Spirituality and religion in clinical practice: The experiences of psychologists in the integration of spirituality and religion in therapy in Aotearoa New Zealand

Dana D. Lee[1], Sonja Goedeke[2] and Christian U. Krägeloh[2]
[1]Counselling Psychologist; [2]Auckland University of Technology

While there are well-documented links between spiritual or religious beliefs and psychological wellbeing, many clinicians may not to address spiritual and religious issues in therapy, and there is some ambiguity around the practicalities of integrating spirituality and religion in psychological practice. The present study aimed to gain a better understanding of this issue and explored the experiences of clinical psychologists in integrating clients' spirituality and religion into their practice. A thematic analysis of six interviews with clinical psychologists in Aotearoa New Zealand identified themes around techniques, meanings, barriers and the importance of the integration of spirituality and religion in clinical practice. It is hoped that the findings will prompt more in-depth discussion and research regarding spirituality and religion in clinical practice.

Keywords: Spirituality, Religion, Psychological Practice, New Zealand.

Scope of Research

Religion is generally defined as an organised system of beliefs, practices, rituals and symbols intended to promote connection to the sacred or transcendent and is usually enacted as part of a community (Koenig, McCullough & Larson, 2001). Spirituality is less clearly defined but also relates to people's sense of a connection with a universal force or divine presence and as giving purpose and meaning to people's lives (Everts & Agee, 1995). While there is some overlap between religion and spirituality, and religion may be a structure for spirituality, spirituality may be considered a broader term and exist independently of religion (Rose, 2001; Cashwell & Young, 2011; Vieten, Scammell, Pilato, Ammondson, Pargament & Lukoff, 2013).

The potentially positive effects of both religion and spirituality on people's wellbeing, mental health and quality of life have been acknowledged across different age and cultural groups, including in Aotearoa New Zealand (Chai, 2009; Chai, Krägeloh, Shepherd & Billington, 2012; Gardner, Krägeloh & Henning, 2014; Hsu, Krägeloh, Shepherd & Billington, 2009; Koenig, 2009; Koenig, McCullough & Larson, 2001). For example, religious and spiritual beliefs have been linked with having a sense of meaning and hopefulness (Bein, 2014), may serve as psychological resources for coping with stress (Koenig, 2009; Heydari-Fard, Bagheri-Nesami, Shirvani & Mohammadpour, 2014), and have been associated with greater optimism and lower levels of depression in both younger and older adults and different cultural groups (Levin, 2013; Krause, 2015). In Aotearoa New Zealand, O'Brien et al. (2013) reported that high school students with high levels of spiritual beliefs were 1.5 times less likely to report high levels of depressive symptoms than students with low levels of spirituality, and Hsu et al. (2009) similarly found a significant correlation between spirituality and quality of life in young adults. Such research highlights the potential significance of religion and spirituality for wellbeing and thus underscores the need to consider their integration into therapy.

Indeed, spirituality and religion are important to many people in Aotearoa New Zealand. Over half of the population identify with at least one religion (Statistics New Zealand, 2016), and while Christianity remains the most common religious affiliation, a greater diversity of faiths is reported, as indicated by the steady rise in the percentage of people affiliating with other religions such as Sikh and Hinduism. Additionally, over half of the indigenous Māori population (the tangata whenua or indigenous people), 83% of Pasifika and 70% of Asian peoples report a religious affiliation (Statistics New Zealand, 2016).

For Māori spirituality is considered one of the four cornerstones of hauora (Māori health). Tāne Ora Alliance (2016) go as far as suggesting that wairua (spirituality) is the most significant requirement for wellbeing for Māori, being intimately connected with issues of empowerment, threatened identity and life purpose (Abbott & Durie, 1987).

It is thus likely that mental health professionals will work with clients in clinical practice for whom spirituality and religion are important components of their identity and culture (Aten & Hernandez, 2004). The ethical codes of many countries including the US, UK and Aotearoa New Zealand specify that psychologists respect, and are responsive to, people's worldviews in therapy (American Psychological Association, 2002; New Zealand Psychologists Board, 2009; New Zealand Psychological Society, 2002; The British Psychological Society, 2009). This implies a need for psychologists to consider how to acknowledge and include people's religious and spiritual beliefs in the therapy setting, especially given research which suggests an association between

spirituality/religion and mental health.

International research however, suggests that while an interest in spirituality and religion has recently emerged in psychological practice (Atan & Hernandez, 2004; Eck, 2002), negative attitudes towards spirituality and religion including their lack of relevance or benefit to mental health have persisted (Azar, 2010; Delaney, Miller & Bisonó, 2013). Furthermore, spirituality and religion are rarely included in clinical practice, and are generally absent in training (Begum, 2012; Delaney et al., 2013; Florence, 2009; Mueller, 2012). Begum (2012), for example, found that trainee clinical psychologists received little education and guidance on the topic both academically and in supervision, and that a large body of psychologists do not address nor explore spiritual and religious issues in their practice.

In this study the experiences of six psychologists who themselves identified as spiritual and/or religious were interviewed regarding their integration of spirituality and religion in clinical practice in Aotearoa New Zealand. The study aimed to explore how these psychologists regarded the role of spiritual and religious beliefs and how they worked to include them in therapeutic work. It is hoped that this study will promote further discussion around the relevance and integration of religious and spiritual beliefs and practices in therapeutic interventions.

