their integration and their ideas about ideal practice. Due to space limitations only some of these (where participants explicitly linked them to their current practice) were explored.

Within the five approaches to integration, it seemed that there was a myriad of different ways of integrating spirituality and therapy. For example, at the discursive level, integration ranged from only integrating spirituality if clients explicitly “forced” spirituality onto the agenda to assessing clients’ spirituality. This diversity may reflect the complexity of this area and also the variety of different ways of integration. It may also reflect that, despite a century of psychological literature on spirituality/religion, integration between these two domains is still in its infancy. On
the other hand, because of the myriad of different therapies (450 or so) and various types of spirituality, a clear, systematic integration of the two may always be impossible.

Most of the existing literature on integration draws on Tan’s (1996) categorisation of integration into two major approaches which are differentiated according to the degree of implicit and explicit integration of religious and spiritual beliefs, values, themes, practices and resources within therapy. In this study, it seemed therapists were more comfortable with and predominantly favoured the implicit approach to integration (for example, seeing therapy as intrinsically spiritual, experiencing a connection to the Spirit while in their sessions, being non-judgemental).

Therapists’ experiences of explicit integration were mainly described in terms of dealing with the spiritual issues clients raised in therapy and in a few cases in terms of assessing clients’ spirituality. There is a large literature on the assessment of spirituality and religiosity (Suarez, 2002). At a minimum level of explicit integration, a number of therapists advocate the inclusion of spirituality into client assessments as they argue that spirituality is as important as other areas (for example family history, social support or stress). Also, asking about clients’ spirituality can show respect for their spirituality, may identify spirituality as a potential coping resource, can indicate to clients that spirituality is a subject that is ‘allowed’ in therapy and enables therapists to determine with their clients whether spirituality will have an overt role in treatment.

Contrary to this existing literature, in this study it seemed that most therapists were reluctant to be the first to bring up spirituality within therapy. To some extent this reluctance may reflect the sample of therapists interviewed in this study. This reluctance may also be because the explicit approach to integration seemed to bring to the forefront many issues and dilemmas with integration, the main one being the struggle to discern the border between spirituality and therapy (for example, participants were worried about self disclosure and becoming evangelical). It seemed that participants felt that discerning the border between spirituality and therapy could never be negotiated in a simple way. Instead it involved a number of shifts (conscious and unconscious) back and forth within each session and also over many years
depending on participants’ surrounding culture, work contexts, client groups/client material, therapeutic models, spiritual development and/or therapeutic development. It seemed that some participants perceived the integration (and especially explicit integration) of spirituality and therapy as an ongoing process of trying to tread a fine line between the opposite pitfalls of going too far or not going far enough into the spiritual territory.

It seemed that in this study the process of analysing and reporting on participants’ experiences was in some ways similar to some participants’ accounts of integration in that it was like trying to tread the very fine line between opposite pitfalls. On the one hand, this study attempted to find a clear, systematic way of integrating spirituality and therapy. However in going for clarity, the danger was that this and other research on integration would produce a theory or account of integration that would have all the spirituality stripped out of it. As one of my participants put it:

The Spirit [] is also going to be the most easily missed, the most overlooked. As soon as you make definitions it is gone. As soon as you try to box it in... If you make mystical [] symbolic definitions that is a different matter. If you make respectful, loving definitions then you can actually state something about the Spirit. (Matthew)

On the other hand, there is the danger that mystical, symbolic, respectful and loving theory of how participants integrated spirituality and therapy would become “airy fairy” as another participant (Claire) described it. In this study, it was difficult to find the balance between the opposite pitfalls of being too prescriptive and stripping the spirituality out of the theory or being “airy fairy”. Also, because of the very limited word count it was difficult do justice to the richness of data generated from the participants.

Nevertheless, despite all these difficulties, with modelling the integration of spirituality and therapy, these findings do provide some guidelines for both training and therapeutic practice, which in the main continues to neglect spirituality despite the literature that suggests a rapprochement between the domains of spirituality and
therapy. The major value of this research was the rich data produced by the participants who all met the criteria for 'key informants' i.e. they were highly articulate, had the ability to reflect and were experts by virtue of their long standing experience in the integration of therapy and spirituality, not only in practice but also in teaching, writing and research on this phenomenon. However, this study provides an incomplete picture due to the under-representation of omission of certain perspectives. For example, despite attempts to select participants from various religious groups, most participants were white and were or had been brought up Christian and therefore, in the main, described their experiences of integration from a Christian perspective.

Further research may be needed to investigate how therapists from other religious/spiritual/ethnic backgrounds (for example, Muslim, Buddhist, etc) attempt the integration of spirituality and therapy. Another missing perspective is that of clients. Future research could interview therapist-client pairs in order to elicit similarities and differences in perspectives. Therefore, this study is a useful step in understanding how therapists integrate spirituality into practice and this theory could be harnessed for the benefit of therapists who might be interested in integrating spirituality into their practice but who currently lack any credible 'road maps' to guide this process. However, in order to get a more complete picture of this phenomenon it is necessary for researches to build up an increasingly comprehensive picture of spiritual integration through a series of complementary studies with each extending the insights gained from previous work.
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24 January 2003

Ms Valerie Suarez  
PsychD Student  
Department of Psychology  
University of Surrey

Dear Ms Suarez

A qualitative exploration of how experienced therapists, who are deeply interested in spirituality, integrate spirituality into their practice (ACE/2002/107/Psych)

I am writing to inform you that the Advisory Committee on Ethics has considered the above protocol and has approved it on the understanding that the Ethical Guidelines for Teaching and Research are observed. For your information, and future reference, these Guidelines can be downloaded from the Committee’s website at http://www.surrey.ac.uk/Surrey/ACE/.

This letter of approval relates only to the study specified in your research protocol (ACE/2002/107/Psych). The Committee should be notified of any changes to the proposal, any adverse reactions, and if the study is terminated earlier than expected, with reasons.

Date of approval by the Advisory Committee on Ethics: 24 January 2003  
Date of expiry of approval by the Advisory Committee on Ethics: 23 January 2008

Please inform me when the research has been completed.

Yours sincerely

Catherine Ashbee (Mrs)  
Secretary, University Advisory Committee on Ethics

cc: Chairman, ACE  
Dr A Coyle, Supervisor, Dept of Psychology
Appendix B - Sample recruitment letter

<Name and address of (potential) participant>

<Date>

Dear <Name of (potential) participant>

A study on the integration of spirituality into therapeutic practice

I am currently studying for a Practitioner Doctorate in Psychotherapeutic and Counselling Psychology at the University of Surrey and as part of my doctorate, I am researching how therapists who define themselves as experienced therapists/counsellors who are deeply interested in spirituality and/or religion (might) integrate these dimensions into their therapeutic practice. The term ‘experienced’ does not only mean therapists/counsellors who have developed a fully worked-out way of dealing with this complex integration process but also therapists/counsellors who have, at least sometimes, integrated spirituality/religion into their therapeutic practice and who are still puzzling over the challenges involved. I would like to invite you to consider taking part in my research, as I believe that you may fit my criteria and may have something valuable to contribute to my research.

While the integration of spirituality/religion into therapy is attracting increasing attention, what seems to be missing from the literature is how integration might work in practice. It is hoped that by drawing on accounts from experienced therapists/counsellors, this study will produce a detailed account of possibilities for ‘best practice’ in this domain. This could then be used to inform practice among therapists/counsellors who would like to integrate spirituality and/or religion into their work but who are currently unsure about how they might achieve this.

If you volunteer to participate, you will be asked to take part in a one-to-one interview with me, focusing on your ideas about and experiences of integrating spirituality into
therapy. This will include some questions about your personal spirituality. These interviews will last approximately one hour and will take place at a time and location that is convenient for you. Each interview will be audio taped and subsequently transcribed. All personal details will be treated in the strictest confidence in accordance with the Data Protection Act (1998): no individual person or organisation will be identifiable in the final research report. When your interview has been transcribed, I will send you a copy of the transcript before the analysis begins so that you can check, amend or elaborate it. You may also decide that you do not wish for your data to be included in the study at this stage. Indeed, if at any time you feel that you no longer wish to participate in the study, you may withdraw without having to explain.

The analysis of the interview transcripts will form the basis of my research report, which I hope to write up for publication. A copy of the final report, which is due for completion in September 2003, will be sent to you. I also hope to use the data for presentations to conferences in appropriate contexts.

If you would like to take part in this research or would like to find out more about it, please contact either myself or my supervisor, Dr Adrian Coyle. We can be contacted via the address above or via the course secretaries on 01482 876 176.

Yours sincerely

Valerie Suarez
Counselling psychologist in training
Appendix C - Information sheet for volunteers

A study on the integration of spirituality into therapeutic practice

➢ My name is Valerie Suarez and I am currently studying for a Practitioner Doctorate in Psychotherapeutic and Counselling Psychology at the University of Surrey. As part of my doctorate, I am researching how therapists who define themselves as experienced therapists/counsellors who are deeply interested in spirituality and/or religion (might) integrate these dimensions into their therapeutic practice. The term ‘experienced’ does not only mean therapists/counsellors who have developed a fully worked-out way of dealing with this complex integration process but also therapists/counsellors who have, at least sometimes, integrated spirituality/religion into their therapeutic practice and who are still puzzling over the challenges involved.

➢ While the integration of spirituality/religion into therapy is attracting increasing attention, what seems to be missing from the literature is how integration might work in practice. It is hoped that by drawing on accounts from experienced therapists/counsellors, this study will produce a detailed account of possibilities for ‘best practice’ in this domain. This could then be used to inform practice among therapists/counsellors who would like to integrate spirituality and/or religion into their work but who are currently unsure about how best to achieve this.

➢ If you volunteer to participate in this research, you will be asked to take part in a one-to-one interview with me, focusing on your ideas about and experiences of integrating spirituality into therapy. This will include some questions about your personal spirituality. These interviews will last approximately one hour and will take place at a time and location that is convenient for you. Each interview will be audio taped and subsequently transcribed. All personal details will be treated in the strictest confidence in accordance with the Data Protection Act (1998): no individual person or organisation will be identifiable in the final research report and information will not be identified with any individual. When your interview
has been transcribed, I will send you a copy of the transcript before the analysis begins so that you can check, amend or elaborate it. You may also decide that you do not wish for your data to be included in the study at this stage. Indeed, if at any time you feel that you no longer wish to participate in the study, you may withdraw without having to explain.

➢ The analysis of the interview transcripts will form the basis of my research report, which I hope to write up for publication. A copy of the final report, which is due for completion in September 2003, will be sent to you. I also hope to use the data for presentations to conferences in appropriate contexts.

➢ If you would like to take part in this research or would like to find out more about it, please contact either myself or my supervisor, Dr Adrian Coyle. We can be contacted via the address above or via the course secretaries on 01482 876 176.
Appendix D - Consent Form

A study on the integration of spirituality into therapeutic practice

I have read and understood the Information sheet provided. I have been given a full explanation by the investigator of the nature, purpose and likely duration of the study and of what I will be expected to do. I have advised about any discomfort and any possible ill effects on my health and well being which may result. I have been given the opportunity to ask questions on all aspects of the study and have understood the advice and information given as a result.

I understand that all personal data relating to volunteers is held and processed in strictest confidence and in accordance with the Data Protection Act (1998). I agree that I will not seek to restrict the use of the results of the study on the understanding that my anonymity is preserved.

I understand that I am free to withdraw from the study at any time without needing to justify my decision and without prejudice.

I confirm that I have read and understood the above and freely consent to participating in this study. I have been given adequate time to consider my participation and agree to comply with the instructions and restrictions of the study.

Name of volunteer (capitals). ..................................................

Signed. ..................................................

Date. ......................................................
Appendix E - Background/demographic Information

<table>
<thead>
<tr>
<th>Interview no.:</th>
<th>Date:</th>
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<tbody>
<tr>
<td>Age:</td>
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<tr>
<td>Gender:</td>
<td>Male/Female</td>
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<tr>
<td>Current marital status:</td>
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<td></td>
<td>Married</td>
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<td></td>
<td>Living together</td>
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<td>Ethnicity:</td>
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<td>Asian</td>
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<tr>
<td></td>
<td>Other</td>
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<tr>
<td>Professional qualifications:</td>
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<tr>
<td>Length of time as a therapist:</td>
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<tr>
<td>Therapeutic model:</td>
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<td>Present employment title:</td>
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<tr>
<td>Work setting:</td>
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<tr>
<td>Have you been brought up within a religious tradition?</td>
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<tr>
<td>If so which one?</td>
<td></td>
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<tr>
<td>Are you a member of a religious or spiritual group?</td>
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<tr>
<td>If so which one?</td>
<td></td>
</tr>
<tr>
<td>What is the significance of spirituality to you in your everyday life?</td>
<td>Very important</td>
</tr>
<tr>
<td></td>
<td>Quite important</td>
</tr>
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<td></td>
<td>Not very important</td>
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<td></td>
<td>Not at all important</td>
</tr>
<tr>
<td>What is the significance of spirituality in your practice?</td>
<td>Very important</td>
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<tr>
<td></td>
<td>Quite important</td>
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<td>Not very important</td>
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<td></td>
<td>Not at all important</td>
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</tbody>
</table>
Appendix F - Interview Guide

Personal spirituality

- How do you define spirituality?
- How do you see your own spirituality?
- How does your spirituality affect your daily life?
- How have you developed your spirituality?
- Can you tell me about your current spiritual practices?
- Have you had any spiritual experiences?

Integration experiences

- What are your views about the advantages and disadvantages of integrating spirituality and/or religion into therapeutic practice?
- Thinking about your own practice experiences (as both therapist and client), can you tell me how you have tried to achieve this integration?
- Can you tell me about any challenges and/or dilemmas that you have faced in integration? (Probe training, therapeutic context, supervision, therapeutic model, client factors, etc)
- What impact do you think integration has on the therapeutic relationship? (probe examples of positive, neutral, negative impacts)
- What impact do you think integration has on the client? (probe examples of positive, neutral, negative impacts)
- How would you decide whether or not to raise/incorporate a spiritual/religious dimension into therapy? (Probe client factors, therapeutic context, model, etc)

Ending the interview

- Those are all the questions I have. Is there anything on the subject you would like to talk about which I haven’t covered?
- Thank you very much for taking part in this 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?
- In what ways do you think that is different from or similar to ‘normal’ therapy?
- How do you make sense of that?
Appendix G - Debriefing Procedure

Each participant will receive the following verbal debriefing.

➢ Participants will be thanked for their time and co-operation.

➢ They will be asked if they would like to hear the interview before it is transcribed.

➢ They will be told that they may withdraw from the study at any time and upon withdrawal, all taped or written material concerning the interviewee will be destroyed.

➢ All tapes will be kept under lock and key and wiped upon transcription.

➢ Transcriptions will be anonymous and all names will be changed to ensure a level of confidentiality.
Interview 10 – 17th May 2003

I – Interviewer
P – Participant
...
(?) – unknown word/s
(assumed word/s?)

..... collect background information.....

I: Can I ask what personal spiritual beliefs you hold?

P: What are the parameters?

I: Yes.

P: I mean I would say I was a Christian, a committed Christian. I worship regularly at S. Is that enough for the moment?

I: Yeah, I think so, it may come up again later. Can I ask what significance spirituality has in your everyday life?

P: Well, I pray every day, I go to morning prayer with the people at the cathedral. But it is kind of part of everything that I do... So it is very important.

I: Can I ask what significance spirituality has in your therapeutic practice?

P: Which is the point of all of this?

I: Yes.

P: Well, it is part of who I am, so it is part of what I offer to clients. It is part of my preparation for seeing clients and then it is part of the actual sessions sometimes... and it is part of my whole philosophy of what my therapy is about and what I am doing. Do you want me to talk more about how I do it?

I: Yes please.

P: Have you read the article, there is a world journal for Person Centred practice which is about presence, they have done some research about presence?

I: No I haven’t. Is that a Rogerian term?
P: Yes, well this article, they have done some research, they are Canadians and they divide presence, therapeutic presence into different sections and the first one is preparation. It would be very interesting for you to read it. I haven’t got it with me but I can email you the reference.

Because I really see that my spirituality is integrated. The first stage of it would be even before I see a client so it would be in my morning prayer, thinking of the people I am seeing that day. Or it would be in terms of, if I am worried about somebody, quite often that is when someone will be most present to me. For example, a student here who is very suicidal for quite a long time. So at that point when I feel like I have no idea whether she is going to live or die and I feel totally like I have done everything that I can but I feel quite powerless. That would be the point when I would draw on that strength and that resource and ... it mirrors what I do with the rest of my life, I would go “I am powerless, helpless” so I just have to have faith that whatever is meant to happen will happen. I guess that is more like religious practice, but then I would be really... someone would be really present for me, but I would have a sense of communicating with God and lifting them up to God. So that is how I would integrate it when I am not with the client. But if I was with that client and I was feeling powerless, quite often that is what I would do as well, I would just say it and be kind of communicating with God at the same time as I am with the person I would be... I don’t know... almost just ... it is a strange thing because I wouldn’t be detaching myself but there is sense of somehow of drawing my self, the self with a capital S out of it and so allowing something else to happen.

I: So can I ask a bit more about what you said about communicating with God?

P: Yes.

I: Could you say a bit more about that?

P: Well, I see it in terms of I will be literately talking to God in my head but it is two way but not in a kind of... I would be verbalising “I don’t know what to do or I am frightened or I am worried or ... I know that this is beyond me” or a kind of “fuck help” but also a kind of visualisation at the same time. I have a visualisation which is of drawing energy which I see as yellow light into me and through my head and out and I actually visualise that it is coming out of my
heart. Very often my heart warms up, so that I can visualise it coming between me and the client. And I will see it as a kind of coming down and through and then out again. So I will have a kind of flow. So that helps me to feel more connected.

I: To both the client and God?

P: Yes and myself, feel more connected to myself. But I don’t know what effect that has, I know what effect it has on me. It grounds me and I feel connected and I feel more able to be there with the clients and as I say I usually draw on that when I am feeling anxious or worried. Having said that, if I feel very powerfully loving towards somebody, I will also feel that but it won’t be that I have kind of asked for that. But I feel that same sense of something quite physical, in terms of that kind of heat of warmth or connection... and I would describe that as spiritual.

The other thing that I do, while I think about it, in terms of practice is... I don’t do it here, I don’t know why, I think it is because of the setting but at home, I will always prepare my room and I have developed this way of... I try to bring in something fresh from the garden so that there is something of nature. And I try to have something of the elements in the room, so some water, and a candle, just a little candle. And in terms of air I will do... and this is something I picked up from a pagan workshop that I was on, which I think for me fits with my Christianity but it is to do with dousing the corners of the room and the north, south, east and west. And just cleansing the room and clearing the room and I find that creates quite a lot of energy. I kind of freshens the whole feeling of the room and I don’t do that here, but I do it at home and that has become quite an important part of my practice. And it is interesting because it is something that I have developed myself from stuff I have read and from that workshop. I will quite often get... I have got rosemary in the garden so I will get a branch of rosemary and dip it in the water and sprinkle water in each corner of the room and the whole round about. At first I felt “my gosh, a priest should do that, this isn’t what I should do as a lay person” and then I thought “well, why should it be a priest? I am a spiritual person” and I don’t see why I have to have holy water or a priest blessing or anything like that.
So that was quite significant for me and I think it has made a difference in terms of energy. I do feel that there is more energy in the room and I feel more energetic. And also after a client goes it changes the energy because something has happened in the room so I guess I would say that was part of my spirituality ... in a kind of more practical sense.

I: You said you only recently started doing that?

P: Yes

I: And the difference you have noticed are that you have more energy?

P: I have more energy, I feel the energy is different in the room

I: Do you notice a difference with the client?

