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.

Reflexivity is the practice of locating one's worldview in relation to the research, and considering how this might influence the research process (cf. Mays & Pope, 2000). This concept is not commonly acknowledged in quantitative research (Ryan & Golden, 2006), although it seems prudent to address this with a topic that is as culturally-bound as spirituality and religion because "How one understands, studies and explains spirituality may be considered as much related to the individual researcher's beliefs and worldview, as to his or her discipline, methods or subjects" (Egan, 2009, pp.118-119). The research presented in this thesis has been influenced by my various identities: as a prior consumer of mental health services, as a Christian, and as a clinical psychology practitioner. While it is not possible to identify all the ways in which my identities have influenced the process and outcome of the research, it should be noted that in the first instance, it was my experience as a consumer and as someone with religious/spiritual beliefs that led me to believe this research was a worthwhile area of investigation.

While religion/spirituality has been particularly important to me, this aspect of my life is less a part of my identity nowadays. I believe this has helped me develop a better understanding of the types of strengths and difficulties both clients and practitioners may encounter along the continuum of R/S experience - from the strongly religious/spiritual to one who has a foot in the world of religion/spirituality and another in the world of agnosticism. Finally, my occupation throughout the research as a clinical psychology trainee and currently as a practicing intern psychologist has reinforced my position that clients' individual values and beliefs are important regardless of the positioning of the practitioner or researcher. This has encouraged me to broaden the scope of my definitions, literature review, and participant recruitment to incorporate a range of religions and spiritualities, and to recognise the value of ontological and epistomological paradigms beyond the positioning of this research.

Through my personal and professional experiences, and the process of this research I have begun to understand the complexity of the roles of religion and spirituality in mental health and mental health care. I am certain there is much more to learn. It is my hope that in drawing together a holistic view of our clients, we would ensure that religion and spirituality do not become 'missing pieces' in this picture.

CHAPTER 1

INTRODUCTION

A burgeoning literature in the last two decades has drawn attention to the role that religion and spirituality play in the lives of countless individuals. From providing meaning and hope in the midst of the most formidable of tragedies, to providing justification for the destruction of innocent lives, religion and spirituality feature in the human psyche in intricate and powerful ways. Although characterised by a detached fascination in the early 20th century, the relationship between religion, spirituality, and the theory and practice of psychology has more recently begun to undergo a period of reconciliation. Part of this has come in the form of a recognition that religion and spirituality are integral parts of many individuals' psychological make-up and should be considered as part of the holistic care of those who find themselves dealing with mental health difficulties. An overview of the dissertation will be provided in this chapter, along with its aims, objectives, and structure.

OVERVIEW

The applicability of religion and spirituality to mental health

> *Try as we might to maximise significance through our own experiences and insights or through those of others, we remain human, finite, and limited. At any time we may be pushed beyond our immediate resources, exposing our fundamental vulnerability. Religion provides some solutions. The solutions may come in the form of spiritual support when other sources of support are lacking, explanations when no other explanations seem convincing, a sense of control through the sacred when life seems out of control, or new objects of significance when old ones are no longer compelling (….) Perhaps that is why the sacred becomes most compelling for many when human powers are put to their greatest test (Pargament & Brant, 1998, p. 125).*

At any one time, a substantial proportion of the population is faced with difficult life circumstances, some which precipitate an ongoing period of psychological distress and dysfunction (Browne, 2006). At times, this distress and dysfunction are significant enough for individuals to seek or require the assistance of a mental health practitioner. As the quote by Pargament and Brant (1998) demonstrates, religion and spirituality are often powerful aspects of human life that provide a source of significance and comfort, protecting individuals from psychological difficulties and helping individuals to cope adaptively with difficult circumstances. At other times, religion and spirituality are 'solutions' which become a source of difficulty and can perpetuate ongoing distress and dysfunction (e.g., Ellison & Lee, 2010). Many individuals who consult with mental health practitioners hold religious and/or spiritual beliefs (Bellamy et al., 2007; de Beer, 1998), and those who rely upon religion and spirituality as a source of significance often express that they would like mental health practitioners to pay attention to the role of religion and spirituality in their recovery (R. D'Souza, 2002; Rose, Westefeld, & Ansley, 2001).

The consideration of religion and spirituality in mental health care

Throughout this dissertation, spirituality is referred to as a personal or group search for the sacred, while religion is referred to as a personal or group search for the sacred that unfolds within a traditional sacred context (Zinnbauer & Pargament, 2005). Due to the degree of conceptual and empirical overlap (Chapter Two explores this issue in more depth), religion and spirituality will be referred to as religion/spirituality (R/S).

Religion and spirituality can be thought of as forms of culture (A. B. Cohen, 2009). The ability of practitioners to consider the cultural aspects of their clients' mental health has been deemed one of six core competencies in psychotherapy (Sperry, 2010). Practitioners' consideration of culture in mental health care has been associated with a range of positive client outcomes (e.g., Constantine, 2002; Huguelet et al., 2011; J. Owen, Leach, Wampold, & Rodolfa, 2011; P. Wade & Bernstein, 1991; E. L. Worthington, Hook, Davis, & McDaniel, 2011). In qualitative studies, clients who feel that their culture and/or religion/spirituality has been appropriately considered in their care often report feeling understood, validated, accepted and safe, and express positive

views of their practitioner (Gockel, 2011; Knox, Catlin, Casper, & Schlosser, 2005). Those who feel their religion/spirituality has not been considered sometimes report a deterioration in their relationship with their practitioner and feel as though an important aspect of their life has been omitted from their care, sometimes resulting in termination of therapy (Gockel, 2011; Knox, et al., 2005; Stamogiannou, 2007).

Respect for and consideration of clients' religious/spiritual beliefs and practices, as an aspect of human diversity, is mandated by many mental health service standards and ethical guidelines (e.g., American Psychological Association, 2002, 2003; Joint Commission on the Accreditation of Healthcare, 2008; New Zealand Psychologists Board, 2002; Standards New Zealand, 2008), yet it is commonly stated that mental health practitioners neglect or minimise R/S in their work with clients (e.g., Neeleman & Persaud, 1995; P. S. Richards & Bergin, 2005; Verhagen, 2010). The limitations of current evidence make it difficult to determine whether clients do indeed feel as though their religious/spiritual beliefs are neglected or minimised in their care. A particular uncertainty is whether the claims of neglect and minimisation are applicable to the unique sociocultural context of New Zealand, where the consideration of indigenous forms of spirituality is mandated by a secular state (Adhar, 2003). If R/S is being considered in clients' care, it is unclear whether clients are generally satisfied with the way this occurs. Finally, more work is needed to understand what factors might predict the consideration of R/S in mental health care. This knowledge is essential to ensuring the future improvement of clients' experiences.

AIMS AND OBJECTIVES OF THE PRESENT STUDY

The importance of religion/spirituality to clients and their mental health outcomes necessitates a closer examination of the consideration of religion/spirituality in mental health care from a client perspective. Clients' perspectives are integral to evaluating cultural competence (Papps & Ramsden, 1996; Ramsden, 1990) and are important to clients' successful recovery (Anthony, 1993). The purpose of the present study was to examine two over-arching questions from a client perspective: First, to what extent is religion/spirituality considered in the mental health care of New Zealand clients? Second, what factors predict the consideration of religion/spirituality in mental health care?

To what extent is religion and spirituality considered in mental health care?

The first aim of the present study was to seek New Zealand clients' perspectives on the extent that they perceived religion/spirituality had been considered in their care. In doing so, the study sought to determine the generalisability of claims that clients' religious/spiritual beliefs are neglected and minimised. It was hoped that providing an estimate of the extent that R/S is considered in clients' care would provide information that will allow stakeholders, including clients, practitioners, service providers, researchers and policy makers to determine whether further action is required. The study intended to fulfill the first aim by surveying 454 New Zealand religious/spiritual clients on their experiences of R/S being considered during their most recent contact with a mental health practitioner. It was intended this would take place outside of the constraints of a particular service or sector so that a range of clients' experiences could be sampled.

The majority of previous studies investigating the consideration of religion/spirituality in mental health care have asked clients one of three questions: whether their practitioner asked about R/S, whether they discussed R/S at all with their practitioner, or whether they perceived R/S was considered in their care (e.g., Awara & Fasey, 2008; Borras, Mohr, et al., 2010; de Beer, 1998; Huguelet, Mohr, Borras, Gillieron, & Brandt, 2006; Lindgren & Coursey, 1995). Drawing conclusions on the basis of response to any one of these questions alone is likely to produce an incomplete understanding of whether R/S is considered by practitioners. To gain a more comprehensive

understanding of the consideration of R/S in clients' care, all three of these questions were asked. In addition, clients were asked whether they were satisfied with the way R/S had been considered. There is evidence that estimates of the consideration of R/S are also more pessimistic when clients who do not place importance on the consideration of their R/S are included in the response (Lindgren & Coursey, 1995; Pieper & van Uden, 1996). This was accounted for by the present study.

Factors that predict the consideration of religion and spirituality

Part two of the study aimed to investigate factors that predict the consideration of religion/spirituality in clients' care and clients' satisfaction with this. It is hoped that identifying such factors will provide avenues for action and/or further investigation. To fulfill this aim, the sampling frame was extended to to an international sample of clients, resulting in a total of 725 participants from New Zealand and other countries including Australia, the United States and England.

Hierachical logistic regression was utilised to investigate the association of eight factors with whether clients discussed religion/spirituality with their practitioner, the extent that clients perceived that R/S was considered in their care, and clients' satisfaction with this consideration. The factors thought to predict these outcomes were drawn from a review of the literature. For example, previous authors have asked whether client-practitioner matching on R/S variables might be of use (Zinnbauer & Barrett, 2009), others have highlighted a need to investigate public/private sector differences in the consideration of R/S (E. L. Worthington, Kurusu, McCullough, & Sandage, 1996), and others have wondered whether asking clients about their religious/spiritual beliefs is useful or detrimental (Knox, et al., 2005). The factors investigated included the importance clients placed on the consideration of R/S, clients' expectations, client-practitioner matching, the direct assessment of clients' religious/spiritual beliefs, practitioner profession, sector, country, and clients' perceptions of the degree to which their practitioner understood the relevance of religious/spiritual beliefs to their recovery.

OUTLINE OF THE DISSERTATION

The dissertation is structured within eight chapters including the introduction, a literature review (Chapters Two through Five), methods (Chapter Six), results (Chapter Seven), and discussion (Chapter Eight). An outline of each chapter is provided here.

The purpose of Chapter Two is to provide an overview of the complex associations between religion, spirituality and mental health. Theoretical and empirical work is reviewed with reference to the ways R/S can increase and decrease the risk of psychological difficulties. To this end, the roles of R/S in predisposing and protecting individuals from future psychological difficulties are reviewed. The roles of R/S in precipitating and perpetuating psychological difficulties are also outlined, as are their roles in ameliorating the effects of difficulties and assisting recovery. From this evidence, it is argued that the religious/spiritual beliefs of individuals require consideration in the provision of mental health care.

Chapter Three introduces contextual issues surrounding the consideration of R/S in mental health care. This starts by considering the historical relationship between R/S and psychology and then the influences of secularism and scientific philosophies on the current relationship. Authors have cited a number of impediments to the consideration of R/S in mental health care. These are outlined and include issues such as differential rates of R/S identification between clients and practitioners, attitudes and assumptions held by practitioners, learning to ethically address 'harmful' religious/spiritual beliefs, issues surrounding professional and personal boundaries, and differences between the ontology and values of religious traditions and spiritualities, and those of psychology. Solutions are offered and an ethical response is outlined for use when R/S clients present to mental health care services. The role of education and training to deal with these impediments is also outlined. The chapter concludes that the contextual issues and challenges faced by clients and practitioners are not insurmountable.

Chapter Four outlines the status of religion and spirituality as forms of culture and examines the applicability of cultural competence models to the consideration of R/S in mental health care. The conceptual foundations of the present study are presented in the

form of the multicultural competencies model and the common factors approach. Because these models lack recognition of sociopolitical issues (common factors) or client participation (multicultural competencies), the concept of cultural safety is presented as a critical addition to these models. The contributions of cultural competence to therapeutic process and outcome variables are outlined. Tools have been developed to assist practitioners in considering R/S throughout assessment, case formulation and treatment. These are outlined, along with relevant outcome research.

Chapter Five outlines criticisms from a number of authors that mental health clients' religious/spiritual beliefs are, in general, neglected and minimised. The current evidence for this is explored, as are its limitations. This chapter outlines ways in which the limitations of the current literature can be addressed. In addition to methodological difficulties, these limitations include (a) the discrepancy between practitioner and client reports of the extent to which R/S is considered in mental health care, (b) the lack of information on clients' satisfaction with consideration, (c) the lack of evidence applicable to the unique sociocultural context of New Zealand and (d) the lack of knowledge about the factors that are associated with clients' perceptions that R/S is considered. The first part of the chapter addresses these first three limitations, while the second part addresses the last limitation. This second part proposes a number of factors that may influence whether the topic of R/S is discussed in mental health care, whether clients perceive R/S is subsequently taken into consideration by practitioners, and their satisfaction with this. These factors include the importance clients place on R/S considerations, clients' expectations of whether R/S will be addressed, client-practitioner matching, practitioners' direct assessment of clients' religious/spiritual beliefs, clients' perceptions that their practitioner understood the relevance of R/S to their recovery, the professional background of the practitioner, the country of consultation, and the sector within which consultation took place. The chapter concludes by summarising the aims and hypotheses investigated by the present study.

Chapter Six presents the methods utilised to achieve the aims of the present study. The recruitment and characteristics of participants are discussed, followed by an outline of the methodological procedures. These include the various factors involved in the development and dissemination of a client self-report questionnaire, as well as the

measures and statistical analysis methods used. The analysis strategy outlines the exploration of two options for analysis; ordinary least squares regression and logistic regression, concluding that logisic regression was the most appropriate analysis method to use. The various considerations in the analysis are outlined, including data management, assumption checks, the types of statistics used, and the hierarchical entry of variables.

Chapter Seven presents the results, dividing the study into two parts. Part One presents descriptive and inferential statistics to examine the extent that New Zealand clients report R/S is discussed and subseqently considered in their care, including their satisfaction with this. Results are provided for all New Zealand participants and two subgroups: those who placed importance on the consideration of their religious/spiritual beliefs, and those who saw practitioners in the public sector. Part Two presents three regression analyses, the first of which was to investigate variables that predict whether clients discuss R/S with their practitioner. The second two analyses were conducted using the subsample of clients who did discuss R/S. These investigated variables that predicted (a) the degree to which R/S was considered in clients' care and (b) clients' level of satisfaction with the way R/S had been considered.

Chapter Eight discusses the findings of the present study, and their implications for practice and religious/spiritual clients. The limitations, strengths, and contributions of the study are outlined. Suggestions for future research are proposed, and the conclusions of the study are presented.

CHAPTER 2

RELIGION, SPIRITUALITY, AND MENTAL HEALTH

The role of religion and spirituality in mental health and mental illness has been a subject of fascination and debate since ancient history (Millon, 2004). The psychology of religion is now far removed from the magical, mythological, and demonological explanations of the human mind and behaviour that have existed for millenia and continue to do so. A number of shifts in modern thought in the last two centuries have led to a proliferation in the empirical investigation of religion and spirituality's influence on mental health. This body of literature has expanded to the point where many health and social care regulators have begun to require that mental health practitioners consider the influences of religion and spirituality in clients' presentations and their subsequent care (e.g., Accreditation Council on Graduate Medical Education, 1994; American Psychiatric Association, 1994; American Psychological Association, 2002). The purpose of this chapter is to present an overview of this body of empirical literature in a manner that allows for practitioners to assess and consider the potential relevance of religion and spirituality for their clients. Before commencing with a review of the ways in which religion, spirituality, and mental health are inter-connected, the definitions of religion and spirituality need to be visited. This has been an area of much debate and requires careful consideration.

WHAT ARE RELIGION AND SPIRITUALITY?

To a large extent, past usage of the terms 'religion' and 'spirituality' has been interchangeable (Tanyi, 2002; Zinnbauer & Pargament, 2005). However, Western societies have moved away from organised religion toward individualised faith in the second half of the 20th century, resulting in increased separation of the terms (P. Hill et al., 2000). This has been reflected in individuals' self-designations as 'religious' and/or 'spiritual'. Although most participants in these studies tend to consider themselves both religious *and* spiritual, a large minority identify as 'spiritual, *not* religious', and a smaller minority identify as 'religious, *not* spiritual' (Shahabi et al., 2002; Zinnbauer et al., 1997).

Research trends have moved toward increasing efforts to distinguish spirituality as conceptually different from religion; nearly a quarter of studies reviewed by Ribaudo and Takahashi (2008) were devoted to this effort. A brief review of the early literature, however, reveals a mass of seemingly unrelated concepts. This is reflected by Pargament's (1999, p. 4) statement "over scores of years, religion has been called the supernatural, the ultimate, the institutional, the creedal, the ritual, the experiential, the ethical, the temperamental, and the directional".

Although a substantial proportion of the [predominantly American] psychological literature continues to use the terms 'religion' and 'spirituality' interchangeably, research needs to consider the unique meanings attached to each term. Important distinctions between these two concepts have been highlighted..For example, participants in a U.S. survey defined religiousness as the observance of traditional, institutionally-based rituals and belief systems. Spirituality was most often defined as a personal experience, connection, or relationship with transcendence or a higher power, and was considered *inclusive* of more traditional forms of observance (Zinnbauer, et al., 1997). Similar distinctions between religion and spirituality have been reported elsewhere (Hyman & Handal, 2006; Mattis, 2000; Nelson-Becker, 2003; L. Walker & Pitts, 1998; Woods & Ironson, 1999; Zinnbauer & Pargament, 2002).

Despite distinctions made between the concepts of religion and spirituality, common elements have been noted to exist (Zinnbauer, et al., 1997). References to beliefs 'in' or 'about' an entity or transcendence tend to be found in definitions of either construct. A behavioural aspect (an outworking of these beliefs) also tends to be a common reference, as are references to the sacred (found in 87% of the definitions provided by Zinnbauer's participants). Belief in the 'sacred' refers to belief in dimension/s, experiences, and entities which transcend/go beyond the self. This can include (among others) super-natural connectedness to others, nature, and transcendent entities, concepts of the divine, and objects or concepts that come to represent or are associated with the sacred (P. Hill, et al., 2000; Zinnbauer, Pargament, & Scott, 1999).

It is important to note that the concept of spirituality is broad and is not necessarily constrained to the sacred. For example, some Māori in New Zealand refer to spirituality (‘wairua’) as a sense or form of transcendent connectedness (Egan, 2009; Valentine, 2009) - similar to the concept of sacredness - while others refer to it as an “intuitive consciousness” (Valentine, 2009, p.135). Other individuals position themselves within humanistic and existential paradigms. Humanistic views of spirituality define spirituality as including values and beliefs, ethics, well-being, or achieving a particular affective state (cf. Egan, 2011; Zinnbauer et al., 1997). Existential views often refer to aspects such as “the vital principle of human beings that gives life” (Hill & Smith, 1990, p.184) and ultimate meaning and purpose (e.g., McCurdy, 1998). Furthermore, individuals often hold ‘summative’ conceptualisations of spirituality that refer to humanistic, existential, and other elements alongside sacred ones (Egan et al., 2011; Unruh, Versnel, & Kerr, 2002). Each of these positions are equally valid given their socially constructed nature, and their relevance is likely to differ according to their context. From a psychological perspective, it is the author’s position that all humans possess value and belief systems (humanist), and engage in the creation of meaning and purpose (existentialist), but that these are characteristics which can exist within or outside a sacred paradigm.

It is common for contemporary definitions of spirituality to contain concepts which overlap with psychological concepts. While this may not be problematic in most settings, it creates some unique challenges for research and practice in mental health care. For example, overlap between spiritual and psychological constructs in mental health research can result in the spurious inflation of associations between spirituality predictors and psychological outcomes (Koenig, 2008a). In following the humanistic idealism of psychology (Bergin, 1980), existential and humanistic issues, particularly those pertaining to meaning, values, and beliefs are already commonly addressed in psychological practice (e.g., Miller & Rollnick, 2013). In contrast, aspects of spirituality that are not usually constructed as part of psychology’s secular paradigm (e.g., transcendence) may be overlooked. This suggests that the sacred aspect of spirituality (and religion) requires particular attention.

To meet these challenges and avoid the re-definition of psychological constructs as spiritual constructs, it is necessary for this thesis (at least until a more satisfying consensus emerges) to constrain the definition of spirituality to that which refers to the sacred (cf. Hill et al., 2000; Pargament, 1999). This starts by ensuring that reviewed literature on the associations between religion, spirituality, and mental health does not conflate these constructs. The same position is held throughout this thesis, including the definition of spirituality presented to participants. While the sacred element is retained as the core feature of spirituality (and religion), it is acknowledged that many participants will also hold non-sacred elements as a part of their construction of spirituality or religion. In practice, clinicians may wish to be open to the likelihood that clients identifying as spiritual[a] will define their spirituality broadly.

Several well-argued definitions of spirituality and religion are available (e.g., P. Hill, et al., 2000; Pargament, 1999; Zinnbauer & Pargament, 2005; Zinnbauer, et al., 1997). However, Zinnbauer's (2005) definitions are most consistent with the popular idea that spirituality is a broader concept than religion. Spirituality is therefore defined as "a personal or group search for the sacred", and religiousness as "a personal or group search for the sacred *that unfolds within a traditional sacred context*" (p.35, emphasis added). The term 'search' is used to denote the pursuit of a goal (Zinnbauer & Pargament, 2005). 'Search for the *sacred'* is used to refer to the process of identifying and articulating what is sacred, as well as maintaining and transforming a relationship with, understanding of, or adherence to the sacred (P. Hill, et al., 2000). As it appears that these definitions maintain the most appropriate balance between inclusiveness and clarity, the remainder of this dissertation will refer to these definitions of religion and spirituality.

The psychological literature and the empirical work contained within it has only recently begun to differentiate between religiousness and spirituality. Therefore, for

[a] One argument suggests that all humans are spiritual (however defined) and therefore have spiritual needs or beliefs they may wish their healthcare practitioners to address (cf. Egan, 2009). The author holds the position that individuals choose whether or not to construct spirituality as a part of their identity, and the content of this construction depends heavily upon the individual's cultural context. From the stance that individuals choose whether to include spirituality in their identity, it is held that the same individuals also choose whether or not they have spiritual needs.

simplicity and to keep in accordance with the bulk of the literature, this dissertation will use the term 'religion/spirituality' (R/S), except where literature refers to one or the other.

THE ASSOCIATIONS BETWEEN RELIGION, SPIRITUALITY, AND MENTAL HEALTH

The most recent New Zealand census indicates that two-thirds (68%) of the New Zealand population affiliate with a religious organisation (Statistics New Zealand, 2006). A survey of 917 New Zealanders reported that 72% identified as being religious, spiritual, or both, and 74% reported believing in God or a higher power. Fewer (17%) regularly attend religious gatherings (International Social Survey Program Research Group, 2008). Like the rest of the general population, a number of those who consider themselves to be religious/spiritual experience mental health difficulties at some point in their lives. A national mental health survey conducted with 12,992 individuals across New Zealand (Browne, 2006) led to the estimation that nearly half (47%) of the population experiences a diagnosable mental illness before the age of 75.

Thousands of studies have investigated the associations between religion, spirituality, and mental health. Until the last two decades, this body of literature was somewhat neglected by the mainstream research community (W. R. Miller & Thoresen, 2003). Its development in relative obscurity, recent exponential growth, and lack of cohesive theoretical foundations has resulted in what Krause (2011) describes as a 'dishevelled' body of literature in need of greater coherence. An attempt will not be made here to review the entirety of this literature; for a more comprehensive coverage the reader is referred to other sources (e.g., Koenig, 1998; Koenig, McCullough, & Larson, 2001; Koenig, King, & Carson, 2012; L. Miller & Kelley, 2008), including the *Handbook of Religion and Health* (Koenig, et al., 2001; Koenig et al., 2012), which reviews over 2500 studies in this field. Attention will be directed toward meta-analyses and longitudinal studies, as longitudinal studies are better able to assist in understanding the directionality of relationships, while meta-analyses provide a summary of findings.

The following review is broadly structured within the 'Five P's framework', which is commonly used by mental health practitioners to bring together and explain the influence of multiple factors on a client's mental health (cf. Weerasekera, 1993). This framework will be discussed in more detail shortly. The review will demonstrate that clients' religious/spiritual beliefs are potentially relevant in multiple ways and should be considered when developing an understanding of these clients' difficulties and strengths. This is particularly true for clients whose religious and spiritual beliefs are a central aspect of their lives.

It must be acknowledged that the majority of the research that will be reviewed here has been conducted with Western (specifically, American), Judeo-Christian populations. Although specific efforts will be made to review research conducted with other religious and cultural groups, the reader is encouraged to keep this limitation in mind. Finally, due to the expansiveness of the literature, the review is restricted to biopsychosocial factors (Engel, 1977) often included in generic and cognitive-behavioural formulations of psychological difficulties. Overall findings drawn from meta-analyses will be reviewed first, followed by a finer-grained analysis of the interactions between religion, spirituality and mental health using the Five P's framework.

Religion, spirituality, and mental health: An overview

When reviewing individual studies, the relationship between religion/spirituality and mental health appears to be inconsistent and often contradictory. An early meta-analysis reviewed 30 outcomes from 24 empirical investigations (Bergin, 1983). Approximately half of the outcomes (47%) were considered salutary, 23% negative, and 30% demonstrated no relationship. Overall, Bergin found a median effect size of -.06 between R/S and psychopathology. Such a result implies that this relationship is, at best, weak. Following this initial finding a number of authors (e.g., Ano & Vasconcelles, 2005; Hackney & Sanders, 2003) criticised the use of crude or global measures of R/S, used frequently in studies prior to the 1990's. Such measures focussed on religious involvement such as frequency of religious service attendance, or single-item ratings of commitment or intensity of belief. These measures did not account for the fact that religiousness and spirituality are multifaceted constructs that possess positive and

negative aspects (P. Hill & Pargament, 2003), likely to cancel each other out within studies (Koenig et al., 1997), and again when results across numerous individual studies are combined. Following Bergin's meta-analysis there has been an increase in published studies utilising multi-dimensional measures of R/S, leading to less ambiguous meta-analytic findings.

Two further meta-analyses were published in 2003. These investigated the relationships between R/S and psychological distress (Hackney & Sanders, 2003), and depression (T. B. Smith, McCullough, & Poll, 2003). Similar to Bergin's (1983) findings, both meta-analyses reported barely perceptible overall effect sizes. Recognising the multifaceted nature of R/S, both investigated 'types' of R/S as a moderator. Measures that assessed ideologies tended to return the lowest effect sizes (-.01 and -.05, respectively). Measures that assessed personal devotion (e.g., subjective attachment to God or conversational prayer) demonstrated the strongest inverse relationship with psychological distress and depression (-.11 and -.18, respectively). Measures of institutional religious involvement and R/S behaviours returned effect sizes that lay between those of attitudes/beliefs and personal devotion. Smith et al. investigated several additional moderators of the religion/spirituality-mental health relationship, finding that extrinsic religious motivation (the self-oriented use of R/S primarily for means and ends other than the sacred) was associated with greater levels of depression (.16). Positive religious coping (e.g., turning to the sacred in times of distress) was associated with lower levels of depressive symptomatology (-.18), while negative religious coping (e.g., making malevolent R/S appraisals of events) was associated with greater levels of symptomatology (.14). Ethnicity, age, and gender did not moderate the relationship between R/S and depression (T. B. Smith, et al., 2003).

Taken together, these meta-analytic findings lend support to the conclusion that a relationship between R/S and mental health exists and that the nature of this relationship depends upon the type of R/S being assessed. It seems that it is the function (i.e., means/ends of R/S, use of R/S in coping, personal devotion) rather than the mere substance of R/S (i.e., ideological beliefs, R/S behaviours) that hold the most robust association with mental health. According to Cohen's (1988) effect size classifications, the aggregated associations between R/S and mental health are small, but both meta-

analyses (Hackney & Sanders, 2003; T. B. Smith, et al., 2003) indicated significant hetereogeneity even after the inclusion of moderators. It is therefore important that practitioners consider the idiosyncratic contribution of R/S to their clients' mental health, neither assuming a strong or a weak association.

How are religion and spirituality relevant to mental health outcomes?

Although it is useful to know that religion/spirituality is related to mental health outcomes, in practice mental health practitioners are primarily concerned with which factors are actually relevant, and *how* they are relevant to specific clients' difficulties (Sturmey, 2009). This requires a synthesis of the theoretical mechanisms thought to explain the involvement of R/S in the development of particular difficulties and the aspects of a client's experience that either support a hypothesised explanation, or indicate alternative explanations (Kuyken, Padesky, & Dudley, 2009).

The 'Five P's' framework is arguably one of the most commonly used methods of achieving this synthesis (cf. Weerasekera, 1993). It is a generic model of case formulation used by a wide range of mental health practitioners (see for example, Dudley & Kuyken, 2006). The Five 'P's' are a useful heuristic for considering factors (including religion/spirituality) involved in the development, maintenance, and resolution of difficulties in a way that guides intervention (Dudley & Kuyken, 2006). The framework requires the practitioner to draw upon psychological theory and research to describe the client's presenting Problems and their possible Precipitants; hypothesise which factors may have Predisposed an individual to experiencing these difficulties, and develop an understanding of how these difficulties may be Perpetuated or maintained. Protective factors, which may have prevented or ameliorated difficulties in the past or have the potential to do so in the future, are identified to help build client resilience. These five areas: presenting Problem, Predisposing factors, Precipitating factors, Perpetuating factors, and Protective factors, make up the five 'P's of the framework.

There is an accumulating body of evidence suggesting that R/S can act as a protective factor and can also act as a predisposing, precipitating, and perpetuating factor. A recent review of the involvement of R/S in addiction treatment, for example, noted that R/S

can be considered as "a *protective* factor against drug addiction (...) and (...) a component of the recovery process (....) in some circumstances, religion may *precipitate* or contribute to *maintain [perpetuate]* drug use." (Borras, Khazaal, et al., 2010, p. 2358, emphasis added). The Five P's framework is traditionally problem-focussed; a shift in the paradigm of clinical psychology has been occuring that allows for a greater emphasis on client resilience and strengths (e.g., Kuyken, et al., 2009). For information on protective factors to be of greater use, practitioners need to consider the impact and utility of these as strengthening factors *throughout* the development and resolution of mental health difficulties rather than as an adjunct factor (Havighurst & Downey, 2009). For this reason, the protective roles of R/S will be considered alongside their predisposing, precipitating, and perpetuating roles. To do this, the impact of religion and spirituality on mental health will be reviewed in terms of their roles as predisposing to *and* protecting from future psychological difficulties; and as precipitating and perpetuating psychological difficulties *and* ameliorating stressors and psychological difficulties.

Predisposing and protective functions

Predisposing factors have been defined as "the distal external and internal factors that increased the person's vulnerability to their current problems" (Dudley & Kuyken, 2006, p. 21). A consideration of the predisposing and protective influences of R/S can contribute to an understanding of how clients' difficulties originated, how vulnerability to relapse might be decreased, and potentially how prevention programs can best be targeted for clients based on empirically identified risk and resilience factors (Dudley & Kuyken, 2006).

The term 'protective' is used here as an over-arching term that denotes R/S as playing two roles: a strength that acts independently to contribute toward mental health and reduce risk of psychological difficulties, and a resilience factor that mitigates the risk-increasing effects of other predisposing factors. Religion/spirituality is also discussed here as a predisposing factor that acts independently to increase the risk of psychological difficulties, and a factor that aggravates the risk-increasing effects of other predisposing factors.

Most research on the predisposing and protective roles of R/S has focused on risk of depression (Braam et al., 2004; Ellison & Flannelly, 2009; Pérez, Little, & Henrich, 2009; Strawbridge, Shema, Cohen, & Kaplan, 2001; van Voorhees et al., 2008). For example, a study conducted with 607 African American participants found that those whose religious/spiritual beliefs provided them with 'a great deal' of day to day guidance at initial assessment were half as likely to experience major depression three years later (Ellison & Flannelly, 2009). Other longitudinal studies link R/S to reduced risk of general psychological distress amongst midlife women (D. E. King, Cummings, & Whetstone, 2005); reduced substance use and dependence amongst adolescents (Brechting & Giancola, 2006; Good & Willoughby, 2011; Newcomb, Madahian, & Bentler, 1986); prevention of alcohol-use disorders amongst at-risk drinkers (Borders, Curran, Mattox, & Booth, 2010); reduced risk of eating disorders amongst young women (Homan & Boyatzis, 2010); reduced personality difficulties amongst young adult Mormons (Bartz, Richards, Smith, & Fischer, 2010); improved adolescent adjustment (Sallquist, Eisenberg, French, Purwono, & Suryanti, 2010); and decreased suicide attempts (Rasic, Robinson, Bolton, Bienvenu, & Sareen, 2011). There have also been several findings of prolonged life among those who are religious or spiritual (e.g., Kark et al., 1996; Koenig, 1999; Musick, House, & Williams, 2004). Findings are not entirely salutory however; one investigation found an increased risk of depressive symptoms amongst older adults with a Jewish religious preference compared to those who identified as Catholic (Kennedy, Kelman, Thomas, & Chen, 1996), although it is not clear how many of the participants in this sample had been exposed to trauma due to war and severe discrimination. Experiencing religious doubts has been associated with later decreases in emotional wellbeing amongst a large, religiously-diverse sample of individuals in the United States (Galek, Krause, Ellison, Kudler, & Flannelly, 2007). Additionally, Christian males who were anxious about their relationship with God have been found to experience increased levels of depression and distress four months later (Calvert, 2010). Overall, most studies lead to the conclusion that religious and spiritual beliefs are protective, consistent with the 'primary protective mechanism' of R/S proposed by McConnell, Pargament, Ellison and Flannelly (2006), although it is clear that this is not always the case. It is possible that religion and spirituality exert these effects by interacting with other predisposing factors, as well as by acting independently

to influence later mental health. The following discussion will focus primarily on the interaction of religion and spirituality with several well-established predisposing factors to mental health difficulties including formative experiences, attachment, cognitive styles, social influences, and personality (Hankin, 2005; Overholser, 1998a).

Formative experiences.

The term 'formative experiences' refers to events and circumstances, which fundamentally influence the development of core schemas and behavioural repertoires and later influence mental health (e.g., Waller et al., 2001). As behavioural patterns and core schemas are, for the most part, laid down during childhood and remain relatively stable into adulthood (Riso et al., 2006; J. E. Young, Klosko, & Weishaar, 2003), the following discussion will focus primarily on this developmental period.

Arguably the most investigated childhood formative experiences, showing the most robust associations with later mental health, are those of a traumatic or stressful nature. Abuse in particular has been prospectively associated with substantially increased odds of a broad range of psychological difficulties (e.g., Silverman, Reinherz, & Giaconia, 1996; Spataro, Mullen, Burgess, Wells, & Moss, 2004; Widom, DuMont, & Czaja, 2007). Religious and spiritual beliefs can both create and interact with formative experiences in ways that influence individuals' views of themselves and others. Specifically, research has demonstrated the role of religion in the perpetration of abuse and coping with abuse (e.g., Bent-Goodley & Fowler, 2006; Bottoms, et al., 2003; Valentine & Feinauer, 1993). Research has also examined the ways in which abuse affects individuals' religious/spiritual beliefs later in life.

In some cases, religious beliefs can be used to justify and perpetuate abuse (Bent-Goodley & Fowler, 2006; Bottoms, Shaver, Goodman, & Qin, 1995; Saradjian & Nobus, 2003) (see the *Qur'an* 4:34 and the *Bible* Proverbs 23:13-14 for examples of texts sometimes used to justify physical abuse), particularly by religious individuals scoring highly on fundamentalism (Fisher, 1999; Koch & Ramirez, 2010) or extrinsic religious orientation (Dyslin & Thomsen, 2005). Religion-related abuse is of particular significance because without religious elements, the perpetrator is the primary threat. In

circumstances of religion-related abuse, however, a powerful sacred (e.g., God) or social (e.g., the Church) figure is added as a threat while simultaneously compromising a potential avenue for coping (Bottoms, Nielsen, Murray, & Filipas, 2003; Pargament, Murray-Swank, & Mahoney, 2008). Although very little empirical research has investigated the compounding effect of religious elements, one retrospective study found that although the basic characteristics of abuse experiences were similar, individuals who had experienced religion-related physical abuse scored significantly higher on scores of depression, anxiety, hostility, paranoia, and obsessive-compulsive tendencies compared to those who had experienced non-religion-related abuse (Bottoms, et al., 2003). Two earlier studies found that the children of parents who used the threat 'God will punish you' tended to engage in higher levels of self-blame than those who did not receive or believe such threats (Nelsen & Kroliczak, 1984; Nunn, 1964). On the other hand, religiousness/spirituality *per se* is not necessarily predictive of abuse (e.g., Koch & Ramirez, 2010). Parental religiosity has been found to positively correlate with observer-rated authoritative (collaborative) parenting styles, and negatively to authoritarian (punitive) parenting styles; over and above the effects of parental education, income, and family structure (Gunnoe, Hetherington, & Reiss, 1999). Authoritative parenting has been longitudinally associated with children's positive adjustment (Adalbjarnardottir & Hafsteinsson, 2001; Shucksmith, Hendry, & Glendinning, 1995). However, when abuse does occur, and when religious elements are involved, the effects on the victim may be particularly detrimental.

Abuse can profoundly affect individuals' subsequent engagement in R/S in at least two ways. First, individuals who have experienced abuse sometimes turn to R/S as a source of comfort and healing. Interviews with adult females who had experienced childhood sexual abuse reported that R/S helped in several ways: to obtain a sense of hope and resilience, reduce self-blame, find meaning and purpose, and provide a social support system (Valentine & Feinauer, 1993). Abuse can also negatively influence R/S engagement; a recent systematic review of the effects of abuse on individuals' R/S suggests that childhood abuse is more likely to influence religious/spiritual beliefs in a negative manner (D. Walker, Reid, O'Neill, & Brown, 2009), potentially removing an important protective factor and leading to the development of beliefs about the sacred as malevolent or disinterested in the plight of the individual (e.g., Fallot & Heckman, 2005;

Kane, Cheston, & Greer, 1993; Reinert & Edwards, 2009). Walker et al.'s findings appeared to be more valid for individuals who were younger at the time of the abuse and who were abused by an attachment figure, suggesting that early maladaptive schemas developed during this time may have also generalised to the individuals' view of the sacred which may, in turn, have negative implications for mental health (cf. Calvert, 2010; Pargament et al., 1990). Noting the mixed results of some studies, however, Walker et al. concluded that those who were able to retain a positive image of the sacred were able to use this in coping and finding meaning and purpose in the aftermath of abuse (e.g., Galea, 2008; Gall, 2006; Gall, Basque, Damasceno-Scott, & Vardy, 2007). Early formative experiences are thought to profoundly influence attachment style, which will be discussed next.

Attachment.

Attachment theory has become one of the most influential theories by which clinicians have come to conceptualise childhood psychological development and the preconditions of psychopathology. Attachment refers to the tendency of individuals to develop emotional bonds with others perceived to be more powerful than the self (Bowlby, 1977). Individuals can be characterised as demonstrating one of four attachment styles, dichotomised as secure or insecure. Individuals with secure attachments find it relatively easy to form trusting relationships with others without fear of abandonment or becoming 'too' close. Insecure attachment styles are characterised as either anxious, including fears of abandonment and persistent seeking of closeness with attachment figures; avoidant, which feature distrust and a preference for emotional distance from attachment figures; or fearful, whereby close relationships are desired but simultaneously perceived as threatening (Bartholomew & Horowitz, 1991; Bowlby, 1977; Hazan & Shaver, 1987). Empirical research has found that insecure childhood attachment styles predict future development of psychological and relational difficulties (Carlson, 1998; Hankin, 2005; Hankin, Kassel, & Abela, 2005). Secure attachment, on the other hand, is thought to be a protective factor; enhancing the resilience of individuals and decreasing their risk of psychological and relational difficulties (Svanberg, 1998). Information on attachment relationships is useful for practitioners as

it provides a better understanding of current relationship patterns and psychological difficulties or strengths, as well as the origins and content of early maladaptive schemas.

Theory and research have drawn attention to the substantive and phenomenological similarity of human attachment and attachment-like relationships with spiritual figures (R. Beck & McDonald, 2004; Granqvist, 2006; Granqvist & Kirkpatrick, 2008; Kirkpatrick & Shaver, 1992). There is evidence that one's relationship with spiritual figures, particularly what theistic religious traditions term a 'relationship with God', functions in a psychologically similar manner to human attachment (see Granqvist, Mikulincer, & Shaver, 2010 for a review). Theoretically, then, it is also expected that spiritual attachments would relate to psychological wellbeing in similar ways to human attachments. This possibility is reviewed, followed by a discussion of how attachment to spiritual figures may mitigate the negative effects of unavailable or insecure human attachments.

Studies investigating the proposition that spiritual attachments relate to later psychological adjustment have been somewhat inconsistent in their findings (Calvert, 2010; Desai, 2006; Homan & Boyatzis, 2010; Kelley, 2003; Reinert, 2005), but these studies have been limited on the basis of low statistical power, short follow-up periods (as little as 4 weeks; Desai, 2006), and potential measurement limitations. Some of these limitations were addressed by Calvert (2010), who surveyed 531 community-based Christian participants on their style of Attachment to God (ATG) and emotional wellbeing (i.e., lack of negative affect, levels of positive affect). An ATG style characterised as secure at Time 1 was predictive of improvements in emotional wellbeing four months later, while an anxious ATG style was predictive of decreases in emotional wellbeing. This finding remained after controlling for human attachment style, suggesting that the relationship between ATG and emotional wellbeing cannot be simply explained by individual differences in human attachment style. It is important to note that Calvert's findings applied to a non-clinical sample and only to males in the sample, with the author suggesting that females' reliance on human relationships may have meant that ATG had less of a salient effect on emotional wellbeing. In contrast to this gender effect, and in line with Calvert's overall findings, Homan and Boyatzis' (2010) study of 156 female college students found that a secure ATG was not only

related to lower levels of eating disorder risk factors at Time 1 (pressure to be thin and internalisation of thinness-ideals), but also buffered the negative effects of these risk factors on body dissatisfaction seven months later.

When primary human attachment figures are unavailable, either due to physical unavailability or caregiver insensitivity, individuals tend to seek out substitute attachment figures, particularly during times of stress (Bowlby, 1977). Similarly, when individuals have insecure attachments, individuals may turn to spiritual attachment figures as a substitute, serving a 'compensatory' function in times of distress. A meta-analysis of 11 studies found that individuals who reported an insecure attachment history had a slightly greater tendency to experience sudden conversions compared to those who reported a secure attachment history (Granqvist & Kirkpatrick, 2004). Sudden religious conversions tend to be preceded by emotional crises (Ullman, 1982), suggesting that this phenomenon may serve a distress-regulation function. Prospective studies have reported that those with insecure human attachment styles at Time 1 tend to be more likely to report finding a 'new relationship with God' at Time 2 (Kirkpatrick, 1997, 1998), suggesting that spiritual attachments may serve a compensatory function in the face of negative human attachment experiences. Another study found that insecure attachment predicted future increases in religiousness, but only following the end of a romantic relationship (Granqvist & Hagekull, 2003), suggesting that the importance of an ATG may become more salient during times of attachment-related stress. Although it appears that individuals may turn to a spiritual attachment as a compensatory behaviour, few studies have investigated whether this actually mitigates the effects of attachment-related distress. Related to this, a prospective study found that those with an insecure human attachment style were more likely to benefit (i.e., experience less grief) from increasing the importance of their religious beliefs following the loss of a spouse (Brown, Nesse, House, & Utz, 2004). Furthermore, an earlier study found that those who reported a secure ATG were more likely to report a secure romantic attachment despite insecure attachments in childhood (Kirkpatrick & Shaver, 1992).

Adult attachment style and ATG style are only moderately correlated (R. Beck & McDonald, 2004), supporting the idea that individuals with an insecure human

attachment style can still experience a secure ATG (or vice versa). However, it is also possible that insecurely attached individuals seek out a relationship with a spiritual figure that serves a compensatory function, but later replicate their insecure attachments with humans in their relationship with that spiritual figure. Indeed, there is evidence to suggest that individuals' human attachment style is often replicated in their ATG style (termed the 'correspondence hypothesis'; R. Beck & McDonald, 2004; McDonald, Beck, Allison, & Norsworthy, 2005). Thus, ones' anxious human attachment style, for example, could be replicated as an anxious ATG with concomitant expectations and perceptions of God as rejecting and the self as being unlovable (R. Beck & McDonald, 2004) which, as previously discussed, may contribute to decreases in emotional wellbeing (Calvert, 2010). This should be considered a possibility when determining predisposing factors for a particular client, but further quality research needs to be conducted to firmly establish spiritual attachments as a predisposing and/or preventing factor in psychological or relational difficulties. As noted earlier, attachment experiences are thought to contribute toward the development of individuals' schemas, where the next section of this discussion will lead.

Cognitive Structures and Processes.

Cognitive psychology deals with the ways in which people attempt to make sense of their world and events in their lives (Eysenck, 2001). In order to achieve comprehensibility, predictableness, and parsimony, people form internal representations of the world (schema), which guide and are maintained by cognitive processes that tend toward selecting and retrieving information most congruent with active schema (Kunda, 1999). While adaptive in their ability to provide predictableness and meaning, schemas and the cognitive processes that function to maintain them can constrain an individuals' ability to think objectively and in a non-biased manner (Turk & Salovey, 1985).