METHODS
Participants

Six clinical psychologists located in the Auckland region were recruited for this study. All participants were female and worked in either the District Health Board and/or private practice. Five identified as Christian, and one as spiritual drawing on her Māori culture. Participants were assigned pseudonyms to ensure confidentiality.

Procedure

Participants were recruited through networks. Psychologists who indicated interest in the study and gave permission to be approached were contacted by the first author through email. The location of interviews was a private meeting room at the Auckland University of Technology or their workplace, whichever was most convenient for the participant. Data were collected via semi-structured interviews of approximately an hour in duration. Semi-structured interviews were selected as they involve open-ended questions that can facilitate new or unanticipated experiences and meaning (Willig, 2013). While the process is systematic, there is freedom to digress and explore topics spontaneously initiated by the participant (Berg, 2009). Interviews explored participants' thoughts about and experiences of integrating religion and spirituality into their clinical practice. Interviews were audio-recorded and transcribed verbatim.

Data Analysis

Data was analysed using Braun and Clarke's (2006) well-established interpretative thematic approach following a six-phase process that identifies, analyses and reports themes across a dataset as follows: 1) familiarisation with data, 2) generating initial codes, 3) identifying themes, 4) reviewing themes, 5) defining and naming themes, and 6) producing the report. Strategies such as triangulation, thick description and reflexivity were implemented to ensure the rigour of this research (Braun & Clarke, 2006). This study was approved by the authors' institutional ethics committee (AUTEC 16/110).

ANALYSIS AND COMMENTARY

The main themes identified in psychologists' talk about integrating spirituality and religion into their clinical practice were: meanings and importance of religion and spirituality for practice, integrating religion and spirituality into practice, and barriers to implementation.

With regards to the first theme, participants spoke of the meaning of spirituality and religion for themselves and for their clients. Participants often used the words 'spirituality' and 'beliefs' interchangeably, with Sybil commenting that "*spirituality and religion are all the same thing*" although she did go on to elaborate that, "*they're all about the same relationship with God.*" Alternatively, they associated spirituality with multiple beliefs, with Diana commenting that "*spirituality could include specific religious beliefs*", or they described spirituality as a broader belief system. Sybil described how spirituality is "*so broad and unique from person to person,*" Anne that it is about "*the bigger picture in terms of the spirit world and the spirit realm*" and for Diana spirituality could also include meanings around nature, music and culture.

While Christianity was seen as stemming from European colonisers, spirituality was seen as encompassing traditional Māori beliefs, which were described as fundamental to Māori culture. Juliet, for example, commented that,

> "*Spirituality .... meant more than just religion, more than a single god, and (was) much more around gods who were acknowledged and practised... [Spirituality] just comes if they are Māori... I think it's really easy for Māori because it's embedded into our culture.*"

Māori spirituality was held to encompass the concepts of whakapapa (genealogy), ancestors and nature. As Juliet said,

> "*There's a way of being held by an essence of your ancestors... The spiritual stuff about the way we thought about it as Māori was much more about balance and harmony with nature and it makes sense in terms of our whakapapa.*"

Sybil emphasised the importance of religion and spirituality, commenting that, "*the Māori and Pacific community... have worked so hard to have recognition of the fact that spirituality and religion are really closely intertwined with culture and that they're very significant in people's lives.*"

Some participants described spirituality as relevant to every individual, irrespective of particular religious beliefs. Diana described it as, "*a crucial part, especially if one comes from a more holistic approach*" and Laurel as, "*at the centre of every human being.*" Laurel went on to discuss the centrality of spirituality in her own life:

> "*[Spirituality] means everything. Spirituality, for me being a Christian, is my relationship with God. And*

it's everything. It contains every other aspect of my life rather than being another aspect of my life. So it's the core of who I am and gives meaning to everything I do."

Since participants regarded therapy as a space in which to explore *identity*, and particularly in the case of loss and grief, existential issues, participants felt that was important to address spirituality and religion in therapy. For example, April said,

"There's a lot of questions, too, that come up around death. You know, people are facing their own mortality; not just people who might be unwell, but when you start looking at yourself and doing therapy, often you end up with existential type of questions, and so I really enjoy having those conversations with people… a lot of people are interested in spirituality."

Likewise, Juliet described how *"[Spirituality] often comes up when young people lose a parent. They talk about where they've gone and a belief about wanting to believe they're being held somewhere. A belief that they might be watching them have a good life."*

Participants believed that spirituality and religion could not only have positive psychological outcomes for clients but might even be pivotal to their recovery. Laurel commented that,

"I've worked with clients whose spirituality has been the most crucial factor in their recovery. And I've had clients who have increased their connection with God and that has been the exact thing that has gotten them better."

And Sybil spoke of a client, where, *"It was like once she reconnected with God, a whole lot of other things seemed to fall into place a lot faster in therapy."*

Finally, participants shared their experiences in therapy when their inclusion of spirituality and religion had had a positive impact on the therapeutic relationship. For example, Laurel shared that,

"It can allow the client to feel understood, empathised with, they know that you get it. And that's a huge part of the therapeutic relationship."