P: It is quite hard to tell that ... um ... yes I think my sense before was that there was a flatness. I am trying to think of a particular client. There have been kind of shifts with clients but I am not sure if that was directly related to that. Although I think because I am more open. I needed to do it for me really but because I am more open it has allowed a different level of connection with the clients. I definitely think that I have become more idiosyncratic. I think that is probably good for my clients that I allow more of myself and I am less restrained. I think I was quite restrained before. So I guess by doing that, that is an idiosyncratic kind of practice, I have more of a feeling of confidence in myself that ... this is me and who I am matters in this relationship. How I am matters in this relationship, I am not a blank screen or an empty chair... Yes, I think it has made a difference to them but they haven’t actually said anything to me.

I: I wonder if you were talking about the relationship because one of my other questions is does it make a difference in the relationship?

P: Well, it definitely does, well as far as I can tell and that’s all I can go by. I feel different and I think there have been shifts in the relationship. But that is very difficult to say because I have shifted quite a lot with a lots of different things. And a part of that is to do with my spirituality, part of that is to do with personal therapy, part of that is to do with other things that are happening in my life. So it is hard to separate out spirituality and say that there is a definite correlation between that. But I think being more open and getting to know myself more
obviously involves my spirituality and it is becoming more important.

I: Your spirituality is?

P: Yes. I mean I have been going to the cathedral every morning for morning prayer for the last 5 years probably. And that is a time of collective prayer, it is kind of the set pattern of prayer that we all say together. But then I also have about 20 minutes on my own in just this kind of silent building with my own thoughts and prayers and feelings. And I think ... I do notice that when I don’t have that, that I feel less ... rooted in a more kind of all over the place...

I think the one thing that has really helped is the exploration of pagan and I guess what people call 'New Age', which I have been very resistant to until now. But I went to a couple of workshops, one with a woman called S, I don’t know if you know her? She is this amazing American, she is a kind of activists, she is a peace activist really. But she is also a witch and she kind of integrates her spirituality and her social action and I found that really helpful because it is integrated. And I sometimes find with the church, I haven’t found it integrated, I found the church service one thing but then the reality of people and what they actually do ...

I: In everyday life?

P: Yes, is another thing. So with her I did find something that was integrated in terms of ... because it was the time in the build up to the war and everything and that really helped me to be... to feel that I could integrate because she was so integrated.

I: And when you say integrated are you talking about her daily life?

P: Yes, and the fact that she went to Israel and stood in front of tanks with the solidarity movement and if there is a demonstration, she will go but she won’t go... I think this was the thing, she won’t go and get aggressive and start shouting and all of that. She will go with her cauldron and she is a regular witch and she will go and do a spell for peace or what I guess the Christian equivalent is, she would go and pray or have a silent vigil or have candles. So she would bring her whole spirituality into that domain.

Because what I found with, for example, the peace demonstrations leading up to
the war with Iraq was they weren’t peaceful. And I found that very difficult to know how to be in that wider context, how to integrate my spirituality because I wanted to have something that reflected… I don’t necessarily see my spirituality as being quiet and calm all the time but I don’t see it as shouting and blowing a whistle. So she is quite a model for me in terms of actually bringing her spirituality into the political arena and being very open about it, which I guess Christian leaders do that too. I just haven’t been around many that would do it in that way.

And then the other person I met was like a William Bloom. I don’t know if you have come across him? He very much talks about energy, that is what helped me to think about energy really, just that we are all made up of energy, everything is energy really. So that when we are in communication there is an energetic component to it. And I think I have always known that but he put it into words and helped me to kind of conceptualise it more and also basically because he is very experienced and he draws together lots of different traditions including Celtic Christianity and the Judaic tradition, what is that?

I: Kabbalah?

P: Kabbalah, yes. I don’t really know but the fact that the energy seems to link all those and I found that really helpful. And for example, I lead the prayers sometimes on a Sunday morning in the Cathedral, so I have to think of that in terms of energy, in terms of calling on energy and aware of people’s energy and trying to bring it together. So I use a lot more visualisations now then I would before and as I said I use it in the Cathedral with the prayers but I would also use it when I am sitting, like I described it with clients.

And I think I do believe that by kind of visualising something, it changes the energy. It doesn’t necessarily make that happen but it does have an impact on what is going on, like I wouldn’t believe that I could stop my client killing herself but I do believe that if I am visualising the kind of …warm, healing energy. I don’t quite know how to describe it, but that that is going to have an impact on her but I wouldn’t do it to heal her but I would do it… I don’t know why I do it… I do it … because I want healing for her really. I want her to find
her path or whatever she needs and so yeah…. So the visualisation would be something I would use much more often now.

I: Earlier you were talking about shifts in the relationship, and I wondered if you could give me some examples?

P: Hmm … I am trying to think … well I can give you an example and I am not sure whether this correlates exactly with when I … because I have always been aware of the spiritual really. So this example, I am not sure if it correlates with me changing my practice in the way that I described, but I have a client who … how does this work with confidentiality?

I: You mean will it be in my report?

P: Yes, I am just thinking in terms of … I mean he would know that I have supervision and that I talk about him but I just don’t know whether it would be… I am just thinking whether if I give you details, he will be identified. I mean I know it is very unlikely because he would never probably read your report but I am just wondering about that. How does that normally work?

I: I think as long as he is not identifiable but if his story is so unique.

P: I don’t think that it is but there are unique elements to it so maybe I just won’t tell you his culture, but that is an important part of it … let’s just say that his culture is non English, non white, non Christian. And the extended family is very important and … their religion is important. Well, he practices his religion in order to be… kind of with his mother, he lives with his mother, so that is part of the set up. And we have been seeing each other for 4 years. We are probably in our 4th year. He is just searching for… he is a very successful person who works in the city, but searching for something, for meaning to his life and wanting to be different. So he spent the first 3 years really wanting from me how to be different. “Can you tell me what I should do to be different, to be more confident, to be more of a man, to be lots of things like that, to be more decisive?” and he was really frustrated and felt that he was going round and round in circles. But then at one point, I am not sure what … how it happened but he said something and I picked up on it. It was something to do with his … his spirituality or he was mentioning that he goes every Sunday with his mother and he does this thing. And I said “well, you know what is your relationship with God?”. And for me that was quite a risky thing to say because he hadn’t
actually talked about his relationship with God, and I don’t like to introduce something that someone isn’t talking about. But on the other hand the joke with him is that he has always wanted me to be more directive and we have had arguments about that. Well, just discussions about where I am coming from, where he is coming from and I felt like I am imposing non-directivity on him and we have just really battled about it. We have quite a combative relationship. He is quite intellectual so quite a lot happens on an intellectual level.

But anyway the point of it is that that question opened up for him a whole other kind of way of thinking because he had never thought about whether he had a relationship with God. So he never thought about his spirituality ... he did this thing but he never thought about how it impacted on him or his life or who he was. But it just changed the relationship just dramatically. Suddenly he wasn’t going round and round in circles anymore and he was just really interested and he described a kind of empty hole inside him. He was able to talk about things in a way which he couldn’t before, he couldn’t name his emotions, he couldn’t get in touch with feelings and it just gave him another dimension and gave us another dimension in our work and what we talked about. Because I say we had developed quite a depth of connection and he is one client that I will be really quite myself with, not in terms of self disclosure but just … I can kind of tease him quite a lot in a way that I would never tease other clients and there is a flirtatious part of our relationship which we have talked about. So there is this kind of lot of discussion about what is actually going on between us at that level. But talking about his spirituality has just opened up a whole... and he feels much more confident. All the things that he wanted are coming and it is really interesting and he feels that things have shifted and he doesn’t quite know how but things have happened in his work life. So it has been quite interesting and it definitely was down to that interaction about God, or his relationship with God, about ... who he is as a spiritual person and about questions... he studied philosophy so I don’t know, but it was almost like he had never integrated it. It was about his integration and I asked him about his prayer life and it is all things that are very difficult, that I wouldn’t normally ask people about.
But I have got bolder about that. If people mention a religious practice, like for example students here, a lot of them would be Muslim, and if they mention that it is important to them, that they are Muslim. I would say "what do you understand by that?" and "do you have a sense of God?" or "what is that about for you?" or "when you pray what is that like?". And I will sometimes ask about whether... because Islamic practice is so physical, whether that is anything... because quite often if someone comes in it is to do with stress. I will ask them if that helps them to relax? Does praying have any impact on how they feel about themselves? And I would never have done that before but now I just feel that it is important and if they mention that they pray regularly, I don't know what that means to them. So I usually ask them what it means.

I: Can I ask what made the difference because you were saying that you wouldn't have asked them before but you do now?

P: I guess it is just my own personal development and growth and awareness and the personal and professional development that I have done in terms of those workshops. And I also do an encounter group every year with B in W during Holy week, that is the week leading up to Easter.

I: And an encounter group is?

P: An encounter group is 20 people together for a week, talking about things that matter to them and encountering each other being in encounter. So it is a concept which came out of Carl Rogers worked a lot in large groups like that. So it comes from that tradition. An encounter obviously being counter to the other and being in relationship. So I have learned quite a lot about myself. And because it is in Holy Week so spirituality is obviously a key part of it. It is kind of an acknowledged part of it. But my training... because I trained in <university> with B and a component of the training is that you look at your spirituality and your experience of ... whatever or however you describe the transcendental. And I chose that course because it had that element in it and I worked with the church for a few years before I became a therapist.

I: Worked for the church in ?

P: In Africa, in the <place>.

I: And was that in a counselling capacity?

P: No, I mean that is how my interest in counselling really began because I was
involved in ... it was time when HIV and Aids were becoming much more
talked about in Africa, I was early 80s or ... no it was early 90s. Because it was
in the 80s we were talking about it here, but in Africa, it was just at the time
when people were realising that it was a really major issue. So I worked with
people in that way and became aware of listening skills and all that stuff. And
then I went to P and worked in P as a teacher. But also did voluntary work with
a HIV organisation and visited people in hospital and worked with people in a
hostel and so that was kind of helping relationships which then meant that when
I came back to England I wanted to train as a counsellor. So I went to
<university> but as I say I chose it because it did openly say, this is an important
element of the training. So I guess this is a long-winded answer to your
question. It has changed but it is probably due to all of that being part of my
development.

I: But there was a time when you felt that you wouldn’t have brought it up?
P: Yes, I wouldn’t have been explicit, I would have said if someone brings it up. If
they want to talk about it, they will talk about it, but I think ...

I: You wouldn’t have explored it with them?
P: Yes, I wouldn’t have. But I think because spirituality ... people don’t often talk
about it. So I want to be able to say, “it is ok, if you want to talk about it” and it
is the same in race in that way, or culture, people often don’t feel it is ok to talk
about. And it also to do with working with this client group, because often I will
only see students for one session, very different from private work where I work
with someone for 4 or 5 years. You know it is like really different. If I am only
going to see someone for one session, there is a kind of urgency that ...
whatever we can talk about whatever they brings and because they are more up
front about things as well. Very often they just say it as it is ... um yeah. I am
just thinking that they are more up front then my other clients, then my more
long-term, private, adult clients, yeah I think they are. And everything is more
immediate.

I: How do you make sense of that, of them being more up front?
P: Well, I make sense of it partly because of their age and they haven’t learned to
hide it, although a lot of them have. So I think the other side of it is that a lot of
them have had to struggle with a lot of issues in their lives and family
breakdown and poverty and racial discrimination and they have lived with those things all their lives. So I think they are more open and up front because they have had to be. Having said that, it is very hard for a lot of people to come to counselling, for young people to come because of the taboo about counselling and the stigma, but I think once they have got here, they have kind of overcome that.

So I am not saying that they find it easy to talk about personal issues because I don’t think they actually do, but they are more – I don’t know – they are more up for being challenged. Some of them. I can’t generalise about all of them because some of them are incredibly shy and really don’t want to say anything and yet know that there is something that is not right. So they just… and a lot of them come in saying “how are you going to help me?” and “what are you going to do about it?” and that kind of thing.

I: So are you saying that spirituality is not something that is any more difficult to talk about than any other personal issue … or are you saying that spirituality is more difficult?

P: I think that it is more difficult, I think it is more difficult for both my private clients and the client here. I think it is but I think the attitude of young people is … more open in general but I still think that that is something which they might not have talked about. Or they might not think is ok to talk about. In much the same way as the reason why you are doing this research, I guess, it that people don’t often talk about it.

I: Yes.

P: I don’t often sit down and talk about it, to people about the details of how my spirituality integrates into my therapeutic practice.

I: You saying that made me think about supervision and does spirituality come up in supervision?

P: It does, my supervisor is quite sceptical (laugh) and he definitely would describe himself as non-mystical or non-spiritual. He would pooh, pooh the spiritual but he is very … his whole background is in ecology, in nature and he studied … what did he study before? T, I don’t know if you know him.

I: No.
P: But he is basically. He writes quite a lot about the Person Centred approach, he teaches at <university> but he has got a ecological view about that. By that I mean it is kind of we are all organisms and this is what organisms do. And the ... actualising tendency, all of that can be made sense of through looking at ... animals, we are like the animal kingdom, biological. I find that really refreshing and he would hate me saying it but I see him as quite a spiritual person. He wouldn’t describe himself as spiritual and I respect that, but I would talk about ... well, I wouldn’t talk about what I said to you about visualisation and what I do when I am desperate with clients. That hasn’t really come up in that way. But I would talk to him about and he would also ask me about ... because my supervision is really about me and how I am with regards to my work rather than bringing specific client material. Although I do bring clients and I often talk about my description of clients is often like a litany because in this job I take on so much, there is just so much kind of despair and distress. I tend to go and have supervision and it is just a litany of “these are the issues, this is what is happening”. So he will often in that context ask me how ... because he knows I go to church and he asks me how that is going, so he is aware that it is important to me but he is very honest about where he is coming from. But I feel very lucky to have him as a supervisor and also to know B because B is more like... he comes from the Anglican tradition. He speaks a language that I understand, his books make a lot of sense to me and I just reviewed his last one for our journal. I don’t know if you read it ‘The Mystical Path, the Person Centred’. That kind of thing really resources me as well, because I just go yeah, yeah, it just really makes sense to me.

I: So I wonder if you are saying that even if these things are something you can’t completely talk about in supervision, you have B or other people you can talk to.

P: Yes, and I would say that the friends I have through the encounter group, because it is therapists, would all be people that I can share that with and I found them increasingly important because we have been doing that encounter group now for 5 years.

I: So it is always the same people?

P: More or less. So that is building up a kind of spiritual, therapeutic community if you like. And interestingly I don’t really ... there is only one person from my
training course who I keep in touch with and I can talk to her on that level. She is from a Sufi tradition but it is very important to her spiritually and in her everyday life. So her and I can talk about things really easily.

I am beginning to integrate the church more with my practice because I am quite involved in the church and I am trying ... because we have this group that is looking at mission and how the church gets involved with local people and that kind of thing. And I have only recently come to realise that I maybe have skills that I can offer from my counselling, just in group work... That has been quite a slow thing for me, to integrate that way. I mean I can integrate my spirituality into my therapy practice but to integrate what I know about therapy and relationships into the church, I found that ... not really happening. And I was on the equivalent of the parish council which is the kind of managing body of the church and ... I found that quite hard being in that kind of a group.

I: In what way?

P: Well because ... because it was quite formal, because it wasn’t about listening, because it was agenda driven, because of the power dynamics, all those issues and I guess I didn’t consciously expect, but I think I expect the church to have similar qualities ... to a therapeutic community. I expect it to be about love, which is what I expect when I meet other therapists. And I was involved in committees to do with the Person Centred world as well and I had a similar disappointment in terms of what happens when it gets institutionalised or into decision making and power and all of those. And obviously some of the qualities get lost, but I have found it really difficult spiritually to be involved in a church which sometimes doesn’t seem to be ... or meet ...

I: Or be very spiritual?

P: Yes, or be concerned with the individual and I was very involved with my local community as well. I chaired the local residence group and there were some issues going on for us and the cathedral could have played a major part in supporting the community and it didn’t. It decided to go with the establishment and the status quo and I found that really disturbing to my sense of what church should be about.
So in a way I want to integrate much more my therapy, my spirituality, my church, my community, for me it is all the same thing. And I think that I just assumed that for everybody it was. You preach about certain qualities or you write about certain qualities, then obviously you put them into practice into everything you do but that is not obviously how it works. That is a bit naïve, isn’t it? I think I had always assumed that things were more integrated than they are. And as I say maybe for me it hasn’t … I have had to be integrating, that is an ongoing process, integrating all those different elements – community, church, therapy institution and my individual practice. It is like “how does that all fit?” Because I really do believe who I am in my… therapy is a way of being. I am a therapist, I am a Christian and I can’t separate those two things…

But I don’t think any of my clients would know that I was Christian, sometimes they might ask. I did have a client here who was a Muslim, a young man and he asked me and I told him because he was interested in different faiths. But the other client I was talking about earlier, my private client, I don’t think, he doesn’t know anything about … although he must realise that I am ...

I: But he never asked?

P: No, and that is why I would be slightly reticent about asking the question about God because like God is important to me. How can I assume … or is this pushing onto my client, letting them know that God is important to me and then they will somehow feel that it has got to be important to them. I think that is underestimating clients really to think like that, it feels such an important thing to bring in and I guess I am quite frightened of someone saying “or what do you believe?” or “Where are you coming from?”.

I: And no one has?

P: No, apart from this one young man… although I think it is implied with this other man that I have worked with because he must … assume that I have some spiritual awareness or otherwise we wouldn’t be talking about the things we are talking about.

I: Hmm because one of the other people I interviewed was saying that spirituality was quite difficult to discuss without self-disclosing in a way.

P: Yes, that is interesting though because I haven’t actually self disclosed verbally
but I guess I have self disclosed just by even asking the question, I have disclosed that …

I: I wonder if things have come up where it has been quite difficult not to self disclose?

P: As a dilemma?

I: Yeah.

P: No I don’t remember, I don’t recall that. I mean the only time I recall someone directly asking me was that young man and I responded because he wanted to know and because it is an issue. I am a white woman, female, Christian therapist and he is a young, Asian, Muslim, man so it is an issue. It is like how does he feel about me being who I am and does he wonder where I am coming from? … Umm but I can’t recall how that developed with him, I think it was more on a discursive level rather than … he was just wanting to talk really rather than explore himself and how he was. So I can’t recall that it made any difference and I certainly didn’t feel exposed in anyway, it felt appropriate.

I: And it didn’t feel difficult deciding whether to tell him or not?

P: No, he asked me if I was Christian.

I: I guess I was wondering what happens if clients’ beliefs are so different from yours, if that has happened and how you have found that? … Or their beliefs seem to be part of their difficulties?

P: There was one client, a young man that I saw here who had a very negative experience with the Christian church, a particular type of Christian church. And I found myself wanting to say to him, I didn’t, but my difficulty was that I wanted to say to him that “not all churches are like that, you don’t have to totally reject God because of that experience with that church”. I could feel an evangelical part of me coming up saying “that is not what church is about”. “Don’t deny yourself access to Christianity because of that” and I didn’t but I wonder if that came out anyway in some form because I was so aware of it. And I did know that I did encourage him to explore it. I was really aware of how hurt and betrayed he felt by his church experience. So I did … I didn’t ignore that. I guess my value judgement was that was an important thing for him to explore and I hope I did that with empathy.
I work with a lot of students who are Muslims, so obviously their views are very different. And I ... it is tricky because I think I do want to see the best in their belief system... And I have talked about religion with... I am thinking of one young woman who described her faith as something to do with the Koran saying that she should be more self accepting. So she wasn’t getting ... sometimes students will talk in terms of imperatives, which feel, to me very limiting and oppressive, which would be the more stereotypical view of what Islam is about.

I: Could you give me an example of that?

