

**An exploration of trainee clinical psychologists' experiences of
engaging with psycho spiritual issues
in clinical practice**

By Jayne Mills

April 2010

Thesis submitted to:

University of Leicester, School of Psychology,
in partial fulfilment of the Doctorate of Clinical Psychology.



STATEMENT OF ORIGINALITY

The accompanying thesis submitted for the degree of Doctorate in Clinical Psychology entitled (please give title of thesis) :An exploration of trainee clinical psychologists' experiences of engaging with psycho spiritual issues in clinical practice is based on work conducted by the author in the Department of Clinical Psychology at the University of Leicester mainly during the period between October 2007 and April 2010

Approximate number of words: 24950 (including references; excluding appendices)

All the work recorded in this thesis is original unless otherwise acknowledged in the text or by references.

None of the work has been submitted for another degree in this or any other University

Signed: Date:

Name: JAYNE MILLS
(Please print)

An exploration of trainee clinical psychologists' experiences of engaging with psycho-spiritual issues in clinical practice

Jayne Mills

Thesis Abstract

Purpose: The purpose of the research was two-fold: to determine the provision of religious and spirituality teaching within UK Clinical Psychology training courses and to explore the experiences of trainee clinical psychologists engagement with psycho-spiritual constructs in clinical practice.

Method: Two studies were conducted. A preliminary survey involved a questionnaire survey of UK Doctorate in Clinical Psychology courses to determine the provision of religious and spiritual teaching currently provided. A qualitative study involved a semi-structured interview of third-year trainee clinical psychologists to explore their experiences of engaging in psycho-spiritual constructs in clinical practice.

Results: Preliminary survey: Inconsistent findings were noted. Courses varied in the time allocated to religious and spirituality teaching, ranging from no teaching to two-and-half days over the three year course. Curriculum content also varied, with an inconsistency of opinion of what should be included in teaching. Qualitative study: Interviews were analysed using Interpretative Phenomenological Analysis. Five super-ordinate themes emerged; provision of religious and spirituality training, trajectory of clinical practice, locus of control, existential issues and personal religion and spirituality ideology.

Conclusion: Whilst many studies support the integration of religion and spirituality in clinical practice (Post & Wade, 2009; Knox et al., 2005) to date, there is little change in the training of clinical psychologists. Recommendations are suggested to influence change at organisational, academic and clinical levels.

Acknowledgements

I would like to acknowledge the participants who gave their valuable time, personal experiences and without whom this study would not have been possible.

I would also like to thank Professor Michael Wang and Doctor Kirsty Williams for their timely support and expertise throughout the duration of this study.

On a personal level, my appreciation extends to my family and friends for their unfailing support over the past few years.

Word Count

	Without references	References	Appendices
Thesis abstract	219	n/a	n/a
Literature review	6005	1172	1899
Research Report	12664	1533	2561
Critical Appraisal	3103	254	473
Total	21991	2959	4933

Contents

Part One	Page
Declaration	2
Thesis Abstract	3
Acknowledgements	4
Word Counts	5
Contents	6
List of Tables	10
List of Figures	11
 Part One: Literature Review	 12
Abstract	13
1. Introduction	14
1.1 Religion and Spirituality and Mental Health	14
1.2 Definitions of religion and spirituality	15
1.3 A recent history of spirituality and mental health	16
1.4 Research: religion and spirituality	17
1.5 National guidelines and professional practice	18
1.6 Aim of the literature review	19
2. Methodology	20
2.1 Inclusion criteria	20
2.2 Exclusion criteria	20
3. Findings	23
3.1 Key findings	23
3.1.1 Responsibility of incorporating religion and spirituality	23
3.1.2 Clinical practice issues	25
3.1.3 Summary of key findings	26
3.2 Characteristics of studies	27
3.3 Quality and methodological issues	28
3.3.1. Quantitative studies	28
3.3.2. Qualitative studies	30
4. Discussion	34
5. References	38

6. Appendices	Appendix A: Data Extraction Tool	44
	Appendix B: Summary of review articles	46
	Appendix C: Summary of course director studies	48
	Appendix D: Summary of qualified clinician studies	50
	Appendix E: Summary of trainee studies	53
	Appendix F: Down & Blacks (1998) quality check list of quantitative studies	54
	Appendix G: Meyrick's (2006) model	55
Part Two: Research Report		56
1. Introduction		57
1.1 Background		57
1.2 Definitions of religion and spirituality		58
1.3 Religious belief, spirituality and mental health		59
1.4 Religion and spirituality: neglected foci?		60
2. Aim of research		63
3. Preliminary survey: Survey of UK Clinical Psychology courses		64
3.1 Introduction		64
3.2 Background		64
3.3 Findings		65
3.4 Conclusion		66
4. Qualitative study: Trainee clinical psychologists' engagement with religion and spiritual issues		70
4.1. The Researcher		70
4.1.2. Researcher's epistemological stance		71
4.2 Rationale for Qualitative Research Method		71
4.3 Rationale for Interpretative Phenomenological Analysis (IPA)		72
4.4 Recruitment		74
4.5 Sample		74
4.6 Interview schedule		75
4.7 Procedure		76
4.8 Data Analysis		76
4.9 Methodological rigour and quality criterion		77
4.10 Analysis		78
4.10.1 Structure of Analysis		78

4.11 Overview of themes	79
4.12 Super-ordinate theme:	80
'Provision of religion and spirituality training'	
4.12.1 Provision of religion and spirituality training sub theme: Academic	80
4.12.2 Provision of religion and spirituality training sub theme: Clinical	82
4.12.3 Provision of religious and spirituality training sub theme: Personal	83
4.12.4 Provision of religious and spirituality training summary	83
4.12.5 Super-ordinate theme 2:	83
'Trajectory of clinical practice'	
4.12.6. Trajectory of clinical practice sub-theme: Then and now	84
4.12.7 Trajectory of clinical practice sub-theme 2: Evolving practice	87
4.12.8 Trajectory of clinical practice summary	88
4.12.9 Super-ordinate theme 3	89
'Existential issues'	
4.12.10 Existential issues summary	90
4.12.11 Super-ordinate theme 4:	91
'Locus of control'	
4.12.12 Locus of control sub-theme 1: Internal locus of control	91
4.12.13 Locus of control sub-theme 2: External locus of control	93
4.12.14 Locus of control summary	93
4.12.15 Superordinate theme 5:	94
'Personal religious and spirituality ideology'	
4.12.16 Personal religion and spiritual ideology summary	95
5. Qualitative study Discussion	95
5.1 Systemic factors	96
5.2 Personal factors	96
6. General discussion	98
6.1 Absence of professional guidelines	99
6.2 Inconsistencies in training	99
6.2.1. Amount of dedicated teaching time	99
6.2.2. Identified modules	99
6.2.3 Ignorance of religious and spiritual therapeutic or conceptual frameworks	100

6.2.4. The culture of clinical psychology and NHS	100
6.3 Individual factors	100
6.3.1. Personal factors	100
6.3.2 Ethical issues	101
6.4 Clinical implications	102
6.5 Recommendations	102
6.6 Future research	103
7. References	104
8. Appendices	112
Appendix A: Survey of UK clinical psychology courses	113
Appendix B: NREC approval letter	115
Appendix C: Semi-structured interview schedule	118
Appendix D: Letter of invitation	119
Appendix E: Participant information sheet	120
Appendix F: Consent form	122
Appendix G: Stages of analysis	123
Part Three: Critical Appraisal	127
1. Critical Appraisal	128
1.1 Research interest	128
1.2 Choice of methodology/limitations	128
1.2.1 Preliminary study	128
1.2.2 Qualitative study	129
1.2.3 Recruitment	130
1.2.4 Data Collection	131
1.3 Analysis	133
1.4 Reflexivity	134
1.5 Process issues	135
1.5.1 Role conflict	135
1.5.2 Parallel processes	136
1.6 Learning points	137
2. References	140
3. Appendices	142
Appendix A: Letter to Ethics Committee	

List of Tables

Table	Title	Page
Table 1:	Summary of databases searched	21
Table 2:	Summary of reasons for excluded articles and duplicates	22
Table 3:	Courses' response to religion and spirituality teaching questionnaire	66
Table 4:	Participants' characteristics	75

List of Figures

Figure	Title	Page
Figure 1:	Process model of super-ordinate themes	80
Figure 2:	Diagram of religious orientation and locus of control	97

PART ONE: Literature Review

A literature review of religious belief, spirituality and clinical psychology: Perspectives within the discipline.

Word count: 6005

Abstract: 172 words

Jayne Mills

Doctorate in Clinical Psychology

2010

University of Leicester

Target Journal: British Journal of Clinical Psychology

Abstract

Purpose:

A literature review of religious belief, spirituality and clinical psychology.

Method:

A systematic approach of the literature surrounding religion and spirituality and clinical psychology was carried out using electronic databases (Psych INFO, Scopus, Web of Science, National Research Register, National Library for Health and Cochrane Database for Systematic Reviews) from 2000 to 2009. Fourteen articles were reviewed and each was assessed on methodological rigour. Three recent review studies were also evaluated.

Results:

Qualitative and quantitative studies were evaluated. Key findings were discussed: responsibility of incorporating religious and spirituality, clinical practice issues, characteristics of the studies and quality and methodological issues.

Conclusion:

Qualitative and quantitative studies were limited by methodological and study design issues. Most consistent findings were produced by course directors and clinicians with limited findings from trainee clinical psychologists. Further research is needed to educate the discipline in the issues surrounding religion and spirituality in clinical practice and to assist clinical psychologists in facilitating inherent strength within assessment, formulation, intervention and evaluation in clinical work.

Keywords: Clinical psychology, spirituality, religion, training

1. Introduction

There is a national agenda for incorporating religious and spiritual issues in to healthcare, and evidence supports the positive effects religion and spirituality have upon both mental and physical health (Mental Health Foundation, 2006; National Institute for Mental Health in England, 2003; Commission for Healthcare, 2007). This agenda highlights the importance of not only acknowledging and assessing for religious, spiritual and other life stance beliefs but also the mediating factors which may make a significant contribution to well being and recovery (McCullough, Hoyt, Larson, Koenig & Thoresen, 2000).

1.1 Religion and Spirituality and Mental Health

Evidence shows that within mental health religion and spiritual dimensions are related to lower levels of depression (Modifi et al., 2006), anxiety (Bell Meisenhelder & Chandler, 2002), cognitive decline (Kauffman, Anaki, Binns & Freedman, 2007) and social isolation (Koenig, 1998). With emphasis being placed upon holistic care, spirituality is being embraced and incorporated into models of care. However, evidence also indicates that health care professionals do not feel equipped to address spiritual needs or to be able to incorporate spiritual components into assessment and treatment (Bartoli, 2007). This may be due to a lack of knowledge and awareness, particularly as very few disciplines provide specific training in spiritual issues. Barriers to addressing religious and spiritual issues include possible discomfort in discussing a personal and private subject, fear of imposing own values and beliefs, and worries about compromising the therapeutic relationship (Hodson, 2008). Such concerns may leave professionals feeling ill at ease with the idea of engaging clients in conversations about

religious or spiritual beliefs. Swinton (2001) postulated that spirituality remains a peripheral issue for many health care professionals, but argued that it can be of central importance to many people who are struggling with mental health problems. By including spirituality and religious resources in a person's coping repertoire, they may feel empowered to pursue and maintain their recovery from mental health difficulties (Swinton, 2001).

It may be argued that professionals have a duty to include spirituality and religiosity within their assessments in such a way that individuals can freely express their views without fear of misinterpretation leading to detrimental consequences. Whilst the interface between research and clinical practice is embracing these evolving paradigms, there remains emerging tension within the public and professional domain as the expression of spirituality continues to be linked with psychopathology (Copsey, 1997). With this knowledge, patients can feel an understandable discomfort in raising their spiritual or religious concerns to their professionals. Indeed, ethnic minority groups may experience such barriers and avoid disclosure for fear of being detained under the Mental Health Act (1983) or for fear of being seen as displaying psychotic symptoms and consequently being prescribed anti-psychotic medication (Copsey, 1997).

1.2 Definitions of religion and spirituality.

In the past, concepts of religiosity and spirituality have been seen as synonymous and an all-encompassing human dimension (Bartoli, 2007). Within more recent literature, a distinction between religiosity and spirituality has been made, thus providing greater equality between people irrespective of their belief system. A definition of religion is seen as acts of worship in a particular faith with its own set of

beliefs and sacred traditions (Royal College of Psychiatry, 2007). Religion has been described as institutional and/or social phenomena defined by boundaries, with specific beliefs, practices, membership and social organisation characterised by other non-spiritual concerns such as cultural, economic, political and social (Miller & Thoresen, 2003). Allport and Ross (1967) highlighted an important factor of religious orientation inferring that there were two primary orientations: intrinsic and extrinsic. Intrinsically religious individuals extend their religion beyond worship into every aspect of their life. Religion appears to be foundational to their concept of self. In contrast, extrinsically religious people are motivated to worship for security, solace, sociability and distraction and are likely to turn to God without turning away from self (Swinton, 2001).

The definition of spirituality comes from the Latin 'spiritus' meaning breath, courage, vigour or life. Cawley (1997) suggested that spirituality has become polarised, at one end having religious connotations and the other end having non-religious connotations. More recently, Worthington and Aten (2009) defined four subtypes of spirituality: religious spirituality, humanistic spirituality, nature spirituality and cosmos spirituality (Worthington & Aten, 2009) providing greater opportunity to distinguish from organised ritualistic forms of religion to diverse and individual personal beliefs and values, which arguably, may be more relevant within psychological contexts.

1.3 A recent history of spirituality and mental health

Historically, mental health has been heavily influenced by the dominance of the biomedical model of cause and effect, specific aetiology, diagnosis and treatment. Individuals exhibiting abnormal behaviour were thought to have hidden disease due to biological causation such as genetic, bacterial or viral factors rather than environmental

or relationship influences (Ogden, 2000). The advent of the bio psycho social model of healthcare considers a broad range of alternative influences including interpersonal, societal, cultural and biological factors, which has increased the focus of the mind and body interaction reflected in the holistic approach to healthcare (Ogden, 2000). More recently there has been a paradigm shift, which places greater emphasis upon recovery and healing¹ rather than cure. However, despite the medical model there continues to be a pervasive view within some religious communities that demonic beings are responsible for mental health problems (Nagai, 2008). Such communities may be reluctant to seek help and guidance from mental health services, preferring to speak with religious scholars or community leaders than health services.

1.4 Research: religion and spirituality

Empirical research on spirituality can be challenging and the diversity, complexity and breadth of empirical research reflects some of the complexities seen within spirituality (Hill & Pargament, 2003). Early research linked spirituality with religiosity, which excluded those individuals who considered themselves not to be affiliated with organised faith. Newer third wave cognitive behavioural therapies such as Mindfulness and Compassion-focused therapy have provided spiritually-based psychological interventions (Moritz et al., 2006; Post & Wade, 2009). These interventions have been derived from philosophical-religious traditions, yet require no religious orientation and illustrate the importance of the spiritual dimension of all humanity, irrespective of religious affiliation (Baer, 2006). Post and Wade's (2009)

¹ Healing has been described as 'a deeply spiritual task that stretches beyond the boundaries of disease and cure' (Swinton, 2001, p. 57).

review of religion and spirituality and clients, clinicians and interventions highlighted several research-driven themes. Themes included: the client's presenting problem may be interrelated with religious and spiritual issues; some, but not all clients wanted to talk about such issues with their therapists and some would like interventions based on religion and spirituality; clients prefer to initiate discussion and for discussions to be gradually introduced into the work, rather than early on; empirical evidence indicates that religious and spiritual interventions are often effective; graduates usually receive little or no education and training, possibly leading to the clinicians' lack of confidence in this area. Similar recommendations were identified by Worthington and Aten (2009) including the need for: research methods to employ both Western and Eastern religious and spiritual needs; more clinically focused religion and spiritual assessments, greater collaboration between therapists and clergy, clinicians to lead and collaborate meaningful research in religion and spirituality; and strengthening areas in graduate training and the provision of guidelines.

1.5 National Guidelines and Professional Practice

The national agenda aims to provide equality for all people, irrespective of their belief system. This is supported within some professional guidelines (American Psychological Association, 2002a), but not all (British Psychological Society, 2008a). The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association, 2000) added an additional religious or spiritual problem 'V-code' to identify distressing experiences such as loss or questioning of faith or spiritual values or converting to a new faith (Hatherway, Scott & Garver, 2004). However, there is little empirical evidence that the inclusion of the 'V-code' has increased clinicians'

attention to religious and spiritual factors (Hatherway et al., 2004).

Professionals form attitudes, biases and values based on their own cultural identity which provides an opportunity for the professional to undertake self-exploration on the impact their bias has upon others. Hage (2006) suggests that spiritual and religious heritage is an important component of identity and argued that a spiritually competent therapist aims to seek and understand a client's spirituality within his or her social and cultural context.

1.6. Aim of the literature review

The aim of this current review is to explore how religion and spirituality issues are, or are not, being integrated into Clinical Psychology. Perspectives from the discipline will include those of course directors, clinicians and trainees.

2. Methodology

Following a small scale scoping literature search, four terms (*clinical psychology, spirituality, religion and training*) were searched in three main psychological electronic databases (Psych NFO, SCOPUS and Web of Science). Additional databases were accessed, including NHS specialist review databases, National Library for Health, Cochrane database for systematic reviews and National Research Register. Grey literature was also searched using resources such as Google Scholar and Department of Health websites to capture important contributions not found in peer reviewed publications. Title and abstracts were scanned and any relevant articles were selected for closer analysis using specified inclusion and exclusion criteria.

2.1 Inclusion criteria

Studies included the afore-mentioned key words within the title or abstract. Peer reviewed articles were included to provide further quality appraisal. Articles were written in English and published between 2000 and 2009. This time frame was introduced following the short scoping review undertaken at the beginning of the search. The chosen search years allowed for a review of the most contemporary literature whilst capturing literature which is still used today.

2.2 Exclusion criteria

Studies excluded from the review included: dissertations, as these may not have been peer reviewed; non-clinical related articles as clinical psychology was the focus of the study and reviews of books in keeping with the essence of reviewing up-to-date literature (however, books did assist in the background reading within the review).

Single case studies and studies which included children were excluded purely to manage the volume of studies.

Key words used in the search were: *clinical psychology, religion, spirituality and training*. A full summary of the searches undertaken can be seen in Table 1.

Table 1: Summary of databases searched.

Database	Dates searched	No of articles retrieved	Key words	Limits set
Web of Science	April 2009 Nov 2009	6	<i>Clinical psychology, religion, spirituality, training</i>	English language, Peer reviewed articles, adults
SCOPUS	April 2009 Nov 2009	24	<i>Clinical psychology, religion, spirituality, training</i>	English language, Peer reviewed articles, adults,
Psych Info	April 2009 Nov 2009	6	<i>Clinical psychology, religion, spirituality, training</i>	English language, Peer reviewed articles, adults
National Library for health	April 2009 Nov 2009	0	<i>Clinical psychology, religion, spirituality, training</i>	None applied
Cochrane database for systematic reviews	April 2009 Nov 2009	0	<i>Clinical psychology, religion, spirituality, training</i>	None applied
National Research Register	April 2009 Nov 2009	0	<i>Clinical psychology, religion, spirituality, training</i>	None applied

Of the 36 articles retrieved from the electronic databases twenty two were excluded (see Table 2). Of the fourteen remaining articles, reference sections were also scanned to find further potential studies which may not have been included in the electronic search to provide further breadth to the literature review.

Table 2: Summary of reasons for excluded articles and duplicates

Database	Number retrieved	Reason for exclusion	Number excluded
Web of Science	6	1 disability and rehabilitation 1 end-of-life	2
SCOPUS	24	1 child/adolescent study 6 medically specific studies 1 non-clinical psych. Focus 2 nursing 4 medical education 2 end-of-life 1 cultural	17
Psych INFO	6	1 cultural 1 medical education 1 university setting	3

A systematic review of each relevant article was undertaken using a data extraction tool (Appendix A). Each article was rated on study aims, methodology, sample characteristics, setting, reliability and validity, funding and researcher characteristics. Quantitative articles were appraised using Downs and Black's (1998) quality checklist. This tool had shown feasibility in assessing methodological strengths and weaknesses in randomized and non-randomized studies. The checklist comprised 27 items related to five areas of evaluating quality of reporting, external validity, internal validity-bias, internal validity-confounds and power. Qualitative studies were evaluated using Meyrick's framework for judging rigour and quality in qualitative studies (Meyrick, 2006). The check-lists are evaluated in detail within the results section. Both quantitative and qualitative studies were appraised on the transparency of the results and write up along with identified limitations.

3. Findings

In total fourteen studies were identified which met the inclusion criteria. In addition several recent review articles were identified which complemented the current review (Hage 2006; Post & Wade, 2009; Worthington & Aten, 2009) summaries of which may be seen in Appendix B. Findings from the published research were multifaceted and so a general overview of the consensus was synthesized. This was achieved by using a synthesis chart to sort and categorise different arguments presented combining separate parts to form a coherent whole. Analysis of the review papers included three components: key findings, characteristics of the studies and quality and methodology issues.

3.1 Key findings

Key findings included the responsibility of incorporating religion and spirituality into clinical training and clinical practice issues.

3.1.1 Responsibility of incorporating religion and spirituality.

Within the literature there is acknowledgement that religion and spirituality issues are 'congruent with the realities of clinical practice' (Schulte, Skinner & Claibon, 2002, p.131) with importance allied with personal identity and self concept (Schafer, Handal, Brawer & Ubinger, 2009). Post and Wade (2009) reviewed the area of psychotherapy and spirituality in therapists, clients and interventions and concluded that therapists would like to evaluate their own stance on religion and spirituality, that clients welcome the inclusion of religion and spirituality into therapy and request that therapists be open with them in relation to religious and spiritual matters. Sixty three percent of course directors reported that some knowledge of religious and spiritual

issues are important to theory, research and practice (Schafer et al., 2009). Collectively, this suggests a consensus in the importance of religion and spirituality across clients, academics and therapists.

However, sixty five percent of course directors reported no didactic teaching on religious and spiritual issues (Russell & Yarhouse, 2006), and in a more recent study, 67% of course directors reported that religion and spirituality was not specifically covered in teaching (Schafer et al., 2009); however, issues were included in other modules. The number of such modules including religious and spiritual issues was extremely variable ranging from eight to fifteen modules (Brawer, Handal, Fabricatore, Roberts & Wajda-Johnston, 2002; Russell & Yarhouse, 2006; Schafer et al., 2009). Whilst it could be argued that such wide coverage was illustrative of the pervasive impact that religion and spirituality has upon clients' lives, an alternative and somewhat more cynical view may be that this potentially creates a dilution of the importance of religion and spirituality issues. It was unclear how much specific focus religious and spiritual issues actually received. Some indication of improvement was seen within the education and training domain as greater numbers of faculty staff and trainees were researching and publishing religious and spiritual research (Schafer et al., 2009), than compared to the earlier study (Brawer et al., 2002).