On the other hand, two participants discussed how self-disclosure of personal beliefs needed to be carefully managed, seeing this as potentially detrimental to the therapeutic relationship if the therapist and client held different views. Laurel commented how,

"It can be a barrier if your beliefs are different… I had a client who took offence to the fact that I was wearing a cross and didn't want to work with me. Also, you've got to be careful in what you say. Sometimes, our view of the world can leak through little things that we don't think have a meaning. So, that same client was offended because… I questioned if things can happen for a reason and for her that was a value statement and it was completely against her view of the world. She didn't like that, and she chose to not work with me anymore… It was the only time that has ever happened to me. So, in my nine years, I've had one experience like that. But it just shows that it could happen."

The therapeutic relationship may thus be strengthened or weakened depending on the beliefs of therapists and clients and how these are valued and incorporated in therapy.

Participants shared a broad range of experiences around the integration of religion and spirituality into therapy and discussed particular ways in which this could be achieved. This included the integration of spirituality and religion into several modalities such as cognitive-behavioural therapy (CBT), acceptance and commitment therapy (ACT) and dialectical behavioural therapy (DBT).

Moriarty and Hoffman (2007) suggested that there is considerable congruence between religious scripture and CBT. This was highlighted by one participant who noted that the Bible was a very powerful source to 'find truth' and could be a tool to challenge negative thoughts since for Christians the Bible is God's Word and has absolute authority. As regards CBT, several participants described how cognitive restructuring and challenging dysfunctional thoughts with positive, helpful beliefs that are aligned with a client's spirituality or religion may be useful in therapy. For example, Diana shared that:

"Some people who have strong religious kind of beliefs might feel really guilty about certain things. And then, to try to understand why they feel guilty and linking it back to what they actually believe more on a religious level can actually help them just to get that clarity. For instance, why they feel so guilty and then it's about asking them 'Okay in terms of your beliefs what would be helpful in this situation?' When people feel guilty… 'Could someone who has similar beliefs to what you have… What would they recommend you actually do?'"

Acceptance and Commitment Therapy (ACT) was similarly described as a modality that fit well with acknowledging the role of religion and spirituality, since it provides a context for clients to discover what is most important to them by exploring their values, and spirituality may be one of these. Diana commented that,

"[Values] is a concept I find very helpful in therapy, especially when people struggle to make decisions, or their feelings, or relationship issues. Just to talk a bit about 'Okay, what are their underlying beliefs?', 'What are their drivers in life, really?'. It helps people to get a better sense of what is really important and what would be really helpful in this situation."

Regarding DBT, another participant discussed the modality's congruence with spirituality and religion, particularly considering the role of mindfulness and the 'wise mind' (Linehan, 2015):

Laurel: "So, the wise mind, Christians call the voice of God. It's that voice within that when you're still and quiet, tells you what is the thing that is going to be effective for you. So, it ties (in) very well… Mindfulness is about being present, being in the present moment; that's part of spirituality and Christian spirituality, being in touch with creation and appreciating what's around you and being grateful for things."

Participants also suggested several more generic ways in which psychologists could integrate spirituality and

religion into therapy. This included undertaking comprehensive assessments of clients' spiritual and religious beliefs in order to gain a broader understanding of the individual. As Laurel commented,

"It all starts from a better, more thorough assessment, so having part of the assessment that explores spirituality. 'Does the person have a spirituality?', 'How important is it to them?', 'What part of life does it contain?', 'How would they like it integrated in therapy?'"

This was seen as relevant to therapeutic work:
Diana: *"It's hard to work with something if you don't really acknowledge it or believe in it…"*

And creating a climate in which clients felt free to explore these issues in therapy:
Anne: *"Clients generally are pretty good at reading us as clinicians, and if they perceive that the clinician would be open to that, then they would share it. But if they perceived they wouldn't."*

One participant described incorporating Maori practices into her therapeutic work. This included the concept of whakapapa:
Juliet: *"It's more about spirituality and the essence of that and being able to help clients to see that they were and are descended from these godly beings and they will have those godly qualities, all those nice qualities and they'll also have some of the not-so-nice qualities. And, so, really for me, it's about a balancing up of which of those ancestors are you most listening to and I've used it almost like a self-analysis. If I'm working with young people, 'Which of the gods from your area, Ngāpuhi or wherever do you know about who were either acknowledged for those qualities or who have a particular relevance for you?'"*

The involvement of kaumatua and kuia (Māori elders) for specific spiritual practices was further identified as a way of integrating Māori spirituality into clinical practice.
Juliet: *"We have had kaumatua and kuia who have lifted tapu off clients, sexually-abused clients… They wanted a name-lifting ceremony and we have been able to provide that with kaumatua and kuia who've got those specific spiritual skills to be able to do that part of the process… There would be a lot of ceremonial stuff around karakia and lifting off the tapu from the abused young person."*

Furthermore, Prayer or karakia was identified by most participants as a method of healing that incorporated spirituality and religion into therapy.
Juliet: *"I've had young kids write their own karakia for certain bits where they felt they needed more strength… It creates what we call whakawātea, that space… a clean, cleansing space where you can bring into it what you need to bring into it and the end it will be clean and cleansing again."*

Laurel: *"Being able to relate with them on that level and to tap into that spirituality and to pray together and to bring the power of prayer into the therapy session."*

Finally, participants also identified bringing in religious works, such as biblical Scripture into therapy as another technique to integrate religion and spirituality into clinical practice. Sybil described using Scripture to discuss certain issues and find truth, saying that
"Using Scripture as source of finding truth; because, for a Christian, if you genuinely believe the Bible is God's Word, then it has so much more authority than any thoughts or any kind of evidence you can come up with yourself or that other people in your life come up with, so it's a very powerful source."