Religion and spirituality are thought to provide a framework through which individuals are enabled to make sense of the world in a way that creates meaning and purpose (Spilka, Hood, Hunsberger, & Gorsuch, 2003). Indeed, religion and spirituality have been referred to as a global orienting system (Pargament & Brant, 1998), a mental model (A. James & Wells, 2003), and an interpretative framework (Petersen & Roy, 1985), among others. In cognitive terms, these descriptions refer to religion and spirituality as a set of schemata that have the potential to guide causal attributions, as

well as the information one pays attention to and recalls (A. James & Wells, 2003). Having such a framework, according to Baumeister (1991) may assist individuals to gain a sense of mastery and control over their environment, providing not only meaning for difficult and/or nonsensical events, but also purpose, structure, and guidance to everyday life (refer to Park, 2005a for a more in-depth discussion). The ways in which religion and spirituality enable people to make sense and meaning of their environment in ways that contribute to a sense of control and mastery can be demonstrated by their influence on individuals' sense of coherence, attributional processes, and self-efficacy.

Sense of coherence. Sense of coherence refers to the belief that one's environment is meaningful, comprehensible, predictable, and manageable (A. Antonovsky, 1993; H. Antonovsky & Sagy, 1986). Possessing a sense of coherence has been positively associated with decreases in risk of psychological and physical health difficulties in several prospective studies (Edbom, Malmberg, Lichtenstein, Granlund, & Larsson, 2010; Flannery & Flannery, 1990; Surtees, Wainwright, Luben, Khaw, & Day, 2006). This includes a large 19-year study of the risk-reducing impact of sense of coherence on psychiatric disorders and suicide in Finland (Kouvonen et al., 2010), although not all studies are unanimous in this finding (e.g., Kivimaki, Feldt, Vahtera, & Nurmi, 2000). Given the proposed ability of R/S to provide a meaningful cognitive framework, sense of coherence has been proposed to play a major role in the relationship between R/S and mental health (George, Ellison, & Larson, 2002). Two studies have found support for this mediating role. The first found that sense of coherence mediated the relationship between spiritual resources and psychological stress amongst cancer patients (Mullen, Smith, & Hill, 1994). The second found that having a sense of meaning and purpose was the strongest explanatory variable in the negative association between religious service attendance and depression/anxiety within a large community sample (Sternthal, Williams, Musick, & Buck, 2010). Other studies have not investigated sense of coherence as a mediator, but have reported small to moderate correlations between this and R/S (Delgado, 2007; Gibson, 2003; Unterrainer, Ladenhauf, Moazedi, Wallner-Liebmann, & Fink, 2010). Early work by Petersen and Roy (1985) demonstrated a relationship between religious salience and participants' belief that their life had meaning and purpose. However, a more recent study found that levels of sense of coherence did not differ between spiritually practicing and non-practicing participants. It is unclear what 'spiritually non-practicing' referred to, as it

appeared that this group was no less likely to identify with a religious institution than the 'spiritually practicing' group (Kohls, Walach, & Wirtz, 2009).

Locus of control. Sense of coherence has been consistently associated with possessing an internal locus of control, a type of attributional style (e.g., Posadzki & Glass, 2009; T. L. Smith & Meyers, 1997) originally included by Rotter (1966) in his locus of control (LOC) theory. An 'internal' LOC refers to a belief that rewards and consequences depend upon ones' own actions and therefore are personally controllable, while an 'external' LOC refers to a belief that rewards and consequences are not under personal control, but under the control of outside influences, such as fate, chance, or powerful others. According to empirical tests of Abramson, Seligman, and Teasdale's (1978) reformulated helplessness theory, for example, depression tends to be preceded and characterised by explanations of positive events as externally controlled, and negative events as internally controlled (Alloy, 1997; Alloy et al., 1999; Nolen-Hoeksema, Girgus, & Seligman, 1986; Southall & Roberts, 2002).

Most world religions encourage trust and dependence upon powerful transcendent and/or human figures, fostering expectations that this figure plays some part in determining the fate of individuals, and the attribution of anomalous experiences and events to this figure. Potentially, this would be expected to be associated with an external LOC (cf. Ellis & Schoenfeld, 1990), which has been correlated with primarily negative outcomes, such as an increased risk of mortality (Dalgard & Haheim, 1998), negative affect amongst adolescent males (Chubb, 1993), and reduced likelihood of recovery from psychiatric disorders (Harrow, Hansford, & Astrachan-Fletcher, 2008). Attribution to powerful others, in particular, has been associated with depression in cross-sectional studies (Brosschot, Gebhardt, & Godaert, 1994; K. White, Lehman, Hemphill, Mandel, & Lehman, 2006), anxiety (K. White, et al., 2006), and passive coping styles (Brosschot, et al., 1994). Contrary to expectations, one study found that 'religious' (broadly defined) females and older males tended to hold an *internal* LOC, which was positively related to life satisfaction. Young religious males, on the other hand, tended to hold an external LOC, which was negatively related to life satisfaction (Fiori, Brown, Cortina, & Antonucci, 2006). Similar gender differences amongst religious individuals were found by Shrauger and Silverman, who also found that an

internal LOC was more likely to be held by Protestants, followed by Catholics and Jews (1971). Fiori et al. suggest that religious individuals who hold an internal LOC tend to view God as a collaborative helper, while those who hold an external LOC may tend to passively defer control to God. The authors further suggest that those who place their trust in a collaborative higher power, superficially appearing as an external locus of control, may paradoxically improve a sense of internal control. A religious example of this would be the scenario of 'David and Goliath', where David declares his trust in God to help him defeat the giant Goliath and the opposing Palestinian army, despite his meagre resources to do so. This was followed by his defeat of Goliath (1 Samuel 17, the *Bible*). In support of the suggestion that referring control to God may improve an internal LOC, a recent Australian study demonstrated a high correlation between 'God-control' and internal control amongst Christians (Ryan & Francis, 2012). In the same study, internal LOC beliefs partially mediated the relationship between individuals' awareness of God in everyday life and better psychological health, while external LOC partially accounted for the association between religious anxiety and poor psychological health. This suggests that insecurity over ones' relationship with the sacred may contribute to a reduced sense of personal control over ones' current circumstance and future.

Self-efficacy. Internal locus of control has been consistently correlated with self-efficacy, the belief that one is able to successfully perform certain behaviours that will lead to a desired outcome (Bandura, 1977) (e.g., Mahalik & Kivlighan Jr., 1988; Strauser, Ketz, & Keim, 2002). Prospective studies have demonstrated a relationship between self-efficacy and psychological and physical health (Holahan, 1987; Mendes de Leon, Seeman, Baker, Richardson, & Tinetti, 1996). Self-efficacy has been cited as an explanation for the positive relationship between R/S and psychological health (George, et al., 2002). Like sense of coherence, verses from sacred texts may facilitate the development of self-efficacy by encouraging trust in collaborative help from a higher power. For example, the *Qur'an* (3:160 [Trans. Abdel Haleem]): "If God helps you [believers], no one can overcome you (…) Believers should put their trust in God", and "I can do all this through Him who gives me strength" (Philippians 4:13, the *Bible* [New International Version]). Support for the role of self-efficacy in mediating the relationship between R/S and mental health has only been investigated with regard to

mortality and adjustment to cancer, and findings have been mixed; two studies found no support for the role of self-efficacy amongst a general community sample or cancer patients (Howsepian & Merluzzi, 2009; Musick, Blazer, & Hays, 2000), while another found support for a mediating role of self-efficacy in the relationship between deferring-collaborative religious coping and adjustment to cancer (Nairn & Merluzzi, 2003). It is possible that this latter study found mediating support as it specifically focussed on a religious form of coping that has been related to internal LOC (Fiori, et al., 2006), while the former studies used less specific measures of R/S (religious service attendance, religious commitment).

Schema flexibility. Returning to religion-as-schema, a discussion of religious schema by McIntosh, Silver, and Wortman (1993) re-iterates the tendency of individuals to attend to and assimilate information that is congruent with their existing schema. Some religious traditions promote the active censoring of incoming information and re-structuring of beliefs that are not conducive to the tenets of the religion (e.g., "We demolish arguments and every pretension that sets itself up against the knowledge of God, and we take captive every thought to make it obedient to Christ" 2 Corinthians 10:5 the *Bible* [New International Version]). In extreme cases, religious schema may become resistant and impermeable to disconfirming evidence. Theoretically and empirically, the development and persistence of beliefs that underlie psychopathology are linked to the degree of impermeability of schema (A. T. Beck, 1967; A. T. Beck, Freeman, & Davis, 2004; Elliott & Lassen, 1997; Riso, et al., 2006; J. E. Young, et al., 2003). The more resistant the schema, the less opportunity one has to modify dysfunctional beliefs about the self, the world, and others.

It has been suggested that religious individuals are less open to schema modification than individuals who make sense of the world in non-religious ways. Some scholars argue that religious individuals are less likely to be open to a rational, 'evidence-seeking' approach. For example, Carone and Barone (2001) state:

> Religious individuals, supported by their confirmatory and in-group biases, will not systematically and objectively evaluate other points of view as a

> naïve scientist would because they already believe that other viewpoints are either wrong or misguided (p.991).

Although this is a sweeping generalisation, it does hold some validity. In fact, Allport and Ross's (1967) seminal work on extrinsic and intrinsic religiousness was validated, in part, by the constructs' ability to predict religious individuals' tendency toward prejudicial attitudes, a social-cognitive construct characterised by schema inflexibility. Participants classed as 'indiscriminately pro-religious' (high scorers on both intrinsic and extrinsic religiousness) tended to score highest on prejudice measures. Allport and Ross suggest that this group tend to rely on overgeneralisations, whereby "religion as a whole is good; a minority as a whole is bad" (1967, p. 442).

More recent work suggests that relationships between extrinsic religiosity, religious fundamentalism and constructs such as prejudice, dogmatism, and authoritarianism (all characterised by schema inflexibility) are partly explained by a high need for closure (i.e., order and predictability) (Brandt & Reyna, 2010; E. Hill, Terrell, Cohen, & Nagoshi, 2010; Saroglou, 2002a). A study by Saroglou (2002a) conducted with 239 college students found that religious fundamentalism and traditional religiousness were positively related to need for closure, need for order, and need for predictability. A more recent study investigated the relationship between religious fundamentalism, need for closure, and prejudice toward LGBT and 'value violating' groups amongst a United States representative sample of 1,618 mostly Christian participants. Closed-mindedness and need for predictability were associated with both religious fundamentalism and prejudice; closed-mindedness was the only significant mediator of fundamentalism and prejudice once its association with need for predictability was controlled for. These studies provide tentative evidence that fundamentalist religious individuals tend to be more prejudiced and dogmatic partly out of a need to maintain order and predictableness. Conceptualising the psychological functions of inflexible schema held by some religious individuals, such as a need for closure, may assist practitioners to target therapeutic interventions toward the functions rather than the content of inflexible beliefs.

Social influences.

No individual stands alone from a broader sociocultural environment, whether that be the more proximal influences of local community groups, or the distal influence of state policy (Bronfenbrenner & Ceci, 1994). These influences serve to shape the values and messages individuals are exposed to, and determine which responses are acceptable from the individual. Religious and spiritual communities may help to increase the protective and/or predisposing functions of R/S. This may occur through the provision of social support and sets of values transmitted within religious communities.

The role of faith communities in providing social support to members has been investigated by a number of empirical studies. Although social support is thought to act as a 'buffer' when stressful events occur (Cobb, 1976; S. Cohen & Wills, 1985), support is found to have a protective effect on mental health even in the absence of life stress (Thoits, 1995). Longitudinal studies have demonstrated the role of social support in protecting individuals from psychological distress (Holahan & Moos, 1981), suicidal behaviour (Reifman & Windle, 1995), major depressive disorder (Kendler, Myers, & Prescott, 2005), and mortality (B. S. Hanson, Isacsson, Janzon, & Lindell, 1989; Penninx et al., 1997). However, evidence for the mediating role of social support on the relationship between R/S and mental health is inconsistent and it appears that the majority of studies do not support the hypothesis of general social support as a mediator (George, et al., 2002; Sternthal, et al., 2010). Several longitudinal studies that have included general social support as an explanatory variable between R/S and depression have failed to find support for a mediating role (Braam, et al., 2004; Ellison & Flannelly, 2009; Granqvist, et al., 2010; Koenig, 2007; Musick, et al., 2000).

It has been suggested that generic measures of social support may be inappropriate (George, et al., 2002), as one study found that social support received from congregation members fully mediated the negative relationship between religious service attendance and psychological distress, while non-congregational social support did not (Ellison, Musick, Levin, Taylor, & Chatters, August 1997). It may be that generic measures of social support are not capturing the effects of a certain 'subset' of support providers (i.e., those in the faith community), or that social support received within a more cohesive community setting may have more potent implications for

mental health. An alternative possibility has been raised by a finding that the longitudinal effects of receiving social support on mortality could be mostly accounted for by *providing* social support to others, even after controlling for a variety of mental health and personality variables (Brown, Nesse, Vinokur, & Smith, 2003). In terms of explaining the effects of R/S this requires exploration, as religious/spiritual communities often provide opportunities for their members to provide instrumental or emotional support to others. This may have positive benefits by providing opportunities to engage in behaviours which are consistent with the community's ethos, creating a greater sense of group cohesiveness and intimacy, contributing toward a sense of purpose, and reducing opportunities to engage in rumination in times of distress.

Religious/spiritual communities teach a number of core values and virtues. These are powerful frameworks that practitioners can explore with clients to determine positive and negative influences on their mental health. For example, Buddhism emphasises a number of values that include (among many others) doing no harm, acceptance of suffering, and selflessness (Harvey, 2000). Similarly, Christianity emphasises selflessness, acceptance of suffering, loving others and God, and the development of characterological virtues (e.g., peace, patience, kindness) (Lovin, 2000). Although not a well-developed area of research, a few studies have investigated the protective influence of R/S on [mental] health via the promotion of healthy lifestyles (Braam, et al., 2004; George, et al., 2002; Musick, et al., 2000; Strawbridge, et al., 2001), extending forgiveness to others (Orcutt, 2006; Orth, Berking, Walker, Meier, & Znoj, 2008), and the virtue and practice of mindfulness in Buddhism (Orzech, Shapiro, Brown, & McKay, 2009). A study in Australia conducted with 265 participants recently found that virtues such as kindness, wisdom, and fortitude fully explained the positive relationship between spirituality and psychological wellbeing (Schuurmans-Stekhoven, 2011). That is, spirituality was only related to psychological wellbeing because of its association with positive virtues. The measure of spirituality used in this study was somewhat unorthodox because it was a subscale of the virtues measure; it will be of interest to discover whether this finding is replicated with other measures of spirituality and/or religion. It is hoped that this area of research will be explored more fully by future investigations.

Personality.

Practitioners and researchers often include personality as an important factor when considering predisposition to mental health difficulties (Block, Gjerde, & Block, 1991; Boyce, Parker, Barnett, Cooney, & Smith, 1991; Kendler, Gatz, Gardner, & Pedersen, 2006). Cognitive-behavioural theory regards 'personality' as persistent affective, behavioural and interpersonal patterns that arise from an expression of core schemas (A. T. Beck, et al., 2004). These may be adaptive or dysfunctional depending on a number of early-life factors, including biology, parenting, attachment, and early formative experiences. Religion and spirituality may influence personality by interacting with these factors or by directly influencing core beliefs about the self, the world, and others.

Unfortunately the influence of R/S on specific core schema does not appear to have been investigated. However, a serious critique of the R/S and mental health literature is that personality acts as a third variable in the relationship, rendering the association between R/S and mental health spurious. Meta-analytic findings have reported that those whose religious/spiritual beliefs are characterised as open or mature tend to be more agreeable (conforming to social rules for the good of others), conscientious (conforming to social rules for the sake of keeping good social order), open to experience (seeking out novel experience and questioning social norms), and to a lesser extent, extroverted (sociable and assertive). Those characterised as extrinsically religious tended to score higher on measures of neuroticism (hostility and insecurity) (Saroglou, 2002b). These personality traits: agreeableness, conscientiousness, extroversion, and openness to experience, have all been associated with positive mental health outcomes (e.g., Bunevicius, Katkute, & Bunevicius, 2008; Podolska et al., 2010), while neuroticism tends to yield an inverse association (e.g., Kendler, et al., 2006; Podolska, et al., 2010). Therefore, a critique of the generally positive religion/spirituality and mental health relationship is that it can be explained by the fact that people with open or mature religious/spiritual beliefs are more likely to have personality traits that protect them from psychological difficulties (cf. Schuurmans-Stekhoven, 2011). If personality traits normally related to positive mental health outcomes lead individuals to develop a more open or mature religiousness/spirituality, then the relationship between religiousness/spirituality and mental health may be incidental (i.e., only observed because of personality as a third variable) rather than

causal. If certain types of religiousness/spirituality (e.g., open and mature) lead to changes in personality or modify the effects of personality on mental health, then the relationship between religiousness/spirituality and mental health may not be incidental.

To determine whether the relationship between R/S and mental health can be fully explained by personality, it is important to know whether those with a particular personality are more likely to be drawn to R/S, and whether R/S leads to changes in personality. This has been investigated by a handful of longitudinal studies (Heaven & Ciarrochi, 2007; McCullough, Tsang, & Brion, 2003; Wink, Ciciolla, Dillon, & Tracy, 2007). A study following 209 individuals over a period of 60 years in California found that agreeableness and conscientiousness in adolescence predicted involvement in religion 60 years later (Wink, et al., 2007), replicating findings by two others (Heaven & Ciarrochi, 2007; McCullough, et al., 2003). Religiousness in adolescence was not associated with longitudinal changes in conscientiousness or openness to experience. This suggests that religiousness does not lead to changes in these facets of personality. Conversely, the same study also found that early religiousness explained 19% of the change in the trait of agreeableness amongst females over time. This trait has been associated with lower levels of depression (Podolska, et al., 2010). Supporting this latter finding, two Dutch twin studies found that having a religious upbringing reduced the manifestation of inherited personality traits including disinhibition (Boomsma, de Geus, van Baal, & Koopmans, 1999) and neuroticism (Willemsen & Boomsma, 2007). High levels of these personality traits are implicated in predisposition to alcohol [ab]use, impulse control disorders, and bipolar disorder (Bayle, Caci, Millet, Richa, & Olie, 2003; Cronin & Zuckerman, 1992; Liraud & Verdoux, 2000), cardiovascular-related mortality (Shipley, Weiss, Der, Taylor, & Deary, 2007), psychological disorders (Cervera et al., 2003; Neeleman, Bijl, & Ormel, 2004) and distress (Ormel & Wohlfarth, 1991). From the above evidence, it appears that a reciprocal relationship between R/S and personality is possible. That is, those with certain personality traits are more likely to be drawn to R/S, and those who are drawn to R/S may experience positive changes in some aspects of their personality.

Another question is whether the observed relationship between R/S and mental health remains once personality is statistically controlled. The longitudinal study by Heaven and Ciarrochi (2007) examined the unique statistical contribution of personality and R/S to social and emotional outcomes. This study found that controlling for changes in conscientiousness amongst female participants only slightly weakened the relationship between R/S and the outcomes of social support, hope, acceptance, mindfulness, and joy. Religion/spirituality was not related to these outcomes amongst males. Therefore controlling for the personality trait of conscientiousness did not fully explain the relationship between R/S and social/emotional variables. This is inconsistent with a more recent finding by Lockenhoff et al. (2009), who reported that personality fully accounted for assocations between R/S and mental health amongst HIV-positive patients. A limitation of this cross-sectional study is that it cannot rule out the possibility that R/S may have influenced personality. This evidence, taken together, lends to the conclusion that a unique influence of R/S on mental health, either apart from personality or by interaction with personality, cannot be excluded.

Quality research investigating the protective and predisposing role of religion and spirituality is still in its infancy; more work needs to be done to understand the manner in which religion and spirituality interact with known predisposing and protective factors. From this discussion, it appears there is enough evidence to point to possible influences of religion and spirituality that may be considered by practitioners in understanding the factors which may have predisposed individuals to, or protected them from, particular difficulties. Considering such factors may also be useful in identifying positive and/or negative influences on the potential for recovery or relapse (e.g., by drawing on a sense of purpose, providing or encouraging the giving of social support, building self-efficacy or challenging negative beliefs about the influence of the sacred or having an excessive need for closure). Including these factors in a discussion regarding the development of a clients' difficulties or strengths can help identify the original sources of these and provide greater understanding that can bring hope and inform treatment.

Precipitating, perpetuating, and ameliorative functions

Within the Five-P's framework, factors thought to precipitate a period of difficulty are considered (Dudley & Kuyken, 2006). These are often events of a perceived traumatic or stressful nature. Identifying these factors allows practitioner and client to frame the client's distress as being logically linked to a definable event or set of events, which in turn leads to an understanding on the part of the client that reduces distress (J. Beck, 1995). This also allows for client and practitioner to form a picture of how the client might respond to similar events in the future (Dudley & Kuyken, 2006; Overholser, 1998b). Perpetuating factors, on the other hand, can be thought of as those that 'keep the difficulties going' (Dudley & Kuyken, 2006). Identifying these is of particular importance in that they often provide the immediate focal point of intervention. Religion/spirituality can act independently as a precipitator or perpetuator of psychological difficulties. Alternately, it can serve a ameliorative function when a period of difficulty ensues. The ameliorating role of R/S is referred to in this section as being to protect individuals from the negative effects of difficult life events, to attenuate the effects of ongoing psychological difficulties, and to help individuals recover.

This section will first discuss the role of R/S in precipitating psychological difficulties and will move on to discuss the role of R/S in coping and recovery. The ameliorative functions of R/S will be covered at this point but it is also acknowledged that maladaptive religious/spiritual responses to psychological and life difficulties can serve to worsen the effects of these. Further discussion of the role of R/S in perpetuating psychological difficulties will follow.

The precipitating role of religion/spirituality.

Research has recently begun to to identify the ways in which religious and spiritual issues can act as stressors in and of themselves. The finding that 15% of 330 community mental health clients in the Netherlands stated that their R/S or worldview played a role in causing their difficulties supports the idea that R/S can work as a precipitant of psychological difficulties (Pieper & van Uden, 1996). Much of the work on the precipitating role of R/S has focused on the effect of 'spiritual struggles'. Three types of spiritual struggle have been identified (Pargament, Murray-Swank, Magyar, & Ano, 2005): divine (e.g., difficulties in one's relationship with the sacred), interpersonal (e.g.,

difficulties with one's faith community), and intrapersonal (e.g., difficulties with chronic religious doubting). There appears to be some overlap between the concepts of 'negative religious coping' and 'spiritual struggles' (see Ellison & Lee, 2010, for example). For the purposes of this discussion, spiritual struggle is defined as beliefs or experiences that are potentially stressful, while negative religious coping (to be discussed later) refers to appraisals or strategies used to cope with a stressful event. The role of R/S in precipitating psychotic episodes will be covered briefly, and religious/spiritual attributions regarding the causes of mental illness will be discussed.

Spiritual struggle. A number of negative outcomes associated with spiritual struggles have been documented. Ellison and Lee (2010) found that all three types of spiritual struggle were cross-sectionally associated with greater levels of psychological distress. A difficult relationship with the sacred was the most important predictor of this (R^2 = 20%). Earlier cross-sectional work associated spiritual struggle with increased levels of anxiety, depression, paranoia, obsessive-compulsiveness and somatic complaints (McConnell, et al., 2006). This struggle was more predictive of psychological difficulties during times of stress (e.g., recent illness). The cross-sectional design of these studies make unclear whether religious/spiritual struggles precipitate psychological difficulties, or if psychological difficulties precipitate spiritual struggle. A recent prospective study suggests that the former explanation is possible: research on the role of negative religious coping amongst Orthodox Jews found that responses to stressful events, such as becoming angry at God and questioning their faith, predicted an increase in depressive symptoms two weeks later (Pirutinsky, Rosmarin, Pargament, & Midlarsky, 2011). Despite the fact that this study investigated negative religious coping rather than spiritual struggle, the authors suggest that negative religious coping amongst this sample could have arisen from a primary spiritual struggle rather than as a reaction to stressful events. Additional evidence found that religious doubt increased amongst Christian older adults who had previously experienced negative interactions in church. Attempting to suppress this doubt predicted poorer self-ratings of general health three years later (Krause & Ellison, 2009). This evidence taken together tentatively suggests that spiritual struggles precipitate psychological difficulties. The study by Krause and Ellison (2009) also suggests that further difficulties may be experienced when individuals do not cope adaptively with these struggles.

It is important to note that many religious and spiritual traditions consider spiritual questioning and feelings of abandonent to be a precursor to growth. The 'dark night of the soul' is one example of a trying, difficult, and seemingly negative spiritual struggle that often results in spiritual growth through an individual's intensified pursuit of the sacred (Durà-Vilà & Dein, 2009). In line with this, Rosmarin, Pargament, and Flannelly (2009), found that very high levels of spiritual struggle were related to *improved* mental health for Orthodox Jews. The authors suggest that Orthodox Jews see such struggle as an avenue for growth and demonstrating commitment to their faith. Hence it is important to be aware that clients who exhibit distressing religious/spiritual doubts and difficulties in their relationship with the sacred may view this as an opportunity for growth.

The role of religion/spirituality in precipitating psychotic episodes. Certain religious/spiritual experiences and messages may have the potential to precipitate a period of mental illness when they intersect with an individual's impaired reality-testing or unduly negative, threat-oriented, and/or all-or-nothing cognitive styles (e.g., C. Miller & Hedges, 2008; Taylor, 2002). For example, cases have been reported where psychosis appears to have been precipitated by excessive guilt and anxiety arising from intense religious group pressure (Galanter, 1990). Unfortunately this does not appear to have been investigated on a larger scale. Linden, Harris, Whitaker, and Healy (2010) noted an increase in admissions for brief psychosis during the Welsh religious revival (1904-1905). Admissions were systematically associated with the occurance of revivial meetings. However, assuming the two occurances are in fact linked, it is not possible to determine whether these religious experiences led to a greater incidence of psychoses or whether the greater rates of hospital admissions reflect a bias toward the pathologisation of 'normal' religious/spiritual experience (cf. Menezes & Moreira-Almeida, 2010; L. Smith, Riley, & Peters, 2009). At this stage there does not appear to be any evidence that the prevalence of psychosis is higher amongst individuals who are religious or spiritual, although it is unclear exactly what impact group processses and intense religious/spiritual experiences have upon the precipitation of psychotic episodes.

Attributions regarding the causes of mental illness. Religious/spiritual explanations regarding the causes of mental illness can differ drastically from those of mainstream psychology. A comprehensive review of these explanations is not possible here, but it is sufficient to say that many religious/spiritual traditions view mental illness as having at least partly a spiritual origin, and therefore as having a spiritual cure (see Hartog & Gow, 2005; E. F. Morrison & Thornton, 1999; Trice & Bjorck, 2006). For example, a study conducted with 343 Protestant outpatients in Switzerland found that 38% believed their difficulties were at least partly caused by evil spirits / demons (Pfeifer, 1994). Nearly a third of the total sample had sought some form of 'deliverance prayer' or exorcism, some of whom experienced negative effects as a result of coercive practices and treatment delays. Beliefs regarding demonic causality was not confined to those with psychotic disorders, 53% of whom held such beliefs. Those diagnosed with mood disorders (33%), anxiety disorders (48%) and personality disorders (37%) also believed in demonic causation. The author provides a useful overview of some specific features of each disorder that align with these causative explanations (e.g., the sense of uncontrollability during a panic attack). It may be important for practitioners to be aware that some clients may believe that their difficulties were precipitated by spiritual causes, particularly if the client has sought concomitant religious/spiritual solutions that were experienced as traumatic or were a factor in treatment delay. Along with this, belief in demonic causation may place control outside of the individual and induce a large amount of fear that may be clinically significant. Beliefs regarding appropriate cure also need to be elicited as this may have implications for adherence to non-religious/spiritual treatments.

Religious coping.

Religion and spirituality are frameworks within which individuals and communities can create meaning in the midst of difficult circumstances (Chan, Rhodes, & Perez, 2012; McIntosh, et al., 1993; Park, 2005b). R/S can be a source of comfort, stimulate personal growth in the midst of trauma (Shaw, Joseph, & Linley), and is an immediately accessible resource in times of need (Pargament & Brant, 1998). At other times, it can serve to create even greater distress (Pargament & Brant, 1998). The use of R/S in these ways has led to a growing body of research dedicated to characterising the ways in

which R/S is used to appraise and cope with difficult events and ongoing psychological difficulties.

One of the assumptions of the stress, appraisal, and coping literature is that traumatic and/or stressful events are not inherently distressing (Lazarus & Folkman, 1984). Instead, the appraisals used (i.e., beliefs about the meaning of the event) and the personal resources subsequently mobilised (i.e., coping efforts) determine whether the event will precipitate distress. Understanding the appraisals and resources used by a client can help to reduce distress by informing relevant interventions and can help to identify factors that will intensify or attenuate the response to similar future events (Dudley & Kuyken, 2006). The following discussion will consider the ways in which religious/spiritual appraisals and strategies both protect people from and intensify the effects of stressful events and ongoing psychological difficulties.

Religion/spirituality and coping. Religious and spiritual beliefs can influence, be an outcome of, or become a part of any element in the coping process (Pargament, et al., 1990), whether it be one's cognitive appraisal of a situation, coping activities themselves, or appraisals of the outcomes of coping. Religious/spiritual coping, in general, appears to be as effective as non-religious forms of coping, more so for individuals whose religious/spiritual beliefs are a central aspect of their lives (Koenig, Siegler, & George, 1989). 'Religious coping' is a phrase utilised by the current literature, but this term is deceptively narrow. Here, 'religious coping' is referred to broadly as any religiously/spiritually-oriented response to a potential stressor (cf. Pargament & Brant, 1998).

A number of positive (adaptive) and negative (maladaptive) forms of religious coping have been identified (Pargament, 1997). 'Positive' religious coping refers to appraisals or strategies which tend to be associated with the attenuation of stress, while 'negative' religious coping refers to those appraisals or strategies associated with increased stress. It requires acknowledgement, however, that forms of religious coping and appraisal are neither inherently positive nor negative; their effectiveness depends upon how, when, and by whom they are used (Broger & Zeni, 2005; Park, 2005b).

Religious coping with difficult life events. In the immediate aftermath of tragedy, individuals and communities often turn to religion and spirituality as a coping resource. A number of authors have documented the ways in which the importance and use of religious/spiritual resources tends to increase when one is faced with stressful life circumstances (Bellamy, et al., 2007; Koenig, Pargament, & Nielsen, 1998; Reed, 1987; Tepper, Rogers, Coleman, & Malony, 2001). A meta-analysis examining the relationship between religiousness and depression (T. B. Smith, et al., 2003) found that religiousness had a greater protective effect against depressive symptoms during highly stressful life circumstances, compared to periods of less stress, indicating that religiousness exerts a 'buffering effect' when people encounter stressful life circumstances (Pargament & Brant, 1998). A study in Connecticut found that participants were more likely to engage in prayer when faced with stressful events, particularly those which were distressing and out of ones' control, such as catastrophies and a decline in health status (Lindenthal, Myers, Pepper, & Stern, 1970). The prevalence of turning to R/S is demonstrated by a survey reporting that a substantial proportion (90%) of a representative sample of Americans used R/S to cope with the September 11, 2001 terrorist attacks (Schuster et al., 2001). A significant religious/spiritual response also occurred in a small New Zealand community following a mining disaster that resulted in the deaths of 29 workers (S. Baker, November 25, 2010; Kersten, November 21, 2010). Other studies have reported that between 20 and 85 percent of people draw on R/S to cope with stressful situations such as illness (Broger & Zeni, 2005; Cigrang, Hryshoko-Mullen, & Peterson, 2003; Ginsburg, Quirt, Ginsburg, & MacKillip, 1995), and death of a loved one (Demmer, 2007; T. A. Richards & Folkman, 1997; Swanson, Kane, Pearsall-Jones, Swanson, & Croft, 2009). These broad estimates may be attributed to methodological and cultural artefacts; lower estimates tend to be found amongst secular societies where religious coping is mentioned as a spontaneous response to an open- rather than close-ended question (e.g., Cigrang, et al., 2003). Individuals in countries outside of the U.S. may not consider religious beliefs to be as important in coping (Koenig & Larson, 2001). For example, interviews with 148 individuals in Sweden found that only 1% spontaneously mentioned R/S as a method of coping with life stressors (Cederblad, Dahlin, Hagnell, & Hansson, 1995).

Certain forms of religious coping and appraisal protect individuals from the impact of stressful events. These include reframing of events within a benevolent religious framework (e.g., believing that the event is intended for one's spiritual growth); viewing problem-solving as a collaborative process between the self and the sacred; and perceiving that one is supported and/or guided by the sacred. A meta-analysis of 49 studies reported a positive relationship (r = .33) between these forms of religious coping and psychological adjustment to stress (i.e., emotional well-being, self-esteem, stress-related growth) (Ano & Vasconcelles, 2005). Additionally, a longitudinal study of 268 medically ill older adults found that these forms of religious coping were related to stress-related growth over a two-year period (Pargament, Koenig, Tarakeshwar, & Hahn, 2004). Individuals who demonstrated more positive psychological outcomes following hurricanes Katrina and Rita were those whose religious/spiritual beliefs provided them with a sense of meaning and purpose in the midst of coping with these events (Chan, et al., 2012).

Forms of religious coping and appraisal that intensify the effects of stressful events include the expression of discontent toward one's religious community and/or a sacred entity, and attributing events to the malevolence of God or sacred entity (e.g., believing that a negative event has occurred as retribution for violating a sacred law). The meta-analysis conducted by Ano and Vasconcelle (2005) reported that these forms of coping and appraisal were moderately associated (r = .22) with negative adjustment to stress, such as guilt, psychological distress, social dysfunction and psychiatric symptomatology. The longitudinal study of religious coping by Pargament, Koenig, Tarakeshwar, and Hahn (2004) found that discontent with ones' relationship with God, interpersonal religious discontent, and pleading with God were associated with a worsening of functional abilities, quality of life, and depressed mood over a two year period. Furthermore, negative religious coping amongst cancer patients predicted significant increases in anxiety and depression, and decreases in emotional wellbeing following treatment (Sherman, Plante, Simonton, Latif, & Anaissie, 2009).

The outcomes of other forms of religious coping appear to depend upon the context and/or controllability of the event. For example, self-directing problem solving, where solutions are believed to be centred within and actioned by the self rather than the

sacred, may be more useful in controllable situations (Pargament, 1997). When events are uncontrollable, pleading (asking the sacred to intervene), and deferring coping styles (when the outcome is deferred to the sacred) may be more beneficial (Pargament, 1997). Although certain forms of religious coping are associated with negative psychological effects, this does not prevent individuals from simultaneously experiencing positive effects. The meta-analysis by Ano and Vasconcelles (2005) reported no inverse relationship between 'negative' religious coping and positive psychological adjustment. This suggests that individuals can engage in both positive and negative religious coping strategies. Awareness of this is important when working with a client to determine the relevance of religious coping in their life.

Coping with ongoing psychological difficulties. Coping does not occur solely within the context of stressful external circumstances. Often an individual's prevailing cognitive, emotional, and personality traits, including those that underlie the etiology of mental illness, can create difficulties for the individual and require the deployment of various coping strategies (Demmer, 2007). The social, emotional and occupational consequences of mental illness are often severe and prolonged (cf. Murray, 2007; Stein & Wemmerus, 2001), necessitating the use of coping strategies to promote recovery.

A number of studies have surveyed mental health clients regarding the nature, importance and role of their religious beliefs (e.g., Bellamy, et al., 2007; Fitchett, Burton, & Sivan, 1997; Heinz et al., 2010; Lindgren & Coursey, 1995; Neeleman & Lewis, 1994; Pieper, 2004; Russinova, Wewiorski, & Cash, 2002), with religion and spirituality emerging as a common narrative in coping with, and recovery from, mental illness (Fallot, 2001). Two-thirds of a large sample of clients (1,835) in Michigan stated that spirituality was important in their lives (Bellamy, et al., 2007), while focus groups conducted with 25 substance users revealed that spirituality was integrally important to many participants in their efforts to recover (Heinz, et al., 2010). Similarly, the importance of R/S in recovery was mentioned by 16 of the 18 participants interviewed by Young and Ensing (1999). The prevalence of religious coping amongst patients in mental health care settings in the United States has been reported to be between 50

(Russinova, et al., 2002) and 80 percent (Tepper, et al., 2001). Many of these patients (30-48%) report that religious/spiritual beliefs are the *most* central factor in helping them to cope with their mental illness (Huguelet, et al., 2006; Sullivan, 1993; Tepper, et al., 2001). Tepper et al.'s survey of 406 psychiatric patients in Los Angeles revealed that 80 percent of the patients used of some form of religious coping method, helping them to cope with frustration or psychiatric symptoms. Sixty-five percent reported that religion helped them cope with symptom severity to a moderate or large extent, and 30% reported that religious practices and beliefs were the most important factor in helping them persevere through mental illness. Conversely, one survey of a community sample found that religious coping was rated as less important by those who had ever been depressed compared with those who had never been depressed (Loewenthal, Cinnirella, Evdoka, & Murphy, 2001). It is not clear if this finding was due to a negative cognitive bias, in which case the efficacy of other coping strategies would have also been given low ratings, or whether the findings specifically applied to religious/spiritual coping strategies.

Empirical research has generally found that when religion or spirituality are employed in an adaptive manner by those experiencing mental illness, quality of life and levels of distress tend to improve. A cross-sectional study of 151 mental health clients in Ohio reported that those who relied on a collaborative (e.g., 'God will help me to overcome this') or deferring religious coping style (e.g., 'God will make sure this all works out') reported improvements in sense of empowerment and quality of life (Yangarber-Hicks, 2004). Longitudinal research with patients diagnosed with psychosis found that more frequent use of positive religious coping strategies predicted fewer negative symptoms, better social functioning, quality of life, and global clinical impression three years later (Mohr et al., 2011). Common narratives that emerged from interviews with individuals who have experienced mental illness included the ability of R/S to provide emotional calmness and stability; a sense of control; support from the faith community; a sense of hope, meaning and purpose in the midst of struggle; and strength to persevere through difficult times (Fallot, 1998; Green, Gardner, & Kippen, 2009; Russinova, et al., 2002; Sullivan, 1993).

In reviewing the literature, George, Ellison, and Larson (2002) observed that while organised religious activity appears to reduce the risk of developing psychological difficulties, positive religious coping appears to be the strongest predictor of recovery. Several investigations appear to support this conclusion, at least for depressive disorders. Hospitalisation rates amongst depressed individuals are reported to be lower amongst those who utilise R/S to cope with their symptoms compared to those who do not (Baetz, Larson, Marcoux, Bowen, & Griffin, 2002; Tepper, et al., 2001), while a study following 865 older medical inpatients with depressive disorders found that those who scored highest on multiple areas of religiousness remitted up to 53% faster than non-religious patients (Koenig, 2007). A similar longitudinal study of depressed older adults found that positive religious coping predicted small to moderate reductions in depression over six months (Bosworth, Park, McQuoid, Hays, & Steffens, 2003).

Few longitudinal studies have investigated the perpetuating effects of using negative religious coping strategies and appraisals to deal with symptoms. Amongst young adults diagnosed with schizophrenia or bipolar disorder, psychological distress and a sense of personal loss were increased amongst those who had appraised their symptoms as being God's punishment a year earlier (Phillips & Stein, 2007). In contrast, a more recent longitudinal study found no relation between negative religious coping with symptoms and 3-year outcome measures amongst patients diagnosed with psychosis (Mohr, et al., 2011), although it is possible that the lack of association may have been due to the low prevalence of negative religious coping and related lack of statistical power. More evidence is required to clarify the role of negative religious coping and appraisal in perpetuating psychological difficulties.

It appears that the religious/spiritual appraisals and coping strategies used by individuals in times of stress may contribute to or protect individuals from the development of ongoing, clinically significant levels of distress. When ongoing distress and dysfunction are experienced, religion and spirituality can be utilised in adaptive ways that help to attenuate these and help individuals to recover. Maladaptive religious/spiritual appraisals and coping strategies, however, may also contribute to the worsening of distress and dysfunction over time. The presence of adaptive or maladaptive forms of religious/spiritual coping can assist clinicians to predict possible responses to future

stressful events, and bolster coping strategies which may help attenuate distress in these times. The same coping strategies can be conceptualised as contributing to ongoing difficulties or strategies that assist clients in the process of recovery.

The perpetuating role of religion/spirituality.

Although religion and spirituality can help ameliorate effects of negative life events and can help individuals to cope with ongoing psychological difficulties, it can also serve to perpetuate them. The perpetuating role of maladaptive religious coping is one example of this. A study by Lindgren and Coursey (1995) found that 17% of a group of U.S. clients believed their religious beliefs had harmed them while they were mentally ill. These harms included negative interactions with religious organisations and a direct exacerbation of symptoms (e.g., delusions), which will be discussed here.

Disorders with religious/spiritual content. In summarising the influence of religion and spirituality on psychopathology, Miller and Kelley (2008, p. 469) note that "it seems that (…) religiosity is generally protective against psychopathology, and helpful in facing symptoms, but when that pathology does occur, the religious often incorporate religious elements into their symptomatic presentation". Indeed, religious/spiritual themes are present in approximately 24% of cases where a psychotic illness has been diagnosed (Siddle, Haddock, Tarrier, & Faragher, 2002), although psychosis itself has a low lifetime prevalence in the general population compared to all other diagnoses (.031% compared to 46.4%), with higher rates in the population seen by mental health practitioners (Kessler, Berglund, et al., 2005; Kessler, Birnbaum, et al., 2005). Rates of religiously-themed psychosis varies according to the level of religion/spirituality in the culture (Siddle, et al., 2002); from 7% amongst Japanese to 80% amongst Afro-Caribbean communities. There do not appear to be any prospective studies pointing to a precipitative role of R/S, but there has been some discussion regarding the ways in which religious/spiritual beliefs can perpetuate such an episode (see Gearing et al., 2010, for a review). Religion and spirituality can be readily used as a coherent explanatory framework by individuals who are experiencing confusing and distressing phenomena and such a framework is more readily accessible to those who already possess religious/spiritual beliefs (Menezes & Moreira-Almeida, 2010).

The evidence linking R/S to perpetuating factors in psychosis is not particularly conclusive. Findings are often inconsistent and confounded with other cultural variables (Gearing, et al., 2010). Research with inpatients has reported worse clinical status amongst those with religious delusions, such as poorer functioning, worse symptomatology, and worse insight (Appelbaum, Robbins, & Roth, 1999; Siddle, et al., 2002), although other research with outpatients has failed to replicate these findings (Mohr et al., 2010). It is possible that those whose religious delusions are causing the greatest distress may be more likely to be found in inpatient samples. Rates of adherence to treatment is inconsistent between studies (Gearing, et al., 2010). There appears to be anecdotal evidence that psychoses with religious/spiritual content are more difficult to treat, but it is difficult to identify specific empirical evidence to support this conjecture. Perhaps the strongest conclusion one can draw from the evidence (cf. Gearing, et al., 2010) is that the involvement of R/S in psychosis is so complex that careful assessment of individuals in clinical settings is an absolute necessity. For example, individuals with psychosis can hold distressing religious delusions which later serve to *reduce* distress, while simultaneously engaging in non-delusional, positive religious coping strategies (T. A. Richards & Folkman, 1997). Such complex relationships require careful consideration in order to address potentially important difficulties while avoiding the pathologisation and possible removal of important coping resources.

The role of the religious/spiritual community. The response from the R/S community toward an individual's psychological difficulties may be particularly important to the perpetuation or amelioration of symptoms. A survey of 293 Christians found that a third encountered what the author considered to be 'negative' attributions and reactions from the R/S community (such as attribution of mental illness to personal sin or demonic activity, discouraging medication use) (Stanford, 2007). A number of the participants in Stanford's study noted that their R/S had been adversely affected by these interactions, damaging a potentially important protective influence, while others noted that their depression was exacerbated as a result of negative responses from the R/S community. Attributions of mental illness as being a result of personal sin, lack of

faith or the work of demonic activity have been found to predict stigmatising attitudes toward individuals with mental illness (Wesselmann & Graziano, 2010). In Wesselman and Graziano's study, these attitudes were more likely to be found amongst non-denominational Christians compared to Roman Catholic/Orthodox Christians, and amongst males compared to females. Further, when those in the religious/spiritual community rely heavily on religious/spiritual explanations, much personal responsibility is placed upon mentally ill individuals to engage in spiritual practices as a cure (Trice & Bjorck, 2006). When recovery is not forthcoming, Trice noted that, "*remaining* depressed may feel incriminating" and lead to a greater sense of self-blame (Trice & Bjorck, 2006, p. 288). Self-blame and shame arising from other- and self-attributions may affect help-seeking. For example, Pilkington, Msetfi, and Watson (2011) found that British Muslims experiencing shame over their mental illness demonstrated a lower intent to access psychological services. The attitudes of the R/S community may be an important factor to consider when assessing the likelihood of an individual's engagement in treatment and possible perpetuation of symptoms by shame and/or guilt and treatment-seeking delays.