Whilst didactic teaching on religious and spiritual issues was limited, there was a consensus amongst course directors advocating addressing such issues within clinical supervision sessions. Brawer et al. (2002) reported that 77% of course directors believed that clinical supervision was the forum for discussing religious and spiritual issues. This number increased to 90% and 84% respectively (Russell & Yarhouse, 2006; Schafer et al., 2009). However, this may be a misguided view from course directors,

given that many supervisors have lacked exposure to religious and spirituality issues during their own graduate or post-graduate training (Aten & Hernandez, 2004).

In America, professional standards and guidelines (APA, 2002b) have provided some impetus to integrate religious and spiritual issues into clinical practice but once again there has been a mixed response. Gradual inclusion of religion and spiritual issues has been noted (Schafer et al., 2009) but not in all cases (Hathaway, Scott & Garver, 2004). In the UK, the BPS (2009) introduced standards relating to religion and spirituality within the Code of Ethics and Conduct, however, no explicit standards relating to religion and spirituality exist in current training accreditation (BPS, 2008b) which may suggest that religion and spirituality continues to lack professional and clinical focus. Subjectivity and lack of operational definition have been frequent criticisms within the literature (Schafer et al., 2009).

Overall, more psychologists are recognising the importance of integrating religion and spirituality into clinical practice (Aten & Hernandez, 2004) and that existential issues affect psychological functioning (Patel & Shikongo, 2006). Ethical dilemmas of disclosure, spiritual conflict or tension remain a source of concern for trainees (Patel & Shikongo, 2006). The impact of neglecting religion and spirituality within clinical psychology may influence the therapeutic relationship and progress of therapy for some clients (Hage, 2006).

3.1.2 Clinical practice issues.

A number of studies report the need for clinicians to have an opportunity to explore their own spiritual or religious stance (Martinez & Baker, 2000; Simmonds, 2004; Souza, 2002) and as reflective practitioners it would seem wise for clinicians and trainees to consider the ethical implications of disclosure of their own beliefs in a

similar way to sharing one's gender, sexuality, race and culture. Knowledge of Allport and Ross' (1967) religious concepts may be a useful framework for clinicians to consider their own and clients' religious positioning. Despite a seven-year gap, Schafer et al. (2009) approved recommendations presented by Brawer et al. (2002). These included: increased sensitivity; curriculum modifications; knowledge and competence; mentors; guest lecturers; access to resources and conferences. Collaboration with others, colleagues, faith communities and generally integrating religion and spirituality within clinical practice was a consensual viewpoint (Baker & Wang, 2004; Brawer et al. 2002; Patel & Shikongo, 2006; Russell & Yarhouse, 2006).

The ability to find therapeutic space was an area which was identified within the qualitative papers with no space to consider religious issues in training therapy and supervision (Martinez & Baker, 2000). Trainees considered the possibility of not approaching religious or spiritual beliefs within therapy but were concerned that this would lead to incomplete assessment, ignoring a very important dimension of a person's life (Patel & Shikongo, 2006).

3.1.3 Summary of key findings.

In summary, there are areas of agreement within the key findings across the studies. The need for operational definitions of religion and spirituality is important for training research and clinical practice. Training in religious and spiritual issues within clinical practice is required across the discipline. Training would be supported by the inclusion of recommendations regarding religion and spirituality within professional guidelines as this would provide an additional impetus in getting religious and spiritual issues onto the training agenda enabling the profession to feel more at ease in exploring such issues. Inclusion of religious and spiritual dimensions can facilitate a person's

recovery by accessing their inner resources and coping strategies, leading to more sustained clinical outcomes.

3.2 Characteristics of studies

Four of the studies involved course directors (Brawer et al., 2002; Russell & Yarhouse, 2002; Schafer et al., 2009; Schulte et al., 2002), seven involved qualified clinicians (Baker & Wang, 2004; Delaney, Miller & Sisono, 2007; Hathaway et al., 2004; Martinez & Baker, 2000; Nagai, 2008; Simmonds, 2004; Scott Young, Wiggins-Frame & Cashwell, 2007) and three involved student therapists (Patel & Shikongo, 2006; Souza 2002; Walker, Gorsuch, Tan & Otis, 2008). A series of summary tables (Appendices C, D & E) outline the key characteristics for each group. The group with the largest number of participants was the qualified clinician group involving a total of 1207 clinicians. These seven studies took place in America, Australia and the United Kingdom, with UK studies solely involving clinicians. The total number of course directors was 366 and all were American studies. Student therapists comprised the smallest group with a total of 171 students taking part in America and South Africa.

The course director group studies provided response rates varying from 32% - 58%. However, the qualified clinicians' response rate was limited with only two of seven studies noting response rates, Hathaway et al. (2004) recording a rate of 33% in study 2 and Delaney et al. (2007) recording a response rate of 53%. Delaney et al. (2007) and Schulte et al. (2002) sent out reminder letters and yielded the greater response rate, 53% and 58% respectively. The student therapist papers provided no indication of response rates.

All of the course director studies involved professionally accredited course programs indicating that they had met American Psychological Association accredited

standards of education (APA 2002b). The qualified clinician studies indicated that all participants were registered with professional bodies which varied depending upon the participant's area of professional practice. Of the seven qualified clinician studies two provided information regarding the length of time in qualified practice ranging from: 5-25 years (Martinez & Baker, 2000) and 0-20+ years (Baker & Wang, 2004). One study reported a mean of 6.6 years of working within an Asian Ethnic Minority Mental Health Specialist service (Nagai, 2008). In another study one third of participants were receiving psychoanalytic training (Simmonds, 2004). Students were studying at Masters degree level (Souza, 2002; Patel & Shikongo, 2006) and Doctoral level (Walker et al., 2008). Comparisons were difficult within this group as not only were the students studying at different academic levels but included students from counselling and clinical psychology courses. However, following reflection, it was decided to include the student studies to illustrate the empirical evidence for this group.

3.3 Quality and methodological issues

Whilst the debate continues regarding the appropriateness of evaluating the quality of quantitative and qualitative studies with the same criteria, the author supports Meyrick's (2006) view that as there is inconsistency in the philosophical, epistemological and ontological positions for quantitative and qualitative research paradigms, there is a rationale for separate quality appraisal approaches. Consequently, quantitative studies were evaluated using Downs and Black's (1998) quality checklist and qualitative studies using Meyrick's (2006) pluralistic approach.

3.3.1 Quantitative studies.

The quality of the quantitative studies (Brawer et al., 2002; Schulte et al., 2002; Russell & Yarhouse, 2006; Delaney et al., 2007; Walker et al., 2008; Hathaway et al.,

2004; Scott Young, 2007; Nagai, 2008; Schafer et al., 2009) was evaluated using Downs and Black's (1998) quality checklist. This tool has been shown to be feasible in assessing methodological strengths and weaknesses in randomized and non-randomized studies. The checklist comprises 27 items related to five areas including evaluating quality of reporting, external validity, internal validity-bias, internal validity-confounds and power. Appendix F summarizes the quality of the quantitative studies using the checklist. The total scores including the current review articles exceeded the randomised study mean score of 14.0 (SD 6.39) and non-randomised study mean score of 11.7 (SD 4.64) highlighted in Downs and Black (1998) paper, possibly indicating higher quality research than that reported in the Downs and Black's (1998) study. However, caution with this interpretation is required as this review consisted of a single appraisal of the quality of the research by the author. There was one exception which failed to exceed the mean scores in both randomized and non-randomized studies, scoring a total of 11 out of 28 (Scott Young et al., 2007).

All studies in the present review were cross-sectional cohort studies, identifying randomised specific populations at a specific point in time. Unfortunately, no longitudinal studies were found, which prevented analysis of temporal change. Hathaway et al. (2004) identified associations between qualified clinician assessment practices, clinicians' beliefs and other process-outcome factors related to religious and spiritual issues. They reported significant correlations between asking clients about religiousness and linking this with religious and spiritual treatment goals, noting changes in religious and spiritual functioning within therapy and setting of religious and spiritual treatment goals in treatment plans. They also found that therapists who consulted with religious professionals regarding clients were more likely to work

collaboratively with religious professionals during therapy. Walker et al.'s (2008) study of Christian trainees found that intervention-specific training is emerging as the most beneficial training to assist therapists in learning to use religious and spiritual interventions. Personal therapy, coursework and integration of psychology and religion may be more relevant whilst in training than after graduation or after having been in qualified practice for some time. Whilst these studies indicate a relationship between such factors, no causation or prediction may be made. The lack of operational definitions of religion and spirituality may have influenced validity (Schafer et al., 2009). Validity will be discussed further in the results section.

An overall aspect of the quality of research was favourable. External validity scored well across all studies indicating a degree of confidence in conclusions given the time, place and people involved. Unsurprisingly, internal validity was consistently moderate to low across all studies and inferences on cause and effect were not possible with the study design and selection bias. Information on statistical power was absent across all studies and consequently the ability to reject the null hypothesis and reduce the chance of type II error was compromised.

3.3.2. Qualitative studies.

The remaining five articles (Martinez & Baker, 2000; Souza, 2002; Baker & Wang, 2004; Simmonds, 2004; Patel & Shikongo 2006) were evaluated using Meyrick's pluralistic model. The model has two key principles: transparency or disclosure in all aspects of the research process and systematicity which involves the use of regular data collection and analytical processes whereby deviant cases are described and justified. Rigour at each stage is reported to educate the reader to look beyond the assessment and make value-based judgements regarding the rigour and quality of the research (Meyrick,

2006). The stages include: epistemological and theoretical stance, methods, samples, data collection, analysis, results and conclusion or applicability (Appendix G).

Epistemological and theoretical stance was not routinely identified within the papers which weakened the rationale for choice of methodology. The exception to this was in Baker and Wang (2004) who justified their epistemological, ontological and methodological positioning. To a lesser degree, Simmonds (2004) justified her methodology and theoretical position in the absence of her epistemological and ontological position. Souza (2002) provided no explanation. One consideration for the absence of such information may have been due to the condensing of words for publication word limitation.

Two of the five studies utilized grounded theory (Martinez & Baker, 2000; Baker & Wang, 2004) an established methodology seen in the literature. Simmonds (2004), utilised a combination of analysis of 'narrative finding' and coding of core ideas. Whilst she gave a reasonable account of her rationale for using qualitative methodology, the processes involved were less clear. Patel and Shikongo (2006) implemented a framework analysis, which is frequently used in applied or policy relevant qualitative research (Pope & Mays, 2000); however, they omitted their rationale for using this methodology. Souza (2002) did not specifically identify the methodology, although one is left to assume that a narrative approach was used within the seminar groups.

Samples across the qualitative studies were self-selected, recruited via professional bulletins (Simmonds, 2004); directories (Martinez & Baker, 2000); official religiously-related organizations (Baker & Wang, 2004); or samples of convenience (Patel & Shikongo, 2006; Souza, 2002). Many studies acknowledged the religious affiliation of their participants (Baker & Wang, 2004; Martinez & Baker, 2000; Patel &

Shikongo, 2006), or of an interest in spirituality within clinical practice (Simmonds, 2004). In total there were 36 female and 20 male participants across the qualitative studies. Participants were from the United Kingdom (Martinez & Baker, 2000; Baker & Wang, 2004), United States of America (Souza, 2002), South Africa (Patel & Shikongo, 2006) or from the United Kingdom and Australia (Simmonds, 2004) thus providing a greater heterogeneity than seen in the quantitative papers.

The semi-structured interview was the data collection method of choice with the exception of Souza (2002), who used seminar group discussion for data collection. Baker and Wang (2004) initially used a repertory grid approach which then led to their development of the interview schedule as they wanted the interview to include issues which were important to their participants rather than the researchers' views of what information was needed. This allowed for increased transparency of the evolution of the research process. Others developed their own interview schedule which was flexible and allowed participants to take the discussion in the direction they wished. Data collection lacked transparency as interview schedules were not included in the papers. Baker and Wang (2004) however, did provide an outline of what their schedule included. The researchers' epistemological stance, their own beliefs and religious or spiritual background were rarely stated. However, the majority of participants did disclose their religious beliefs (Baker & Wang, 2004) or how their beliefs had led them into training (Martinez & Baker, 2000).

In summary, the analysis within the qualitative papers was reviewed with a focus upon the quality rather than key findings, as these have been previously discussed. The areas critiqued included: transparency of process from data to conclusions, systematic processing, inclusion of all cases, triangulation of method, source, sample

and research, validation, reflexivity and audit trail. The studies varied quite considerably in the quality of this section. On the whole, little attention was given to all cases, with no study acknowledging or explicitly discussing deviant cases. All participants were part of an organised group with a religious focus. The non-inclusion of participants with no particular religious belief was a frequent weakness and alternative viewpoints were rarely provided. This along with self-selecting or convenience sampling increased research bias and reduced the researchers' ability to make generalisations to groups other than those included in the study. Inter-rater reliability was a particular weakness within the qualitative papers, with the exception of Baker and Wang (2004), who obtained good reliability for category allocation (kappa .614). Simmonds (2004) was the only author who used computer software to enhance the thoroughness and tracing of themes, providing some independence of coding and a systematic comparison across the interviews.

4. Discussion

Overall, scientifically, there were an adequate number of studies to reflect the current perspectives of religion and spirituality within the discipline of clinical psychology. These included three main stakeholder groups: course directors, clinicians and trainees. The literature is dominated by research that is US-based and largely drawn from populations where the main religious tradition is Judea/Christian. The level of sophistication within the studies varied considerably yet the combination of quantitative and qualitative studies produced a more comprehensive perspective. Literature included the most recent reviews within the area (Hage, 2006; Post & Wade, 2009; Worthington & Aten, 2009). Despite increased interest and empirical research relating to religion and spirituality within clinical psychology, the constructs remain elusive.

Very few studies have provided operational definitions, as such; there are no clear definitions to guide course directors on what the religious and spiritual components of the curriculum should be. Participants were left to respond to the questionnaires with subjective interpretations of the concepts, consequently weakening the validity. Although the definition of religion appears to be easier to conceptualise, spirituality seems to be much more diverse and subjective. Worthington and Aten (2009) have proposed four subgroups of spirituality in a move to operationalise the concept. This may not only provide greater understanding of the diversity of spirituality within clinical practice but also increase the validity of research by providing greater objectivity across participants.

The general impression across all parties was that religion and spirituality did have an importance in clinical practice, yet there appeared to be a distinct lack of

ownership or responsibility. Course directors did not systematically include religion and spirituality within the curriculum, giving the impression that religion and spirituality is slotted into other domains within didactic teaching. In addition to this, there was an opinion shared by course directors that spiritual and religious issues should be explored within clinical supervision, possibly indicating a preference for shifting this responsibility over to clinical supervisors. Whilst ethical considerations such as timing and pace of enquiry into religious and spiritual matters, personal disclosure, areas of conflict, boundary issues or dealing with opposing views are familiar for clinical psychologists; there may be difficulties with this as many clinical supervisors have not received training in religious and spiritual issues (Aten & Hernandez, 2004), thus making it difficult for supervisors to know their role and responsibilities.

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 2000) introduced a religion and spiritual 'V-code' in an attempt to incorporate these issues into diagnosis. However, no clinician working within exemplar clinics had given a religion or spiritual V-code to a client (Hathaway et al., 2004). Until 2003 there were no professional guidelines aimed at specifically addressing religious, spiritual and multicultural issues within clinical psychology. In 2003 the American Psychological Association (APA; APA, 2002b) produced multicultural guidelines which included reference to religion and spirituality issues. Whilst several of the current review articles pre-dated these guidelines, other papers post date the guidelines and suggest a very gradual improvement (Schafer et al., 2009). Schafer et al. (2009) report that course directors have a mild interest in incorporating religion and spiritual issues into their courses, but recognise an improvement, when compared to Brawer et al. (2002), suggesting that the professional accreditation guidelines have

provided some impetus for change. In contrast, to date, the BPS Committee on Training in Clinical Psychology (2008b) has not introduced explicit religious and spiritual guidelines into clinical practice, leaving individual courses to make their own interpretation of required training needs. This may mean that religion and spirituality continues to lack professional and clinical focus, when compared with the inclusion of professional standards related to diversity and ethnicity issues. Findings suggest that personal and professional experience has greater influence than guidelines and codes in the development of multicultural competence (Hansen et al., 2006). Such contradiction warrants further investigation and research.

Religion and spirituality are personal concepts with individual meanings and exploration of such private matters needs to be taken very carefully and sensitively. Allport and Ross (1967) distinguished between intrinsic and extrinsic orientations of religion. This conceptualisation may be relevant as a guiding principle within the training of clinical psychologists as it distinguishes between religious belief which is fundamental to an individual's self concept (intrinsically religious) and religious belief which is more detachable from sense of self (extrinsically religious) (Swinton, 2001). However, these orientations are not discrete categories and do not exhaust all possible orientations to being religious. Batson, Schoenrade and Ventis (1993) suggested that a third dimension be included. This was named as the *quest* dimension, a form of being religious where questions, doubt and self-critical thinking are seen to be as important as answers.

If religious and spiritual issues are salient and this domain is neglected, internal resources may be overlooked leading to lengthier than necessary therapy, clients experiencing an inadequate service from clinical psychology and potentially suboptimal

clinical outcome. This will have financial and political implications for the NHS.

An overlap of methodological issues crossed qualitative and quantitative studies. Countries included America, South Africa, Australia and the United Kingdom, which limits the ability to generalise the findings as the population of each country differs and was beyond the scope of the review. All studies included self-selected participants, most of whom were religiously affiliated in some way or other. This makes representiveness complicated as details of non-respondents were absent across both methodologies, leaving the reader with many more questions. There was a lack of transparency in the authors' epistemological stance, which prevented the reader from fully appreciating the rationale for the methodology and design decisions. Operational definitions were absent across all studies, leading to less than optimal quality of research.

Absent from the review were: longitudinal and comparative studies between affiliated and non-affiliated religious groups; contrasts between intrinsically or extrinsically religious individuals (Allport & Ross, 1967); UK-based studies exploring the views of trainee clinical psychologists to gain an understanding of their perspective of engaging with clients in religious and spiritual matters; the views of clinical supervisors and the role of clinical supervision in religious and spiritual issues. The relevance of religion and spirituality in working with people experiencing distress warrants further investigation. Above are a few recommendations for the discipline of clinical psychology.

5. References

- Allport, G. & Ross, J. (1967). Personal religious orientation and prejudice. *Journal of Personality and Social Psychology*, 5, 432-43
- American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders (4th Ed., Text Revised)*. Washington, DC: Author.
- American Psychological Association (2002a). *Ethical Principles of Psychology and Code of Conduct*. Retrieved from the World Wide Web on 22nd November 2009: <http://www.apa.org/ethics/code>
- American Psychological Association (2002b). *Guidelines on multicultural education, training, research, practice and organisational change for psychologists*. Washington DC: APA.
- Aten, J.D. & Hernandez, B.C. (2004). Addressing religion in clinical supervision: A model. *Psychotherapy: Theory, Research, Practice, Training*, 41 (2), 152-160
- Baer, R.A. (2006). *Mindfulness-Based Treatment Approaches. Clinicians guide to evidence base and applications*. America: Academic Press.
- *Baker, M. & Wang, M. (2004). Examining connections between values and practice in religiously committed UK clinical psychologist. *Journal of Psychology and Theology*. 32 (2), 126-136
- Bartoli, E. (2007). Religious and spiritual issues in Psychotherapy practice: Training the trainer. *Psychotherapy: Theory, Research, Practice, Training*, 44 (1), 54-65.
- Batson, C. D., Schoenrade, P. A. and Ventis, W. L. (1993). *Religion and the Individual:*

A Psycho-social Perspective. New York: Oxford University Press

Bell Meisenhelder, J. & Chandler, E.N. (2002). Spirituality and Health outcomes in the elderly. *Journal of Religion and Health*, 41 (3), 243-252.

*Brawer, P. A., Handal, P.J., Fabricatore, A.N., Roberts, R. & Wajda-Johnston, V.A. (2002). Training and education in religion/spirituality within APA-accredited clinical psychology programs. *Professional Psychology: Research and Practice*, 33 (2), 203-206
British Psychological Society (2008a). Generic Professional Practice Guidelines. 2nd Edition. Leicester: BPS.

British Psychological Society (2008b). Committee on Training in Clinical Psychology. Criteria for the Accreditation of Post Graduate Training Programmes in Clinical Psychology. Leicester: BPS.

British Psychological Society (2009). *Code of Ethics and Conduct*. Leicester: BPS.
Cawley, N. (1997). An exploration of the concept of spirituality. *International Journal of Palliative Nursing*, 3 (1), 31-36

Commission for Healthcare Audit and Inspection (2007). Caring for dignity. A national report on dignity in care for older people while in hospital. London: Healthcare Commission.

Copsey, N. (1997). Keeping faith.: The provision of community mental health services within a multi-faith context. London: Sainsbury Centre for Mental Health

*Delaney, D., Miller, W. & Sisono, A.M. (2007). Religiosity and Spirituality among psychologists: A survey of clinician members of the American Psychological Association. *Professional Psychology: Research and Practice*. 38, 5, 538-546

Downs, S. H. & Black, N. (1998). The feasibility of creating a checklist for the assessment of the methodological quality both of randomised and non-randomised studies of healthcare interventions. *Journal of Epidemiology and Community Health*, 52, 377-384

Hage, S. (2006). A closer look at the role of spirituality in psychology training programmes. *Professional Psychology: Research and Practice*, 37 (3), 303-310

Hansen, N.D., Randazzo, K.V., Schwartz, A., Marshall, M., Kalis, D., Frazier, R., Burke, C., Kershner-Rice, K. & Norvig, G. (2006). Do we practice what we preach? An exploratory survey of multicultural psychotherapy competencies. *Professional Psychology: Research and Practice*, 37 (1), 66-74

*Hathaway, W. L., Scott, S. Y. & Garver, S. A. (2004). Assessing religious/spiritual functioning: A neglected domain in clinical practice? *Professional Psychology: Research and Practice*, 35 (1), 97-104.

Hill, P. C. & Pargament, K. I. (2003). Advances in the conceptualisation and measurement of religious and spirituality. *American Psychologist*, 58 (1), 64-74.