However, despite its many advantages, participants identified a number of barriers to the integration of spirituality and religion in clinical practice, such as a lack of training, as indicated by Laurel:
"One thing that struck me… is just how much more need there is for training on integrating spirituality in clinical practice and how much our clients need it. I think there was a research by [the organisation] that asked something about that and showed that people really wanted their spirituality integrated."

Other barriers also included resistance, shame and anxiety regarding spirituality and religion from both clients and psychologists. Indeed, most participants identified resistance to spirituality and religion within mental health settings and communities, and spoke of how this could cause difficulties for both clients and psychologists.
Juliet: *"For some reason, spirituality is less tolerated than other issues. Abuse, trauma all seems to be tolerated. Even anger, discontent, all of those kinds of stuff, but I think spirituality is less well acknowledged."*

Participants also expressed the belief that there are prevailing negative attitudes about spirituality and religion among mental health professionals themselves:
Anne: *"That does disappoint me when you hear that someone will present a case in a team environment and they'll say 'Oh, you know the client said that God wants him to change schools or God wants him to go to another church' and people will sort of go 'pff'… which is a shame."*

Juliet: *"Pākehā people are pretty used to karakia and stuff, but other people (practitioners) coming into New Zealand are often like 'I don't believe in God', 'I don't have to listen to this' and 'I think it's unfair that your religion should overtake my lack of religion'. So, we've had some interesting discussions… often filled with tension and difficulties."*

Anne commented how such negative attitudes could lead to a pathologising of clients' religious or spiritual practices:
Anne: *"It used to really irritate me that often mainstream psychiatry and psychology would see that as evidence of disorder if somebody wanted to carry their Bible with them; that meant they were unwell. Or, if somebody had a particular Scripture that they wanted to read, over and over again, that meant that they were unwell and we need to up their medication or we need to think about other options… I think, too*

often, very unwell clients wanting to draw close to God is seen as an illness as opposed to wellness."

Such negative perceptions were often seen as a barrier to individuals expressing their beliefs in therapy, and to a lack of focus on or only token attention to these issues. Anne commented that *"a client's faith may be just mentioned in their notes at the beginning of an assessment and that's about it."* Similarly, Juliet said:

"The spiritual stuff is often the stuff that's left behind. Even though for Māori we have great models which says it's there, but I will tell you that a lot of Māori clinicians leave it out because either they don't believe it themselves or they are worried that it might be off-putting for the young person."

Likewise, Sybil commented:

"We don't often initiate those conversations, like a lot of people don't actually ask, so, some clients then would probably feel they're not necessarily allowed to talk about it… I think it will probably be in their best interests to start doing it more routinely because you don't know what you're missing otherwise."

Negative perceptions thus created anxiety from both clients and psychologists in relation to talking about spirituality and religion in therapy.

Laurel: "There can be a lot of fear in practising Christian spirituality or integrating a spirituality… People are really scared of prayer or asking those questions because they may impose values or they may do the wrong thing."

April: "When you choose a therapist you want to choose somebody who you feel you can be yourself with, and I think a lot of clients are probably a bit anxious about their faith and whether it's going to be respected and not dismissed."

What was interesting is that some participants spoke of counsellors as being *"much more accepting than psychologists"* about religion and spirituality in general. Juliet even noted that:

"There are Christian counsellors, and they've got their own association in New Zealand, and they have their own conferences and stuff. Counsellors do a lot of talking about stuff like that."

Participants however, also expressed some caution in regards to integrating spiritualty and religion into therapy. As April commented, there was awareness that, *"while faith and belief can be a very wonderful and powerful strength for people, it can also have its restrictions."* For example, participants identified a need for discernment to determine what is a spiritual experience and what may be part of clients' mental health issues (e.g. psychosis).

Juliet: "I think that the concern is when they're very unwell that the way in which they're hearing or feeling spiritually or religiously is very skewed and that it can actually be harmful for them."

April: "Being able to be discerning about when somebody's faith or the way their faith is being practised is actually problematic, when to challenge it and when to support it, and to be able to have confidence in that discernment."

Participants also highlighted how clients may present with spiritual and/or religious beliefs that may be dysfunctional or unhelpful for their recovery, and how they needed to challenge such beliefs in therapy.

April: "Sometimes, I find that religion can be used very powerfully as a defence. People build up all sorts of mechanisms to defend themselves. I'm thinking of a woman I saw years and years and years ago who… it was almost like her faith… she used her faith, unconsciously, as a way of almost not taking responsibility… It was a barrier. It was a way that perhaps was even harder for me to challenge because then here's me put in the position of challenging God, not challenging her defences… I gently and persistently try to challenge my clients around their beliefs and about being authentic and about really connecting with their own sense of self and meaning."