The rates of religious and spiritual coping with the symptoms of mental illness are relatively high amongst psychiatric populations. To a large extent, these methods of coping appear to be effective both immediately and over time, assisting in a number of ways to support the goal of recovery. On the other hand, religion and spirituality may also serve to perpetuate symptoms when individuals use R/S in maladaptive ways to cope with symptoms. Religion and spirituality can also perpetuate psychological difficulties when these beliefs support the content of psychoses and when religious/spiritual communities express unhelpful reactions toward individuals who are experiencing difficulties. Together, these are issues that may form an immediate focal point of intervention, either by increasing the protective role of R/S, or by targeting the precipitating or perpetuating roles of R/S. Two authors summed up the relationship between R/S and mental health particularly well, stating "[it is] clear that a consistent, robust, and unidirectional relationship between mental health and religiosity or spirituality is an illusion – the reality is far more subtle and complex" (L. Miller & Kelley, 2008, p. 462). It is hoped that by gaining a greater understanding of the various

ways in which religion and spirituality interact with mental health, practitioners may be able to consider the role of religion and spirituality in their conceptualisations of clients' difficulties and strengths in a more nuanced and integrated manner (cf Havighurst & Downey, 2009). The inclusion of R/S in the care of mental health clients now moves beyond discussion of the empirical associations between religion, spirituality and mental health, to discussion of the context within which such considerations occur. The following chapter will address the historical, sociocultural, and situational issues that impact upon the consideration of religion and spirituality in mental health care.

CHAPTER 3

CONSIDERING RELIGION AND SPIRITUALITY: CONTEXTUAL ISSUES

To understand the current relationship between religion/spirituality and mental health care, one must understand the context within which this relationship has developed. The historical relationship between religion/spirituality and mental health care has been a dynamic and complex one that has changed and grown along with significant shifts in societal thinking. This will be reviewed briefly, although for a more comprehensive review the reader is encouraged to consult David Wulff's (1996) book, *Psychology of Religion: Classic and Contemporary*. Following this will be a discussion of current sociocultural and institutional influences that impact upon the consideration of religion/spirituality in mental health care, as well as issues that are often cited as impediments to this.

Before continuing, a definition of religious/spiritual 'consideration' is required. The involvement of religion/spirituality in mental health care is referred to variously as 'integration', 'inclusion', 'intersection', 'interaction', and 'consideration'. The term 'consideration' is used throughout this dissertation as it appears to be the most inclusive and overaching term available. Consideration refers to the attention practitioners give to the influence of religion/spirituality on a client's presentation and the delivery of mental health care. This is similar to Shafranske's (2005) 'intentional orientation' toward religion/spirituality in mental health care. The consideration of religion/spirituality may involve explicit efforts to involve religion/spirituality in therapy, or implicit efforts such as being mindful of the way one responds to religious/spiritual topics when they arise.

HISTORICAL CONTEXT

Prior to the scientific revolution of the 16th to 18th centuries, mental illness was readily explained within natural and supernatural contexts (Rosen, 1968), with seemingly little concern about contradictions between the two (Thielman, 1998). The role of physician and priest were considered as one, leaving the diagnosis and care of those with mental illness to religious authorities and institutions (Sevensky, 1984; Thielman, 1998). The scientific revolution marked a gradual shift in Western ontological and epistemological paradigms (P. S. Richards & Bergin, 2005). Illness was no longer considered to be the result of unseen, untestable and undiscoverable forces. References to the supernatural disappeared from the medical literature, replaced by positivist epistemologies (Sevensky, 1984; Thielman, 1998). As a result, mental health became the domain of medicine and the care of the mentally ill became the responsibility of non-religious institutions.

The opinions of the founding fathers of 20th century psychology reflected divergent views on the role of R/S in mental illness and mental health care. Psychologists and psychiatrists such as Carl Jung and William James tended to emphasise the positive role of R/S in mental health. In the field of psychoanalysis, Jung wrote of the role of R/S in helping to facilitate the process of integrating the conscious and unconcious minds (Jung, 1938), while James believed that R/S enriched and expanded human experience, helping both 'healthy-minded' and 'sick souled' individuals (W. James, 1902).

The three most well known psychologists who expressed somewhat negative views toward R/S in the early to mid 20th century included Sigmund Freud, B.F. Skinner, and Albert Ellis. Skinner interpreted the function of R/S as being to control and exploit human behaviour (Skinner, 1953), while Freud was most notably outspoken on the subject of religion in his book *The Future of An Illusion* (Freud, 2012 [1927]). Freud likened humanity's attachment to religion as an infantile obsessional neurosis, arising out of the Oedipus complex. This, he wrote, would resolve as humanity matured. While Freud recognised the function of religious belief as protection from other forms of personal neuroses, he advocated for the separation of religion from society, stating that "Religious teachings [are] (…) neurotic relics, and we may now argue that the time has

probably come (…) for replacing the effects of repression by the results of the rational operation of the intellect" (p.41). The duality between religion and the 'rational mind' was also advocated by Albert Ellis in the 1980s, who wrote extensively about the harmfulness of religious/spiritual beliefs (e.g., Ellis, 1980; Ellis & Murray, 1980). Ellis argued that all devout religious/spiritual beliefs were associated with emotional disturbance (Ellis, 1980), and that the "less religious [people] are, the more emotionally healthy they will tend to be" (p.637). Further, Ellis advocated for the promotion of atheistic values in psychotherapy, proposing that "the elegant therapeutic solution to emotional problems is to be quite unreligious (....) [then people] would tend to give up all absolutist thinking and stop making themselves emotionally disturbed" (p.637).

A shift toward a more moderate view on the role of R/S in mental health in the late 20th century was helped, in part, by the publication of empirical evidence outlining the complex inter-relationships between R/S and mental health, including the positive impact of certain religious/spiritual beliefs. As a result, Ellis retracted his view that devout religiousness was inherently harmful and revised his position to state that "religious and nonreligious beliefs in themselves do not help people to be emotionally 'healthy' or 'unhealthy'. Instead, their emotional health is significantly affected by the kind of religious and nonreligious beliefs that they hold" (Ellis, 2000, p. 30). This view has been reflected most significantly in Pargament's work on the effect of positive and negative religious coping, discussed in Chapter Two (Pargament, 1997).

CURRENT CONTEXT

Political and philosophical paradigms

While the literature on religion/spirituality and psychology now leans toward a more moderate stance, it must be noted that secularism is the dominant sociopolitical environment within which the relationship between R/S and psychology is currently embedded in Western society (Cook, Powell, Sims, & Eagger, 2011; Reber, 2006). Secularism refers to the exclusion of religion from state policies, laws, and services that has occurred within a broader sociocultural process of secularisation; the movement of

society away from traditional religious beliefs and practices (D. Martin, 2005). Professional training in the mental health disciplines, funding for research, and the provision of mental health services are often a publically provided and/or publically mandated commodity, and therefore a secularised one where Western economies are concerned (Cook, et al., 2011). In addition, the disciplines of psychology and psychiatry have become entrenched within two major philosophical paradigms that are basically in conflict with those of religion and spirituality (P. S. Richards & Bergin, 2005): metaphysical naturalism, which is "essentially [a natural] explanation of everything without recourse to anything supernatural" (Carrier, 2005, p. 4), and positivism, which constrains the theory and practice of these disciplines to that which is based upon objective, observable evidence. These two paradigms are in conflict with the core tenets of many religious/spiritual orientations, which assume the existence of supernatural, unobservable, and immeasurable phenomena.

The dominance of science as the only source of knowledge and its assertions of universal truths has softened recently as scholars have recognised that scientific 'truth' is couched within a sociocultural context. In psychology, this has necessitated a movement toward social constructionism; the notion that knowledge, truth, and reality are constructed within ones' social context. As writers argue that the very definition of social constructionism is socially constructed, few offer any definitive meaning to the phrase (Gergen, 2009). This shift in paradigm has assisted the discipline of psychology to become more sensitive to the impact of cultural differences, although psychology's reliance on relativist interpretations of truth and reality are often in conflict with the universal truths asserted by some religious traditions.

Together, the increasing dominance of secularism and the philosophies of metaphysical naturalism and positivism over the 20th century and beyond contributed to the retreat of religion and spirituality from the theory, research, and professional practice of mental health care. Despite increasing attempts to reverse this trend and indications that this may be happening, those who wish to consider R/S in mental health care are doing so within a culture that in Cook et al.'s words is "deeply biased against the transcendent" (2011, p. 37).

Contextual issues unique to New Zealand: Biculturalism, wairua Māori, and diversity.

The 'bias against the transcendent' also exists within secularised New Zealand, although an interesting pluralism exists here due to the political and ethical mandate of biculturalism (Turbott, 1996). On one hand, like other Western nations, New Zealand is a secularised country (Ahdar, 2006); R/S does not generally feature in or have any bearing upon healthcare policies. A significant exception to this is the attention paid to indigenous (Māori) religion and spirituality in policy, which has arisen from New Zealand's political and social commitment to an equitable partnership between the indigenous people of the land (tangata whenua / Māori) and non-indigenous people (Pakeha). This equitable partnership is expressed in the form of biculturalism as a fulfilment of the Treaty of Waitangi, which was signed following British colonisation.

The recogition of Māori religion/spirituality has led to the development of state and district health board policies that explicitly incorporate Māori religious/spiritual values and practices (see Capital and Coast District Health Board, 2009; Chief Advisor Tikanga, 2003; Ministry of Health, 2002; 2006 for examples). Additionally, New Zealand practitioners have been socialised and trained to be aware of spirituality as an integral facet in Māori models of health such as Te Whare Tapa Wha ('The four sides of the house'). This is an influential and widely-utilised model that emphasises the importance of four aspects of health for Māori: physical, psychological, familial, and spiritual (Durie, 1994). The spiritual aspect includes a sacred connection to whānau (family), whenua (the land), tupuna (ancestors), and an emphasis on traditional healing methods, although Māori forms of R/S often incorporate aspects of Christianity as a result of missionary influence in the 1800's. For some Māori, spirituality forms an integral part of identity and everyday reality (Valentine, 2009). Connection, communication, and balance with the natural and transcendent world, and to ones' whānau and whakapapa are thus considered an important aspect of taha hinengaro (mental health) (cf. Tse et al., 2005; Valentine, 2009). As a result, New Zealand mental health services generally espouse a commitment to considering Māori spirituality, to the point that commentators have held up New Zealand mental health services as an exemplar of attention paid to indigenous spirituality (Egan, et al., 2011; Hollins, 2008).

It is possible that acknowledgement of Māori spirituality has contributed to a greater recognition of spirituality within New Zealand mental health care in general, making the New Zealand context unique. A pluralism remains however; secularism continues to be the dominant influence, and mental health policy has a tendency to place relatively little emphasis on the religious/spiritual beliefs and practices of non-Māori (cf. Adhar, 2003; Standards New Zealand, 2008; Stirling, Furman, Benson, Canda, & Grimwood, 2010). With changes in population demographics, it has become increasingly important to (a) continue to reaffirm our focus on spirituality and religion for Māori, recognise its importance and continue our commitment to biculturalism, and (b) broaden our focus to ensure the religious/spiritual beliefs of non-Māori are also considered. For example, the 2013 census found that nearly a quarter of those living in the most populous city in New Zealand identified as Asian (Statistics New Zealand, 2013). Asia is one of the most religiously/spiritually diverse continents on earth, where religions and spiritualities range from Dharmic (e.g., Buddhism and Hinduism) in South Asia, Taoistic (e.g., Confucianism and Daoism) in East Asia, and Abrahamic (e.g., Islam, Christianity) in West and South Asia. Following from this, fifty percent of the New Zealand Asian population identifies as Hindu, Buddhist, or Islamic (Statistics New Zealand, 2006). In parallel with New Zealand's primary commitment to Māori spirituality, it is important for mental health practitioners to be aware that religious/spiritual beliefs are potentially relevant to any client, and to be open and ready for diversity in this regard.

Institutional and practitioner views

Despite the influences of paradigms that are in conflict with religion and spirituality, views expressed in the literature on the consideration of R/S in mental health have become more moderate. This has been helped, in part, by empirical work that has helped the discipline to gain a better appreciation of the intricacies involved in the relationships between R/S and mental health. There have been an increasing number of conference symposia, fora, research grants and special issue publications devoted to the consideration of R/S in mental health care. The literature has undergone an exponential increase; a keyword search of 'religio* or spiritu*' and 'psych* or mental' in the title of artcles returned 313 publications from the 1980's, 796 in the 1990's, and 1520 in the 2000's. In response to this and several other influences to be discussed later,

the consideration of R/S has been mandated by a number of influential institutions in the last twenty years. The American Psychological Association (2002) included the consideration of R/S in their Code of Ethics Principle E 'Respect for People's Rights and Dignity', stating that:

> Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, *religion*, sexual orientation, disability, language, and socioeconomic status and consider these factors when working with members of such groups. Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices (p.4, emphasis added).

Similarly, the New Zealand Code of Ethics for Psychologists (New Zealand Psychologists Board, 2002, p. 5), Principle 1 'Respect for the Dignity of Persons and Peoples' states:

> Respect requires sensitivity to cultural and social diversity and recognition that there are differences among persons associated with their culture, nationality, ethnicity, colour, race, *religion*, gender, marital status, sexual orientation, physical or mental abilities, age, socio-economic status, and/or any other personal characteristic, condition, or status. Such differences are an integral part of the person (p.5, emphasis added).

Similar statements can be found in the British Psychological Society Code of Ethics under Principle 1.1: Standard of General Respect (Ethics Committee of the British Psychological Society, 2009) and in the Australian Psychological Society Code of Ethics under Principle A.1: Justice (Australian Psychological Society, 2007). In 1994 religious/spiritual problems were included in the fourth edition of the Diagnostic and Statistical Manual (DSM-IV) under 'Other Conditions That May Be A Focus of Clinical Attention', coinciding with the inclusion of a section on cultural formulation (Appendix

I; American Psychiatric Association, 1994). Additionally, the United States Accreditation Council on Graduate Medical Education added training in sensitivity and responsivity to culture, including R/S, in their 1994 requirements for psychiatry training (Accreditation Council on Graduate Medical Education, 1994). While not a standard for accreditation in the American Psychological Association, the consideration of R/S has been included within guidelines for multicultural considerations in training, practice, and organisational change (American Psychological Association, 2002).

When practitioners are asked about their attitudes toward the consideration of R/S in mental health care their responses are generally positive, although practitioners' confidence in being able to competently consider R/S in practice tends to be low (Durà-Vilà, Hagger, Dein, & Leavey, 2011; Lawrence et al., 2007; J. Q. Morrison, Clutter, Pritchett, & Demmitt, 2009; Shafranske & Malony, 1990; J. S. Young, Wiggins-Frame, & Cashwell, 2007). A survey by Hathaway, Scott and Garver (2004) found that 74% of 332 American Psychological Association members believed clients' religious/spiritual beliefs were an important area of functioning, while a later survey of the same group found that 82% believed religious and spiritual beliefs had beneficial effects on mental health (Delaney, Miller, & Bisono, 2007). A random sample of American Counseling Association members found that 92% agreed it was important to be sensitive and respectful toward clients' religious/spiritual beliefs (J. S. Young, et al., 2007), although a large proportion (44%) believed they were unable to competently consider R/S in practice. An early survey of clinical psychologists (Shafranske & Malony, 1990) found that 74% believed that religious/spiritual issues were within the scope of their psychological practice and 87% believed it was important to know of their clients' religious/spiritual background. However, 68% of the respondents in this study believed they did not have the knowledge or skill to help clients with religious/spiritual issues.

The attitudes of practitioners toward the consideration of R/S have been found to influence practitioner-reported consideration of R/S in the care of their clients (Kvarfordt & Sheridan, 2009; Shafranske & Malony, 1990; Sheridan, 2004). Kvarfordt and Sheridan's study found that social workers' attitudes accounted for 52% of the variance in practitioner-reported consideration of R/S. This was lower (21%) in

Sheridan's study. Positive attitudes such as "knowledge of clients' religious or spiritual beliefs is important for effective practice" and the eschewing of attitudes such as "religious concerns are outside of the scope of social work practice" were facilitative of greater religious/spiritual consideration. A smaller group of practitioners hold less favourable opinions toward the consideration of R/S and others are often conflicted on this matter despite their support of positive attitudinal items in surveys (Durà-Vilà, et al., 2011; Magaldi-Dopman, Park-Taylor, & Ponterotto, 2011). Such conflict arises from several sources, including perceptions regarding the role of R/S in psychotic illnesses and inflexible religious mindsets (sometimes referred to pejoratively as fundamentalist) (Koenig, 2008b; Magaldi-Dopman, et al., 2011; Neeleman & Persaud, 1995; Sullivan, 1993), a fear of opening a 'pandora's box' (Lindgren & Coursey, 1995), ethical concerns (e.g., Cook, et al., 2011; Gonsiorek, Richards, Pargament, & McMinn, 2009), and a lack of preparedness and training in dealing with religious/spiritual subjects (Durà-Vilà, et al., 2011; Magaldi-Dopman, et al., 2011). These studies point to a gap between awareness of best practice and practitioners' comfort with implementation. In addition to those just mentioned, there are a number of barriers to considering R/S that are relevant and require attention. These will be discussed next.

IMPEDIMENTS TO CONSIDERING RELIGION AND SPIRITUALITY IN MENTAL HEALTH CARE

Despite the generally positive attitude toward the consideration of religion/spirituality in mental health care, there may be a number of reasons why practitioners report they are less confident to actually consider R/S in practice. Some impediments to practitioners' comfort and confidence in considering R/S in mental health care will be discussed here, including the religiousness/spirituality of practitioners, the beliefs and attitudes held by practitioners toward R/S in mental health care, concerns around dealing with harmful religious/spiritual beliefs, professional and personal boundary issues, and ontological and value differences between religion/spirituality and psychology. Solutions to these impediments will be discussed, including an ethical decision-making response to religion/spirituality in mental health care (Barnett & Johnson, 2011), and the role of education and training.

The 'religiosity gap'

Mental health practitioners, particularly psychologists and psychiatrists, tend to hold religious/spiritual beliefs at a lower rate than the general population and the population of clients they serve. A survey of 258 psychologists across the United States (Delaney, et al., 2007) found that psychologists were less likely to believe in God than the general American population (32% vs. 64%) and were more likely to endorse R/S as 'unimportant' in their lives (48% vs. 15%). These results were similar to those reported by an earlier survey of U.S. psychologists (Shafranske, 1996). Similarly, a survey of psychiatrists in Canada found that 54% of psychiatrists believed in God, compared with 71% of clients and 81% of the general population (Baetz, Griffin, Bowen, & Marcoux, 2004), while 88% of a group of psychiatric patients in New Zealand stated they believed in God or a higher power, compared to 63% of their psychiatrists (de Beer, 1998). It is important to keep in mind the previous discussion regarding the paradigms of secularism and positivism that dominate the relationship between R/S and mental health care. This may, in part, explain why practitioners are generally found to be less religious or spiritual than the general population. Indeed, religious migrant psychologists in London reported that they felt they had to 'leave their religion behind' when they started work as practitioners in England (Durà-Vilà, et al., 2011). The religiosity gap creates an impediment for both religious/spiritual and non-religious/spiritual practitioners: religious/spiritual practitioners in Dura-Vila, Haggar, Dein and Leavey's British study felt that two major barriers to considering R/S in their practice were the fear of being perceived as "'anti-modern', 'unscientific', and 'unprofessional'" (p.57) by colleagues and supervisors and the fear they might not fit into a secular working environment. For non-religious/spiritual practitioners, religion and spirituality rarely feature as salient aspects in their personal, social or occupational spheres. It is possible that this lack of salience may lead to a relative inattention to this aspect in clients' lives.

The gap between the beliefs of practitioners and clients is not insignificant in its impact. In a grounded theory analysis of psychologist's views on the consideration of R/S, Magaldi-Dopman et al. (2011, p. 295) found that:

> Psychologists' backgrounds affected the way they conceptualized clients' spiritual/religious material in psychotherapy, influenced the way they chose to approach the material, affected their attitude toward spiritual/religious material, and ultimately had bearing on the importance psychologists placed on clients' religious/spiritual concerns (p.295).

This association between the religiousness/spirituality of practitioners and their in-therapy behaviours has been documented by two quantitative studies. Baetz et al. (2004) found that practitioners' intrinsic spirituality was strongly associated with their self-reported frequency of enquiring about religious/spiritual concerns, while Kvarfodt and Sheridan (2009) found that social workers' personal religious/spiritual beliefs strongly influenced their attitudes regarding the consideration of R/S in mental health care. The influence of these attitudes will be discussed next.

Practitioner attitudes and assumptions regarding religion and spirituality

The consideration of religion/spirituality in mental health care is a subject fraught with strong ideologies and powerful emotions. One example is an exchange between several authors regarding recommendations published by Harold Koenig (2008). Koenig's recommendations included taking a spiritual history from clients, showing respect and support for clients' religious/spiritual beliefs, challenging distress-inducing religious/spiritual beliefs, praying with clients, and consulting with clergy. These recommendations were presented alongside an appropriate acknowledgement of clinical and ethical issues (e.g., it is almost never appropriate to pray with clients), yet they were met with vigorous opposition and, despite the underlying merits of Koenig's recommendations, a lesser degree of support (Carter, 2008; Dein, Cook, Powell, & Eagger, 2010; Hilton, 2008; Lepping, 2008; Mushtaq & Hafeez, 2008; Poole et al., 2008). Most of the opposing authors cited professional boundaries and unrealistic demands as reasons for not upholding Koenig's recommendations. While some pointed to the need to 'respect' clients' religion/spirituality by not offending them (ignoring the possibility that offence can be taken to omission), none acknowledged the potential importance of R/S to clients' mental health. The concerns raised were mostly valid but were often based upon miscontruals of Koenig's recommendations and disregard of his rationale.

In such a climate, even general discussion regarding R/S in clinical practice with colleagues can seem intimidating (M. Baker & Wang, 2004; Delaney, et al., 2007; Durà-Vilà, et al., 2011; Myers & Baker, 1998). A reluctance to discuss such matters due to the risk of an emotionally charged response from others can mean that misunderstandings about the role of R/S in mental health are not challenged or are perpetuated, along with a reduced openness and curiosity toward the religious/spiritual beliefs of clients in clinical practice. Practitioner beliefs and attitudes have a bearing on the consideration of R/S in mental health care, so it is essential that practitioners are able to engage in honest, respectful, and open discussions with colleagues and supervisors, with the view to exploring and evaluating their own beliefs regarding the role of R/S in mental health.

Assumptions and heuristics. Koenig (2008) suggests that practitioners can become biased against recognising R/S as a positive influence in clients' lives because of religious/spiritual content in psychological disorders such as psychosis and the use of R/S by a small number of individuals to justify harm. It is important to note that recent longitudinal evidence points to a primarily positive influence of R/S in the lives of clients with psychosis, finding that only 14% of patients held 'harmful' religious/spiritual beliefs (e.g., those associated with distress), while 83% held 'helpful' beliefs (e.g., those associated with acceptance and positive coping). Helpful beliefs were associated with better social functioning, quality of life, clinical global impression, and fewer negative symptoms three years later. Harmful beliefs were not associated with negative longitudinal outcomes (Mohr, et al., 2011).

Koenig's (2008) suggestion coincides with warnings by Plante (2007) and Ridley and Kelly (2007) to avoid judgement heuristics. When a discussion of R/S arises, the salient involvement of R/S in severe mental illness and in justifying harm is readily recalled but is rarely the most significant issue for the majority of religious/spiritual clients and can distract attention from the positive role of R/S. The three most common judgement heuristics that Ridley and Kelly warn against include the availability heuristic, whereby practitioners make judgements on the basis of salient information; the anchoring

heuristic, whereby practitioners fixate on the first piece of information that is raised in an assessment and do not attend to new information; and the representativeness heuristic, whereby practitioners rely upon 'prototypical' stereotypes and ignore the base rates of pathological expression.

There is empirical evidence to suggest that practitioners over-estimate pathology when they use heuristics and their own cultural frame of reference to decide whether clients' religious/spiritual beliefs are pathological (Houts & Graham, 1986O'Connor, 2010 #805; S O'Connor & Vandenberg, 2005). This leads to the labelling of certain religious/spiritual beliefs and experiences as 'bizarre' when clinicians (secular or religious/spiritual) are unfamiliar with the client's cultural context (Bray, 2010; Ng, 2007; S O'Connor & Vandenberg, 2005; S. O'Connor & Vandenberg, 2010; L. Smith, et al., 2009). It requires noting that religious/spiritual practitioners also have the tendency to over-pathologise non-religious/spiritual clients' difficulties by making more internal attributions for their difficulties than for religious/spiritual clients (Houts & Graham, 1986). This suggests the tendency to over-pathologise is a danger for any practitioner (secular or religious/spiritual) who is seeing a culturally-different client.

Findings such as this have led authors to recommend a thorough and careful assessment of the role of clients' religion/spirituality in order to avoid over-pathologisation. Several sets of criteria have been established to help clinicians differentiate between 'non-pathological' and 'pathological' beliefs and experiences in a way that separates clinical importance (e.g., distress and preoccupation vs. content and conviction) from practitioners' personal reaction toward subjectively bizarre or objectional beliefs (Menezes & Moreira-Almeida, 2010). A similar approach can be taken for clients who hold particularly rigid religious/spiritual beliefs. In addition, Ridley and Kelly (2007) outline several 'debiasing strategies' to help practitioners avoid the use of judgement heuristics. These include searching for alternative explanations, reframing interpretations of behaviour (e.g., viewing a client's dependence on spiritual messages, traditional healers or religious rituals as a strength instead of, or in addition to a weakness), and delaying decision making until further information has been gathered.

As practitioner attitudes are important in the consideration of religious/spiritual beliefs (Kvarfordt & Sheridan, 2009), personal awareness and willingness to investigate ones' own overly positive or negative attitudes toward R/S are important (Plante, 2007). Practitioners should be aware of any heuristics they may rely upon and be willing to identify and empirically challenge any assumptions they may make with regard to the role of R/S in mental health and clinical practice. Of course, valid concerns do arise when considering clients' religious/spiritual beliefs. Some of these will be discussed next.

Harmful religious/spiritual beliefs

As discussed in the previous chapter, clients' religious/spiritual beliefs can both help and harm in numerous ways. Although the weight of evidence is toward a helpful role of R/S, practitioners are sometimes faced with the dilemma of how to address religious/spiritual beliefs that appear to be harming their clients' or others' wellbeing. Knapp, Lemoncelli, and VandeCreek (2010) provide a thoughtful discussion on this topic, suggesting the practitioner carefully consider the reasons and threshold for modifying the clients' beliefs using Beauchamps and Childress' (2001) ethical decision-making process. One of their key assertions is that religious/spiritual beliefs should only be challenged in situations where not doing so would allow harm to the client or others, keeping in mind the tendency to over-pathologise religious/spiritual beliefs that one is not familiar with (Knapp, et al., 2010; S. O'Connor & Vandenberg, 2005). If the belief is partially harmful (i.e., causing low-level stress), Knapp et al. suggest that the practitioner engage in a respectful, nonjudgemental discussion regarding the different options and viewpoints available to the client and accept the client's eventual choice (see also Lomax, Karff, & McKenny, 2002). A recent suggestion has been to utilise motivational interviewing techniques if required (W. R. Miller & Rollnick, 2013; Rosenfeld, 2011). A trusted clergy-person can be included in this process if needed (refer to Edwards, Lim, McMinn and Dominguez, 1999 and McMinn, Aikins and Lish, 2003 for suggestions and examples). Additionally, harm reduction strategies can be implemented if the client chooses to retain the harmful belief. In the rare exception of highly harmful beliefs (e.g., threat of violence to self or others) that do not shift in response to the above interventions, Knapp et al. suggest the practitioner respectfully

acknowledge the client's justifications for holding this belief and any benefits this belief has had. Within the context of a well-developed therapeutic relationship, a comprehensive assessment of the client's R/S values, and appropriate consultation they then suggest the practitioner directly challenge these specific beliefs using incongruencies within the client's belief system (e.g., how does being violent toward your spouse fit with the fruits of the Spirit in the Bible, such as being peaceful, patient, kind?). Allowing the client time to consider these questions may shift the client toward re-evaluating their current belief. Incongruencies can be uncovered using Socratic questioning or can be built by reinforcing adaptive beliefs or behaviours that are incompatible with the client's maladaptive ones.

Professional and personal boundaries

Several boundary issues will be touched on here. First, the decision making process involved in deciding whether a particular religious/spiritual belief needs to be challenged is heavily influenced by practitioners' attitudes and assumptions; mental health care is inherently value-laden. Professional boundaries also become an issue when practitioners try to serve the roles of both mental health professional and clergy. Additionally, boundaries come to the fore when clients ask practitioners to engage in religious/spiritual rituals with them. Finally, self-disclosure of religious/spiritual beliefs is sometimes expected by clients and can be useful in the informed consent process, but also has the potential to be detrimental; this issue will also be discussed.

Practitioner values.

Values and their related biases become an issue of concern when practitioners implicitly encourage their clients to take on their own viewpoint or overlook a seemingly positive belief that might in fact be harmful to the client. At the extreme, the imposition of practitioners' own values can include attempts to convert clients to the practitioners' own R/S orientation (Plante, 2007) or overlooking potentially serious mental health issues disguised as religious devotion (e.g., scrupulosity; Gonsiorek, et al., 2009). This can also include attempts to modify clients' religiously/spiritually-informed beliefs that the practitioner disagrees with but are not in fact harmful to the client (Knapp, et al., 2010). Respect for the clients' beliefs is of utmost importance, and

practitioners must be aware of the potential influence of their own values and associated biases (Bergin, 1980; P. S. Richards & Bergin, 2005).

Dual relationships.

Another difficulty involves negotiating and maintaining the boundary between mental health practitioner and religious/spiritual advisor or clergy in a way that does not place the practitioner in the position of having multiple roles in the client's life (Plante, 2007). Ethical boundaries around informed consent, confidentiality, and value transfer can differ greatly between clergy (e.g., pastoral care workers, religious leaders) and mental health professionals (Gonsiorek, et al., 2009; Plante, 2007). Mental health practitioners who also provide counselling/pastoral services within a religious/spiritual community may need to be particularly clear about which role they are operating in (e.g., psychologist or pastoral care worker) and the boundaries and limitations of their particular role in that setting, especially if they are likely to frequently encounter their client outside of consultations. On this issue of dual roles, Gonsiorek et al. (2009, p. 388) also warn against "(…) a careless slide from religiously sensitive psychological services to primarily religious services". It is suggested this can occur either by the failure to maintain standards of psychological practice (ethical and empirical) or because clergy often maintain a more personal relationship with individuals in their religious/spiritual communities. Clergy subsequently acting as mental health practitioners may find it difficult to shift to a professional relationship with fewer personal elements. Plante suggests that mental health practitioners avoid this ethical dilemma by either not treating clients from their religious/spiritual community under their professional role, or by carefully considering the potential for a dual relationship to emerge before accepting a referral.

Participating in religious/spiritual rituals.

Rosenfeld (2011) offers several suggestions to explain why practitioners tend not to pray with their clients. These included a fear of 'diluting' psychological services with religious services or a fear of crossing professional boundaries and imposing their own values upon the client. Interestingly, neither of these explanations consider the personal boundaries of the practitioner. That is, practitioners may not consider it personally acceptable to pray with clients or engage in other religious/spiritual rituals because they are uncomfortable with this. Participating in religious/spiritual rituals with clients is a

level of R/S consideration that has a high risk of causing discomfort for both practitioner and client, unless the practitioner identifies with the same religious/spiritual belief system and both client and practitioner have discussed their level of comfort with utilising such interventions (Koenig, 2008b; Lomax, et al., 2002). With the exception of explicitly consented religious/spiritual interventions delivered by explicitly religious/spiritual practitioners, practitioners should not assume their participation in R/S rituals in therapy is acceptable to their client, nor should they have to do so if they believe that doing so is personally unacceptable (Lomax, et al., 2002). According to Koenig (2008), such rituals should only be requested and initiated by the client. If this occurs, it may be helpful for practitioners to have already considered their level of personal comfort, competence to participate in such rituals, and defined the activities in therapy/care that are acceptable or unacceptable to them. Ideally, this level of comfort and involvement is discussed as part of the ongoing informed consent process that will be discussed later (Barnett & Johnson, 2011).

Self-disclosure.

Several authors have recommended that practitioners disclose their own religious/spiritual beliefs to clients (Kuczewski, 2007; McMinn, 1984; Zinnbauer & Pargament, 2000). Religion and spirituality are highly personal aspects of individuals' lives and can engender a range of reactions when shared with others. However, when dealing with a client where R/S is a potentially important factor to be considered, disclosing whether one shares similar beliefs may allow clients to feel more comfortable opening up about their own religious/spiritual beliefs and can assist in the informed consent process. By doing this, religious/spiritual clients can also choose their own level of religious/spiritual self-disclosure and whether they are comfortable continuing with this practitioner or would prefer referral to another. Frazier and Hansen (2009) found that most practitioners in their study did not regard self-disclosure of R/S as important, but warned that "unlike racial/ethnic differences, which are typically more visible, the invisible nature of the religious/spiritual similarities or differences between therapist and client may produce distinctive psychotherapy dynamics" (p.85).

To date, it appears there is little empirical research on the effects of disclosing religious/spiritual beliefs to clients, except an analogue study of male college students of Jewish and Christian affilitation (Chesner & Baumeister, 1985). This study found

that the intimacy of clients' self-disclosures was highest when practitioners disclosed a similar religious/spiritual affiliation or who did not disclose at all. Clients' intimacy of self-disclosure was lowest when the practitioner disclosed different religious/spiritual beliefs to the client. The finding regarding non-disclosure is contrary to research on practitioners' disclosure of other aspects of their personal life, which has generally demonstrated positive effects. In a study of the effects of therapist disclosure, Hanson (2005) found that clients were twice as likely to find disclosure helpful (as opposed to neutral). Non-disclosure, on the other hand, was twice as likely to be experienced as unhelpful rather than neutral. Some helpful effects of disclosure included a feeling of connectedness to the practitioner, increase in trust and safety, a decrease in alienation, a feeling of being understood and cared for, and an opportunity to identify with the therapist as 'human'. Non-disclosure was generally experienced as unhelpful in that it tended to erode trust and was experienced as breaching the therapeutic alliance, sometimes causing embarrassment and inhibiting clients' own disclosures.

There are risks involved when practitioners are not judicious in their use of self-disclosure, such as taking the focus away from the client and encouraging poor therapeutic boundaries (Kramer, 2000). Hanson reported that unhelpful effects of self-disclosure included feeling less safe around the therapist and feeling a need to become the therapist's caretaker. Disclosure can be considered on a case by case basis and only after considering the likely clinical outcome of doing so, examination of ones' motives for disclosure, personal boundaries and comfort with disclosing such information (Denny, Aten, & Gingrich, 2008; Passmore, 2003). Practitioners' skillfulness in handling self-disclosure (i.e., having established rapport, using disclosure that is purposeful, in context, and brief with few details) may be an important determinant of whether the client finds the self-disclosure helpful (J. Hanson, 2005). In situations where the practitioner discloses that they hold religious/spiritual beliefs, the client should be reassured the practitioner will expect and respect differences between their own and the clients' beliefs. The American Psychological Association's Division 36 preliminary guidelines for considering R/S includes several guidelines on self-disclosure of religious/spiritual beliefs (Hathaway & Ripley, 2009, p. 48):

> M.4. Psychologists are mindful of factors that influence the appropriateness of their own religious/spiritual self-disclosure to a client. These include but are not limited to disclosures that are
>
> (a) Congruent with the treatment orientation or approach used,
>
> (b) Consistent with other general background self-disclosures offered to a treatment at the outset of treatment,
>
> (c) Facilitative of the treatment, and
>
> (d) Necessary to address a potential value conflict that might impede treatment.

For those do not wish to disclose, Leach et al. (2009, p. 81) provide an example of a 'professional self-disclosure of view on spirituality', whereby the practitioner does not specifically self-disclose their own religious/spiritual beliefs, but discloses their view of the role of R/S in therapy when required. This is a potentially useful way to balance the risks and benefits associated with religious/spiritual self-disclosure.

Ontological and value differences

Difficulties considering religion/spirituality in mental health care are not solely limited to practitioner or institutional variables, and these difficulties are not limited to discussions of R/S. There are a number of topics that are simply difficult to discuss with others, such as political ideologies, sexuality and sexual experiences, evaluative thoughts about the other, and religion/spirituality. Naturally, as with other value-laden topics and/or topics likely to cause discomfort, one would expect some clients to avoid initiating discussion of R/S despite the relevance of this in their life. Indeed, a small number of clients have reported they would not raise religious/spiritual matters in therapy because they generally feel uncomfortable doing so (Lindgren & Coursey, 1995). For some, this may be because they believe it is irrelevant to their care (Rose, et al., 2001). For others, discomfort may arise because of expectations that mental health practitioners will negatively evaluate or be disinterested in their religious/spiritual beliefs, will not understand their beliefs, or will cause them to act in opposition to their values (Keating & Fretz, 1990; King Jr, 1978; Mayers, Leavey, Vallianatou, & Barker, 2007; Mitchell & Baker, 2000; E. L. Worthington & Scott, 1983). Religious/spiritual

clients are right to be concerned as the historical relationship between psychology has been somewhat antagonistic at times. In addition to this historical distrust, some basic ontological and value differences exist between R/S and psychotherapy that can make it difficult for clients to discuss R/S.

A survey of Evangelical Christians in San Diego found that 33% of those who expressed negative views toward professional psychological services did so because they felt the theories of psychology were incompatible with their religion/spirituality (King Jr, 1978). For some, the fundamental differences between the core tenets and values of religion and psychotherapy were too great to ignore. A suspiciousness about the psychological professions exists amongst many religious communities. Extreme examples can be found in books such as Ed Bulkley's *Why Christians Can't Trust Psychology* (Bulkley, 1994) and Christian web-based news articles such as *Psychology and Psychiatry: Rotten To The Core* (Blake, 2012). Much of this incompatibility is based upon basic differences in ontology that influence theories regarding the cause and cure of difficulties.

A number of authors (e.g., Bergin, 1980, 1991; Cook, et al., 2011; Kelly & Strupp, 1992; Ellis, 1980; Pargament, 2009) have pointed out that mental health care is inherently value-laden, and mainstream psychotherapy and religion often differ substantially on the values they espouse (Bergin, 1980; Giglio, 1993). In the process of psychotherapy and mental health care in general, everything from selecting the desired outcomes to identifying factors that require change and the process by which change occurs, requires decisions that label one alternative as more desirable than another (Bergin, 1980; Pargament, 2009; E. L. Worthington & Scott, 1983). Such decisions must emerge from value systems. In Bergin's (1980, p. 98) view, "Two broad classes of values are dominant in the mental health professions [clinical pragmatism and humanistic idealism]. Both exclude religious values, and both establish goals for change that frequently clash with theistic systems of belief". Clinical pragmatism refers to the practitioner as an agent of culture; a conduit of the values held by the majority culture. In mental health care services, these values are to reduce disturbance to self or others (Bergin, 1980). As noted earlier in the discussion on the 'dark night of the soul',

disturbance is not always pathological. Although distress and suffering are not necessarily sought after as a religious/spiritual value, they are not always avoided either. For example, Christians often refer to Romans 5:3-4 in the *Bible* (New Living Translation)*:* "We rejoice in our sufferings, knowing that suffering produces endurance, and endurance produces character, and character produces hope". The second value system discussed by Bergin was humantistic idealism. This is a value system which is more applicable to individualist societies and refers to the promotion of an ideal state of being that includes self-focussed values such as self-worth, independence, individual happiness and striving to reach ones' full potential (Bergin, 1980). In contrast, theistic religions place the will of God above the will of self. Islam, for example, literally means 'submission to God'. In contrast to the comfort sought by clinical pragmatism and humanistic idealism, fufilling God's will is acknowledged in theistic religions as sometimes painful and counter-cultural. For example, the *Bible* (New Living Translation)*:* Matthew 5:10 "God blesses those who are persecuted for doing right…" and Romans 12:2*:* "Don't copy the behavior and customs of this world, but let God transform you into a new person by changing the way you think. Then you will learn to know God's will for you". While some of these value systems are not entirely incompatible, many incompatibilities do exist. A more comprehensive list of differences is offered by Bergin (1980). Encouragingly, Jensen and Bergin (1988) later published a list of values that do not appear quite so antithetical to those of religious/spiritual clients, such as being committed to relationships and being sensitive, trustworthy and nurturant; displaying good interpersonal communication; forgiving others and oneself, having values, meaning, purpose, and fulfillment; awareness and motivation for growth; caring for ones' physical being; possessing adaptive coping skills and having integrity.

As Bergin noted (1991, p. 396): "The real issue is how to use values to therapeutic advantage without abusing the therapist's power and the client's vulnerability". Being aware of ones' own values may assist practitioners to be more aware of differences and similarities compared to their clients' values, and how these may or may not benefit the process of therapy. This awareness will possibly reduce the risk that clients will feel their values are considered unimportant or imposed upon. Given that psychotherapy values affect the types of goals and changes that are selected (Bergin, 1980; E. L. Worthington & Scott, 1983), the risk of ignoring or changing clients' values may be

further reduced by the use of a collaborative approach in the psychotherapy relationship, where problems, goals, and formulations are agreed on by both client and practitioner (Bergin, 1991; Kuyken, et al., 2009). Familiarising oneself with the types of values religious/spiritual clients hold, such as understanding the authority attributed to religious/spiritual leaders, sacred texts and in-group norms (E. L. Worthington, 1988) may be helpful for understanding how the values of religious/spiritual clients may differ to psychotherapy values.

DEALING WITH IMPEDIMENTS

Authors have offered a number of specific and practical solutions for dealing with the various impediments that have been outlined here. In addition to those already discussed, an ethical decision-making process with regard to addressing religion/spirituality in mental health care, the role of education and training, and the role of self-practice/self-reflection will be discussed.

Responding ethically to religion and spirituality

A number of publications have been devoted to ethical issues regarding the consideration of religion/spirituality in mental health care (e.g., Barnett & Johnson, 2011; Cook, et al., 2011; Gonsiorek, et al., 2009; Knapp, et al., 2010; Warnock, 2009). While some argue that religion and spirituality have no ethical place in the practice of psychotherapy (e.g., Poole & Higgo, 2011), others argue that the failure to consider R/S is an ethical transgression. As Turbott (1996, p. 723) notes, "Harm to patients is possible by both omission and commission", suggesting that practitioners should carefully consider their reasons for not considering R/S as well as potential issues that may arise when they do choose to consider R/S. The Code of Ethics for Psychologists working in Aotearoa/New Zealand (New Zealand Psychologists Board, 2002) states in Principle 1.4.2: "Psychologists recognise that people with whom they work have cultural and social needs, and take reasonable steps to help them meet these needs", which is applicable to recognising the role of R/S in clients' care. The concerns that are raised with regard to practitioner attitudes and assumptions, dealing with harmful

religious/spiritual beliefs, negotiating professional and personal boundaries, and grappling with ontological and value differences all share the commonality that ethical principles should underpin practitioners' responses.

A useful ethical decision making process for the consideration of R/S has been offered by Barnett and Johnson (2011). The phases suggested by the authors fit well with a number of issues discussed here and should be useful for practitioners. These phases include (1) respectfully assessing clients' religious/spiritual beliefs, (2) assessing the connection between clients' presenting difficulties and their religious/spiritual beliefs, (3) establishing informed consent, (4) considering counter-transference reactions, (5) evaluating ones' competence to consider religion/spirituality, (6) consulting with relevant experts, (7) consulting with clergy where appropriate, (8) choosing whether to proceed or refer, and (8) assessing outcomes, making adjustments where required.

With regard to the first two phases, including R/S in assessment helps to ensure a potentially relevant area of the client's life is not omitted from the client's care and is a chance for any ethically difficult issues to be highlighted early rather than later in the professional relationship (Barnett & Johnson, 2011). Assessing religious/spiritual beliefs will be discussed in more depth later.

The third phase outlined by Barnett and Johnson (2011) is to use information from the assessment in establishing informed consent. According to Barnett and Johnson, informed consent is a process which "should provide clients with information that they would generally find relevant to deciding if they want to participate in the professional relationship" (p.151). This is supported by Principle 1.7.6. of the Code of Ethics for Psychologists in Aotearoa/New Zealand (New Zealand Psychologists Board, 2002). Informed consent with regard to the role of R/S in mental health care is important because preferences and expectations on the behalf of both client and practitioner sometimes differ with regard to the extent and manner that religion and spirituality are addressed in care.

The fourth phase suggested by Barnett and Johnson (2011) is to honestly consider countertransference reactions to religious/spiritual beliefs raised by the client. This fits with the issues of practitioner attitudes, assumptions, and values outlined earlier. To determine whether one's own attitudes, assumptions or values impact upon the therapeutic process, one must pay attention to them and give thought to how they affect clinical decision making and the professional relationship. Failure to do so would contradict ethical principles such as Principle 2.2.5. of the Code of Ethics for Psychologists working in Aotearoa/New Zealand (New Zealand Psychologists Board, 2002):

> Psychologists seek to maintain an awareness of how their own experiences, attitudes, culture, beliefs, values, social context, individual differences and stresses, influence their interactions with others and integrate this awareness into all aspects of their work (p.10).

The fifth phase is to honestly evaluate one's level of competence to deal with these beliefs at the level required and if needed, consult with relevant experts (phase six). With regard to this, the Code of Ethics for Psychologists working in New Zealand/Aotearoa Principle 1.4.1 states: "Psychologists seek to be responsive to cultural and social diversity and, as a consequence, obtain training, experience and advice to ensure competent and culturally safe service or research" (New Zealand Psychologists Board, 2002). Identification with a particular religious/spiritual orientation does not automatically qualify one as competent to address R/S with clients who identify with a similar R/S orientation, nor with clients from a different orientation (Gonsiorek, et al., 2009; Plante, 2007). However, having knowledge of the basic tenets of a client's religious/spiritual orientation does assist in developing competence (Barnett & Johnson, 2011), as does having a basic interest in and appreciation for the impact of clients' religious/spiritual beliefs (Gonsiorek, et al., 2009). To develop competence, Richards and Bergin (1997) suggest that practitioners seek out foundational training in multicultural practice skills, read scholarly publications written to assist practitioners in considering religious/spiritual issues in mental health care including those that outline the specific religious/spiritual beliefs and practices of clients the practitioner is likely to

encounter, attend relevant workshops and other professional development opportunities, and seek supervision and discussion with colleagues. Training and education will be discussed in more detail later.