Hodson, R. (2008). Religion and therapeutic intervention with older people: Reflections on a thorny issue. *PSIGE Newsletter*, 104, 28-33.

Kauffman, Y., Anaki, D., Binns, M. & Freedman, M. (2007). Cognitive decline in alzheimers disease: Impact of spirituality, religiosity and QoL. *Neurology*, 68 (8),1509-1514.

Koenig, H. (1998). Religious attitudes and practices of hospitalized medically ill older patients. *International Journal of Geriatric Medicine*, 13, 213-224.

*Martinez, S. & Baker, M. (2000). 'Psychodynamic and Religious?' Religiously

committed psycho dynamic counsellors, in training and practice. *Counselling Psychology Quarterly*. 13, 3, 259-264

McCullough, M. E., Hoyt, W.T., Larson, D.B., Koenig, H.G. & Thoresen, C. (2000). Religious involvement and mortality: A meta-analytic review. *Health Psychology*, 19, 211-222.

Mental Health Act 1983: Elizabeth II, 1983. Chapter 20 reprinted July 2003, August 2005. Great Britain. Her Majesty's Stationery Office.

Mental Health Foundation (2006). *The impact of spirituality on mental health: A review of the literature*. London: Mental Health Foundation.

Meyrick, J. (2006). What is good qualitative research? A first step towards a comprehensive approach to judging rigour/quality. *Journal of Health Psychology*, 11 5, 799-808

Miller, W. R. & Thoresen, C. E. (2003). Spirituality, religion and health: An emerging research field. *American Psychologist*, 58, 24-35

Modifi, M., Devellis, R., Blazer, D., Devellis, B., Panter, A. & Jordan, J. (2006). Spirituality and depressive symptoms in a radically diverse US sample of community-dwelling adults. *The Journal of Nervous and Mental Diseases*, 194 (12), 975-977.

Moritz, S., Quan, H., Rickhi, B., Lui, M., Angen, M., Vintila, R., Sawa, R., Soriano, J. & Toews, J. (2006). A home study-based spirituality education program decreases emotional distress and increases quality of life – a randomised controlled trial. *Alternative Therapy Health Medicine*, 12 (6), 26-35

*Nagai, C. (2008). Clinician-assessment of Cultural and Spiritual Competency: Working with Asians and Asian Americans. *Community Mental Health Journal*, 44,

National Institute for Mental Health in England (2003). *Inspiring hope. Recognising the importance of spirituality in a whole person approach to mental health*. Leeds:

Department of Health.

Ogden, J. (2000). *Health Psychology: A textbook*. Buckingham: Open University Press

*Patel, C. J. & Shikongo, A.E.E. (2006). Handling spirituality/religion in professional training: Experiences of a sample of Muslim psychology students. *Journal of Religion and Health*, 45 (1), 93-111

Pope, C. & Mays, N. (2000). *Qualitative research in health care*. London: British Medical Journal Books

Post, B. C. & Wade, N. G. (2009). Religion and Spirituality in Psychotherapy: A practice-friendly review of research. *Journal of Clinical Psychology*, 65 (2), 131-146

Royal College of Psychiatry (2007). *Spirituality and mental health*. Retrieved from the World Wide Web Dec 22nd 2007: <http://www.rcpsych.ac.uk/publications>

*Russell, S. R. & Yarhouse, M.A. (2006). Training in Religion/Spirituality within APA-accredited Psychology Predoctoral Internships. *Professional Psychology: Research and Practice*, 37 (4), 430-436

*Schafer, R., Handal, P.J., Brawer, P.A. & Ubinger, M.(2009). Training and education in religion/spirituality within APA-accredited clinical psychology programs. Retrieved from the World Wide Web October 20, 2009: *Journal of Religion and Health online issue*.

*Schulte, D.L., Skinner, T.A. & Claibon, C. D. (2002). Religious and Spiritual Issues in Counselling Psychology Training. *The Counseling Psychologist*, 30 (1), 118-134

- *Scott Young, J., Wiggins-Frame, M. & Cashwell, C.S. (2007). Spirituality and counselor competence: a national survey of American Counseling Association members. *Journal of Counseling and Development*, 85 (1), 47-56
- *Simmonds, J. (2004). Research with psychoanalysts and psychoanalytic psychotherapists about spirituality. *International Journal of Psychoanalysis*, 85, 951-971
- *Souza, K.Z. (2002). Spirituality in counselling: What do counselling students think about it? *Counselling Values*, 46, 213-217
- Swinton, J. (2001). *Spirituality and Mental Health Care. Rediscovering the forgotten dimension*. London: Jessica Kingsley Publishers.
- *Walker, D., Gorsuch, R., Tan, S.Y. & Otis, K. (2008). Use of religious and spiritual interventions by trainees in APA-accredited Christian clinical psychology programs. *Mental Health, Religion & Culture*, 11 (6), 623-633
- Worthington, E.L. & Aten, J.D. (2009). Psychotherapy with religious and spiritual clients: An Introduction. *Journal of Clinical Psychology*, 65 (2), 123-130.

* Articles included in the review

6. APPENDICES

Appendix: A

DATA EXTRACTION FORM

Bibliography details	Author		
	Publication year		
	Refers to same study Y/N		
Details of study	General details		
	Number of participants		
	Number of groups		
	Number in each group		
	Country		
	Gender	Male	
		Female	
	Ethnicity	Y/N	% of total
	Socio-economic		
Method			
Data collection			
Setting			
Timing			
Power			
Participation rate			
Attrition rate			
Randomised	Y/N		
Reliability	Y/N		
Validity	Y/N		

Reasonable choice of statistics?

Y/N

Cost

Funding/ Sponsorship

Conclusions

Ethics

References to obtain

Appendix B: Summary of review studies

Author/Study/ Year	Methodology/Design	Sample/Country	Results	Future Research
Hage (2006)	Critical discussion of research related to R/S issues in clinical training	<p>USA</p> <p>Clinical Psychology</p> <p>Counselling Psychology</p> <p>Marriage and Family Therapy</p> <p>Rehabilitation Psychology</p>	<p>Discussions of R/S issues in programs rare or non existent with the exception of supervision. Conceptual guidelines for supervisee competence in working with religious clients recently presented in literature (Aten & Hernandez, 2004).</p> <p>Collaboration with clergy. Lead in multicultural issues and expand into R/S issues Little effort being made to introduce R/S issues into coursework R/S diversity not considered to be as important as other aspects of diversity Absence of standards or R/S</p> <p>Greatest attention to R/S in clinical training R/S importance in clients lives Most therapists identify with an organised religion unlike counselling and clinical psychology colleagues Standards for R/S added to accreditation</p> <p>R/S issues essential to understanding clients view of recovery Incorporating R/S coping methods supports rehabilitative efforts.</p>	<p>Grants for research specifically related to R/S diversity could be offered to support students pursuing research. Implications for practice challenge ahead for faculty and students to enhance knowledge skills and awareness in working with R/S diverse communities and individuals.</p>

Post & Wade (2009)	Practice-friendly review of research	USA	<p>A review of research religion and spirituality: clients; therapists and interventions. Highlighting predominant research driven themes. Therapists identify less with religion and more with spirituality. They have little or no education. More R/S clients want to talk about R/S in therapy, but not all.</p> <p>Some clients wish for R/S intervention in session. R/S is sometimes interrelated with presenting problem. Clients usually find R/S discussion helpful when initiated by client and gradually brought in.</p> <p>Empirical evidence shows R/S interventions to be effective. R/S can be effectively delivered by therapists of all R/S beliefs.</p>	
Worthington & Aten (2009)		USA	<p>Clinically useful definitions noted. More clinically-focused R/S assessments. Greater clergy-psychotherapist collaboration. Identify areas for graduate training that require strengthening and provision of corresponding guidelines.</p>	<p>New methods of clinical practice that employ both Western and Eastern R/S needs to be developed and tested</p> <p>To develop more meaningful research on R/S issues</p>

Appendix C: Summary of course director studies

Author/Year	Methodology/Design	Response rate	Sample/Country	Results	Future Research
Brawer, Handal, Fabricatore, Roberts & Wajda-Johnston (2002)	Quantitative study survey	51.00%	98 Directors of Clinical training APA -accredited program USA	77% R/S most likely addressed in supervision but inconsistent, not incorporated into usual supervisory process 61% R/S issues are most likely to come up in other areas e.g. cultural diversity, ethics/professional issues 13% specific course related to R/S (24 contemplating adding R/S course in 10yrs) 30% faculty have R/S research interest 43% students have R/S research interest. 20% students want R/S added to curriculum	Eight recommendations to foster a training environment in which faculty can enhance R/S in the lives of their patients Future research with regard to student experiences with these issues
Russell & Yarhouse (2006)	Quantitative study survey	32.00%	139 APA-accredited pre-doctoral training Directors USA	65% no didactic R/S teaching 35% offer R/S teaching – 49% once/yr, 20% once/semester, 6.6% monthly training. Most reported R/S included in multicultural diversity 91% report R/S covered in supervision (by client 37%, intake instrument 21.8% discretion of supervisor 4.3%, intern 3.5%) 35% consultation, 25% in-services, 23% crisis, 22% teaching 68% never foresee R/S training being offered 73% staff not interested 82% no published scholarly works in R/S 83.5% no student interest in R/S and Psychology	Identifying and removing constraints to R/S training

				82% no student re R/S training	
Schafer, Handal, Brawer & Ubinger (2009)	Quantitative study survey USA	39.00%	89 Directors of Clinical Training APA -accredited program USA (Canada and Puerto Rico undeliverable) 21 religiously affiliated school 68 no religious affiliation	84% R/S issues covered in supervision 68% R/S covered in cultural diversity, ethics/ professional issues 25% R/S major content 42% faculty have published scholarly work in R/S 50% students have research interest in R/S 29% students interest including R/S on course. 43% R/S systemically covered in religious affiliated schools, 9% in non affil schools Importance of R/S within Psychology 53% importance in supervisors expertise, 56% course directors importance in therapists expertise 63% R/S issues important in the domain of theory, practice and research.	To investigate the effect of including education and training in R/S both in terms of research and practice
Schulte, Skinner & Claiborn (2002)	Quantitative study survey	58.00%	40 Counselling Psychologist Directors APA -accredited program USA	Few courses offer R/S content. Do not expect faculty members to be knowledgeable about R/S issues, nor is it important for supervisory role R/S development not taught R/S manifestations of psychological disorder not taught Open to discuss issues in classroom or supervision Open to research R/S Willing to supervise R/S research	Practitioners perceive training concerning religion and spiritual psychology is congruent with the realities of clinical practice

Appendix D: Summary of qualified clinician studies

Study (Year)	Methodology/Design	Response rate	Sample/country	Results/Themes	Future research
Baker & Wang (2004)	Qualitative Interview Repertory grid and Grounded Theory	Not noted	14 religiously committed clinical psychologists BPS-accredited UK	An added dimension – added value of dual role, not problematic Speaking out – dilemma of disclosure to client and colleagues Integration – challenging aspects of professional practice and clash of values, juxtapositions and defences	Research heterogeneous sample of clinical psychologists
Delaney, Miller & Bisono (2007)	Quantitative Questionnaire	53.00%	258 APA members USA	95% American believe in God 70% Psychologists believe, 48% report rel to be unimportant in their lives compared to 15% general population. Continuing widening gap between Psychologists and gen pop. This with a lack of training risk of undervaluing the relevance of rel and clinical practice. Majority view religion as beneficial (82%) rather than harmful (7%).	Need to emphasize religious issues in cultural competency training to differentiate between healthy and unhealthy R/S experiences.
Hathaway, Scott & Garver (2004)	Quantitative Correlation	Not noted	Study 1 25 qualified clinicians at exemplar clinic USA	56%/36% asked about R/S 48% enq re: impact of disorder on R/S functioning 48% consulted with religious prof re:client none had given R/S a V code 72% R/S functioning is sign and important domain of functioning 92% could distinguish unhealthy and healthy R/S functioning 56% treatment impacted on clients R/S functioning	R/S not entirely neglected but has not received adequate levels of clinical attention

		33%	Study 2 Randomised study of 333 clinicians APA members	>50% ask about R/S issues 50% of the time, 12% /18% never ask about R/S >50% rarely or never examine the impact a disorder may have on R/S functioning Most never or rarely set R/S goals 80% rarely consulted a religious professional. Correlation between assessment practices clinicians beliefs and other outcome factors relating to R/S issues	
Martinez & Baker (2000)	Qualitative Grounded Theory	Not noted	8 religiously committed psycho dynamic therapists BAC -accredited or UK NeCIP	Changes in personal faith occurs during training and therapy. Insight into others' religious beliefs, knowing or not knowing A lack of space given to religious issues in training, therapy and supervision	Many lines of investigation are required: How neglectful is current counselling training of religious issues? Should trainees endure neglect or insist on 'space' in the curriculum?
Nagai (2008)	Quantitative Questionnaire ANOVA & t test	71.00%	30 Asian ethnic minority mental health specialists USA	Clinicians perceive themselves as less spiritually competent than culturally competent. Awareness and counselling process/relationship scored higher than knowledge and skills scores in cultural and spiritual competency self assessment. Knowledge and skills can be gained more cognitively and can be objectively measured/compared with others	Categorise sub ethno- cultural groups to explore ethnic variables. Consider socio cultural variables such as age, gender, acculturation level of clinicians. Test effectiveness of integration model approach of culture and spirituality. Pursue qualitative study regarding how spirituality is understood and/or responded to in clinical settings.
Scott Young Wiggins- Frame & Cashwell (2007)	Quantitative Questionnaire ANOVA & Correlation	50.00%	505 ACA members USA	Overall strong support in spiritual competencies. 53% prepared to practice in support of	Competencies need to be submitted to rigours of empirical research

				competencies, 28% neutral and 16% disagreed/strongly disagreed. 21% feel unprepared	
Simmonds (2004)	Qualitative Narrative finding and coding of core ideas	Not noted	25 psychoanalysts and psychoanalytical psychotherapists UK & Australia Affiliated with professional registration	Concepts of God What is spiritual? Spiritual experience The relationship between psychoanalysis and spirituality Experiences as analysands and patients regarding spirit An important domain of human experience The therapists 'quality of mind' Three categories of questions regarding spirit Challenge and comfort dimensions what do patients with spiritual issues want?	No future research suggested

Appendix E : Summary of trainee studies

Study (Year)	Methodology/Design	Sample/country	Results/Themes	Future research
Patel & Shikongo (2006)	Qualitative “Framework “ approach	5 Muslim psychology students Masters level South Africa	Definition/understanding of spirituality The perceived role of spirituality in therapy Experiences in training Disclosure Recognition of need for training	Evidence for integrating spiritual aspects in the therapeutic encounter is mounting, the challenge for training lies in what constitutes appropriate education and guidance on how to deal with the multicultural diversity
Souza (2002)	Qualitative Focus group	4 counselling students Masters level USA	Level of comfort discussing spiritual issues Difficulty in defining spirituality Client and counsellor readiness to explore spirituality training issues in the area of spirituality	How counsellor educators can effectively integrate spirituality into education programs? Is multicultural curriculum the appropriate place? In what ways does spirituality have an impact on counsellor education? What are some of the ethical challenges of incorporating spirituality into education.
Walker, Gorsuch, Tan & Otis (2008)	Quantitative Multiple correlations Hierarchical regression	162 Christian student clinical psychologists APA-accredited program USA	Intervention-specific training is potentially the most efficient training to help therapists learn to use R/S interventions in therapy Coursework involving theology and integration of psychology and religion and personal therapy during training may be more relevant than after graduation. Personal religiousness failed to correlate with self reported frequency of using R/S interventions but did correlate with self reported competency using R/S interventions	Need for well defined definition of competency Professors at religious institutions might consider developing intervention specific training for trainees for secular institutions Continue studying the multiple factors related to therapists use of R/S intervention in psychotherapy using larger heterogeneous samples

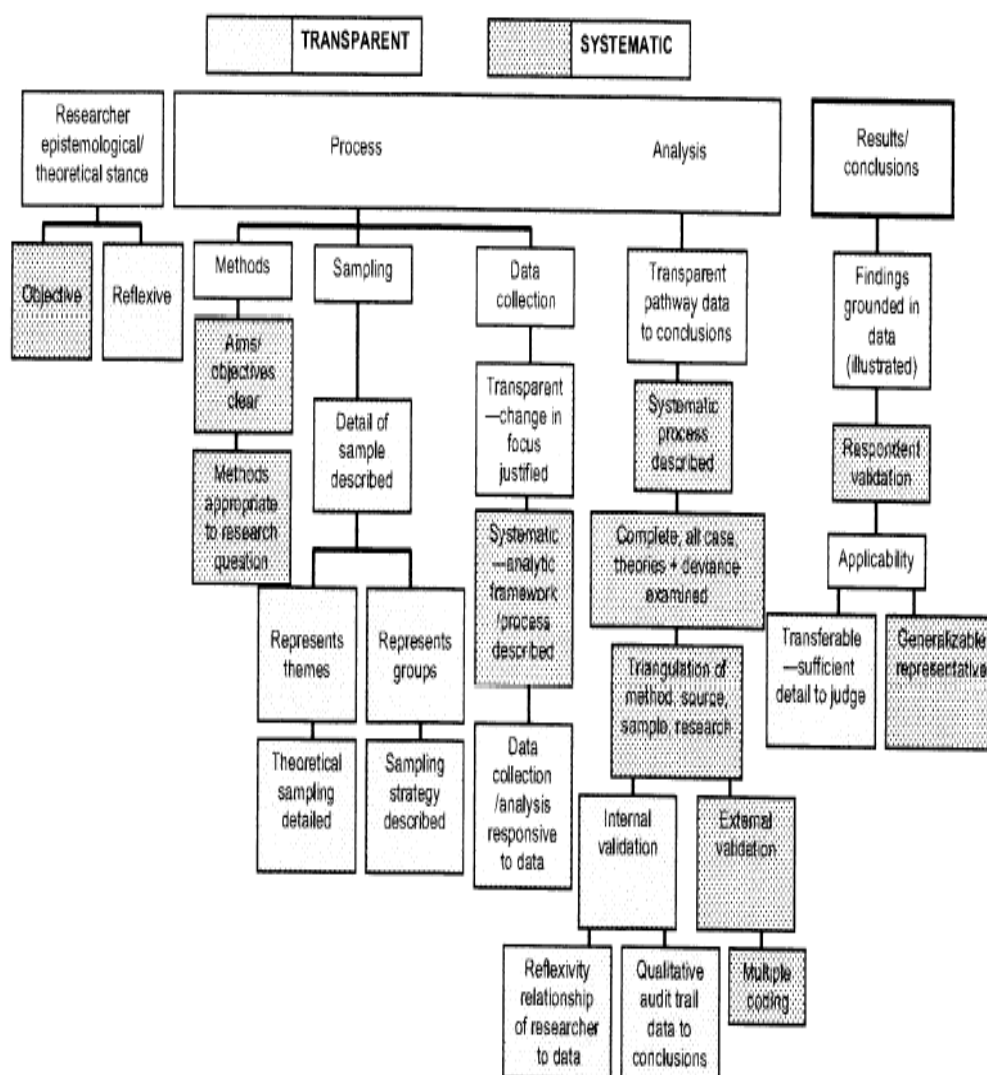
Appendix: F

Downs & Black (1998) Quality checklist scores applied to quantitative studies

Study	Power (Max 1)	Reporting (Max. 11)	External Validity (Max. 3)	Internal Validity Bias (Max.7)	Internal Validity Confounding (Max. 6)	Total score (Max. 28)
Course Directors						
Schulte et al. (2002)	0	5	3	4	3	15
Brawer et al. (2002)	0	5	3	4	0	12
Russell & Yarhouse (2006)	0	5	3	4	0	12
Schafer et al. (2009)	0	5	3	5	4	17
Qualified Clinicians						
Hathaway et al. (2004)	0	8	3	4	3	18
Delaney et al. (2007)	0	7	3	4	3	17
Nagai (2008)	0	8	2	4	2	16
Scott et al. (2007)	0	3	3	2	3	11
Students						
Walker et al. (2008)	0	8	3	4	3	18

APPENDIX G

Meyrick (2006) Quality framework for qualitative research



PART TWO: Research Report

**An exploration of trainee clinical psychologists' experiences of
engaging with psycho spiritual issues in clinical practice**

1. Introduction

1.1. Background

Within Psychology, diverging views regarding the meaning and importance of religious belief and spirituality in therapy exist. Divergence ranges from religious expression and experiences as being seen as neurotic or pathological through to religion and spirituality being a necessary component for healing (Knox, Catlin, Casper & Schlosser, 2005). Some studies have suggested that treatment effectiveness with religiously-oriented clients may be increased if a client's belief is respected and incorporated in treatment (Plante & Sharma, 2001). For some clients, religion and spirituality seen as central for healing and growth (Rose, Westefeld & Ansley, 2001) whilst many therapists remain uncertain about how to address such topics due to lack of religious and spiritual training (Shafranske & Maloney, 1990). A disparity between client and therapist viewpoints suggests the importance of religious and spirituality training for clinical psychologists.

In a move to provide equity within our multicultural society, there has been a recent emphasis on addressing cultural and ethnic diversity within mental health services, and in congruence with the core competencies required by clinical psychologists (BPS, 2006). This, along with the national agenda for the development of spiritual healthcare (Mental Health Foundation, 2006; Commission for Healthcare, 2007) highlights the importance of not only assessing for religious, spiritual and other life stance beliefs, but also acknowledging the mediating factors which may make a significant contribution to treatment outcomes, well being and recovery (McGee & Torosian, 2006). The consequences of excluding religious or spiritual needs within psychological assessment affect case formulation, intervention and evaluation of

psychological therapy and potentially exclude an individual's intrinsic and extrinsic resource, thereby affecting treatment and recovery.

1.2 Definitions of religion and spirituality

Attempts have been made to distinguish the two concepts, to recognise the changing face of religion and spirituality within our society (Hill & Pargament, 2003). Koenig, McCollough and Larson (2001) viewed religion as an institutional, formal, outward, doctrinal, authoritarian, inhibiting expression. More recently, religion has been described as an institutional and social phenomenon defined by boundaries, with specific beliefs, practices, membership and social organisation characterised by other non-spiritual concerns such as cultural, economic, political and social aspects (Miller & Thoresen, 2003).