P: Like well that ... the men of the family are more important than the woman, that they have to pray five times a day otherwise they are not good Muslims, that they shouldn’t drink and that they shouldn’t smoke and that they will be outcasts if they are discovered. So it creates huge kind of like conditions on them. There is an awful lot of conditionality and they don’t fit... You know their parents will not love them if they don’t comply with these. Or for a young woman is might be wearing the scarf, they have to wear the scarf, they have to cover themselves up because if they don’t their parents won’t accept them. They want to be wearing their own thing, they want to be with boyfriends. Why can’t they be with boyfriends? It is not allowed and that is religious and cultural. And some students will come and talk about how their parents have got it wrong and religion is one thing and they have read the Koran and the Koran says that you should accept yourself and it is about love. And it is about very similar values to Christian values about loving yourself, and your neighbour and caring for other people. But their parents mix that up with culture and cultural traditions and back home traditions and so I guess when they are struggling with those dilemmas it is hard for me to be really ... equitable, if you like, valuing both sides and not making a judgement. Because from my religious and spiritual viewpoint it is like I just find that ... quite intolerable that they should feel cut-off from their families and unable to communicate with them and feel unloved for the sake of religion. And that is hard for me, it is a dilemma that I have to sit with while I am with them, but I don’t, I hope I don’t in any way kind of come down on one side or the other. But often what they are coming to me with is that they want more, they want ... to have a more loving relationship with their family, they want to be trusted. Quite often a young person will come and say
“everyone thinks that I am bad, evil. My mum treats me like I am bad and I am just trying to be good and I am just trying to live a good... I am not going out and I am not with boys but they think I am because if I am 5 minutes late and all of this kind of thing”. And I think for me that is a deeply ... I don't know if spiritual is the word but it is existential. Imagine believing that you are bad, that everyone thinks you are bad. And yet they are coming because they know that they are not. They know that they are good and they are struggling to show and to be “good” in inverted commas. They know they are worthwhile human beings, something in them knows that even though their whole lives they have been told otherwise. So I find that quite kind of .... well I find that very moving and I guess my faith helps me with that as well. I mean it is like, it is about their intrinsic worth as human beings and the fact that they somehow know that. I kind of feel from my conception of the world that God is kind of with them. Or that they ... or as my supervisor would say their organism is actualising even though... somewhere, some part of them is aware that they want to grow towards light or belief in themselves and in other people and in the world. That it is trustworthy even though they are in such difficult conditions. And their parents and their culture and their religion is telling them that they are bad for being who they are.

So that is a daily struggle, I find that quite hard, I wrote a paper last year about trying to have hope in all of the despair because I do find it hard to be hopeful. I called it 'staying alive' because I think that most of what my clients are about is about staying alive. But I have often found as a therapist it is hard to stay alive here and just to keep hopeful and keep ... and obviously my spirituality is part of that. But I have quite often found myself in the wilderness because of just the grimness of people's lives, especially young people who have been treated really badly and for whom there is no hope really. They have the choice about whether they leave home or if they stay home in what I would call an emotionally abusive situation, and sometimes physically and sexually abusive. Although sexual abuse is a whole other issue, obviously if someone is being sexually abused we do try and act to get them out of the situation. Very often I will support students to get out of the situation but you know they will not want to or
they will go back or ... it is that very difficult transition, quite apart from the ordinary adolescent transition to independence.

Something I was reminded of just as I was talking about difficult dilemmas. I had this student who really... She was in very, very difficult situation at home and it was just horrific. But she came in one day and she ripped off ... she had a crucifix round her neck and it was more one of those ones that was jewellery but still I think it was important to her. And I think her grandmother, well there was some religious hopeful element in her life and she certainly used to talked about talking to her grandmother, who was the one person who believed in her and who loved her but she’d died. But she still talked to her, she was still very much present for her. And one particular... she was just feeling so, so just desperate that she ripped off her crucifix and she just threw it in the bin. And that was quite hard for me to just... It was such a kind of violent rejecting gesture and obviously we talked about it. And I took it out of the bin and kept it in an envelop for her in the filing cabinet, just in case she ever wanted it back and you know I asked her about it on several different occasions later on and she never wanted it back again. And so in the end I threw it away because that was what she wanted, she wanted to throw it away. But it was really hard for me, I couldn’t leave it in the bin because I thought maybe she will want it again. And I think that the fact that it was a crucifix meant that I ... and it was also because it was jewellery and it was gold, probably wasn’t real but it just felt that it was valuable on many levels and she had thrown it away. But she knew what she wanted and she didn’t want that but it was a very vivid rejection of anything of value really, including God or Jesus and I mean I will never forget that. So I guess my beliefs come in quite a lot, come into my practice quite a lot.

I: I think you have answer most of my question but I am just trying ... um I wondered if you had had any spiritual experiences maybe that is one question you haven’t talked about?

P: ... I have but not in therapy, not in the therapeutic relationship.

I: And do you feel you can talk about them?

P: Yes, well two really, one was when I was working in Africa with the church, I was quite unhappy, it was quite difficult for many different reasons..., mostly to
do with the context rather than to do with me. Although I think they was a lot to do with culture shock and all of that. But I had an experience of being ... I was actually listening to a tape, it was kind of a yoga tape, it wasn't a yoga tape, it was a visualisation basically, a kind of a guided visualisation on a tape that my sister had sent me. I was lying on my bed listening to that and that was to do with light as well that visualisation and just had this sense of... because I had been really disturbed and distressed, of a real sense of calm and that everything was going to be ok and that I just had to leave, which was a really big thing. I hadn't really thought that I could leave the situation. So it was a real like... it was very physical, something just changed inside me and I just knew that it would be ok. And I was aware of God and I was kind of at one with myself and God. I think that was what was different about it, that is why I would describe it as a spiritual experience because there was that kind of harmony. And it stayed with me because I was able to... because it was quite difficult to leave. I had to... for me to leave it was like letting down loads of people who had paid, I was in Africa and it was a major decision. And it came about through that kind of... through a moment of kind of revelation if you like but as I say I was listening to a tape that was a visualisation but it was to do with relaxation but out of that came this kind of experience.

And then the other one was the feeling when I was on the encounter group in W and I was very lost and couldn't even stay in the group. I was out walking. I felt like I had disconnected from everything, it was really like being in the wilderness, I couldn't talk to people. I couldn't get in touch with God. And I ended up going to the church in the village, it is a little village in W and I don't know why. I think I was thinking "where is God? Is God in the church?" in term of physically, in a church building but also in a wider context. So I obviously knew that I needed something and ... the guy came to lock up the church and locked me in the church. And that was a kind of ... In a way, I don't know if this is really a spiritual experience, but it had great spiritual significance to me because I kind of had to reconnect with the rest of the world. I had to get out of the church, I had to... In the end I ended up ringing the bell, which is a really big symbol of a cry for help. It is like in times of war people ring the
church bell and apart from that it is just rung for services. So it felt like I had to be very out there, asking for help and for me ... and then the guy who locked it up came and let me out, but for me that was a kind of ... I understood it to mean that God was kind of... It felt like an act of intervention in terms of saying “you need to learn to ask for help and receive help and ... you don’t have to be on your own and doing it all yourself”. So that is how I understood that. So it wasn’t a kind of vision or anything but it was something which happened which can only make sense to me through God. I can’t make sense of that in any other way.

I: You talked a couple of times about being in the wilderness and I wondered if you were saying that being in the wilderness meant being disconnected from God?

P: Yes, being disconnected from God and not knowing where I am and feeling lost and... Yes not being able to pray and not being able to connect to myself or being depressed, not knowing what life is about. Yes, I have had lots of different times of wilderness in different kind of settings. But yes I would describe it as wilderness and sometimes it would have been depression but ... sometimes it isn’t. Sometimes I can function quite normally and carry on but have a sense that internally I am not ... I am in an internal wilderness. But then other times it can be more ... everything feels ... it is a more complete, overall thing. And in those times I have just learned to just keep going, to just keep going and things will happen like that experience in the church or something will happen. And I do have a faith that there is a meaning, even if it isn’t apparent at the time.

I: There is a meaning in being in the wilderness?

P: Yes, that it is creative. And I have quite a good therapist as well and he talks to me about the spiritual. He in fact reminds me quite often “I know this is important to you, so why aren’t you talking about it?” He is quite directive in that. I mean he is not Person Centred and he is great. He is from a Jewish background but he is very aware and he will encourage me to talk about my spirituality and I have a spiritual director as well. Well I did have who I see every 3 months who is a Franciscan monk so I guess I talk to him about my work and about myself and I guess that is another important resource.
I: I was interested in your spiritual director and your personal therapist and your supervision. Would they be very different?

P: Yes, they would be very different. They are all men, which is very interesting. They wouldn’t be different in what I talk about. I would be talking about the same thing but they are three very different men. Three older men, with very different responses, although all respectful of me. They all know that it is important to me but yes, it is quite a good mixture but I do miss a kind of significant... I think that is why Star Hawk was quite an important figure for me because she was an older woman who had a deep spirituality that was integrated.

I: Do you mean a role model in a way?

P: Yeah. And I haven’t … obviously within the church, Anglican church I have met very few women priests … I was thinking that of course I have met lay people but very few people really who inspire me in that way. But I think it is because I haven’t been searching for it. You know, I kind of … but that is what I need that is my own personal journey. I need to search for what I need, I need to recognise what I need and search for it. But my personal story is all about helping other people, being there for other people, rather than being aware of my own needs. So the loving your neighbour bit, the bit that I always focussed on rather than loving yourself bit of that Christian, what Jesus was saying.

I: Those are all my questions. Is there anything else that you would like to say that I haven’t covered?

P: No, it seems like we have gone all over the place.

I: Do you have any comments about the interview?

P: No, I was just thinking about you transcribing it and how hard it is going to be and how long it is going to take. Because I have just edited a book about idiosyncratic Person Centred therapy. That is quite interesting because quite a lot of the… One of the things I was looking at was obviously idiosyncrasies, because everyone’s different. So each thing is written different and talking about… there is quite a lot of transcript material with clients and stuff. But one of the common themes, I am trying to draw common threads, and one of them is spiritual discipline and quite a lot of them will have mentioned, out of the 10, quite a lot of them mentioned either praying when they are sitting with a client or … more eastern kind of spirituality.
I: Meditation?
P: Yes, meditation and clearing space and... somebody talked about the yin and yang and the kind of the coherence of that, the both and. That is quite interesting to me that that has come up as a kind of constant. Two people go into real detail about their meditation practice and one comes from a Muslim background and the other comes from a more western kind of eclectic spirituality background. But doing the book on idiosyncrasies is quite interesting

I: Is that published?
P: It is coming out in July. So I mean that has helped me a lot as well looking at idiosyncrasies in my own practice and see it in other people's practice. And see how central it is to the Person Centred approach. It is just about embodying theory and about trusting yourself and about trusting your client and about the unique combination of client and therapist and how that can produce kind of unexpected things which is an idiosyncratic relationship really. But also about the presence, that quality of presence of how if the core conditions are present then something more can emerge, which is beyond words and which is healing and which is to do with... I mean the Rogers quote, one of the well known quotes by him about presence is about "when I am most present to myself then something other emerges". So it is very much about being... what I argue about in the introduction is idiosyncrasies and isn't about being weird, and wacky and irresponsible. It is about actually being present to yourself in a congruent way and that is what is healing. So it has been quite interesting for me and it has really helped me trust that more in myself.

I: Sort of made it more acceptable?
P: Yes.

I: Thank you for your time.

----- end of interview -----
Appendix I - Table 1: Therapists’ experiences - Summary of complete analysis of transcripts

<table>
<thead>
<tr>
<th>Contextual Factors</th>
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<tbody>
<tr>
<td><strong>Therapists’ therapeutic Development</strong></td>
</tr>
<tr>
<td>Practice Evolving</td>
</tr>
<tr>
<td>Therapeutic Model/s</td>
</tr>
<tr>
<td>Training and teaching</td>
</tr>
<tr>
<td>Writing on spirituality and therapy</td>
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<td>Therapeutic and theological literature</td>
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### Therapists’ experiences of integrating spirituality and therapy

<table>
<thead>
<tr>
<th>Border between spirituality &amp; therapy</th>
<th>Integration at a discursive level</th>
<th>Integration at an experiential Level</th>
<th>Integration at a theoretical level</th>
<th>Therapy as intrinsically spiritual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overlap/shared territory</td>
<td>Discuss clients’ spirituality</td>
<td>Therapists awake/open/call spiritual realm</td>
<td>Framework/Discourse compatible</td>
<td>Similar values/goals/process of change</td>
</tr>
<tr>
<td>Definite border</td>
<td>Dilemma of therapists’ disclosure</td>
<td>Therapists actively seek connection to spiritual realm</td>
<td>Framework/Discourse complementary</td>
<td>Therapy as a calling</td>
</tr>
<tr>
<td>Vague border</td>
<td></td>
<td></td>
<td>Framework/Discourse conflict</td>
<td>The religious roots of therapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Therapists’ personal spirituality</td>
<td>Resolution of conflicts within/between spiritual and therapeutic discourses</td>
<td>Scientific therapeutic models likened to religion</td>
</tr>
</tbody>
</table>
**Appendix I - Table 1: Therapists’ experiences - Summary of complete analysis of transcripts**

### Impact of integrating spirituality and therapy

<table>
<thead>
<tr>
<th>Impact on therapeutic relationship</th>
<th>Impact on Clients</th>
<th>Impact on Therapists</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Enhances relationship</td>
<td>- Relief</td>
<td>- Therapists</td>
</tr>
<tr>
<td>- Interferes relationship</td>
<td>- Opportunity to make informed choice</td>
<td>strengthened by the spirit</td>
</tr>
<tr>
<td></td>
<td>- Enables clients to sort out feelings/conflicts about spirituality</td>
<td>Therapists illuminated/directed by the spirit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Allow therapists to be where clients are.</td>
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<tr>
<td></td>
<td></td>
<td>- Therapist nourished by the spirit</td>
</tr>
</tbody>
</table>

### Ideal Integration of spirituality and therapy

<table>
<thead>
<tr>
<th>Pitfalls</th>
<th>Ways to mitigate pitfalls</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Going too far into the spiritual territory</td>
<td>- Discernment between authentic &amp; Inauthentic spirituality</td>
</tr>
<tr>
<td>- Not going far enough into the spiritual territory</td>
<td>- Spirituality rooted in therapists’ life</td>
</tr>
<tr>
<td>- Escapism</td>
<td>- Faithfulness to spiritual discipline</td>
</tr>
<tr>
<td>- Evangelical</td>
<td>- Don’t know how to mitigate some pitfalls</td>
</tr>
<tr>
<td>- Egotistical/Narcissism</td>
<td>- Humility</td>
</tr>
<tr>
<td></td>
<td>- Heart centred spirituality</td>
</tr>
</tbody>
</table>
Appendix J - Figure 5: Diagrammatic representation of findings on therapists' experiences of the integration of spirituality and therapeutic practice.
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(b) for books:

(c) for chapters within multi-authored books:

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Tables should be submitted on separate sheets, numbered in Arabic numerals, and their position indicated in the text (e.g. Table 1). Each table should have a short, self-explanatory title. Vertical rules should not be used to 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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ABSTRACT

One of the major obstacles to integrating spirituality and therapy seems to be the bewildering array of approaches to integration discussed in the ever-expansive literature on this subject. This study attempted to alleviate some of this confusion by producing an account of practice possibilities that are grounded in therapists’ and clients’ experiences of actual spiritual integration in their therapy. Interviews were conducted with 10 clients who perceived their therapists as integrating spirituality and/or religion into their therapeutic practice. The interview data were subjected to grounded theory analysis. Clients’ perspectives of spiritually integrated therapy were used to elaborate the theory produced in a previous research study based on the views of 10 therapists who reported having integrated spirituality into their therapeutic practice. The findings from clients corresponded to and extended three of the categories which therapists viewed as lying at the heart of integration, namely discerning the border between spirituality and psychotherapy and integrating spirituality at discursive and experiential levels. Therapists also identified two extra categories: integrating spirituality at a theoretical level and seeing psychotherapy as intrinsically spiritual. The implications of this study for psychotherapeutic practice and training will be considered.
INTRODUCTION

Current research suggests that there is a resurgence of public interest in spirituality. Numerous surveys in Britain and the USA state that the number of individuals who report that they personally believe in God or some spiritual force is on the increase (Bergin and Jensen, 1990; Duffy, 1998; Greeley, 1992; Miller & Thoresen, 1999; Shafranske, 1996; Woodward, 1994). Moreover, clients often say that spirituality is the most important aspect of their lives in that it is central to their meaning, identity and well-being and that they would like their spirituality to be incorporated into the realm of psychotherapy (Butler, 1990; Gorsuch & Miller, 1999; Miller & Thoresen, 1999; Steere, 1997).

In addition, many contemporary therapists argue that our understanding of what it means to be human cannot be contained solely within narrowly defined psychological models. They argue that spirituality is as much a part of human existence as emotionality and mentality and therefore therapists' understanding of their clients is incomplete without knowing about their spirituality (Butler, 1990; Duffy, 1998; Kurtz, 1999; Newnes, 2001; Schultz & Gutheil, 1997; Spooner, 2001; West, 2000). Some research also suggests that spirituality has the potential to be a significant influence in the mental health of individuals (Argyle, 2002; Gartner, 1996; Gartner et al., 1991) and that spirituality is relevant to and can have a significant influence on healing and change within the process of therapy (Bergin et al., 1997; Clarkson, 2000; Gorsuch & Miller, 1999; Loewenthal, 2000; Shafranske, 1996; Spooner, 2000).

Despite these compelling arguments for the relevance of spirituality in clinical practice, it seems that the integration of spirituality into therapy still remains the exception rather than the rule (Butler, 1990; Miller & Thoresen, 1999; Spooner, 2001). Much of the psychological literature on the subject has focussed on the possible explanations for this neglect: for example, the difficulties with defining and measuring spirituality (and psychotherapy), the difficulty of distinguishing between helpful and harmful elements of both, the lack of therapists' training in this area and the taboo of spirituality within the secular framework of therapeutic practice (Suarez,
However, some literature has focussed on how therapists from a range of backgrounds are trying to make room for religion and spirituality in their therapy (Abbott et al., 1990; Adams, 1995; Anderson & Worthen, 1997; Healey 1993; Mahrer, 1996; Northcut, 2000; Patterson et al., 2000; Prest et al., 1999; Propst, 1996; Randour, 1993; Spero, 1996; Sperry & Giblin, 1996). These investigations have been categorised into two major approaches which have been differentiated according to the degree of implicit and explicit integration of religious and spiritual beliefs, values, themes, practices and resources within therapy (Tan, 1996). However, one difficulty in this area is that there is a range of confusing and sometime contradictory variations within these implicit and explicit approaches, which seems to leave the ‘ordinary’ therapist who would like to accommodate spirituality (and religion) within therapy unsure about how to do this.

My previous research attempted to alleviate some of this confusion by drawing upon the experience of therapists who had explored the integration of spirituality into therapy and who had, at least sometimes, integrated spirituality into their therapeutic practice. The outcome of the study was a tentative theory of the integration process (Suarez, 2003). The current study extends the insights gained from previous research with therapists by focussing on the views and experiences of clients who are in receipt of what they perceive as spiritually integrated therapy. In specific terms, this study aimed to investigate clients’ experiences of spiritually integrated therapy and asked them to reflect upon the processes by which they/their therapists sought to achieve this integration, their reflections upon the helpful and unhelpful elements of this endeavour as well as the perceived effects on the therapeutic relationship, their therapist, themselves and their difficulties.

As it seems the integration of spirituality into therapy is still at an exploratory stage, investigation into this domain appears ideally suited to qualitative research. The qualitative research principles of grounded theory seem especially relevant as the existing theory or research seems insufficient in helping therapists understand how to integrate spirituality and/or religion into therapy. In addition, subjecting the data obtained from clients in the current study to the same analysis (i.e. grounded theory analysis) as the data obtained from therapists in the previous study enables an
elaboration of the theory produced in the previous work as using the same analytic method can facilitate a comparison between therapists’ and clients’ views and experiences.

