

Copyright is owned by the Author of the thesis. Permission is given for a copy to be downloaded by an individual for the purpose of research and private study only. The thesis may not be reproduced elsewhere without the permission of the Author.

**Missing Pieces?  
Considering Religion and Spirituality in Mental Health Care**

**A dissertation presented in partial fulfilment of the requirements  
for the degree of**

**Doctor of Philosophy  
in  
Psychology**

**At Massey University, Albany, New Zealand**

**Bronwyn Denise Castell**

**2013**



## ABSTRACT

---

There is a substantial body of evidence to show that religion and spirituality are important to mental health. Religious/spiritual individuals who utilise mental health services often express a preference for religion/spirituality (R/S) to be considered in their care and a growing number of studies have suggested that the consideration of R/S is important for client outcomes. However, a consistent rhetoric in the literature has been that R/S is largely neglected and minimised by mental health practitioners. It is unclear to what extent New Zealand mental health clients perceive that R/S is considered in their care. Furthermore, no research has uncovered factors that predict clients' perceptions that R/S has been considered and their satisfaction with this. This dissertation helps to address these gaps through an international survey of religious/spiritual mental health clients, with a focus on the New Zealand portion of the sample. Hierarchical logistic regression was used to investigate the factors that predict discussion and consideration of R/S in mental health care and clients' satisfaction with this. Results indicated that just under half of New Zealand participants had discussed R/S with their most recent mental health practitioner and perceived that R/S was satisfactorily considered in their care. It was also found that the likelihood of clients discussing R/S was strengthened by the similarity of practitioners' religious/spiritual beliefs to their clients' (client-practitioner matching), more positive client expectations, greater importance placed on R/S considerations by clients, seeing a psychotherapist as opposed to a psychiatrist, and seeing a practitioner in the United States as opposed to New Zealand or England. The extent that R/S was subsequently perceived by clients to have been considered in their care was influenced by all but the last two of these factors. Clients' satisfaction with the way R/S was considered did not differ between unmatched and matched clients, but was lower for clients who were uncertain regarding similarity of their practitioners' religious/spiritual beliefs. Clients' perceptions that their practitioner understood the relevance of R/S to their recovery predicted a greater degree of satisfaction. Satisfaction was affected when clients' expectations were not met. Findings suggested the need for practitioners to strive to become more aware of clients' religious/spiritual beliefs and related concerns, to understand their relevance, and to take collaborative action on the basis of this knowledge. Recommendations for practice are discussed, as are recommendations for clients and future research.

## ACKNOWLEDGEMENTS

---

The process of writing this dissertation has been unlike any experience I have encountered before. Not only has it equipped me with better skills to conduct research, it has grown me as a person and helped me to better my own clinical practice. This process would not have been possible without the input of a number of people along the way, whom I wish to acknowledge here.

First and foremost, I would like to acknowledge my supervisors. To my primary supervisor Dr. Dianne Gardner, who helped me to find a pathway after my many wanderings into this incredibly interesting but convoluted area of research. Your advice and support has been invaluable beyond measure. To my original primary supervisor Dr. Jennifer Stillman: thank you for helping me to set out on this journey in the first place, for your constant enthusiasm, and for patiently answering my many emails and door-knocks. To Dr. Paul Merrick, your advice and feedback helped shape this dissertation into the piece of research it is today, for which I am very grateful. To Dr. Beverley Haarhoff, thank you for the time you spent discussing the research with me. You provided a new perspective that made me look beyond my own. In addition to my supervisors, I would like to acknowledge Dr. Barry McDonald for helping me to identify and navigate the many statistical analysis options available to answer the questions of this research.

This dissertation was supported financially by a doctoral scholarship from the Tertiary Education Commission and a graduate assistantship at the School of Psychology, Massey University. Thank you for believing in the value of this research enough to give it financial backing, and to the School of Psychology for providing me with the facilities to complete my research and the opportunity to work with such admirable colleagues and students.

Thank you to my participants. Without the time you spent to take part, this research would never have been possible. I would also like to thank Malcolm Dixon and those at Changing Minds (formerly Auckland Regional Consumer Network) who work tirelessly

to support, inform, and advocate. Thank you for pitching in by taking part in the research, promoting it, and the practical assistance provided by several members. Thank you also for reminding me of the value of my own experience as a consumer.

To my friends and family who have continued to support me for so long. I would especially like to thank Sarah Calvert for helping me to gather up the courage to follow this path of research in the first place, for supporting me as a friend and someone who I have looked up to through this process. To Joanna Sheridan for bringing music back into my life at a time when I needed it most and for encouraging me to dream big. Thank you also to those who provided practical assistance: Alexis Brook for helping me fight with Word and those who responded to my various requests for help.