As mentioned above (p.16) the definition of spirituality comes from the Latin 'spiritus' meaning breath, courage, vigour or life (Ingersoll, 1994). Knox et al. (2005) expanded this definition, as spirituality being a phenomenon unique to the individual and defined as the "breath" that animates life or a sense of connection to one's self or others and that which is beyond self and others (p.287). Cawley (1997) suggested that spirituality has become polarised, at one end having religious connotations and at the other having non-religious connotations. Worthington and Aten (2009) recently contributed to the debate by suggesting four types of spirituality, defined by the objects that people treat as the sacred. Worthington and Aten's (2009) attempt to standardise definitions may be seen as a move towards addressing the individual interpretation and subjective nature of the concepts involved.

Other criticisms surrounding the definitions have been posited. The lack of clarity related to the definition of the two constructs adds to the confusion both within

the literature and in clinical practice. It may be difficult for professionals to 'own' spiritual care of patients. Indeed, should professionals 'own' spiritual care? In areas where professional identity and boundaries are constantly being evaluated it may be difficult for professionals to take on this responsibility. In addition, an individual without recognised faith may feel excluded from sharing their spiritual sense of self as definitions tend to identify people in terms of their affiliated faith. This has potential implications for both clinical work and research.

1.3 Religious belief, spirituality and mental health

It has been argued that the assumptions of science, empiricism and positivism have exerted a powerful influence upon Western culture and health practices (Swinton, 2001). With regard to religion and spirituality, the clinical picture may be more complicated. In some religions and culture there remains belief in demonic beings as being responsible for mental health problems. For others, religion and spirituality can be an important factor in making sense and coping with illness and other life events, however, problems may arise when symptoms, such as delusions with religious elements, develop (Koenig, 1998; McCollough, Hoyt, Larson, Koenig & Thoresen, 2000). Furthermore, mental health professionals frequently ignore or pathologise religious or spiritual issues (Lukoff, Turner & Lu, 1992; Nagai, 2008; Swinton, 2001). With this knowledge, clients can feel an understandable discomfort in raising their spiritual or religious concerns. Indeed, ethnic minority groups may experience such barriers and withhold such discussion for fear of being detained under the Mental Health Act (1983), or for being seen as displaying psychotic symptoms and subsequently being prescribed anti-psychotic medication (Copsey, 1997).

As mentioned above (p.36) religious commitment may be characterised in terms

of the intrinsic and extrinsic religious orientation dimension. This dimension is considered to be an important framework for empirical research within the psychology of religion (Kirkpatrick & Hood, 1990). Intrinsically-religious people are observed as individuals whose religious orientation is fundamental to their self concept (Allport & Ross, 1967). In contrast, those defined as extrinsically-oriented are people whose religious role is somewhat detachable from their essential sense of self and who use religion for their own ends, often providing security and social support for themselves (Allport & Ross, 1967). The dimensions lead to two distinct sets of psychological effects; intrinsically religious individuals tend to have better mental health than the extrinsically religious (Mickley, Carson & Soechen, 1995) although discrete orientations has been widely debated (Batson, Schoenrade & Ventis, 1993).

Newer psychological models such as Mindfulness and Compassion-focused therapy have been derived from Eastern philosophical-religious tradition, yet require no religious orientation and may illustrate the importance of the spiritual dimension for all humanity (Baer, 2006). In order to experience the spiritual dimension of life, it is not necessary to hold formal religious beliefs or to engage in religious practices but to have a sense of belonging, meaningfulness and purpose in life. Whilst the interface between research and clinical care is embracing of these evolving paradigms, the national agenda aims to provide equality for all individuals irrespective of belief system. Consequently, healthcare professionals have a duty to include spirituality and religiosity within their clinical assessments in such a way that individuals can freely express their views without fear of misinterpretation leading to detrimental consequences.

1.4 Religion and spirituality: neglected foci?

Many practitioners feel ill-equipped to deal with religious or spiritual beliefs

(Frame, 2001). Within psychology, academic staff are likely to have been trained during the 1960's and 1970's, when therapists were strongly encouraged to be neutral and detached from their clients and when religion was a taboo subject (Powers, 2005). This may have left therapists feeling inept and fearful of an inability to offer information or guidance on religious or spiritual issues. Therapists may feel they lack expertise in the field of religion and spirituality and worry that their own values or beliefs may be subject to counter transference (Aten & Hernandez, 2004). There may be concern about religion and spirituality being too personally sensitive or worry about the risk of proselytising. Such concern may be due to lack of training or scepticism of religion and spirituality as being unscientific or pathological (Keller & Prest, 1993). Bartoli (2007) postulates that if clinical training does not invite trainees to become aware of their own spiritual history and bias, then as graduates they will remain unaware of resources which focus upon this knowledge and skill acquisition. Clinically, this may negate direct clinical work but also broader aspects of the clinical psychologist's consultative role within service delivery systems, multidisciplinary working, communication and teaching (BPS, 2006).

Few professional training programmes in psychology address religious and spiritual issues (Shafranske & Malony, 1990). Religiosity and spirituality have been seen as neglected foci of psychological and psychiatric care (Mohr, 2006). The reasons for the neglect are multifaceted. Historically, religion and spirituality have been seen as synonymous and interdependent, however, contemporary research has begun to delineate the two (Hill & Pargament, 2003). This has been seen in the bifurcation of definition and the separation of religiosity and spirituality measurement tools (Exline, Yali & Lobel, 1999). Separation of the two constructs may be an attempt to provide

equality, irrespective of the presence or absence of faith: however, Hill and Pargament, (2003), postulate such polarisation may lead to the duplication of concepts and measures, which in turn may confuse practitioners.

Golsworthy and Coyle (2001) note an absence of therapeutic or conceptual frameworks to guide therapists about religious and spiritual issues. However, conceptual frameworks are emerging in the literature (Beveridge & Monik, 2004; Hill & Pargament, 2003). Hill & Pargament (2003), in their paper on advances in the conceptualisation and measurement of religion and spirituality, identified four psycho-spiritual constructs; closeness to God, orienting and motivating forces, religious and spiritual support and religious and spiritual struggle. These psycho-spiritual constructs offer an integration of evidenced-based theory within clinical practice and may provide a religious or spiritual framework for practitioners feeling uncertain and unclear.

Much of the empirical research has been available through specialist psychology and religion-based journals, yet little is available in specialist psychology journals, psychology textbooks or clinical training (Hill & Pargament, 2003), arguably limiting clinical psychologists' access to empirical evidence.

2. Aim of the Research

The purpose of the present research is two-fold; to explore the current provision of religion and spirituality training included within Doctorate in Clinical Psychology programmes within the United Kingdom and to explore the level of engagement with religion and spirituality of trainee clinical psychologists, to gain perspectives regarding the importance of religion and spirituality within training and clinical practice.

A preliminary survey was conducted. This consisted of a questionnaire survey of UK Doctorate in Clinical Psychology course directors to determine the provision of religion and spiritual teaching currently provided within course programmes. A qualitative study aimed to provide information about trainee clinical psychologists' level of engagement with religion and spirituality and the importance placed on these issues within training and clinical practice. Each will be presented separately and a general discussion section will follow, synthesising and evaluating the findings of both studies and exploring the implications upon clinical practice.

3. Preliminary survey: A Survey of UK Clinical Psychology courses

3.1. Introduction

Very little is known about religious and spiritual training offered to UK trainee Clinical Psychologists and published studies are limited, many having been conducted in America, representing a more diverse population when compared with the United Kingdom. Consequently, it felt timely to explore as this would provide contextual information for the main qualitative study and would provide evidence of UK Clinical Psychology religious and spirituality training and current academic opinion.

3.2. Background to the survey

A short, single point measure questionnaire survey (Appendix A) was developed by the researcher to gauge current provision of teaching related to religious or spiritual issues within clinical training and sent to all UK clinical psychology training courses.. The questionnaire was deliberately brief to encourage completion and questions included: Are religious issues included within teaching? If yes, how much time is spent in year 1, 2 and 3? How do you think trainees acquire their knowledge, skill and awareness in spiritual issues within clinical practice: didactic teaching; clinical supervision; reflective practice; personal interest or other?

Nine out of thirty UK Doctorate in Clinical Psychology courses initially responded to the survey. A second request, ten months later, yielded an additional three responses producing an overall total of twelve courses contributing to the study.

The questionnaire was sent via email to UK Doctorate in Clinical Psychology Courses identified by a course contact list provided by the Post Graduate Clearing House. The initial point of contact for the various courses was the course administrator, who circulated the questionnaire to academic staff. The survey was

completed by course staff. Once completed the surveys were returned to the researcher, via email, for analysis.

3.3. Findings from preliminary survey

Descriptive statistics were utilised for the analysis which allowed for some comparison with published literature. Initially, a response rate of 30% was obtained. The survey was recirculated ten months later subsequently providing an overall response rate of 40%. Allocation of teaching days dedicated to religion and spirituality varied between centres from no teaching time to two-and-half days. Twenty-five percent of courses acknowledging that no teaching time was allocated. One centre stated that areas of clinical practice, such as, Adult Mental Health, Learning Disability and Older Adult were providing teaching but gave no further detail or explanation of content. Some centres specifically stated that they did not teach religion yet reported teaching spiritual or existential issues. However, one centre noted that they did not distinguish between religion and spirituality. The Diversity module was the most frequent module identified, with five centres (44.6%) stating this as being the module in which religious and spiritual teaching was included. When asked about other modalities of learning, 50% of respondents indicated religion and spiritual issues were included within reflective practice, 44.6% were included in clinical supervision and 33% within personal reading/study. Four centres failed to complete this section of the questionnaire. Table 3 provides an overview regarding the amount of time spent teaching about religion and spiritual issues over the three-year teaching programme.

Table 3 : Courses response to religion and spirituality teaching questionnaire.

Course Centre ²	Year 1	Year 2	Year 3	Total (approx)
1	3 hrs			3hrs
2	2 days (diversity)	½ day diversity		2 ½ days
3				0
4	Adult mental health, LD	Older Adults/Child	Health teaching	?
5	4 hrs overall. (No religious teaching, spirituality and existential issues)			4hrs
6				0
7	No religious teaching. 12hr diversity including spirituality	3hrs		15hrs
8	No religious teaching Spirituality-yes		2 day workshop mindfulness across therapeutic interventions	2days plus additional
9		Religion 4hrs Spirituality 9hrs		Religion 4hrs Spirituality 9hrs
10	No	No	No	0
11	Overall, one day across three years. Explicit session in year 3 religion and spirituality. Invite clinical psychologists with strong allegiance to their faith to discuss issues which may arise in clinical work			1 day
12	5hrs. Do not distinguish between religion and spirituality	4hrs	Difficult to answer, embedded into a lot of teaching	9hrs plus additional
Total (approx)	39hrs	24hrs	15hrs plus additional	85.5 hrs

3.4. Conclusion

There was a wide variety of responses to the short questionnaire. Some centres made no distinction between religion and spirituality, others stipulated that whilst they did not offer religious-based teaching they did offer teaching on spirituality or

² ID numbers were used to preserve centres anonymity

existential issues, indicating a possible acknowledgement of the distinction or delineation of the two related constructs identified by Hill & Pargament (2003).

As within American literature, the diversity module was the most frequently identified module (44.6%) for teaching of religious and spiritual issues (Brawer, Handal, Fabricatore, Roberts & Wadja-Johnston, 2002; Schafer, Handal, Brawer & Ubinger, 2009). Other modules or themes included: older adults; learning disability; psychological models such as systemic, acceptance and commitment therapy and mindfulness; client/society in context; personal and professional issues; constructions of life and death; psychosis; loss and sexuality. These results support published studies which identified very few courses offer specific religious and spirituality modules with content being devoted to much broader issues, such as diversity (Schulte, Skinner & Claibon, 2002; Schafer et al., 2009).

More time was spent teaching religious and spiritual issues in the first year of postgraduate training, with a pattern of decreased teaching time as training progressed, from an overall total of 39 hours of teaching in Year 1, 24 hours in Year 2 and 15 hours in Year 3. There were no comparable figures within the literature. Therefore, third-year trainees, who will be working as qualified clinical psychologists within a year and who will be supervising trainees in the near future appear to receive less training than first-year trainees, possibly suggesting that the current low-level provision of teaching will continue, with religion and spirituality continuing to be neglected; religious and spiritual issues may be misunderstood and individual spiritual and religious resources may be underutilised.

It was noted that sixty percent of UK centres did not reply to the questionnaire, despite two circulations within a ten month interval. Published literature exploring

American doctorate level courses, reported similar response rates, ranging between 32% and 51% (Brawer et al., 2002; Russell & Yarhouse, 2006; Schafer et al., 2009). It was difficult to determine whether the responses represented individual staff views or collective course staff opinion. Furthermore, it would be unethical to make assumptions about the centres who did not reply and it may be noted that the results are based on self-reports from individuals of a self-selected sample. Respondents with an interest in religion and spiritual issues, either personally or within their clinical practice, may have been more willing to provide information than those without a personal faith or professional interest, consequently leaving non-responding centres' views unknown.

Overall, these results highlight a lack of consistency across UK Doctorate in Clinical Psychology course programmes. The reasons for the lack of consistency may be multifaceted. Many academic staff may not have received training in religious and spiritual issues (Shafranske & Maloney, 1990), others may never foresee religion and spirituality being offered, some may not be interested or do not have access to training materials or published material (Russell & Yarhouse, 2006). One may postulate that academic staff may not have considered including religion and spirituality, that there isn't space within the curriculum, or that they lack knowledge or confidence in delivering such training. Alternatively, neglect may be due to the absence of professional standards or guidance, which may leave centres having to make unilateral decisions upon what to include within training. Other reasons for the lack of consistency may be due to religion and spirituality being unscientific, too personally sensitive or worry about the risk of proselyting, especially for atheists, humanists and secularists.

However, the results do need to be treated with some caution. It became apparent during the analysis that the questionnaire design was weak. Simple changes such as

stipulating the unit of time to be recorded, identifying the status of the person completing the questionnaire and their overall knowledge of the curriculum would have provided useful demographic information. In hindsight, more thought and consideration of the desired data collection and rigorous statistical analysis would have strengthened the results. However, given the limited sample size, the results do provide some contextual information for the main research study and current teaching provision. A larger study obtaining the views of non-responding centres would be of great interest.

4. Qualitative study: Trainee clinical psychologists' engagement with religious and spiritual issues

The aim of the qualitative study was to explore trainee clinical psychologists' level of engagement with religion and spirituality and the importance placed on these issues within training and clinical practice. This section will begin by discussing the researcher's background and epistemological position prior to discussing the rationale for using a qualitative, Interpretative Phenomenological Analysis methodology, concluding with details of the current study.

4.1. The Researcher

The researcher is a 45-year old white female, trainee clinical psychologist in her final year of training. The researcher acknowledges that she has been influenced by her Christian faith, the faith of her family and that religion and spirituality have been important in both career choice and clinical work. Her interest in the role religion and spirituality has upon healthcare begun prior to commencing clinical psychology training. The researcher had worked in the position of Hospital Macmillan Nurse within a Specialist Palliative Care service based in an Acute Hospital NHS Foundation Trust. She had anticipated similar themes relating to religion and spirituality to cross-over from her work in physical health into mental health care. However, during training, she noticed a high interest in diversity issues, particularly ethnic and cultural issues but little attention in the diversity of religious and spirituality issues. The researcher anticipated that her experience during training will be similar to other trainees in that little attention is given towards religion and spirituality, however, she was interested in exploring trainees' views on this area.

4.1.2. Researcher's Epistemological Stance

The epistemological stance adopted by the researcher was most closely aligned to a contextual constructionist approach (Madill, Jordan & Shirley, 2000). She believes that results will vary according to the context in which data is analysed and that all knowledge is 'local, provisional and situation-dependent' indicating that no one reality may be revealed. From a phenomenological perspective, contextual constructionists formally acknowledge the interaction between the researcher and the participant, recognising the historical, contextual and power imbalances within the relationship whilst encouraging transparency and reflexivity (Pope & Mays, 2000), thereby suggesting that differing perspectives generate different insights into the same phenomenon (Willig, 2001).

4.2. Rationale for Qualitative Research Method

Historically, research methods were, in essence, hypothetico-deductive, laboratory based and observational in nature, with emphasis placed on objectivity, measurement, replicability and generalisability and predictions made and tested. Researcher bias was seen to undermine the validity and reliability of results and so safeguards, such as, standardised instructions across experimental conditions were put into place to guard against such bias.

Later, the progress of philosophy (Husserl, 1931) challenged reductionist thinking about human sciences. Qualitative methodologies questioned the assumptions of the hypothetico-deductive approach, which led to the emergence of alternative paradigms such as post positivism, critical theory and constructivism. The various qualitative research paradigms share a set of preferences for: words and images, naturally occurring data, meanings and for inductive, hypothesis-generating research

rather than hypothesis-testing (Hammersley, 1992). However, many have labelled qualitative methodology as unscientific, subjective and therefore biased (Pope & Mays, 2000). Such criticisms are often defined by reference to quantitative research in an attempt to evaluate qualitative studies with the same criteria as quantitative studies. Recent advocates are now reporting qualitative-specific evaluation criteria such as reflexivity, transparency, iteration and phenomenology (Pope & Mays, 2000; Meyrick, 2006).

The present study, based on the phenomena of religion and spirituality, explored the idiosyncrasies within clinical practice rather than employing statistics or arbitrarily defined variables. The desire was to know more about the individual's subjective experience and their accounts relating to this aspect of human experience within their social world (Smith, Flowers & Larkin, 2009). It felt important to obtain both a factual record and a phenomenological perspective from trainees in order to explore the “insider's knowledge” (Pidgeon & Henwood, 1997). The ontological positioning was such that the nature of reality was dependent on the participant holding fluid and changeable constructions and the researcher acknowledging a reflexive rather than a neutral and objective stance. The decision to opt for qualitative methodology was seen as primarily gaining greater insight into religion and spirituality from the trainee clinical psychologist's perspective.

4.3. Rationale for Interpretative Phenomenological Analysis (IPA)

Interpretative Phenomenological Analysis employs both phenomenological and hermeneutic principles. Husserl, (1859-1938), founder of phenomenology, was critical of both experimental and behaviourist psychology. Husserl argued that fundamental concepts were lacking in both clarity and relevance in that they were not grounded in

experience. Husserl's core philosophies involved commencing the investigation of phenomena with the examination of the idiosyncrasies of what is experienced (Ashworth, 2008).

Hermeneutics distinguishes two types of interpretation: the hermeneutics of meaning-recollection and the hermeneutics of suspicion (Ricoeur, 1970). More specifically, in keeping with the epistemology of IPA, a double hermeneutic is employed, such that the researcher makes sense of the participant making sense. IPA integrates an empathic hermeneutic with a questioning hermeneutic approach (Smith et al., 2009) by trying to understand the phenomenon from the participant's perspective.

IPA's theoretical underpinning draws from the social cognition paradigm, focusing upon beliefs, attitudes and feelings. Phenomenologically, it focuses upon the world as it is subjectively experienced by individuals within a context and as it is interpretative, it leaves room for increasing creativity and freedom for the researcher (Smith et al., 2009). IPA shares many features with Grounded Theory (GT) in that it produces a cognitive map that represents a person or group view of the world (Willig, 2001). IPA differs from GT in that GT was founded to study basic social worlds whereas IPA is a specific psychological research method and provides insights into psychological worlds thus providing better understanding of the quality and texture of individual perspectives (Willig 2001). IPA does not aim to build inductive theory from data in contrast with GT (Charmaz, 1995) and with IPA; interpretation may be informed by direct engagement with existing theoretical constructs (Larkin, Watts & Clifton, 2006).

IPA researchers differ from Discourse Analysts in their perceptions of the status of social cognition. Discourse Analysis (DA) is concerned with the interactive tasks being performed by verbal accounts whereas IPA is more concerned with understanding

what the participant thinks or believes about the subject of discussion (Smith, Jarman & Osborn, 1999). However, IPA does have limitations: IPA is reliant on representational validity of language, in that it constructs rather than describes reality (Willig, 2001); and IPA relies on a person's ability to articulate their experience.

4.4. Recruitment.

Following National Health Service (NHS) Research and Ethical Committee (NREC) approval (Appendix B) and Research and Development (R & D) approval. Course Directors from three course centres were contacted to request permission to contact trainees.

4.5. Sample.

Third year trainee clinical psychologists were recruited from three Doctorate of Clinical Psychology programs and all were employed by the National Health Service within the United Kingdom. Third- year trainees were selected as they had a minimum of two years clinical training, were considered to have a greater breadth of clinical experience than first or second year trainees and were preparing for qualified practice. Eight participants were recruited and all were female, despite the study being open to both genders. Participant ages ranged from twenty-six to thirty-nine years-old. Seven trainees opted for a telephone interview and one for a face-to-face interview. Participants consisted of a homogeneous sample, in respect to having an interest in discussing religious and spiritual matters, yet diverse with respect to individual religious affiliations (six (75% from four traditional religious Christian/Hindu/Islamic/Buddhist, and two (25%) non-religious) – and possibly unusual in that the broader population of UK clinical psychology workforce would be likely to have a much larger proportion identifying as non-religious (Smiley, 2001 reports 61.8% in a sample of N=246).

Religious affiliation was obtained during the interview but precise detail was omitted in the write-up to preserve participants' anonymity. Table 4 illustrates the personal characteristics of the participants. To protect participants' confidentiality, no names, religious affiliation or academic affiliation were used throughout transcribing, analysis and write up of the study.

Table 4: Participant characteristics³

Trainee ID	Gender	Age	Religion stated
A	Female	38 years	Yes
B	Female	20's	Yes
C	Female	26 years	Yes
D	Female	32 years	No
E	Female	27 years	Yes
F	Female	26 years	Yes
G	Female	39 years	No
H	Female	30 years	Yes

4.6. Interview schedule.

A semi-structured interview schedule (Appendix C) was designed to elicit a breadth of information about religion and spirituality within clinical practice, with an aim to go beyond the surface and explore in detail, uncovering areas which were not anticipated at the start (Pope & Mays, 2000). The main area of the interview schedule was exploring the trainee's experiences of working with religious or spiritual issues

³ Trainees ID's do not correlate with transcript ID's in order to preserve anonymity

within clinical practice. The schedule served as a guide for exploration providing considerable scope for the participants to influence the direction of the interview. Two pilot interviews were conducted: one face-to-face and one telephone interview; which allowed for the refinement of the interview questions and familiarisation with recording equipment. Pilot interviews were not included in the final sample.

4.7. Procedure

Individual course centre representatives initially contacted trainees on behalf of the researcher. This was to protect the trainees' confidentiality and to enable trainees who did not wish to participate to feel less pressurised. A letter of invitation to the study (Appendix D) and participation information leaflet (Appendix E) were sent via email and trainees were asked to contact the researcher directly if they required further information or wished to participate. The participants were then offered the choice of telephone or face-to-face interview. Written consent (Appendix F) was obtained prior to the interview and the participant's right to withdraw from the study was explained. All interviews were audio-recorded using a digital recorder (and telephone adapter) and lasted between 30 – 90 minutes. The researcher, which allowed for familiarisation of data, transcribed the interviews (Addendum). All identifying references were removed.