Therefore, this study aimed to follow the principles of grounded theory and collect qualitative data from clients who received what they perceived as spiritually integrated therapy in an attempt to capture the complex assumptions, meanings and contradictions that enter into the process of spiritually integrated therapy. In this study ‘spirituality’ points to a larger construct than ‘religion’, and although it may involve organised religion, it is meaningful in its own right. The psychological literature proposes a wide variety of conceptualisations for the term ‘spirituality’ (Suarez, 2002). Multidimensional conceptualisations seem best able to capture this complex phenomenon and, although therapists are still debating what these dimensions are, the most commonly proposed spiritual dimensions in the literature are practice/behaviour, experience/emotion, belief/faith, intellectual/cognitive and application (how the first four are applied in daily life) (Argyle, 2002; Loewenthal, 2000; Miller, 1999). Alternatively, Swinton (2001) suggests more spiritually (rather than psychologically) orientated dimensions namely intrapersonal (quest for inner connectivity), interpersonal (relationships between people) and transcendent (connection to something beyond self and others).

By comparing and contrasting the findings from clients with the tentative theory of integration produced previously from the therapists’ perspective, this study aimed to produce an increasingly comprehensive picture of spiritually integrated therapy which can be used to construct a detailed (if partial) account of possibilities for ‘best practice’ in this domain. This model could be used to inform practice among therapists who would like to integrate spirituality and/or religion into their practice, at least with some clients, but who are currently unsure about how best to achieve this.
METHOD

PARTICIPANTS

Eligibility for participation required that individuals were interested in spirituality/religion and had been or were currently engaged in therapy that they perceived as spiritually integrated therapy. An attempt was made to recruit a heterogeneous sample and capture a diversity of perspectives (for example, varied religious orientations, therapeutic models and settings). Also, as part of the theoretical sampling strategy (Glaser & Strauss, 1967), participants who had felt unable to bring in their spirituality into their therapy were sought.¹

Participants were recruited through professional contacts of the researcher and her supervisor, through contacting therapists interviewed in previous research and through counselling and psychology organisations which claimed to provide spiritually integrated therapy. Further attempts to recruit participants were made by ‘snowballing’ from participants who had been contacted through the above channels. Ten participants were eventually interviewed by the researcher at a place that was convenient to them. Eight participants felt that they were engaged in/had been engaged in spiritually integrated therapy. Two participants felt unable and/or unwilling to bring spirituality into their current therapy.

INTERVIEW GUIDE

The guide for the main interview was semi-structured. Questions were as non-directive as possible to avoid leading participants and thus to keep to the aim of discovering the participants’ views. The interview guide was based on the research aims which emerged from issues identified in a review of the relevant literature (Suarez, 2002). The main content areas of the interview guide (see Appendix H) were participants’ personal definition of spirituality, their experiences of therapy and the

¹ The decision to recruit people who had felt unable to bring their spirituality into their therapy was made during the fieldwork process and in light of the emerging analysis.
extent to which/ways in which they felt their spirituality was/was not integrated into their therapy.

Two pilot interviews were conducted to assess the suitability of the interview guide. As only minor adjustments were subsequently made to the guide, these pilot interviews were included in the study.

PROCEDURE

Ethical approval was obtained from the University of Surrey Ethics Committee (see Appendix A).

The interviews began with the completion of the consent form, which outlined details of confidentiality procedures (see Appendix F). This was followed by the collection of demographic information (see Appendix G) and finally the main interview. Despite the linear format of the interview guide, the participants influenced the flow and direction of the discussion. The guide was used as a checklist to ensure the research aims were met. Each interview lasted between one and two hours. All interviews were audio taped and transcribed (see Appendix K for specimen transcript).

ANALYTIC STRATEGY

The grounded theory method (Glaser & Strauss, 1967; Henwood & Pidgeon, 1992; Pidgeon, 1996; Pidgeon & Henwood, 1996; Charmaz, 2003) guided the data analysis. Each taped interview was transcribed and labelled with the topic, interview number and date. Each transcript was entered into Windmax, a software program for computer-assisted analysis of text-based data.

Starting with one transcript, an indexing system was initiated by taking each unit of meaning in turn (that is, a phrase, sentence or longer extract that was seen as constituting a discrete unit) and giving this a category name which captured its essence. As the coding progressed, similarities and differences between categories
were noted and explored and category names were changed, re-changed and adjusted until the 'fit' of these names to the text was improved. Thus in this way, categories were refined, extended and related to each other as additional material was explored. Categories were derived from the interviewee's discourse, the researcher's theoretical ideas and from previous research on therapists' accounts of integration.

A research diary and theoretical memos were also constantly updated to record any changes in category names, any splitting or amalgamation of categories, any thoughts that the researcher had about possible connections with existing literatures or any hunches or reflections concerning the emerging theory. This process assisted the later theoretical elaboration.

As the categories developed, the researcher eventually found that no more new examples were being produced that could add more richness or diversity to the category. At this point, the category was considered saturated. When a final set of saturated categories was produced, a detailed definition of each category was written, which summarised the commonalities between the data extracts that constituted the category. Emerging categories were finally integrated by identifying links between them and elaborating a coherent theoretical account for these interconnections, where possible. Diagrammatic representations, such as matrices and flow charts, were constructed to aid with this explanation. The process of coding was interrupted at various times by the collection of further data by theoretical sampling.

The grounded theory analysis obtained from this research study (i.e., clients' perspectives of spiritually integrated therapy) was used to elaborate the theory produced in a previous research study (i.e., therapists' perspectives of spiritually integrated therapy). The two studies should therefore be seen as elements of the same grounded theory research project.

Since such a methodology relies upon the subjective interpretations of the researcher, the traditional methods of evaluating research which concentrate on checking for researcher objectivity and disengagement are inappropriate for assessing this study (Henwood & Pidgeon, 1992). Instead, alternative evaluative criteria have been
suggested by qualitative researchers and these include the criterion of persuasiveness by grounding in examples (Elliott, Fischer, & Rennie, 1999). Meeting this criterion involves illustrating the analysis with extracts from the data set so that the reader can evaluate the interpretations in light of the data. Finally, the work as a whole should be transparent so that readers may understand the motives and interpretations of the researcher as well as be able to follow arguments clearly (Yardley, 2000).

ANALYSIS

DEMOGRAPHIC INFORMATION

Six female and four male therapy clients participated in the study. They ranged in age from 30-52 years (mean = 39.3; SD = 7.87). Eight participants described themselves as White, one described themselves as British Asian and another described themselves as Black British.

Participants had been raised in and currently belonged to varying spiritual/religious traditions (See Figures 1 and 2).

Six participants had changed spiritual/religious traditions (for example, Atheist to Buddhist, Roman Catholic to none) and four had remained within their original spiritual/religious tradition. Six participants rated their spirituality as currently
extremely important, two rated it as very important and two rated it as quite-to-very important.

The number of times each participant had been in therapy ranged from 1 to 5 (mean 2.3; SD = 1.16). Eight out of the ten participants had been in therapy more than once and had experienced more than one type of therapy with different therapists (for example, psychoanalytic followed by family and cognitive behavioural therapy (CBT), psychodynamic followed by transpersonal). Participants who did know their therapists' approach described these as CBT, eclectic, existential, family therapy, group therapy, integrative, person centred, psychoanalytic, psychodynamic, transactional analysis and transpersonal. Some participants' experiences of therapy had spanned many (up to 20) years. The amount of time participants had been in therapy ranged from 6 months to 8 years (mean 3.5 years; SD = 2.66). All participants had some experience of private therapy. Only two participants had received therapy within the National Health Service (NHS). Other therapy settings were student counselling and low cost counselling. Nine out of the ten participants interviewed were currently in therapy.

Participants had various reasons for seeking therapy. Some described their reasons as 'life crises' such as exam stress, family bereavements, relationship difficulties, work difficulties and physical illness. Some participants also described their reasons for seeking therapy as stress, depression, anxiety and mental breakdown. Four participants went into their current transpersonal therapy as a requirement of their counselling training.

Most participants had studied to degree level (see Figure 3). Participants had worked in various occupations (see Figure 4).
Six participants were considering a change of career. One participant was in the process of becoming a healer.

PRESENTATION OF FINDINGS

The analysis of the data yielded an extensive diagrammatical representation of all inter-linking categories which are summarised in Table 1 (see Appendix L). Figure 5 (see Appendix M) suggests how the categories that arose during the analysis might be related to one another. Connecting lines indicated participants' expression, within interviews, that the categories were related in some way. A line with an arrow indicates a reported directional causative relationship; a line with an arrow at either end indicates a mutual causative relationship and a line with no arrows indicates a non-causative association.

All client categories are reported in Table 1 and in Figure 5. Table 2 (see Appendix N) and Figure 6 (see Appendix O) combine the findings from this research based on clients' experiences of integration with the findings from previous research based on therapists' experiences on integration (Suarez, 2003).

However, due to space limitations, only the categories most directly related to clients' current experiences of integration will be discussed in detail in the next section i.e. categories encompassed within the inner circle of 'clients' experiences of integrating
spirituality and therapy’ (see Appendix M). These categories seem to be a subset of those found in previous research with therapists and consist of three overlapping but distinct forms of integration, namely, discerning the border between spirituality and therapy and integrating spirituality at discursive and experiential levels. These central categories will be elaborated and associations between them will be explained; any overlap between them will be noted. Clients’ experiences in this study will also be compared and contrasted with therapists’ experiences found in the previous study (Suarez, 2003).

The categories in the outer circle represent various background categories. Combining both clients’ and therapists’ experience (see Figure 6, Appendix O) these consist of:

- the ‘contextual factors’ participants perceived as having an influence on their experiences of integration i.e. therapists’ therapeutic development, therapists’ and clients’ therapeutic setting, personal spirituality and surrounding culture
- participants’ descriptions of the ‘impact of integration’ on the therapeutic relationship, the client and the therapist
- participants’ conceptions of ‘ideal integration’ which, in the main, both therapists and clients described in terms of the pitfalls of integration and the possible ways to avoid these pitfalls. Clients also described ‘ideal integration’ in terms of the role and qualities of their therapists

Some of these background categories will be discussed when they seem particularly relevant to the central categories.

In the quotations from the data set, empty square brackets are used to indicate where material has been omitted; material within square brackets is clarificatory; and ellipsis points indicate a pause in participants’ speech. Pseudonyms indicate the various sources of the quotations.

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BORDER BETWEEN SPIRITUALITY AND THERAPY

The elaboration of the central themes within Figure 5 is initiated with the category concerning the 'border between spirituality and therapy' as both therapists interviewed in a previous study and clients interviewed in this study perceived a border or boundary between spirituality and therapy and perceived discerning this border/boundary as a core process in integration. In other words, this category is strongly associated with the other categories within the inner circle of 'clients' experiences of integrating spirituality and therapy'.

There is a boundary of sorts. [] I can tell the difference between the two.

(Simon)

SHIFTING DEPENDING ON VARIOUS FACTORS

Whereas therapists discussed the border/boundary in terms of how definite or vague it was, clients seemed to perceive the border/boundary between spirituality and therapy as shifting depending on various factors.

Clients' interest in and openness to spirituality

Clients described the border shifting depending on their fluctuating interest and openness to spirituality. They described times when they had no interest in spirituality and/or were even disillusioned with and/or anti religious or spiritual and therefore did not bring spirituality into therapy and/or would have withdrawn if their therapist had mentioned it. A few clients described their therapists as sensitive enough to “meet me where I am”:

[My therapist] had already gathered in our conversations that I had been raised in the church and had really kind of conflicting feelings about religion and didn’t really understand the difference between religion and spirituality and so she was very gentle in the way she approached that, because if I thought she
was going to talk about God I was going to shut down and so she was just very careful.

(Lorraine)

In contrast, some clients also described times when spirituality was one of the main areas they wanted to focus on in therapy:

[Spirituality] was an element right at the start and it was one of the subjects that I was interested in ... very strongly, at that point in my life. [...] I needed to figure out this other realm

(Katherine)

Some clients linked the level of integration of spirituality into therapy with the difficulties they brought to therapy and with how much these difficulties were related to spirituality (for example, conflicts between religion and sexuality):

With a Christian, Catholic upbringing I have this conflict with ... my sexuality so that is how it came up in the early stages.

(George)

Most clients pinpointed major turning points in their life (for example, death of family member, illnesses, moving away from home, difficulties at work, trying out a different spiritual practice, practising in a different faith) where they either turned towards or away from spirituality and/or religion. Some clients felt that during these times of transition and/or conflict, spirituality came to the fore in their therapy:

Well in the period that I have been working with my current therapist, I started [...] practising with the Zen Buddhists [...] So that brought up a lot of material

(Ian)
Clients' comfort with bringing spirituality into therapy

However, even when spirituality was at the forefront in clients' lives, many felt that it took them a "long time" before they felt able to be "honest" with their therapist about their spirituality. Some clients felt that their "hesitation" was similar for any other "sensitive" subject. However, others felt that spirituality was "more personal" than other subjects and a few clients felt that they never got to the point where they trusted their therapist or therapy enough to bring their spirituality into therapy:

I think maybe if I had the faith... I was very... suspicious the first time and that is why I didn't, but if I had more ... confidence in the process or in the therapist. I remember I felt uncomfortable with her right from the start.
(Karen)

Clients were more comfortable bringing spirituality into therapy when they knew/perceived that they and their therapist had similar "models", "ideas", "beliefs" and/or "understanding" of spirituality. They felt that this gave them a "common language" with which to discuss spirituality:

I know that I can say ... things ... []... the way I feel and he will have a similar understanding, similar beliefs ... and that makes it quite easy for me to bring these sorts of ... images and names that come up.
(Maria)

Clients were more "resistant", "hesitant", "cautious" and/or ambivalent about bringing spirituality into therapy when their therapists' spirituality was unknown or when they assumed that their therapists' spirituality would be different from theirs:

I wonder if she might be Jewish, I don't know. I just have a feeling. [] So I am just wondering if she is Jewish what will she think if I had a different faith.
(Alison)
A few clients were unwilling to bring spirituality into therapy as they were fearful that their therapist would undermine their faith by trying to "convert" them and/or by "dissecting", "taking apart", "analysing" and/or "rationalising" their spirituality:

Faith is not a rational thing and it feels that in the therapy session it might be rationalised and... dissected and then a lot of the mystery will be... lost.
(Karen)

A few clients were also fearful that if they found out that their therapist's views on spirituality were very different from their own it would "prejudice" them against their therapist and undermine their faith in their therapist and their therapeutic work. For example, Alison describes how she would feel if her therapist had an "orthodox, strict faith":

So I feel that if I find out that [my therapist] is an orthodox Jew [] I would wonder if that coloured everything else she said and I suppose at the moment I have great faith in everything that she says and all the work that we have done together [] and I don't want to lose that.
(Alison)

Some clients were fearful that if they shared their spirituality with their therapist, their therapist might be judgmental, disapproving and/or rejecting and perceive them as "wishy-washy", a "religious" fanatic, "nuts", "weird" and/or "insane":

It is so important that my therapist didn't think I was nuts.
(Katherine)

A few clients were "careful" about discussing their spirituality in therapy as they were fearful that it would increase their vulnerability to conflict and might "jeopardise" their therapeutic relationship as they associated some spiritualities/religions - both their therapists' and their own - with "rigid", "judgmental", "strict", "fixed" and "strong views":

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Talking about spirituality and religion it is like talking about politics isn’t it? People have quite strict, fixed ideas, strong views... you are putting yourself in quite a vulnerable position. We can be doing fine and then suddenly ..

(Alison)

Clients' perception of where their therapist drew the boundary

Another factor that affected the border between spirituality and therapy was clients’ perception of where they felt their therapist drew the boundary.

Some clients made “assumptions” about this based on their therapists’ model or approach. Clients who had experience of more than one type of therapy and who knew their therapists’ approach felt more able to bring spirituality into therapy when their therapists’ model was integrative, existential or transpersonal and less able to bring in spirituality into the CBT or psychoanalytic approach. Clients seem to perceive the CBT approach as too “practical” and the psychoanalytic approach as antagonistic towards spirituality/religion:

I knew [my first therapist’s] counselling style was a real mixture [] She integrates everything so maybe unconsciously I thought, “Well, she integrates everything, everything is integrated” kind of thing. Whereas I know that I have cognitive behavioural therapy with [my second therapist] [] so I thought “Ok so this is very practical” and I made assumptions about it. So it kind of comes from my head thinking “Can I say this or not?”

(Alison)

Other clients’ perception of the appropriateness of integrating spirituality into therapy also depended on their therapeutic environment. Clients described environments where they felt more “comfortable” (for example, church, transpersonal centre) and settings where they felt less comfortable (for example, university) bringing spirituality into therapy:
It was a university, I didn't really think that it would be appropriate to bring [my spirituality] there.

(Maria)

Two clients deliberately sought out therapists whom they knew, from their published work, were “very interested in the subject of spirituality” and therefore would be willing to integrate spirituality into therapy:

I wanted a therapist who was... aware of spiritual issues because I suspected that those would be involved in... what I wanted to... investigate or deal with.]
I knew of him through my own reading and research

(Simon)

**Clients tested the boundaries**

It seemed that whereas some clients looked for “clues” about their therapists’ openness to spirituality depending on their therapists’ therapeutic model, their environment and/or their published writing on spirituality and therapy, other clients tested/explored their therapists’ openness to spirituality by raising the subject of spirituality and monitoring their therapists’ reaction.

When testing their therapists’ openness to spirituality, clients who did not perceive any sign of “resistance”, criticism, discomfort and/or “rejection” from their therapists brought more of their spirituality into therapy:

I have slowly explored where I thought there might be boundaries and found there weren't. It has allowed me to go into great depth with... my thinking and my feelings ... and because of no sign of rejection.

(George)

Other clients drew the line or boundary between spirituality and therapy when they noticed any sign of discomfort or embarrassment from their therapist:
I didn't bring up the fact that I was seeing the nun, but I brought up the fact that a colleague of mine at work is very religious and I thought that the therapist became embarrassed and... wasn't really looking at me and I was tempted to talk about the nun but somehow I thought... "Oh no I shouldn't because he is not comfortable with it actually".

(Karen)

Only one client, whose spirituality was very different from his therapist's, received explicit permission from their therapist to bring spirituality into therapy:

[My therapist] said “You need to educate me much more so that I can understand where you are coming from”. That was very helpful for me because I sensed an interest on her side.

(Sanjeev)

Some clients felt that it would have been helpful if their therapist had given them explicit permission up front to bring spirituality into therapy:

Had I been told in the beginning “If you have spiritual beliefs feel free to bring them up”... then I might have been more open.

(A Alison)

However, other clients thought that ‘ideally’ any integration of spirituality into therapy should be initiated by the client as there was a danger that therapists initiating a discussion on spirituality would be meaningless and/or even frightening for the client:

The signs have to come from the person because you can say a lot to somebody but if they are not in a place where they can hear you ... then it makes no sense.

(Lorraine)
The associations between this category and the categories of ‘integration at a discursive level’ and ‘integration at an experiential level’ will be addressed within discussion of these categories.

INTEGRATION AT A DISCURSIVE LEVEL

Some therapists and clients described “discussing matters of a spiritual nature” in therapy. Most clients reported that they, rather than their therapist, were the first to raise the subject of spirituality in therapy. This finding corresponded to the finding with therapists interviewed in previous research, most of whom reported that they were reluctant to raise the subject of spirituality or religion and instead waited for their clients to introduce this into therapy.

Many factors influenced whether and/or to what extent clients felt able to bring their spirituality into therapy. These were discussed in ‘border between spirituality and therapy’. Clients who felt able to explicitly discuss their spirituality in therapy recounted raising some similar issues to those reported by therapists in my previous research, for example; clients’ conflict/disillusionment with their religion/religious institution, forgiveness of self and others, search for meaning and purpose in life and/or bereaved clients’ questioning their faith.