Phase seven of Barnett and Johnson's (2011) ethical response process involves consulting with the client's clergy if required and/or if the client believes this may be of use. Clergy may be available to consult when a practitioner is unsure whether their client's religious/spiritual beliefs are culturally normative. Clergy can also act as a support to the client, help to collaborate with religious/spiritual interventions, and assist with religious/spiritual questions that might impact upon the client's mental health (Edwards, Lim, McMinn, & Dominguez, 1999). McMinn, Aikins and Lish (2003) provide a useful and practical discussion of the opportunities and issues surrounding collaboration with clergy that practitioners can refer to as a starting point.

Phase eight includes making a decision as to whether to proceed or to refer. This should be done on the basis of whether the practitioner believes harm may result from continuing the professional relationship and the relative benefits of continuing (Barnett & Johnson, 2011). Relevant to referring on, the New Zealand Code of Ethics states as a comment to Principle 1.2.2. (choosing to not provide a service):

> It is recognised that psychologists cannot always provide a service for reasons of resources and/or expertise. In these circumstances, where the psychologist would usually provide such a service as the one requested, it is best practice to assist the person to find an alternative (p.5).

The final phase involves assessing outcomes and considering any required adjustments. Supervision, maintaining a collaborative working alliance with the client, and seeking feedback from the client on how therapy (or other professional service) is proceeding is integral to this process (Barnett & Johnson, 2011; Plante, 2007). Further assessment and consultation may be required at this point.

Education and training

Many of the difficulties outlined in this chapter could be ameliorated through education and training (Barnett & Johnson, 2011; Wiggins, 2009). Herein lies another difficulty; training on the topic of religion/spirituality in mental health care professions is sparse and it is not clear whether these training components are adequate in their treatment of the subject (Hage, 2006). A recent survey of APA accredited clinical psychology training programmes found that only nine percent of programme directors who oversaw non-religiously affiliated programmes reported that R/S was systematically included in training (i.e., with dedicated coursework, supervision, and research). R/S was covered in a non-systematic/informal manner within 76% of courses through lectures on cultural diversity and ethics/professional issues (R. M. Schafer, Handal, & Brawer, 2011).

Despite the large number of programmes providing at least informal training, practitioners report feeling underprepared and lacking the confidence to address religious/spiritual beliefs in practice. Practitioners often express a desire for more training in this area (Hofmann & Walach, 2011; J. S. Young, et al., 2007). Although R/S may be covered informally by many training programmes, the survey by Schafer et al. did not assess how many students were actually exposed to training. Studies from countries outside of the United States suggest that many students do not receive this exposure; the majority (81%) of 895 German psychotherapists reported that R/S was rarely or never broached in training (Hofmann & Walach, 2011). This proportion was greater (94%) amongst a group of 33 psychiatrists surveyed by de Beer (1998) in New Zealand.

It appears that training in religious/spiritual matters within graduate training programmes has not been subjected to any systematic evaluation, so it is unclear whether students find current training practices effective. The survey of German psychotherapists found that a large proportion (43% of 895) believed their training in religious/spiritual matters was inadequate (Hofmann & Walach, 2011). Perhaps it is the quality of exposure to training on the consideration of R/S that requires further attention rather than a count of training programmes that ‘tick the box’. There is some

preliminary evidence that specific and/or ongoing training in the consideration of religious/spiritual issues is associated with confidence and self-reported practice in addressing religious/spiritual beliefs in health care (Frazier & Hansen, 2009; Hofmann & Walach, 2011; Meredith, Murray, Wilson, Mitchell, & Hutch, 2012). It would be useful for research such as this to elucidate the most effective components of training so recommendations can be applied to graduate training programmes. For example, Hwang (2006) suggest that skills-based training to deal with cultural concerns in mental health care would be a useful addition to awareness-based cultural competency education. In the meantime, practitioners can seek out additional training to gain competence in considering R/S in mental health care (Hage, 2006; P. S. Richards & Bergin, 1997).

Self-practice/self-reflection

It has been noted that the most consistent predictors of practitioners' own reports of considering religion/spirituality are the importance of R/S in their own lives and their attitudes toward the consideration of R/S (Kvarfordt & Sheridan, 2009; Sheridan, 2004). Frazier and Hansen (2009) have suggested that practitioners examine their own reasons for not considering clients' R/S in their care more often. Practitioners sometimes have valid reasons for not raising the subject of R/S or raising it but not considering it further. Equally likely is that practitioners' attitudes, assumptions, concerns, and other challenges that stop them from considering R/S often go unidentified, unexplored, and unchallenged (Giglio, 1993; La Torre, 2002; Magaldi-Dopman & Park-Taylor, 2010; Magaldi-Dopman, et al., 2011). Qualitative research with psychologists that examined their experiences of discussing religion/spirituality in therapy (Magaldi-Dopman, et al., 2011) found that:

> Psychologists attempt to be 'unbiased guides' but express biases and make assumptions that can impede the therapeutic process. They have limited academic training in spiritual/religious issues, with few or no opportunities that foster increased self-awareness in this area during their training (p.292).

This is where practitioner self-training tools, such as self-practice/self-reflection (SP/SR), may be useful. Self-reflection is not a new concept in the literature on considering R/S in mental health care. Several authors have recommended that

practitioners engage in a process of self-reflection to assist them in understanding the role of R/S in their own lives, that of their clients, and in therapy (e.g., Frazier & Hansen, 2009; La Torre, 2002; Magaldi-Dopman & Park-Taylor, 2010), but systematic techniques for actually doing this are rarely referenced. There has been an increased focus on the use of self-reflection/self-practice as a self-training tool in cognitive therapy (e.g., Bennett-Levy et al., 2001; Haarhoff, Gibson, & Flett, 2011; Laireiter & Willutzki, 2003). This refers to the practice of cognitive therapy on oneself (self-practice), followed by refection on this process and its learning outcomes for the practitioner (self-reflection). Recent empirical work on the use of an SP/SR workbook amongst recent graduates of a CBT training programme found that as a result of SP/SR, graduates reported qualitative improvements in various aspects of their understanding of CBT and their clinical practice, including an improved sense of empathy for clients; a better ability to conceptualise the therapeutic relationship; and improved recognition of the importance and utility of collaborative case conceptualisation (Haarhoff, et al., 2011). Self-practice/self-reflection may also be useful for training practitioners to identify and address their own schema, assumptions, and even some of the practical issues that affect their consideration of R/S in therapy. In support of this application of SP/SR, its use has begun to be incorporated into cultural competence training at Massey University in New Zealand. The utility of SP/SR is not confined to training institutions however; practitioners can employ this tool outside of training to assist them in improving their ability to consider R/S in the care of their clients.

This chapter has outlined a number of contextual issues in the consideration of religious/spiritual beliefs in Western mental health care. Historically, the relationship between R/S and psychology has been marked by a number of extreme views which have become more moderate over time. A gradual acceptance of the role of R/S in clients' lives has been reflected in the publication of ethical standards and guidelines, increasing dialogue in the literature, and practitioners' more positive views toward the role of R/S. However, the current relationship exists within the context of several philosophical differences that have the potential to affect integration attempts, as well as a number of additional concerns that can be viewed as impediments to the consideration of R/S. Encouragingly, these impediments are not insurmountable and a number of useful recommendations have been made by authors and practitioners who are open and

committed to investigating a range of approaches to ensure the wellbeing of clients. Having reviewed the contextual issues, impediments and possible solutions, the next chapter reviews models pertaining to the theory and practice of considering R/S in mental health care.

CHAPTER 4

CONSIDERING RELIGION AND SPIRITUALITY: MODELS AND METHODS

Now that impediments and solutions in considering religion/spirituality have been discussed and a context for these has been laid out, attention will now turn to the various approaches used to consider clients' religious/spiritual beliefs in the practice of mental health care. As with the literature investigating the associations between religion/spirituality and mental health, the literature outlining the methods that would see this knowledge applied to mental health care is in need of a theoretical and conceptual basis. For this reason, the purpose of the first half of this chapter is to derive a theoretical and conceptual foundation from the multiculturalism literature. To this end, three complementary models are presented and their relevance to the consideration of religion/spirituality are explored. The second half of this chapter presents a brief overview of methods available to assist practitioners in the consideration of religion/spirituality. Additionally, a summary of empirical research concerning the outcomes of utilising these models and methods is provided.

MODELS OF CONSIDERING RELIGION AND SPIRITUALITY

The increasing focus on the intersection between religion/spirituality and mental health care has developed in tandem with a number of other literatures on the consideration of diverse groups (Hwang, 2006). Overarching these and providing a coherent conceptual foundation is the literature on multiculturalism. Interestingly, the R/S literature rarely refers to the multiculturalism literature and vice versa. This may be partly due to the primary focus of the multiculturalism literature on the consideration of ethnocultural diversity, although many of the general principles are applicable to the consideration of R/S (A. B. Cohen, 2009; Lukoff & Lu, 1999; Whitley, 2012; Zinnbauer & Barrett, 2009).

There are a number of key models that assist in the consideration of multicultural issues. Three will be discussed here, each with a different perspective. D. W. Sue's cultural competence model provides the 'what' (content-focus) perspective of multicultural practice (D. W. Sue, Arredono, & Davis, 1992; D. W. Sue et al., 1982). Fischer's

(1998b) common factors approach provides a perspective on the 'how' (process focus) and, finally, Ramsden's (1990) concept of cultural safety provides an alternative perspective on the definition and evaluation of cultural competence.

Multicultural competencies model

A well-recognised model for the consideration of culture in mental health care is the multicultural competencies (MCC) model (D. W. Sue, et al., 1992; 1982). The first version of the model was published in 1982 in response to increasing recognition of cultural issues in mental health care, its impetus provided by the US Civil Rights movement and empirical evidence that ethnic minorities were being underserved by mental health care services (Ponterotto, 2008). In particular, ethnic minorities were observed to underutilise mental health services, drop out of therapy at a higher rate than American Caucasians, and preferred therapists from similar ethnic backgrounds (Atkinson & Thompson, 1992). Interestingly, similar trends have been found for religious/spiritual groups. This includes R/S clients' reluctance to utilise professional mental health services (Mitchell & Baker, 2000; Wang, Berglund, & Kessler, 2003), apprehension when expecting to see a secular mental health professional (Keating & Fretz, 1990; King Jr, 1978; Mayers, et al., 2007; Pilkington, et al., 2011; E. L. Worthington & Scott, 1983), a preference for practitioners with a similar religious/spiritual orientation (Belaire & Young, 2002; Gockel, 2011; Lindgren & Coursey, 1995; Pieper & van Uden, 1996; D. Walker, Worthington, Gartner, Gorsuch, & Hanshew, 2011; E. L. Worthington, et al., 1996), and high levels of therapy drop-out when religious/spiritual clients experience a neglect of their religious/spiritual beliefs in mental health care (Gockel, 2011; Lindgren & Coursey, 1995).

In general, the MCC model outlines the 'what' of cultural competence. In this model, culturally competent practitioners are defined as being those who (a) are aware of their own biases, values, and assumptions, (b) actively attempt to understand the worldview of their client, and (c) develop appropriate intervention strategies and techniques. Each of these characteristics is defined as having three dimensions: attitudes/beliefs, knowledge, and skills. The competencies defined by each of these characteristics and dimensions were published in 1992 and informed the multicultural competencies

adopted by the American Psychological Association's *Guidelines for Multiculturalism in Psychological Training and Practice* (2003). A condensed version of the competencies is outlined in Table 1.

A large proportion of the competencies outlined in Table 1 are relevant to the consideration of R/S in mental health care. For example, the competency 'Mental health practitioners [MHPs] understand the generic characteristics of mental health service provision and how they may clash with the values of other cultural groups' is applicable to the issues of ontological and value differences discussed in Chapter Three. Similarly, the competency 'Mental health practitioners are familiar with relevant research regarding mental health of various cultural groups' is reflected in the literature which discusses mental health issues relevant to religious/spiritual clients.

Table 1. *D. W. Sue et al.'s (1992) model of cultural competencies*

Characteristics of culturally competent MHPs	Dimensions of each characteristic		
	Beliefs/Attitudes	Knowledge	Skills
MHPs are aware of their own assumptions, values and biases	MHPs believe that cultural self-awareness and sensitivity to one's own cultural heritage is essential	MHPs have specific knowledge of their own cultural heritage and how this affects their definitions of normality/abnormality and the process of MHSP	MHPs seek out educational and consultative experiences to enrich their understanding and effectiveness in working with culturally different populations
	MHPs are aware of how their own cultural background and experiences have influenced attitudes, values, and biases about psychological processes	MHPs understand how oppression, racism, discrimination and stereotyping affect them personally and professionally	MHPs seek to understand themselves as racial and cultural beings and seek a nonracist identity
	MHPs are able to recognise the limits of their multicultural competency and expertise	MHPs possess knowledge about their social impact upon others and are knowledgeable about communication style differences	
	MHPs are comfortable with differences that exist between themselves and clients		
MHPs understand the worldview of culturally different clients	MHPs are aware of their negative emotional reactions toward other groups. They hold a non-judgemental awareness of differences	MHPs possess specific knowledge of the group and culturally-different clients they are working with	MHPs are familiar with relevant research regarding mental health of various cultural groups
	MHPs are aware of their stereotypes and preconceived notions toward other cultural groups	MHPs understand how culture may affect personality, vocational choices, psychological disorders, help-seeking behaviours and appropriateness of MHSP approaches	MHPs become actively involved with minority individuals outside the professional setting so their perspective is more than an academic or helping exercise
		MHPs understand sociopolitical influences that impinge upon the life of minority clients	

Note. MHP = Mental Health Practitioner. MHSP = Mental Health Service Provision.

Adapted from Sue, D. W., Arredono, P., & Davis, M. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling & Development, 70*, 477-486

Table 1. *D. W. Sue et al.'s (1992) model of cultural competencies ... cont.*

Characteristics of culturally competent MHPs	Dimensions of each characteristic		
	Beliefs/Attitudes	Knowledge	Skills
MHPs develop appropriate intervention strategies and techniques	MHPs respect clients' religious/spiritual beliefs about physical and mental functioning	MHPs understand the generic characteristics of MHSP and how they may clash with the values of other cultural groups	MHPs are able to engage in a variety of accurate and appropriate verbal and nonverbal helping responses
	MHPs respect indigenous helping practices	MHPs are aware of institutional barriers that prevent minorities from accessing mental health services	MHPs are able to exercise institutional intervention strategies on behalf of their client and help the client to determine whether problems stem from bias in others
	MHPs value bilingualism and do not view another language as an impediment to MHSP	MHPs possess knowledge of the potential bias in assessment instruments	MHPs seek consultation with traditional healers or religious/spiritual leaders when appropriate
		MHPs possess knowledge of minority family structures, hierarchies, values, and beliefs. They are knowledgeable about community characteristics and resources in community and family	MHPs take responsibility for MHSP in the language requested by the client which may require referral to outside resources
		MHPs are aware of discriminatory practices at the social and community level that affect the psychological welfare of the culturally different client	MHPs have training and expertise in the use of assessment instruments and are aware of their cultural limitations and uses
			MHPs work to eliminate biases, prejudices, and discriminatory practices
			MHPs take responsibility to orient clients to the processes of psychological intervention, such as goals, expectations, legal rights, and the practitioner's orientation

Note. MHP = Mental Health Practitioner. MHSP = Mental Health Service Provision.

Adapted from Sue, D. W., Arredono, P., & Davis, M. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling & Development, 70*, 477-486

Some revisions to this model were suggested by S. Sue (1998). These included the addition of three skills: (a) scientific mindedness, (b) dynamic sizing, and (c) culture-specific skills. Scientific mindedness means that culturally competent practitioners search for and test alternative hypotheses relevant to their culturally different clients, rather than relying upon assumptions. The term 'dynamic sizing' refers to practitioners' ability to fit knowledge about cultural groups to individuals, or "knowing when to generalize and be inclusive and when to individualize and be exclusive" (S. Sue, 1998, p. 446). Culture-specific skills refers to knowledge relevant to specific cultural groups. Although the first two skills are a useful addition to D. W. Sue's original model (D. W. Sue, et al., 1982), the last (culture-specific skills) is already included in the MCC model.

The multicultural competencies were later operationalised for the purposes of evaluation, training, and research (Arredondo et al., 1996). Each competency was assigned a specific set of behaviours. For example, 'Awareness of how [the practitioner's] own cultural background and experiences have influenced attitudes, values, and biases about psychological processes' was operationalised using five criteria. An example of these criteria include: "[The counselor] can identify at least five personal, relevant cultural traits and can explain how each has influenced the cultural values of the counselor" (Arredondo, et al., 1996, pp. 59-60). As a result of these efforts to operationalise the multicultural competencies, a number of scales assessing the MCCs have been developed (e.g., D'Andrea, Daniels, & Heck, 1991; Gamst et al., 2004; Hansen et al., 2006; Like, 2001; Ponterotto, Sanchez, & Magids, 1990; Sodowsky, Taffe, Gutkin, & Wise, 1994) and utilised in research on the correlates of multicultural competence (e.g., Constantine, 2000, 2002; Constantine & Ladany, 2000; K. A. Smith, 2010; Sodowsky, Kuo-Jackson, Richardson, & Corey, 1998; Tummala-Narra, Singer, Li, Esposito, & Ash, 2012).

More recently, the Multicultural Practices and Beliefs Questionnaire, developed to measure the MCCs in psychotherapy (Hansen, et al., 2006) has been adapted for assessing practitioners' use of similar competencies in the consideration of R/S (Frazier & Hansen, 2009). Examples of items found in Frazier and Hansen's scale can be found in Table 2. These cover a range of competencies in areas such as assessment and

treatment, training, the therapeutic relationship, and in-session interventions. In addition to measuring the extent that practitioners demonstrate competencies relevant to R/S in their practice, the scale also acts as a self check list to determine which competencies require further development (Frazier & Hansen, 2009). The scale has not yet been refined to assess the most relevant and/or appropriate behaviours based upon empirical research and client input. It also requires further alignment with the MCC model as it ignores some of the sociocultural issues that the MCC model covers, such as the competency 'Mental health practitioners understand the generic characteristics of mental health service provision and how they may clash with the values of other cultural groups' (Table 1). Nevertheless, the scale is a useful starting point for practitioners and researchers.

Table 2. *Frazier and Hansen's religion/spirituality in psychotherapy competencies*

Type of behaviour	Examples of practitioners' behaviours
Assessment and treatment planning	- Ask questions to assess clients' religious/spiritual involvement
	- Accurately determine when religious/spiritual beliefs are adversely affecting the client's well-being
	- Include R/S dimensions in case conceptualisation
	- Use interventions which have been shown to be effective for individuals with specific religious/spiritual beliefs
In-session interventions	- Refer client to a more religiously/spiritually qualified provider and local community resources
	- Disclose one's own religious/spiritual beliefs
	- Use religious metaphors in treatment
	- Use prayer
Therapeutic relationship	- Actively communicate respect for clients' religious/spiritual beliefs
	- Strive to repair R/S based mistakes in treatment
	- Explore religious/spiritual differences between therapist and client
	- Actively seek client feedback about psychotherapy provided
Self reflection	- Evaluate when one's religious/spiritual values and biases impact treatment
	- Self-assess one's competence to counsel clients regarding religious/spiritual issues
Training	- Use extra-therapy resources to inform oneself about a client's specific religious/spiritual beliefs
	- Seek out continuing professional education
	- Develop and implement a professional development plan to improve one's R/S psychotherapy competence
Supervision	- Seek out religiously/spiritually informed case consultation
	- Actively seek feedback on one's R/S psychotherapy competence from colleagues

Note. R/S = Religious/Spiritual.
Adapted from Frazier, R. E., & Hansen, N. D. (2009). Religious/spiritual psychotherapy behaviors: Do we do what we believe to be important? *Professional Psychology: Research and Practice, 40*, 81-87.

The MCC model is one of the broadest and most inclusive, in that it not only focuses on attitudes and beliefs, it advocates for the proactive accumulation and critique of knowledge and more importantly, the actual practice of cultural competency (i.e., skills). This model (and Frazier and Hansen's scale) summarises many of the competencies required of practitioners when considering clients' religious/spiritual beliefs.

Common factors approach

Underlying the attitudes/beliefs, knowledge, and skills outlined by the MCC model are therapeutic elements foundational to informing practitioners' approach to clients' religious/spiritual beliefs. For example, when discussing solutions to the impediments to considering religion/spirituality, Chapter Three repeatedly used modifiers such as 'respectful', 'non-judgemental', 'accepting', 'genuine', 'understanding' and 'empathic'. Such descriptors are indicative of factors common to many therapeutic approaches. Jerome Frank (1971; 1991) advocated the 'common factors' approach in psychotherapy, asserting that the equivalence of outcomes across a wide range of therapies was due to underlying commonalities rather than techniques unique to each approach. This proposition was later adapted as an attempt to consolidate the various approaches to multiculturalism in psychotherapy (Fischer, et al., 1998b), with the suggestion that each approach 'worked' because of several underlying, common factors. Of those originally named by Jerome Frank, Fischer et al. identified four that were relevant to the consideration of multicultural issues in psychotherapy: the therapeutic relationship, a shared worldview, clients' expectations for change, and an intervention intended to reduce client distress.

The therapeutic relationship consists of both the personal qualities embodied by the practitioner (e.g., genuineness, warmth, empathy) and the nature of the therapeutic relationship (e.g., trusting, positive). In support of the relevance of this to R/S, several authors have suggested that it may be the manner in which practitioners' address clients' religious/spiritual beliefs rather than how beliefs are addressed that determines perceptions of the interaction as positive or negative. For instance, respectfully valuing the view of the client regardless of whether one agrees is more important than simply considering whether or not to initiate discussion regarding R/S (Denny, et al., 2008;

Mayers, et al., 2007; Morrow, Worthington, & McCullough, 1993). In a qualitative study by Mayers, Leavey, Vallianatou, and Barker (2007), participants identified the importance of a good therapeutic relationship in being able to open up about their religious/spiritual beliefs. One participant stated "If there wasn't some kind of warmth and compassion and empathy there then I would just feel quite resentful at having to share [my religious/spiritual beliefs] with them" (p.323). For religious/spiritual clients and undoubtedly others, a therapeutic relationship lacking in these qualities has been cited as a cause for terminating therapy (Gockel, 2011).

The next common factor is a shared worldview between client and practitioner. This includes a shared understanding regarding the explanation, classification, and concomitant treatment for the clients' difficulties. In essence, "a shared worldview provides a common framework from which both client and counselor think about their work together" (Fischer, et al., 1998b, p. 534). This factor is different to the characteristic 'understanding the worldview of culturally different clients' in the MCC model, in that it goes beyond understanding to *sharing* the client's worldview. This requires a collaborative approach, in which practitioner and client co-construct a worldview of the client's difficulties and strengths within their broader social and cultural context. The utility of collaborative case conceptualisation in establishing a shared worldview will be discussed later.

Fischer et al. note that a shared worldview contributes toward positive client expectations, which constitute the third common factor, stating "The more client and counselor operate in a shared worldview, and the more the client accepts the rationale given for his or her problems, the more the client is likely to believe that (…) the interventions (…) will be helpful" (Fischer, et al., 1998b, p. 537). Mitchell and Baker (2000) conducted interviews with 14 British Christians who had not utilised mental health services. Their qualitative analysis found that these participants preferred to seek help from a counsellor who shared similar religious/spiritual beliefs to themselves, partly because they believed such a counsellor would understand their belief system and work within it. Many participants expected that counsellors who shared their worldview would be more helpful than those who did not share their worldview.

The success of the final factor, an intervention to reduce client distress, is set up by the previous three factors. The positive effects of this fourth factor arise from "having clients practice new patterns of thinking, learn adaptive behaviors, achieve insight or greater understanding of their problems, or gain a sense of accomplishment in facing some personally frightening problems" (p.539). In support of this, Mormon clients attending a religious counselling centre often stated that having religious/spiritual interventions in therapy helped them to reframe and understand their difficulties, improve their in-session comfort and sense of connection with their practitioner, and improve their perception of the practitioner's credibility (Martinez, Smith, & Barlow, 2007).

The 'therapeutic alliance' is an additional common factor that was not specifically identified by Fischer (1998b) as important to culturally competent practice, but could perhaps be thought of as underpinning several of the common factor components and the process of mental health care in general (Hatcher, 2010). This construct broadly refers to agreement on the goals and tasks in therapy, collaboration in the therapeutic relationship, and the emotional bond between client and practitioner. The therapeutic alliance has been consistently linked with positive outcomes in therapy (D. J. Martin, Garske, & Davis, 2000). Quantitative research is yet to investigate the extent to which this alliance assists in working with religious/spiritual issues in mental health care, although qualitative research suggests that a positive therapeutic alliance is essential when working with religious/spiritual clients (e.g., Gockel, 2011; Mayers, et al., 2007).

Concerns regarding universalist approaches such as the common factors model were expressed by D. W. Sue, Ivey, and Pedersen (1996). This argument follows an ongoing dialectec between emic (specific) and etic (general) approaches to the consideration of culture. Specifically, universalist approaches may translate into concepts that are so ambiguous or general that they cannot be readily integrated into practice, and may not take into account specific issues that need to be addressed with culturally different clients. In defense of the common factors model, Fischer et al. (1998b) argue that common factors allow for the integration of the many recommendations offered by the

MCC model and others like it. Further, they argue that common factors actually require that practitioners develop specific multicultural competencies. To demonstrate this, they suggest that practitioners ask:

> What do I know or need to know about this individual, about his or her cultures(s), and about people in general that will likely help me (a) to develop a good therapeutic relationship with him or her; (b) to discover or construct with the client a shared worldview or plausible rationale for distress; (c) to create an environment in which the client's expectations be raised; and (d) to plan a healing procedure in which my client(s) and I both have confidence? (pp.542-543).

In other words, Fischer et al. (1998b) demonstrate that the multicultural competencies can be utilised in the service of enhancing the common factors. While the MCC model focuses on specific competencies that assist practitioners to consider culture in their work, the common factors assist to enhance the likelihood that practitioners' use of multicultural competencies will contribute toward positive therapeutic outcomes.

Cultural safety

Several authors have made attempts to define cultural competence more broadly than the attitudes/beliefs, knowledge, and skills of the MCC model (cf. Ridley & Kleiner, 2003). For example, S. Sue (1998) defined cultural competence as the ability to appreciate and recognise other cultural groups, as well as being able to work with them in effective ways. What is common about the definitions offered, and the operationalisation of the MCC's in particular, is that cultural competence is primarily defined and evaluated from the perspective of researchers and practitioners rather than clients. The lack of client input into the operationalisation of cultural competence has been a major critique of the MCC model in particular, which "assumes that the client shares a similar conceptualization of multicultural competence to that of the counselor" (Pope-Davis et al., 2002, p. 360). A potential danger of relying on 'check list' evaluations of cultural competence is the assumption that high ratings imply that the

practitioner is in fact practising in a culturally competent manner. The apparent lack of client input in operationalisation and evaluation means that we cannot be certain that practitioners are practicing in a manner which clients themselves perceive to be culturally competent (Pope-Davis, et al., 2002). This critique is also applicable to measures of practitioners' behaviours and attitudes when considering religion and spirituality (e.g., Belaire & Young, 2002; Frazier & Hansen, 2009; Keating & Fretz, 1990; Martinez, et al., 2007).

Unlike reseacher- and practitioner-based conceptualisations of cultural competence, the concept of cultural safety (Ramsden, 1990) relies on the perspective of the client. 'Cultural safety' (in the Māori language, 'Kawa Whakaruruhau') is a concept developed in New Zealand after Māori nursing students expressed concern that their cultural identity was not being attended to during training, and that they were not being equipped to respond to the cultural needs of Māori patients. Training in cultural safety is now a part of the New Zealand Psychologists Board's registration requirements (New Zealand Psychologists Board, 2009). Acknowledging the process of colonisation in New Zealand and minority/majority culture dynamics between Māori and Pakeha (New Zealand Europeans) provided the context and impetus for the concept of cultural safety. The definition of cultural *safety* provided by Papps and Ramsden (1996) states:

> Safety is defined as (…) [practitioner] action to protect from danger and/or reduce risk to patient/client/community from hazards to health and wellbeing. It includes regard for the physical, mental, social, spiritual, and cultural components of the patient/client and the environment. Unsafe (…) practice on the other hand is defined as (…) any action or omission which endangers the wellbeing, demeans the person or disempowers the cultural identity of the patient/client (p.493).

Cultural safety is broader than that of the MCC model in that it requires practitioners to go further than specifying specific attitudes and behaviours deemed culturally competent. Practitioners are expected to examine attitudes or behaviours that reduce risk to the client and avoid omissions or commissions that have the potential to harm clients' wellbeing and identity. The lack of a prescriptive approach acknowledges that

clients' conceptualisation of cultural competence may go beyond that of researchers or practitioners.

One of the most importance facets of cultural safety is its evaluation: "It is not the [practitioner] who determines the issue of safety. It is consumers or patients who decide whether they feel safe with the care that has been given" (Papps & Ramsden, 1996, p. 494). This implies that certain competencies employed by practitioners may not always be appropriately delivered or applicable given variations in clients' worldviews and contexts. In essence, a practitioner is not culturally competent until their client experiences them as culturally safe.

The MCC model requires practitioners to be aware of the sociopolitical context of their clients, but the concept of cultural safety requires practitioners to be conscious of the way sociopolitical factors play out in the therapeutic relationship. Papps and Ramsden (1996) have been careful to specify that 'culture' is referred to broadly, meaning that matters of minority/majority culture dynamics and the importance of client input can be applied to considering R/S in mental health care too.

The process of secularisation and evidence pointing to a 'religiosity gap' between clients and practitioners suggests that clients with religious/spiritual beliefs effectively constitute a minority group. In support of this assertion, similar difficulties are experienced by some religious/spiritual clients as those experienced by clients from minority ethnic groups. This includes a lack of professional help seeking, suspicion of mainstream treatments and culturally different practitioners, early therapy termination, concern around raising religious/spiritual issues in therapy, and experiences of religious/spiritual beliefs being neglected, minimised, or ridiculed. According to Papps and Ramsden (1996):

> Cultural safety addresses power relationships between the service provider and the people who use the service. It empowers the users of the service to express degrees of felt risk or safety (….) [cultural safety] assumes that each health care relationship between a professional and a consumer is unique, power-laden and culturally dyadic (p.494).

Similarly,

> Cultural safety is about power relationships in (…) service delivery. It is about setting up systems which enable the less powerful to genuinely monitor the attitudes and service of the powerful, to comment with safety and ultimately to create useful and positive change which can only be of benefit to nursing and to people we serve (Polaschek, 1998, pp. 453-454).

Both of the above quotes highlight the importance of client feedback in helping to address power imbalance. Feedback can be sought informally, or formally through the use of tools such as the four-item Session Rating Scale (Duncan et al., 2003). Seeking client feedback displaces the role of the practitioner as expert with regard to the consideration of R/S or culture and places clients in a more empowered and powerful position. With this empowerment should come greater participation, interest, and investment in mental health care.

Although the concept of cultural safety is presented here as a critique of the researcher- and practitioner-based perspectives of the MCC and common factors models, this does not imply there is anything inherently 'wrong' with either. The concept of cultural safety is more likely to enhance the MCC and common factors models than to detract from them. Cultural safety does not do away with cultural competence, instead it offers a new perspective on the definition and evaluation of it (cf. Hera, 2011). The strengths of each approach can be taken together, including the specific guidance (content) of the MCC model, the general approach of the common factors (process) model, and the primacy of the client perspective in the concept of cultural safety (definition and evaluation). In other words, cultural safety (i.e., cultural competence as defined and evaluated by the client) can be enhanced by practitioners who allow the multicultural competencies and common factors to inform their approach.

Cultural competence outcome research

A review of 20 years of empirical literature on multicultural competence by Worthington et al. (2007) noted there has been too little research to ascertain whether the practice of multicultural competence actually results in better outcomes for clients. At the time of Worthington et al.'s publication, few studies had been conducted with actual clients; all other research investigating client outcomes were analogue studies utilising pseudo-clients. No quantitative studies have investigated the outcomes of practising multicultural competence with religious/spiritual clients (also referred to as 'religious/spiritual competence'; P. S. Richards, 2009), although two qualitative studies with religious/spiritual clients found that clients who experienced positive discussion of R/S with their practitioner felt that these discussions facilitated their progress and satisfaction with therapy (Gockel, 2011; Knox, et al., 2005).

With regard to research with actual therapy clients, an early study found that satisfaction and drop-out rates improved amongst 80 female ethnic minority clients when their practitioner received four hours of cultural sensitivity training. Clients rated these practitioners as more credible, empathic, and trustworthy (P. Wade & Bernstein, 1991). The effect of training was observed even for practitioners who were of the same ethnicity as their client. In two later studies, multicultural competence predicted clients' satisfaction with therapy (Constantine, 2002; Fuertes et al., 2006). In one of these, the effect of multicultural competence on satisfaction was observed over and above practitioners' general counselling competence (Constantine, 2002). In the only clinical outcome study published so far, practitioners' multicultural competence predicted clients' psychological wellbeing after controlling for pre-therapy psychological distress (J. J. Owen, Tao, Leach, & Rodolfa, 2011). This finding was applicable to both White and ethnic minority clients in the United States. The therapeutic alliance partly mediated this, suggesting that practitioners' multicultural orientation partly exerted its effect by contributing to clients' perception of a shared worldview and positive therapeutic relationship.

In addition to developing cultural competence, practitioners can consider various ways that religion and spirituality can be taken into consideration during different stages of the therapeutic process. Methods of considering religion and spirituality in assessment, case conceptualisation, and treatment will be discussed next.

METHODS OF CONSIDERING RELIGION AND SPIRITUALITY

Cultural competence is listed as one of six core psychotherapeutic competencies by Len Sperry (2010). Given this and recommendations from a number of agencies to consider clients' religious/spiritual beliefs, various practical methods to assist practitioners have been offered (e.g., Aten & Leach, 2009; Griffith & Griffith, 2002; Josephson & Peteet, 2004b; G. Miller, 2003; Paloutzian & Park, 2005; Pargament, 2007; P. S. Richards & Bergin, 2005). As Zinnbauer and Barrett (2009) have noted, no single framework has been identified as a standard, and they suggest that practitioners work first from models in the multiculturalism literature. The following section will provide a brief overview of practical approaches. It is expected these methods would be implemented by practitioners who value the principle of cultural safety and are familiar with the delivery of multicultural competencies from an approach that values the therapeutic relationship and alliance (cf. Fischer, et al., 1998b; Ramsden, 1990; D. W. Sue, et al., 1992; Zinnbauer & Barrett, 2009).

Assessment

Clients rarely present to a secular mental health service citing religion or spirituality as their reason for seeking help. However, like a client's living situation, physical health, activities, and wider social network, religion and spirituality have the potential to impact upon the presenting problems in ways that can both help and hinder. It is important to include R/S as part of a wider assessment of clients' psychosocial contexts. The purpose of this is multifold, allowing the practitioner to empathically understand the client's worldview; determine the impact of R/S on the presenting problems; determine whether the client's religion/spirituality could be utilised as a resource; identify whether spiritual interventions could be utilised in treatment; and determine whether there are spiritual issues or needs that should be addressed (P. S.

Richards & Bergin, 2005, pp. 220-222). Although time constraints have been cited as a reason for not assessing R/S (cf. Borras, Mohr, et al., 2010), it is possible to genuinely assess clients' religious/spiritual beliefs even when time is strictly limited (Carter, 2008; Coyle & Lochner, 2011). Depending on context, the inclusion of R/S in assessment can take the form of a single question (e.g., Coyle & Lochner, 2011) or a comprehensive, multi-stage assessment (e.g., Huguelet, et al., 2011). Religion/spirituality can also be included as part of a broader assessment of cultural beliefs. For example, the ADDRESSING acronym is useful for helping practitioners to remember the types of cultural contexts practitioners may want to assess, including Age and generational differences, Developmental or acquired Disabilities, Religion and spiritual orientation, Ethnicity, Socioeconomic status, Sexual orientation, Indigenous heritage, National origin, and Gender (Hays, 2008).

The assessment of R/S sometimes requires a multi-stage approach (P. S. Richards & Bergin, 2005; Shafranske, 2005). This starts with a preliminary assessment of clients' identification with R/S (e.g., 'would you consider yourself to have any religious or spiritual beliefs?'), identifies the centrality of any religious/spiritual beliefs (e.g., 'how important is your religion/spirituality to you?'), continues by identifying whether the client believes their religion/spirituality is a source of struggle or strength in the context of their presenting problems, and assesses the client's level of comfort with discussing religious/spiritual beliefs with the practitioner. This can be followed by an in-depth assessment if indicated, which can include specific questions designed to elicit information relevant to case conceptualisation and treatment planning (see Griffith & Griffith, 2002; Hodge, 2001; Pargament, 2007; P. S. Richards & Bergin, 2005 for more information on assessment approaches). A number of standardised measures have been developed to assess a variety of religious/spiritual beliefs and functioning, such as the Religious Commitment Inventory (E. L. Worthington et al., 2003), Intrinsic Spirituality Scale (Hodge, 2003), Royal Free Interview for Religious and Spiritual Beliefs (M. King, Speck, & Thomas, 2001), and the Brief Religious Coping Inventory (Pargament, Smith, Koenig, & Perez, 1998). Several lists of quantitative measures have been compiled (e.g., P. Hill & Hood, 1999; Monod et al., 2011). Following on from the principle of cultural safety, it is important to check with the client whether the standardised test is appropriate (Zinnbauer & Barrett, 2009). For example, many measures of R/S use

theistic language, which may not be appropriate for some religious groups or clients who consider themselves to be spiritual, not religious.

There are differing opinions on whether practitioners should rely more on an explicit/direct assessment of R/S than on an implicit/indirect approach (Pargament, 2007; Tan, 1996). Compared to explicitly raising the subject of R/S during assessment, implicit assessment involves gathering information by being attentive to clients' mentions of religious/spiritual activities and beliefs (Griffith & Griffith, 2002; Pargament, 2007), or asking less direct questions such as 'what/who do you put your hope in?' (Pargament & Krumrei, 2009, p. 113). Questions such as this can be followed up by further implicit or explicit assessment. The advantage of implicit assessment is that it allows the client to determine the extent to which R/S features in the session, without any expectations that may arise from the practitioner explicitly assessing R/S (Pargament, 2007). On the other hand, explicit assessment communicates an openness toward considering the relevance of R/S to the client (Knox, et al., 2005; Shafranske, 2005) and may be more likely to elicit relevant information (Pargament & Krumrei, 2009).

Case conceptualisation

The literature that outlines methods of considering religious/spiritual beliefs in mental health care has primarily centred on assessment and treatment protocols and has rarely addressed the process of case conceptualisation. While assessment seeks to delineate the relevance of client's religious/spiritual beliefs to presenting difficulties and strengths, and treatment represents an 'action plan' of how the client's goals for therapy might be met, case conceptualisation bridges the gap between these by integrating information gathered during the assessment with knowledge of psychological theory and research in a way that informs treatment. In other words, it answers the question of *how* religion and spirituality are relevant to a particular client's presenting difficulties and treatment (Kuyken, et al., 2009; Needleman, 1999). Constantine and Ladany (2000, p. 156) have defined multicultural case conceptualisation as "a counselor's ability to (a) comprehend and integrate the impact of various cultural factors on a client's presenting

issues and (b) articulate an appropriate treatment plan for working with a client based on this knowledge."

The process of developing a formal case conceptualisation has been associated with a number of benefits (Kuyken, et al., 2009). An empirical study of clients' and therapists' experience of the use of case conceptualisation in treatment for psychosis found that the most highly-ranked benefit from the process of case conceptualisation was an improved understanding of their client (Pain, Chadwick, & Abba, 2008). This was followed by having a clearer sense of direction and more positive perceptions of the therapeutic relationship. The process of case conceptualisation in this study was collaborative in that it was developed with clients' input and the case conceptualisation was shared with clients. Fifty-four percent of clients in this study spontaneously reported that this process strengthened their relationship with their practitioner, and a number reported that it improved their level of hope.

Very little work has been done on the structured integration of religious/spiritual issues into case conceptualisation, and it appears that none have investigated the outcomes of doing so. While this area of research is still developing, practitioners can utilise multicultural frameworks such as the cultural formulation model outlined in Appendix I of the Diagnostic and Statistical Manual IV (American Psychiatric Association, 1994). Working from this, practitioners can include in their conceptualisation the ways in which culture may impact upon the client's presentation and outcome. For a religious/spiritual client, a practitioner would consider how R/S affects and gives context to a client's (a) environmental stressors and supports; (b) relationship with the practitioner; (c) help-seeking preferences and experiences; (d) explanations for the causes of their difficulties and (e) expectations of outcomes. This approach was well illustrated with a Christian Korean American client in Shea, Yang, and Leong's (2010) recent article on integrating aspects of culture into case conceptualisation. Preliminary evidence suggests that practitioners may find an expanded version of the DSM-IV cultural formulation useful (Kirmayer, Thombs, Jurcik, Jarvis, & Guzder, 2008). Another potentially useful model that emphasises a more process-oriented approach is phase two of the Multicultural Assessment Procedure (MAP) of Ridley and Kelly (2007). Ridley and Kelly outline seven guidelines to assist in the formulation of

practitioners' working hypotheses, including considering whether the client's behaviour is harmful or helpful, whether cultural values contribute to impairment, whether clients' behaviour is culturally normative, whether deficits may in fact be strengths and strengths may in fact be deficits, the inclusion of environmental and sociocultural influences, clients' interpretation of their difficulties, and how one's biases and assumptions affect the interpretation of clients' behaviour. Despite some overlap with the DSM-IV cultural formulation model, the MAP offers several unique facets to consider in multicultural case conceptualisation.

In addition to these more structured approaches, practitioners' case conceptualisations can be guided by the theory and research that link R/S with mental health outcomes, such as those outlined in Chapter Two. An example is the religious coping literature that emphasises how clients utilise their religious/spiritual beliefs in coping with stressors (Pargament & Brant, 1998). The incorporation of theory and research can be achieved within traditional formulation models. For example, Padesky and Greenberger (1995) encourage practitioners to conceptualise how religion and spirituality (e.g., religious values) influence clients' idiosyncratic thoughts, emotions, physiological reactions, and behaviours. Similarly, Sulmasy (2002) and Josephson and Peteet (2004a) advocate for the inclusion of R/S within the generic biopsychosocial formulation by renaming it the 'biopsychosocial*spiritual*' formulation.

When drawing upon theory and research for case conceptualisation, it is important that practitioners use the principle of dynamic sizing (S. Sue, 1998). Certain types of religious beliefs and practices have been linked to positive mental health outcomes but each religious/spiritual belief and practice has the potential to function differently for each client. For example, an external locus of control ('God-control') has been associated with positive outcomes, which might be reflected in the belief "My future is in the hands of God". While most, according to the research, would draw comfort from this, others may find it anxiety-provoking. Likewise, an avoidant attachment to God is generally linked with negative outcomes, but for an individual this avoidance may be effective in reducing distress associated with a difficult relationship with God. In addition, while some religious/spiritual clients hold suspicions regarding secular mental health services, others welcome the opportunity to gain a different perspective on their difficulties.

When developing a case conceptualisation, practitioners may prefer to incorporate R/S into their preferred 'school' of psychological theory (e.g., cognitive, psychodynamic), but it is important to keep in mind the ontological viewpoint of the client. A case conceptualisation that explains religious/spiritual beliefs and practices simply as a set of psychological processes can be experienced by the client as a devaluation of their lived experience (Josephson & Peteet, 2004a). Although the effects of religion and spirituality can sometimes be explained via psychological processes, there is evidence to suggest that they sometimes function in ways that are unique (Pargament, Magyar-Russell, & Murray-Swank, 2005). For example, a 'search for the sacred' can become an important motivation that supersedes other motivations such as those characterised by biological and fundamental psychological needs. Case conceptualisations are more likely to be accepted by the client when they are developed out of a collaborative process that relies upon the language and understanding of the client as much as possible (cf. Kuyken, et al., 2009). The theme of collaboration is central to multicultural considerations in mental health care (Hays, 2008, 2009) and is important for achieving the 'shared worldview' factor in Fischer et al.'s (1998b) common factors approach. Of course, this does not require the practitioner to take on the ontological position of the client but to respect it as the reality of the client and work from their viewpoint. A collaborative approach is fostered by explicit discussion of ideas and by setting up a 'collaborative framework' in which interactions are continually framed as collaborative to avoid the expert-patient dynamic entering into the therapeutic relationship (Kuyken, et al., 2009). Not only will a collaborative approach assist in the development of a shared worldview, it is also consistent with the development of cultural safety. Collaboration requires client and practitioner to be *equal* contributors (Kuyken, et al., 2009), thus valuing the perspective of the client and reducing the power dynamic in the therapeutic relationship.