4. 8. Data Analysis

Utilising IPA (Smith et al., 2009) the first transcript was read several times and the left-hand margin was used to annotate interesting and significant comments. The transcript was then re-read and in the right-hand column emerging themes and sub themes were identified (Appendix G). Reference to the original material was recorded under each theme in order to validate existence within the text. This idiographic

approach to analysis is recommended by Smith et al. (2009). Once this process was completed with the first interview all of the subsequent interviews were analysed in the same way. The ability to recognise repeating patterns whilst acknowledging new issues allowed for convergences and divergences in the data (Willig, 2001). The next step involved themes being clustered together to produce a number of super-ordinate concepts. From here a coherent list of themes was produced which captured the trainee's issues and concerns related to their clinical practice. This final process required the selection of themes not purely based on prevalence, but on how the themes illustrated other aspects of the account (Smith et al., 2009). Within the super-ordinate list, the transcript identifying code, page number and line number were used to organise and facilitate the checking of the original material to allow for a systematic approach to the analysis. Themes were dropped if they did not fit well into the emerging superordinate themes (Fade, 2004).

4.9. Methodological rigour and quality criteria

Traditional criteria seen in quantitative research, such as reliability, validity and objectivity cannot be standardised in qualitative research and are seen as inappropriate (Flick, 2004). Yet modifications of such concepts are necessary. Applying methodological rigour and quality is continuous, commencing with good research questions sensitive to the phenomenon along with clear decisions regarding the methodology and transparency during all steps of the qualitative research process (Meyrick, 2006).

Historically, researchers of phenomenological issues have suspended their preconceptions related to the area of study; however with IPA, the aim is to study the participant's perspective with the researcher's conscious biases being transparent as they

contributed to the process of making sense of the experience of others (Fade, 2004). Therefore the formal reflexive technique of *bracketing* was not implemented in the present study (Rolls & Relf, 2006). Reflexivity has been described by authors as: epistemological and personal (Willig, 2001) or personal, functional and disciplinary (Wilkinson 1988). Each of these presents a number of differing perspectives which influenced the research from conception to completion. In the present study, engaging with the different types of reflexivity enabled the researcher to have greater insight into the conscious biases held and allowed the researcher and reader to evaluate the assumptions and practices behind the research, analysis and interpretation (Chamberlain, 2004).

Good quality research is not just a methodology problem but a “moral problem” and a “question of ownership” (Brydon-Miller & Tolman, 1997), in that it includes doing justice to the participants and sharing results with them. However, this technique seemed epistemologically flawed, as the original source was the participant's account of the phenomenon and it was this primary account which required analysis, not the participant's interpretations of the analysis.

4.10 Analysis

The objective of the interview was to explore the participant's experience in engaging with psycho spiritual constructs in clinical practice. All interviews were included as all made a valuable contribution to the analysis. In keeping with other IPA studies (Fade, 2004; Golsworthy & Coyle, 1999), the format for this section is a narrative account of the process of interpretative analysis.

4.10.1 Structure of Analysis.

The methodology section provides an overview of data analysis in IPA.

However, specific examples illustrating the various stages of the analytic processes, within the present study, are seen in Appendix G. The following conventions were used in relation to excerpts. All transcript excerpts are illustrated in italic font. Participants are identified by an identification number and excerpts are allocated a line number that corresponds with the start of the excerpt. Empty brackets () denote irrelevant text omitted for clarity and a series of dots indicate a pause in conversation. If the pause is in excess of 2 seconds then the length of pause is documented, in brackets, for example,(3 secs) indicates a pause of three seconds. Non-verbal information is also recorded within brackets, to conceptualise the excerpt or facilitate clarity, for example, (laugh). Identifying agencies were anonymised.

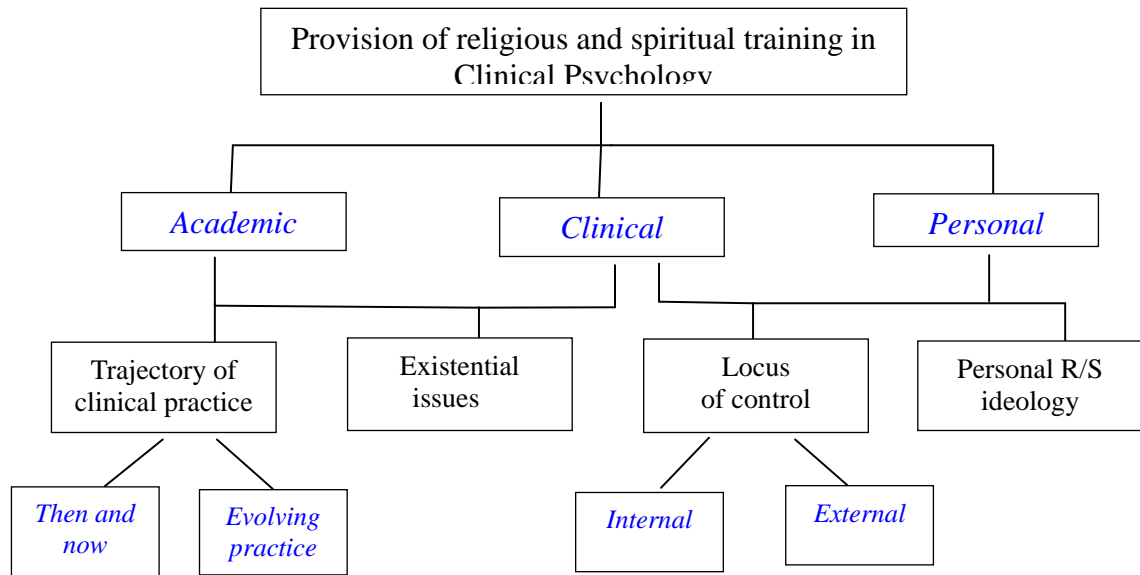
A total of five super-ordinate themes and seven clusters or sub-themes were generated which reflected participants' experiences. The super-ordinate themes capture the essence of the interviews and draw together psychological, abstract and interpretative super-ordinate themes from the individuals' data. The five super-ordinate themes are: 'provision of religion and spirituality training in clinical psychology', 'trajectory of clinical practice', 'existential issues', 'locus of control' and 'personal religious and spiritual ideology'.

4.11. Overview of themes

Through an iterative process of repeatedly reading the transcripts, themes were generated. Two levels of analysis were employed: some themes were descriptive and phenomenological and others sought to extend the analysis to a higher order of abstraction and interpretation, extending beyond participants' conscious awareness. Figure 1 illustrates the process model of the super-ordinate themes. The model is visualised with an over-arching theme of 'provision of religious and spirituality training

in clinical psychology' with four other super-ordinate themes in supportive positions providing foundation for the overarching theme. The themes collectively capture the personal and professional investment along with aspects which prevented the integration of religious and spirituality into clinical psychology.

Figure 1: Process model of super-ordinate themes⁴



4.12. Super-ordinate theme 1: 'Provision of religion and spirituality training'.

It became apparent that the three interdependent sub-themes: academic; clinical and personal captured different elements of the overarching theme. Each will be discussed separately.

4.12.1. Provision of religion and spirituality training sub-theme:

Academic.

Participants felt that the current level of religious and spirituality training on the Doctorate of Clinical Psychology was inadequate. Very little specific formal teaching was provided. Teaching offered was often described as being 'tagged on' to other

⁴ *Italics indicate sub-theme*

sessions such as diversity, sexuality and ethnicity. None of the participants had any knowledge of spiritual tools, theories or models (Allport & Ross, 1967; Frame, 2001; Pulchalski & Romer, 2000). The absence of teaching created many areas of concern. Participants were unsure of the stance of Psychology, as a profession, in relation to religion and spirituality. They were unsure of their own position and comfort in disclosing their own belief or lack of belief. If religion and spirituality was to be included in assessment, they had little knowledge of tools or frameworks to guide them clinically. Consequently, participants had many confusing messages about whether religion and spirituality should be included in psychological assessments. Furthermore, euphemisms were frequently used by participants and included: 'below the radar'; 'sweep it under the carpet'; 'gets dropped in' implying a covert message that religion and spirituality is something to be hidden or concealed. Yet despite this apparent neglect in training, there was a strong view from participants that religion and spirituality ought to be embedded into training, to be seen as a core element or a thread weaving itself through the three years, rather than in its current rather tokenistic way.

It has to be, very much about part of the whole way we assess, the way we are thinking, a thread that runs throughout clinical training and the way we are assessed. That's what I think, rather than a tokenism approach.

ID01: l. 373-377

As one interview progressed the participant began to see the benefit of enquiring about clients religious and spiritual beliefs and to give clients permission to choose whether to discuss religion and spirituality or not.

without doing the whole prying thing () but you can sort of give the impression that you are open to talking about (religion and spirituality), in that if the client wants to do that at a later date, you know and open that door almost..

ID 05: l. 330-332

4.12.2 Provision of religion and spirituality training sub-theme: Clinical.

The tension between the science and clinical work is present in many aspects of psychology, including the field of religion and spirituality. Many participants were very aware of the limitations which this brought to clinical work.

I think that clinicians who are really scientific have a problem with religion because its like, well where is God,()I can't see it and I can't feel it, therefore it doesn't exist and I think that () as scientists and practitioners () we have to do our science and our research, but as a human being, (), you have got to be more open-minded, you can't be too rigid.

ID 03: l. 475-480

In the next excerpt, the participant acknowledges the theoretical limitations.

if somebody has or feels like they are sinning or what they are doing is wrong in a religious sense then that's something that cannot be challenged. You can't evidence against that, you can't use a CBT approach because faith is unchallengeable in that sense

ID 07: l. 570-573

As newer psychological theories and models embrace and merge Eastern and Western religious philosophies, opportunities to bridge the gulf between science and clinical work have been missed, according to one participant.

() if sharing the information that these therapies are based on the religion of Buddhism, then it may put people off () they are depriving the individual of some opportunity to explore the Buddhist culture. I was working within a DBT service and they briefly mentioned that it was based on Buddhism, but it was quickly countered by "but we don't link it with religion".

ID 02: l. 182-190

For others, newer models, such as Mindfulness create personal religious dilemmas.

I guess that I have been quite careful in that, I suppose that Mindfulness would be one of the ones which is more kind of influenced by () Eastern sort of religions and I would avoid that because of my own beliefs

ID 05: l.469-471

It may be argued that most practitioners are unlikely to be aware of the above tension and may inadvertently commence a treatment which is incongruent with a client's religious belief. The consequences of this may affect clinical outcome, client engagement and commitment to therapy. Trainees may either choose to draw on their

more familiar personal knowledge of religion and spirituality or protect themselves from the unknown through defensive behaviour, such as avoidance or moving onto more familiar ground.

when we deal with things that we know more about, then we feel more comfortable a bit off pat, I think but it becomes a bit more scary, its about causing offence too, (), so we don't ask about it for fear of causing offence.

ID 01: l. 551-554

4.12.3 Provision of religious and spirituality training sub-theme: Personal.

Irrespective of their own identified religion or absence of religion, the process of the interview often led participants to reflect upon their own spiritual and religious development. Some of the participants had changed or lost the religious belief they once had in childhood. One participant was actively looking for a God, but had not yet found Him. She felt that her lack of belief may compromise her ability to work at relational depth with religious patients.

or is it me, who's not bringing it, you don't know though do you? When you said "do you think about it? " that's when I think about well is it a weakness, is it me who doesn't bring it to them?

ID 07: l. 420-422

4.12.4 Provision of religious and spirituality training summary.

When considering the provision of religious and spirituality training, there were many collective factors influencing this overarching theme. Academic, clinical and personal factors all had a contribution to make but with different emphases depending upon the individual participant. The individual differences created an inconsistency in overall self-rated knowledge and confidence.

4.12.5 Super-ordinate theme:2 – 'Trajectory of clinical practice'

The number of years committed to clinical psychology varied among the participants from eight to twelve years with some of the participants having alternative

careers prior to commencing clinical psychology training. 'Trajectory of clinical practice' implies a linear process in which trainees perform the requisite range of skills, or expertise, for qualified practice. During the interviews it became apparent that participants were at different points of the trajectory, in relation to their attitudes towards religion and spirituality.

Various models recognise the development of expertise, from novice to expert as identified by Dreyfus and Dreyfus (1986), which has been influential within the nursing profession. The model was further developed by Atherton (2003). In a similar way to Maslow's (1954) hierarchy of needs, the model is visualised as a pyramid, which presupposes the levels below as foundation. The ascending levels include: competence, contextualisation, contingency and creativity. As expertise is developing, greater focus is given to the higher more abstract levels. In recognition of the development of expertise, two sub-themes were identified: 'then and now' and 'evolving practice'. These factors are not thought to be exclusive, as other factors, such as, personal religious and spiritual ideology will be explored later in the analysis.

4.12.6 Trajectory of clinical practice super-ordinate sub-theme: Then and now.

Previous experience appeared to have some influence in the participant's ability to access information in relation to religion and spirituality. This was particularly noticeable during the early stage of the interview when asked about their general views about religion and spirituality within mental health services. One participant had experience in an Assistant Psychologist post where religion and spirituality were integral to the Trust's philosophy of care.

the Unit had a 'Wheel of Values' which () anyone involved with the Trust was encouraged to offer all patients... to be aware of individual faith, the way faith was important to the people.

ID 01: l. 86-90.

However, for others, ambivalence was present. They were unclear about the purpose of religion and spirituality in mental health services and had some difficulty in identifying where religion and spirituality fitted in to clinical practice.

Well to be honest, I don't think that it (religion and spirituality) comes up at all in Mental Health services, especially with my experience within the NHS.

ID 02: l. 10-11.

A similar polarised pattern in thinking was seen within present practice. Some participants appeared to be curious and inquiring with regard to religion and spirituality,

(Religion) is so fundamental to people's presentations () talking about it (The Bible) in lots of detail or speaking about repenting their sins and they seem really anxious and distressed about that and ..its about interpreting that and you need to have some understanding.

ID 03: l. 100-106

whilst others were more dismissive, appearing to link religion and spirituality with issues related to general diversity, rather than as a specific focus. Contradictory messages were being relayed to participants from the psychology profession, course staff, NHS Trusts and clinical supervisors. There appeared to be some confusion about whether the participant should or should not explore religion and spirituality. For participants who are entering the profession, this can seem like unsafe territory.

what do clinicians think (about religion and spirituality)? what do the profession think (about religion and spirituality)?(That) would be really useful, I think in terms of thinking about how do we portray ourselves as a profession?

ID 05: l. 285-287

On one hand there was an awareness that psychology, as a profession, is trying to address inequality and improve access to services, for example applications from ethnic minority groups into clinical psychology are being encouraged, but on the other, little is being done to raise professional awareness and understanding in the area of religion and spirituality. Participants from ethnic minority backgrounds also struggled to understand the complexities involved, suggesting that recruitment of ethnic minority

clinical psychologists is not the only solution; education, collaborative working and greater understanding of cultural differences for all clinical psychologists will need to support the recruitment issue.

There are so many people who are, like my age, who are educated, born in this country that will turn round to me and say, "X, I know that you have been studying this psychology thing for several years,() but I think all mental health is related to spirits".(), because the thing is, how do I bring this person round to the two differences here, looking at mental health.

ID 03: l. 437-445

But tension does not stop with ethnic minority groups. One participant shared her memory of speaking with course staff about an elderly client speaking about the afterlife:

I've found that (the afterlife) as well quite important with people, especially Older Adults, erm, but often that's not touched upon, that's a real, sort of erm, 'well, we (course staff) don't talk about that' (laugh).

ID:01. l. 462-465

Participants quickly realised that asking about an individual's belief system is not encouraged and are often resort to thinking about how they would like to be treated. This appeared to require a level of self-confidence and self-belief.

I think that it is not something that is encouraged or asked of clients in the beginning, but I do not think that should discourage any clinician from exploring it themselves

ID:03. l. 316-318

However, two of the eight participants were very cautious about doing this. Their caution was based on a local incident, whereby a member of staff was disciplined, by the NHS Trust, for offering to pray with a client.

the disciplinary side of it really (concerns me). In terms of talking about spiritual issues always seems like a bit of er..... a.....contentious subject and for me, personally, () I'd be really careful about how I would answer something,because there have been incidences where people have discussed their faith and have then been disciplined for it.

ID: 05 l.234-242

More direct criticism has been levied at one participant for the wearing of a piece of jewellery. This conversation (with her supervisor) left the participant to make her own inferences of what message was being relayed.

so I guess if wearing a silver cross, a fashionable one not a religious one, if that's inappropriate then.... I guess from that I draw how appropriate they would feel that it would be, will feel it would be to discuss religion.

ID01: l. 161-164

Whilst highlighting the pervasive difficulties, there were also aspects related to religion and spirituality which were very encouraging. Most participants felt able to explore issues generally, but were apprehensive about their knowledge base.

I feel fine exploring it () give the client breathing space to, you know, explore that if they felt that that was what they wanted and it came up as really important.

ID 06: l. 389-392

For one participant, personal and professional growth was recognised. She attributed her growth to her current supervisor and his interest in religion and spirituality.

(I) feel a lot better now that I am in my third year. If you'd have asked me six months ago I probably wouldn't feel equipped (in dealing with religious and spiritual issues).

ID 08: Line 396-398

4.12.7 Trajectory of clinical practice sub-theme: Evolving practice.

There was an unspoken understanding that participants had a responsibility for their continued professional development. One participant was able to articulate her understanding of the evolving process of learning, which may be applied to religion and spirituality.

You learn a little about a lot of things but its not until you qualify that you actually () really learn and rather than having things given to you, you have the time to consider what type of psychologist you want to be and explore those areas that you haven't been able to.

ID04:l.361-365

Another, spoke of embracing this responsibility and being proactive and independent in her own continual development rather than expecting others to provide this for her in a reactive or passive manner. However, for others there remained a questioning element towards the subject of individual responsibility,

Should we be asking people about their religion, should we be trying to understand what sense people are making and I suppose as Psychologists we should be thinking about people's values systems are and what peoples belief systems are and to be able to work within that and sometimes I get concerned that we spend, that we either don't go there or if

we do go there we don't understand it or respect it as a valid part of being.

ID 05: l. 112-118

Despite the collaborative nature of clinical psychology work, one participant openly stated that she would not have thought about contacting faith leaders for further advice relating to religion and spirituality.

if I'm honest, it is not something that I would have thought of. Erm, although I do know that that is the avenue that other clinicians, outside of clinical psychology...

ID 04: l. 405-408

She went on to explain, that within the current climate of recording clinical activity, how would collaborating with faith leaders be recorded and she questioned whether clinical psychologists have the 'permission' to work in this way? Caution with involving faith leaders was identified in another transcript. Such collaboration was associated with the term 'minefields', with ethical issues of confidentiality and consent being aspects for concern.

Then I might seek help elsewhere, as long it was, kind of anonymous and you could agree that within a kind of errr.....(pause 3 secs) safe way, you know you would need to get consent to do that

ID 07: l. 649-651

A preference for contacting members of the participant's own family or a professional colleague was shared. It appeared to be important that it was with someone with whom the participant may have had previous conversations about religion.

4.12.8 Trajectory of clinical practice summary.

Participants who had received prior exposure to religious and spiritual training or clinical application appeared to have a degree of confidence in thinking about how they would approach religion and spirituality in clinical practice. Participants with no clinical experience to draw upon, appeared to be less confident about their role in exploring religion and spirituality in practice. Training was not consistently provided and gaps in knowledge were not identified within personal development plans or

assessments.

4.12.9 Super-ordinate theme 3 - 'Existential issues'

This theme was generated to capture the emotive content of participants' accounts of working with people's religious belief and spirituality. Participants experienced personal and professional dilemmas when issues surrounding life and death were present within their work. Tension was created when the client's views differed with the participant's own views of life and death. Key areas highlighted included: loss, grief, suicide, euthanasia, homosexuality, afterlife, abortion, deportation to country of origin (with a strong probability of genocide). Existential issues cropped up in clinical sessions with little warning, leaving the participants having to deal with their own emotional response whilst concurrently listening to often highly emotive narratives, often with little preparation or theoretical knowledge to assist or guide them through the situation. Support networks such as clinical supervision, access to faith leaders, buddies and mentors were available but these were accessed retrospectively following the discussions. One participant captured an interesting aspect when sharing her experience of a man struggling with severe depression, who was wishing to end his life, yet feeling completely disempowered to do so due to his religious faith. She needed to conduct a detailed risk assessment, yet the risk assessment was not her primary focus. There was an acknowledgement by the participant that the conversation was so much more than risk assessment and documentation.

(I asked) "how does it (religion) impact on your life?" "How does it help you?" and it came from his feelings of helplessness and hopelessness and feelings of suicide that erm.....how religion prevented him, I think that was the word he used, from acting on that.....erm....and so if you were doing a risk assessment then it was something that you acknowledged in a risk assessment, but the conversation was more than that.

ID 04: 1. 160-169

Working with Older People created many dilemmas for the participants. Such clients were often dealing with role transition in many aspects of their life, whilst also recognising that their remaining life was limited. Participants found that older people often spent time reflecting upon their lives and were frequently wishing to discuss issues surrounding loss and grief (Golsworthy & Coyle, 1999). Opportunities to discuss issues such as the afterlife were not uncommon, yet, participants acknowledge that they are unprepared and ill-equipped for such conversation.

So its OK to talk about religion and its OK to talk about spirituality but we don't talk about life after death.

ID01: l. 467-468

Another participant acknowledged her perceived inability to work with someone who was considering abortion or euthanasia as these were against her own religious beliefs. At a point in the interview, she felt that she would be unable to work with the individual and would request to pass the case over to another colleague. However, whilst talking about this, she appeared to realise that despite where she chose to work, she may be faced with similar ethical and moral dilemmas.

perhaps you will come across people who might have had an abortion and who have had difficulties following on from that, I'm thinking of adult mental health () or () sexual health clinics and places like that where issues might arrive.

ID05: l. 609-612

4.12.10 Existential issues summary.

All of the participants were able to identify clinical situations when they have felt challenged by existential issues. It would appear that these issues are pervasive across all clinical settings. There was a sense that these conversations were often spontaneous and there was a feeling from participants of being unprepared for these situations.