Other spiritual issues clients in this research raised were difficulties with their spiritual practices (for example, mainly meditation but also some church attendance, prayer groups, Aikido, Yoga, Shiatsu), their spiritual beliefs (for example, in God, guardian angels, universal energy, spiritual healing, the soul, synchronicity, life after death), their spiritual experiences (both within and outside therapy, discussed in more detail in ‘integration at experiential level’), the “loneliness” of feeling that their interest in spirituality made them an outsider at work, within their family and within “mainstream” culture and clients’ struggle to integrate spirituality in their everyday lives (for example, their work, relationships and/or sexuality).
DISCUSS CLIENTS’ SPIRITUALITY

In these discussions on spirituality, clients experienced their therapist in various ways; for example some described their therapist as “exploring”, “encouraging”, “acknowledging”, “accepting” and “deepening” their spirituality:

When I share my spirituality she tends to acknowledge it and accept it and explore it with me [] …which deepens the process.
(Sanjeev)

Some clients also experienced their therapists as “criticising”, “judging” and/or “challenging” their spirituality; for example, a few clients described occasions when their therapists suggested that clients may be using spirituality as a way of “escaping”, “avoiding”, “rejecting” and/or “bypassing” “reality” and/or difficult experiences; for example, uncertainty and struggles of life, illness, their own imperfections, “disappointment in situations or relationships”, “non-spiritual” feelings like “anger”, “lust”, “fear”, “frustration”. A few clients reported that their therapist labelled this as “spiritual bypass” which is a term used in some psychological literature. Cashwell et al. (2004) suggest a model for working with clients in spiritual bypass.

Some clients disagreed with their therapists’ scepticism, which they perceived as due to their therapist belonging to a very different tradition from their own and therefore misunderstanding their spirituality:

I think some times [my therapist] [] has been sceptical about Zen Buddhism and um … especially … around the earlier stages when I started to practise. [] I didn’t feel antagonism. I just felt that the therapist was in a different kind of tradition and a different space himself and that was ok, actually.
(Ian)

Other clients reported initially feeling “insulted” and “criticised” and/or “judged” but in time finding their therapists’ challenges as helping them discern/distinguish between inauthentic/compartmentalised/defensive/“lofty [spirituality that] didn’t
actually apply to anything” and authentic/”real” spirituality that integrated all aspects
of themselves and their experiences. Some clients reported struggling with how to
integrate / “build a bridge” between their “spiritual” and “non-spiritual” side:

I think my difficulties... are more about ... you know this bypass idea is
longing to acknowledge .... and to integrate and to come to terms with... the
non-spiritual side of me... and how to bring those two sides together.
(Sanjeev)

USE SPIRITUAL/RELIGIOUS STORIES SYMBOLICALLY/METAPHORICALLY

In a few cases it seemed that therapists used the religious/spiritual stories clients
raised “symbolically” or “metaphorically”. The most common approach involved
drawing parallels between the clients’ feelings about their difficulties/situation and
Jesus’ burden of responsibility, anxiety, loneliness, pain and/or fear at his crucifixion.
A few clients reported finding this level of discussion helpful as it acknowledged their
spirituality but did not attempt to deconstruct it:

I think I once did with the psychoanalyst... I brought up ... [] We were talking
about Jesus being alone... because anxiety was a big feature for me ... [] I really
felt that I could identify with him [] And I found that very helpful because it
was something very ... real.[] With the analytic therapy because a lot of the talk
was very symbolic... [...] you could talk about the symbolism of religion
without that getting deconstructed.
(Karen)

CLIENTS SEEK/RECEIVE GUIDANCE FROM THERAPISTS

The few clients who had knowledge of their therapists’ spirituality from their
therapists’ writing explicitly sought out their therapists’ guidance and teaching on
spirituality and on spiritual experiences as they felt their therapists had “covered the
ground” they wanted to explore. One client reported that her therapists guided her by
recommending “spiritual” workshops, practices and reading:
She said “No, go do some more of this, what you need is to take a bigger bite and ... here is what you do and here is how you do it”. And that was really useful
(Katherine)

Another client reported noticing his therapist’s discomfort at his seeking of guidance/teaching. This is related to the category discerning the ‘border between spirituality and therapy’:

Because [my therapist] has so much personal experience in each of those areas which I am aware of ...I try to ... on some occasions use him as a ... coach and a guide ... just a source of understanding and information [] ... about those aspects of practice and my own practice [] I think he is sometimes quite uncomfortable with that... because obviously his job ... should be therapy rather than teaching.
(Simon)

LIMITATION OF WORDS/LANGUAGE

Many clients felt that ‘integration of spirituality at a discursive level’ was limited as spirituality was mysterious and paradoxical and they were unable to express the depth of their spiritual experiences and/or the feeling in words. Some clients also felt that “talking too much” sometimes distanced them from “direct experience” of spirituality as words reduced spirituality to rational explanations, intellectual understanding and/or banalities:

I don’t think spirituality is all about words and arguments and mindsets.... I think it is much deeper than that. It is what is in my heart, what’s in my soul.
(Sanjeev)

Clients also felt that talking did not have a profound effect on them; talking was too safe, comfortable, easy, familiar and did not challenge them. Most clients felt that
they needed to move to unfamiliar territory, to the direct experience of spirituality to allow the words to drop down into their heart and soul and/or to be able to change/be transformed:

I talk too well... I use logic. I do all of that stuff. It doesn’t help me... [] I have to go to the other place... so that the words are allowed to drop down because I get it here (points to head) but I need to feel it... in order for the change to actually happen.

(Lorraine)

Clients linked “going to the other place” with “direct experience” of the spiritual/transpersonal. Therefore this links to the final category of ‘integration at an experiential level’

INTEGRATION AT EXPERIENTIAL LEVEL

Both therapists and clients described the integration of spirituality into therapy in experiential terms.

THERAPIST BEING AWAKE/OPEN/CONNECTED TO THE SPIRITUAL REALM

Most therapists had reported being awake/open/connected to the spiritual realm and this strengthening, illuminating and/or directing them in their sessions with clients. A few clients reported that their therapists were “open” about this “spiritual contact” in therapy. For example, Anne who described her therapist as “a transpersonal psychotherapist, [[]who] was psychic and [] a spiritual healer” reported her therapist giving her “insights” into the “areas [she] needed to focus on”. This client reported feeling that these insights “led [her] quickly to issues” and “pushed [her] to reveal herself” which was helpful in speeding up the process of therapy but also resulted in the client, at times, feeling very “emotionally sensitive” and “exhausted”:

As an example, the first day that I went to her, we were chatting and she said [] “Did you have a happy childhood?” and I said "Yes" as one does [] and then
she said "Hmmm, that is interesting because I feel that there is something there to do with your sister" [] and that made me think "Oh my God, that was true" and that was a major issue in my childhood, in my life which I have pushed so far behind me,... that [] I didn't think of it as an issue. So that is how she worked... so she was very ... intuitive

(Anne)

THERAPISTS ACTIVELY SEEK CONNECTION TO THE SPIRITUAL REALM FOR THEIR CLIENTS

Most therapists in the previous study reported seeking a connection to the spiritual realm for their clients through silent prayer, meditation and/or visualisations. Only a few reported explicitly helping their client to connect to the spiritual realm. In contrast, most clients in this study reported that their therapist explicitly helped them get in touch with the spiritual realm through different techniques such as “dream work” (for example, paying attention to messages in dreams), “artwork” (for example, working with clay, drawing their soul), “body work” (for example, appreciating and listening to the body), “creative/guided visualisations” (for example, focussing on/relating to archetypes) and/or “straight meditation”. Clients reported that their therapists used these techniques in therapy, especially when clients were feeling overwhelmed, upset, tense, stressed, experiencing conflict over decisions, obsessing about something, confused, blocked, in physical pain, using their intellect/words as a defence, unable to talk through things and/or unable to access childhood memories. Clients reported that these techniques enabled them to go into a deep, quiet, spiritual place and cultivate a “different sense of awareness” which they described in various terms, for example a “greater sense of who I am”, “out of body experience”, “altered state of consciousness”, “heightened awareness”, state of clarity, connection/experience/awareness of the spiritual/divine/transpersonal:

The momentary direct awareness of changing consciousness which ... you experience as an immediate thing ... you are there,... heightened awareness

(Simon)
They described these states ranging from “subtle” to “powerful” and as “transitory rather than sustained”:

I don't have constant... access to any of these states ... or even constant ability to get there frequently... (Simon)

A few clients reported at times feeling “resistant”, “judgmental” and/or “prejudiced” when their therapists suggested one of these techniques:

There was one day we were talking and I said “God, I am so confused I cannot even work out what to say” and she said “Maybe it would be better if you were just... quiet for a moment, maybe then it would just kind of clear itself”... So she just stopped me... and asked me to breathe... and she said “You know that is kind of meditating” and I said “Oh really [] that is so weird... and I am not sure if I want to do that”.

(Lorraine)

Despite some resistance, most clients described the impact of these techniques in positive terms; for example helping them feel “grounded”, “centred”, helping them align/integrate different/conflicting parts of themselves (for example, intellectual self, an emotional self, a child self, a mature self and/or their spiritual and non-spiritual self and/or body and mind, shadow, ego, internalised parent, soul), helping them integrate conflicting emotions (pain and joy, anger and compassion), enabling them to let go of negative thoughts and emotions, release worry/tension/physical pain/stress/upset, helping them make decisions, making them more aware of how flimsy, small, tight, knotted the ego is, helping them relax, slow down their busy/active/frenetic lives, helping them access repressed childhood memories/feelings and helping them awaken/open up to spirituality. For example, Maria described the impact of a guided visualisation exercise in therapy:
[My therapist] guided this visualisation exercise [] I don't remember much now, but it helped to let go... this worry [] ... the stress, the tension, the upsetness ... [] I completely relaxed.

Simon described his experience of bodywork:

I had a heart operation last year ... and I did carry for quite a long time a ... discomfort in my chest ... and [] the work in the therapy really ... was to focus on it and ... embracing that rather than trying to deny it... obviously it was a very scary thing to have ... but it did eventually fade away ... sort of trying to look inside and appreciate it.

And Lorraine described the effect of artwork:

We did a lot of art work and clay work and this kind of thing. And one of the few things that opened up the bird phobia and allowed that memory to come back um was actually a drawing of what my soul looked like. [] And I had never been asked that before and had no idea but I drew something the way you do with these things and it completely mirrored what was ...happening for me on the inside. So it was extraordinary but... that was the opening.

**THERAPISTS EXPLORE CLIENTS’ SPIRITUAL EXPERIENCES**

In addition, many clients also described their therapist helping them explore the spiritual experiences they had outside therapy. This is linked to ‘integration at a discursive level’. Clients mainly connected these experiences to their spiritual practices and/or spiritual/transpersonal courses/workshops/retreats they attended (for example, Zen retreats, shamanic practices, experiential workshops) which included intensive meditation and/or guided exercises; for example “role playing the family Christmas lunch”, “witnessing their own death”, giving birth to themselves and/or using music to induce feelings/altered states.
Some clients described having “powerful experiences” as a result of these practices or exercises which included feelings of joy, pain, sorrow, love, going into a deep place, inducing altered states. They also described these experiences as “healing” and “rectifying” in that they enabled them to “drop the ego”, identify their patterns, “pay attention to/be alive to the miraculous”, “absorb/take in love”, align/integrate different/conflicting parts of themselves. For instance (Katherine) described a “shamanic type practice”:

At another point during the giving birth phase, [] one of the teachers who ... was guiding that came and sat with me and held me and gazed at me ... as a mother might gaze at a child. And afterwards, taking to her, that was clearly her intention, in that gaze ... the transmission of loving energy ... that by virtue of the altered state ... I was able to take in and apparently so too were others ... in a way that is healing and ... rectifying and ... filling in places where one’s own experience ... may not have been totally perfect ... and you may not have gotten everything that you might need... in that sense of just ... absorbing the love. And I think ... it was an experience of absorbing the love.
(Katherine)

Some clients described their therapist as very helpful in “grounding”, “holding”, and “interpreting” their experiences:

I have worked with [] a number of ... shamanic type practices and again focussed on inducing altered states in which .... a person has a direct experience with ... the transpersonal ... and those were very powerful experiences for me. And part of what was very helpful for me [] was having somebody to interpret and ... um ... kind of ground me as I wandered in some territory that ... was pretty new and pretty wild ... for me at the time.
(Katherine)
Many of the clients and therapists talked about the struggle to integrate their spirituality and their “spiritual experiences” into their everyday life. They described this struggle as “lifelong”, “ongoing”, “taking years of hard work”, and sometimes involving “surrendering their ego” and making “radical/major life changes”. Some clients and therapists reported feeling “pushed”/“pulled”/“forced” by the Spirit to do things that they found frightening, challenging, difficult, “threatening to [their] status quo” and disruptive to their comfortable lives. Many clients and therapists wondered if they had the “courage”, “commitment”, “endurance”, “grace”, “stamina”, “dedication”, “seriousness” and/or “discipline” required to make spirituality “more constant”/integrated in their lives and/or to be true to the Spirit. For instance, Katherine, considering a career change said:

There is this thing in me that ... needs to, wants to, is forced to ... by something other than me ... perhaps to do this work. And that threw my life into a real tailspin. Like “Ok, all this stuff is starting to come out now”. [] I felt if I could just get myself and my ego out of the way, that there would be ... guidance and clarity and energy and a message and a .... It would, it would do it ... through me, it wasn’t me making it happen, but being a conduit in some way.[] And because I didn’t start out in my career as ... a therapist, for example, or as a poet, I now have a bigger piece of work to say “Do I have the courage to change in the middle of my life and start all over again?” and to say “I don’t care anything about all that career stuff and all the achievement and all that”.[] You know what do they call it? ... It is the burden of enlightenment.

OVERVIEW

This research aimed to employ the experiences of clients, who were in receipt of what they perceived as spiritually integrated therapy, to extend the localised theory of spiritual integration generated in a previous study based on the experience of therapists who had integrated spirituality into their practice (Suarez, 2003).
Arising from the qualitative data collected from both therapists and clients were five overlapping approaches to integrating spirituality and therapy. Two conceptual maps (Figure 5 and 6) of the phenomenon were produced, which highlighted the links participants made between these different approaches. The maps also highlighted clients’ and therapists’ views of the conceptual factors that affected integration, the impact of integration and their ideas about ideal practice. Due to space limitations, only some of these (where clients explicitly linked them to their experiences in therapy) were explored.

Both therapists and clients identified discerning the ‘border between spirituality and therapy’ as a core process. Clients’ and therapists’ perceptions of where the border was shifted/evolved over time and varied on a wide continuum from keeping spirituality and therapy completely separate to therapists taking the role of spiritual guide and teacher to their clients.

It seemed that therapists largely favoured more cautious implicit forms of integration (for example, perceiving ‘therapy as intrinsically spiritual’ and ‘integration at a theoretical level’). Even in the categories where findings from both therapists and clients corresponded (for example, integration at discursive and experiential levels) therapists’ accounts of these levels of integration were more implicit (for example, therapists silently seeking a connection to the spiritual realm for their clients) than clients’ accounts (for example, using explicit techniques in therapy to connect to the spiritual realm). This may reflect the sample of therapists and clients interviewed in that seven out of the ten clients had some experience of transpersonal therapy, whereas only one of the ten therapists described himself as transpersonal in orientation.

Despite these sample differences, both sets of participants reported that it was rare for therapists to be the first to introduce spirituality into therapy. It seemed that clients who advocated/experienced a more cautious level of integration were ambivalent about introducing spirituality into therapy as they had more fears about it having a detrimental effect on their spirituality, their therapeutic work and/or their therapeutic
relationship. Clients on the opposite end of the continuum who advocated/experienced the most ambitious forms of integration (i.e. therapists as spiritual guide and teacher) had their fears assuaged to some degree by prior knowledge of their therapists’ beliefs, views and willingness to integrate spirituality into therapy through reading their therapists’ publications on the area. These findings may suggest that some form of matching therapists’ and clients’ religious and spiritual values and/or therapists’ disclosure on their spirituality may be helpful. Self-disclosure was a dilemma that therapists struggled with in previous research. Their main fear seemed to be going too far into the spiritual territory and becoming evangelical.

Another difficulty with integration was discerning between real and false/defensive spirituality. Therapists interviewed in previous research touched upon this (mainly in their ideas on ‘ideal’ integration) but it came much more to the forefront in many clients’ descriptions of their difficulties with spirituality both within and without therapy. How to separate ways of ‘being spiritual’ that are regarded as ‘intrinsic’, ‘authentic’ and ‘desirable’ from ways of being spiritual that are seen as less genuine and less constructive is still hotly debated in the psychological literature (Suarez, 2002). Some therapists and clients interviewed suggested that one of the criteria for discerning between authentic and inauthentic spirituality was the extent to which spirituality is integrated into individual’s everyday life. Many clients and therapists interviewed reported an ongoing struggle to “live” their spirituality in their daily lives.

On the other hand, Cashwell et al. (2004) argue that what may look like healthy, integrated spirituality may be a repetition of the client’s unhealthy childhood coping strategies/patterns. Cashwell et al. (2004) cite several examples of clients who used spirituality to bypass/avoid their difficulties and suggest that an assessment of clients’ spirituality should be considered in context of their psychological history. The complexity involved in assessing clients’ spirituality may explain in part most therapists’ reluctance to introduce spirituality explicitly into therapy even though there is a large literature which advocates the assessment of spirituality and religiosity (Suarez, 2002). This literature argues that asking about clients’ spirituality can show respect for their spirituality, may identify spirituality as a potential coping resource,
can indicate to clients that spirituality is a subject that is 'allowed' in therapy and enables therapists to determine with their clients whether spirituality will have an overt role in treatment. Clients in this study had mixed views on their therapist initiating the subject of spirituality in therapy. Some clients felt that it would have helped them be more “open” about their spirituality whereas other felt that there were times when they would have found it alienating, meaningless and even alarming if their therapists had asked about their spirituality. This seems to suggest that the integration of spirituality into therapy (just like ‘ordinary’ psychotherapy) needs to be tailored to “meet [clients] where they are” (Lorraine).

Despite all the difficulties and contradictions, these findings do provide some guidelines for both training and therapeutic practice, which in the main continues to neglect spirituality despite the literature that suggests a rapprochement between the domains of spirituality and therapy. The major value of this research was the rich data produced by both the therapists and clients who were highly articulate and had the ability to reflect on the subject. Clients were psychologically sophisticated in that most had experience of more than one type of therapy and thus were able to compare and contrast different types of therapy and speculate about the reasons for the varying degrees of integration within their therapeutic experiences. They were also well read on the subject of spirituality.

However, this study provides an incomplete picture due to the under-representation or omission of certain perspectives. For example, despite attempts to select participants from diverse cultural and spiritual/religious backgrounds, most participants were White and were or had been brought up Christian, although the clients interviewed included some Hindu, Buddhist and New Age religious perspectives. Still, further research may be needed to investigate how therapists and clients from other religious/spiritual/ethnic backgrounds in Britain (for example, Islam, Sikhism, Judaism, etc) experience/attempt the integration of spirituality and therapy.

Therefore, this study is another useful step in understanding ways therapists can integrate spirituality into practice and this theory could be harnessed for the benefit of therapists who might be interested in integrating spirituality into their practice but who
currently lack any credible 'road maps' to guide this process. However, in order to get a more complete picture of this phenomenon, it is necessary for researchers to build up an increasingly comprehensive picture of spiritual integration through a series of complementary studies with each extending the insights gained from previous work.
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Dear Ms Suarez

Extending the qualitative exploration of psychotherapists' accounts of integrating spirituality into psychotherapeutic practice by exploring the experiences of clients who are in receipt of spiritually integrated therapy (EC/2004/19/Psych)

I am writing to inform you that the Ethics Committee has considered the above protocol, and the subsequent information supplied, and has approved it on the understanding that the Ethical Guidelines for Teaching and Research are observed. For your information, and future reference, the Guidelines can be downloaded from the Committee's website at http://www.surrey.ac.uk/Surrey/ACE/.

This letter of approval relates only to the study specified in your research protocol (EC/2004/19/Psych). The Committee should be notified of any changes to the proposal, any adverse reactions, and if the study is terminated earlier than expected, with reasons.