Treatment

Treatments that consider R/S range from those that integrate religious/spiritual beliefs into mainstream treatment protocols (e.g., including prayer and utilising sacred texts), to the use of explicitly religious/spiritual interventions developed exclusively for specific religious/spiritual groups. Saunders, Miller, and Bright (2010) characterise

these methods as falling onto a continuum of integrative practices. Saunders et al. outline four approaches that differ according to their level of focus on R/S in treatment: 'spiritually-directive care', 'spiritually-integrated care', 'spiritually conscious care', and 'spiritually-avoidant care'. These therapies differ in their extent of focus on R/S as a treatment goal and level of formal inclusion of R/S as a means to reach other treatment goals. Interventions may be delivered entirely by the main practitioner, in collaboration with religious/spiritual leaders (Edwards, et al., 1999; McMinn, et al., 2003), or in conjunction with other practitioners who feel comfortable delivering the appropriate treatment.

Spiritually-directive therapy.

Spiritually-directive therapies explicitly focus on R/S to either conserve or transform the client's religion/spirituality (Saunders, et al., 2010). An example of a spiritually-directive therapy includes Refocussing Therapy (RFT), developed by Dianne Divett in New Zealand (2011; Kay, 2002; Sharkey, 2005). This therapy was developed for Christian clients based on the theory that distress is caused by unmet needs that can be met by focussing on Christ for solutions. Clients are encouraged to find a 'God-space' (psychological or physical) where they can encounter God as a benevolent and loving attachment figure. Clients are oriented to this experience of God by the therapist, who encourages the client to seek resolution of their distress within this context. For example, the therapist may ask what God would/is doing with the client's feelings of hopelessness. The client's experience of God in this space would be accessed in the future as a solution to later feelings of hopelessness. An unpublished outcome study of with 63 Charismatic Christian clients found that those treated using refocussing therapy experienced significant pre-post changes in mental health status compared to a group of 23 participants who received standard pastoral care, and the intervention group was more likely to rate the therapy experience as helpful (Sharkey, 2005).

A recently developed multifaith 'spiritually-based intervention' for generalised anxiety disorder draws upon religious/spiritual practices from seven major religious traditions, with the premise that spiritual wellbeing and growth arising from certain religious/spiritual practices have been linked to decreased anxiety (Koszycki, Raab,

Aldosary, & Bradwejn, 2010). Interventions include psychoeducation, meditation, forgiveness, mindfulness, seeking and recognising the sacred, improving ethical living, generosity and service to others, and self-acceptance, amongst others. A small study found preliminary evidence that this intervention's effectiveness was comparable to that of cognitive behaviour therapy (Koszycki, et al., 2010). This intervention is particularly useful in that it can be used with clients from diverse religious/spiritual backgrounds, but practitioners may need to check that their client is comfortable engaging in practices from religious traditions other than their own.

An issue relevant to the delivery of these therapies is whether or not mental health practitioners should utilise any form of spiritually-directive therapy or if this should be left to religious/spiritual advisors (Saunders, et al., 2010). Drawing on several examples where practitioners have made assumptions about their client's religion/spirituality to the detriment of the therapeutic relationship, Saunders et al. argue that attempts to use spiritually-directive therapy may cause role confusion between practitioner and spiritual advisor. Indeed, the above two examples of spiritually-directive therapies were delivered by practitioners who were explicitly providing spiritually-directive therapy or, in the second example, were ordained ministers. These therapies may be best delivered by practitioners who are trained to do so. A number of such practitioners can be found in private practice providing services for clients of specific religious/spiritual orientations who wish to pursue this avenue of treatment.

Spiritually-integrated therapy.

In comparison to spiritually-directive therapies, spiritually-*integrated* therapies do not have the conservation or transformation of clients' religion/spirituality as a primary goal of treatment, but R/S remains a central component (Saunders, et al., 2010). These therapies incorporate elements of R/S within a broader treatment protocol (e.g., Alcoholics Anonymous), or add religious/spiritual components to existing treatments (e.g., interpersonal psychotherapy). Examples include adding components such as prayer or meditation, religious bibliotherapy and religious practices as homework. The most common and empirically tested approaches are the addition of religious/spiritual components to cognitive behavioural therapy (CBT) (e.g., R. F. D'Souza & Rodrigo,

2004; Koenig, 2012; Propst, Ostrom, Watkins, & Dean, 1992). The underlying premise of CBT is retained: that distress and dysfunction result from an interplay between unhelpful cognitions, emotions, and behaviours, that can be modified to reduce problematic outcomes and enhance psychological wellbeing. Interventions, such as cognitive restructuring, utilise religious/spiritual resources available to the client (R. F. D'Souza & Rodrigo, 2004; Hodge, 2006a).

Most treatment protocols have been developed to integrate Christian beliefs and practices (e.g., Hathaway & Ripley, 2009; Propst, et al., 1992), but work is progressing on examining the suitability of spiritually-integrated CBT for a range of religious/spiritual groups (e.g., Mathieson, Mihaere, Collings, Dowell, & Stanley, 2012; Naeem, Gobbi, Ayub, & Kingdon, 2009; Thomas & Ashraf, 2011; Vasegh, 2011). Others have sought common ground as a starting point. For example, Vasegh (2011) recently published a number of religious principles common to both Christianity and Islam that could be helpful for spiritually-integrated CBT. Examples are provided from the *Bible* and the *Qur'an* that deal with themes such as suffering, guilt, loss, self-worth, acceptance of suffering, the benevolence of God, the normalacy of sin, and focussing on gratitude and hope, among others (see also Hussain, 2010; Kidwai, 2012; Meyer, 2004).

Rosmarin et al. (2011) developed a protocol for use with clients from diverse religious/spiritual backgrounds and those who are not religious/spiritual but interested in how R/S might assist them in recovery. Although developed for use in a group inpatient setting, this protocol also appears to be readily applicable to individual outpatient settings. A rationale is presented at the beginning of therapy that explores the use of R/S as a resource in CBT and the various connections between religion, spirituality and mental health. With the facilitation of a group therapist, clients are encouraged to identify how religion and spirituality are relevant to their current difficulties, identify R/S statements that elicit an emotional response (e.g., 'no matter how bad it gets, I am never alone'), and to identify how these can be incorporated into thought records and coping statements. Incorporating R/S into behavioural strategies is discussed, including the role of religion and spirituality in self-care and behavioural activation. Additional religious/spiritual practices are discussed as a resource for coping

and clients are encouraged to engage in personal religious/spiritual study. Pilot results suggested that almost all clients found this intervention helpful. Clients' personal levels of R/S did not predict responses, suggesting that clients with low through to high levels of religiousness/spirituality may find this intervention useful.

Spiritually-conscious care.

This approach is based upon the premise that practitioners assess and remain open and ready for the discussion of R/S in treatment, including its applicability as a resource and relevance to the presenting problem/s. Religion/spirituality is not formally integrated into intervention (Saunders, et al., 2010). In this approach, addressing and engaging religious/spiritual beliefs and practices as a part of therapeutic activities is not 'prescribed', but occurs as needed. For example, discussion of R/S may provide evidence for a client's core belief or guidance on ways the client can address conflict in interpersonal relationships. This is possibly the most common method of considering clients' religious/spiritual beliefs in mental health care and may be the approach many practitioners feel most comfortable with from an ethical and competence standpoint (Saunders, et al., 2010). However, as always, the extent and method of R/S consideration should be determined primarily by the client.

Outcomes of spiritually-directive and -integrated treatments

The outcomes of providing culturally competent care have already been discussed, concluding that cultural considerations appear to result in better satisfaction with treatment and potentially better psychological outcomes for clients. Outcome research has also been conducted on the more formal and structured integration of R/S in treatment. A recent randomised-controlled trial of religious/spiritual assessment is worth mentioning, particularly as it is the first of its kind (Huguelet, et al., 2011). A group of clients (78) diagnosed as schizophrenic were randomly assigned to either standard treatment or standard treatment that included a religious/spiritual assessment. While no differences were observed for satisfaction with treatment or medication adherence three months after the assessment, attendance at sessions and willingness to ask for help were better in the R/S-assessment group compared to the non-assessment group. The authors noted that willingness to ask for help has been associated with

improved recovery rates amongst clients with psychosis. It is possible that the observed effects were due to psychiatrists spending more time with the clients to complete the religious/spiritual assessment rather than specifically asking about R/S so this needs to be explored in future studies. Nevertheless, the initial results of this study are promising and further research would be useful to clarify the effects of formal religious/spiritual assessment.

A recent meta-analysis conducted by Worthington, Hook and Davis (2011) investigated the outcomes of spiritually-directive and -integrated treatments, restricting the inclusion criteria to randomised-controlled trials and investigating clinical and religious/spiritual outcomes separately. The overall effect size for R/S-directive or -integrated treatments compared to non-R/S treatments was statistically significant (d = .26, d = .41, for clinical and R/S outcomes, respectively). When the comparison groups received identical treatment except for the integration of R/S components (dismantling studies), clinical outcomes did not differ between R/S and non-R/S treatments but religious/spiritual outcomes were significantly better in R/S-integrated treatment groups (d = .33). Clinical outcomes in the R/S-integrated treatment groups appeared to improve slightly over and above non-R/S treatment groups at follow-up (d =.13 to d = .22) but this was statistically non-significant, possibly because of the small sample size. It is unclear whether religious/spiritual outcomes may have had a positive effect on clinical outcomes over time as clients who experience the consideration of their religious/spiritual beliefs in therapy often point to the reciprocal influence between the process of therapy, clinical improvement, and religious/spiritual growth (Goedde, 2000; Mayers, et al., 2007). It would be beneficial for future research to clarify this.

A particularly notable trial of spiritually-integrated CBT by Propst, Ostrom, Watkins, and Dean (1992) was one of the dismantling studies included by Worthington et al (2011). This trial utilised a 2x2 treatment design to investigate the effect of two treatment variables: CBT with or without religious/spiritual components, and CBT delivered by religious or non-religious therapists. Consistent with Worthington et al.'s conclusions, the inclusion of religious/spiritual components did not exert a more positive effect on client outcomes than non-R/S CBT, but practitioners delivering non-R/S CBT were asked to be sensitive to clients' religious/spiritual beliefs which may have 'contaminated' the 'non-R/S' treatment condition. Non-religious therapists were

just as effective in delivering CBT with religious/spiritual components as religious therapists. The authors noted an interaction effect between the conditions, which they termed an 'extreme dissimilarity effect': clients treated by non-religious therapists, using non-religious/spiritual CBT, experienced the poorest outcomes. This suggests that non-R/S practitioners may be able to deliver an R/S-integrated treatment as effectively as R/S practitioners when they are directed to do so, but their consideration of clients' religious/spiritual beliefs may not be as consistent when they have not received a directive to do this.

A randomised-controlled trial of spiritually-integrated vs. secular CBT is currently underway in the United States (Koenig, 2012). This trial will be adapted for a variety of faith traditions and will test the effects of each therapy on medically ill adults who hold religious/spiritual beliefs and are diagnosed with major depression. Unlike Propst et al.'s (1992) trial, the non-R/S condition in Koenig's study will specifically avoid discussion of clients' religious/spiritual beliefs to provide an adequate comparison between R/S and non-R/S conditions. It is hoped that this spiritually-integrated version of CBT may be used by non-R/S practitioners if results from the trial support its use.

There do not appear to be any published reports showing that the formal inclusion of R/S in treatment causes harm. Two studies have indicated that the inclusion of R/S in treatment is generally perceived to be helpful by clients (J. Q. Morrison, et al., 2009; Rosmarin, et al., 2011). In Morrison et al.'s study, 74% of participants reported that the inclusion of R/S in treatment was helpful for them in reaching their treatment goals. An even greater proportion (95%) of participants involved in a group treatment that included R/S components found this useful (Rosmarin, et al., 2011). No participants in either study reported that religious/spiritual inclusions were unhelpful in reaching their treatment goals.

In all, it appears that formal integration of R/S in therapy produces positive clinical and religious/spiritual outcomes and is generally perceived as helpful by clients. However, aside from the study on including R/S in assessment, short term outcomes indicate that the formal/structured inclusion of R/S in treatment does not produce better clinical results than when R/S is informally considered within already-established 'secular'

therapies. Where the conservation or transformation of R/S is a primary goal of treatment, R/S-directive or -integrated therapies may be a useful approach due to their positive effects on religious/spiritual outcomes that are not observed using secular treatments (E. L. Worthington, et al., 2011). Thus far, it is unclear whether better religious/spiritual outcomes eventually have a positive reciprocal influence on clinical outcomes; only studies with long-term follow up periods will be able to answer this.

So far, it has been shown that religion/spirituality is relevant to mental health outcomes and mental health care. Contextual issues, including impediments to the consideration of clients' religious/spiritual beliefs have been addressed. Conceptual foundations for the consideration of R/S have been provided in the form of the multicultural competencies, the common factors approach, and cultural safety. Tools to assist practitioners in considering R/S have been presented and critiqued. Springboarding from this foundation, the next chapter seeks a client perspective on two primary questions: (1) are clients' religious/spiritual beliefs being considered in mental health care? and (2) what factors predict the consideration of clients' religious/spiritual beliefs?

CHAPTER 5

CLIENTS' PERSPECTIVES AND THE PRESENT STUDY

Mental health care underwent a number of major changes in the latter part of the 20th century and continues to do so. One significant change was the de-insitutionalisation of individuals diagnosed as mentally ill in the 1960's and 70's, whereby the care of those who were previously hospitalised were moved to community-based services (Lamb & Bachrach, 2001). The paternalistic approach of instutionalisation was later accused of replicating itself in community-based services (Chamberlain, 2005), whereby opportunities for clients to influence decisions regarding their care have been limited (Lammers & Bappell, 2003). The paternalistic approach gradually gave way to clients' calls to be autonomous and active participants in their care, resulting in the consumer movement which gained momentum in the 1970's and 80's (Frese & Davis, 1997). This shift was reflected in changes in the use of language, whereby clients who were formerly referred to as 'patients' by mental health service providers are now frequently referred to as 'consumers' (Heubel, 2000). Underlying the consumer movement is the assumption that mental illness and mental health are social constructs. Related to this are questions about who and what defines psychopathology and who and what determines appropriate treatment approaches. Clients now rightly expect to be more involved in determining the answers to these questions (Chamberlain, 2005). Allowing clients to have a more active role in their care, as well as in the development, provision, and evaluation of services provides a 'check and balance' to a system which has historically been biased toward the views of practitioners and researchers. It appears consensus has been reached on the need to collaborate with clients in multiple areas of their care, that clients should be supported in a way that allows them to voice their needs, and for these to be given genuine consideration (Lammers & Bappell, 2003).

Emerging from the themes of empowerment and self-determination in the consumer movement is an approach to mental health care termed the 'recovery model' (Anthony, 1993; Frese & Davis, 1997). The recovery model is difficult to define but best summarised by Anthony as a process whereby recovery is characterised as reaching ones' potential even within the limitations of ongoing symptoms. Anthony likens

recovery efforts to that of an individual with a spinal cord injury who, despite continuing to live with the effects of the injury, still strives to live a fulfilling, meaningful, and purposeful life. The involvement of practitioners in assisting clients to strive toward recovery is articulated by Frese and Davis (1997):

> Psychologists embrace a recovery framework when they assist a person in realizing his or her potential as a unique human being who is not defined by an illness (….) by supporting the person's life choices and by working in partnership with the person to help him or her better cope with the challenges of an ongoing and serious illness (p.244).

A New Zealand author pushed the boundaries of the concept 'recovery' further, by describing her own process of experiencing mental illness as that of "discovery", "transformation", and "transcendence" - a journey characterised by much more than survival or eventual return to baseline (Leibrich, 2002, p.148). Ultimately, the recovery approach shifts mental health care from a deficit-based model to a strengths-based model, partners with the client to find what recovery 'looks like' to them, and finds resources already available to the client in assisting their efforts to recover. This supports the autonomy and empowerment of the client (Anthony, 1993).

Consumer involvement in mental health care and the recovery model has been well accepted in New Zealand. National standards for service providers require evidence of client participation in service planning, implementation, and evaluation (Standards New Zealand, 2008), thus consumer involvement is integrated throughout service provider policy (e.g., Ministry of Health, 1995; O'Hagan, 2001; Waitemata District Health Board, 2010). Consumer advisors with personal experience of mental illness and mental health services are employed full time by District Health Boards to provide advice on the needs of consumers; these advisors sit on an advisory committee and consumer input is fed back to the health board through a consumer consultant. In addition, annual evaluation surveys are sent to consumers and consumers' views are sought in the process of strategic planning. A number of consumer-driven organisations also exist to advocate for the needs of consumers (e.g., Changing Minds [http://changingminds.org.nz/], Consumer Action on Mental Health [http://awarenesscanterbury.com/]).

THE CONSUMER AND RECOVERY MOVEMENTS: APPLICABILITY TO RELIGIOUS/SPIRITUAL CLIENTS

These changes in mental health care have important implications for religious/spiritual clients. The consumer movement and the recovery approach to mental health care emerged during the time that the concept of cultural safety was proposed (Ramsden, 1990). Cultural safety shares with the consumer and recovery movements a recognition of the power dynamics between client and service provider, and emphasis on clients' perspectives and collaboration between client and practitioner. The importance of cultural safety in the consideration of R/S has already been outlined, and it is encouraging to observe that two major approaches to mental health care show overlap with this concept. Unfortunately, research from Australia suggests that it is not uncommon for clients to feel as though opportunities for participation are tokenistic; an activity that is mandated by policy but not genuinely invested in by service providers (Lammers & Bappell, 2003). This can only change if all parties involved in service provision and usage are genuinely invested in the process of client particpation (Lammers & Bappell, 2003; Ministry of Health, 1995).

The implication of the recovery model in discovering what clients believe will help them recover gives religious/spiritual clients the opportunity to voice the role of R/S in their mental health (e.g., Leibrich, 2002). Clients have stated that R/S helps them to cope with the frustration of symptoms, provides them with an avenue for social support, a sense of wholeness, is helpful in gaining a sense of control, emotional stability, and provides meaning and purpose in the midst of seemingly insurmountable difficulties (Fallot, 1998; Green, et al., 2009; Hustoft, Hestad, Lien, Moller, & Danbolt, 2013; Leibrich, 2002; Russinova, et al., 2002; Sullivan, 1993). In recognition of this, a set of 'recovery competencies' published for New Zealand practitioners includes R/S as an aspect of recovery (O'Hagan, 2001). These relevant competencies involve 'understanding the importance of spirituality in coping and in forming understandings of mental illness'. Although this reflects a somewhat truncated vision of how R/S might be addressed in recovery, it is certainly a start and does not restrict practitioners and clients from gaining an understanding of how R/S can assist in other ways (e.g., providing a social support network and an avenue for creative expression) A more

holistic view - one of 'making space' for spirituality in recovery - has been published by Leibrich (2002), herself a consumer of mental health services in New Zealand. It is hoped that such writings will soon find their way into policy documents such as the recovery competencies.

Client participation in service evaluation

The consumer movement values and advocates for client participation in the evaluation of mental health services. Equally, this places importance on the perspective of religious/spiritual clients when evaluating whether their needs are adequately considered. As Carter (2008, p. 358) proposes: "The real question which we should be asking is to service users themselves and how they feel religion has been accounted for in treatment". The importance of client participation in evaluation is outlined by Manthei (2005), who argues that client input is valuable because (a) clients and practitioners often have different perceptions of what occurs in therapy, (b) clients can readily describe what they find helpful and unhelpful and are therefore important contributors to the betterment of mental health services, (c) clients are often reticent to communicate dissatisfaction and tend to withhold certain topics and information from their practitioner unless their views are sought, and (d) many clients believe that participating in evaluation is a way in which they can help other clients. Manthei's first point that clients and practitioners can have different views about what occurs in therapy will be demonstrated later, where it appears that clients and practitioners have very different views about the extent to which R/S is considered in mental health care. In line with the third point (c), clients occasionally find it difficult to discuss R/S with their practitioner for a variety of reasons, including fear of being judged, misunderstood, or labelled as pathological (Keating & Fretz, 1990; King Jr, 1978; Mayers, et al., 2007; E. L. Worthington & Scott, 1983). Hence, it may be difficult for clients to communicate that their religious/spiritual beliefs are not being considered unless their views are openly sought. Regarding the second and final points (b) and (d), seeking clients' evaluation of services can communicate that clients are valued and their experiences have meaning and purpose.

Involving clients in the evaluation of services also fits with the market economy approach of service delivery recently adopted by a number of Western healthcare systems, otherwise known as managed care. The basic premise of this approach is to deliver the highest quality of care for the lowest possible economic cost (Carroll, 2006). Without discussing the limitations of a market-driven mental health care system (see Enthoven & Eccles, 2002; Heubel, 2000), an approach that seeks clients' views on best practice standards to ultimately improve treatment efficacy and efficiency would seem desirable. In the process of achieving this goal, the success of a market economy is ultimately determined by consumer demand. If a service does not gauge the needs and expectations of consumers, it will cease to be viable by virtue of the fact that it will produce products that are not desired. In a mental health service, this can be reflected in clients' underutilisation of services, high attrition rates, and low treatment efficacy. To gauge the dynamic needs and expectations of consumers and remain viable, the purveyor of a service regularly engages in market research. It makes sense within a consumer-driven mental health care system to do the same (J. K. Morrison, 1978). Following from this point, it would seem prudent to check whether clients desire the consideration of their religion/spirituality and whether they feel this is being provided.

CLIENTS' PREFERENCES

Research on client preferences in mental health care has shown that those with religious/spiritual beliefs would generally like these to be considered. Much of the research on client preferences emerged as the consumer movement began to gain significant momentum and clients' perspectives were becoming more sought after. A group of clients attending a treatment clinic in the U.S. were generally supportive of the consideration of spirituality in treatment clinics (Heinz, et al., 2010). A survey of 79 clients in Australia found that 82% thought their therapist should be aware of their religion/spirituality, while 69% thought their therapist should consider their religious/spiritual needs (R. D'Souza, 2002). Similarly, an earlier survey conducted among 74 clients from several practices in the U.S. found that three-quarters of the participants wanted to discuss religious or spiritual issues with their therapist (Rose, et al., 2001). Such findings have been echoed in several qualitative studies (e.g., Knox, et al., 2005; Lindgren & Coursey, 1995; Mayers, et al., 2007; Stamogiannou, 2007). There

are no New Zealand-based studies that specifically examine client preferences, although a study conducted with 43 clients in a psychiatric inpatient unit found that 80% believed it was acceptable to discuss R/S with their practitioner (de Beer, 1998). Twenty percent added that this would depend on the R/S orientation of their practitioner and/or their level of acceptance toward clients' religion/spirituality. Clients in studies from other countries have added similar caveats to their preferences for discussing R/S (e.g., Lindgren & Coursey, 1995; Rose, et al., 2001).

Accommodating clients' therapy preferences is positively associated with client outcomes and retention in therapy. This has been examined by 35 studies, which have been meta-analysed by Swift, Callahan, and Vollmer (2011). In this study, client preferences were referred to broadly as relating to client/practitioner role (e.g., active vs. passive), therapist characteristics (e.g., gender), and therapy characteristics (e.g., type of therapy). Clients who felt their preferences had been accommodated had a one-half to one-third lower odds (OR = 0.59) of dropping out therapy than those whose preferences had not been accommodated. Additionally, accommodating client preferences had a moderate effect on client outcomes (d = .31). It does not appear that the meta-analysis examined the accommodation of clients' religious/spiritual preferences, but accommodating these is likely to be important. For example, a recent qualitative study found that it was not uncommon for clients to drop out of therapy when they felt their R/S had not been considered (Gockel, 2011).

IS RELIGION AND SPIRITUALITY CONSIDERED IN MENTAL HEALTH CARE?

It is largely stated that clients' religious/spiritual beliefs are neglected and minimised by mental health practitioners (e.g., Borras, Mohr, et al., 2010; R. D'Souza, 2002; P. Hill & Pargament, 2003; Neeleman & Lewis, 1994; Neeleman & Persaud, 1995; Nelson-Becker, 2003; P. S. Richards & Bergin, 2005; Tepper, et al., 2001; Verhagen, 2010; Whitley, 2012). For example, Verhagen (2010, p. 550) states that "although [the importance of R/S] is a known fact, psychiatrists underestimate, neglect, and do not initiate discussion of the topic themselves". Empirical evidence for these claims is rarely presented. In response, there have been calls for a more balanced view on this issue (Poole, et al., 2008).

Over-generalised statements regarding current practice are not necessarily benign. Substantial resource has been committed to developing a multitude of assessment, treatment, and, to a lesser extent, formulation strategies to assist practitioners to consider R/S (e.g., Aten & Leach, 2009; Gordon, Kelly, & Mitchell, 2011; Griffith & Griffith, 2002; Hodge, 2001; Josephson & Peteet, 2004b; Pargament, 2007). Presumably these efforts have been justified on the basis that service delivery is not already meeting the needs of religious/spiritual clients sufficiently. Resources are scarce. If they are to be directed at improving service delivery, then they should be directed at areas where there is evidence of a need for improvement. Where a significant gap in service delivery is assumed but not verified by clear empirical evidence there is a risk that the focus turns toward inadequacies in service delivery, rather than toward the affirmation and reinforcement of practices that may in fact be adequate. Additionally, where researchers and reviewers report that clients' beliefs are generally not considered, clients understandably develop an expectation that their religion/spirituality will not be considered. This holds potentially serious implications for engaging religious/spiritual clients in mental health services. Therefore, it is important to evaluate and investigate in more detail the claims that clients' religious/spiritual beliefs are being neglected and minimised, rather than accepting these claims without evidence.

Current empirical evidence

Supporting the conjecture that religious/spiritual beliefs are generally not considered in mental health care, a meta-analysis of self-report results from 1,156 therapists who were not explicitly 'religious therapists' (i.e., do not advertise their services as religiously-oriented) found that 82% never or rarely incorporated R/S into therapy (D. Walker, Gorsuch, & Tan, 2004). Other evidence shows discrepancies between practitioners' and clients' reports of religious/spiritual considerations. A survey of 1,204 Canadian psychiatrists found that 50% 'often' or 'always' asked their clients about R/S (Baetz, et al., 2004). This is contrasted with the responses of 157 clients in the same study (not necessarily seen by the aforementioned psychiatrists), where only 17% stated that their psychiatrist had 'often' or 'always' asked about R/S. While this does appear to be a large discrepancy between practitioner and client reports, the questions are essentially different, making comparison difficult. It is possible that psychiatrists interpreted 'often' or 'always' as a proportion of all clients they had seen,

while clients may have interpreted ‘often’ or ‘always’ as a proportion of the amount of time they spent with a single psychiatrist. Nevertheless, other research has found discrepancies as well. A study of practitioners in Geneva and Quebec found that 92-93% stated they would feel comfortable discussing clients’ religious/spiritual beliefs. Their clients reported that this occured in only 36% of cases (Borras, Mohr, et al., 2010; Huguelet, et al., 2006). A similar discrepancy has been reported in New Zealand; all of the 33 psychiatrists surveyed by de Beer (1998) stated it was ‘occasionally’ or ‘always’ important that information should be gathered about clients’ religious and spiritual beliefs, while only 11% of their clients recalled being asked about R/S. The discrepancies between practitioner and clients’ reports lend support to the idea that clients’ perspectives should be sought first and foremost (Manthei, 2005).

In addition to these studies, four client-perspective surveys have been conducted. A study conducted in the U.S. with clients interested in R/S found that a third of the 30 participants discussed R/S with their practitioner, although this was fewer than the two-thirds who wanted to discuss R/S (Lindgren & Coursey, 1995). A second study in England found that half of the 43 clients surveyed indicated that their cultural beliefs and values were considered in their care. The authors went on to re-interpret this as being client’s *spiritual* beliefs and values, even though only half of the 43 participants actually held religious/spiritual beliefs (Awara & Fasey, 2008). A third study, conducted in the Netherlands, found that the half of the 755 clients surveyed were asked about their religious/spiritual beliefs by their practitioner. This figure rose to 70-87% across different services when only clients who wanted to discuss R/S were included. Amongst all clients in the study, only 36% felt that the treatment they received was consistent with their religion/worldview (Pieper & van Uden, 1996). Again, the authors reinterpreted the question wording. In this case, ‘religion/worldview’ was interpreted to simply mean ‘religion’. A more recent survey by Morrison, Clutter, Pritchett and Demmitt (2009) found that a third of religious/spiritual clients surveyed in a private secular practice in the United States reported that R/S had been incorporated into their therapy. Taken together, the current evidence suggests that between one-third to one-half of clients experience the consideration of their religious/spiritual beliefs in some way. Figures may be higher (50% - 87%) when results are restricted to clients who actually want to discuss R/S (Lindgren & Coursey, 1995; Pieper & van Uden, 1996).

Limitations of current literature

The extent to which these surveys provide an accurate indication of current practice is difficult to gauge for a number of reasons. First, as already noted, the questions being asked of participants are occasionally reinterpreted by the authors (e.g., Awara & Fasey, 2008; Pieper & van Uden, 1996). The concurrent use of the words 'culture' and 'worldview' in these surveys make findings difficult to interpret, because 'culture', 'worldview' and religion/spirituality are different but overlapping concepts (cf., Hicks & Gwynne, 1996; Palmer, 1996). It is unclear which concept respondents in these surveys were referring to. Second, aside from the notable exception of the Netherlands study which surveyed 755 clients 21 years ago (reported in Pieper & van Uden, 1996), the numbers of clients represented in most of these surveys are small, ranging from 30 to 73 (Awara & Fasey, 2008; de Beer, 1998; Lindgren & Coursey, 1995; J. Q. Morrison, et al., 2009). Third, in most studies, all clients (or the majority) were recruited from a single service (Awara & Fasey, 2008; Baetz, et al., 2004; Borras, Mohr, et al., 2010; de Beer, 1998; Lindgren & Coursey, 1995), so findings may reflect only the practices of that service. Fourth, recruitment was occasionally made by clients' own practitioners (e.g., Lindgren & Coursey, 1995; J. Q. Morrison, et al., 2009). Practitioners' knowledge of the study may have influenced findings, given that practitioners tend to present their multicultural competence in a positive light (Constantine & Ladany, 2000). Finally, aside from two studies (Lindgren & Coursey, 1995; Pieper & van Uden, 1996), it is unclear how many of those whose religion/spirituality was not discussed or considered actually wanted this to occur. Clients in previous studies have indicated that their decision to engage in discussion about R/S is contingent upon whether they think it is important to do so (Knox, et al., 2005; Rose, et al., 2001). Estimates of the extent to which practitioners consider R/S need to take account of this, because in some cases, it may be inappropriate for R/S to be discussed beyond an initial cursory question. If estimates account for this, results may be more positive than is being communicated by current rhetoric in the literature. Given these five critiques, the applicability and generalisability of the findings from these surveys are limited.

Satisfaction with consideration. In addition to addressing these limitations, it would be beneficial to address another gap in this literature. When clients report that their religious/spiritual beliefs are considered by practitioners, are they satisfied with the way this has occured? The concept of cultural safety requires that a practitioner does not consider culture blindly, but relies upon collaboration and feedback from the client to determine whether their actions are appropriate (Ramsden, 1990). This implies that practitioners should gauge clients' satisfaction with the way culture or R/S is being considered in their care. The distinction between clients' perceptions that R/S has been considered, versus clients' satisfaction with this, can be likened to that of quantity vs. quality. It is feasible for a practitioner to consider a client's religious/spiritual beliefs, but do so in a manner that is unsatisfactory or culturally unsafe. This may occur by virtue of the issue at hand (e.g., engaging in an in-depth discussion of R/S when the client believes this is irrelevant to the issue), or by practitioners' behaviours (e.g., using religious language that does not fit with the clients' own religious/spiritual background). Owen et al. (2011, p. 274) make a similar distinction by differentiating between 'multicultural orientation' and 'multicultural competency', which they use to refer to differences "between the ways in which psychotherapists conduct therapy and their ability to effectively deliver an intervention".

Estimates of client satisfaction with the consideration of R/S are scarce. Qualitative work by Knox et al. (2005) suggests that clients are often satisfied when R/S is considered in their care, although some do report experiences which negatively affect their satisfaction. The survey of clients in the Netherlands by Pieper and van Uden (1996) attempted to provide a quantitative estimate of client satisfaction by reporting that one in three clients were "satisfied with the way in which the treatment fitted the religious/worldview aspect of the problems" (p.76). Besides the confounding between religion and worldview, this may be a mis-interpretation of the question that was asked, which was agreement with the statement "The treatment I've got fitted the religious/worldview aspects of my problems" (p.75). This appears to refer to the act of considering religion/worldview, rather than actual satisfaction with this consideration. Because the study was conducted in the Netherlands, the difference in these two statements may be due to translation. Nevertheless the result is difficult to interpret and further investigation of clients' satisfaction is required.

The New Zealand context

Not only do these limitations make it difficult to ascertain current practice, it is difficult to know whether the surveys just discussed apply to a New Zealand context. One of the aforementioned surveys was an unpublished pilot study conducted in New Zealand with a small group of clients (43) from an inpatient service (de Beer, 1998). It appears this is the only publically available client-perspective survey conducted in New Zealand. Recruitment in this study targeted all clients in the service, not just those who were religious/spiritual (30% regularly attended religious services, 88% believed in God or a higher power). In this survey, 11% of clients reported being asked about R/S, a figure much lower than findings in other countries (J. Q. Morrison, et al., 2009; Pieper & van Uden, 1996). Four questions remain unanswered from this study: (1) did clients go on to discuss R/S even if they were not asked about R/S? (2) did these clients feel that the consideration of R/S in their care was important? (3) of the clients who were asked about R/S, how many perceived that R/S was subsequently considered in their care? and (4) of the clients who were asked about R/S, how many were satisfied with the way their religious/spiritual beliefs were considered?

Two additional studies have been conducted in New Zealand, although neither are based upon a client perspective. One unpublished study was presented at a conference in 2009 (Perkins, 2009). The study audited 30 active case files at an older adult mental health service. Of these files, 13 noted clients' religious/spiritual affiliation or matters related to R/S on a standard intake form or elsewhere. Of 23 completed care plans, religion or spirituality was not mentioned in any, although a referral for spiritual support was noted elsewhere in one file. This suggests that although R/S was noted in some cases, it was generally not considered in intervention planning. In some instances practitioners may have discussed R/S with their clients without noting this in the file. A second [published] study compared the practices of 162 social workers in New Zealand to those of 789 in the United Kingdom (Stirling, et al., 2010). It is unknown how many of these social workers were employed in a mental health setting. Of the New Zealand social workers, 80% reported that they had helped their clients to consider the ways their religious/spiritual support systems were helpful. Forty-seven percent reported they had helped their clients to consider the ways their religious/spiritual support systems were harmful and 54% stated they had helped a client to develop a religious/spiritual ritual as

a part of clinical intervention. It is unclear how many assessed clients' R/S. While the findings of the study are somewhat positive, they are unable to shed light on how many clients perceived that R/S was considered in their care.

Findings in other countries (e.g., Awara & Fasey, 2008; Borras, Khazaal, et al., 2010; J. Q. Morrison, et al., 2009; Pieper & van Uden, 1996) may not generalise to New Zealand. The proportion of New Zealanders who state that R/S is an important aspect in their lives (32%) is lower than those residing in the United States (64%) and Canada (44%) (Gallup, 2012), where several surveys mentioned earlier were conducted. This may impact upon the generalisability of findings because importance placed on R/S would be expected to influence the importance clients place on R/S in dealing with mental health concerns (e.g., Cederblad, et al., 1995). This may also mean that practitioners in less religious countries are less likely to identify as religious/spiritual or to view R/S as important to mental health care (Baetz, et al., 2004; Hofmann & Walach, 2011). Lower levels of R/S in a population may also influence upon the general salience and pervasiveness of this in a society. This means that in New Zealand, religion/spirituality may not be at the forefront of either clients' or practitioners' minds to the extent that it might be in countries with higher levels of R/S. Conversely, it is possible that the holistic perspective held in Te Ao Māori (Māori worldview) and mandated by policy may increase New Zealand practitioners' general awareness of spirituality.

Other than the study conducted by de Beer (1998), which was limited by a small and very specific sample, there is no substantive evidence in New Zealand to answer the question 'To what extent do New Zealand mental health clients perceive that religion/spirituality is considered in their care?'. The present study aims to address several limitations of the current literature by investigating this question from a client perspective within a New Zealand context, and investigating clients' satisfaction with the consideration of their religious/spiritual beliefs. Methodological limitations, such as small sample sizes, lack of sample diversity, practitioner-based recruitment, and survey wording difficulties will be addressed. The present study aims to achieve the following:

Aim 1: To determine the the proportion of religious/spiritual clients in New Zealand who have discussed their religious/spiritual beliefs with practitioners, perceive that these beliefs were considered in their care, and to determine clients' levels of satisfaction with the way their religious/spiritual beliefs have been considered.

This aim will be investigated with a general sample of New Zealand mental health clients and for two specific groups: those who place importance on the consideration of religion/spirituality in their care, and those who have utilised public mental health services. Differentiating between public and private sector services is necessary because individuals often seek out religiously/spiritually-oriented treatment services in the private sector, whereas public sector clients are often unable to seek out such services (Knox, et al., 2005; Mayers, et al., 2007).

FACTORS THAT PREDICT THE CONSIDERATION OF RELIGION AND SPIRITUALITY

Given that clients typically prefer their religious/spiritual beliefs to be taken into consideration and that the consideration of R/S is associated with positive client outcomes, under what factors is consideration more likely to occur, in a way that clients are satisfied with? This question will be answered by an investigation of the factors that predict the discussion and consideration of clients' religious/spiritual beliefs and their satisfaction with this. In support of the goal of empowering clients as per the consumer movement and the recovery model, it is hoped this will allow clients to make more informed choices when they would prefer R/S to be considered in their care. It is also hoped that it will shed light on areas where consideration could be further maximised. Additionally, it is hoped that investigating factors that predict clients' satisfaction with the way R/S has been considered will assist to improve cultural safety.

A number of factors could predict the consideration of R/S in clients' care and clients' satisfaction with this consideration. No studies have yet set out to investigate factors that predict client-reported consideration of R/S, although several studies have

investigated those which influence practitioner-reported consideration of R/S. These studies have found that practitioners' personal level of R/S is associated with their reports of considering R/S in clients' care (Baetz, et al., 2004; Frazier & Hansen, 2009; Hofmann & Walach, 2011; Kvarfordt & Sheridan, 2009; Stewart, Koeske, & Koeske, 2006). Practitioner-reported consideration has also been found to correlate with practitioners' attitudes toward the role of R/S in mental health care (Kvarfordt & Sheridan, 2009; Sheridan, 2004; Stewart, et al., 2006); training in the consideration of R/S (Frazier & Hansen, 2009; Hofmann & Walach, 2011), and practitioners' therapeutic orientation (Hofmann & Walach, 2011). It is important to note that social desirability is associated with practitioner reports of attitudes and behaviours deemed to be culturally competent (Constantine, 2000; Constantine & Ladany, 2000). If socially desirable responding is wide-spread, it is possible the consideration of R/S is over-reported by practitioners and that associations between attitudes and self-reported practice behaviours are inflated.

Given the limitations associated with practitioner-reported consideration of R/S and the need to focus on clients' perceptions of consideration from a cultural safety standpoint, it is desirable to investigate the factors that influence whether *clients* feel that R/S has been considered. The studies just mentioned have only investigated the contribution of practitioner variables but it is unlikely that the consideration of R/S is solely influenced by these. There is a need to investigate the possibility that a broader range of factors may influence clients' perceptions that R/S has been considered. There is no over-arching theoretical framework to guide the selection of these factors. In the absence of such, variables of potential importance can be extracted from a review of the literature.

In the section that follows, factors that may predict three outcomes are discussed. These are (1) whether clients discuss religion/spirituality with their practitioner, (2) whether clients perceive that religion/spirituality has been considered in their care, and (3) whether clients are satisfied with the consideration of their religion/spirituality. Because these are highly related outcomes, similar factors may predict all three. Despite this, the outcomes are examined separately because it is possible for a particular factor to impact more strongly upon one than the other. For example, a factor may influence whether R/S is discussed, but have no impact upon whether R/S is subsequently considered in

clients' care. Likewise, it is possible for a factor to be strongly associated with the consideration of R/S, but to have a lesser association with clients' satisfaction with this consideration. In the next section, eight factors that may predict these outcomes are outlined. These include the importance clients place on the consideration of R/S, clients' expectations, client-practitioner matching, direct assessment of R/S, practitioner understanding, profession, sector, and country.

Importance to clients

The importance mental health clients place on religion/spirituality being considered in their care may influence whether these beliefs are discussed and considered. In fact, it is hoped that the importance of considering R/S to the client would be attended to, as it reflects a client's preference for consideration of a particular area of their life. In most cases, considering R/S when a client places no importance on this would not be appropriate, and vice versa.

It has been noted that subtle and/or explicit references to R/S are often made by clients to whom this is important (Griffith & Griffith, 2002; Knox, et al., 2005; Stamogiannou, 2007). Ideally, this would alert attentive practitioners to the fact that religion/spirituality requires consideration (Griffith & Griffith, 2002). Whether this actually occurs is uncertain. A study by Huguelet et al. (2006) found the majority of practitioners in their study (62%) were unable to identify the level of importance clients placed on R/S in coping with mental illness, but an earlier study (Pieper & van Uden, 1996) found that a greater number of clients were asked about their religious/spiritual beliefs if they placed importance on them. Compared to the full sample (half of whom were asked), between 70-87% of those who placed importance on R/S were asked. Similarly, Lindgren and Coursey (1995) asked clients whether they had discussed R/S with their practitioner at all. Amongst their subset of clients who stated that religious/spiritual consideration was important to them, 70% discussed R/S with their practitioner, compared to 33% in the total sample. Interviews with nine clients regarding their experience of discussing R/S in therapy led Stamogiannou (2007) to conclude that clients who felt such beliefs needed to be addressed were more likely to have discussed them. From these studies, it appears that discussion of religious/spiritual beliefs is more likely to occur when clients

place importance on this. It is yet to be seen whether this importance affects the extent that R/S is considered in clients' care, particularly when they utilise secular services. Additionally, the effect of importance was not tested statistically in any of these studies, so the effect of importance on discussion and consideration will be investigated in this study. The following hypotheses are proposed:

Hypothesis 1: The importance clients place on the consideration of R/S will be positively related to (a) whether clients discuss R/S and (b) the extent that clients perceive that R/S has been considered in their care.

Client expectations

Much work in the psychotherapy literature has been devoted to examining the influence of client expectations on the process of therapy (Glass, Arnkoff, & Shapiro, 2001; Greenberg, Constantino, & Bruce, 2006). In particular, clients' expectations have been shown to be related to clinical outcomes, satisfaction, and perceptions of the therapeutic alliance (Glass, et al., 2001; Greenberg, et al., 2006). The negative expectations of religious/spiritual clients are often highlighted in the literature, particularly in relation to consulting with secular practitioners or those who have different religious/spiritual beliefs to themselves (Dougherty & Worthington, 1982; Goedde, 2000; Keating & Fretz, 1990; Mitchell & Baker, 2000; E. L. Worthington & Scott, 1983). As a result, it is not uncommon for clients to prefer practitioners who share similar religious/spiritual beliefs to themselves, or are at least empathic toward their beliefs (Belaire & Young, 2002; Gockel, 2011; Keating & Fretz, 1990; Lindgren & Coursey, 1995; D. Walker, et al., 2011; E. L. Worthington, et al., 1996).

When clients choose to consult with a mental health practitioner, particularly one who does not share similar religious/spiritual beliefs, it is unclear what impact clients' expectations have. In particular, it is unclear whether clients' expectations influence whether the topic of R/S is raised, and whether these expectations influence the way clients perceive the consideration of their religious/spiritual beliefs. One study on client preferences found no relationship between client expectations and their preferences for

discussing R/S with practitioners (Rose, et al., 2001), although the expectations that were measured in this study were only general expectations regarding the practitioner, such as their sensitivity and openness. A qualitative study by Mayers et al. (2007) concluded that clients' expectations of secular practitioners affected their comfort in initially choosing to discuss R/S. Those who expected their practitioner to respond in an unsatisfactory way to their religious/spiritual beliefs were initially reluctant to discuss the topic. Some avoided the topic until later in therapy when they were sure their practitioner would not confirm their negative expectations. When clients eventually discussed R/S, negative expectations tended to not be confirmed because practitioners often considered clients' religion/spirituality. A smaller group of clients who held initially negative expectations did perceive that there was a lack of consideration with regard to their R/S and were generally dissatisfied with this.

Other than this qualitative research and the research by Rose et al. (2001), there have been no studies which have investigated the impact of client expectations on whether they discuss R/S with their practitioner, or the influence of these expectations on clients' perceptions of whether R/S has been considered once the topic has been discussed. It appears there are no comparable studies in the multiculturalism literature either, particularly with regard to the influence of client expectations on clients' actual experiences (Pope-Davis, Liu, Toporek, & Brittan-Powell, 2001). Returning to the general psychotherapy literature, a number of experimental and correlational studies have demonstrated a positive association between clients' pre-therapy expectations and how they later 'perceive and receive' their therapist (Greenberg, et al., 2006). For example, an experimental analogue study found that manipulating pseudo-clients' pre-contact expectations of a videoed therapist as warm/cold and experienced/inexperienced subsequently affected their ratings of the therapist's persuasiveness, attractiveness and competence (Greenberg, 1969). Those who were led to believe the therapist would be warm and experienced gave higher ratings on these attributes, while those who believed the therapist would be cold and inexperienced gave lower ratings. Findings such as this suggest that clients who have more positive expectations regarding their practitioner's consideration of R/S will be more likely to perceive that R/S has been considered, and vice versa. A similar suggestion has been made by Pope-Davis, Liu, Toporek and Brittan-Powell (2001), who hypothesised that clients who expect their practitioner to be

more culturally competent would display a positive perceptual bias toward interactions with that practitioner. It is also possible that clients who are unconstrained by poor expectations will be more open to addressing R/S in therapy, thus leading to an actual (i.e., not just perceived) increase in the extent that R/S has been considered. Clients who place less importance on the consideration of their religious/spiritual beliefs would naturally expect that R/S would not feature as part of their care, so this possibility needs to be controlled for when assessing the impact of client expectations. The following hypotheses are proposed:

Hypothesis 2: Clients' expectations of whether R/S will be addressed in their care will be positively related to (a) whether clients discuss R/S (b) the extent that clients perceive that R/S has been considered and (c) clients' levels of satisfaction with this consideration.

