Missing Pieces?
Considering Religion and Spirituality in Mental Health Care

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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.

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

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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 priviledge 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.