Date of approval by the Ethics Committee: 21 April 2004
Date of expiry of approval by the Ethics Committee: 20 April 2009

Please inform me when the research has been completed.

Yours sincerely

Catherine Ashbee (Mrs)
Secretary, University Ethics Committee
Registry

cc: Professor T Desombre, Chairman, EC
    Dr A Coyle, Supervisor, Psychology
Appendix B - Recruitment Poster

Integrating Spirituality and Therapy

Have you received therapy that you felt took into account your spirituality?

My name is Valerie Suarez and I am a trainee Counselling Psychologist based at the University of Surrey. As part of my studies I am conducting a research study on clients who are interested in spirituality/religion and who have received therapy where they felt that their counsellor, psychologist or therapist integrated spirituality/religion into therapy.

It is hoped that this study will provide valuable information for counsellors, psychologists and therapists who would like to integrate spirituality/religion into therapy but who are currently unsure about how to do this in a way that would be most helpful to clients.

If you volunteer to participate, you will be asked to take part in a one-to-one interview with me, focusing on your personal spirituality/religion and your ideas and experiences of therapy where you felt that your therapist integrated spirituality/religion into therapy. These interviews will last approximately one hour and will take place at a time and location that is convenient for you.

If you would like to take part in this research or would like to find out more about it, please contact either myself or my supervisor, Dr Adrian Coyle. We can be contacted via the address below, by email at Valerie_Suarez@hotmail.com and A_Coyle@surrey.ac.uk or telephone on 0775 942 7049.

Valerie Suarez
Counselling Psychologist in Training
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Appendix C - Sample Letter to organisation/therapist

<Date>

<Name and address of (potential) participant>

Dear <Name of organisation/therapist >

A study on the integration of spirituality into therapeutic practice

I am currently studying for a Practitioner Doctorate in Psychotherapeutic and Counselling Psychology at the University of Surrey and as part of my doctorate, I am conducting a research study on clients who are interested in spirituality/religion and who have received therapy where they felt that their counsellor, psychologist or therapist integrated spirituality/religion into therapy. It is hoped that this study will provide valuable information for counsellors, psychologists and therapists who would like to integrate spirituality/religion into therapy but who are currently unsure about how to do this in a way that would be most helpful to clients.

I am writing to find out if it is possible to recruit some of your clients for my research. I am interested in clients with a wide range of presenting problems (anxiety, depression, etc) who have been/are in receipt of individual psychotherapy (humanistic, psychodynamic, cognitive behavioural, etc) from a therapists who has a formally recognised accreditation or is eligible for accreditation (for example, British Psychological Society division of counselling and clinical psychology (BPS), British Association of Counselling (BAC), etc) where clients felt that their therapists integrated spirituality/religion into therapy.

Participants will be asked to complete a demographic questionnaire and take part in a one-to-one interview with me, which will focus on their definition of spirituality/religion and their ideas and experiences of spiritually integrated therapy. These interviews will last approximately one hour and will take place at a time and
location that is convenient to the participants. Each interview will be audio taped and subsequently transcribed. All personal details will be treated in the strictest confidence in accordance with the Data Protection Act (1998): no individual person or organisation will be identifiable in the final research report. If at any time participants feel that they no longer wish to participate in the study, they may withdraw without having to explain. The analysis of the interview transcripts will form the basis of my research report. A copy of the final report, which is due for completion in September 2005, will be available to you at your request.

If you would like to take part in this research or require any further information, please contact either myself or my supervisor, Dr Adrian Coyle. We can be contacted via the address above or via the course secretaries on 01482 876 176.

Yours sincerely

Valerie Suarez
Counselling psychologist in training
Appendix D - Sample Letter to potential participants

<Date>
<Name and address of (potential) participant>

Dear <Name of (potential) participant>

A study on the integration of spirituality into therapeutic practice

I am currently studying for a Practitioner Doctorate in Psychotherapeutic and Counselling Psychology at the University of Surrey and as part of my doctorate, I am conducting a research study on clients who are interested in spirituality/religion and who have received therapy where they felt that their counsellor, psychologist or therapist integrated spirituality/religion into therapy. I would like to invite you to consider taking part in my research, as I believe that you may fit my criteria and may have something valuable to contribute to my research. It is hoped that this study will provide valuable information for counsellors, psychologists and therapists who would like to integrate spirituality/religion into therapy but who are currently unsure about how to do this in a way that would be most helpful to clients.

If you volunteer to participate, you will be asked to take part in a one-to-one interview with me, focusing on your personal spirituality/religion and your ideas and experiences of therapy where you felt that your therapist integrated spirituality/religion into therapy. These interviews will last approximately one hour and will take place at a time and location that is convenient for you. Each interview will be audio taped and subsequently transcribed. All personal details will be treated in the strictest confidence in accordance with the Data Protection Act (1998): no individual person or organisation will be identifiable in the final research report. If at any time you feel that you no longer wish to participate in the study, you may withdraw without having to explain. The analysis of the interview transcripts will
form the basis of my research report. If you wish, a copy of the final report, which is
due for completion in September 2005, will be sent to you.

If you would like to take part in this research or would like to find out more about it,
please contact either myself or my supervisor, Dr Adrian Coyle. We can be
contacted via the address above or via the course secretaries on 01482 876 176.

Yours sincerely

Valerie Suarez
Counselling psychologist in training
Appendix E – Information sheet for volunteers

A study on the integration of spirituality into therapeutic practice

➢ My name is Valerie Suarez and I am currently studying for a Practitioner Doctorate in Psychotherapeutic and Counselling Psychology at the University of Surrey. As part of my doctorate, I am conducting a research study on clients who are interested in spirituality/religion and who have received therapy where they felt that their counsellor, psychologist or therapist integrated spirituality/religion into therapy. It is hoped that this study will provide valuable information for counsellors, psychologists and therapists who would like to integrate spirituality/religion into therapy but who are currently unsure about how to do this in a way that would be most helpful to clients.

➢ If you volunteer to participate in this research, you will be asked to take part in a one-to-one interview with me, focusing on your personal spirituality/religion and your ideas and experiences of therapy where you felt that your therapist integrated spirituality/religion into therapy. These interviews will last approximately one hour and will take place at a time and location that is convenient for you. Each interview will be audio taped and subsequently transcribed. All personal details will be treated in the strictest confidence in accordance with the Data Protection Act (1998): no individual person or organisation will be identifiable in the final research report and information will not be identified with any individual. If at any time you feel that you no longer wish to participate in the study, you may withdraw without having to explain.

➢ The analysis of the interview transcripts will form the basis of my research report. A copy of the final report, which is due for completion in September 2005, will be sent to you at your request.

➢ If you would like to take part in this research or would like to find out more about it, please contact either myself or my supervisor, Dr Adrian Coyle. We can be contacted via the address above or via the course secretaries on 01482 876 176.
Appendix F – Consent form for volunteers

_A study on the integration of spirituality into therapeutic practice_

- I have read and understood the Information sheet provided. I have been given a full explanation by the investigator of the nature, purpose and likely duration of the study and of what I will be expected to do. I have advised about any discomfort and any possible ill effects on my health and well being which may result. I have been given the opportunity to ask questions on all aspects of the study and have understood the advice and information given as a result.

- I understand that all personal data relating to volunteers is held and processed in strictest confidence and in accordance with the Data Protection Act (1998). I agree that I will not seek to restrict the use of the results of the study on the understanding that my anonymity is preserved.

- I understand that I am free to withdraw from the study at any time without needing to justify my decision and without prejudice.

I confirm that I have read and understood the above and freely consent to participating in this study. I have been given adequate time to consider my participation and agree to comply with the instructions and restrictions of the study.

Name of volunteer (capitals). ............................................................
Signed ................................................
Date.............................................................
Interview no.: ______________________ Date: ______________________

Age: ______________________
Gender: Male/Female
Current marital status: Single/Married/Living together/Divorced/Separated/Widowed

Ethnicity: White/Black/Asian/Other

Highest education/professional qualification: None/CSE(s)/GCSE(s)/A levels/Diploma (HND, etc)/Degree/Postgraduate degree/diploma

Occupation: ______________________

Have you been brought up within a religious tradition? Yes/No
If so which one?
Are you a member of a religious or spiritual group? Yes/No
If so which one?
What is the significance of spirituality to you in your everyday life? Extremely important/Very important/Quite important/Not very important/Not at all important

How long have you been in therapy?
What are your main reasons for seeing a therapist?
How long have you been in therapy?
Therapeutic setting? NHS/Private/Other
What is your therapist’s therapeutic model?
Appendix H - Interview Guide

Therapy – general questions

• How did you choose your therapist?
• What role did spirituality play in your therapy?
• What role would you have liked spirituality to play in therapy?
• How would you have liked spirituality to be introduced into therapy?

If spirituality NOT integrated into therapy

• How come spirituality wasn’t raised in therapy?
• Have there been times when you have been tempted to bring it in?
• What held you back?
• How do you think your therapist would respond?
• What made you say that?
• Do you think it would have made any difference if you were able to bring spirituality into therapy? (probe impact on difficulties, therapeutic relationship, helpful/unhelpful elements)?

If spirituality integrated into therapy

• What effect did the integration of spirituality into therapy have on you? (probe impact on difficulties, therapeutic relationship, helpful/unhelpful elements)?
• What are your views about the advantages and disadvantages of integrating spirituality and/or religion into therapeutic practice?
• Do you have any advice for therapists who would like to integrate spirituality into their practice?

Personal spirituality

• How do you see your own spirituality?
• How does your spirituality affect your daily life?
• In what way has spirituality been helpful to you?
• In what way has spirituality been difficult for you?
• How have you develop your spirituality?
• Can you tell me about your current spiritual practices?
• Have you had any spiritual experiences?

Ending the interview

• Those are all the question I have. Is there anything on the subject you would like to talk about which I haven’t covered?
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 make you say that?
- How useful/helpful do you find that?
- In what ways do you think that is different from or similar to ‘normal’ therapy?
- How do you make sense of that?
Appendix I - Debriefing Procedure

Each participant will receive the following verbal debriefing.

➤ Participants will be thanked for their time and co-operation.

➤ They will be asked if they would like to hear the interview before it is transcribed or like a copy of the transcription.

➤ They will be told that they may withdraw from the study at any time and upon withdrawal, all taped or written material concerning the interviewee will be destroyed.

➤ All tapes will be kept under lock and key and wiped upon transcription.

➤ Transcriptions will be anonymous and all names will be changed to ensure a level of confidentiality.

➤ Participants will also be told that they can contact me if they have any ill effects from the interview and I will try and assist them in finding appropriate help.
Appendix J – List of supportive resources for participants

Below is a list of supportive resources in case you experience any distress by taking part in this interview and you feel that you need help.

You can contact your GP and ask him/her for referral to a (local) counsellor.

Contact any of the following confidential telephone help-lines:

- Samaritans 084 5790 9090
- Sane Line 084 5767 8000

Or contact any of the following psychological support organisations:

- British Association for Counselling and Psychotherapy
  1 Regent’s Place
  Rugby
  Warwickshire
  CV21 2PY
  Tel: 0870 443 5252

- WPF Counselling Psychotherapy
  23 Kensington Square
  London
  W8 5HN
  (sliding scale of fees)
  Tel: 020 7361 4800

- UK Council for Psychotherapy
  www.UKCP.org.uk
  Tel: 020 7436 3002
Appendix K - Sample Interview transcript

Interview 6 - 2nd March 2005

I - Interviewer
P - Participant

... - pause
(?) - unknown word/s
(assumed word/s?)

...... collect background information.....

I: How did you choose your therapist?

P: Because I was starting the course with C and I... wasn’t in therapy it just made sense really to just go along ... and be interviewed by them where they would then make a recommendation, so that is how ... my therapist was found.

I: And did you have any choices?

P: Well what they do in the interview, they obviously ... these are the professionals, if you like, the people who are regular staff at C actually are ones who conduct the interviews. So ... I think they are pretty good intuitively to work out who... you were likely to be matched with and that is not only obviously on that level, emotional level but also financially... because this has to be a factor. And I had already said “I can’t afford to pay more than x, if I was going to be doing this every week”. So they matched me with somebody and it was actually a very good match ... I think.

I: I got the impression on the phone that you have had therapy before?

P: Yes, that’s right.

I: How did you choose that one?

P: Actually, that was quite funny. It was about ... 14 maybe 15 years ago I guess, and I had heard about his woman from a friend... In those days particularly... it was something that you kind of ... I whispered about certainly. I was not even comfortable mentioning the word therapy but I knew that I was kind of in
trouble and so this friend said “Actually, I have heard about this woman and you know she is not... typical” whatever that meant and of course I went “Oh, ok” (laugh). ... And I went along and had a meeting with her and she was very funny and she actually laughed at me. She said, “What do you think this was going to be about?”. And I said, “I have no idea”. And she said “But I think you have” and we laughed about the fact that I came expecting ... to have to say “This is my problem and I have got this and I have got the other, and will you help me?”. Anyway by the end of the hour I was frightened ... because even in an hour she had managed to ... well she had opened something, so I ran away.

I: Hmm

P: And it took me a year to go back.

I: To the same woman?

P: To the same woman. So it was very interesting ... and we worked together for two years ... and it was extraordinary. It had a huge breakthrough. Something that I had lived with all my life and I didn’t really think... was relevant. Oh I just thought “I am used to it now” was that I had a bird phobia. And in the two years that was one of the things, in fact that was the major thing that we got rid of, which was extraordinary.

I: So would you say that spirituality was integrated into that therapy?

P: Definitely,... because she has a way of working... She was actually trained as a clinical psychologist but very much worked across, of course I didn’t know what half those things were at the time, ... but we did a lot of art work and clay work and this kind of thing. And one of the key things that opened up the bird phobia and allowed that memory to come back um was actually a drawing of what my soul looked like.

I: Hmm

P: And I had never been asked that before and had no idea, but I drew something, the way you do with these things, that completely mirrored what was ...happening for me on the inside. So it was extraordinary but... that was the opening.

I: So it wasn’t when ... when you friend said, “She isn’t typical” it was a lot of creative techniques that she used?

P: Absolutely
I: Can you tell me how spirituality was introduced?
P: That therapy or this one?
I: It would be really great if you could compare them ... if that is possible?
P: Oh ok. I am just trying to think... I think what it was with the first one... was that looking back on it now, of course, retrospectively it is so much easier of course, but at the time, ... she obviously picked up very quickly on the fact that I was very heady and ... we needed to move into the area ôf feeling but the only way she could get me to do that... there was no point in talking. I remember on one occasion she said to me “Before I finish this sentence... you already know where I am going to go, so this is pointless” and we laughed. So that is when she introduced... the work. So I had to go away and I had to make things. And I remember the first time... she asked me to work with clay and of course I am quite an obedient person and I would go “Ok” and I would go off to the art shop and I would get the clay. And I remember I took the clay out and thought “I don't know what the hell to do with this” and I picked up a piece and I started working it with my hands ... and burst into tears.

I: Hmm

P: And so I went back and I told her and she said, “What do you think happened then? What happened?”. And as we started to talk ... that is where the layers started... to change. And I think that was the beginning of the introduction so that we could even start to have a conversation like soul. She had already gathered in our conversations that I had been raised in the church and had really kind of conflicting feelings about religion and didn’t really understand the difference between religion and spirituality and so she was very gentle in the way she approached that, because if I thought she was going to talk about God I was going to shut down and so she was just very careful. She did it very much from a feeling... perspective so I had no (???) to say, “Yeah, I guess I am engaged... in that kind of way”.

With this therapist, my present therapist it is different because... I am doing a course about transpersonal, so it was absolutely right at the beginning and also I am at a very different place now. I have a completely different relationship, in fact I have a new relationship with what I call my God, it has nothing to do with
religion. This truly is a kind of spiritual encounter and so … and she knew that
instantly, the minute I opened my mouth and started talking.

I: The first therapist?

P: No the second, my present therapist was very aware of that. Just because of the
way, the way I spoke the kind of imagery I use… the metaphors I used. So it
was very easy to just keep going where I was going.

I: Do you feel comfortable sharing an example of that? You know when you say
she knew exactly about your relationship with spirituality… what she said that
gave you that impression or how she was?

P: Yes, in fact .. because… I told her about … this was in our very first session and
I was telling her about the first experience of … being in therapy and what that
was like and told her because it was the most important thing, the whole
business of the bird phobia and I gave her the back story of that which
ultimately involved a relative of mine, … an aunt in fact. And my parents were
incredible… the way they supported me in very different ways. My dad was
like “If you never want to speak to this woman again, that is absolutely fine
because you have been right because she was appalling”. And my mum, who …
was a much more kind of spiritual being said, “Imagine being in… the position
where you don’t understand what love is… and therefore you are incapable of
giving it? Whatever you feel about her she will never have that and you do...
Just think about it in that kind of way”.

I: Hmm

P: which was beautiful. I tell my therapist this story and she then tells me a story
… and the story she tells me is the story of the two souls. One little soul … says
to God “How do I experience light?” and God says “But you are light” … and
the little soul says “Yes, but I don’t understand that. How am I light” and God
says “Well light is all around you, so I guess it is a difficult thing to understand
… but I promise you that is what you are”. And another little soul comes along
and says, “I’ll help you experience light”. And the first soul says, “How will
you do that?”. And the other soul says “We have to leave here and I will slow
down my vibration and when I do, … you will be able to experience your
lightness against my darkness, but it is really important when I do that that you
don’t forget who you are or else we are both going to get lost”. And instantly I
said, “You know what something else has just shifted for me”.

I: Hmm

P: I feel I have just shifted something else with my aunt because I now understand that there could be another role that she was playing. It wasn’t just that she was this evil, horrible person... who had been really... who just didn’t understand and was quite nasty. That there could be ... another way of looking at this and it just ... released something from the first session.

I: So from the first session she was talking about your soul?

P: Absolutely.

I: So earlier you said that your first therapist also talked about your soul?

P: At that point yes, but ... we were 18 months in at this point. So she could safely say a word like soul ... without me freaking out. But at the same time being aware that I didn’t know... I didn’t know what my soul looks like but going off and kind of opening that up to be able to look at it... And we did talk about ... we talked about things being lodged... She had a really interesting way of... kind of expressing herself which she did... on all the levels. I can’t think of a better way of ... expressing it really.

I: You know you were saying if she talked about your soul earlier on, it would have freaked you out, can you say a bit more about that?

P: I had walked away from the church because there was so many things that I just felt... were a huge disappointment to me but also I was really aware of the fact that ...I had gone, as a child, and I continued going... because I felt I needed the structure of it at some... subconscious level but then I had gone out to work and that was really entering... the world. Everything was really tiny until then and I had gone out into the world and realised... I don’t see the difference between the people on the outside and the people inside here, expect they appear to be less guilty than me.

I: People on the inside?

P: i.e. the church had... there was such a kind of ... there was a tightness and a real kind of sense of not being able to be who you were and... all of that was wrapped up in guilt and somehow that had something to do with God, as it was being taught to me. And I looked at the outside and thought... these people are actually less hypocritical that these people. I think I am going to... go hang over
here and so I walked away from it. And literally it was the baby and the bath water... all going out at the same time. So the idea ... in fact I couldn’t see a lot of the people that were connected to the church, I am absolutely fine with them now, but at that point I couldn’t because every time I looked at them that kind of brought the guilt back.