Sybil: "Their relationship with God is marked by this big struggle because they don't have a sense of His love or acceptance… So, with a couple of clients, that's been a big part of our work has been looking at who God is, where those views have come from and how their experience of God actually relates back to their parents…"

Sybil then shared how this type of work in therapy could result in clients reconnecting with their faith which in turn could lead to positive changes in their mental health.

DISCUSSION

Participants in this study supported the integration of religious and spiritual beliefs and practices into therapy. Participants shared examples of working with clients whose faith had led to improvements in their wellbeing or had even been pivotal in recovery. The integration of religion and spirituality was also seen as helpful in therapy because of its applicability to addressing loss, grief, guilt and existential issues. During times of loss and death, clients may explore the meaning of life and the afterlife (Walsh, 2004). Some may find comfort in greater meaning (e.g. they are part of God's greater plan) whereas others may question, distance or even abandon their religious beliefs (Marrone, 1999; Walsh, 2004). In either case, practitioners need to understand their clients' spiritual or religious beliefs about adversity and death, because these may be instrumental in helping clients cope and make meaning out of such experiences (Frame, 2003). By not exploring spiritual and religious beliefs, therapists may be overlooking a helpful source of counselling support and a critical part of a client's worldview (Begum, 2012; Everts & Agee, 1995). Further, participants in this study pointed to the positive impact of acknowledging and involving spirituality and religion on the therapeutic relationship, which may be fundamental for successful outcomes in therapy (Young, Dowdle & Leach, 2009). Understanding and accepting a client's spirituality and/or religion may develop empathy which strengthens the therapeutic relationship (Bohart, Elliot, Greenberg & Watson, 2002; Horvath & Bedi, 2002).

However, despite the participants in this study acknowledging the role of spirituality and religion, they

discussed that many psychologists do not bring spirituality and religion into therapy, either because they do not hold spiritual or religious beliefs themselves, are worried about the clients' reactions, or face organisational prejudice. This is reinforced by Begum (2012) and Delaney et al. (2013) who reported that many psychologists do not assess nor explore their clients' spirituality or religion in therapy. Findings from the UK (Begum, 2012; Mueller, 2012), US (Delaney et al., 2013) and Aotearoa New Zealand (Florence, 2009) suggest this is a global concern in the psychological field of clinical practice. The ethical principles of respect and responsible caring as set out in the NZ Code of Ethics (New Zealand Psychological Society, 2002), however, imply that psychologists should be responsive to their clients' cultural and social needs, which may include spiritual and religious needs. This would however, imply a need not only to be open to including religious and spiritual beliefs into practice, but also potentially to have some degree of knowledge about clients' beliefs and practices, which in itself may present a challenge.

Participants experienced and/or witnessed further challenges such as anxiety, resistance and negative attitudes that hindered the integration of spirituality and religion in clinical practice. As was the case in Florence (2009) and Young et al.'s (2009) studies, who reported that Christian clients fear their faith may be pathologised by non-Christian psychologists, participants suggested that clients were hesitant about disclosing their faith because they did not know if it would be acknowledged and validated. Researchers have noted negative attitudes towards religion since the early days of psychology when it was generally believed to be pathological and problematic (Azar, 2010; Bartholomew & O'Dea, 1988; Gerson, Allen, Gold & Kose, 2000). While there is emerging interest in research on religion and spirituality in the psychological field (Aten & Hernandez, 2004; Eck, 2002), resistance and shame in this regard may still be prevalent in current psychological practice.

In contrast, one participant suggested that counsellors talk more about spirituality and religion than psychologists. This reflects current literature on spirituality and religion in clinical practice which is dominated by studies from the field of counselling. Certainly in Aotearoa New Zealand, counsellors have shown more interest in this area than psychologists, facilitating presentations and annual conferences related to this topic (Everts & Agee, 1995; New Zealand Christian Counsellors Association, 2019). Similarly, the US discipline of counselling among other health care fields have established training, research and competencies on spirituality and religion much earlier than has the psychological field (Vieten et al., 2013). There has been a relatively recent growing emergence of psychological studies on spirituality and religion in the literature (Aten & Hernandez, 2004; Eck, 2002), perhaps reflecting a move away from more medical models of understanding wellbeing to more holistic models.

Participants unanimously agreed that there is a lack of training in this area of clinical practice, a finding mirrored by UK and Aotearoa New Zealand unpublished studies on psychologists and psychotherapists which indicated an absence of training and confidence in this area (Begum

2012; Florence, 2009; Mueller, 2012). This may present an ethical concern for psychologists regarding competence.

It is important that the integration of spirituality and religion is client-led however, because the definition of spirituality may be subjective and, as one participant stated, it is dependent on the clients and their needs. Indeed, the present study identified multiple meanings of spirituality held by the participants and their clients which reflected the numerous definitions cited in the literature. It is also possible that a client may be religious but not wish to explore faith in therapy or, alternatively, a client may not be religious but would like to explore spiritual or religious content. Psychologists should acknowledge and accept clients' religious and/or spiritual beliefs (Waller, Trepka, Collerton & Hawkins, 2010) and engage in comprehensive assessments to gain a holistic understanding of the client as well as to decide the extent to which religion and/or spirituality are integrated into therapy.