4.12.11 Super-ordinate theme 4 – 'Locus of control'

During the interviews, participants identified many barriers in exploring religious and spiritual issues with clients. Vocabulary used within published literature included terms such as, 'neglected foci' (Mohr, 2006), 'constraints' (Russell & Yarhouse, 2006) and 'competency' (Nagai, 2008; Richards & Bergin, 1997) pertaining to religion and spirituality. However, these terms seemed pejorative and were not in keeping with the essence of the participants' interviews and subsequent interpretation. The researcher wished to capture the essence of the complexities identified within participants' accounts of engaging with religious and spiritual issues during clinical practice and was not wishing to be personally blaming in nature. During the iterative process of analysis, two specific factors helped to organise the data: internally and externally located barriers. This assisted with the researcher's thinking to identify the fourth super-ordinate theme of 'locus of control'. Locus of control is seen as the extent in which individuals believe that they can control events which affect them. Those with a high internal locus of control will believe that events are a result of their own behaviour, whereas those with a high external locus of control will believe in the power of others, fate or chance which determines results (Rotter, 1975). The accounts provided many examples of such complexities and there was a perceived need to justify or defend such barriers.

4.12.12 Locus of control sub-theme: Internal locus of control.

The value of the therapeutic relationship was revered by all of the participants and it seemed that this was the one thing that had to be protected at all cost. The key theme was a genuine fear of compromising the therapeutic relationship through attributes which were personally located within the participants. Such attributes included biases, ignorance, not knowing, being on unsafe ground, invested interest

and personal disclosure. This was a thought-provoking finding. There was a real sense of personal accountability in ensuring that participants did not inadvertently cause harm to their clients. The sense of accountability was very powerful, yet seemingly one-directional. It seemed as though the participants were isolated with internally-located barriers and they appeared to be left to manage this situation alone in a way that is different to other aspects of the psychologist's work. What made this so different from other aspects of clinical practice was very difficult to capture.

For me, early on in my training, I feared opening a can of worms by saying to someone "OK what do you believe spiritually?" and they responded by saying something that didn't fit with the norm, kind of having to place my clinical judgement as to whether that is just normal spiritual beliefs or whether that's a sign of mental distress.

ID 08: l. 249-254

Other sensitive and subjective areas in clinical work, such as sexuality and ethnicity, did not appear to have a similar response to that of religion and spirituality and it is difficult to know why. During one interview this aspect was explored further. The participant was asked 'what stops us from making those exploratory avenues?' She responded with:

Good point.. yes.....because we do ask about other things don't we? We ask about family history and that can be intrusive and we ask about childhood experiences and the relationship with parents and things. I think if you think about that context and you think about religion and spiritual issues, I suppose it does raise the question why?

ID 06: l. 123-128

For others, the question appeared to have shifted across boundaries from being professional into personal, with fears of having 'invested interest'.

And I suppose for me, I've always felt like I might be having invested interest in it and that's why I might ask about it or think about it more than other people erm, so it seems as though it would be good to have wider debates.

ID 05: l. 647-650

An awareness of how personal culture can inadvertently filter through from the therapist to the client in a clinical assessment was also present.

and again you can question whether clients do not bring that detail out unless asked that

question erm....because I think clients are very attuned to their therapist's viewpoint
ID 04: l. 131-135

4.12.13 Locus of control sub-theme: External locus of control.

Participants also articulated other barriers which are better placed as external locus of control. Many factors appeared to be influenced by systemic factors which were thought to be outside of participants' control. Organisational issues provided the greatest number of external factors. These included: NHS Trust and service philosophies; political and societal viewpoints; an absence of professional guidelines or training and knowledge of the profession's ill-defined position on incorporating religious and spiritual into clinical practice.

You know, maybe, our trainers are not comfortable with, you know, training us on it, You know, maybe its an area outside their competency, expertise. I'm not sure, I'm guessing here...

ID 06: l. 134-136

Other externally-located barriers involved the participant's ability to have access to all of the information required and remembering to cover everything during assessment.

Other barriers.....I don't know, I'm trying to cover everything and unless its glaringly obvious, I'm trying to cover all this other stuff, I suppose, in that sense, still trying to figure out the model that you are using or trying to figure out the particular presenting problem erm.. incorporating everything else.

ID 04: l. 229-235

For some participants there was a clear view that communication about religious and spiritual issues should be client-led and should not be initiated by psychologists, so as to avoid intrusion.

in a thorough assessment that you can just give enough information that somebody may come back to it later and then you haven't had to do the whole prying thing

ID05: l. 325-327

4.12.14 Locus of control summary.

'Locus of control' captured the participants' difficulties in exploring religion and

spirituality with clients. It was practically helpful to organise the various factors in this way and once the theme was identified, it felt congruent not only what the participants had spoken about, but also congruent with the researcher's experience of conducting the interviews and analysis. It was important not to personally judge an individual's difficulties as the barriers were much more extensive than being purely personally located, yet there was evidence that personal factors such as the participant's locus of control were influential in how the participants approached and perceived religion and spirituality in clinical work.

4.12.15 Super-ordinate theme 5: 'Personal religious and spirituality ideology'

It became apparent through the iterative process of analysis, that some of the participants' religious orientations may be influencing their clinical practice. To illustrate these further, excerpts from contrasting orientations will be provided. This first excerpt comes from a participant who appears to be open to discussing religion and spiritual issues.

people who are religious and they think that there is only one reason for being on this planet and the reason can vary according to the religion and that is a really strong belief system and you can sometimes use it to facilitate therapy.

ID03: l. 499-502

In contrast, the next illustration suggests an important knowledge base, yet with a more defensive response.

() there are certain dress codes such as.....that it is not respectful to show the soles of your feet, and for me who wears flip flops the majority of the year, ()But I don't ask, because I'm not sure what to do if they did say that it caused offence. I'm not sure how I would respond to this.

ID02: l. 87-92

During several extracts, the researcher felt as though the participant were sharing their own religious philosophies, providing insight into their own religious orientation.

*you don't need anything else or anyone else, yeah, you don't need to rely on (spirituality)
() its not something you don't necessarily do or rely on other people,() its your own*

interpretation and its great, its not someone else's

ID 06: l. 225-229

Participants who openly shared their absence of faith, still managed to portray genuine interest in their clients' religious and spiritual beliefs and a real sense of self-awareness.

but hope that I am able to offer a reasonable relationship and service, without having a faith myself. If someone has a faith, I hope that I can be understanding of that and... respond appropriately

ID07: l. 202-205

In addition, there was concern in distinguishing between healthy or unhealthy religious belief.

You need to be able to put their conversation into religious context, do you know what I mean, to understand whether or not what they say is abnormal or not.

ID 03: l. 106-108

hearing the voice of God or, or feeling that there is someone in the room with them and that's automatically seen once you are in a mental health service as a symptom of psychosis

ID 08: l. 113-116

4.12.16 Personal religion and spiritual ideology summary.

The sharing of personal belief appeared to be something which was welcomed within the interviews. There was openness in the discussions and irrespective of their own belief there were several consistent areas of conflict and tension, such as: disclosure, confidentiality, personal biases, making assumptions and risk of causing offence.

5. Qualitative study Discussion

'Provision of religion and spirituality training' emerged as an overarching theme which illustrated the participants' accounts of engaging with psycho spiritual constructs in clinical practice. The themes introduce consistencies and inconsistencies, along with positive and negative standpoints. The five super-ordinate themes should be viewed as non-hierarchical, interdependent rather than as isolated or independent themes. Multiple

factors were found to influence the experience of engagement in psycho spiritual issues. Such factors can be organised into a combination of systemic and personal influences.

5.1 Systemic factors

Systemic influences, such as, National Health Service and Clinical Psychology policy and culture were frequently referred to throughout the transcripts. Nationally, the message conveyed is the need to integrate religion and spirituality into assessment, formulation, intervention and evaluation (Commission for Healthcare, 2007; Mental Health Foundation, 2006), yet it would appear that within the culture of clinical psychology, this aspect of clinical work is often neglected both within the academic and clinical field. This, along with an absence of professional guidelines provides a contradiction of national policy documents. This leads to a degree of uncertainty or ambivalence and creates an overall lack of clinical confidence in the participants. Participants fear exploring religious and spiritual issues for fear of causing offence, proselytising or insensitivity. It was interesting to note that participants felt that asking about religious belief was seen as prying or intrusive but asking about other sensitive areas, such as, sexuality or ethnicity was seen as normal clinical practice.

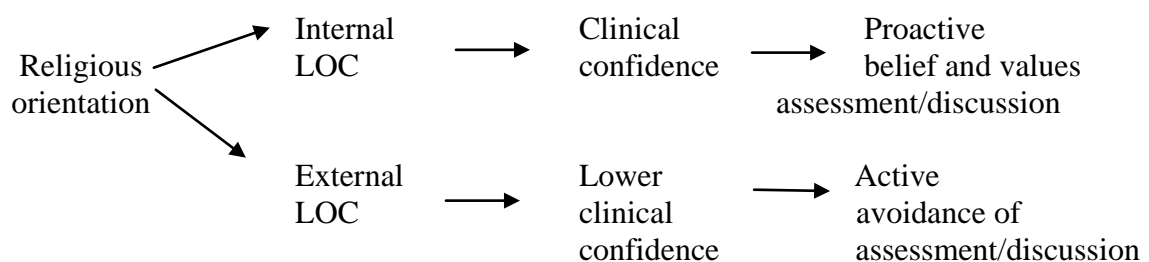
5.2. Personal factors.

During the higher order analysis of 'personal religious and spiritual ideology' super-ordinate theme, theoretical links were made between the data and the influential work of Allport and Ross (1967) in relation to intrinsic and extrinsic religious orientation. Allport and Ross (1967) identified that individuals who were intrinsically religious extended their religion beyond worship into every aspect of their life with religion appearing to be foundational to their concept of self. In contrast, extrinsically religious people were found to be motivated to worship for security, solace, sociability

and distraction and were likely to turn to God without turning away from self (Swinton, 2001). Positive correlations are seen between intrinsically religious orientation and mental health (Swinton, 2001). Through the process of interviews there was a sense that participants were able to identify clients who held fundamental religious or spiritual beliefs, however, there was no formal recognition of the theoretical concept of religious orientation, consequently, participants had little experience of applying such information into their assessment, formulation, intervention and evaluation of cases.

The super-ordinate theme 'locus of control' (Rotter, 1975) also provides recognition of a personal contribution to clinical work and when combined with 'personal religious and spiritual ideology' theme, two distinct categories may be seen (Figure 2). An internal locus of control together with intrinsic religious orientation appeared to provide some trainees with professional (and personal) confidence in their ability to explore religion and spirituality with clients, irrespective of the clients' beliefs. Whereas, those with an external locus of control (with or without extrinsic religious orientation) appeared to exhibit lower levels of confidence, which may lead to active avoidance of exploring clients religious and spiritual issues.

Figure 2 Diagram of religious orientation and locus of control



Challenging cases involving existential issues were highlighted by all of the participants indicating that existential issues are pervasive across all settings, yet the trainees felt unprepared in dealing with these emotive areas.

This study provided insight into the experiences of eight trainee clinical psychologists, across three UK courses, engaging in religious and spiritual issues in clinical practice. It captured the idiosyncratic yet symbiotic relationship between the personal and professional self and the impact that this had upon the participant's ability and confidence to explore religion and spirituality with clients. A potential limitation of the study was the reliance on self-report. The participants may have had a desire to provide contrived responses, to avoid displaying clinical weakness or inadequacies. However, as the interviews progressed, personal narratives evolved providing honest and frank accounts of their practice. A mixed gender sample may have provided an opportunity for further interpretation to be considered.

6. General Discussion

The aim of the current research was to explore the provision of religion and spirituality teaching included in the Doctorate of Clinical Psychology programmes within the United Kingdom and to explore the level of engagement with religion and spirituality of trainee clinical psychologists. The purpose of this discussion section is to review and synthesise the findings from both studies, to consider the scientific, clinical and policy implications and to offer recommendations for future research and training. Results from the preliminary study highlighted a lack of consistency across UK Doctorate in Clinical Psychology course programmes along with third-year trainees receiving less training than first-year trainees suggesting the current low-level provision

of teaching will continue. The qualitative study identified an over-arching theme of 'provision of religious and spirituality training in clinical psychology' with four super-ordinate themes capturing personal and professional investment and aspects which prevented the integration of religious and spirituality into clinical psychology.

6.1 Absence of professional guidelines

Findings from the survey and the study are comparable to previous studies (Brawer et al., 2002; Schafer et al., 2009) and indicate a lack of consistency across UK Doctorate in Clinical Psychology course programmes and clinical training with regard to religion and spirituality. Reasons for the inconsistency may be multifaceted, such as, lack of professional standards or guidelines or hesitancy to include a subject that has been previously seen as unscientific or too personally sensitive (Keller & Prest, 1993), within the curriculum. The absence of guidelines gave participants in the current study the impression that the profession regards religion and spirituality as unimportant.

6.2 Inconsistencies in training

6.2.1. Amount of dedicated teaching time.

Allocated teaching time for religion and spirituality ranged from no time (25%) to two-and-a-half days over the three-year course programme in the survey. This differs from previous studies whereby an average of 66% of no time dedicated to religious and spirituality teaching (Russell & Yarhouse, 2006; Schafer et al., 2009). Three out of eight participants participating in the qualitative study stated that they had received no teaching in religion and spirituality at all, suggesting some consistency of opinion between current and previous studies.

6.2.2. Identified modules.

The Diversity module was the most frequently stated module in which religion

and spirituality teaching took place by academic staff and trainees. This finding is supported within the literature (Brawer et al., 2002; Schafer et al., 2009). However, in these previous and current studies, it was not uncommon for religion and spirituality to be "tagged on" to other modules in a "tokenistic way". Participants in the qualitative study were generally dissatisfied with this and welcomed the idea of an integrated, more holistic approach.

6.2.3. Ignorance of religious/spiritual therapeutic or conceptual frameworks.

Findings from the qualitative study highlight that participants have minimal knowledge of specific religious and spiritual therapeutic tools or models (Beveridge & Monik, 2004; Hill & Pargament, 2003), with which to guide clinical care. Implicitly there appeared to be an overall lack of knowledge related to religious or spiritual psychological interventions, supporting contemporary research that religion and spirituality are not being cascaded into training programmes (Hill & Pargament 2003).

6.2.4. The culture of clinical psychology and NHS.

Emergent themes from the current studies include systemic and cultural factors, including the NHS and the discipline of clinical psychology. Both played important roles in participants' experience of engaging with religious and spiritual issues in clinical practice. Mixed messages are currently being conveyed at local and national level and this, along with an absence of formal guidelines and limited religion and spiritual teaching, participants are often left feeling confused and under confident.

6.3 Individual factors

6.3.1. Personal factors.

Personal religion and spiritual ideology and locus of control appeared to mediate the participant's level of engagement in religious and spiritual issues with clients. This

appeared to be irrespective of presence of faith. Participants with no affiliation to faith appeared to be acutely aware and sensitive to their values and biases potentially influencing their clinical practice regarding religion and spirituality. Generally, this finding appeared to be contrary to the survey of academic staff, as individual factors appeared to be unrecognised in responses provided by them. One centre provided an exception to this, as they invite clinical psychologists with strong allegiance to their faith to discuss issues which may arise in clinical work. Whilst this is a valuable contribution, it may seem to discriminate against atheist, agnostic and secularist clinical psychologists and trainees.

Participants took personal responsibility for managing these personal factors, as there was no dedicated forum for exploring religious and spiritual issues. Although general forums, such as reflective practice groups and clinical supervision are available for participants, the consensus was not to discuss religious and spiritual issues there. Overall, these forums appeared to be dependent upon other parties being receptive to religious and spirituality issues. Furthermore, some participants had experienced discrimination when trying to discuss religious and spiritual issues in these forums, previously identified by Patel and Shikongo (2006).

6.3.2 Ethical issues.

Religion and spirituality issues evoked many ethical dilemmas for participants. Self-disclosure, fear of disciplinary action, conflicting values and beliefs, and confidentiality were some of the issues frequently articulated. The survey of course staff did not include any teaching time dedicated to exploring religious or spiritual-related ethical dilemmas. Consequently, participants were in the position of feeling ill-equipped in dealing with ethical issues when they are raised within the clinical setting.

6.4. Clinical implications

Potentially, inequality of service provision due to ethnicity, sexuality or religion and spirituality, within a profession which recognises the importance of addressing diversity in a developing multicultural society, maybe considered a clinical priority. The participants and course directors identified a lack of attention to religion and spiritual issues within clinical placement and training may lead to poorer clinical outcomes, such as, recovery, reduced concordance and prolonged time in therapy (McGee & Torosian, 2006). Furthermore, for the participants, there was a sense that professional development and broader aspects of their consultative role within service delivery, multidisciplinary working and training may be compromised (BPS, 2006).

6.5. Recommendations

Many studies provide evidence to support integration of religion and spirituality in clinical practice (Post & Wade, 2009; Knox et al., 2005), yet, to date, there is little change in the training of clinical psychologists. The following recommendations reinforce the need for change. Firstly, the findings of the current studies indicate a perceived lack of religious and spiritual attention at organisational, academic and clinical level. To influence change at strategic and operational level, inclusion of religious and spiritual issues within the Doctorate in Clinical Psychology curriculum and the promotion of professional accountability via professional guidelines may be a necessary requirement to ensure high quality care and equality across psychological services. Encouragingly, the British Psychological Society (2009) has recently produced a policy document '*Code of Ethics and Conduct*' which includes the need to respect individual differences and explicitly identifies religion within this. This may be an early step towards the validation of integrating religion and spirituality into clinical

practice.

Secondly, the development of minimum standards may be a consideration. Standards may include: trainees to personally reflect upon their religious and spirituality development and self-awareness through use of therapeutic tools such as the spiritual genogram (Frame, 2001) and integrating spirituality into clinical supervision (McInnes Miller, Korinek & Ivey, 2006) and teaching; judicious use of spirituality assessment tools during initial assessments, along with collaborative working when religious and spiritual issues are included in formulation, intervention and evaluation work.

Thirdly, closer collaboration with faith and spiritual leaders, clinical supervisors and with clinicians who have a dedicated interest in working with religious and spiritual clinical issues may be beneficial. This may include cascading of research, sharing of case study material and hypothetical debate to ensure religion and spirituality not only gets onto the agenda for training, but makes a valuable contribution to our clinical work.

6.6. Future research

An empirical investigation of trainee clinical psychologists' views would provide greater representation of trainees' engagement in psycho spiritual constructs in clinical practice and may assist in substantiating the findings of this current study. Smiley's (2001) survey, which investigated '*clinical psychology and religion: the attitudes and practices of clinical psychologists in South East England*' could be extended to include spirituality and a geographically wider, more representative population. Obtaining views from clinical psychologists from atheist, agnostic and secularist standpoints would provide some balance to what is present in the current literature.

7. References

- Allport, G. & Ross, J. (1967). Personal religious orientation and prejudice. *Journal of Personality and Social Psychology*, 5, 432-43
- Ashworth, P. (2008). Conceptual foundations of qualitative psychology. In J.A. Smith (Ed.), *Qualitative Psychology. A practical guide to research methods*. (pp. 4-25). London: Sage Publications
- Aten, J.D. & Hernandez, B.C. (2004). Addressing religion in clinical supervision: A model. *Psychotherapy: Theory, Research, Practice, Training*, 41 (2), 152-160
- Atherton, J. S. (2003). *Doceo: Competency, proficiency and beyond*. Retrieved from the World Wide Web. 20th April, 2008. <http://www.deceo.co.uk/background/expertise.htm>
- Baer, R.A. (2006). *Mindfulness-Based Treatment Approaches. Clinicians guide to evidence-base and applications*. San Diego, CA: Elsevoir.
- Bartoli, E. (2007). Religious and spiritual issues in Psychotherapy practice: Training the trainer. *Psychotherapy: Theory, Research, Practice, Training*, 44, (1), 54-65.
- Batson, C. D., Schoenrade, P. A. and Ventis, W. L. (1993). *Religion and the Individual: A Psycho-social Perspective*. New York: Oxford University Press
- Beveridge, K., & Monik, C. (2004). A Spiritual framework in incest survivors treatment. *Journal of Child Sexual Abuse*, 13 (9), 105-120.
- Brawer, P. A., Handal, P.J., Fabricatore, A.N., Roberts, R. & Wajda-Johnston, V.A. (2002). Training and education in religion/spirituality within APA accredited clinical psychology programs. *Professional Psychology: Research and Practice*, 33 (2), 203-206
- British Psychological Society, (2006). *Core competencies-clinical psychology- A guide*. Leicester: BPS.

- British Psychological Society, (2009). *Code of ethics and conduct*. Leicester: BPS
- Brydon-Miller, M., & Tolman, D.L. (1997). Special issue: Transforming psychology: interpretative and participatory research methods. *Journal of Social Issues*, 53, 597-810
- Cawley, N. (1997). An exploration of the concept of spirituality. *International Journal of Palliative Nursing*, 3, 1, 31-36
- Chamberlain, K. (2004). Qualitative research, reflexivity and context. In M, Murray (Ed.), *Critical Health Psychology* (pp. 121-136:). London: Palgrave Macmillan
- Charmaz, K. (1995). Grounded theory. In J.A. Smith., R. Harré., & L. Van Langenhove (Eds.), *rethinking methods in psychology* (pp. 27-49). London: Sage Publications
- Commission for Health Care Audit and Inspection, (2007). *Caring for dignity. A national report on dignity in care for older people while in hospital*. London: Healthcare Commission
- Copsey, N. (1997). *Keeping faith: The provision of community mental health services within a multi-faith context*. London: Sainsbury Centre for Mental Health
- Dreyfus, H. L., & Dreyfus, S.E. (1986). *Mind over Machine: The power of human intuition and expertise in the era of the computer*. Oxford: Basil Blackwell
- Exline, J. J., Yali, A.M. & Lobel, M. (1999). When God disappoints: Difficulty forgiving God and its role in negative emotion. *Journal of Health Psychology*, 4, (3), 365-379
- Fade, S. (2004). Using interpretative phenomenological analysis for public health nutrition and dietetic research: a practical guide. *Proceedings of the Nutritional Society*, 63, 647-653

- Flick, U. (2004). Qualitative research as social transformation. In M. Murray (Ed.), *Critical Health Psychology* (pp. 137-154:). London: Palgrave Macmillan
- Frame, M.W. (2001). The spiritual genogram in training and supervision. *Family Journal: Counselling and Therapy for Couples and Families*, 9, (2), 109-115
- Golsworthy, R. & Coyle, A. (2001). Practitioners' accounts of religious and spiritual dimensions in bereavement therapy. *Counselling Psychology Quarterly*, 14 (2), 183-202.
- Golsworthy, R. & Coyle, A. (1999). Spiritual beliefs and the search for meaning among older adults following partner loss. *Mortality*, 4, 1, 21-40
- Hammersley, M. (1992). *What's wrong with ethnography? Methodological expectations*. London: Routledge.
- Hill, P.C. & Pargament, K.I. (2003). Advances in the conceptualisation and measurement of religion and spirituality. *American Psychologist*, 58 (1), 64-74.
- Husserl, E. (1931). *Ideas: General introduction to pure phenomenology*. London: Allen and Unwin
- Ingersoll, E. (1994). Spirituality, religion and counselling: Dimensions and relationships. *Counseling and Values*, 38, 98-111
- Keller, J. F. & Prest, L.A. (1993). Spirituality and family therapy: Spiritual beliefs, myths and metaphors. *Journal of Marital and Family Therapy*, 19 (2), 137-148.
- Kirkpatrick L. A. & Hood, R. W. (1990). Intrinsic-Extrinsic Religious Orientation: The boon or bane of contemporary psychology of religion. *Journal for the Scientific Study of Religion*, 29, (4), 442-462

Knox, S., Catlin, L., Casper, M., & Schlosser, L. Z. (2005). Addressing religion and spirituality in psychotherapy: Clients' perspectives. *Psychotherapy Research*, 15, 287-303

Koenig, H. G. (1998). Religious attitudes and practices of hospitalised medically ill older adults. *International Journal of Geriatric Psychiatry*, 13, 213-224

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

Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology*, 3, 2, 102-120

Lukoff, D., Turner, R., & Lu, F. (1992). Transpersonal Psychology Research Review: Psycho spiritual Dimensions of Healing. *The Journal of Transpersonal Psychology*, 24, 1, 41-60

Madill, A., Jordan, A., & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies. *British Journal of Psychology*, 91, 1-20

Maslow, A. H. (1954). *Motivation and personality*. New York: Harper & Row.