Client-practitioner matching

If clients have a preference for the consideration of their religious/spiritual beliefs, and if consideration of R/S is related to positive client outcomes, is it important for clients and their practitioners to share similar religious/spiritual beliefs? Religious/spiritual clients often prefer and seek out practitioners who hold religious/spiritual beliefs similar to their own (Belaire & Young, 2002; Gockel, 2011; Lindgren & Coursey, 1995; D. Walker, et al., 2011; E. L. Worthington, et al., 1996). Additionally, a quarter of the 157 clients surveyed by Baetz et al. (2004) stated that religious/spiritual orientation was a factor in their selection of a psychiatrist. Such preferences have resulted in growing numbers of practitioners offering explicitly religious/spiritual psychotherapy to religious/spiritual clients (E. L. Worthington, et al., 1996).

For clients, seeking a practitioner with similar beliefs to themselves may have advantages in terms of greater consideration of R/S in their care and improved satisfaction with this consideration (cf. Gannoway, 1996). No studies have specifically investigated the effect of client-practitioner matching on the consideration of clients'

religious/spiritual beliefs and clients' satisfaction with this, but some hypotheses can be drawn from the literature. With regard to the extent that R/S is considered in clients' care, practitioners with religious/spiritual beliefs are more likely to report integrating R/S into therapy (Frazier & Hansen, 2009; Hofmann & Walach, 2011; D. Walker, et al., 2004). Supporting this, clients seen in a private religious practice in the United States were substantially more likely to report that R/S had been incorporated in their care compared to those who were seen in a private secular practice (J. Q. Morrison, et al., 2009). It is not clear whether practitioners in this study held similar beliefs to their clients.

Three studies have investigated the direct effect of client-practitioner matching on clinical outcomes. An early study found that similarity on the value of 'salvation' was associated with practitioner-reported improvements in client symptomatology, but not client-reported improvements (Kelly & Strupp, 1992). Propst et al. (1992) found that cognitive behaviour therapy incorporating R/S could be delivered by either religious or non-religious practitioners, with no difference in clinical outcomes. It was not clear from this study whether clients and practitioners shared similar religious/spiritual beliefs and whether clients were as satisfied with the way R/S was considered by those who did not share similar beliefs. A more recent study investigated the effect of similarity between client and therapist religious commitment, finding no effect on clients' perceived closeness with their therapist or clients' self-rated change (N. G. Wade, Worthington, & Vogel, 2007). This finding is complicated by the fact that almost all clients in this study were seen in a Christian counselling service, so in most instances religious/spiritual beliefs were not likely to have differed substantially, even if religious commitment differed. The findings from these last two studies can be interpreted in two ways; either the consideration of R/S in clients' care is not related to clinical outcome, or that practitioners who do not have similar religious/spiritual beliefs or commitments to their clients are as likely to consider their clients' beliefs in a satisfactory manner as those who do. On the basis of previously-reviewed research on clients' outcomes, it appears the latter explanation is the more likely of the two.

A need for further research on the effects of client-practitioner matching has been noted in the literature (Gannoway, 1996; Mayers, et al., 2007; Zinnbauer & Barrett, 2009). The effect of client-practitioner matching on the likelihood of clients discussing R/S

with practitioners will be investigated, along with its effect on clients' perceptions that R/S has been considered in their care. The effect of matching on client satisfaction with this consideration will also be investigated. Clients who place importance on the consideration of their religious/spiritual beliefs sometimes seek out a matched practitioner with the expectation that their religious/spiritual beliefs will be considered. For this reason, importance and expectations will be controlled for when assessing the effects of client-practitioner matching.

Hypothesis 3: Compared to unmatched clients, matched clients will be more likely to (a) discuss R/S with their practitioner, (b) perceive their religious/spiritual beliefs have been considered to a greater extent and (c) report greater satisfaction with this consideration.

Profession

Findings from a meta-analysis of 26 studies suggest there may be differences between professions in the extent to which R/S is considered in therapy (D. Walker, et al., 2004). Results in this meta-analysis were not systematically reported for every profession mentioned here. For example, moderation effects were reported for some professions but not others. Relevant findings will be noted but there is clearly a need for a more systematic evaluation of cross-profession differences. As a summary, Walker et al. found that clinical and counselling psychologists were more likely to endorse being agnostic, athiest, or of no religion compared with marriage and family therapists. Psychiatrists working in secular services were less active in the organisational facets of religion (32%) compared with clinical/counselling psychologists (40%) and family/marriage therapists (60%). Practitioners' personal level of R/S correlated with their self-reported consideration of R/S in therapy (r = .24). This would lead one to expect that family/marriage therapists would be most likely to consider R/S, followed by psychologists and psychiatrists, although this was not directly tested by Walker et al.'s analysis.

An additional finding of Walker et al.'s (2004) meta-analysis was that the consideration of R/S was not only predicted by practitioners' personal R/S, it was also moderated by profession. Clinical psychologists, when they identified as religious/spiritual, were more

likely to consider R/S in their practice than family/marriage therapists. This may be due to differences in focus between these two professions: clinical psychologists are trained to conduct comprehensive individual assessments that consider multi-factorial etiologies and avenues for intervention (Kingsbury, 1987). The work of family/marriage therapists requires greater attention to the processes and patterns of interaction that occur between individuals in therapy (interpsychic issues) (Goldenberg & Goldenberg, 2012). This is in comparison to clinical psychologists who tend to be more concerned with intrapsychic issues, which may include religion and spirituality. Practitioners' therapeutic orientations have been found to differ in the extent to which emphasis is placed on R/S (Hofmann & Walach, 2011). Those who hold cognitive-behavioural orientations tend to place least emphasis on R/S, followed by psychodynamic and eclectic orienations. Humanistic orientations place the most emphasis on R/S. In New Zealand, psychologists tend toward cognitive-behavioural orientations (Kazantzis & Deane, 1998), while psychotherapists tend toward psychodynamic, humanistic, or eclectic orientations (S. Manning, personal communication, January 16, 2013). Taking the above into account, it is possible that practitioners from varying professional backgrounds differ in the extent to which they discuss R/S with clients. Due to the lack of systematic evaluation in the literature, the direction and magnitude of these differences is unclear. The following hypotheses are proposed:

Hypothesis 4: (a) The likelihood that clients will have discussed R/S with their practitioner and (b) the extent that they will have perceived that R/S has been considered will differ according to the type of professional they saw.

Sector

Some clients prefer to seek out practitioners with similar religious/spiritual beliefs in the private sector, where they have more freedom to choose the characteristics of their therapist and therapy (Mayers, et al., 2007). This may not always be possible either for financial reasons or because of the severity of psychological difficulties. In these cases, clients are provided assistance by the public/state sector. In a review of

religion and psychotherapy (E. L. Worthington, et al., 1996, p. 479), the authors noted that "religious counseling in the public mental health sector has been ignored (…) families, communities, and providers of services join mental health consumers in desiring better services to consumers, many of whom are religious". Clients experiencing the most severe difficulties in the clinical population are often served in these settings. It is these clients who may benefit the most from the consideration of their religious/spiritual beliefs as an important coping resource in dealing with distress and assisting recovery (cf. Fallot, 2001; Sullivan, 1993; Tepper, et al., 2001). Researchers concerned with R/S have begun to conduct research with participants in the public sector (e.g., Huguelet, et al., 2006; Knox, et al., 2005; Pieper & van Uden, 1996). However, no study has directly compared private and public services with regard to their responsiveness toward clients' religion/spirituality.

There are a number of reasons why differences might be observed between sectors. Client-practitioner dyads in the public sector are unlikely to have entered into the professional relationship with the expectation that R/S will become a part of the client's care (Knox, et al., 2005). This may be partly because clients in the public sector do not have as much freedom to choose a practitioner with similar religious/spiritual beliefs as themselves. Practitioners in public services may not prioritise the consideration of R/S because public resources are often limited and concentrated toward short term therapy or practical concerns such as symptom management and ensuring the client has access to the basic necessities of life (Borras, Mohr, et al., 2010; Coyle & Lochner, 2011). Differences between sectors may also arise from the fact that public mental health services in some Western countries are explicitly secular. With this may come the expectation on behalf of religious/spiritual clients that R/S does not have a 'place' in these settings, and practitioners may feel less comfortable discussing R/S in a secular context (M. Baker & Wang, 2004; Delaney, et al., 2007; Mayers, et al., 2007). For example, Mayers et al. (2007, p. 322) noted that "clients were reluctant to disclose their religious/spiritual beliefs, feeling that such issues could not be discussed within a secular model". From a practitioner perspective, a recent publication from the United States noted that "[Family therapy students] feel ill-equipped to address spiritual issues in therapy, especially when in publically funded agencies (…) students do not seem to feel as though they can attend to spirituality at sites where bills are paid by the state"

(Ahn & Miller, 2010, p. 103). Due to the fact that clients would be more likely to see a practitioner with simlar religious/spiritual beliefs in the private sector, client-practitioner matching needs to be controlled for when investigating any differences between sectors. The following hypothesis proposes that:

> Hypothesis 5: Compared to clients who consult with practitioners in the public sector, those in the private sector will be more likely to (a) discuss R/S with their practitioner and (b) perceive that R/S has been considered to a greater extent in their care.

Discomfort around discussion of R/S in the public sector does not appear to be restricted to non-R/S practitioners. Religious/spiritual practitioners may also feel less comfortable discussing R/S with clients in the public sector (M. Baker & Wang, 2004; Durà-Vilà, et al., 2011). A Christian practitioner in New Zealand recently noted that as an employee of a public service, she believes that many practitioners feel an obligation to reflect the [secular] values of their employer, regardless of their client's religious/spiritual beliefs (S. Calvert, personal communication, March 3, 2012). This is consistent with D. W. Sue et al.'s (1992, p. 479) observation that "counseling oftentimes reflects the values of the larger society". Religious/spiritual practitioners in England have expressed a number of conflicts with regard to considering clients' R/S in secular public settings (M. Baker & Wang, 2004; Durà-Vilà, et al., 2011). This includes difficulties deciding whether to explicitly disclose or discuss R/S with clients given the perceived risk of being seen as unprofessional or trying to proselytize. Practitioners have also identified that discussing R/S with colleagues raises some difficulties. The fear of being seen as unprofessional was again cited as a reason for this, although some recounted actual experiences of being marginalised by colleagues as a reaction to their religious/spiritual beliefs (M. Baker & Wang, 2004; Durà-Vilà, et al., 2011).

It is unclear whether these concerns actually affect practitioners' consideration of their clients' religious/spiritual beliefs. For example, practitioners interviewed by Durà-Vilà et al. (2011) mentioned a number of instances where they actively avoided the discussion of R/S with clients as a result of their concerns. Practitioners interviewed in Baker and Wang's (2004) study shared similar concerns, but in contrast they did not

mention any instances where these concerns actually affected their practice. It is possible that practitioners in Durà-Vilà et al.'s study had actively avoided discussing R/S with clients because they were migrant practitioners who commonly mentioned concerns about 'fitting in'. These practitioners may have perceived the consequences of discussing R/S with clients as more severe than those who were not as concerned with assimilation. Earlier, client-practitioner matching was proposed to be a factor that would predict the consideration of clients' religious/spiritual beliefs. Due to the difficulties faced by R/S practitioners in deciding whether to allow R/S to become a part of care in secular settings, the following hypothesis is also proposed:

Hypothesis 6: Compared to clients who see a matched practitioner in the public sector, those who see a matched practitioner in the private sector will perceive that their religious/spiritual beliefs have been considered to a greater extent.

Country

Religion/spirituality may be more likely to become a subject of therapeutic discussion in certain countries compared to others. This possibility has been investigated by one study (Borras, Mohr, et al., 2010). Borras et al. compared the proportion of French-Switzerland clients who had discussed R/S, to clients in French-Canada, finding no difference between the two countries. There are a number of reasons why this finding might not hold across other countries. Individuals in Switzerland and Canada place similar importance on R/S; 41% in Switzerland state that R/S is important in their lives, compared with 44% in Canada. This varies from other countries; 32% of individuals in New Zealand and Australia state that R/S is important, compared to 29% in England and 64% in the United States (Gallup, 2012). Similar differences in religious service attendance are found between these countries (Gallup, 2012), along with differences in rates of practitioners' religious/spiritual identification (D. Smith & Orlinsky, 2004). These differences would be expected to impact upon the importance clients and practitioners place on R/S in dealing with mental health concerns (e.g., Cederblad, et al., 1995).

The pervasiveness of R/S in a society may influence policies that mandate the consideration of R/S in mental health care. Most mental health services follow a set of standards set by an accreditation council or health regulator. This includes Australia (Australian Council on Healthcare Standards, 2010), the United States (Joint Commission on the Accreditation of Healthcare, 2008), England (Her Majesty's Government, 2012; National Health Service, 1999), and New Zealand (Standards New Zealand, 2008). These standards differ in the extent to which the consideration of R/S is prescribed, ranging from direct instructions to consider R/S in the United States standards, through to an almost complete omission of religious/spiritual matters in the English standards.

Standards set for hospitals and behavioural health services in the United States require that providers conduct a spiritual assessment (Hodge, 2006b; Joint Commission on the Accreditation of Healthcare, 2008). For example, the hospital standard PC.01.02.13 states: "Based on the patient's age and needs, the assessment for patients who receive treatment for emotional and behavioral disorders includes the following: The patient's religion and spiritual beliefs, values, and preferences (…)" (Joint Commission on the Accreditation of Healthcare, 2012b, pp. PC-12). The behavioural health standard CTS.02.03.07 states "For organizations providing care, treatment, or services to individuals with addictions: The organization obtains the individual's perceptions of the role of religion or spirituality in his or her life" (Joint Commission on the Accreditation of Healthcare, 2012a, pp. CTS-28). Guidance around the types of questions practitioners could ask are provided by the Joint Commission (2008).

In New Zealand's Health and Disability Services Standards (Standards New Zealand, 2008), R/S is primarily covered under Standard One: Consumer Rights. In particular, Standard 1.6 requires that "consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values and beliefs" (p.11). Standard 1.4 requires that "consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs" (p.9). The guidance for this standard, which recommends non-mandatory actions, states that Standard 1.4 may be achieved by "recognising that spirituality is inextricably linked to Māori wellbeing" (p.6). Later guidance also points to the need to

recognise and validate Māori spiritual perspectives on health, and for all clients, the recording of religious/spiritual orientation in client files.

In Australia's National Standards for Mental Health Services (Australian Council on Healthcare Standards, 2010), religion/spirituality is included with several groups (e.g., gender, socioeconomic class) in Standard Four: Diversity Responsiveness. This requires the collection of information regarding religious/spiritual orientation, requires that "differences and values of [the service's] community are recognised and incorporated as required" (p.12), and requires that staff are trained to find information and resources to help them consider the diverse needs of their clients. These standards are similar to the New Zealand ones in their recognition of R/S, but are less prescriptive and do not include the consideration of spirituality for indigenous groups.

England's National Service Framework For Mental Health (National Health Service, 1999) makes provision for the consideration of R/S under Standard One: Mental Health Promotion (promotion across whole population), where a reference to a report by the Mental Health Foundation is made. This reference points to the need to "consider the physical and spiritual facets of mental health and mental health problems, and to tailor individual programmes to individual circumstances" (p.15). The most recent version, the No Health Without Mental Health framework (Her Majesty's Government, 2012), does not mention R/S at all, except in a footnote acknowledging that throughout the implementation of the Standards, diverse groups need to be recognised and provided for. This set of standards is the least prescriptive regarding the consideration of R/S, and are the only standards amongst the four countries mentioned here which do not have a specific standard addressing considerations for diverse groups.

Countries differ in the extent to which their mental health standards prescribe and facilitate the consideration of R/S. It would be expected that even after controlling for international differences in the importance clients place on the consideration of their R/S, clients may experience a greater likelihood of discussing their religious/spiritual beliefs in some countries compared to others. The present study investigates whether the likelihood of discussing R/S differs between four countries: New Zealand, Australia, United States, and England. In light of the above, the following hypothesis is proposed:

Hypothesis 7: Compared to clients who consult with practitioners in New Zealand, Australia or England, those who consult with practitioners in the United States will be more likely to discuss R/S with their practitioner.

Direct assessment

Practitioners often prefer to wait for their clients to initiate discussion of R/S before addressing this topic (Crossley & Salter, 2005). It is unclear whether clients' satisfaction would be affected negatively or positively when practitioners themselves raise the topic, instead of waiting for their client to do so. Qualitative research has provided mixed conclusions on this. An observation by Knox et al. (2005) was that in all cases where practitioners initiated discussion of R/S, clients found this unhelpful. As a result, the authors suggested extra caution in choosing to include questions about R/S in standard intake assessment. It is not clear whether the discussions clients found unhelpful were in the context of initial assessment, or were intended as a therapeutic intervention. Findings from a qualitative study with 125 clients who consulted with practitioners in a Mormon counselling centre (Martinez, et al., 2007) indicated that a small number (17) believed clients should raise the topic of R/S rather than practitioners. On the other hand, participants responding to the quantitative section of Martinez et al.'s survey tended to rate religious/spiritual assessment as appropriate and helpful.

Others suggest that sensitive enquiry on the behalf of the practitioner shows they are interested, accepting, and sensitive toward R/S (e.g., Leach, et al., 2009; Shafranske, 2005; Stamogiannou, 2007). A qualitative study conducted by Pope-Davis et al. (2002) found that clients perceived practitioners as more culturally competent when they showed a genuine interest in their culture. In support of the idea that direct assessment may be perceived by clients as a helpful way of considering their religious/spiritual beliefs, Huguelet et al.'s (2011) study found that spiritual assessment improved attendance at sessions and a willingness to ask for help. Direct assessment was 'well tolerated' among these clients and they retained their willingness to discuss R/S with their practitioner after the assessment. The religious setting of Martinez et al.'s (2007)

study, and the design of Huguelet et al.'s (2011) study meant clients would have expected the direct assessment of their R/S. It is unclear whether clients who do not expect this would be as accepting. Knox et al. (2005) identified a need to understand clients' probable reactions to direct assessment, asking "would clients experience [questions about R/S] as an invitation to address this content if they wished, or would they perceive them as at best irrelevant, at worst invasive or frightening?". Given the precedent set by the Joint Commission (2008) in mandating the direct assessment of clients' religious/spiritual beliefs in the United States, it is important to determine whether this assessment is related to clients' overall satisfaction with the way their religious/spiritual beliefs have been considered.. On the basis of the above preliminary evidence, the following hypothesis is offered:

Hypothesis 8: Clients who experience the direct assessment of their religious/spiritual beliefs will be more satisfied with the consideration of their religious/spiritual beliefs than those who do not experience direct assessment

Practitioner understanding

Clients' satisfaction with consideration may also be maximised when clients perceive that their practitioner understands the relevance of R/S to their recovery. This has not been empirically tested, but it is consistent with Fischer et al.'s (1998b) adaptation of Frank's common factors theory. Fischer et al. suggest that when client and practitioner share a common understanding and conceptualisation of a clients' difficulties and the best avenue for intervention, client outcomes may be maximised. In support of this, a prospective study by Zane et al. (2005) found that clients consulting with ethnically different practitioners expressed more favourable impressions of therapy sessions and reduced psychological distress when client and practitioner were similar in their goals for treatment and their ideas of how clients should best cope with difficulties. The authors suggest that this shared understanding helped clients to view their therapists as more credible and assisted in building the therapeutic relationship.

In qualitative studies of clients' views on R/S in therapy, participants have described practitioners' understanding as being important, and facilitative of their satisfaction with the way R/S has been considered in therapy (Goedde, 2000; Knox, et al., 2005; Mayers, et al., 2007; Stamogiannou, 2007). This is illustrated by a client's response in Stamogiannou's study (2007):

> I think if a therapist doesn't understand the very rock upon some people can be tenuously holding on to life (…) then they miss understanding a vital part of that person's existence and strengths that keep that person going (p.185).

Although it is rarely clear what clients are referring to when they use the word 'understanding' (e.g., understanding the core tenets of their R/S, understanding the importance of R/S to the client, or understanding the relevance of this to their recovery), it is possible that it points to a general sense of the practitioner being 'on board' with the clients' own conceptualisation of how R/S might be involved with their difficulties and efforts to recover. The following hypothesis is proposed:

Hypothesis 9: Practitioners' understanding will be positively related to clients' satisfaction with the way R/S has been considered in their care.

In summary, clients' perspectives on the care they receive in mental health services are important to their perceived outcomes and the efficacy of the services they receive. Clients often state that it is important to them to have their religious and spiritual beliefs considered. Despite this, researchers have stated that practitioners tend to neglect and minimise clients' religious/spiritual beliefs, and a number of surveys conducted in North America and Europe appear to support this assertion. It is unclear whether this is also the case in New Zealand as the cultural context is different to other countries, and available evidence is somewhat limited in methodology and scope. Findings also point to a need to report the extent to which R/S is considered for groups of clients who believe R/S is important in their care, and clients' satisfaction with the consideration of their religious/spiritual beliefs also requires investigation. The present study addresses these issues by surveying religious/spiritual clients from New Zealand. It investigates

what proportion of these clients have discussed R/S with their practitioner, ascertains the extent to which these clients perceive their religious/spiritual beliefs have been considered in their care, and gauges clients' satisfaction with the way R/S has been considered.

Also of interest to the present study are factors that predict whether clients discuss R/S with their practitioner, clients' perceptions that R/S has been considered in their care, and clients' satisfaction with this. To investigate this, the survey is extended beyond New Zealand participants to include clients from other coutnries, including Australia, England, and the United States. The following factors are proposed to predict the discussion of R/S: importance of consideration to the client, client expectations, client-practitioner matching, professional background of the practitioner, service sector, and country. These factors, excluding country, are also expected to influence the extent that religion and spirituality are considered in clients' care. The following factors are proposed to predict clients' satisfaction with the way R/S has been considered: client expectations, client-practitioner matching, direct assessment of R/S, and clients' perceptions that practitioners understand the relevance of religion or spirituality to their recovery. It is hoped that identification of predictive factors will assist clients to make more informed choices regarding their care and assist practitioners and researchers to remedy factors that may hinder the consideration of religion/spirituality.

SUMMARY OF AIMS AND HYPOTHESES

Aim 1: To determine the the proportion of religious/spiritual clients in New Zealand who have discussed their religious/spiritual beliefs with practitioners, perceive that these beliefs were considered in their care, and to determine clients' levels of satisfaction with the way their religious/spiritual beliefs have been considered.

Aim 2. To investigate factors that predict the Discussion and Consideration of religion/spirituality in mental health care, and clients' Satisfaction with the way this has occurred.

Hypothesis 1: The importance clients place on the consideration of R/S will be positively related to (a) whether clients discuss R/S and (b) the extent that clients perceive that R/S has been considered in their care.

Hypothesis 2: Clients' expectations of whether R/S will be addressed in their care will be positively related to (a) whether clients discuss R/S (b) the extent that clients perceive that R/S has been considered and (c) clients' levels of satisfaction with this consideration.

Hypothesis 3: Compared to unmatched clients, matched clients will be more likely to (a) discuss R/S with their practitioner, (b) perceive their religious/spiritual beliefs have been considered to a greater extent and (c) report greater satisfaction with this consideration.

Hypothesis 4: (a) The likelihood that clients will have discussed R/S with their practitioner and (b) the extent that they will have perceived that R/S has been considered will differ according to the type of professional they saw.

Hypothesis 5: Compared to clients who consult with practitioners in the public sector, those in the private sector will be more likely to (a) discuss R/S with their practitioner and (b) perceive that R/S has been considered to a greater extent in their care.

Hypothesis 6: Compared to clients who see a matched practitioner in the public sector, those who see a matched practitioner in the private sector will perceive that their religious/spiritual beliefs have been considered to a greater extent.

Hypothesis 7: Compared to clients who consult with practitioners in New Zealand, Australia or England, those who consult

with practitioners in the United States will be more likely to discuss R/S with their practitioner.

Hypothesis 8: Clients who experience the direct assessment of their religious/spiritual beliefs will be more satisfied with the consideration of their religious/spiritual beliefs than those who do not experience direct assessment

Hypothesis 9: Practitioners' understanding will be positively related to clients' satisfaction with the way R/S has been considered in their care.

CHAPTER 6

METHOD

To investigate whether clients' religious/spiritual beliefs are considered in mental health care and the factors that predict this, a survey was administered to an international convenience sample of 725 religious/spiritual individuals who had consulted with a range of mental health practitioners. Hierarchical logistic regression were used to test hypotheses 1 through 9. The recruitment of participants, demographic characteristics, development of the survey, measures, and data analysis strategies are outlined in this chapter.

PARTICIPANTS

Sampling and recruitment

Participants were invited to take part in the study if they (a) held religious or spiritual beliefs, (b) had seen a mental health practitioner in the past or currently, and (c) were over the age of 16. A total of 725 responses were included in the analysis: 712 participants completed an internet-based version of the questionnaire (situated at www.beliefs-survey.co.nz) and 13 completed a paper-based version. Of the 1,710 individuals who visited the opening page of the survey website, 1,002 (59%) chose to start the survey by confirming they met the inclusion criteria. Of these, 775 (77%) completed the survey. Completion was defined as having responded to at least one of the three outcome variables and at least one explanatory variable. Twenty-six cases were identified as possible duplicates and removed. A further 24 cases were removed because these participants did not hold religious or spiritual beliefs at the time of consulting with their mental health practitioner.

Participants were recruited using a variety of means over a 13-month period from the 1st of March 2010 to the 1st of April 2011. An invitation to take part in the survey was initially extended to the researcher's own networks in New Zealand, resulting in approximately 100 responses. A further 127 responses were received by advertising

through a New Zealand participant recruitment website, www.researchstudies.co.nz. Additional recruitment included direct contact with non-government mental health and religious organisations in New Zealand and abroad (Changing Minds, Framework Trust, emails to New Zealand, British, and Australian religious organisations listed in Yellow Pages), print advertising (local newspaper, university newsletters), and targeted Internet advertising (Facebook, Google Adwords). Figures 1 and 2 in Appendix A provide advertising examples. Participation was encouraged by offering entry into a prize draw. As it is not known how many potential respondents were exposed to advertising, response rates could not be estimated.

Specific efforts were made to recruit groups of participants in New Zealand who have been under-represented in past research, such as minority ethnic and religious participants and older adults. Two colleagues in the researcher's academic department with close links to Māori communities distributed paper-and-pencil, postage-paid questionnaires to their own contacts, while the researcher passed on questionnaires to her own Māori, Pacific Island, Buddhist, and Muslim contacts with the request for the invitation to be extended to others. In addition to these efforts, 4,200 advertising flyers were distributed in urban suburbs where high concentrations of ethnic and religious minorities were known to reside, and to three retirement villages. Facebook advertising was targeted toward users who associated their online profiles with minority religious or ethnic Internet pages.

Demographic characteristics

Demographic descriptors of the full (international) sample are summarised in Table 3. The majority of participants had seen a mental health practitioner in New Zealand (63%), were female (78%), Christian (69%), of Caucasian ethnicity (82%) and young (*Mdn* = 32). Twelve percent of the sample chose to identify as being spiritual, not religious. The average Religious Commitment Inventory (RCI) score was 33 (*SD* = 12), comparable to the religious commitment of mental health clients in the United States (*M* = 34, *SD* = 13) (E. L. Worthington, et al., 2003). The average Intrinsic Spirituality Scale (ISS) score was 44 (*SD* = 12). No normative data are available for this scale, but this average score is similar to that of spinal rehabilitation patients in the

Southern United States (M = 46, SD = 10.2) (B. White, Driver, & Warren, 2010). The majority of the sample saw mental health practitioners who did not identify as having similar religious/spiritual beliefs to themselves, or did not know whether their practitioner held similar beliefs (66%). Half (49%) of the participants saw a mental health practitioner provided by the public sector. Counsellors were the most commonly consulted mental health practitioners (39%), followed by psychologists (18%). Participants' self-rated religiousness/spirituality was slightly higher at the time of completing the survey (M = 6.5, SD = 1.9) than at the time of consultation with their mental health practitioner (M = 6.0, SD = 2.3) (t = 7.54, $p < .001$).

Table 3. *Demographic characteristics of participants, full [international] sample*

Characteristic	Frequency % (*n*)
Gender (female)	77.9 (565)
Age (*Mdn*, IQR)	32 (24 - 46)
Country	
New Zealand	62.6 (454)
United States of America	15.4 (112)
Australia	9.8 (71)
England	7.9 (57)
Other	4.3 (31)
Ethnicity	
NZ Māori	6.3 (46)
NZ European	50.5 (370)
English/Welsh/Irish/Scottish	20.4 (149)
North American	6.7 (49)
Australian	4.6 (34)
Asian	4.4 (32)
Other	7.1 (52)
Religion	
Christian (Anglican, Presbyterian)	12.2 (87)
Christian (Catholic, Methodist)	8.4 (61)
Christian (Baptist, Evangelical, Fundamentalist)	23.2 (168)
Christian (Other, NFD)	25.3 (183)
Buddhist	4.4 (32)
Other religion	14.4 (104)
No religion	12.1 (88)
RCI (*M, SD*)	33.0 (12.15)
ISS (*M, SD*)	43.6 (11.89)
Self-rated R/S at time of consult (*M, SD*)	6.0 (2.26)
Self-rated R/S at time of survey (*M, SD*)	6.5 (1.91)
Sector (Public)	48.5 (350)
Profession of practitioner	
Counsellor	38.9 (282)
Psychologist	18.3 (133)
Psychiatrist	9.5 (69)
Psychotherapist	9.0 (65)
Other[a]	24.3 (176)
Match Status	
Matched	34.1 (250)
Unmatched	38.8 (281)
Uncertain	26.8 (194)

Note. Grouping of Christian denominations made on the basis of Hoverd and Sibley's (2010) classifications. NFD = Not Further Defined. Match Status = client-practitioner matching.

[a]Includes participants who selected multiple practitioner categories.

Because the first aim of the present study is to gauge the experiences of New Zealand mental health clients, demographic descriptors of the New Zealand sample are summarised in Table 4. The majority of these participants were female (78%), Christian (60%), New Zealand European (76%) and young (*Mdn* = 32). Seventeen percent of the sample chose to identify as spiritual, not religious. These clients were less religious and less spiritual than the international sample (excluding NZ clients), with an average RCI score of 30 (*SD* = 12.2, $F = 73.90$, $p < .001$), and an average ISS score of 42 (*SD* = 11.9, $F = 34.67$, $p < .001$). More than half (56%) of the participants saw a mental health practitioner provided by the public sector. Participants' self-rated religiousness/spirituality was higher at the time of completing the survey (*M* = 6.1, *SD* = 1.8) than at the time of consultation with their mental health practitioner (*M* = 5.6, *SD* = 2.1) ($t = 6.29$, $p < .001$).

National data suggests that some characteristics of this sample are representative of New Zealand mental health clients, while others are not. Females are substantially over-represented, as only 48% of New Zealand mental health service users are female (Ministry of Health, 2010a). This may be because females in New Zealand are more likely to be religious compared to males (Hoverd & Sibley, 2010), and females in general respond to surveys at twice the rate of males (Sax, Gilmartin, & Bryant, 2003). The median age of mental health service use falls in the 30-35 year age group (Ministry of Health, 2010b), which is similar to the median age of those surveyed in the present study. New Zealand Europeans are over-represented (Ministry of Health, 2010a), and Māori, who represent 21% of the public mental health service user population, are represented by only 10% of the participants in the present study. Pacific peoples, who represent 5% of service users, were represented by under 2% of the participants in the present study. Of those who identified with a religious organisation in the present study, the representation of Christian and Buddhist individuals is approximately equivalent to New Zealand census statistics. Muslim and Hindu groups are under-represented (Statistics New Zealand, 2006), potentially because of the low response from ethnic groups who tend to identify with these religions. Of the Christian denominations, the Baptist/Evangelical/Fundamentalist denominations appear to be over-represented, although this is difficult to gauge because no data are available to indicate what

proportion of this group should be expected in the mental health population. Because younger people are more likely to identify with these denominations compared to others, such as Anglican and Presbyterian (Hoverd & Sibley, 2010), it is possible they are highly represented because of the low median age of the sample and the mental health population in general. It may also be a result of the researcher using her own networks for initial recruitment.

Table 4. *Demographic characteristics, New Zealand sample*

Characteristic	Frequency % (*n*)
Gender (female)	78.2 (355)
Age (*Mdn*, IQR)	32 (21 - 43)
Ethnicity	
NZ Māori	9.5 (43)
NZ European	76.2 (346)
Asian	2.9 (13)
Pacific peoples	1.6 (4)
English/Welsh/Irish/Scottish	5.1 (23)
Other	5.5 (25)
Religion	
Christian (Anglican, Presbyterian)	9.3 (42)
Christian (Catholic, Methodist)	7.7 (35)
Christian (Baptist, Evangelical, Fundamentalist)	22.3 (101)
Christian (Other, NFD)	20.8 (94)
Buddhist	4.4 (20)
Other religion	18.1 (82)
No religion	17.3 (78)
RCI (*M, SD*)	29.64 (12.23)
ISS (*M, SD*)	41.73 (11.85)
Self-rated R/S at time of consult (*M, SD*)	5.62 (2.10)
Self-rated R/S at time of survey (*M, SD*)	6.13 (1.83)
Sector (Public)	56.2 (254)

Note. Grouping of Christian denominations made on the basis of Hoverd and Sibley's (2010) classifications. NFD = Not Further Defined.

PROCEDURE

Ethics

Massey University Human Ethics Committee (MUHEC) approval was gained for the study under protocol number 10/008. A participant information sheet was provided with the online and paper administrations of the questionnaire (Appendix B). This outlined the inclusion criteria, participants' rights to skip any part of the questionnaire, and the anonymity and confidentiality of their responses.

Questionnaire

Data were gathered using a 41-item questionnaire designed to gather a range of information on the expectations and experiences of religious/spiritual clients in mental health care. The questionnaire was structured under three sections. Section One included basic demographic items such as age, ethnicity and religious affiliation. Section Two included the Religious Commitment Inventory (RCI; E. L. Worthington, et al., 2003) and the Intrinsic Spirituality Scale (ISS; Hodge, 2003), and Section Three included items to assess participants' expectations and experiences of religion/spirituality in mental health care.

Development considerations.

Questionnaire development was an iterative process occurring over several phases, including pre-pilot and pilot studies and consultation with a number of relevant parties. Pre-pilot feedback on the appropriateness and user-friendliness of the questionnaire was sought from Christian residents of a private psychiatric residential facility and 13 people from the researcher's own networks from various religious/spiritual affiliations (including Jewish, Buddhist, Muslim, and spiritual/not religious). Additional feedback was sought by consultation with local District Health Board employees and consumer advisors who were familiar with the dissemination of questionnaires to service users. Consultation regarding the bicultural appropriateness of the questionnaire was also sought during a hui (meeting) with the researcher's local Māori mental health service provider and the District Health Board Māori Ethics Committee. In addition to suggestions provided by these parties, decisions with regard to response format and wording were made as follows:

Response format. Variables for which there were no standardised measures were measured as 10-point Likert-type items. This number of points was chosen to reduce the likelihood of ceiling and/or floor effects, to allow for a greater range of responses for analysis, to approximate a continuous scale of measurement (Olson, 2008), to maintain consistency with the response format of the ISS, and to allow for dichotomisation of the items. A unipolar option (complete agreement vs. absence of agreement, rather than complete agreement vs. complete disagreement), was chosen on the basis of recent evidence that respondents do not necessarily view categories, such as satisfaction vs. dissatisfaction, as mutually exclusive concepts (Mazaheri & Theuns, 2009).

A paper version of the questionnaire was used for those with limited access to the web version. Some concerns have been raised regarding the equivalence of web versus paper administration. Differential responses could arise from the different layout (e.g., presentation of one question or set of questions at a time), different response formats (e.g., click vs. circle), and difficulties some participants may have with the computer interface. However, a meta-analytic comparison of participant responses across web and paper versions of 278 outcome measures found no evidence of differential responding between internet and paper versions of questionnaires (Gwaltney, Shields, & Shiffman, 2008).

Question wording. Two strategies to protect against inattentive responding and 'yay-saying' were employed during pre-piloting: interspersing positively worded questions with negatively worded questions (e.g., "during their work with me, my mental health practitioner did not take my religious/spiritual beliefs into consideration"), and reversing the response options (i.e., 1-10, 10-1) (Barnette, 2000). Feedback suggested that some respondents found the negative wording difficult to comprehend. It was also found that some participants did not attend to the reversals and provided incorrect responses. As a result, both strategies were removed from the final version of the questionnaire.

It was unclear whether respondents would respond to items asking about religiousness or spirituality similarly. For this reason, several items in the pilot study were duplicated to allow participants to respond to one item using the word 'religiousness', and the

same item again using the word 'spirituality'. For example, the 'consideration' item was duplicated in the following manner: "During their work with me, my mental health practitioner took my *religious* beliefs into consideration" … "During their work with me, my mental health practitioner took my *spiritual* beliefs into consideration". The majority of these splits were removed after correlations between them indicated that participants were responding in very similar ways to both. Only for the question assessing consideration of religion and spirituality did participants appear to sufficiently distinguish between the two, so this particular split was retained for the final version.

Questionnaire piloting.

A pilot study was conducted to uncover potential obstacles to data collection and elicit feedback from participants on the structure, wording, and response format of the questionnaire (van Teijlingen, Rennie, Hundley, & Graham, 2001). Massey University Human Ethics Committee (MUHEC) approval was gained for the pilot study under protocol number 09/036.

Approximately 150 undergraduate psychology students attending a lecture at Massey University in Auckland, New Zealand, were invited to complete the questionnaire. No exclusion criteria were set; feedback on any section of the questionnaire was welcomed. Participants were informed that the questionnaire was a pilot version to be used for assessing its user-friendliness. Participation was voluntary and anonymous; questionnaires were returned to drop-boxes in subsequent lectures and tutorials in the three weeks following recruitment. A total of 83 students returned the questionnaire, giving an approximate response rate of 55%. The pilot sample was predominantly young (*Mdn* = 19 years, range 17 – 57), NZ European (70%) and female (87%). Fifty-four percent identified as Christian, 14% identified as either agnostic or atheist, and 4% identified as Muslim.

Amendments to questionnaire. The questionnaire was well received by pilot participants. Feedback was used to make changes to the definitions of religion and spirituality provided in the questionnaire, and to make some wording changes to Section Three. A number of participants who had not discussed R/S with their mental health

practitioner indicated that other questions regarding their practitioners' consideration of R/S were not applicable. To address this, the questionnaire was formatted with a skip structure, whereby those who had not discussed R/S with their practitioner were not asked about the consideration of their religious/spiritual beliefs or their satisfaction with this. The final version of the questionnaire can be found in Appendix C.

Variables and measures

Religiousness.

Religiousness was measured using the Religious Commitment Inventory (RCI; E. L. Worthington, et al., 2003). The scale consists of 10 Likert items with five points each, with a possible minimum score of 10 and maximum of 50. The reliability and validity of the RCI have been tested with 1,364 participants from several populations in the United States, including mainstream university students, Christian university students, and clients and therapists from mainstream and Christian counselling centres. The individuals in these groups held a range of religious beliefs (Hindu, Muslim, Christian, Buddhist), of diverse ethnicities and ages. Estimated internal consistency coefficients ranged from 0.88 to 0.96 (E. L. Worthington, et al., 2003). Internal consistency of the RCI in the present study was estimated to be $\alpha = .96$, and the total score was moderately correlated with participants' self-rated religiousness ($r = .62$).

In addition to completing the RCI, participants in the present study also self-rated their religiousness for the time they consulted with their practitioner and for the time of completing the survey. This was rated on a scale of 1 to 10 (1 = *not religious at all*, 10 = *highly religious*). These self-ratings were guided by the following definition of religiousness: "Being religious sometimes involves adhering to the beliefs and practices of a formal religion. Often it involves commitment to sacred rules or laws" (cf. Zinnbauer & Pargament, 2002).

Spirituality.

Spirituality was measuring using the Intrinsic Spirituality Scale (ISS; Hodge, 2003) which measures the centrality of spirituality to individuals' lives. The ISS is a modified version of Allport and Ross' widely used measure of intrinsic religiousness (Allport & Ross, 1967). It has six items, with a minimum total score of 0 and maximum of 60. The ISS has been tested with a group of 172 university students from a Christian-affiliated university in the United States. Internal consistency was estimated by Hodge to be .96. Although its psychometric properties have not been investigated with diverse populations, the fact that this scale allows respondents to use their own interpretation of spirituality, does not use theistic language, and is brief, resulted in it being judged the most appropriate measure of spirituality for this study. Internal consistency of the ISS in the present study was satisfactory at α = .95, and the total score was moderately correlated with participants' self-rated spirituality (r = .62).

Participants also self-rated their spirituality for the time they consulted with their mental health practitioner and for the time of the survey. This was rated on a scale of 1 to 10 (1 = *not spiritual at all*, 10 = *highly spiritual*). These self-ratings were guided by the following definition of spirituality: "Being spiritual sometimes involves having a belief in, experience of, or connection with a God, spiritual being, ancestor, or realm outside of ordinary human experience. This can also include oneness with nature" (cf. Zinnbauer & Pargament, 2002). The average of the two single-item spirituality and religiousness measures were used for sample demographics.

General information relevant to Section Three measures.

Clients were asked to respond to Section Three questions in relation to the most recent mental health practitioner they had seen. Clients who had seen both private and public mental health practitioners were asked to respond in relation to the most recent *public* practioner they had seen. This was done to ensure a large enough representation of clients' experiences from the public sector. 'Public' was defined as a practitioner provided by a district health board or government health service. Definitions of religion and spirituality were provided for participants to guide their responses on items that differentiated between these.

For the following five variables (Consideration, Satisfaction, Importance, Understanding, Expectations), no appropriate multiple-item standardised measures had been developed at the time of the research. These variables were measured using agreement with a set of statements on Likert-type items with two anchors. Possible responses ranged from 1 = *do not agree at all* to 10 = *agree completely*. Although several measures were available for the measurement of Consideration and Expectations (Belaire & Young, 2002; Keating & Fretz, 1990; Martinez, et al., 2007), they were not used because they had been developed for specific religious groups, using items that were not appropriate for other religious/spiritual groups. Furthermore, these scales relied upon researchers' ideas of what religious/spiritual clients should expect of practitioners, rather than what clients themselves had deemed to be appropriate.

Consideration of religion/spirituality.

The extent that religion/spirituality was considered in clients' care ('Consideration') was measured using level of agreement with two statements: "During their work with me, my mental health practitioner took my *religious* beliefs into consideration" and "During their work with me, my mental health practitioner took my *spiritual* beliefs into consideration". Because participants who did not identify as religious tended to skip the first item and responses on the two versions of the question were highly correlated (Spearman's rho [r_s] = .85), the mean of the two items was used. Participants who had not discussed religion/spirituality with their practitioner were not asked these questions.

Satisfaction with consideration.

Clients' satisfaction with the way religion/spirituality was considered in their care ('Satisfaction') was measured using level of agreement with the statement "I am satisfied with the *way* in which my mental health practitioner took my religious/spiritual beliefs into consideration". The emphasis on 'way' was used to ensure participants paid attention to the method, manner or appropriateness of how religion/spirituality was considered in their care, rather than the extent. Participants who had not discussed religion/spirituality with their practitioner were not asked this question.

Importance.

The importance clients placed on the consideration of their religious/spiritual beliefs ('Importance') was measured using agreement with the statement "It was important to me for my religious/spiritual beliefs to be taken into consideration".

Practitioner understanding.

The extent to which clients perceived their practitioner understood the relevance of religion/spirituality to their recovery ('Practitioner Understanding') was measured using agreement with the statement "My mental health practitioner understood how my religious or spiritual beliefs were relevant to my recovery". Participants who had not discussed religion/spirituality with their practitioner were not asked this question.

Expectations.

A brief scale was developed for the purposes of this study, using clients' pre-consultation expectations abut three experiences: direct assessment of religion/spirituality, consideration of religion/spirituality, and practitioners' understanding. Agreement with three statements was measured. Each started with "Prior to contact with my mental health practitioner…" and ended with either "…I expected to be asked about any religious or spiritual beliefs that I had", "…I expected they would understand how my religious or spiritual beliefs were relevant to my recovery", or "…I expected that my *religious/spiritual*[b] beliefs would be taken into consideration" (1 = *do not agree at all* to 10 = *agree completely*). Participants' total score on the three items were used, with lower scores indicating lower expectations, and higher scores indicating higher expectations (min = 3, max = 30). These items together demonstrated satisfactory internal consistency reliability ($\alpha = 0.88$).

All other variables were measured using categorical response options (refer to the questionnaire in Appendix C).

Match Status.

Client-practitioner match ('Match Status') was assessed by asking participants "Did your mental health practitioner identify with similar religious or spiritual beliefs as yourself?". Reference was made specifically to 'beliefs' rather than 'affiliation' or 'orientation' due to evidence in the ethnic matching literature that matching effects may

[b] This item was originally split into two items using the terms 'religious' and 'spiritual' separately.

be due to similar attitudes or beliefs rather than group identification (S. Sue, 1998). Three response options: 'yes', 'no' and 'don't know' were provided. These were designated 'matched', 'unmatched' and 'uncertain', respectively.