The present study suggests various psychological interventions and techniques that therapists may employ to integrate spirituality and religion into clinical practice. Participants discussed the relevance of religion and spiritualty for use in modalities such as CBT, where key constructs and beliefs fundamental to their religious perspective could be used to challenge clients' negative or dysfunctional beliefs. This is supported by Aten and Hernandez (2004) and Eck (2002) who recommended using spiritual and/or religious interventions to address dysfunctional thoughts. The synchronicity between other modalities such as ACT and DBT and religious/spiritual beliefs was also noted.

Religious and spiritual practices may also lend themselves to being successfully integrated into theory. A Māori psychologist in the study shared how conversations about whakapapa, myths and stories in relation to self-analysis could be incorporated to enhance practice, particularly with Māori clients. This is reinforced by Hopkirk and Wilson (2014) who noted that spirituality is vital for Māori and can assist in therapy. The participant also commented on the relevance of involving kaumatua and kuia with specific spiritual skills in her treatment with Māori clients. Similarly, Ybañez-Llorente and Smelser (2014) recommended consulting with religious and/or spiritual leaders when clients experience distress in relation to religious or spiritual issues.

Māori services in New Zealand, as pointed out by one participant, tend to have processes that involve spirituality because for Māori spirituality may be embedded into Māori culture. It is possible that spirituality may be more easily integrated into therapy for Māori than other groups, and psychologists may employ specific practices to ensure spirituality is acknowledged for Māori clients. However, this does not imply that spirituality is necessarily well-integrated into therapy for Māori clients by psychologists. One participant shared that despite having helpful Māori models for practice, *"a lot of Māori clinicians leave it out because either they don't believe it themselves or they are worried that it might be off-putting."* Therefore, the lack of integration of spirituality and religion by psychologists applies to both Māori and non-Māori clients.

Karakia (prayer) and religious scripture were the most common practices discussed by participants as ways of integrating spirituality and/or religion into therapy. Prayer was used for strength, healing and to open and close therapy sessions. Similarly, Knabb (2012) has pointed to the value of centring prayer for Christians in remission, and Bennett to karakia for Māori clients (Bennett, 2009; Bennett, Flett & Babbage, 2008). Religious scripture was seen as another tool useful to explore religious perspectives on certain issues. Aten and Hernandez (2004) likewise have recommended religious scripture for cognitive interventions which can provide comfort and relief. While there is little research on the topic of scripture and therapy, the present study indicated that religious scripture may be useful in therapy. However as one participant noted, using scripture as a tool required in-depth knowledge which would limit this practice to those with the knowledge. Nonetheless, where psychologists lack knowledge in particular religious scripture but wish to use it in therapy for the benefit of their clients, it could be helpful to consult with a religious leader of the clients' faith, similar to the use of involving kaumatua and kuia for Māori clients.

Clinical implications

This study is consistent with the observation that psychologists may not integrate spirituality and religion into their clinical practice despite their perceived usefulness and significance. Stigma around spirituality and religion needs to be addressed in order to facilitate the discussion of spiritual and religious content in therapy. As reflective practitioners, psychologists may need to consider their own spiritual and religious beliefs and practices and their impact on their work. Training providers, psychological associations and accrediting bodies such as the New Zealand Psychological Society and the New Zealand Psychologists Board need to give consideration to acknowledging the role of spiritualty and religion, and ensure that psychologists are trained and competent to integrate these into their practice or able to draw on appropriate support services to help them do so. Additionally, action needs to be taken to promote the acceptance of religion and spirituality in mental health services. This could include displaying informative posters that welcome religion and spirituality in therapy in waiting rooms, thus encouraging clients to share their religious and/or spiritual beliefs in therapy. Mental health services should also emphasise to their staff the need for respect and sensitivity around individuals' religious and spiritual beliefs and offer continued professional development to ensure these areas are sufficiently addressed. Finally, services could also partner with spiritual or religious advisors to provide informational and instrumental support to mental health professionals. However, it is important to recognise that there are many important areas for these services to explore such as gaining a deeper understanding of Māori culture and their currently active discussions and efforts with limited resources are acknowledged.

Study limitations and future research

As this study was a small scale qualitative study, the data is likely representative of the six participants interviewed rather than of the wider population of psychologists. The participants were those who themselves held spiritual or religious views, and most research suggests a lack of religiosity amongst psychologists (Bergin & Jensen, 1990; Delaney et al., 2013; Rosmarin, Green, Pirutinsky & McKay, 2013). Participants may have chosen to take part in the study because they are spiritual or religious and wanted to discuss their ideas in this area of research. Additionally, psychologists who are neither spiritual nor religious may not have participated in this study because they did not have much experience integrating religion and spirituality into clinical practice. As one participant suggested, non-religious psychologists may not see the significance of integrating religion in therapy. And as mentioned earlier, Delaney et al. (2013) found that many non-religious psychologists do not believe religion can be beneficial to mental health. Nonetheless, it would be important to explore the experiences of non-religious psychologists in this area.