I: Hmm

P: And it was all about how I ran off and I was the prodigal child and ran off and ventured all over the place but not really... necessarily being that much happier. I knew there was something missing. I didn’t particularly want to find out what it was. I did it in lots of different ways and finally... I had an experience... of um... in fact to fill it out, I had at 18 which is year I left the church, it was the last year I had gone to the lake district. I used to climb and I loved it. But part of that was... we would join with the Christian community for one week and then we would go off on holiday for the next 10 days... and so we had done it. And I just knew, interestingly, I am not going to be doing this again... And went off and had this holiday, walked and it was fabulous. Fast forward to ...two years ago, I meet a new friend and she lived in the lakes and... I went and spent a weekend with her and I said “do you know I haven’t been here since I was 18” and we were walking around and these incredible feelings are coming over me that I can’t really explain. I am awe-struck, it is a beautiful part of the country but I knew it was deeper than that. It was kind of like “wow, God, yes”... And I was struggling with this thing even as I was... loving it and then we popped into a bookshop and I came across... ‘Conversations with God’. I had heard about this book but the God word was in it and I wouldn’t touch it ... and I walk into this place and it was the right time I thought “I will give this a try” and picked it up... Didn’t read it over the weekend but started reading it on my journey back and I was on this train. And I remember as I was getting on the train I thought... “I really don’t want to sit with the plebes today... I just want to be on my own” and I got on the train and I had booked a seat. So this was actually highly impossible to me... that I wouldn’t be sitting near people. As I got on the train I started looking for my seat, it had gone, it didn’t exist... and I said to the guard “My seat” and he said “Don’t worry, go and sit down in first class and we will sort you out” and of course they never did... So there I was
and ... so I sat down and I started reading this book and it just ... connected and it connected and I burst into tears and I cried... for about an hour on the train with absolute ache and joy all at the same time. It was extraordinary and I thought, “That is what has been missing”.

I: Would you ... label that as a spiritual experience?

P: Absolutely, totally. And also... because what was extraordinary about it was that it was no longer... something that was being dictated to me... but it literally was me... responding to something that I guess... finally... I wanted to explore... in my way and there was just... it was a wonderful moment. And I remember when I finally stopped crying I rang my friend and said “You will not believe what has just happened to me, something huge has just shifted and it is just fantastic” and so really from there on... I have been quite comfortable but in my way... That is the best way I can think of describing it.

I: Yeah.

P: It didn’t mean I don’t meet people who understand God in... a similar way to me. But I am also not shanghaied by the fact that somebody might be... a Christian and that they have a particular way of believing that I can’t share with them. That is so... fine now and there really was no space for that... prior to that experience

I: So you don’t belong to a spiritual group at the moment?

P: No.

I: (???)

P: It is difficult to say actually because it is what it is really... No, because I suspect that with another client... the approach again would be different... based on the client’s information. I am where I am and... it is where we sit in terms of... the kind of things that we talk about... the way that I think. I very much feel that... she meets me where I am.

I: So your therapists were sensitive enough to... judge where you were and meet you there?

P: Absolutely, and occasionally she would introduce something... where she might say something and I might say “I don’t understand what that means” and she would say “All right, we will just leave that”. And she is also open enough to say to me ... “I am directly... in contact when I talk to you because sometimes
there are things you talk about... and I don’t know where to go and I have to ... and I wait to get information” and I think that is a very brave thing to say... I didn’t know that a therapist might say something like that.

I: So quite self-disclosing?

P: Yeah. It is a very... transparent way of working.

I: So this is your second therapist, it is very different from your first therapist’s way of working?

P: Yeah, I think it would be because... it truly must be about... at least my sense of it, it must be about... where the client is,... that is where you have to meet them. Now my first therapist I think responded very well to me... and helped me kind of open up to a place. Had she come in ... there is no way if I had walked into a therapy session... and it would never happen actually... with my present therapist and she said the soul story... I would have run for the hills, absolutely run for the hills. But she knew from the way I was describing what had happened... that I could hear this.

I: Yeah. I am curious about how you felt when you first therapist said “Go away and draw you soul”.

P: It is very funny... The funny thing is I have actually shared with her two things... just before saying the soul drawing,... and maybe this is what actually allowed her... to say it. I was working with a director friend and this guy was Brazilian... His English wasn’t very good and in fact I worked very closely with him. I was working as a producer and I worked closely with him... because of the language problem and because I... we kind of clicked... I could understand what he was saying, I could described it very well to other people. And this particular day this man who doesn’t speak very good English, held my face and said to me “You have to get rid of this thing because if you don’t your angel can never come... and even if he does you can’t hold him because he has wings”... Now for anyone ... I looked at him... I stood there and I went cold and when he walked away I stood there thinking... “What just happened?”.

And then the following day... I was... at the bus stop in B and I would do ... I call it bird patrol. You know there are some places where you are standing and you are very conscious that they might land and whatever... And I stood at the
bus stop and a bus came round the corner... but just before the bus came round the corner there was a woman standing at the bus stop and for some reason she made me uncomfortable, it was like a knot in my tummy. And just before the bus came round the corner she opened up two carrier bags and she tipped them upside down and they were full of breadcrumbs and the birds it felt like were coming from around the world... And they were flying in as this bus came round the corner and that is death to me... And I remember ... literally at the bus stop I blacked out, I don’t remember this, it was a split second and somebody was helping me to get on the bus... and I tried to reach for my purse and I was shaking... so much that the bus driver said “Just go and sit down”. So those are the two things that I told her. But I think that... they were what informed her that this was where we should go... because we were not going to be able to talk through this, she had to take me to another place to be able to access it. So that is what... I think happened.

I: That’s interesting that you think you couldn’t talk through it.

P: I would have attempted to explain it... and it would have left me in exactly the same place... I was very clear about the fact that I had a bird phobia... I didn’t understand... how I could access this because for whatever reason... my memory had shut down and I understood this... logically but that didn’t help me though... I still couldn’t change... the physiological reaction in my body. So we had to go to a different place to be able to access it... and she... and I guess the way that I look at it now is that... my desire... finally... or my courage to finally go “You know what, I think maybe we could look into this area of the bird phobia”... is what was actually allowing all this to happen... So it was my yearning. It was my soul... asking... and saying “I do want this gone” at some kind of subconscious level that allowed for those two incredible things... to happen around me,... that then led me to say “What does this mean?” and she said “I think you want to get rid of it” and I said “Ok”.

I: So when you went into therapy, you didn’t have a clear idea that the bird phobia was what you wanted to work on?

P: No idea... I was just in crisis, lots of things had gone wrong... I just wasn’t coping and I knew that... And the fact that I managed to delay it for another year... extraordinary really when I knew really... that I needed to talk to
somebody in a... very different way from the way I would speak to friends and I wasn’t even sure that what I was saying was making any sense... I think that was the thing... that finally frightened me enough.. to go back.

I: The thing about phobias is interesting.. and also that you saw a clinical psychologist because some therapists would work on that in a very Cognitive behavioural way ... but she didn’t.

P: Yeah,... and I think that is real acknowledgement... about the person that is sat in front of them. Because I am sure they are people that CBT works very well with,... I am not one of them... That is not how I operate.

I: You may have answered my next questions which is... what effect do you think integrating spirituality into therapy had on your difficulties?

P: Um ... I think it allowed,... certainly for me, it allowed for work... at a very deep level and it... also allowed for... for me to be aware of the role I was playing within my life. I know that sounds silly because I know... you sit in a room and there it is this container and you work within in... but somehow talking... talking was one aspect of it, which in fairness I was quite comfortable with. To move away from that, to kind of go into places where... I didn’t know what was likely to happen... showed me the role I was playing within it, as opposed to psychobabble, for want of a better expression... Quite dismissive really but you understand what I am saying?

I: Yes

P: For me, it was really important that there was... this other space... that had to be found to work within... I don’t know if that kind of answers it?

I: Yes (???)

P: (???) In fact I am lying, it was 12 years we worked together because I have been phobic free for 10. Yeah,... and it is very funny actually, we did a weekend session at C and I was walking with a bunch of people, walking by the canal and there were lots of birds around and they flew up as we were walking past and one guy said “You really had a phobia?” and I said “I know” (laugh). It is extraordinary, if you can find whatever the root is,... things really can go. And I think there is a huge... kind of power in that. And obviously there must be something about... the way that I am as a person that makes that make more sense for me. In a way I think it would be very difficult... I went to a...
therapist, in fact it was to stop smoking... and his method is CBT and after I had done the smoking I went to see him for about 2 or 3 sessions and thought... “This just doesn’t work for me”. I talk too well... I use logic. I do all of that stuff. It doesn’t help me... The two need to be married up but I have to go to the other place... so that the words are allowed to drop down because I get it here (point to head) but I need to feel it... in order for the change to actually happen and that... is what was kind of missing for me.

I: So when you talk about going to this other place, can you tell me a bit more about that?

P: Yeah, kind of around... this kind of area that feeling around the middle bit of the body as a place where ... I used to go to a homeopath who used to talk about... a very quiet place... where no one else can go,... just you. And I think that is the kind of place that I talk about. And in my way ... it is the place where the God like part of me exists,... that’s the place and if that is the soul then... I guess it could be. I don’t know, I don’t know the words, I just know the feelings. Well it is this place where,... if I allow myself to be open, I can find... stuff. I do believe in the fact... that everything... was experienced once and actually what we are going through now is a process of remembering. This is place where the memories are. And so that is kind of ... what it is for me.

I: When you say that if you open up you are able to find it, do you have any ways of becoming open?

P: I meditate... and that is the way I find to be able to get in because I believe,... for somebody who was always rushing around like a lunatic and who has always been very impatient, it was stillness... that allowed the access... Being in a space that was mine and... being still in that space and trying to... quiet down the brain, which I do mainly by breathing. Just allowing... that moment to kind of come and in there... 9 times out of 10 I will find an answer.

I: When you say find an answer (???)

P: It is where I go everyday in fairness... Sometimes it just about... it like having a bath, it is about... getting the day right. I am not saying there aren’t some days when you go “No, I won’t wash today” and of course there are days when I go “Nah, I don’t fancy meditating today”... But 99% of the time I do and it like brushing my teeth or doing something else. It is the spiritual aspect... that is the
mirror of the physical stuff that I do, it is preparing the day, really that's what it is. I do it first thing in the morning.

I: Do you have any other spiritual practices?

P: Meditation is kind of it really… Because I think everything else is… actually not a spiritual practice but it is about … you know now about 70% of the books I read, if there are not to do with course work, are probably to do with… spiritual aspects. So I read lots of people's theories… I am constantly exploring.

I: And how did you learn to meditate?

P: Funny enough the first time… of trying meditation was with the first therapist and...

I: So while you were in therapy together?

P: Yeah, but I didn’t do it after that.

I: How did she introduce it into therapy?

P: Um … there was one day we were talking and I said “God, I am so confused I cannot even work out what to say” and she said “Maybe it would be better if you were just… quiet for a moment, maybe then it would just kind of clear itself”… So she just stopped me… and asked me to breath… and she said “You know that is kind of meditating” and I said “Oh really” because everything was “That is so weird… and I am not sure if I want to do that”. Just breath… and so I did it for the period that I was in therapy and then I kind of faffed about with it, maybe a little bit after that and then just… stopped and it really only started back about… it is probably 8 years ago. So it is interesting that I would try this little practice but I wasn’t interested in anything spiritual because that still meant God. And so I would say the last… 3 years it has had… a completely different kind of… feeling. I keep a journal and I have done, but I have done that… for about 10 years.

I: And do you know what made the difference… how it changed 3 years ago?

P: 3 years ago was my illness… I was diagnosed with a condition called (?) and basically… I produced anti-bodies and they were eating away at the muscle tissue in my main strength area. It is a real wake up call to kind of sit back and go… “What is that all about?”. For me it became interesting to look at the fact that… I was kind of a power house out there, I would kind of run around and I got things done and all of a sudden my power,… my physical power had been
taken away… and I thought “This is really interesting, now what is this about?”. I guess I started looking inwards at that point, probably more strongly than I had before and so it probably made sense that a year later I would then end up in the lake district. You know it is following through. And I often think with the illness, now looking back at it, with hindsight that… that was what I was doing. I desperately wanted to work out how to slow down,… I wanted to work out how to put me in my own picture and I didn’t know how to do that and I think this… came in as an answer. It may not have been the answer I would have liked, but it was the answer that allowed me to be able to start looking… in much kind of deeper level.

I: That is really interesting… (???) you said you had 3 types of therapy. Can you say what effect integrating spirituality, or not, had on your different therapeutic relationships?

P: In fairness… it would be unfair to comment on the guy in the middle because it was so few sessions. I just thought he was a very sweet man but… with the other two… I think that the fact that… there was sharing at that level… I mean I know… or I am starting to understand the business of therapy and the fact that you have to… you have to engage with your client… if you are going to be able to help them. But I think there is something about… about that sort of spiritual level that just kind of… I feel in quite a deep relationship with both of these therapists. It was amazing and I have to assume it was that… because I think that the more levels that you share at… surely the more deeper and more meaningful the relationship is and yeah so I guess for me… it would be that way round…

But I do think you know… again it is that point about… the consideration… of the therapist… that makes a difference because I don’t think… I think about some of my friends who are… not even sure if therapy is a good idea or not. If… any of the levels of conversation I had been having with my therapist was had with them… quite rightly they would run for the hills, it doesn’t make any sense… So I think that it is about… no matter what kind.. of therapy… of reason for coming into therapy,… I think you have to gauge… It is no different from any other aspect of… therapeutic practices, you have to be able to gauge
when is the right time... on any of these levels. When do you introduce this? When do you talk about it? And the signs have to come from the person and I suspect that you know... if somebody was coming to this new... that transpersonal is not the first place that you would go.

I: As a client?

P: As a client yeah... and even as a therapist... I don’t know whether that is necessarily... You might use it in terms of how... instinctively how you find what is happening with a person but I don’t think you are using it... in a practical way, if you can say that about the transpersonal... You have to be very careful.

I: So timing is very important and it sounds like you are saying that your two therapists had got the timing right.

P: I think so, because certainly... it was about... where I was at... and that is where they met me. And I could certainly tell the difference between the two and how one had helped me to kind of move to a certain place and then I had been journeying after that and therefore this one... also met me where I am.

I: I guess it would be quite hard to pin point the signs you were giving that enabled them to meet you where you were at?

P: Yes I think it would be. It would be difficult to say... exactly what it was, but also one of the things... with the present therapist was that I did mention that I did a course while I was ill... called the Hoffman Process. And I think that if someone has touched Hoffman,... chances are that they have already touched a bit of transpersonal... or at least have some kind of ideas.

I: Can you say a bit about that process?

P: Yeah,... it was... an 8 day residential course... set up by... this guy called Bob Hoffman who realised... that for him to be able to understand ... your patterns and how to start unravelling them you need to go back to the basics, you need to go back to childhood. And I know everybody kind of understands that but his point is... that you go back there and actually identify... what each of the patterns are that you have and which came from which parent or any other kind of... protector or... other influential adults in your life. To identify these things... and to look at them and to look at the contrast of that and out of that to try to find patterns that literally could be yours, as opposed to the ones that are
theirs. And then it is an unravelling which is actually looking at the fact that, of course, if you do something like the Hoffman process is that, you probably are not very happy with some of these patterns... So to undo them... is to be able to go into the place where... you are angry and... let it go... all of this anger that you have towards these people, deal with that... And if in doing that you genuinely arrive in a place where you have let go... you can start to be able to look at your own patterns... You can even start to identify with them and no longer see them... as being the worst thing on the planet. To be able to get to a point where you can genuinely... forgive your parents because... for a lot of people, including myself, it was possible to see other aspects of my parents... where I could see them as... another aspect of their humanness, for want of a better description... So therefore forgiving them became much easier... That was really kind of what the Hoffman was about... It was also things like... where the transpersonal aspects came in, was... identifying the fact that the little child, the physical little child is still with you on the psychic level... and that if she felt hurt at that point that she is going to be hurt now and so... going through... kind of a physical exercise but actually they were kind of transpersonal. You know taking a cushion... and the cushion became you and then mothering yourself, fathering yourself that kind of way and it is extraordinary... I thought it was an amazing process to go through and... some people say... it is the equivalent of 2 years worth of therapy. I think they are probably right... because you do go thought incredible depths and then are able to kind of emerge feeling quite clean... And I think that is probably true provided that you then go to therapy. Because I think what happens is that you have unravelled a lot of stuff but it needs to be... needs to be held in some way... so that you can actually go to the process of really... being able to integrate it into your life. But it was an extraordinary process and she had heard of it, so the minute I touched on that she knew that... a transpersonal aspect was included.

I: When you talk about the cushion that sound very experiential ... is that what you would see as spiritual?

P: Well we meditated every morning and every afternoon and every night, so it was very much... in fact it was the most holistic approach to anything... that I had
ever witnessed and... put myself through. And now that I,... in my first year of training and obviously having done the foundation last year... I become more and more conscious... of how incredible... a process it truly was and how many elements it used... and put them together in such a beautiful way that it was possible to take people... quite safely through that kind of exploration.

I: So when you say a lot of elements were used... is it possible to identify them?

P: I definitely felt... existentialism, gestalt, you just felt it. Well I didn’t feel it at the time, I didn’t know what that was at the time. But looking back now as I am starting to understand it, I absolutely see all of those elements and the transpersonal definitely. There was even one experience where... we had to witness our own death... and talk about what that would be like if we were able to see it. It was an amazing thing to do. You do that and you never quite feel the same again. It was extraordinary.

I: Can you talk about what effect that had?

P: Well... I had a very deep experience with it, partly because I still couldn’t ... I did the process on crutches

I: So it was the time you were ill?

P: I was very ill. I was taking very heavy steroids. It was quite a difficult time and yet... there was something very important about doing it at that particular time. So, whereas other people were able to... we had find a space where we wanted to go off... and experience this thing of being... dead and then to come back and to write... what that was like. And of course I couldn’t go very far and the only thing I could do... I thought, “I can’t lie down because I can’t get up”. So, in the end I used a bench because it was the right height... and it was also the first time... and getting up from the bench for the first time I realised that it actually it doesn’t matter about where you think you need to go to do something, the truth is... if you really want the experience it will happen right where you are. So I lied down on this bench and started thinking about... if I didn’t change anything in my life, therefore what that death would be like. What would it be like for the people closest to me... and what they would say if they told the absolute truth... And I came back and I wrote it down and it was just extraordinary. And I knew I wanted to change... I knew I didn’t want to be that person.
So I think being that ill was very important for me to be able to really experience... what I no longer wanted to be my story. I didn’t want to be the faith. I didn’t want to be the person who ... would put a sheen on things and pretend that everything was fine and that I was fine and that it was all ok. I actually wanted them to know who I was. Because in this death experience I realised that people could see who I was,… they saw a shadow... I thought it was nicely hidden and of course it wasn’t... and of course it is my... story... It was very interesting for me... knowing that, in the context of my own story and I no longer wanted the shadow to remain in shadow. And that was an extraordinary thing.

I: So the bits you thought you had hidden, other people had seen it anyway?

P: Yeah... at least in my mind they had seen it and that was good enough... and therefore it was something to be looked at.

I: It seems like you have talked about some advantages of integrating spirituality into therapy, are there any disadvantages you can think of?

P: (???) It was painful and I think that pain … pain is just what it is because there is joy. In fact I had an experience this weekend, just gone, we were doing course work... and we were listening to music as part of a meditation and it was... this wonderful sense of... absolute ache... mixed up with joy and I realised that sorrow and joy genuinely are... the opposite sides of the same coin and such an amazing feeling and that to me... is transpersonal. It quite often hurts because you are going into a deep place. Quite often going into a place you haven’t been before and that experience... quite often has a lot of pain attached to it.. but the transformation also is very joyful, so... I can’t find a disadvantage.

I: I have one more question about spirituality in therapy.... And you may have answered this but do you have any advice for therapists who would like to integrate spirituality and therapy?

P: Even when talking about transpersonal the... the rule would be the same for any... kind of therapeutic practice. I still think it is about... being able to meet them where they are, because you can’t go any faster than they can anyway. I think the transpersonal can be no different... I think also it is useful... But again it kind of needs to come up... as an issue before you can... probably talk about
it. Because it is one of those things... it is a bit like... how would I describe it? ... being able to hear something but not necessarily being able to listen... or vice versa. I am not quite sure of the right way to say it. So you can say a lot to somebody but if they are not in a place where they can hear you... then it makes no sense. Because the only thing I would say about transpersonal is that the fact that you step into an area of the unknown... is that the person needs to be reassured that it is still safe... in fairness... actually even as I say that I think that is the truth for therapy. That somehow, that the space that the therapist and the client work in... must feel safe and that has been created by them... somehow and yeah transpersonal... would be the same. It is... risky to open yourself up... on any of those kinds of levels. And I suspect that whatever the elements you are using... would still open you up and therefore the need to feel safe... is important.