Country.

Clients were asked "In which country did you consult with this mental health practitioner?" This was an open-ended response.

Profession.

Clients were asked to indicate the professional background of the practitioner they had seen. Clients were asked "What is the job title of the mental health practitioner you are answering these questions about?". Response options included a list of nine professions, an 'other, specify' option and a 'don't know' option.

Direct Assessment / 'Asked'.

Practitioners' direct assessment of religion/spirituality was measured by having participants indicate whether their practitioner asked if they had any religious or spiritual beliefs ('yes', 'no').

Discussion of religion/spirituality.

If the response to the above question was 'no', participants indicated whether they discussed their religious/spiritual beliefs at all with their practitioner ('yes', 'no'). If no discussion occurred, participants were not asked the questions measuring Consideration, Satisfaction, and Practitioner Understanding.

Other measurement considerations.

Because it was unclear whether participants were interpreting the items measuring Consideration and Satisfaction with consideration differently, the discriminability of two variables was assessed. This was done by asking a convenience sample of 14 participants to rate the semantic similarity of the items on a scale of 0 to 100 (0 = *they have completely different meanings*, 100 = *they mean exactly the same thing*) and to provide their interpretation of the two items. The average similarity rating was 14 (*SD* = 21; *Mdn* = 0; IQR = 0 - 20). The majority of these participants referred to Consideration as a general statement regarding the extent that religion/spirituality was included in the therapeutic encounter (e.g., discussion of religion/spirituality), and to Satisfaction with consideration as assessing the subjective quality of consideration (e.g., discussing

religion/spirituality in a respectful manner, satisfaction with the amount of discussion that took place). This suggests that participants interpreted the two items differently, and that the variables measured different constructs.

To check whether questionnaire items were precise enough to be interpreted in the same manner by participants over time and that participants' reports were reliable, four-week test-retest reliability was assessed with a convenience sample of 19 participants. Test-retest reliability of categorical variables using Cohen's kappa was satisfactory, ranging from 0.76 (Match Status) to 1.0 (Country). Test-retest reliability of ordinal variables using Spearman's rho was also satisfactory, ranging from 0.88 (Consideration) to 0.96 (Understanding) (cf. Tabachnick & Fidell, 2007).

ANALYSIS STRATEGY

The data analysis for the present study was conducted in two parts. The first part examined whether religion and spirituality were considered in the care of New Zealand mental health clients who were religious/spiritual (Aim 1). Data from New Zealand respondents were used, and focussed on two subsets of clients: those who indicated it was important for their religious/spiritual beliefs to be considered, and those who consulted with a public sector practitioner. The second part of the analysis examined the factors that predicted consideration of clients' religious/spiritual beliefs. Hierarchical logistic regression was used to test hypotheses 1 through 9 in three separate analyses. The first analysis tested the effects of explanatory variables on the odds of clients discussing religion/spirituality with their practitioner, the second tested the odds of religion/spirituality being considered, and the third tested the odds of clients being satisfied with this consideration.

Part one

The analysis strategy for Part One involved reporting the percentages of New Zealand participants who had discussed religion/spirituality with their practitioner, perceived that religion/spirituality was considered in their care, and were satisfied with the way this occurred. These percentages were also provided for two subsets of clients: those who placed importance on the consideration of their beliefs, and those who saw

practitioners in the public sector. The percentage of clients who had been asked about their religious/spiritual beliefs was also reported.

For an overall understanding of clients' experiences, the total percentage of clients who had (a) Discussed their religious/spiritual beliefs *and* perceived these beliefs were Considered and (b) Discussed religion/spirituality *and* were Satisfied with the consideration of their religious/spiritual beliefs were also reported.

Data management.

For Part One of the analysis, the 10-point Importance, Consideration, and Satisfaction scales were dichotomised into two categories 'non-affirmative response' (points 1 - 5) and 'affirmative response' (points 6 - 10). This was done for comparison with similar studies (e.g., Borras, Mohr, et al., 2010; de Beer, 1998; Huguelet, et al., 2006; Lindgren & Coursey, 1995; Pieper & van Uden, 1996). Different splits were used for Part Two. Strategies to deal with missing data are outlined in the second part of the analysis strategy.

Case weighting.

Because certain groups were disproportionately represented in the sample of New Zealand clients, cases were weighted to better reflect the representation of these groups in New Zealand mental health care services (Ministry of Health, 2010b; Pfeffermann, 1996). This is a common practice in the analysis of survey data where the researcher wishes to adjust for potential bias created by disproportionate representations, so that results can be generalised to a broader population (Biemer & Christ, 2008). Results adjusted by case weighting are often presented alongside unadjusted results (e.g., Browne, 2006) so that the effects of adjustment are clear to readers. This was done in the present study. While case weighting is not a panacea to the problems of bias and non-representativeness created by non-probability sampling and non-response, in this instance it was considered the most appropriate way to at least partly correct for any bias resulting from the disproportionate representation of certain groups (Biemer & Christ, 2008; Kish, 1990; Pfeffermann, 1996).

Weighting was achieved by assigning individual case weights, using the ratio of the sample proportion to the population proportion (Kish, 1990; Pfeffermann, 1996). Population proportions were derived from mental health usage statistics provided by the New Zealand Ministry of Health (2010b). A weight of 2.30 was assigned to males, 0.62 to females, 1.03 to Asian, 0.81 to New Zealand Europeans/U.K. Caucausian/Other, 2.21 to Māori, and 3.07 to Pacific Island. Weights were not assigned to religious groups because no national mental health data were available to calculate appropriate weights. Instead, a sensitivity analysis was conducted to check that responses of the potentially over-represented religious group (Baptist/Evangelical/Fundamentalist Christians) did not unduly influence the results of Part One. Test statistics did not show statistically significant change when this group was removed from the sample, indicating the results were not biased toward the responses of Baptist/Evangelical/Fundamentalist Christians.

Inferential statistics.

The Pearson's chi-square statistic was used to compare clients' experiences across the public and private sectors. All chi-square analyses fulfilled the assumption of expected cell counts greater than five (Utts & Heckard, 2007). For the analysis of differences between sector percentages, greater emphasis was placed on differences between unadjusted (as opposed to adjusted) percentages, as case weighting increases sample variance and can result in other complications in the use of inferential statistics (Kish, 1990).

Part Two

Considerations for Part Two of the analysis included searching for an appropriate regression technique, the treatment of missing data, reduction of categories, dummy coding, assumption checks, the use of variable and model statistics, and the hierarchical entry of variables into the regression models.

Testing assumptions of linear regression.

Characteristics of the data were inspected to determine whether hypotheses pertaining to Consideration and Satisfaction could be tested using linear (ordinary least squares [OLS]) regression. Linear regression requires a number of stringent assumptions regarding the underlying distribution of the outcome variable and the relationship between explanatory and outcome variables (see Tabachnick & Fidell, 2007 for an overview). These include the assumptions of an underlying normal distribution, linearity, homoscedasticity, and normally-distributed residuals. The distribution of the outcome variables were assumed to be non-normal if standardised values of skew and kurtosis exceeded 2.58 and histograms showed marked non-normality (Field, 2009). The limit for skew and kurtosis was exceeded on both outcome variables (Consideration, Satisfaction). A normal distribution could not be achieved through the use of statistical transformation because participants favoured responding at the very low, moderate, and very high ends of the ordinal scales. The assumptions of linearity, homoscedacity, and normally-distributed residuals were checked using a standardised versus predicted residual plot (Tabachnick & Fidell, 2007). Residuals did not show consistent variance across all values of the outcome variables, suggesting the presence of heteroscedascity in the data. For the Satisfaction outcome variable, the data appeared approximately linear, evidenced by the consistent clustering of residuals around zero across all values of the response scale. For the Consideration outcome variable, residuals appeared to be biased toward negative values at the lower end of the scale. Restriction in the range of the scale meant that residuals could not be normally distributed at the extremes of the scales. Overall, it appeared the data did not exhibit the characteristics required to meet the assumptions of linear regression.

Logistic regression analysis.

Distribution-free estimators (e.g., the arbitrary distribution function [ADF] and weighted least squares [WLS]) can be used when the assumptions of OLS regression are not met, but these require very large samples for accurate estimates and empirical support is lacking for the use of certain estimators when data are extremely skewed (refer to Kline, 2011). With this in mind, logistic regression was chosen as the most appropriate method to test the hypotheses of the present study. Binary logistic regression was used to test hypotheses pertaining to the Discussion of religious/spiritual beliefs, while ordinal logistic regression was used to test hypotheses pertaining to the Consideration of clients' religious/spiritual beliefs and clients' Satisfaction with consideration.

Logistic regression is an alternative approach to analysis where traditional assumptions of OLS regression, such as multivariate normality, are not met (Menard, 2002; Sweet & Grace-Martin, 2003; Tabachnick & Fidell, 2007). Like linear regression, logistic regression allows for the simultaneous entry of multiple explanatory variables (e.g., Country, Importance) to assess their effect on an outcome variable (e.g., Consideration of religious/spiritual beliefs). Not only does this reduce the amount of hypothesis testing, simultaneous entry allows for confounding effects between explanatory variables to be assessed so the unique effect of each explanatory variable can be estimated separately. Logistic regression enables the prediction of membership in one or more nominal or ordered groups by transforming the odds of being in each group compared to a reference group using a natural logarithmic transformation. The effects of the explanatory variables are then estimated on the resultant logit, or 'logged odds' (Menard, 2002). The interpretation of the regression co-efficients are made relatively straightforward by exponentiating the logit to produce an odds ratio. In binary logistic regression, the observed odds of belonging to group A (e.g., clients who Discussed their religious/spiritual beliefs) compared to B (e.g., clients who did not Discuss) are produced. Ordinal logistic regression produces the observed odds of belonging to a group that provided higher versus lower ratings on a response variable (e.g., the odds of reporting high levels of Satisfaction compared to all lower levels). This is also known as the proportional odds model (McCullagh, 1980). The analysis proceded using guidelines produced by Menard (2002), Hosmer and Lemeshow (1989) and Jaccard

(2001). IBM SPSS v.19 was utilised for all analyses. For logistic regression models, the SPSS Binary Logistic analysis and Polytomous Universal Model (PLUM) for ordinal logistic regression were used.

Missing data.

For the ordinal scales, an average of 6.1% of data were missing (range 3.3% - 8.1%). For nominal variables, an average of 0.01% of data were missing (range 0.00% - 0.03%). Because rates of missingness were similar across items, it was not expected that any particular item created difficulties for participants. It was assumed that the data were missing at random [MAR] (Little & Rubin, 1987), such that missingness was not related to the items themselves but may have been related to other variables, such as participant characteristics.

The multiple imputation method of expectation maximisation is currently the most accepted method of estimating missing data values in continuous and ordinal scales (Finch, 2010; J. L. Schafer & Graham, 2002). Multiple imputation is relatively insensitive to violations of normality in large samples (≥ 500) under the MAR assumption, and can be used with ordinal scales with at least five categories (Finch, 2010; J. L. Schafer, 1997). According to Finch, the most conservative method of handling missing data, listwise deletion, tends to produce greater bias than multiple imputation. Expectation maximisation imputation was used for the 10-point items measuring Consideration, Satisfaction, Importance, Understanding and Expectations. Imputed values were rounded to the nearest integer (J. L. Schafer, 1997). Where missing data could not be estimated because no information was available for estimation, listwise deletion was used. The small proportion of missing categorical data (e.g., Country) were dummy coded into 'other' categories (cf. Hardy, 1993; Sun et al., 2000). Where an 'other' category was not available (as in the case of Sector and Match Status), listwise deletion was used.

Reduction of categories.

When analysing responses on a 10-point scale using ordinal logistic regression, the effective sample size is limited to the point on the scale containing the smallest number of cases (Babyak, 2004), meaning that a 10-point scale would require an excessively

large number of cases to fulfill the minimum ratio of cases per explanatory variable (≥ 10) (Babyak, 2004; Hosmer & Lemeshow, 1989). With this in mind, the Consideration and Satisfaction scales were collapsed into a smaller number of ordered groups. The distribution of responses showed that participants responded in three clusters, with natural breaks occurring between points 4-5 and 9-10. These breaks were defined as the cut-points for each group. Points 1-4 on the scale were classified as low agreement, 5-9 as moderate, and 10 as high. Compared with abitrary equal-width cut points, using natural breaks in the scale does not assume equal distance between points on the larger scale. Additionally, it takes into account participants' interpretation of the scale, and allows for the minimisation of within-group variance while simultaneously maximising between-group variance (cf. Jenks, 1967).

Dummy coding.

Categorical variables were dummy coded for the purposes of the regression analyses. The choice of reference category does not affect the statistical outcome of the analysis (Hardy, 1993), so the reference category was chosen on the basis of criteria requiring that the category: (a) be relatively homogeneous and well-defined, (b) be of theoretical interest (c) reduce the need for ad hoc testing, and/or (d) be large enough for statistically significant differences to be detected (Hardy, 1993, p. 9).

Assumption checks and data screening for logistic regression.

Like linear regression, logistic regression requires a number of statistical assumptions to be met (Hosmer & Lemeshow, 1989; Menard, 2002). Data were investigated for evidence of nonlinearity, collinearity, numerical problems, and influential values. Specifically, nonlinearity between continuous explanatory variables (Importance, Understanding, Expectations) and the logits of the outcome variables were investigated using the Box-Tidwell test; collinearity between explanatory variables was investigated using tolerance statistics with a threshold of ≤.20 to indicate collinearity problems; numerical problems were investigated by checking for infinite parameter estimates and counts of zero-frequency cells, and outlier cases were identified using three indicators: studentized residuals greater than ± 2, leverage values higher than $3((k+1)/N)$, and dfbeta values (changes in parameter estimates with case removed)

greater than 1 (Menard, 2002). The proportional odds assumption (equality of effects across all levels of the outcome variable) was checked for the ordinal logistic regression models using the test of parallel lines. The results of these checks are presented in the next chapter. Efforts were also made to retain a case-to-variable ratio of ≥ 10:1, using the sample size in the smallest outcome category (Babyak, 2004).

Variable and model statistics for logistic regression.

Associations among explanatory and outcome variables were explored during preliminary descriptive and inferential analyses. These were conducted using the Pearson's chi-square statistic. All analyses fulfilled the assumption of expected cell counts greater than five in 100% of 2x2 tables and at least 90% of all cells in large tables (Utts & Heckard, 2007). 'Other' categories were not included in chi-square tests to allow for meaningful comparison between categories.

Case weighting was not used in Part Two of the analysis because there were no theoretical or empirical reasons to suggest that the disproportionate representation of certain groups would influence the inter-relationships between explanatory and outcome variables. To check this, preliminary runs of all regression analyses were conducted, controlling for the effects of gender, ethnicity and religious/spiritual affiliation. Parameter estimates and model statistics showed little change when these variables were added, so they were excluded from the final analysis.

The regression analyses in this study were conducted using a theory-driven approach; any additional findings in the preliminary data analysis not specified by a priori hypotheses were not tested further but were noted for the purposes of formulating hypotheses for future research (cf. Babyak, 2004; H. White, 2000). Such 'incidental' findings were noted only if they obtained a significance value of $p \leq .01$. No hypothesised explanatory variables were removed from the regression analysis if their associations with outcome variables did not reach significance in the preliminary analyses. This was done so any suppression effects could be detected in the appropriate regression model. Any hypothesised associations were noted as statistically significant

when $p \leq .05$. Significance values of $p \leq .10$ were also noted, as were any relatively large differences in effect size (Schmidt, 1996). All significance tests were two-tailed.

With the exception of incidental findings, corrections for multiple tests were not used due to their tendency to reduce statistical power (Nakagawa, 2004), and their assumption that the validity of findings are conditional upon the number of other tests performed, regardless of their theoretical validity (Perneger, 1998). Odds ratios, confidence intervals and exact *p* values were reported to allow readers to form their own conclusions regarding the significance (statistical or otherwise) of reported associations (Cabin & Mitchell, 2000; Nakagawa, 2004; Schmidt, 1996).

The statistical significance of parameter estimates were assessed using Wald confidence intervals and the Wald statistic, which is the ratio of the coefficient estimate to its standard error. Despite being the most commonly-utilised inferential statistic in logistic regression, Menard (2002) and Pampel (2000) advise caution when using the Wald with relatively small samples as it may lead to a failure to detect statistically significant associations. An oft-recommended alternative, the likelihood ratio statistic (Menard, 2002; Pampel, 2000; Stevenson, 2008), was calculated for all parameter estimates in the present study but excluded from the results as it did not alter the substantive conclusions produced by the Wald statistic.

Goodness of fit was evaluated using the chi-square statistic of the likelihood ratio (-2LL). The likelihood ratio evaluates the discrepancy between estimated and observed values for two competing models (Maydeu-Olivares & Garcia-Forero, 2010). The goodness of fit for the full model was assessed by comparing the -2LL of a full model inclusive of all explanatory variables versus the intercept-only (null) model. Incremental improvements in goodness of fit were assessed by calculating the change in -2LL as new variables are entered into the model. The significance of this change was assessed using the chi-square statistic.

The coefficient of determination, pseudo R^2, was also reported. Pseudo R^2 in logistic regression represents the improvement in explained 'variance' (based on reductions in -2LL) when additional explanatory variables are included in the model. The designation 'pseudo' is used because -2LL refers to the likelihood that the data could have been

produced by one model compared to another and is not quite analogous to the sum of squared errors in OLS regression (Menard, 2002; Pampel, 2000). The Nagelkerke R^2 (R^2_N; Nagelkerke, 1991) is the most commonly used pseudo R^2 value in the literature. Although R^2_N is often interpreted as similar to adjusted R^2 in OLS regression, it has been argued that pseudo R^2 cannot be interpreted as 'explained variance' and is only useful for comparing the goodness of fit of two models using the same data set (ULCA Statistics Consulting Group, 2011).

Goodness of fit indices that compare the model to a fully saturated / perfectly predicted one (i.e., Pearson and -2LL Deviance) were not interpreted, as they tend not to follow a chi-square distribution in relatively complex models when zero-cell frequencies are high (Hosmer & Lemeshow, 1989; Menard, 2002). As will be explained in the next chapter, high zero-frequency cell counts did not allow for the interpretation of these statistics. Indeed, Menard suggests that indices other than -2LL produce little additional information, with the exception of cases where the purpose of the analysis is to establish a parsimonious prediction model.

Hierarchical entry of explanatory variables.

Variables were entered in a hierarchical manner determined on the basis of expected relationships between explanatory variables. Explanatory variables expected to have a confounding effect on others were entered separately as per recommendations by Peyrot (1996). To minimise the risk of overfitting the models, relationships expected to demonstrate a low level of covariance were not entered as separate steps (Babyak, 2004). The three regression analyses proceeded as outlined below:

Discussion regression. The Discussion regression analysis consisted of four hierarchical steps. Country, Profession and Sector were entered into the model first, Importance was entered second, Match Status third, and Expectations last.

Importance was entered second because it was anticipated that Importance may partly explain any effects observed for Country and Sector. It is likely that levels of Importance differ across countries and that clients placing greater levels of importance on the consideration of their religious/spiritual beliefs may seek out practitioners in the private sector.

Match Status was entered third because it was anticipated that this may partly explain the effect of Importance. Clients placing greater Importance on the consideration of their religious/spiritual beliefs would be expected to seek out practitioners who shared similar beliefs to themselves. It was also expected that Match Status may partly explain differences observed across Professions, due to potential differences in proportions of matched dyads. This is because some professions (e.g., psychiatrists and psychologists) have been found to be less likely to hold religious/spiritual beliefs compared to others. It was also expected that a greater proportion of matched dyads would exist in the private sector and so may partly explain any effect of Sector.

Clients' pre-consultation Expectations were entered last because it was anticipated that lower expectations may be associated with public Sector consultations, and that any effect of Importance may be due to a positive relationship with Expectations. It was also anticipated that Expectations would partly explain the effect of client-practitioner Matching, whereby discussion occuring with matched practitioners may occur on the basis of expectations that religion/spirituality would feature as a part of care.

Consideration regression. The Consideration regression analysis consisted of five steps. This analysis proceeded in a similar manner as the Discussion analysis, except that an interaction term (Match Status*Sector) was entered in the final step so its contribution over-and-above the main effects of the explanatory variables could be assessed (Jaccard, 2001). The Country variable was excluded from this analysis because of the relatively large number of variables already included and because of the lack of evidence to suggest that practitioners from different countries would consider clients' religious/spiritual beliefs to a lesser or greater extent once the topic has been raised.

Satisfaction regression. The Satisfaction regression analysis was a three-step model. Consideration, Direct Assessment and Match Status were entered into the model first, client Expectations second, and Practitioner Understanding third.

Consideration was entered first because controlling for the extent of Consideration allowed for the unique association between other explanatory variables and Satisfaction to be assessed.

Client Expectations were entered in the second step because it was anticipated these would partly explain the effects of client-practitioner Matching, whereby clients who see matched practitioners would hold higher expectations.

Practitioner Understanding was entered last because it was anticipated this would partly explain the effect of Match Status, whereby practitioners with similar beliefs to their clients would be more likely to understand the relevance of religion/spirituality. It was also anticipated that clients' perceptions regarding their practitioners' understanding would be be associated with their pre-consultation expectations.

Decisions regarding exclusion of variables. Although it was expected that the variables which influenced Discussion, Consideration and Satisfaction would be similar, only the explanatory variables considered to be of most relevance were included in each analysis. This was to avoid including too many variables in each model. This was particularly true for the Satisfaction regression, where unexplained variance was greatly reduced once extent of Consideration was controlled for. Country was included in the Discussion analysis but excluded from the Consideration and Satisfaction analyses because it was of more interest to know whether country influenced whether religion/spirituality was raised in clients' care than the extent that R/S was considered in clients' care. Importance and Profession were not included in the Satisfaction analysis because it was of greater interest to know the impact these variables had on the degree to which religion/spirituality was Considered in clients' care, rather than on clients' Satisfaction with the way this happened. Similarly, Direct Assessment and Practitioner Understanding were not included in the Consideration analysis because it was of greater interest to know how these variables affected clients' Satisfaction with the way religion/spirituality had been considered in their care.

SUMMARY OF PLANNED ANALYSES

The analysis will start by addressing the first question of the present study: To what extent is religion/spirituality considered in the care of New Zealand mental health clients? This question constitutes Part One of the analysis. Clients' responses on pertinent survey questions are presented in the form of the percentage of clients who provided an affirmative response to five measures: Importance of religion/spirituality being considered, whether the client was Asked if they had religious/spiritual beliefs, whether the client Discussed religion/spirituality at all with their practitioner, whether the client perceived that religion/spirituality was Considered in their care, and whether they were Satisfied with the way this occurred. Results are adjusted for the disproportionate representation of gender and ethnic groups. The results are presented for all New Zealand clients and then for clients who saw practitioners in the public [vs. private] sector. This process is repeated for clients who indicated it was important for religion/spirituality to be considered in their care.

Part Two of the analysis uses the full (international) sample to address the question: 'What factors predict the consideration of religion/spirituality in mental health care?'. Three outcomes are explored: Discussion of religion/spirituality, Consideration of religion/spirituality, and clients' Satisfaction with this consideration. The analysis starts by using contingency tables to explore bivariate relationships between explanatory variables and the three outcomes. The statistical significance of these relationships are investigated using Pearson's chi-square. Using contingency tables and Pearson's chi-square again, bivariate relationships between explanatory variables are explored. The analysis moves on to investigate whether the data fit the assumptions required by logistic regression and then moves on test hypotheses 1 through 9 using three hierarchical logistic regression models, one for each outcome (Discussion, Consideration, Satisfaction).

CHAPTER 7

RESULTS

The current chapter starts by examining the extent to which religion and spirituality are discussed and considered in New Zealand mental health care. Following this is an examination of factors that predict the discussion and consideration of religion and spirituality, and clients' satisfaction with this.

PART ONE: TO WHAT EXTENT IS RELIGION AND SPIRITUALITY DISCUSSED AND CONSIDERED IN THE CARE OF NEW ZEALAND CLIENTS?

This question was investigated for the sample of 454 R/S clients who consulted with a mental health practitioner in New Zealand. Results can be found in Table 5. The majority of New Zealand participants (78% [77%][c]) reported it was Important[d] to them that their practitioner consider their religion/spirituality. Sixty-five percent (63%) Discussed their religious/spiritual beliefs with their practitioner. This decreased to 60% (60%) in the public sector and increased to 72% (68%) in the private sector ($\chi^2 = 7.52$, $df = 1$, $p = .006$). Forty-two percent (42%) of the sample were Asked by their practitioner whether they had religious/spiritual beliefs. This did not differ by sector.

Of the 297 participants who discussed their religious/spiritual beliefs, 61% (59%) agreed that their beliefs were Considered in their care. This reduced to 54% (56%) in the public sector and increased to 69% (62%) in the private sector ($\chi^2 = 6.59$, $df = 1$, $p = .012$). Satisfaction with the way religious/spiritual beliefs were considered was endorsed by 72% (71%) of participants who discussed their beliefs, decreasing to 63% (65%) in the public sector and increasing to 83% (80%) in the private sector ($\chi^2 = 14.71$, $df = 1$, $p < .001$).

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[c] Figures in parentheses are adjusted for gender and ethnicity.
[d] Figures in Part One are based upon dichotomisation of the original scales.

Of all 454 New Zealand participants, a total of 40% (37%) Discussed religion/spirituality *and* perceived that religion/spirituality was Considered in their care. This decreased to 32% (34%) in the public sector and increased to 50% (42%) in the private sector (χ^2 = 13.75, *df* = 1, $p < .001$). A total of 47% (45%) Discussed religion/spirituality *and* were Satisfied with the way their religious/spiritual beliefs were considered, decreasing to 38% (39%) in the public sector and increasing to 60% (55%) in the private sector (χ^2 = 21.97, *df* = 1, $p < .001$).

Table 5. *New Zealand clients' experiences of religion/spirituality in mental health care*

									Clients who discussed R/S (n = 297)			
	Sector	n	Important % (95% CI)	χ^2_{df}	Asked % (95% CI)	χ^2_{df}	Discussed % (95% CI)	χ^2_{df}	n	Considered % (95% CI)	χ^2_{df}	Satisfied % (95% CI)	χ^2_{df}
Unadjusted	All	454	77.5 (73.7, 81.3)		42.1 (38.3, 45.9)		65.4 (61.6, 69.2)		297	61.3 (57.5, 65.1)		72.4 (68.6, 76.2)	
	Public	254	76.4 (71.2, 81.6)	0.37_1	38.2 (32.2, 44.2)	3.06_1	59.8 (53.8, 65.8)	7.52_1^{**}	152	53.9 (47.8, 60.0)	6.59_1^{**}	62.5 (56.5, 68.5)	14.71_1^{***}
	Private[b]	198	78.8 (73.1, 84.5)		46.6 (39.7, 53.5)		72.2 (66.0, 78.4)		143	68.5 (62.0, 75.0)		82.5 (77.2, 87.8)	
Adjusted[a]	All	454	76.9 (73.1, 80.7)		41.9 (38.1, 45.7)		63.3 (59.5, 67.1)		297	58.6 (54.8, 62.4)		71.3 (67.5, 75.1)	
	Public	254	79.6 (74.6, 84.6)		41.2 (35.1, 47.3)		60.0 (54.0, 66.0)		152	56.0 (49.9, 62.1)		64.7 (58.8, 70.6)	
	Private	198	73.0 (66.8, 79.2)		42.3 (39.7, 53.5)		68.1 (61.6, 74.6)		143	62.2 (55.4, 69.0)		80.2 (74.6, 85.8)	

[a]Adjusted for gender and ethnicity. Significance not tested for this category. [b]Significance not indicated as category is redundant.
$^{*}p \leq .05$. $^{**}p \leq .01$. $^{***}p \leq .001$.

Clients who placed importance on consideration of religion/spirituality

Of those who placed importance on the consideration of their religious/spiritual beliefs (n = 352), 73% (70%) Discussed their beliefs with their practitioner. Differences between Sectors were similar to those observed in the full New Zealand sample (refer to Table 6). Of those who discussed their beliefs (n = 258), 67% (66%) agreed that their beliefs had been Considered in their care and 75% (74%) were Satisfied with this consideration.

Of all clients who stated it was important that religion/spirituality was considered, a total of 49% (46%) Discussed religion/spirituality *and* perceived that religion/spirituality was Considered in their care. This decreased to 40% (41%) in the public sector and increased to 60% (62%) in the private sector (χ^2 = 13.04, df = 1, p < .001). A total of 55% (51%) Discussed religion/spirituality *and* were Satisfied with the consideration of this in their care, decreasing to 44% (45%) in the public sector and increasing to 67% (62%) in the private sector (χ^2 = 18.42, df = 1, p < .001).

Table 6. *New Zealand clients' experiences of religion/spirituality in mental health care ('Importance' group)*

							Clients who discussed R/S (n = 258)			
	Sector	n	Asked % (95% CI)	χ^2_{df}	Discussed % (95% CI)	χ^2_{df}	n	Considered % (95% CI)	χ^2_{df}	Satisfied % (95% CI)	χ^2_{df}
Unadjusted	All	352	45.2 (40.8, 49.6)		73.3 (68.9, 77.7)		258	67.1 (62.7, 71.5)		74.8 (70.4, 79.2)	
	Public	194	42.4 (35.4, 49.4)	2.88_1	68.6 (62.1, 75.1)	4.66_1^*	133	58.6 (51.7, 65.5)	8.29_1^{**}	64.7 (58.0, 71.4)	14.46_1^{***}
	Private[b]	156	51.7 (43.9, 59.5)		78.8 (72.4, 85.2)		123	75.6 (68.9, 82.3)		85.4 (79.9, 90.9)	
Adjusted[a]	All	352	47.0 (41.8, 52.2)		70.0 (65.2, 74.8)		258	65.6 (60.6, 70.6)		73.6 (69.0, 78.2)	
	Public	194	46.2 (39.2, 53.2)		67.3 (60.7, 73.9)		133	61.2 (54.3, 68.1)		67.2 (60.6, 73.8)	
	Private	156	48.2 (40.4, 56.0)		73.9 (67.0, 80.8)		123	72.4 (65.4, 79.4)		83.9 (78.1, 89.7)	

[a]Adjusted for gender and ethnicity. Significance not tested for this category. [b]Significance not indicated as category is redundant.
$^*p \leq .05$. $^{**}p \leq .01$. $^{***}p \leq .001$.

PART TWO: FACTORS THAT PREDICT THE CONSIDERATION OF RELIGION AND SPIRITUALITY

For part two of the analysis, bivariate relationships between and across explanatory and outcome variables are explored. Data are then checked to ensure the assumptions of logistic regression are met and the analysis proceeds on to hypothesis testing.

Associations between explanatory and outcome variables

Responses on the three outcome variables (Discussion of religious/spiritual beliefs, Consideration of these beliefs, and Satisfaction with the way they were considered) as a function of explanatory variables are shown in Table 7. Note that of the 725 participants from the international sample who were included in the analysis, 221 did not engage in any discussion regarding their religious/spiritual beliefs with their practitioner. That is, they were not asked about their religious/spiritual beliefs, nor did they choose to raise the subject. These clients did not complete the measures assessing Consideration or Satisfaction. Response frequencies for these variables are based upon the remaining 504 participants who discussed their religious/spiritual beliefs with their practitioner. In addition to the outcome variables, the Understanding, Importance, and Expectation variables were also collapsed into 3-4 categories each, for analytic reasons that will be discussed later.

Table 7. *Associations between explanatory and outcome variables*

Explanatory variable	*n*	Discussion			Consideration				Satisfaction			
		No (*n* = 221)	Yes (*n* = 504)	χ^2_{df}	Low (*n* = 121)	Moderate (*n* = 273)	High (*n* = 110)	χ^2_{df}	Low (*n* = 96)	Moderate (*n* = 242)	High (*n* = 166)	χ^2_{df}
Importance (%)				70.80_2^{***}				71.41_4^{***}				74.44_4^{***}
Low	86	67.4	32.6		42.9	57.1	0.0		35.7	60.7	3.6	
Moderate	324	30.6	69.4		27.6	64.9	7.6		17.3	64.4	18.2	
High	315	20.3	79.7		18.7	44.2	37.1		18.7	31.9	49.4	
Sector (%)				18.65_1^{***}				20.88_2^{***}				21.70_2^{***}
Public	350	38.3	61.7		32.9	52.3	14.8		28.2	45.4	26.4	
Private	371	23.5	76.5		17.3	56.0	26.8		12.3	49.6	38.0	
Match (%)				119.68_2^{***}				127.06_4^{***}				138.23_4^{***}
Matched	250	6.8	93.2		5.2	56.2	38.6		5.6	41.6	52.8	
Uncertain	194	32.0	68.0		47.0	47.0	6.1		46.2	41.7	12.1	
Unmatched	281	50.5	49.5		33.8	57.6	8.6		15.8	64.7	19.4	
Profession (%)				15.07_3^{***}				6.06_2				3.37_2
Psychiatrist	69	42.0	58.0		35.0	55.0	10.0		22.5	57.5	20.0	
Psychologist	133	26.3	73.7		25.5	53.1	22.6		18.4	48.0	33.7	
Psychotherapist	65	12.3	87.7		17.5	56.1	26.3		15.8	49.1	35.1	
Other[a]	458	32.5	67.5		23.3	54.0	22.7		19.4	46.6	34.0	
Country (%)				20.02_3^{***}				3.28_3				6.41_3
New Zealand	454	34.6	65.4		25.3	54.5	20.2		18.2	50.2	31.6	
United States	112	17.0	83.0		21.5	51.6	26.9		21.5	39.8	38.7	
England	57	38.6	61.4		31.4	51.4	17.1		28.6	45.7	25.7	
Australia	71	18.3	81.7		22.4	53.4	24.1		13.8	51.7	34.5	
Other[a]	31	32.3	67.7		9.5	66.7	23.8		19.0	47.6	33.3	
Expectations (%)				110.60_3^{***}				64.60_3^{***}				25.35_3^{***}
Low	178	57.3	42.7		47.4	42.1	10.5		27.6	48.7	23.7	
Moderate-Low	151	35.8	64.2		26.8	60.8	12.4		18.6	52.6	28.9	
Moderate-High	202	16.3	83.7		19.5	64.5	16.0		15.4	57.4	27.2	
High	193	16.1	83.9		16.0	45.1	38.9		19.1	35.2	45.7	
Assessment (%)								21.79_2^{***}				23.26_2^{***}
Direct	308				18.5	55.2	26.3		13.6	47.4	39.0	
Other	393				37.2	46.5	16.3		31.4	42.4	26.2	
Understanding (%)								516.08_4^{***}				533.53_4^{***}
Low	107				83.2	16.8	0.0		76.6	21.5	1.9	
Moderate	264				11.7	83.7	4.5		4.5	78.8	16.7	
High	133				0.8	25.6	73.7		1.5	8.3	90.2	

Note. Percentages are row percentages.

[a]Category excluded from chi-square test.

$^{*}p \leqslant .05$. $^{**}p \leqslant .01$. $^{***}p \leqslant .001$.

Discussion of religious/spiritual beliefs.

The associations between each explanatory variable and discussion of clients' religious/spiritual beliefs can be found in Table 7. Higher levels of Importance were associated with Discussion of religious/spiritual beliefs (χ^2 = 70.80, *df* = 2, $p < .001$). A greater likelihood of Discussion was observed for consultations that occurred in the private Sector (77%) compared to the public Sector (62%) (χ^2 = 18.65, *df* = 1, $p < .001$), and in England (61%) compared to the United States (83%) (χ^2 = 20.02, *df* = 3, $p < .001$). The likelihood of Discussion was substantially higher when practitioners held similar religious/spiritual beliefs to their client (93%) compared to those who did not (50%) or where Match Status was uncertain (68%) (χ^2 = 119.68, *df* = 2, $p < .001$). In addition, clients who consulted with psychiatrists were least likely to discuss religion/spirituality (58%), followed by psychologists (74%) and psychotherapists (88%) (χ^2 = 15.07, *df* = 2, $p = .001$). Clients' Expectations of whether their religious/spiritual beliefs would be addressed were also significantly related to whether the topic was raised in therapy; those with the lowest expectations were the least likely to have Discussed R/S (43%), while those with the highest expectations were most likely to have Discussed R/S (84%) (χ^2 = 110.60, *df* = 3, $p < .001$).

Consideration of religion/spirituality.

The associations between each explanatory variable and Consideration of religion/spirituality are presented in Table 7. Clients who placed greater Importance on the Consideration of their religious/spiritual beliefs agreed that religion/spirituality was considered to a greater extent (χ^2 = 71.41, *df* = 4, $p < .001$). Clients' Expectations were associated with the extent that religion/spirituality was Considered, whereby clients with lower expectations were less likely to agree that religion/spirituality had been considered, and vice versa for higher expectations (χ^2 = 64.60, *df* = 6, $p < .001$). A greater proportion of clients in the private Sector agreed that religion/spirituality was Considered in their care compared to those in the public Sector (χ^2 = 20.88, *df* = 2, $p < .001$). Clients were also more likely to agree that Consideration occurred to a greater extent when they saw pracititoners with similar beliefs to themselves, compared to those who were unmatched or uncertain (χ^2 = 127.06, *df* = 4, $p < .001$). Differences between Countries and Professions were not statistically significant ($p = .638$ and $p = .384$, respectively).

Table 8 explores whether the association between client-practitioner Matching and Consideration of religion/spirituality in clients' care is moderated by Sector. Clients were no more likely to report lower levels of consideration when they saw a matched practitioner in the public sector (7%) compared to those who saw a matched practitioner in the private sector (5%) (χ^2 = 0.57, *df* = 2, *p* = .751). This finding was similar for clients who were uncertain of whether their practitioner shared similar beliefs (χ^2 = 1.65, *df* = 2, *p* = .438) and those whose practitioner did not share similar beliefs (χ^2 = 0.93, *df* = 2, *p* = .627).

Table 8. *Association between Match Status and Consideration: Moderation by Sector*

			Consideration			
Match Status	Sector	*n*	Low (*n* = 121)	Moderate (*n* = 273)	High (*n* = 110)	χ^2_{df}
Matched	Public (%)	56	7.1	55.4	37.5	0.57_2
	Private (%)	175	4.6	56.6	38.9	
Uncertain	Public (%)	79	49.4	43.0	7.6	1.65_2
	Private (%)	53	43.4	52.8	3.8	
Unmatched	Public (%)	81	34.6	59.3	6.2	0.93_2
	Private (%)	56	32.1	57.1	10.7	

Note. Percentages are row percentages.

Satisfaction with consideration.

The associations between each explanatory variable and clients' Satisfaction with the consideration of R/S in their care are presented in Table 7. Clients were more likely to express greater satisfaction when they saw a practitioner with similar religious/spiritual beliefs (χ^2 = 138.23, *df* = 4, $p < .001$). Clients were least likely to be satisfied when they were unsure whether their practitioner held similar religious/spiritual beliefs. Higher levels of Satisfaction were endorsed by clients when they held greater Expectations that R/S would be addressed (χ^2 = 25.35, *df* = 6, $p < .001$). Clients were also more likely to express greater Satisfaction when they perceived their Practitioner Understood the relevance of religion/spirituality to their recovery (χ^2 = 533.53, *df* = 4, $p < .001$), and when their practitioner Directly Assessed their religious/spiritual beliefs (χ^2 = 23.26, *df* = 2, $p < .001$),

Extent of Consideration and Satisfaction with consideration were highly associated (χ^2 = 410.68, *df* = 4, $p < .001$)[e] (Table 9). That is, when level of Consideration was high, clients were generally Satisfied with the way this occurred; when level of Consideration was low, clients generally lacked Satisfaction with the way religion/spirituality had been considered (Table 9). These two variables were not perfectly associated, suggesting that some explanatory variables may be associated with changes in Satisfaction independently of the extent to which religion/spirituality is Considered.

[e]Spearman's rho correlation between original 10-point Consideration and Satisfaction scales was r_s = .81

Table 9. *Association between extent of Consideration and Satisfaction with consideration*

		Satisfaction			
Consideration	*n*	Low (*n* = 96)	Moderate (*n* = 242)	High (*n* = 166)	χ^2_{df}
Low (%)	121	63.6	33.1	3.3	410.68_4^{***}
Moderate (%)	273	7.0	71.4	21.6	
High (%)	110	0.0	6.4	93.6	

Note. Percentages are row percentages.
$^{***}p \leq .001$.

Associations between explanatory variables

Associations between all explanatory variables are presented in Table 10. Of particular note was the observation that client-practitioner Matching demonstrated significant associations with all other explanatory variables. Clients who saw practitioners with similar religious/spiritual beliefs to themselves were more likely to perceive that their Practitioner Understood the relevance of R/S to their recovery, while those who were unsure of their practitioner's religious/spiritual beliefs were less likely to feel this way (χ^2 = 134.07, *df* = 4, $p < .001$). Clients who placed greater Importance on the consideration of their religious/spiritual beliefs were more likely to see a practitioner with similar beliefs (χ^2 = 52.04, *df* = 4, $p < .001$), and clients who saw practitioners with similar beliefs held higher Expectations compared to those who saw practitioners with dissimilar beliefs (χ^2 = 85.22, *df* = 6, $p < .001$). Client-practitioner Matching was more likely to occur in the private Sector compared to the public Sector (χ^2 = 86.86, *df* = 2, $p < .001$), and more likely to occur in Australia (51%) compared to England (15%) (χ^2 = 40.17, *df* = 6, $p < .001$). Clients who saw practitioners with similar beliefs to themselves were more likely to have been asked if they had religious/spiritual beliefs (χ^2 = 9.29, *df* = 2, $p = .01$), and were more likely to have seen a psychotherapist (46%) compared to a psychiatrist (10%) (χ^2 = 24.19, *df* = 5, $p < .001$).

With regard to Sector, clients who consulted with private sector practitioners were more likely to agree that their Practitioner Understood the relevance of R/S to their recovery (χ^2 = 25.04, *df* = 2, $p < .001$) and were more likely to have consulted with a psychotherapist (82%), as opposed to a psychiatrist (38%) (χ^2 = 26.47, *df* = 2, $p < .001$). Clients who consulted with practitioners in England were least likely to see a practitioner based in the private sector (27%), especially compared to those in Australia (81%) (χ^2 = 71.31, *df* = 3, $p < .001$).

Client Expectations also held strong associations with almost all other variables. Clients who placed greater Importance on the consideration of R/S in their care held greater expectations that R/S would be addressed (χ^2 = 151.41, *df* = 6, $p < .001$) and were more likely to agree that their Practitioner Understood the relevance of R/S to their recovery (χ^2 = 67.68, *df* = 6, $p < .001$). Lower Expectations were held by clients who consulted

with public Sector practitioners (χ^2 = 11.27, *df* = 3, *p* = .01). Clients' Expectations did not differ according to Country (*p* = .055) or Profession (*p* = .159).

Some additional associations were observed. Clients in Australia were more likely to consult with a psychologist (38%) compared to those in England and New Zealand (14%) (χ^2 = 17.43, *df* = 6, *p* = .008). Clients in the United States were more likely to be asked whether they had religious/spiritual beliefs (56%), particularly compared to those in England (30%) (χ^2 = 11.91, *df* = 3, *p* = .008). Clients who were asked whether they had religious/spiritual beliefs were more likely to perceive that their Practitioner Understood the relevance of R/S to their recovery (χ^2 = 26.16, *df* = 2, *p* < .001).