And finally, to Christ, who is my constant when nothing else is certain.

## TABLE OF CONTENTS

---

<b>ABSTRACT</b> .....	<b>i</b>
<b>ACKNOWLEDGEMENTS</b> .....	<b>ii</b>
<b>TABLE OF CONTENTS</b> .....	<b>iv</b>
<b>LIST OF TABLES</b> .....	<b>vii</b>
<b>LIST OF FIGURES</b> .....	<b>vii</b>
<b>PROLOGUE</b> .....	<b>viii</b>
<b>CHAPTER 1: INTRODUCTION</b> .....	<b>1</b>
<b>Overview</b> .....	<b>1</b>
The applicability of religion and spirituality to mental health .....	1
The consideration of religion and spirituality in mental health care .....	2
<b>Aims and objectives of the present study</b> .....	<b>4</b>
To what extent is religion and spirituality considered in mental health care? .....	4
Factors that predict the consideration of religion and spirituality .....	5
<b>Outline of the dissertation</b> .....	<b>6</b>
<b>CHAPTER 2: RELIGION, SPIRITUALITY, AND MENTAL HEALTH</b> .....	<b>9</b>
<b>What are religion and spirituality?</b> .....	<b>9</b>
<b>The associations between religion, spirituality, and mental health</b> .....	<b>13</b>
Religion, spirituality, and mental health: An overview.....	14
How are religion and spirituality relevant to mental health outcomes? .....	16
Predisposing and protective functions.....	17
Precipitating, perpetuating, and ameliorative functions .....	35
<b>CHAPTER 3: CONSIDERING RELIGION AND SPIRITUALITY: CONTEXTUAL ISSUES</b> .....	<b>49</b>
<b>Historical context</b> .....	<b>50</b>
<b>Current context</b> .....	<b>51</b>
Political and philosophical paradigms.....	51
Institutional and practitioner views .....	54
<b>Impediments to considering religion and spirituality in mental health care</b> ....	<b>57</b>
The ‘religiosity gap’ .....	58
Practitioner attitudes and assumptions regarding religion and spirituality .....	59
Harmful religious/spiritual beliefs.....	62
Professional and personal boundaries .....	63
Ontological and value differences .....	67

<b>Dealing with impediments.....</b>	<b>70</b>
Responding ethically to religion and spirituality.....	70
Education and training.....	74
Self-practice/self-reflection.....	75
<b>CHAPTER 4: CONSIDERING RELIGION AND SPIRITUALITY: MODELS AND METHODS.....</b>	<b>78</b>
<b>Models of considering religion and spirituality .....</b>	<b>78</b>
Multicultural competencies model .....	79
Common factors approach.....	86
Cultural safety.....	89
Cultural competence outcome research.....	93
<b>Methods of considering religion and spirituality.....</b>	<b>94</b>
Assessment .....	94
Case conceptualisation.....	96
Treatment.....	99
Outcomes of spiritually-directive and -integrated treatments .....	103
<b>CHAPTER 5: CLIENTS' PERSPECTIVES AND THE PRESENT STUDY .....</b>	<b>107</b>
<b>The consumer and recovery movements: Applicability to     religious/spiritual clients .....</b>	<b>109</b>
Client participation in service evaluation .....	110
<b>Clients' preferences .....</b>	<b>111</b>
<b>Is religion and spirituality considered in mental health care? .....</b>	<b>112</b>
Current empirical evidence.....	113
Limitations of current literature.....	115
The New Zealand context.....	117
<b>Factors that predict the consideration of religion and spirituality .....</b>	<b>119</b>
Importance to clients.....	121
Client expectations .....	122
Client-practitioner matching.....	124
Profession .....	126
Sector .....	127
Country .....	130
Direct assessment .....	133
Practitioner understanding.....	134
<b>Summary of aims and hypotheses .....</b>	<b>136</b>
<b>CHAPTER 6: METHOD .....</b>	<b>139</b>
<b>Participants .....</b>	<b>139</b>
Sampling and recruitment.....	139
Demographic characteristics.....	140