McCullough, M. E., Hoyt, W.T., Larson, D.B., Koenig, H.G., & Thoresen, C. (2000). Religious involvement and mortality: A meta-analytic review. *Health Psychology*, 19, 211-222.

McGee, M.D. & Torosian, J. (2006). Integrating spiritual assessment into psychiatric in-patient unit. *Psychiatry*, 3 (2), 60-64.

McInnes Miller, M., Korinek, A. W., & Ivey, D. C. (2006). Integrating spirituality into training: The spiritual issues in supervision scale. *The American Journal of Family*

Therapy, 34, 355-372

Mental Health Act 1983: Elizabeth II, 1983. Chapter 20 reprinted July 2003, August 2005. Great Britain: Her Majesty's Stationery Office.

Mental Health Foundation (2006). *The impact of spirituality on mental health: A review of the literature*. London: Mental Health Foundation.

Meyrick, J. (2006). What is good qualitative research? A first step towards a comprehensive approach to judging rigour/quality. *Journal of Health Psychology*, 11, (5), 799-808

Mickley, J. R., Carson, V. & Soechen, K. L. (1995). Religion and Adult Mental Health: The state of the science in Nursing. *Issues in Mental Health Nursing*, 16, 345-360

Miller, W. R. & Thoresen, C. E. (2003). Spirituality, religion and health: An emerging research field. *American Psychologist*, 58, 24-35

Mohr, W. K. (2006). Spiritual issues in psychiatric care. *Perspectives in Psychiatric Care*, 42 (3), 174-183.

Nagai, C. (2008). Clinicians self-assessment of Cultural and Spiritual Competency: Working with Asians and Asian Americans. *Community Mental Health Journal*. 44, 303-309

Larkin, M. (2003). *Interpretative Phenomenological Analysis: Power point presentation IPA conference Plymouth 2003*: wwwpsy.dmu.ac.uk/michael/qualitative.htm

Patel, C. J. & Shikongo, A.E.E. (2006). Handling spirituality/religion in professional training: Experiences of a sample of Muslim psychology students. *Journal of Religion and Health*, 45 (1), 93-111

Pidgeon, N. & Henwood, K. (1997). Using grounded theory in psychological research. In N. Hayes (Ed.), *Doing qualitative analysis in psychology* (pp. 245-273). Hove:

Psychology Press.

Plante, T.G., & Sharma, N.K. (2001). Religion, faith and mental health outcomes. In T.G. Plante & A.C. Sharman (Eds), *Faith & Health: Psychological perspectives* (pp. 240-261). New York: Guilford Press.

Pope, C. & Mays, N. (2000). *Qualitative research in health care*. London: British Medical Journal Books

Post, B. C. & Wade, N. G. (2009). Religion and Spirituality in Psychotherapy: A practice-friendly review of research. *Journal of Clinical Psychology*, 65 (2), 131-146

Powers, R. (2005). Counseling and spirituality: A historical review. *Counseling and Values*, 49, 217-225

Pulchalska, C. & Romer, A.L. (2000). Taking a spiritual history allows clinicians to understand patients more fully. *Journal of Palliative Medicine*, 3, 1, 129-137

Riceour, P. (1970). *Freud and philosophy: Essays on interpretation*. Yale: Yale University Press

Richard, P. S. & Bergin, A.E. (1997). *A spiritual strategy for counseling and psychotherapy*. Washington DC: American Psychological Association

Rolls, L. & Relf, M. (2006). Bracketing interviews: Addressing methodological challenges in qualitative interviewing in palliative care and bereavement. *Mortality*, 11, (3), 286-305

Rose, E.M., Westefeld, J.S. & Ansley, T.N. (2001).Spiritual issues in counseling: Clients' beliefs and preferences. *Journal of Counseling Psychology*, 48, 61-69

Rotter, J.B. (1975). Some problems and misconceptions related to the construct of

internal versus external control of reinforcement. *Journal of Consulting and Clinical Psychology*, 43, 55-67

Russell, S. R. & Yarhouse, M.A. (2006). Training in Religion/Spirituality within APA-accredited Psychology Predoctoral Internships. *Professional Psychology: Research and Practice*, 37 (4), 430-436

Schafer, R., Handal, P.J., Brawer, P.A., & Ubinger, M. (2009). Training and education in religion/spirituality within APA-accredited clinical psychology programs. Retrieved from the World Wide Web October 20, 2009: *Journal of Religion and Health online*.

Schulte, D.L., Skinner, T.A., & Claibon, C. D. (2002). Religious and Spiritual Issues in Counseling Psychology Training. *The Counseling Psychologist*, 30 (1), 118-134

Shafranske, E.P. & Maloney, H.N. (1990). Clinical psychologists religious and spiritual orientations and their practice of psychotherapy. *Psychotherapy*, 27, 72-78.

Smiley, T. (2001). *Clinical Psychology and religion: A survey of attitudes and practices of clinical psychologists in South east England*. Unpublished doctoral dissertation. University of Surrey, Guildford, Surrey, England.

Smith, J. A., Flowers, P. & Larkin, M. (2009). *Interpretative phenomenological analysis. Theories methods and research*. London: Sage Publications

Smith, J. A., Jarman, M. & Osborn, M. (1999). Doing interpretative phenomenological analysis. In M. Murray & K. Chamberlain (Eds.), *Qualitative Health Psychology: Theories and methods* (pp. 218-240). London: Sage Publications.

Swinton, J. (2001). *Spirituality and Mental Health Care. Rediscovering the forgotten dimension*. London: Jessica Kingsley Publishers.

Wilkinson, S. (1988). The role of reflexivity in feminist psychology. *Women's Studies*

International Forum, 16, 493-502

Willig, C. (2001). *Introducing Qualitative Research in psychology: Adventures in theory and method*. Buckingham: Open University Press

Worthington, E.L., & Aten, J.D. (2009). Psychotherapy with religious and spiritual clients: An Introduction. *Journal of Clinical Psychology*, 65 (2), 123-130.

8. Appendices

APPENDIX A

University of Leicester
Clinical Psychology Department

Survey of UK Clinical Psychology Courses

1. Are religiosity issues included in your teaching? Yes/No

If yes, approximately how much time is spent in:

Year 1	Year 2	Year 3	Overall
--------	--------	--------	---------

Please provide information on the content.

2. Are spirituality issues included in your teaching? Yes/No

If yes, approximately how much time is spent in:

Year 1	Year 2	Year 3	Overall
--------	--------	--------	---------

Please provide information on the content.

3. How do you think Trainees acquire their knowledge, skills and awareness in spiritual issues within clinical practice?

Didactic teaching

Clinical supervision

Reflective practice

Personal interest/reading

Other, please state

APPENDIX: B

06 March 2009

Mrs Jayne Mills
Trainee Clinical Psychologist
University of Leicester
School of Psychology, Doctorate in Clinical Psychology,
104 Regents Road, Leicester
LE1 7LT

Dear Mrs Mills

Full title of study: Exploring trainee clinical psychologists engagement
with psychospiritual constructs in clinical practice
REC reference number: 09/H0405/6

Thank you for your letter of 22 February 2009, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). The favourable opinion for the study applies to all sites involved in the research. There is no requirement for other Local Research Ethics Committees to be informed or SSA to be carried out at each site.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission at NHS sites ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Covering Letter		03 December 2008
Protocol	V 2	18 November 2008
Investigator CV	June 2005	
Application	V 5.6 (lock code AB/141554/1)	03 December 2008
Letter of invitation to participant	V 1, JM/Oct 08	
Investigator CV		03 December 2008
Letter from funder		25 November 2008
Peer Review		12 November 2008
Letter from Sponsor	Including study principles	28 November 2008
Interview Schedules/Topic Guides	Semi-structured Interview Schedule, JM/July 08	
Summary/Synopsis	Flow Chart, Dec 08	
Response to Request for Further Information	Email received	
Participant Consent Form	V 4 - Feb 09	
Participant Information Sheet	V 4 - Feb 09	
Response to Request for Further Information		02 February 2009
Response to Request for Further Information		22 February 2009

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document “After ethical review –guidance for researchers” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Progress and safety report
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

09/H0405/6

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely

**Dr
Chair**

Email: jill.marshall@

Enclosures: "After ethical review – guidance for researchers" [SL-AR2]

Copy to: Mr

APPENDIX: C
Semi-structured Interview Schedule⁵

Introduction

Introductions, background to research, confidentiality, format (tape recording and transcribing) consent form, any initial questions from the participant.

Background. Age gender nationality religion training history

1. I was wondering if I could start by asking you to tell me a little bit about yourself and how you came to clinical training? Define R/S?
2. What are your general thoughts about religious and spiritual issues within Mental Health?
3. What are your thoughts about religious and spiritual issues within clinical psychology? Can you give me any examples?
4. Do you feel any barriers in gaining information related to a patient's belief system/spirituality?
5. What type of teaching/education have you received prior to/ during training?
6. Do you have experience of these issues being raised within clinical supervision/reflective practice?
7. Do you have experience of using religious and spiritual measures/tools?
8. Which measures did you use?
9. How important, do you think, are religious and spiritual issues in clinical practice?
10. How equipped do you feel in exploring this area within your clinical psychologist role?
11. What additional support is needed to enable you to integrate religious and spiritual issues into assessment, formulation evaluation?
12. Who would you go to for additional support in this area of work?

JM/July 08

⁵ Interview schedule was used flexibly to enable participants to provide their experiential accounts.

APPENDIX: D

Version 2

Letter of invitation to participants

Title of Study: Exploring trainee clinical psychologists' engagement with psycho spiritual constructs in clinical practice.

Dear Trainee,

Several studies have looked at the area of spirituality and religiosity within a therapy context highlighting the positive effects of spiritual and religious factors into therapeutic work. However, little is known about trainees' experience of integrating religion and spiritual issues into clinical practice. As part of my thesis I am interested in exploring whether 3rd year trainee clinical psychologists feel ready, willing and are able to acquire knowledge and skills to explore religious and spiritual issues within clinical practice and I would value your views on this subject. I am as interested in trainees whom do not feel engagement in this area is relevant as those that do. It is hoped that the results from this study will influence future training and clinical practice.

If you decide to take part in this study you will be required to participate in a one-to-one interview, which will be audio-taped for analytical purpose. The interview will be conducted over the telephone or at your place of work or University. Participants (and centres) will not be identifiable and the tapes will be destroyed after transcription. I have enclosed a participation information (version 4) leaflet for additional information.

If you are interested in taking part of this research or you wish to discuss this with me further, then please contact me via email: jm320@le.ac.uk

Yours faithfully,

Jayne Mills
Trainee Clinical Psychologist
University of Leicester.

JM/April 09

APPENDIX E

Version 4

Participant Information Sheet

Title of Study: Exploring trainee clinical psychologist's engagement with psycho spiritual constructs in clinical practice.

Principal Investigator: Jayne Mills (Trainee Clinical Psychologist)
**University of Leicester, Clinical Psychology Unit,
104 Regents Road, Leicester. LE1 7LT**
Telephone: 0116 2231639
Email address: jm320@le.ac.uk

Invitation

As part of my thesis I am interested in exploring whether 3rd year trainee clinical psychologists feel ready, willing and are able to acquire knowledge and skills to explore religious and spiritual issues within clinical practice and I would value your views on this subject.

What is the purpose of the study?

Several studies have looked at the area of spirituality and religiosity within a therapy context highlighting the positive effects of spiritual and religious factors in therapeutic work. However, little is known about trainees experience of integrating religion and spiritual issues into clinical practice. This study is hoping to learn more about how trainee clinical psychologists gain knowledge skills and awareness of religious and spiritual issues within clinical practice. The findings should have implications for education, training and clinical practice. I am interested in trainees who do not feel engagement in this area is relevant to their practice and those that do.

What will be involved if I take part in the study?

The study has received NHS ethical approval and permission from your course to invite you to participate. You will be one of twelve trainees asked to participate in an individual interview. Written consent will be obtained and will include permission to audio-tape and to use direct quotes from the interview. You will be given the choice of a telephone interview or a face-to-face interview which will last approximately 1–1.5 hours. Following the interview, no further involvement will be required.

Will the information obtained in the study be confidential?

Your information will remain confidential and will be identified by code only. The audio-tape and transcription will remain confidential and the tape will be stored securely and destroyed following transcription. The interview will be transcribed and analysed by the Principal

Investigator. Your confidentiality will be maintained throughout the publication process unless information obtained threatens the well-being of others. In this event, the Principal Investigator is bound by the law and the British Psychological Society code of conduct to reveal such information. The study will complete in April 2010. If you would like to know the results of the study then please let me know via my email address.

Individual course centres will be provided with general information and comments only. It is hoped that the results of the study will be published in an academic journal and shared within the discipline of Clinical Psychology.

What happens if I do not wish to take part in this study or wish to withdraw from the study?

If you do not wish to participate or if you wish to withdraw from the study you may do so at anytime without justifying your decision. All information will be destroyed and not included in the study or publication.

Thank you for your time and attention in reading this information. If you would like to take part in or discuss any aspect of this research, then please contact me via email: jm320@le.ac.uk

APPENDIX F

Version

Consent Form

Title of study: Exploring trainee's engagement with psycho spiritual constructs in clinical practice

Name of Principal Investigator: Jayne Mills

This form should be read in conjunction with the Participant Information Sheet, version 4 dated Feb 09.

I agree to take part in the above study as described in the Participant Information Sheet
I understand that I may withdraw from the study at any time without justifying my decision.

I understand that members of the research team may wish to review sections of my interview, but that the information will be treated as confidential

I have read the information sheet on the above study and have had the opportunity to discuss the details with Jayne Mills and ask any questions
The nature and purpose of the study have been explained to me.
I understand that the interview will be audiotaped and that direct quotes may be used.

Tick box

☐☐☐

Signature of participant.....Date.....
(Name in BLOCK LETTERS)

I confirm that I have explained the nature of the study as detailed in the Participant Information Sheet, in terms which in my judgement are suited to the understanding of the participant.

Signature of Investigator.....Date.....
(Name in BLOCK LETTERS)

JM/Feb 09

Appendix G: Stages of Analysis

Example of the analytical process using ID 01

Interpretative Phenomenological Analysis consists of four stages: pre-transcript, micro-analysis, macro-analysis and inter-transcript themes. Analysis initially commences with an idiographic analysis of one case which is then repeated with other transcripts and culminates with inter-transcript analysis (Smith et al, 2009).

Participant background information

ID 01 is a third-year clinical psychology trainee. She is 38 years-old and is of Christian denomination. She is a mother and has worked in a voluntary capacity within the field of social work and psychology prior to training.

Stage 1 – Pre-transcript analysis

Following each interview the researcher made field notes of her early thoughts and feelings which arose after the interview.

Excerpt from field diary

The interview appeared to go well. Feeling quite excited at the content of the discussion. It would seem that the conversation was generating a lot of thought. The participant was very honest about her perceived lack of training in relation to religion/spirituality and mental health. I had a strong need to reassure her with this which may have been influenced by my need not to appear critical.

It seemed as though the interview was perhaps the first time that she had shared her thoughts about religion and spirituality and clinical practice. I was shocked to hear about her fears regarding disciplinary action being taken on a member of staff within her Trust. This had left her feeling extremely cautious.

Stage 2 – Micro-level analysis

This stage involves the reading of the transcript a number of times with the left hand margin being used to annotate the researcher's initial reflections and tentative ideas about what the respondent had said. An example of stage 2 process is seen below.

Def 50	50	Errm, I think that that is different, errmm...I wouldn't necessarily think	
hard to define	51	of that being with an organised faith. I think errmm...they errmm	
much more	52	spirituality, would follow a Muslim faith or whatever, it's not easy	
to define	53	sometimes to think of ... errm an awareness of an Other, an awareness	
difficultly	54	of ...errm ...less concrete, their... I think that it's really hard to define.	existing
in that	55	Yes, yes it is...	definition
less concrete	56	I think ... I think it's a way of living that is more about values and	
ways way	57	personal beliefs, perhaps linked to higher faiths but there are	
faith	58	alternatives to organised faiths.	
religion	59	So, I think what you are saying to me is that it is something that is	
connected	60	difficult to define, errm it can be connected with a religious faith	
but it doesn't	61	but it doesn't have to be connected to a religious faith in that... it	
doesn't have to	62	doesn't have to be about a formal religion...	
be about a formal	63	Yes, and errm, I don't think that it means going to church or a Synagogue	
religion	64	or have specific dates on the calendar, errm more personal than defined	
errm, yes	65	errm, yes	
Yes, OK. Will you be	66	Yes, OK. Will you be comfortable for me to use the terms	
comfortable for me	67	interchangeably today?	
to use the terms	68	Yes, that's fine.	
interchangeably today?	69	OK,What are your general views about religion and	
Yes, that's fine.	70	spirituality within mental health services?	
OK,What are your	71	Well, I'd say.... I haven't really come across them, it's difficult. I've	because of
general views about	72	come across previously errmm in the NHS, but not within mental	ill in NHS
religion and	73	health services or training	or training
spirituality within	74	Right, can you explain to me a little about when you came across	
mental health services?	75	them previously, before training?	
Well, I'd say.... I haven't	76	Errm ...yes, when I worked as an assistant psychologist, I was	but present
really come across them,	77	working as an assistant within a Stroke Unit and the Unit had a 'Wheel	of values
it's difficult. I've	78	of Values' which part of that was where, basically we were all anyone	of work
come across previously	79	involved with the Trust was encouraged to offer all patients... to be	
errmm in the NHS,	80	aware of individual faith, the way faith was important to the people,	Trust wide
but not within mental	81	but that was more of a Trust wide policy. I later went into more mental	policy
health services or	82	health and went on training in which religion, ethnic minorities and	
training	83	errmm... not really teaching more about an awareness of people with	
Errm ...yes, when I	84	different faiths but I can't, I can't remember	
worked as an assistant	85	what that was, of what that was about....	
psychologist, I was	86	Yes, yes.	
working as an assistant	87	I can't remember what that was. And in terms of clinical training it has	
within a Stroke Unit	88	been more about an awareness of ethnic minorities and getting together	Diversity
and the Unit had a	89	and finding about the way of life and differences, but not about talking	
'Wheel of Values'	90	religion, although that was part and parcel of it, not a formal training	
which part of that	91	sense, I think, errm... so yes that's the outline as much as I can say	
was where, basically	92	about it.	
we were all anyone	93	Do you feel that there are any barriers in gaining information	
involved with the	94	about religion and spirituality issues?	
Trust was encouraged	95	Errm.... there are a lot of barriers, I think. There is a nervousness	nervousness
to offer all patients...	96	about ... errm going in that direction, because, a little while ago a nurse	disciplinary
to be aware of individual	97	working in the community working with the elderly, errm she talked	
faith, the way faith	98	about religion with clients she visited clients and she was told off for	
was important to the	99		
people,	100		
but that was more			
of a Trust wide			
policy. I later went			
into more mental			
health and went on			
training in which			
religion, ethnic			
minorities and			
errmm... not			
really teaching			
more about an			
awareness of			
people with			
different faiths			
but I can't,			
I can't remember			
what that was,			
of what that			
was about....			
Yes, yes.			
I can't remember			
what that was.			
And in terms of			
clinical training			
it has been more			
about an awareness			
of ethnic minorities			
and getting			
together and			
finding about the			
way of life and			
differences,			
but not about			
talking religion,			
although that			
was part and			
parcel of it,			
not a formal			
training sense,			
I think, errm...			
so yes that's			
the outline as			
much as I can			
say about it.			
Do you feel that			
there are any			
barriers in			
gaining			
information			
about religion			
and spirituality			
issues?			
Errm.... there			
are a lot of			
barriers, I			
think. There			
is a			
nervousness			
about ... errm			
going in that			
direction,			
because, a			
little while			
ago a nurse			
working in the			
community			
working with			
the elderly,			
errm she			
talked about			
religion with			
clients she			
visited clients			
and she was			
told off for			

Following this, emergent sub-themes and psychologically focused ideas will be noted in the right-hand margin. These themes were threaded back to the transcript to validate their presence within the text.

Example of the analytical process using ID 01

Stage 3 – Macro-level analysis

Emergent themes were then listed on a separate sheet of paper and reviewed for connections between them. The themes clustered together to produce a number of superordinate themes. As these emerged they were continually checked in the transcript in order to ensure that they were grounded in the primary data. The themes were given names that represented their overall super-ordinate theme and an identifier was added to each excerpt to aid the organisation of the analysis and facilitate the constant checking of the original transcript.

Larkin et al. (2006) recommends asking questions of the data at the interpretative stage 2 and integrative stage 3.