Target areas for future research include further exploration of the interaction between clinician spirituality, client spirituality and therapeutic intervention using a larger and more representative sample. Additionally, the study may benefit from a comparison sample of counsellors as there may be a difference in approach between psychologists and counsellors and the field of counselling has a longer history of acknowledging the role of religious and spiritual beliefs and practices on mental health and including these in counselling interventions.

References

Abbott, M., & Durie, M. (1987). A whiter shade of pale: Taha Māori and professional psychology training. *New Zealand Journal of Psychology, 16,* 58-71.

American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist, 57,* 1060-1073.

Aten, J. D., & Hernandez, B. C. (2004). Addressing religion in clinical supervision: A model. *Psychotherapy: Theory, Research, Practice, Training, 41*(2), 152-160.

Azar, B. (2010, December). A reason to believe. *Monitor on Psychology, 41*(11)*,* 52.

Bartholomew, R. E., & O'Dea, J. D. (1988). Religious devoutness construed as pathology: The myth of 'Religious Mania'. *The International Journal for the Psychology of Religion, 8*(1), 1-16.

Begum, N. (2012). *Trainee clinical psychologists talking about religion and spirituality in their work* (Doctoral thesis). University of East London, England.

Bein, A. (2014). *Dialectical Behavior Therapy for Wellness and Recovery: Interventions and activities for diverse client needs*. Hoboken, New Jersey: John Wiley & Sons.

Bennett, S. T. (2009). Te Huanga o te Ao Māori: Cognitive behavioural therapy for Māori clients with depression – development and evaluation of a culturally adapted treatment programme (Doctoral dissertation). Retrieved from https://mro.massey.ac.nz/bitstream/handle/10179/1159/02 whole.pdf

Bennett, S. T., Flett, R. A. & Babbage, D. R. (2008). The adaptation of cognitive behavioural therapy for adult Māori clients with depression: A pilot study. In M. Levy, L. W. Nikora, B. Masters-Awatere, M. Rua, & W. Waitoki (Eds.), Claiming Spaces: Proceedings of the 2007 National Māori and Pacific Psychologies Symposium 23rd-24th November 2007 (pp. 83-91). Hamilton, New Zealand: Māori and Psychology Research Unit, University of Waikato.

Berg, B. L. (2009). *Qualitative research methods: For the social sciences* (7th ed.). Boston, Massachusetts: Ally & Bacon.

Bergin, A. E., & Jensen, J. P. (1990). Religiosity of psychotherapists: A national survey. *Psychotherapy, 27*(1), 3-7.

Bohart, A. C., Elliott, R., Greenberg, L. S., & Watson, J.C. (2002) Empathy. In J. C. Norcross (Ed.), Psychotherapy relationships that work: Therapist contributions and responsiveness to patients (pp. 89-108). New York: Oxford University Press.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology 3*(2), 77-101.

Cashwell, C. S., & Young, J. S. (2011). *Integrating spirituality and religion into counseling: A guide to competent practice.* Alexandria, VA: American Counseling Association.

Chai, P. (2009). *Religion/spirituality as a stress coping mechanism for international students* (Masters dissertation). Auckland University of Technology, New Zealand.

Chai, P. P. M., Krägeloh, C. U., Shepherd, D., & Billington, R. (2012). Stress and quality of life in international and domestic university students: cultural differences in the use of religious coping. *Mental Health, Religion & Culture*, *15*(3), 265-277.

Delaney, H. D., Miller, W. R., & Bisonó, A. M. (2013). Religiosity and spirituality among psychologists: A survey of clinician members of the American Psychological Association. *Spirituality in Clinical Practice, 1*(S), 95-106.

Eck, B. E. (2002). An exploration of the therapeutic use of spiritual disciplines in clinical practice. *Journal of Psychology and Christianity, 21*, 266–280.

Everts, J. F., & Agee, M. N. (1995). Including spirituality in counsellor education: Issues for consideration, with illustrative reference to a New Zealand example. *International Journal for the Advancement of Counselling, 17*, 291-302.

Florence, H. (2009). *What are the therapeutic implications of psychoanalytic conceptualisations of God when working psychoanalytically with Christian clients?* (Masters dissertation). Auckland University of Technology, New Zealand.

Frame, M. W. (2003). *Integrating religion and spirituality into counseling: A comprehensive approach.* Pacific Grove, CA: Brooks/Cole.

Gardner, T. M., Krägeloh, C. U., & Henning, M. A. (2014). Religious coping, stress, and quality of life of Muslim university students in New Zealand. *Mental Health, Religion & Culture*, *17*(4), 327-338.

Gerson, J., Allen, R., Gold, J., & Kose, G. (2000). Multiple belief systems in psychotherapy: The effects of religion and professional beliefs on clinical judgment. *Journal of Contemporary Psychotherapy, 30*(1), 27-32.

Heydari-Fard, J., Bagheri-Nesami, M., Shirvani, M. A., & Mohammadpour, R. (2014). Association between quality of life and religious coping in older people. *Nursing Older People, 26*(3), 24-30.