I: And when you say risky, do you have some ideas of the risks?

P: I suppose is it just there are sometimes where it can feel like ... what is that book? Is it 'dark night of the soul'? and now I kind of look at ways of being able to express it for myself. I remember when I saw 'the Passion of Christ' and thought “Yeah, that is useful kind of metaphor” or it is a useful kind of bit of symbolism to look at... which is Jesus in the garden of Gethsemane and even though there were disciples around him, he was very much on his own. And think that sometimes when you go into that kind of place... you can feel incredibly on your own... and it just feels as if “What am I doing? What is this all about?”... But it is the kind of place that you hit... before being able to come up again and I think it can be... quite scary sometimes. I haven’t got a specific example right now but it is somewhere... I have been in there a few times and it is just somewhere where I think... well actually... now I accept the fact, that even with the pain,... that that is where I go in there and I emerge with something new. It is like... kind of going off and finding the treasure... and then bringing it back and that is a part... of the journey. But I guess... if somebody was working with somebody who has never moved into the transpersonal before, that actually... they would guide them in very gently because I think it is ... if they are a good therapist they will be good at handling that too.
I: So when you say that the transpersonal is like any other area, you mean like your childhood for instance?

P: Yeah, those kind of elements are in there... I just kind of think that... I sense... that there is just this other layer... that you go into and I suspect that you would have to... have gone through a number of the other layers and felt quite... safe with those before you could enter this one... and I am sure that a good transpersonal therapist would know that... It is not a place you can jump into.

I: Because the client would have to trust the therapist enough?

P: Absolutely.

I: Because you were saying that with your first therapist didn’t go there until 18 months into therapy.

P: Absolutely. She didn’t rush me in there... because I think I would... yeah I would have run away.

I: Those are all my questions on spirituality and therapy and I wondered if I could ask you about your personal spirituality?

P: Sure

I: Can I start by asking how you see your own spirituality?

P: It is kind of what I call... In fact it is something that... I used to see with my mum because even though I went to church and was sent to church in fact, she didn’t go... And I realise,... she is dead now, in fact both my parents are dead now, but I realise that what she was... was a very spiritual person. She had what I call a walking, talking relationship with God... It is just that I couldn’t see it very clearly because... I had gone into this very kind of... formal, traditional sort of religion and then coming out of that went completely the other way. I still couldn’t quite see it, I always thought she was kind of interesting but... my appreciation for her grew more after I left the church. I could see that she had something... that I didn’t quite have that. This is subconscious... I don’t know how much I really got of this at the time. And I would say that I have something that is quite similar,... which is that I believe... that there is a God in the sense that there is a divine and that aspect of me... I have an aspect of that here that marries up with the divine that is all the rest of the stuff that I can’t see. My experience here is... obviously mainly a very physical one but this aspect is the aspect that reminds me of the fact that this is eternity. It is the physical bit that
will drop away but the eternity part is actually the bit that is on the inside. It is
the place where the answers lie... but I have to be able to get it I have to be able
to experience it here (end of side one of tape)

(???) difficult for me... because of... and still... I guess it is something that I
will be exploring for the rest of my life... lots of different levels but ... it was
one of the things I found very difficult in religion because religion had such a
kind of... well orthodox Christianity, had such a kind of... stronghold of things
that you must not do... and I struggled with that and it was one of the things that
gave me a huge amount of guilt... What I feel I have now, in terms of my own
spiritual practice, is... that there is nothing... that I do that isn’t... about my
relationship with God and so that includes... having a conversation with
somebody on the tube, helping somebody down the road, having sex, all of
this... is about my relationship with God. I can experience all of this divinely...
it is my choice and it just kind of... it is about kind of understanding it in that
way and this has been the journey of really the last... really the last 2 years.
And I am loving the things that I am finding. I am loving the fact that I... again
quite recently, only about 3 weeks ago,... forgave myself for things I didn’t
even realised I hadn’t forgiven myself for. And again it was just about self-
acceptance and I think that.. certainly in my former life, I couldn’t have done
that because I wasn’t worthy of being forgiven. And even in thinking about the
forgiveness... even as I was saying “Oh my God, I have never forgiven myself, I
have been walking around with all this stuff” but even saying it, as the
realisation of that was dawning, which was very painful, came the other
realisation which was that... I had already been granted immunity, there is
nothing. It is just me that needs to do this. It is not about God... In God’s eyes
there is nothing... that I can do that is wrong. There is nothing that in God’s
eyes that would ever stop... God’s love.

I: So a very different view from the view of God that you were brought up with?

P: Absolutely, which always felt at bit like... it felt like he would get angry... and
judge you, all this kind of stuff and it was very different and I took it on, you
know, in the way that lots of children do... It is very easy at that time and you
are very impressionable and so I wonder about some of that stuff and really how
it should be taught. I don’t have a real problem with organised religion but I really think about the way that it is described to children certainly is... worth considering, you know... We see the world in a very black and white way and you walk away with this stuff.

I remember reading in a magazine once... this woman... she was now 48 and was still a virgin and it was because of being a Christian. She talked about the little girl that had gone to church... and believing in all these things and tentatively asking the vicar “Is this ok?” and the vicar saying “No, it is one of the commandments and you are not allowed... sex before marriage”. And so this poor woman had gone all her... up to this point of her life and there was a fabulous moment where she says in the article “I just had this picture of... finally arriving in heaven and saying to God “Did you mean it when you said you are not allowed to have sex before marriage” and God said “I didn’t think anybody would take me literally” and I thought that was so fantastic. But it is that kind of thing and I just wanted to be... free from that. I guess to start experiencing me and this is the way it has made the most... sense. So the last two years have been really... really interesting, a fabulous kind of journey.

I: You know you talking about being in relationship with God in everything you do, are there times when... that relationship has been disconnected or difficult?

P: Oh, always... as many times as I am doing it, as many times as I am not because each time I am discovering that there is something else I haven’t looked at. Something else that... I still have locked down in a particular thought process and finding the way of... releasing myself from that. The only way I can do that is by actually... living it out and becoming more conscious and as I become more conscious I find more things. And as I unravel one I find another. So it is a constant, you know.

I: Are there any examples of that you feel you can share?

P: If I can think of one... I mean certainly the forgiveness thing I felt was quite important. I would have said, if somebody had asked me the question, “So you believe in forgiveness?” “Yeah” and “You forgive people?” “Yeah” and I would have just said “Yes” but the truth is what I had done is I had forgiven other people and ... even that was a process... and for the first time I think I
said... with regards to my aunt for example I said “Yeah, actually I have forgiven her”. I think it is awful that she lived the kind of life that she has where she felt she had to do what she did to me. I have forgiven her and then a year on I would find that actually there was another aspect of forgiveness... that it was that little bit deeper and every time it deepened it changed my relationship with her... What is the best way of describing it? I know that ... one of my archetypes is being a rescuer and I would... rescue my aunt, prior to knowing that she was the key to my bird phobia, I rescued her. So whatever she did... in her life I would try and overcompensate for it. I would be the good... child, the good niece and whatever it was that she needed... somehow at a soul level I was playing out... the very thing that I didn’t know consciously which was this is where the ache is. This is where your phobia is... I didn’t know but I was playing it out... but as I have gone on over the years I less and less feel the need,... on a physical level, to do, if you like, what she required and actually doing now what I want and in fact it is in that particular time that this is ok. There was no guilt attached to that and every time we go through another layer... I find I have forgiven her more, if that makes sense? It is that and I hadn’t realised in all of this because I was so busy doing it for everyone else which is obviously... part... one of my issues,... but I hadn’t done it for me (???) It has taken time... to get to the point where I could recognise that and I don’t think that is finished, in any stretch of the imagination, but that is a process now... that has been started.

I: A sort of step by step.

P: Absolutely.

I: Um ... so it seems that spirituality had a big effect on your everyday life?

P: I do feel that really... which doesn’t mean that... which was my problem before... the first year of the illness I was very much... because I think I was starting to reconnect... but I hadn’t done until the following year, but it was very much... in my head and it was very... lofty thoughts. In fact it was incredibly pious for somebody who didn’t want to do Christianity, it was very funny. But it wasn’t real. It didn’t actually apply to anything and it was easy in that year not to apply because I couldn’t walk. I was lying here most of the time, so I could have these loft thoughts and think all these amazing things and it meant
nothing. It was being on that train and being in a real place that allowed that connection to happen. So I guess it is that... for me.

I: Any examples of these lofty thoughts?

P: (laugh) one of the lofty thoughts was that “Yes, it is very important that in order for you to slow down... that of course illness had to be introduced to your life, this is an opportunity to learn”. This is a great theory. The truth is... that is one aspect of it, the other is you have to get fucking angry or else... nothing has changed. All it is... is my head still running the show. But you understand why this happened. It doesn’t matter that that it makes sense up here (point to head)... unless it becomes a holistic experience... you haven’t really experienced it and down here (point to solar plexus) I believed that I had done something wrong... to become ill and I had to be able to explore that... and then I had to be able to forgive myself for the fact that I had become ill... because of course it must have been my fault. These were the other aspects of it. The fear that maybe I wouldn’t get better... because it is such a rare condition that they can’t tell. They don’t have the information that says “Oh yeah, the normal pathology is x, y and z”, they don’t know that there are like a 100 cases. All of these other aspects were as important... as my very lofty ideas and they had to be... I had to be able to face them all in a different way. So that is the change... and that is the God that I... believe in which is the one that actually works on all of those areas, not just on my lovely lofty ones.

I: I guess sometimes spirituality can be a way of avoiding all the other painful feelings.

P: Absolutely... and it means jack... it just doesn’t mean anything if you are not facing it for real and I realise that that was one of the things... for me with the church and... I guess that it is the one aspect that makes me feel a little bit sad... And I went through a thing of regret the other day... about the little girl and I... we go through lots of different stories... my little inner child... about the fact that she sat with some of this stuff for such a long time... of just not... understanding it and the belief somehow... that perfection played such an important role. I saw this being played out with my vicar and a number of other people who had to behave in a particular way and yet... when they fell, it was such a fall from grace, to use a biblical term, and the truth is it is not, that’s
reality,... to me it is an acknowledgement of... who I am. It is about learning about another aspect of me... is the fall, as opposed to this terrible, terrible crime. I remember a young woman... in fact a couple, they weren’t a couple but a man and woman in church when I was probably 15, 16... it had been found out that they had been having sex and... the elders of the church kind of gathered together. What was very interesting was the outcome of this was that... the man, of course, was chastised, a terrible thing, he should have known better and whatever but she... was taken out. She actually had to leave the church. And I thought isn’t this interesting... they had both done and they had both been treated, I thought, in actually quite an appalling way... looking back at it and it added to the terror that actually you must not have sex because this is what happens. Added to that was the whole story of Eve... We get so wrapped up in all of that stuff that no matter how much you punish the guy, she lured him in. Oh boy, this is horrible stuff... to give to a human being and the God that I believe in would never do that, would never to that... and I guess that is one of the... differences and I thought that it was so sad that I believed that for as long a I did.

I: You had a harder time as a woman?

P: Yeah, very, very unfair. And at the time I didn’t have the words to say, “I don’t like this” other than “I don’t like this”.

I: ... I think you have answered all the questions but can I just check? You have talked about what way has spirituality been helpful to you?

P: It is that thing about... feeling a sense of connectedness within me as a person, my good stuff, my bad stuff,... my positive, my negative. It is all of that... it just feels that there is this fantastic journey that started at the point of spirituality to be able to spend the rest of my life just... doing that. I mean that not just within myself but also in... relation to the people and how I get on in my life. It is just ... crucial and a real kind of... sense of freedom about being able to make those kind of discoveries is kind of great. Without the spirituality... I am not quite sure how ... I just wondered –“could I have done that without it?” and I am not convinced at this time that I could have done. (???) could be in the position where I could make this kind of exploration. I don’t think... that without that element ... because I really believe that we are the mind, the body
and the spirit and, if we are those three, than is it possible to feel the sense of integration, even glimpses of senses of integration, if not all three parts…?

I: If you ignore one bit?

P: Absolutely

I: Are there any ways spirituality has been difficult for you? You talked about religion?

P: I think that is probably, in a sense, the majority of it but I also think that the spiritual journey is, in of itself,… difficult because it is about stepping into an area that doesn’t make a lot of sense. And I also think that sometimes the answers that come … they are not necessarily clear… and sometimes you are having to trust something that doesn’t really make a huge amount of sense and you are thinking “Where am I going with this?” but I think that is what I heard so I am going to try and… go with that. And quite often you get a revelation… So I think it is … difficult just because it is… It is like… what I feel emotionally is not how I respond to things physically and therefore this is another aspect of something that I just don’t understand and I guess maybe the better I get to know it maybe that becomes clearer. I don’t know.

I: Because you have talked about getting answers a few times, can you say a bit more about that?

P: I get pictures, I get a lot of pictures. They are fabulous some of them. (???) One picture I got, even when I didn’t think I was connected… this was the first year of the illness, I got this thing… when I first came out of hospital… it was a fabulous image… and it was the middle part of my body and… it was a stage and I work in the arts so of course that would be the image. But it was stage, a black box stage… and there were lots of what I thought were little actors running around and there was a microphone and a spotlight and I could see them going up to the spotlight and going up to the microphone and speaking and running off. And I thought, “What is that?” and as I kind of… stayed with it more… the actors were actually my feelings and my feelings… I never really allowed them to come out and so … what they were trying to do… well what I thought was being told to me in this image was that… the feelings were kind of gathered up backstage and because they couldn’t get out they were jostling… and that jostling… caused physical pain in my body because they weren’t free to
speak and all they wanted to do was to get an opportunity to go up to the microphone and say “I feel dah, dah, dah”. And some of them were literally... because I stayed with this for ages and some of them were literally,... like anger would come up and around and kind of push someone else out of the way and still be back again... because it just had so much to say. And I though what a fantastic image.

I: And how did that image come to you?

P: I was meditating (???) and most stuff comes to me when I am meditating and I do get... it is pictures like that. Sometimes... they are not as clear as that. Having said that I do have to think, “What does that mean?” and then... the realisation will come afterwards but I tend... to start with images.

I: That's really interesting. My next question is about your spiritual practices, you talked about meditation about how you tried it ... and dropped it and then picked it up again

P: Yeah, but I would certainly... the last two years of my life this is my practice. It is that I do it every day and you know I get drawn to... books or I hear about a lecture. There is so much to learn where as before... the first time I was in therapy I thought “Oh great, that’s finished with. Ok lets get on with life”. Now I don’t believe that anymore,... now I believe this is life.

I: You were cured and that was the end of it? (laugh)

P: Exactly (laugh)

I: That’s the last question I have and I wondered if there was anything you thought was important that I haven’t asked about?

P: The minute you walk out the door something will occur to me. I know that I talk a lot... so I suspect that I have probably said most of what I wanted to say and God help you with transcription.

I: That was really interesting. Thank you very much.

P: My pleasure... It is nice you know... because it is a moment of reflection for me as well and sometimes there are things you forget or take for granted and you hear it back and you think “Actually that is quite interesting”. So I enjoyed that, thank you.

----- end of interview -----
### Appendix L - Table 1: Clients' experiences – Summary of complete analysis of transcripts

<table>
<thead>
<tr>
<th>Contextual Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Therapeutic setting</strong></td>
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<tr>
<td>- Therapeutic model/approach</td>
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<tr>
<td>- Therapeutic environment</td>
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### Clients' experiences of integrating spirituality and therapy

<table>
<thead>
<tr>
<th>Integration at a discursive level</th>
<th>Integration at an experiential level</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Shifting depending on various factors</td>
<td>- Therapists awake/open/call spiritual realm</td>
</tr>
<tr>
<td>- Discuss clients' spirituality</td>
<td>- Therapists seek connection to spiritual realm for clients</td>
</tr>
<tr>
<td>- Use spiritual/religious stories symbolically/metaphorically</td>
<td>- Therapists explore clients' spiritual experiences</td>
</tr>
<tr>
<td>- Clients seek/receive spiritual guidance from therapists</td>
<td></td>
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<tr>
<td>- Limitation of words/language</td>
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</tbody>
</table>

### Impact of integrating spirituality and therapy

<table>
<thead>
<tr>
<th>Impact on therapeutic relationship</th>
<th>Impact on Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Enhances relationship</td>
<td>- Enables clients to reveal more of themselves in therapy</td>
</tr>
<tr>
<td>- Jeopardises relationship</td>
<td>- Helps clients with struggle to integrate spirituality into everyday life</td>
</tr>
<tr>
<td></td>
<td>- Enables clients to sort out feelings/conflicts about spirituality</td>
</tr>
</tbody>
</table>
## Appendix L - Table 1: Clients’ experiences – Summary of complete analysis of transcripts

<table>
<thead>
<tr>
<th>Role of therapists</th>
<th>Qualities of therapists</th>
<th>Pitfalls</th>
<th>Ways to mitigate pitfalls</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Therapists not interfere with clients' spirituality</td>
<td>- Passive / non judgmental / exploring</td>
<td>- Going to too far into the spiritual territory</td>
<td>- Discernment between authentic &amp; inauthentic spirituality</td>
</tr>
<tr>
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<td>- Affirming/ Encouraging/ Open to spirituality</td>
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<td>- Spirituality rooted in therapists' life/ Faithfulness to spiritual discipline</td>
</tr>
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<td>- Tolerance of different traditions/paths</td>
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<td>- Experienced in spirituality/ Walking spiritual path</td>
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<td>- Loving/Hold spiritual vision of clients</td>
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<td>- Imaginative</td>
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</tbody>
</table>
Appendix M - Figure 5: Diagrammatic representation of findings on clients’ experiences of the integration of spirituality and therapeutic practice
Appendix N - Table 2: *Clients' & Therapists' experiences* - Summary of complete analysis of transcripts

<table>
<thead>
<tr>
<th>Therapists' therapeutic Development</th>
<th>Therapeutic setting</th>
<th>Therapists' &amp; Clients' personal spirituality</th>
<th>Surrounding culture</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice Evolving</td>
<td>Therapeutic model/approach</td>
<td>Definition of spirituality</td>
<td>Rational/Technological</td>
</tr>
<tr>
<td>Therapeutic Model/s</td>
<td>Therapeutic environment / Work context</td>
<td>Spiritual development – lifelong process</td>
<td>Religion/spiritual taboos</td>
</tr>
<tr>
<td>Training and teaching</td>
<td>Therapeutic community</td>
<td>Influential people/texts/workshops/life events</td>
<td>Materialistic</td>
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<tr>
<td>Writing on spirituality and therapy</td>
<td>Client group/s</td>
<td>Spiritual experiences</td>
<td>Secular</td>
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<tr>
<td>Therapeutic and theological literature</td>
<td>Supervision</td>
<td>Impact on daily life</td>
<td>Judgmental</td>
</tr>
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<td>Border between spirituality &amp; therapy</td>
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<tr>
<td>-------------------</td>
</tr>
<tr>
<td>--Shifting depending on various factors</td>
</tr>
<tr>
<td>Overlap/shared territory</td>
</tr>
<tr>
<td>Definite border</td>
</tr>
<tr>
<td>Vague border.</td>
</tr>
</tbody>
</table>

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**Appendix N - Table 2: Clients' & Therapists' experiences - Summary of complete analysis of transcripts**

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**Ideal Integration of spirituality and therapy**

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<td>- Too narrow</td>
<td>- Humility</td>
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<td></td>
<td>- Imaginative</td>
<td>- Evangelical</td>
<td>- Heart centred spirituality</td>
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</tbody>
</table>
Appendix O - Figure 6: Diagrammatic representation of findings on therapists' and clients' experiences of the integration of spirituality and therapeutic practice.
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