See example of Stage 3 analysis

ID01

Page	Line	
1	31-34	<i>Valuing clinical experience over academia</i>
2	57-74	<i>Evolving definition of spirituality</i>
2	82	<i>Absence of R/S in MH services or clinical training</i>
	91	<i>Trust -wide policy</i>
	99-102	<i>Linked with BME and diversity</i>
3	108	<i>Nervousness</i>
	113	<i>Disciplinary threat</i>
3	115	<i>Restrictive autonomy</i>
	134	<i>Personal lack of knowledge</i>
	140	<i>Time limitations</i>
	142	<i>Biases</i>
	149-151	<i>Symbols creating barrier (fashion not religion)</i>
4	163-165	<i>Interpretation of what is/is not appropriate</i>
4	179-188	<i>Trainees response Parallel process of therapy</i>

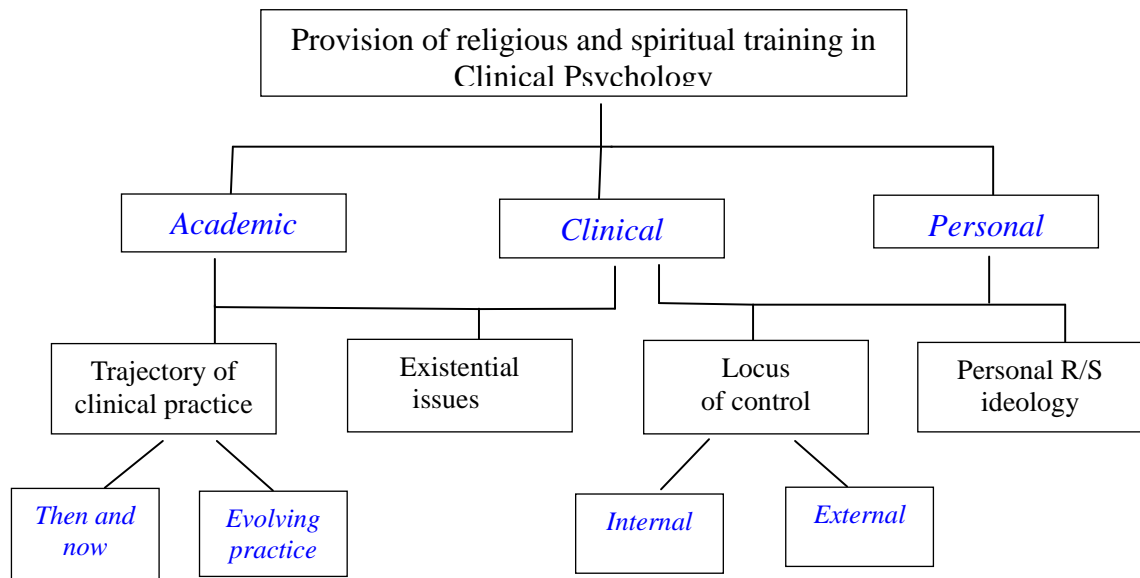
Stage 4 – Inter-transcript themes

Themes from the first transcript were then used to ordinate the analysis of subsequent transcripts. Repeating patterns were noted along with the emergence of new themes

Stage 4 analysis: Emerging super-ordinate themes

Clinical context	Barriers	Autonomy – client/professional
<i>Suicide</i>	<i>Ethics</i>	<i>Self-expression</i>
<i>memory difficulties</i>	<i>Biases</i>	<i>Conflict potential harm</i>
<i>Religion-specific</i>	<i>Pathologising</i>	<i>Religion protective</i>
<i>deportation</i>	<i>How to begin</i>	<i>Emotional crutch</i>
<i>bereavement</i>	<i>Discrimination</i>	
<i>eating disorder</i>	<i>Evangelical</i>	
<i>older people</i>		
<i>abortion</i>		
<i>euthanasia</i>		
Training		
<i>Equipped to explore (Transferable skills)</i>		
<i>therapeutic relationship</i>		
<i>Alternative perspectives</i>		
<i>Curiosity</i>		
<i>Professional trajectory</i>		
<i>Absence of model/guidelines</i>		
<i>Paucity of science</i>		
<i>Tokenistic</i>		

Figure 1: Process model of super-ordinate themes



Italics indicate sub-themes

PART THREE: Critical Appraisal

1. Critical Appraisal

A reflective diary was kept throughout the research process. This was found to be a therapeutic tool and an important record of evolving thoughts and developments throughout the research process. In an attempt to make the critical appraisal more interesting for the reader I have decided to write about the developing themes occurring within the reflective diary rather than a chronological list of events.

1.1 Research Interest

The genesis of the research has spanned a couple of decades. Previously, whilst working as a Registered General Nurse in Cancer and Palliative Care, the role of religion and spirituality was an important clinical dimension in my work with patients. I anticipated that religion and spirituality would have a similar emphasis within mental health care due to the chronic nature of healthcare problems and subsequent quality of life issues transferable across both client groups. During clinical training, I have found that religion and spirituality has been given little attention in teaching and this has left me feeling curious as to why this would be so. Discussions with clinicians, academic staff and fellow trainees led me to consider the implications of this on clinical practice.

1.2. Choice of Methodology/Limitations

1.2.1. Preliminary survey

The preliminary survey was suggested following internal peer review of the research proposal. The rationale for surveying UK courses was recommended to provide further context for the main study. Due to time restraints, the survey was rather quickly developed and did not receive the same level of attention as the main study. The survey

may have been strengthened by replicating previously conducted surveys investigating the inclusion of religion and spirituality within course programmes (Schafer , Handal, Brawer & Ubinger, 2009; Brawer, Handal, Fabricatore, Roberts & Wadja-Johnston, 2002). This would have enabled direct comparisons between American and UK course programmes.

1.2.2. Qualitative study.

A personal interest and paucity of published evidence exploring trainee experience in engaging with psycho spiritual issues in clinical practice directed the research question. The research question was considered to be best answered using a qualitative methodology, as it was felt that this approach would allow for richer data to be obtained. This exploratory study was viewed as the initial stage of the research with the possibility of incorporating quantitative methodology at a later date. Previously, I had used Interpretative Phenomenological Analysis (IPA) in my undergraduate study and found it to be a valuable methodology. However, on reflection, my undergraduate research lacked academic rigour and an understanding of epistemological and ontological issues, which I now appreciate, are paramount for research design and methodology. Through the process of studying at Doctorate level and conducting the present research, I began to identify other gaps in my qualitative research knowledge and felt personally driven to develop my skill and ability in higher level interpretation required of IPA.

The process of interviewing participants over a series of months allowed for familiarisation with the interview process and my confidence gradually developed as time progressed. Initially, during the early interviews, I felt clumsy and anxious about my interviewing skills, especially in the ability to build rapport with participants within

the context of research. However, I became aware that rapport was building and my level of inquiry deepened as time progressed. The rationale behind examining the lived experiences of trainees was to raise questions and create ideas about future analytical possibilities. The findings are specific to the eight third-year trainees involved in the research and should not be generalized to a larger population of trainees.

Whilst homogeneity is an important factor in IPA, an all female sample was not anticipated at the outset of the study. The reason why only female trainees volunteered was unclear. Male trainees are less representative within UK courses, representing 15 percent of total applicants in 2009 (Clearing House, 2009). Consequently, there were fewer male trainees which met the study's inclusion criteria. The decision to recruit third-year trainees was made in recognition that, as third-years, they will have had similar clinical work exposure, were preparing for qualified practice and would be supervising trainees in the near future.

1. 2.3. Recruitment.

The survey of the inclusion of religious and spiritual teaching in the Doctorate of Clinical Psychology also generated a slow response. The initial survey was circulated in the summer of 2008 and nine out of thirty courses replied. The survey was re-circulated a year later and three additional courses responded.

In the main study recruitment was initially very slow and this created some tension for the researcher. Ethical approval had requested Research and Development (R & D) approval, which in practice required approval from six centres, all of which had different requirements and lacked consistency within the application process. One of the centres was requesting a fee of several hundreds of pounds, which I had not accounted for in my project budget and consequently this led to the centre being withdrawn from

recruitment. Fortunately, the decision for R & D approval was removed by NREC following an appeal by my academic supervisor (Appendix A).

The first contact with the courses coincided with selection week for the forthcoming new intake of trainees. This is an exceptionally busy time for all courses and understandably my research request was less of a priority for the courses and was initially overlooked by administration staff. Third year trainees were also very busy with their own research studies, oral examinations, job applications and this may have affected their willingness to commit to an interview. I quickly began to realise that recruitment was dependent upon others. In an attempt to reduce the reliance on others, I offered to personally present the study to trainees within each centre. This request was declined by the academic staff on one course and the two remaining courses did not offer a reply to the request.

These recruitment issues left me feeling very demoralised. There was a sense that there was no space for the study which reinforced my pre-existing thought of there being a lack of space for religion and spirituality within clinical psychology. It also created some doubt as to the feasibility of the research and dampened some of my initial enthusiasm. However, as the new academic year commenced, trainee recruitment increased as the next wave of third-years provided me with a new group of potential participants.

1.2.4. Data Collection.

Despite interviews being conducted over a five month period, my anxiety did not reduce over this time. As each interview drew closer, my anxiety levels increased. Notes taken from my research diary indicate that my main anxiety appeared to be surrounding rapport building.

5th July, 2009

I feel intrusive asking for her personal land line number, yet I didn't want her to be subjected to the cost of the phone call. I feel very concerned about developing a rapport with her, despite having had email correspondence, which clearly shows her willingness to participate despite having to juggle childcare and family considerations.

Rapport developed smoothly – similar background to me, a Mum, mature trainee, and similar stage of training.

Seven out of eight participants chose telephone rather than face-to-face interview. I found the prospect of conducting a telephone interview more anxiety-provoking than meeting and speaking to participants personally. In an attempt to control my own anxiety, I was careful in my preparation prior to the telephone calls. All calls were made from my home and all participants participated in their own time, using their personal landlines or mobile telephones. I ensured privacy by placing 'do not disturb' notices on doors and 'interview in progress' on telephone extensions in an attempt to minimize interruptions as much as possible. Despite my efforts, two of the interviews were interrupted; a low battery alarm sounded and one of the participant's mobile phone rang. The interruptions did not appear to be too disruptive to the interview.

The one face-to-face interview was problematic from the outset. This was the only interview conducted whilst the participant was on clinical placement. The journey was in excess of one hundred miles, return trip. The journey was unfamiliar and despite having the use of satellite navigation, I still managed to get lost. On arrival, the participant had been very busy, had missed her lunch and had another appointment immediately after the interview. Initially, she seemed preoccupied and was somewhat dismissive of religion and spirituality. It was difficult to know whether this was due to feeling pressured for time or that she was genuinely dismissive of religion and

spirituality. However, she appeared to be processing information and her views appeared to evolve as the interview progressed.

1.3. Analysis

During the analysis, a strong sense of responsibility was continually present, with a desire to do justice to the valuable data obtained. This sense of responsibility increased as the analysis developed and the move from first order into second order analysis, with greater focus on abstract interpretation was a particularly difficult time. This was possibly for two reasons: the knowledge that this level of interpretation was necessary for qualification and that this level of sophistication had been absent in my undergraduate research.

Initially, I approached the analysis as described in the literature (Smith, Flowers & Larkin, 2009) but this felt restrictive. In my experience, the process appeared to be too linear. Overwhelmed with the volume of data, differing perspectives and awareness of my own subjectivity on the subject, I was unsure how I would be able to integrate it into meaningful and abstract interpretation. This uncertainty was compounded with reading around validity, anecdotalism (Silverman, 2001) and of discussing the phenomenon without attempting to analyse less clear or contradictory data (Silverman, 1993). Following a constructive research supervision meeting, I began to recognise that I was not getting beyond the descriptive accounts of the participants.

22nd January, 2010

Productivity has been low and in hindsight, this is probably because I am not on the right track in applying an ethical framework as it is not capturing the essence of the participant's accounts. I wonder whether I have been trying to fit the data into neat boxes rather than emotionally connecting with the complexity.

So, I began to approach the analysis differently and started to write down my

thoughts, initially by going with an idea which I had had for some time but which I had resisted pursuing because it had felt to be too presuming. The outcome of this approach was positive and appeared to have the desired effect of freeing up my creative thought. Concurrently, I found the work of Elliot, Fischer and Rennie (1999) to be a very useful, transparent framework recognising the importance of owning one's perspective, situating the sample, grounding analysis in examples, providing credibility check-lists, developing coherence, accomplishing general and specific research tasks and ensuring that the narrative resonates with the reader. Interestingly, my earlier presumptions did not survive this process or the deeper analysis but were invaluable in moving the analysis forwards.

1.4. Reflexivity

Reflexivity has been defined as an ongoing process of reflection whereby researchers consciously understand how their values, interests and social context influence their field of study (Rolls & Relf, 2006). As previously mentioned in the methodology section, the differing types of reflexivity identified by Willig (2001) and Wilkinson (1988) assisted in maintaining a reflexive approach throughout the current study. IPA studies engage a double hermeneutic process which involves the researcher making sense of participants making sense of their lived experiences. This complex process requires introspection and reflection on the researcher's part. From the outset, I was aware that religion and spirituality was sensitive research which required ethical and professional attention.

I found myself constantly evaluating my professional identity during the interview, at times my identity fluctuated between being researcher, peer, expert and clinician. It was often difficult to distinguish between 'being alongside' the participant

and taking 'an expert' position. My own emotional response to the interviews also fluctuated from containing emotional expression to utilising connection which appeared to overlap with my clinical role. This has been identified as the three voices in which researchers respond to emotionally intense data; the voice of academic discourse, the collaborative 'we' voice used between co-researchers and the individual 'I' voice of individual researchers (Rolls & Relf 2006). Lewis (2008), report that the verbal and non-verbal response of the researcher establishes the emotional climate of the interview and shapes the participant's narrative. I was aware that this began from my initial contact with the participant and in the use of silences and humour and my counter transference during the interview.

Sensitivity to the participant's personal religious belief and the possibility of revealing personal or professional inadequacies was very important to me. I opted to avoid using the word competency, as this appeared to be a value-laden concept, which was thought to be unhelpful in the research remit. My personal biases were present from the genesis of the study influencing the choice of study, perceptions and interpretation. Biases were acknowledged and subsequently managed through the processes of transparency, research supervision and audit trail.

1.5. Process Issues

1.5.1 Role Conflict.

Conducting research interviews with third-year trainees produced a personal and professional dilemma. I found myself interviewing my peers about a very personal and private matter. During the interview my identity was confusing: Was I a fellow trainee; a researcher; an expert or a critic? Towards the end of the first interview, my position became unclear when I asked the participant if there was anything which she would like

to ask. She began to speak about end-of-life issues, stating that there was reluctance from academic staff to enter into conversations about end-of-life issues. This subject immediately connected with my previous work in palliative care. I found myself responding in an expert position, I found myself almost seizing the opportunity to share, educate and inform the participant. My response appeared to close down the communication pathway between us. However, I also felt strongly that the participant had been deprived of an opportunity to fully explore the issue with academic staff and later realised that the research interview was providing an opportunity to explore an existential issue which had been previously dismissed. As the interviews continued existential issues were frequently discussed and 'existential issues' was identified as a super-ordinate theme suggesting that participants lacked opportunities to explore existential issues within their clinical or academic areas. Personally, and in response to the discomfort felt, I recognised the importance of curtailing my enthusiasm to enable greater access to the participant's experience.

1.5.2 Parallel Processes.

Parallel processes are frequently experienced within clinical supervision as interpersonal dynamics are enacted concurrently in the supervision dyad as in the therapy dyad, with 'the therapist's problem in supervision expresses the client's problem in therapy' (Andersson, 2008, p. 37), highlighting unconscious processes at work. During the research interviews, I felt hesitant in asking the participants about their own religious belief, for fear of intruding into a potentially deeply personal aspect of their life. My hesitancy was similar to that I experience within the clinical setting. Another example of parallel-processing was experienced during the analysis stage. I felt compelled to fit the interpretation into a neat, structured and familiar ethical framework

rather than grapple with the uncertainty of the data. But in doing this, I became aware that much of the information which had stimulated and inspired me during the initial stages of the interviews was absent and the interpretation was not uniquely related to third-year trainees but could be applied to any health worker. In hindsight, the process of trying to make data fit, appeared to be providing me with a means of managing the intangible aspects of religion, spirituality and clinical practice by providing a neat and familiar model to replace the non-existent model, identified in the participants' accounts. Once I realised this I was able to reject my initial themes and allowed me to develop themes which captured the participants' individual experiences.

Was this another message indicating a need to anchor religion and spirituality onto something more tangible and concrete?

1.6 Learning Points

Throughout my Doctoral training and the undulating process of research, there have been many learning points. Firstly, I have felt immensely privileged that eight participants have chosen to share their experiences with me. They have shared personal and professional information in an open and trusting way. For some, it was an opportunity to articulate their thoughts about religion and spirituality in a way that they hadn't been able to before; consequently this has positively influenced my clinical practice.

Secondly, I have had the opportunity to consolidate and build upon my research knowledge and appreciate the epistemological and ontological positioning required when designing research. This has enhanced my overall knowledge of both quantitative and qualitative research paradigms. My knowledge of IPA has increased and I am able to make comparisons between my approaches to IPA research as an undergraduate to

postgraduate level. Reflexivity was a new concept, but one that resonated with me. Attending a local conference on reflexivity provided me with resources which were most helpful throughout the research. Whilst I consider myself a novice researcher and realise that I still have a lot to learn, I take comfort in what I have gained as a result of this process.

Thirdly, I have found myself feeling challenged on many occasions. Such times include attending the ethics committee meeting and responding to their request for clarity and during research interviews with participants. I wasn't sure whether my interview schedule would achieve appropriate data or how participants would respond to my questions. There were times during some interviews when I was tempted to act as therapist/expert rather than researcher and I have learned to manage this in a way that will be useful in future research projects. The research has highlighted my own biases and assumptions within the interview process, analysis and clinical practice. The main learning points included learning to deal with conflicting views and dealing with my own uncertainty. However, these experiences have provided me with greater personal and professional confidence along with a realistic understanding of my limitations.

On reflection, there are some things that I may have done differently, these include: early face-to-face contact with potential participants rather than relying upon course administration staff during selection week and offering interviews earlier on in the third-year, so as to avoid thesis deadlines and oral examinations. One regret I have is the lack of service-user involvement. The study may have been strengthened by involving service-users during the planning phase of the study, such as sharing the early ideas or the development of the interview schedule. Service-user involvement may be addressed retrospectively during the cascading of the results, as many course curriculum

committees now have service-user representation.

2. References

Andersson, L. (2008). Psychodynamic supervision in a group setting: Benefits and limitations. *Psychotherapy in Australia*, 14, 2, 36-41

Brawer, P. A., Handal, P.J., Fabricatore, A.N., Roberts, R. & Wajda-Johnston, V.A. (2002). Training and education in religion/spirituality within APA accredited clinical psychology programs. *Professional Psychology: Research and Practice*, 33 (2), 203-206

Clearing House for Postgraduate courses in Clinical Psychology (2009). Retrieved from the World Wide Web. 3rd March, 2010. <http://www.leeds.ac.uk/chpccp.htm>

Elliot, R., Fischer, C.T., & Rennie, D.L. (1999). Evolving guidelines for the publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, 38, 215-229.

Lewis, I. (2008). With feeling: Writing emotion into counselling and psychotherapy research. *Counselling and Psychotherapy Research*, 8, 1, 63-70

Rolls L., & Relf, M. (2006). Bracketing interviews: Addressing methodological challenges in qualitative interviewing in palliative care and bereavement. *Mortality*, 11, 3, 286-305

Silverman, D. (1993). *Interpreting qualitative data: Methods for analysing talk, text and interaction*. London: Sage Publications

Silverman, D. (2001). *Interpreting qualitative data*. London: Sage Publications

Schafer, R., Handal, P.J., Brawer, P.A. & Ubinger, M. (2009). Training and education in religion/spirituality within APA-accredited clinical psychology programs. Retrieved from the World Wide Web October 20, 2009: *Journal of Religion and Health*, 1-9

Smith, J. A., Flowers, P. & Larkin, M. (2009). *Interpretative phenomenological analysis. Theories methods and research*. London: Sage Publications

Wilkinson, S. (1988). The role of reflexivity in feminist psychology. *Women's Studies International Forum*, 16, 493-502

Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in theory and method*. Buckinghamshire: Open University Press

3. Appendices

Appendix A: Letter to Ethics Committee

13th August 2009

Dear Dr

Full title of study: Exploring trainee clinical psychologists engagement with psychospiritual constructs in clinical practice

REC reference number: 09/H0405/6

Principle Investigator: Mrs Jayne Mills, Trainee Clinical Psychologist

I write as academic supervisor and course director for the above. I am writing to ask you and the ethics committee to reconsider the stipulation for Mrs Mills to contact and seek approval from Trust R&D departments. The reasons for my request are as follows:

As Course Director of the clinical psychology training course at the University of Leicester I regularly receive requests from trainees like Mrs Mills from other clinical psychology training courses to conduct questionnaire and interview research on my trainees. I always check that these studies have had some form of ethical review before allowing these trainees access to my trainees (with consent) via our course administrator. None of these researchers approach or obtain approval from our local Trust R&D department, even though the trainees are technically employees of the Trust. My trainees are viewed as university students (which is what they are) and the approach is made through the university. This is also the case for my fellow course directors on other courses. I would argue that it is entirely within my remit as course director and head of the academic department to judge whether it is appropriate for my trainees, in their capacity as postgraduate students (albeit receiving professional, NHS-funded healthcare training) to be approached by a trainee from another course.

Although clinical psychology trainees are NHS employees, they are effectively seconded full-time to the University for training purposes. Considerations regarding the impact of research on NHS resources which is rightly the primary concern of Trust R&D committees do not have the same relevance or application in the case of trainees being approached. My concern is that by stipulating Mrs Mills must approach R&D committees, she is being greatly impeded and unfairly disadvantaged in comparison with her peers. She has already discovered that the XXXCommunity Trust which employs the XXX clinical psychology trainees is requiring a payment of £1,000 (for which Mrs Mills has no budget) for them to even look at the proposal. This means she is effectively barred from access to 50% of the recruitment population identified in her original proposal. Ironically I have only recently received a request from a XXX trainee to undertake a study including my trainees in Leicester and she has been given access without recourse to the Leicester Trust.

I would be most grateful for your sympathetic consideration of these issues and the special case of clinical psychology trainees as participants in research.

I would be happy to discuss these issues further or provide more information if this would be helpful. Please feel free to contact me on 0116 223 1648.

Yours sincerely,

Professor Michael Wang, Course Director and Head of Clinical Psychology,
University of Leicester