<b>Procedure .....</b>	<b>146</b>
Ethics .....	146
Questionnaire.....	146
Variables and measures .....	149
<b>Analysis strategy .....</b>	<b>154</b>
Part One .....	154
Part Two .....	157
Summary of planned analyses .....	166
<b>CHAPTER 7: RESULTS .....</b>	<b>167</b>
<b>Part one: To what extent is religion and spirituality discussed and considered in the care of New Zealand clients? .....</b>	<b>167</b>
Clients who placed importance on consideration of religion/spirituality.....	170
<b>Part two: Factors that predict the consideration of religion and spirituality... 172</b>	
Associations between explanatory and outcome variables .....	172
Associations between explanatory variables .....	179
Tests of hypotheses .....	183
<b>CHAPTER 8: DISCUSSION.....</b>	<b>193</b>
<b>Findings .....</b>	<b>194</b>
Religion and spirituality in New Zealand mental health care: Missing pieces?... 194	
Factors that predicted discussion of religion/spirituality .....	195
Factors that predicted consideration of religion/spirituality.....	197
Factors that predicted clients' satisfaction with consideration of religion/spirituality .....	199
<b>Implications and recommendations.....</b>	<b>201</b>
Implications and recommendations for practice and policy.....	201
Implications and recommendations for religious/spiritual clients .....	204
<b>Limitations .....</b>	<b>205</b>
<b>Contributions and strengths .....</b>	<b>207</b>
<b>Future research.....</b>	<b>211</b>
<b>Conclusion .....</b>	<b>214</b>
<b>REFERENCES .....</b>	<b>215</b>
<b>APPENDICES.....</b>	<b>250</b>
<b>Appendix A: Participant recruitment .....</b>	<b>250</b>
<b>Appendix B: Participant information sheet.....</b>	<b>252</b>
<b>Appendix C: Questionnaire .....</b>	<b>253</b>
<b>Appendix D: Post-hoc analyses .....</b>	<b>260</b>

## LIST OF TABLES

---

Table 1. <i>D. W. Sue et al.'s (1992) model of cultural competencies</i> .....	81
Table 2. <i>Frazier and Hansen's religion/spirituality in psychotherapy competencies</i> ....	85
Table 3. <i>Demographic characteristics of participants, full [international] sample</i> ....	142
Table 4. <i>Demographic characteristics, New Zealand sample</i> .....	145
Table 5. <i>New Zealand clients' experiences of religion/spirituality in mental health care</i> .....	169
Table 6. <i>New Zealand clients' experiences of religion/spirituality in mental health care ('Importance' group)</i> .....	171
Table 7. <i>Associations between explanatory and outcome variables</i> .....	173
Table 8. <i>Association between Match Status and Consideration: Moderation by Sector</i> .....	176
Table 9. <i>Association between extent of Consideration and Satisfaction with consideration</i> .....	178
Table 10. <i>Associations between explanatory variables</i> .....	181
Table 11. <i>Discussion logistic regression model</i> .....	186
Table 12. <i>Consideration logistic regression model</i> .....	189
Table 13. <i>Satisfaction logistic regression model</i> .....	192
Table 14. <i>Matching-Expectations-Assessment crosstabulation</i> .....	260
Table 15. <i>Matching-Country-Assessment crosstabulation</i> .....	260
Table 16. <i>Consideration-Expectations-Satisfaction crosstabulation</i> .....	260

## LIST OF FIGURES

---

Figure 1. <i>Facebook advertisement</i> .....	250
Figure 2. <i>Letterbox flyer</i> .....	250

## PROLOGUE

---

The decision to investigate certain research questions inevitably arises from researchers' own professional and/or personal experiences and background. This can simultaneously colour the conclusions of research and bring them life. The topic of this dissertation arose from my own lived experience as a consumer of mental health services during my adolescence. During this time I strongly adhered to evangelical Christian beliefs that were important themes in my difficulties but also greatly assisted my coping and recovery. During my time of being unwell, I accessed both public and private mental health care services but held a particular suspicion of public 'secular' mental health services. Indeed, it was this suspicion and associated sole reliance on church-based solutions that delayed much needed treatment. At a certain point, publically provided services became essential to my treatment, and I was fortunate to be assisted by a clinician who shared and was respectful of my faith. At the time, however, I felt that she was limited in the extent to which she could explore the impact of those beliefs and practices with me. Not long afterward I was admitted to a residential facility in Australia whose treatment principles were founded on Christian doctrine, but lacked the professional training that may have made my journey to recovery less convoluted. Nevertheless, the assistance I received from the 'secular' public service, the 'religious' residential facility, and my personal faith led me to recovery over a period of three years that I continue to enjoy ten years later.

During the period of these ten years my personal faith has changed greatly, being coloured by many 'grey areas' during my own adult development and in the context of eight years of clinical psychology training. This has occurred alongside three years of working with young Christian women in a residential facility similar to the one in which I was treated myself, and providing psychological services in several mainstream services during my training. In the former, I have witnessed young women utilise their faith in ways that have brought both profound healing and profound pain, and I have had the privilege of supporting some through this journey. In the latter as a psychology trainee, I have struggled with the question of whether to raise the topic of religion/spirituality during assessment and therapy, and questioned whether I would be censured by my peers and supervisors for doing so.