Hopkirk, J. & Wilson, L. H. (2014). A call to wellness – Whitiwhitia i te ora: Exploring Māori and occupational therapy perspectives on health. *Occupational Therapy, 21,* 156-165.

Horvath A. O., & Bedi R. P. (2002). The alliance. In J. C. Norcross (Ed.), Psychotherapy relationships that work: Therapist contributions and responsiveness to patients (pp. 37-69). New York: Oxford University Press.

Hsu, P. H., Krägeloh, C. U., Shepherd, D., & Billington, R. (2009). Religion/spirituality and quality of life of international tertiary students in New Zealand: An exploratory study. *Mental Health, Religion, & Culture*, *12*(4), 385-399.

Knabb, J. J. (2012). Centering prayer as an alternative to mindfulness-based cognitive therapy for depression relapse. *Journal of Religion and Health, 51*, 908–924. doi:10.1007/s10943-010-9404-1

Koenig, H. G. (2009). Research on religion, spirituality, and mental health: A review. *Canadian Journal of Psychiatry, 54*(5), 283-291.

Koenig, H. G., McCullough, M. E., & Larson, D. B. (2001). *Handbook of religion and health*. Oxford, United Kingdom: Oxford University Press.

Krause, N. (2015). Trust in God and psychological distress: Exploring variations by religious affiliation. *Mental Health, Religion & Culture, 18*(4), 235-245.

Levin, J. (2013). Religion and mental health among Israeli Jews: Findings from the SHARE-Israel study. *Social Indicators Research, 113*(3), 769-784.

Linehan, M. M. (2015). *DBT skills training manual* (2nd ed.). New York: Guilford Publications.

Marrone, R. (1999). Dying, mourning, and spirituality: A psychological perspective. *Death Studies, 23,* 495–519.

Moriarty, G., & Hoffman, L. (Eds.). (2007). *The God image handbook for spiritual counselling and psychotherapy: Theory, research and practice.* London: Routledge.

Mueller, J. (2012). *An exploration into the meaning of spirituality and spiritual experience for counselling psychologists, and implications for their practice* (Doctoral thesis). University of Roehampton, England.

New Zealand Christian Counsellors Association. (2019). *NZCCA.* Retrieved from http://www.nzcca.org.nz

New Zealand Psychological Society. (2002). *Code of ethics for psychologists working in Aotearoa/New Zealand.* Wellington: Author.

New Zealand Psychologists Board. (2009). *Guidelines for cultural safety: The Treaty of Waitangi and Māori health and wellbeing in education and psychological practice.* Wellington: Author.

O'Brien, L., Denny, S., Clark, T., Fleming, T., Teevale, T., & Robinson, E. (2013). The impact of religion and spirituality on the risk behaviours of young people in Aotearoa, New Zealand. *Youth Studies Australia, 32*(4), 25-37.

Rose, S. (2001). Is the term 'spirituality' a word that everyone uses, but nobody knows what anyone means by it? *Journal of Contemporary Religion, 16*(2), 193-207.

Rosmarin, D. H., Green, D., Pirutinsky, S., & McKay, D. (2013). Attitudes toward spirituality/religion among members of the Association for Behavioural and Cognitive Therapies. *Professional Psychology: Research and Practice, 44*(6), 424-433.

Statistics New Zealand. (2016). 2013 Census QuickStats about culture and identity. Retrieved from http://www.stats.govt.nz/Census/2013-census/profile-and-summary-reports/quickstats-culture-identity/religion.aspx

Tāne Ora Alliance. (2016). Taha wairua – spiritual health. Retrieved from http://www.māorimenshealth.co.nz/te-whare-tapa-wha-health-whare/taha-wairua-spiritual-health/

The British Psychological Society. (2009). *Code of ethics and conduct: Guidance published by the ethics committee of the British Psychological Society.* Leicester: Author.

Vieten, C., Scammell, S., Pilato, R., Ammondson, I., Pargament, K. I., & Lukoff, D. (2013). Spiritual and religious competencies for psychologists. *Psychology of Religion and Spirituality, 5*(3), 129-144.

Waller, R., Trepka, C., Collerton, D., & Hawkins, J. (2010). Addressing spirituality in CBT. *The Cognitive Behaviour Therapist, 3,* 95-106.

Walsh, F. (2004). Spirituality, death, and loss. In F. Walsh & M. McGoldrick (Eds.), *Living beyond loss: Death in the family* (2nd ed., pp. 182–210). New York: Norton.

Willig, C. (2013). *Introducing qualitative research in psychology* (3rd ed.). Berkshire, England: McGraw-Hill Education.Ybañez-Llorente and Smelser (2014)

Ybañez-Llorente, K., & Smelser, Q. K. (2014). Client as expert: Incorporating spirituality using the tree ring technique. *Counseling and Values, 59*(1), 35-48.

Young, J. S., Dowdle, S., & Flowers, L. (2009). How spirituality can affect the therapeutic alliance. In J. D. Aten & M. M. Leach (Eds.), *Spirituality and the therapeutic process: A comprehensive resource from intake to termination* (pp. 167-192). Washington, DC: American Psychological Association.

Corresponding Author
Dana D. Lee
Email: dlee4260@gmail.com