Table 10. *Associations between explanatory variables*

Variable	Category	*n*	Importance			χ^2_{df}	Understanding			χ^2_{df}	Sector		χ^2_{df}	Match			χ^2_{df}	Assessment		χ^2_{df}
			Low	Mod.	High		Low	Mod.	High		Pub.	Pri.		Yes	Unc.	No		Dir.	Other	
Importance	Low	86					50.0	46.4	3.6	79.54_4^{***}	60.5	39.5	5.59_2	14.0	31.4	54.7	52.04_4^{***}	64.3	35.7	25.48_2
	Moderate	324					22.2	66.7	11.1		46.6	53.4		27.8	25.9	46.3		63.9	36.1	
	High	315					17.1	40.2	42.6		47.3	52.7		47.0	26.3	26.7		64.4	35.6	
Understanding	Low	107	13.1	46.7	40.2	79.54_4^{***}					64.2	35.8	25.04_2^{***}	10.3	57.9	31.8	134.07_4^{***}	43.9	56.1	26.16_2^{***}
	Moderate	264	4.9	56.8	38.3						39.3	60.7		44.7	20.8	34.5		67.6	32.4	
	High	133	0.8	18.8	80.5						34.1	65.9		78.2	11.3	10.5		74.2	25.8	
Sector	Public	350	14.9	42.9	42.3	5.59_2	31.5	47.7	20.8	25.04_2^{***}				17.4	34.3	48.5	86.86_2^{***}	59.8	40.2	15.26_1
	Private	371	9.2	46.4	44.5		13.4	56.0	30.6					50.4	19.9	29.6		67.8	32.2	
Match	Matched	250	4.8	36.0	59.2	52.04_4^{***}	4.7	50.6	44.6	134.07_4^{***}	24.6	75.4	86.86_2^{***}					71.3	28.7	78.37_2^{*}
	Uncertain	194	13.9	43.3	42.8		47.0	41.7	11.4		61.9	38.1						57.1	42.9	
	Unmatched	281	16.7	53.4	29.9		24.5	65.5	10.1		60.6	39.4						58.8	41.2	
Assessment	Direct	308	5.8	41.9	52.3	25.48_2	15.3	52.9	31.8	26.16_2^{***}	40.8	59.2	15.26_1	51.6	23.4	25.0	78.37_2^{*}			
	Other	393	5.8	42.4	51.7		34.9	45.3	19.8		49.4	50.6		37.2	31.4	31.4				
Expectations	Low	178	30.3	44.9	24.7	151.41_6^{***}	38.2	50.0	11.8	67.68_6^{***}	56.2	43.8	11.27_3^{**}	14.6	41.7	43.7	85.22_6^{***}	20.9	79.1	77.75_3^{***}
	Mod-Low	151	11.3	55.0	33.8		24.7	59.8	15.5		54.4	45.6		28.5	38.2	33.3		34.2	65.8	
	Mod-High	202	3.5	55.4	41.1		16.0	64.5	19.5		44.3	55.7		37.1	29.2	33.7		55.9	44.1	
	High	193	3.6	25.4	71.0		16.7	52.4	46.9		41.7	58.3		54.9	23.4	21.7		61.3	38.7	
Profession	Psychiatrist	69	17.4	50.7	31.9	6.85_4	32.5	55.0	12.5	6.32_4	62.3	37.7	26.47_2^{***}	10.1	39.1	50.7	25.41_2^{***}	37.2	62.8	2.37_2
	Psychologist	133	10.5	47.4	42.4		23.5	52.0	24.5		39.1	60.9		32.4	24.5	43.2		36.8	63.2	
	Psychotherapist	65	9.2	38.5	52.3		14.0	59.6	26.3		17.9	82.1		45.6	26.5	27.9		58.1	41.9	
	Other [a]	458	11.8	43.9	44.3		20.4	50.6	29.0		53.9	46.1		35.5	26.0	38.5		42.0	58.0	
Country	New Zealand	454	13.0	46.5	40.5	10.95_6	21.0	55.3	23.7	9.67_6	56.2	43.8	71.31_3^{***}	28.9	25.7	45.3	40.17_6^{***}	42.1	57.9	11.91_3^{**}
	United States	112	5.4	44.6	50.0		22.3	42.6	35.1		26.5	73.5		46.0	25.7	28.3		55.8	44.2	
	England	57	14.0	38.6	47.4		31.4	54.3	14.3		72.9	27.1		15.3	45.8	39.0		29.8	70.2	
	Australia	71	5.6	43.7	50.7		20.3	49.2	30.5		19.2	80.8		51.4	24.3	24.3		49.3	50.7	
	Other [a]	31	29.0	32.3	38.7		4.8	57.1	38.1		40.6	59.4		48.5	21.2	30.3		45.2	54.8	

Note. Percentages are row percentages.
[a]Category excluded from chi-square test.
$^{*}p \leq .05$. $^{**}p \leq .01$. $^{***}p \leq .001$.

Table 10. *Associations between explanatory variables ... cont.*

Variable	Category	*n*	Expectations				χ^2_{df}	Profession				χ^2_{df}	Country					χ^2_{df}
			Low	M-L	M-H	High		Psychi.	Psychol.	Psychot.	Other[a]		NZ	US	Eng.	Aust.	Other[a]	
Importance	Low	86	63.5	20.0	8.2	8.2	151.41_6^{***}	14.0	16.3	7.0	62.8	6.85_4	68.6	7.0	9.3	4.7	10.5	10.95_6
	Moderate	324	24.7	25.6	34.6	15.1		10.8	19.4	7.7	62.0		65.1	15.4	6.8	9.6	3.1	
	High	315	14.0	16.2	26.3	43.5		7.0	17.8	10.8	64.4		58.4	17.8	8.6	11.4	3.8	
Understanding	Low	107	27.1	22.4	25.2	25.2	67.68_6^{***}	12.0	21.3	7.4	59.3	6.32_4	58.3	19.4	10.2	11.1	0.9	9.67_6
	Moderate	264	14.4	22.0	41.3	22.3		8.3	19.2	12.8	59.8		62.4	15.0	7.1	10.9	4.5	
	High	133	6.8	11.3	24.8	57.1		3.7	17.8	11.1	67.4		52.6	19.4	3.7	13.3	5.9	
Sector	Public	350	28.6	23.1	25.4	22.9	11.27_3^{**}	11.8	14.9	3.3	70.0	26.47_2^{***}	74.9	8.8	12.4	3.8	3.6	71.31_3^{***}
	Private	371	21.1	18.4	30.3	30.3		6.8	22.0	14.4	56.8		56.3	23.3	4.3	16.2	5.0	
Match	Matched	250	10.4	17.2	30.0	42.4	85.22_6^{***}	2.8	17.9	12.4	66.9	25.41_2^{***}	54.2	20.7	3.6	15.1	6.4	40.17_6^{***}
	Uncertain	194	28.3	20.0	28.4	23.3		13.4	16.8	8.9	60.9		59.9	14.4	13.4	8.9	3.5	
	Unmatched	281	29.1	21.1	24.3	25.5		11.8	20.3	6.4	61.5		72.0	10.8	7.8	6.1	3.4	
Assessment	Direct	308	12.0	16.2	33.8	38.0	77.75_3^{***}	8.3	17.9	10.3	63.5	2.37_2	63.3	19.7	5.8	11.2	4.5	11.91_3^{**}
	Other	393	35.7	24.5	20.9	18.9		7.5	21.4	12.7	58.4		68.1	12.2	10.6	9.0	4.3	
Expectations	Low	178						32.4	50.0	17.6	61.8	9.27_6	65.1	11.8	13.0	10.1	5.1	16.62_9
	Moderate-Low	151						26.3	56.1	17.5	62.3		66.7	15.0	10.9	7.5	2.6	
	Moderate-High	202						27.5	45.0	27.5	60.4		65.8	17.9	4.1	12.2	3.0	
	High	193						16.1	50.0	33.9	67.9		64.1	19.3	6.1	10.5	6.2	
Profession	Psychiatrist	69	31.9	21.7	31.9	14.5	9.27_6						59.4	14.5	13.0	8.7	4.3	17.43_6^{**}
	Psychologist	133	25.6	24.1	27.1	23.3							48.2	21.6	5.8	20.1	4.3	
	Psychotherapist	65	18.5	15.4	33.8	32.3							63.2	13.2	11.8	4.4	7.4	
	Other[a]	458	24.1	20.6	26.7	28.7							67.4	13.5	7.2	7.8	4.0	
Country	New Zealand	454	24.3	21.6	28.5	25.6	16.62_9	8.7	14.3	9.1	67.4	17.43_6^{**}						
	United States	112	17.9	19.6	31.3	31.3		14.5	26.5	8.0	56.6							
	England	57	38.6	28.1	14.0	19.3		15.3	13.6	13.6	57.6							
	Australia	71	23.9	15.5	33.8	26.8		8.1	37.8	4.1	50.0							
	Other[a]	31	29.0	12.9	19.4	38.7		9.1	18.2	15.2	57.6							

Note. Percentages are row percentages. M-L = Moderate-Low. M-H = Moderate-High.
[a]Category excluded from chi-square test.
$^{**}p \leq .01$. $^{***}p \leq .001$.

Tests of hypotheses

This section starts by presenting the results of assumption checks. Following this, the results of the three regression analyses intended to test hypotheses 1 through 9 are presented.

Regression diagnostics.

Assumptions of logistic regression were checked prior to analysis. No evidence was found for problems of multicollinearity in either of the three analyses. The proportional odds assumption, checked using the test of parallel lines, was upheld in both ordinal logistic regression analyses (Consideration and Satisfaction). Case 227 exceeded thresholds on all three criteria for outlier observations. However, this case was retained in the analysis as it did not exhibit any data entry errors and did not appear to unduly influence parameter estimates or model fit.

Zero cell counts reached a maximum of 41% when all explanatory variables were added to the Consideration model. It appears there are no published conventions on acceptable zero-cell frequencies, but those which are too high have a tendency to cause infinite parameter estimates and large standard errors (Menard, 2002; Suchower & Copenhaver, 1997). No problems were encountered with infinite parameter estimates, but it was accepted that zero cell counts may have increased the standard errors of parameter estimates (Menard, 2002). This was unlikely to have affected the pattern of relationships between explanatory variables (Menard, 2002), and standard errors did not appear to be over-inflated in proportion to group sizes.

The Box-Tidwell test indicated a lack of linearity between the continuous explanatory variables ‘Importance’, ‘Understanding’, ‘Expectations’ and the logits of the collapsed 3-point outcome variables ‘Considered’ and ‘Satisfied’. Running the Box-Tidwell test with all variables in their original format provided no evidence of underlying non-linearity. This indicated that non-linearity found by the first test was due to transforming the outcome variables into fewer categories, whilst not applying a similar transformation to the explanatory variables. No evidence of non-linearity was found after collapsing all variables (except Expectations) into similar 3-point categories, a strategy recommended elsewhere (Stevenson, 2008). Unlike the Importance and

Understanding variables, which followed similar distributions to the outcome variables, responses on the Expectations variable did not follow any defined pattern. As a result, the scale was collapsed into four instead of three groups using quartile cut points. A score of 3-7 was coded as low expectations, 8-14 as moderate-low, 15-21 as moderate-high, and 22-30 as high. This method of classification did not not show evidence of non-linearity with the logits of the outcome variables.

Regression analysis one: Discussion of religion/spirituality.

Step one. Profession, Sector and Country were entered into the model to test hypotheses 4(a), 5(a), and 7(a). Results are presented in Table 11. All three of these variables were associated with the odds of discussing religion/spirituality. Clients who consulted with practitioners in New Zealand (*OR* = 0.43, CI = 0.25, 0.75, p = .003) or England (*OR* = 0.38, CI = 0.18, 0.82, p = .013) experienced a lower odds of discussing R/S with their practitioner compared to those in the United States. Clients who consulted with a psychotherapist experienced a greater odds of discussing R/S with their practitioner (*OR* = 4.47, CI = 1.81, 11.06, p = .001) compared to those who consulted with a psychiatrist, and those who saw a public sector practitioner had a lower odds of discussing R/S compared to those in the private sector (OR = 0.66, CI = 0.46, 0.94, p = .020). These three variables together were significantly better in predicting Discussion than the intercept-only (null) model (null -2LL = 886.32, model -2LL = 842.13, χ^2 = 44.19, df = 8, p <.001). Pseudo R^2 was small (R^2_N = .08).

Step two. Importance was entered into the analysis to test hypothesis 1(a): that clients who placed a greater level of Importance on the consideration of religion/spirituality in their care would have a greater odds of Discussing religion/spirituality with their practitioner. Importance was significantly related to discussing R/S; for each incremental increase in Importance (i.e., low to moderate, moderate to high), the odds of discussing religion/spirituality increased nearly two-and-a-half times (*OR* = 2.40, CI = 1.86, 3.10, p < .001). Model fit improved significantly over step one (model -2LL = 794.57, $\Delta\chi^2$ = 47.56, Δdf = 1, p < .001) and pseudo R^2 increased (ΔR^2_N = .09). All other previously significant explanatory variables including Sector and Country remained so, suggesting that Importance did not explain the effect of these variables.

Step three. Match Status was entered into the model next to test hypothesis 3(a): that clients who saw practitioners with similar religious/spiritual beliefs to themselves would have a greater odds of Discussing their beliefs. Matched clients had a nearly eleven-times greater odds of discussing religion/spirituality compared to clients whose practitioner did not share similar beliefs (*OR* = 10.87, CI = 6.06, 19.49, $p < .001$). Those who were uncertain whether their practitioner held similar beliefs also had a greater odds of discussing their beliefs compared to unmatched clients (*OR* = 2.00, CI = 1.34, 2.99, $p = .001$). Model fit improved significantly from the previous step (model -2LL = 708.90, $\Delta \chi^2 = 85.67$, $\Delta df = 2$, $p < .001$) and pseudo R^2 increased ($\Delta R^2_N = .14$). Country, Profession and Importance remained significantly associated with Discussion. As a result of including Match Status in the model, the effect of Sector reduced to a non-significant level (*OR* = 1.01, CI = 0.67, 1.51, $p = .964$).

Step four. Client Expectations were entered next to test hypothesis 2(a): that clients with higher Expectations would have a greater odds of Discussing their religious/spiritual beliefs with their practitioner. Expectations were significantly associated with the odds of discussing R/S. For each one-unit increase in clients' expectations (i.e., from low to mod-low, mod-low to mod-high, mod-high to high), the odds of discussing R/S increased by a factor of 1.6 (CI = 1.36, 1.96, $p < .001$). The inclusion of client Expectations significantly improved model fit over step three (model -2LL = 680.51, $\Delta \chi^2 = 28.39$, Δ df = 1, $p < .001$) and pseudo R^2 increased slightly ($\Delta R^2_N = .04$). The effects of Country (New Zealand) and Profession remained significant. Although the odds for England improved only slightly, the odds ratio of 0.52 lost statistical significance.

Table 11. *Discussion logistic regression model*

Variable	Step 1			Step 2			Step 3			Step 4		
	B (*SE*)	Exp(B) (95% CI)	Wald	B (*SE*)	Exp(B) (95% CI)	Wald	B (*SE*)	Exp(B) (95% CI)	Wald	B (*SE*)	Exp(B) (95% CI)	Wald
Intercept	1.281 (.354)			-.678 (.464)			-1.030 (.492)			-1.030 (.514)		
Country[a]												
New Zealand	-.837 (.279)	0.43 (0.25, 0.75)	9.02**	-.704 (.286)	0.49 (0.28, 0.87)	6.07**	-.587 (.304)	0.56 (0.31, 1.01)	3.72*	-.663 (.312)	0.52 (0.28, 0.95)	4.51*
Australia	-.136 (.401)	0.87 (0.40, 1.91)	0.12	-.144 (.408)	0.87 (0.39, 1.93)	0.12	-.308 (.439)	0.74 (0.31, 1.74)	0.49	-.227 (.453)	0.78 (0.33, 1.94)	0.25
England	-.959 (.388)	0.38 (0.18, 0.82)	6.12**	-.906 (.400)	0.40 (0.18, 0.89)	5.12*	-.748 (.417)	0.47 (0.21, 1.00)	3.22*	-.648 (.424)	0.52 (0.23, 1.20)	2.33
Other	-.907 (.470)	0.40 (0.16, 1.01)	3.73†	-.529 (.496)	0.59 (0.22, 1.56)	1.14	-.913 (.543)	0.40 (0.14, 1.16)	2.83	-1.065 (.567)	0.35 (0.11, 1.05)	3.53†
Profession[b]												
Psychotherapist	1.497 (.462)	4.47 (1.81, 11.06)	10.49***	1.354 (.476)	3.87 (1.52, 9.84)	8.09**	1.098 (.488)	3.00 (1.15, 7.08)	5.06*	1.090 (.498)	2.98 (1.12, 7.90)	4.79*
Psychologist	.479 (.324)	1.62 (0.86, 3.05)	2.19	.401 (.338)	1.49 (0.77, 2.90)	1.41	.301 (.348)	1.35 (0.68, 2.67)	0.75	.357 (.357)	1.43 (0.71, 2.88)	1.00
Other	.387 (.271)	1.47 (0.87, 2.50)	2.04	.250 (.283)	1.28 (0.74, 2.24)	0.76	-.064 (.291)	0.94 (0.53, 1.66)	0.05	-.086 (.297)	0.92 (0.51, 1.64)	0.08
Sector[c]												
Public	-.418 (.179)	0.66 (0.46, 0.94)	5.46*	-.417 (.185)	0.66 (0.46, 0.95)	5.07*	-.009 (.207)	1.01 (0.67, 1.51)	0.00	.023 (.210)	1.02 (0.68, 1.55)	0.01
Importance				.874 (.131)	2.40 (1.86, 3.10)	44.56***	.676 (.139)	1.97 (1.50, 2.58)	23.52***	.426 (.149)	1.53 (1.14, 2.05)	8.13***
Match Status[d]												
Matched							2.386 (.298)	10.87 (6.06, 19.49)	64.24***	2.167 (.303)	8.73 (4.83, 15.80)	51.26***
Uncertain							.693 (.205)	2.00 (1.34, 2.99)	11.41***	.566 (.212)	1.76 (1.16, 2.67)	7.11**
Expectations										.488 (.093)	1.63 (1.36, 1.96)	27.34***
Model statistics												
Model -2LL[e]	842.13			794.570			708.90			680.51		
χ^2 (Δ)	44.19***			91.75***	(Δ 47.56)***		177.42***	(Δ 85.67)***		205.81***	(Δ 28.39)***	
df (Δ)	8			9	(Δ 1)		11	(Δ 2)		12	(Δ 1)	
R^2_N (Δ)	.08			.17	(Δ .09)		.31	(Δ .14)		.35	(Δ .04)	

[a]Ref = USA. [b]Ref = Psychiatrist. [c] Ref = Private. [d] Ref = Unmatched. [e] Null model -2LL = 886.32

† $p \leq .10$. * $p \leq .05$. ** $p \leq .01$. *** $p \leq .001$.

Regression analysis two: Consideration of religion/spirituality.

Step one. Profession and Sector were entered into the analysis first to test hypotheses 4(b) and 5(b): that clients who saw psychiatrists or public sector practitioners would perceive that their religious/spiritual beliefs had been Considered to a lesser extent compared to those who saw other professionals or a private sector practitioner. Results are presented in Table 12. The extent that clients perceived R/S was considered was not influenced by the type of professional they saw, but was significantly influenced by Sector. Those who consulted with practitioners in the public sector had a lower odds of reporting that R/S had been considered (*OR* = 0.45, CI = 0.32, 0.65, $p < .001$). That is, for clients who consulted with a public sector practitioner, the odds of reporting successively higher levels of religious/spiritual consideration (i.e., mod/high vs. low; high vs. mod/low) was half that of clients who consulted with private sector practitioners. Sector and Profession together were significantly better in predicting the Consideration of R/S in clients' care compared to the intercept-only / null model (null -2LL = 628.11, model -2LL = 603.52, $\chi^2 = 24.59$, $df = 4$, $p < .001$). Pseudo R^2 was small ($R^2_N = .06$).

Step two. Importance was entered into the model next to test hypothesis 1(b): that clients who placed greater Importance on the consideration of religion/spirituality in their care would report that practitioners Considered religion/spirituality to a greater degree. Importance was positively associated with the extent that R/S was considered in clients' care. The odds of reporting successively higher levels of Consideration increased by a factor of 2.7 for each one-unit increase in Importance (CI = 2.02, 3.69, $p < .001$). The effects of Profession and Sector remained unchanged. Model fit improved significantly from the previous model (model -2LL = 558.31, $\Delta \chi^2 = 45.21$, $\Delta df = 1$, $p < .001$) and pseudo R^2 increased ($\Delta R^2_N = .10$).

Step three. Match Status was entered into the model next to test hypothesis 3(b): that clients who saw practitioners with similar religious/spiritual beliefs would perceive that their religious/spiritual beliefs were Considered to a greater extent than those who saw practitioners with dissimilar beliefs. Match status was significantly associated with the extent that clients perceived R/S was considered in their care. Compared with

unmatched clients, those whose practitioner shared similar religious/spiritual beliefs had a greater odds of experiencing the consideration of their religious/spiritual beliefs (*OR* = 5.78, CI = 3.43, 9.75, $p < .001$). Clients who were uncertain whether their practitioner shared similar beliefs experienced a lower odds of R/S being considered compared to unmatched clients (*OR* = 0.51, CI = 0.31, 0.84, $p = .007$). Model fit improved significantly from the previous step (model -2LL = 461.92, $\Delta \chi^2 = 96.39$, $\Delta df = 2$, $p \leq .001$) and pseudo R^2 increased ($\Delta R^2_N = .18$). The effect of Sector reduced to a statistically non-significant level (*OR* = 0.83, CI = 0.56, 1.23, $p = .356$). A notable change included reductions in the odds ratios for all Professions compared to psychiatrists. This suggests that Match Status may have influenced the extent that psychiatrists, in particular, considered R/S in clients' care.

Step four. Client Expectations were entered next to test hypothesis 2(b): that clients with higher Expectations would report that religion/spirituality had been Considered to a greater extent in their care. Expectations were positively associated with reported consideration. For each one-unit increase in clients' Expectations, the odds of reporting higher levels of consideration increased by a factor of nearly 1.5 (CI = 1.21, 1.77, $p < .001$). The inclusion of client Expectations significantly improved model fit over step three (model -2LL = 445.86, $\Delta \chi^2 = 16.06$, $\Delta df = 1$, $p < .001$) and pseudo R^2 increased slightly ($\Delta R^2_N = .03$). No substantial changes were observed for the estimates of any other variables included in the model.

Moderation of client-practitioner matching by sector. The interaction terms for Match Status*Sector were entered into the model to test hypothesis 6; that Sector would moderate the effect of Match Status on the Consideration of religion/spirituality. The effect of Match Status (matched or uncertain compared to unmatched) on Consideration did not differ across the public and private sectors. Compared to step four, the interaction term did not improve model fit (model -2LL = 445.76, $\Delta \chi^2 = 0.10$, $\Delta df = 2$, $p = .957$) and pseudo R^2 did not change, indicating that the relationship between Match Status and Consideration was not significantly moderated by Sector.

Table 12. *Consideration logistic regression model*

Variable	Model 1			Model 2			Model 3			Model 4		
	B (*SE*)	Exp(B) (95% CI)	Wald	B (*SE*)	Exp(B) (95% CI)	Wald	B (*SE*)	Exp(B) (95% CI)	Wald	B (*SE*)	Exp(B) (95% CI)	Wald
Intercept 1	-1.016			1.298			.386			1.432		
	(.329)			(.490)			(.396)			(.525)		
Intercept 2	1.527			4.032			3.159			4.800		
	(.332)			(.526)			(.425)			(.577)		
Profession[a]												
Psychotherapist	.570	1.77	1.95	.462	1.59	1.23	.094	1.01	0.05	-.019	0.98	0.00
	(.408)	(0.80, 3.91)		(.415)	(0.71, 3.54)		(.428)	(0.48, 2.51)		(.431)	(0.43, 2.26)	
Psychologist	.452	1.57	1.53	.444	1.56	1.42	-.074	0.93	0.04	-.128	0.88	0.11
	(.365)	(0.77, 3.21)		(.363)	(0.75, 3.23)		(.384)	(0.44, 1.96)		(.386)	(0.42, 1.87)	
Other	.607	1.84	3.48†	.607	1.84	3.32†	-.033	0.97	0.01	-.152	0.86	0.19
	(.326)	(0.97, 3.46)		(.333)	(0.96, 3.51)		(.347)	(0.49, 1.90)		(.349)	(0.44, 1.69)	
Sector[b]												
Public	-.790	0.45	18.49***	-.789	0.46	17.99***	-.185	0.83	0.85	-.179	0.84	0.79
	(.184)	(0.32, 0.65)		(.186)	(0.32, 0.66)		(.200)	(0.56, 1.23)		(.202)	(0.56, 1.24)	
Importance				1.004	2.73	42.05***	.793	2.20	24.33***	.668	1.95	16.43***
				(.155)	(2.02, 3.69)		(.161)	(1.62, 3.03)		(.165)	(1.41, 2.69)	
Match Status[c]												
Matched							1.755	5.78	43.61***	1.575	4.83	34.44***
							(.266)	(3.43, 9.75)		(.268)	(2.85, 8.20)	
Uncertain							-.668	0.51	7.25*	-.819	0.44	10.42**
							(.248)	(0.31, 0.84)		(.254)	(0.27, 0.73)	
Expectations										.380	1.46	15.96***
										(.095)	(1.21, 1.77)	
Model statistics												
Model -2LL[d]	603.52			558.31			461.92			445.86		
χ^2 (Δ)	24.59***			69.80***	(Δ 45.21)***		166.19***	(Δ 96.39)***		182.25***	(Δ 16.06)***	
df (Δ)	4			5	(Δ 1)		7	(Δ 2)		8	(Δ 1)	
R^2_N (Δ)	.06			.15	(Δ .10)		.33	(Δ .18)		.35	(Δ .03)	

[a] Ref = Psychiatrist. [b]Ref = Private. [c]Ref = Unmatched. [d]Null model -2LL = 628.11

$^{\dagger}p \leq .10$. $^{*}p \leq .05$. $^{**}p \leq .01$. $^{***}p \leq .001$.

Regression analysis three: Satisfaction with consideration.

During the preliminary analysis, the association between extent of Consideration and clients' Satisfaction with the way consideration occured was found to be particularly strong. Hence, Consideration was entered into this regression model first so the unique effects of the explanatory variables on Satisfaction could be assessed, after controlling for their covariance with Consideration.

Step one. Match Status and Direct Assessment were entered into the analysis to test hypotheses 3(c) and 8: that clients whose practitioners shared similar religious/spiritual beliefs to themselves would report a greater level of Satisfaction with the way their beliefs were considered, and that Direct Assessment of clients' religious/spiritual beliefs would also be associated with greater levels of Satisfaction. Results can be found in Table 13. Compared with those who saw a practitioner with dissimilar religious/spiritual beliefs, seeing a practitioner with similar beliefs was not associated with higher levels of satisfaction. Unexpectedly, clients who were uncertain about their practitioner's religious/spiritual beliefs had a three-times lower odds of reporting high satisfaction compared to those who knew their practitioner had dissimilar beliefs (*OR* = 0.30, CI = 0.17, 0.52, $p < .001$). Clients tended to have a greater odds of being satisfied when their practitioner directly assessed their religious/spiritual beliefs (*OR* = 1.44, CI = 0.93, 2.23, $p = .10$). The statistical significance of this was marginal, although it improved in the next step.

Compared to an intercept-only / null model, the three variables entered in the first step, including Consideration, contributed significantly to model fit (null -2LL = 779.19, model -2LL = 385.08, $\chi^2 = 394.11$, df = 4, $p < .001$). This large improvement in model fit is likely due to the strong association between Consideration and Satisfaction. Therefore, the unique contribution of Match Status and Direct Assessment were assessed by comparing their contribution to a model containing only Consideration (model -2LL = 390.20). Match Status and Direct Assessment did not contribute to model fit ($\Delta \chi^2 = 3.91$, $\Delta df = 3$, $p = .271$). However, these two variables alone demonstrated good fit compared to a null model (χ^2 138.15, $p < .001$). Additional analyses confirmed that these two variables were able to uniquely explain variance in

Satisfaction: Direct Assessment and Match Status were regressed upon Satisfaction at each level of Consideration (low, mod, high), thus holding Consideration constant. At each level of Consideration, these variables held similar associations with Satisfaction as in the current regression model and significantly contributed to model fit.

Step two. Client Expectations were entered next to test hypothesis 2(c): that clients with higher Expectations would report greater Satisfaction with the way religion/spirituality had been considered in their care. Contrary to the hypothesis, clients who held higher expectations had lower odds of being satisfied; for every one-unit increase in Expectations, the odds of higher levels of satisfaction decreased by a factor of 1.35 (*OR* = 0.74, CI = 0.60, 0.91, $p = .005$). Client Expectations contributed to model fit above step one (model -2LL = 377.40, $\Delta \chi^2 = 7.68$, Δ df = 1, $p < .001$), but pseudo R^2 showed minimal change ($\Delta R^2_N = .01$). No changes were observed for other variables included in the model, except for a small increase in the effect of Direct Assessment from 1.44 to 1.57, resulting in an improvement in statistical significance ($p = .046$).

Step three. The extent that clients perceived their Practitioner Understood the relevance of religion/spirituality to their recovery was entered next to test hypothesis 9: that Practitioner Understanding would be associated with greater Satisfaction with the way religion/spirituality had been considered. When clients perceived that their practitioner held a greater understanding of religion/spirituality's relevance, clients' odds of being more satisfied with the way their beliefs were considered increased substantially: 17.8 times for each one-unit increase in Practitioner Understanding (i.e, low to moderate, moderate to high) (CI = 10.16, 31.05, $p < .001$). The effect of Direct Assessment reduced to a non-significant level (*OR* = 1.34, CI = 0.81, 2.20, $p = .252$), suggesting that the effect of Direct Assessment was mostly due to clients perceiving that their practitioner understood the relevance of R/S to their recovery. Estimates for other variables did not change. The inclusion of Practitioner Understanding in the model improved model fit over step two (model -2LL = 258.40, $\Delta \chi^2 = 119.00$, $\Delta df = 1$, $p < .001$) and pseudo R^2 increased ($\Delta R^2_N = .11$).

Table 13. *Satisfaction logistic regression model*

Variable	Step 1			Step 2			Step 3		
	B (*SE*)	Exp(B) (95% CI)	Wald	B (*SE*)	Exp(B) (95% CI)	Wald	B (*SE*)	Exp(B) (95% CI)	Wald
Intercept 1	3.007 (.391)			2.463 (.432)			4.404 (.532)		
Intercept 2	6.902 (.506)			6.408 (.529)			9.114 (.674)		
Consideration	3.066 (.233)	21.45 (13.66, 33.68)	173.21***	3.203 (.243)	24.44 (15.30, 39.05)	174.21***	1.772 (.288)	5.88 (3.35, 10.34)	37.77***
Assessment[a]									
Direct	.365 (.222)	1.44 (0.93, 2.23)	2.70†	.451 (.226)	1.57 (1.01, 2.44)	3.97*	.291 (.254)	1.34 (0.81, 2.20)	1.31
Match[b]									
Matched	.125 (.261)	1.13 (0.68, 1.89)	0.23	.279 (.268)	1.32 (0.78, 2.24)	1.08	-.014 (.300)	0.99 (0.55, 1.78)	0.00
Uncertain	-1.217 (.287)	0.30 (0.17, 0.52)	17.95***	-1.094 (.292)	0.33 (0.19, 0.59)	14.01***	-1.035 (.330)	0.36 (0.19, 0.68)	9.81***
Expectations				-.303 (.109)	0.74 (0.60, 0.91)	7.74**	-.484 (.126)	0.62 (0.48, 0.79)	14.63***
Understanding							2.877 (.285)	17.76 (10.16, 31.05)	102.13***
Model statistics									
Model -2LL [c]	385.08			377.40			258.40		
χ^2 (Δ)	394.11***			401.79***	(Δ 7.68)**		520.79***	(Δ 119.00) ***	
df (Δ)	4			5	(Δ 1)		6	(Δ 1)	
R^2_N (Δ)	.64			.65	(Δ .01)		.76	(Δ .11)	

[a]Ref = other. [b]Ref = unmatched. [c]Null model -2LL = 779.19

† $p \leq .10$. * $p \leq .05$. ** $p \leq .01$. *** $p \leq .001$.

CHAPTER 8

DISCUSSION

Support has grown for the consideration of religion/spirituality in mental health care, and research suggests this may be beneficial to client outcomes (e.g., Huguelet, et al., 2011; Rosmarin, et al., 2011; E. L. Worthington, et al., 2011). The importance of client participation in the delivery and evaluation of their care has also become more widely recognised, and research has increasingly sought a client perspective (e.g., Knox, et al., 2005; Mayers, et al., 2007; Rose, et al., 2001). In the midst of this, some authors have claimed that R/S continues to be neglected and minimised in clients' care (e.g., Nelson-Becker, 2003; P. S. Richards & Bergin, 2005; Tepper, et al., 2001). Evidence is rarely presented to support these claims and available evidence is limited both methodologically and conceptually. In particular, practitioners' reports of considering their clients' religion and spirituality are often inconsistent with clients' reports (Baetz, et al., 2004; Borras, Khazaal, et al., 2010). This indicates the need to seek clients' perspectives directly when investigating the extent to which religion and spirituality are considered. A lack of methodologically robust client-perspective studies, the absence of information on client satisfaction with consideration, and the lack of evidence applicable to the unique sociocultural context of New Zealand resulted in the present study. The first question to be addressed was 'To what extent do New Zealand clients, who identify as religious/spiritual, report that religion/spirituality is discussed and considered in their care?'. The lack of knowledge about factors that predict the consideration of R/S and clients' satisfaction with this led to a second question: 'What factors predict the consideration of religion/spirituality in clients' care?'. This question was investigated using a larger, international sample of clients. The current chapter seeks to outline the findings of the present study, to explore their implications, limitations and contributions, to make suggestions for future research, and to present the conclusions of the dissertation.

FINDINGS

Religion and spirituality in New Zealand mental health care: Missing pieces?

Of the New Zealand mental health clients who took part in this study (all of whom identified as religious/spiritual), two-thirds[f] discussed their religious/spiritual beliefs with their practitioner, and over half of the clients who discussed their beliefs reported these were considered in their care. When clients' beliefs were considered, most were satisfied with the way this occurred. Just over half of all New Zealand clients either did not discuss their religious/spiritual beliefs or discussed them but were not satisfied with the way these were considered in their care. Overall, findings were more positive for clients who placed greater importance on the consideration of their religious/spiritual beliefs, and for those who saw private sector practitioners.

The finding that the majority of clients had discussed their religious/spiritual beliefs is substantially more positive than the New Zealand findings of de Beer (1998), who reported that only 11% of clients had been asked whether they had religious/spiritual beliefs. The discrepancies in the findings of the two studies are likely to be due to a range of methodological differences. For example, the present study extended the scope of questioning beyond whether clients had been asked about their beliefs by their practitioner, to allow for the possibility that clients initiated this discussion themselves.

These findings suggest that many practitioners are open to considering R/S in clients' care. In fact, the experiences of New Zealand clients who are religious/spiritual do not strongly support the claim that practitioners largely neglect and minimise clients' R/S. While religion and spirituality are not always 'missing pieces' in the care of New Zealand clients, sometimes these aspects are omitted. As would be expected, there is room for improvement. While it should not be assumed that religious/spiritual clients always wish for R/S to feature in their care, most participants expressed a lack of satisfaction when their beliefs were minimally considered. It was therefore of interest to understand what factors predicted whether clients discussed their religious/spiritual beliefs, as well as the extent to which clients perceived these beliefs were considered in their care and were satisfied with this.

[f] Findings discussed in this section are adjusted for gender and ethnicity.

Factors that predicted discussion of religion/spirituality

Religiously/spiritually-matched clients or those who were uncertain regarding their practitioner's R/S orientation were more likely to discuss R/S with their practitioner compared to unmatched clients. Client-practitioner match was more likely to occur in the private sector, which was associated with a greater likelihood of the topic being raised in this sector. Clients were more likely to discuss their religious/spiritual beliefs when they held greater expectations that their beliefs would be addressed, when they placed greater importance on the consideration of their religious/spiritual beliefs, when they saw a psychotherapist compared to a psychiatrist, and when they consulted with a practitioner in the United States compared to New Zealand or England. These results were found after controlling for all other explanatory variables proposed by this study.

It appears that religiously/spiritually matched clients were more likely to have discussed their religious/spiritual beliefs partly because their practitioners were more likely to ask about R/S. Post-hoc analysis (Table 14, Appendix D) indicates that this was the case even when clients did not expect their religious/spiritual beliefs to be addressed. Clients were no less likely to report being asked about their R/S when their practitioner did not share similar beliefs, compared to clients who were uncertain about their practitioner's religious/spiritual beliefs. However, the former group of clients were less likely to report discussing their R/S with their practitioner, suggesting they may have felt less comfortable broaching the subject of R/S when they knew their practitioner did not share their beliefs. This suggests that practitioners who do not share similar beliefs to their clients may need to be more cognizant of addressing this topic with clients.

Public sector clients were less likely to discuss their religious/spiritual beliefs, apparently because they were less likely to see a practitioner with similar beliefs. It is notable that they were no less likely to indicate that R/S was important for their care compared to private sector clients. More work is required to identify how public sector clients (or more accurately, clients who come to perceive that their practitioner does not share their beliefs) could be better served. It is interesting that client-practitioner

matching was the sole reason for between-sector differences. It is possible that clients generally feel safe discussing R/S with practitioners who they know share their beliefs, regardless of the sector they are in. It is also possible that the lack of discussion in the public sector (due to resource or sociopolitical constraints) meant that fewer clients had the opportunity to discover whether their practitioner shared their beliefs.

The subject of religion/spirituality was more likely to be raised when clients placed importance on the role of R/S in their care, but a number of clients who believed the consideration of their religious/spiritual beliefs was important did not raise the topic and were not asked about this (clients in this situation represented a third of the New Zealand sample). This was partly because a number of clients who placed importance on the consideration of their religious/spiritual beliefs did not expect their practitioner to address their beliefs (37%); low expectations sometimes prevented clients from raising the topic. In other cases, it was unknown why clients did not raise the topic. Perhaps some felt it was unnecessary at the time, or may have interpreted their practitioner's failure to ask about their beliefs as an indication they were not interested, or held concerns about allowing the conversation to steer in that direction. Practitioners need to be aware that clients may be prevented from mentioning their religious/spiritual beliefs, even if the client feels they are important to their care.

Clients were less likely to discuss their religious/spiritual beliefs with psychiatrists than with psychotherapists[g]. This may have been partly because psychiatrists were less likely to be identified by their clients as holding similar religious/spiritual beliefs. Psychiatrists may also have comparatively less scope and time available to assess religious/spiritual aspects of mental health in the settings and roles that they occupy. In addition, psychiatry tends to place less emphasis on holism (Benning & Broadhurst, 2007), while psychotherapists place greater emphasis on this (S. Manning, personal communication, January 16, 2013).

[g] The term 'psychotherapist' is used in some countries to refer to a combination of other psy-disciplines. However, the title 'psychotherapist' is associated with a distinct professional identity in New Zealand, Australia, and the United Kingdom (New Zealand Association of Psychotherapists, 2012; Psychotherapy and Counselling Federation of Australia, 2012; United Kingdom Council for Psychotherapy, 2012).

Clients in the United States were more likely to agree that it was important for R/S to be considered in their care, but this did not completely explain the finding that these clients were more likely to have discussed their religion/spirituality compared to those in New Zealand and England. It is possible that R/S is a more pervasive aspect of U.S. mental health care. Alternatively, U.S. health care policy may influence the likelihood that R/S is discussed in these settings. In support of this, clients in the U.S. were more likely to be asked whether they held religious/spiritual beliefs compared to clients in other countries. However, this difference only seemed to apply when clients saw religious/spiritual practitioners (Table 15, Appendix D). It is unclear why this is so, but a tentative explanation is that religious/spiritual practitioners (compared to those who are not religious/spiritual) may be more responsive to policy-based recommendations to assess clients' religion/spirituality.

Factors that predicted consideration of religion/spirituality

Not all clients who discussed their religious/spiritual beliefs with their practitioner reported that these beliefs were considered in their care. The type of professional clients saw or the country[h] they saw them in did not appear to influence the extent that clients' beliefs were considered. All other factors that predicted discussion of R/S, however, also predicted consideration. The influence of client-practitioner matching changed slightly; matched clients were still more likely to report that R/S had been considered compared to unmatched clients, but compared to unmatched clients those who did not know the R/S orientation of their practitioner were less likely to perceive that R/S was considered.

It appears that not knowing the religious/spiritual orientation of ones' practitioner is facilitative of the topic being raised in therapy but once the topic is raised, uncertainty becomes an impediment to R/S being considered in clients' care (or at least, clients' perceptions that this has occurred). Neither of these were expected findings. In the absence of knowing how clients realised the similarity of their practitioners' religious/spiritual beliefs, one explanation is that practitioners who are transparent enough to allow the dissimilarity of their beliefs to be known are also more cognizant of

[h] As per the bivariate analysis.

considering the beliefs of religiously/spiritually dissimilar clients. Alternatively, clients who are uncertain may be left feeling unsure as to 'where they stand' with their practitioner with regard to R/S, affecting their willingness to make any further mention of these matters or to engage with practitioners' efforts to consider R/S (see J. Hanson, 2005; Stamogiannou, 2007). With religious/spiritual clients, it may be useful for practitioners to be explicit regarding their views of the role of R/S in mental health care, or to consider disclosing their own R/S orientation.

Although the effect of importance on clients' perceptions that their religious/spiritual beliefs were considered was not strong, it suggests that practitioners are at least somewhat responsive to the importance clients place on the consideration of their religion/spirituality. The finding that clients' expectations impacted upon the consideration of their religious/spiritual beliefs suggests that clients with more negative expectations (controlling for the fact that some clients who rate R/S as less important also tend to hold lower expectations) may be less willing to engage with their practitioner's efforts to consider R/S even after the topic is broached. Alternatively, clients' expectations may set them up to be more attentive to confirmatory evidence. Once it has been established that a client holds religious/spiritual beliefs, it may be useful for practitioners to carefully gauge the degree to which their client would like R/S considered in their care, and whether negative expectations are likely to be a barrier to this.

When clients saw practitioners with similar religious/spiritual beliefs to themselves, they were no less likely to report that their beliefs had been considered when they saw these practitioners in the public sector compared to the private sector. Despite concerns expressed by R/S practitioners that the topic of R/S in public services is somewhat taboo, it is possible that these practitioners' fears of being seen as unprofessional or going against their employer's values are not actually outworked in practice, at least not to the extent that it is perceived by religious/spiritual clients. It would be useful for future research to more specifically elucidate the effects that these concerns have, but the present study has not found support for the idea that they affect clients' experiences.

Factors that predicted clients' satisfaction with consideration of religion/spirituality

Not all clients whose religious/spiritual beliefs were considered were satisfied with the way this occurred, and not all clients were unsatisfied when their beliefs were not considered. After controlling for the extent that R/S was considered, unmatched clients were no less likely to be satisfied compared to matched clients. Clients who were uncertain regarding match were less likely to be satisfied, and clients' satisfaction was affected when their expectations of the extent that R/S would be addressed were not met. Clients who perceived their practitioner understood the relevance of R/S to their recovery were likely to be more satisfied with the way their beliefs were considered. These clients were also more likely to have been asked whether they held religious/spiritual beliefs, which contributed to their satisfaction.

All of the factors discussed in this section predicted both Satisfaction and Consideration because of the strong association between the two variables. Controlling for this association allows this section to focus on factors that affect clients' satisfaction, regardless of the extent that R/S was actually considered. It is likely that the association between Consideration and Satisfaction is bi-directional. That is, clients' satisfaction with consideration may have influenced the extent that R/S was considered (and vice versa). For example, a client who is unhappy with their practitioner's efforts to consider R/S is likely to withdraw from conversations regarding R/S (cf. Knox, et al., 2005; Mayers, et al., 2007), affecting the extent to which R/S is considered in that client's care.

When religiously/spiritually unmatched clients perceived that R/S was considered in their care, they were no less satisfied with the way this occurred compared to matched clients. In addition, two-thirds (66%) of the unmatched clients who discussed their R/S with their practitioner were satisfied with the way their beliefs were considered[i]. These findings indicate that practitioners with dissimilar beliefs to their clients often competently consider their clients' beliefs and when this occurs, they appear to be as effective as practitioners with similar beliefs to their clients. This is encouraging because it shows that the 'religiosity gap' between practitioners and clients is not an insurmountable barrier.

[i] Based upon dichotomisation of the original Satisfaction scale.

Clients who were uncertain regarding the religious/spiritual orientation of their practitioner were less likely to be satisfied, even when they perceived that their practitioner had made an effort to consider their religious/spiritual beliefs. The effect of this uncertainty on both clients' perceptions that R/S was considered *and* their satisfaction suggests that it has a pervasive effect on clients' experience. This was unexpected and may warrant further exploration into how religious/spiritual clients perceive and react to practitioners' non-disclosure of religious/spiritual beliefs or views on R/S.

The negative association between client expectations and satisfaction was also unexpected. Post-hoc analysis indicated that this was found because clients' satisfaction was negatively affected when they held high expectations that were not met (in the form of their religion/spirituality not being considered), and vice versa (see Table 16, Appendix D). This finding is consistent with the expectancy-disconfirmation model of consumer satisfaction (Anderson, 1973) which asserts that satisfaction is a function of whether consumers' experience of a product or service is consistent with their expectations (Greenberg, et al., 2006; Stallard, 1996). Although a number of clients who placed importance on the consideration of R/S entered therapy with low expectations regarding whether their beliefs would addressed, it is encouraging to note that most did not have their expectations confirmed; 67% of these clients were satisfied with the consideration of their beliefs[j]. Nevertheless, practitioners may need to be aware that clients' satisfaction is likely to be negatively affected if efforts to consider R/S are too inconsistent with expectations.

Practitioner understanding was, by far, the most important predictor of clients' satisfaction, contributing the most to model fit and demonstrating the strongest relationship with satisfaction. Although practitioners who held similar beliefs to their clients were more likely to be perceived as having a greater understanding of the relevance of R/S, this similarity was not a necessary or sufficient condition for clients' satisfaction. In fact, only a quarter of unmatched clients who discussed their religious/spiritual beliefs with their practitioner indicated that their practitioner

[j] Based on dichotomisation of the original Expectations and Satisfaction scales.

displayed a low level of understanding. This suggests that it is entirely possible for religiously/spiritually unmatched practitioners to develop an understanding of how R/S is relevant to their clients' recovery, and furthermore that it is important to do so. It would be useful for further work to be directed toward tools that help practitioners develop this understanding.

Asking religious/spiritual clients whether they have religious/spiritual beliefs does not appear to have a detrimental impact upon their satisfaction. It is unclear whether direct assessment actually improves clients' satisfaction however; clients who were asked were only more likely to be satisfied because they were more likely to perceive that their practitioner understood the relevance of their religion/spirituality. It is possible that certain practitioners (not just those with similar religious/spiritual beliefs to their clients), who are more likely to understand the relevance of R/S to clients' recovery, are also more likely to ask about R/S.

IMPLICATIONS AND RECOMMENDATIONS

Implications and recommendations for practice and policy

Practitioners can be encouraged that many religious/spiritual clients do indeed perceive that their religious/spiritual beliefs have been considered in their care and are often satisfied with the way this has occurred. This section will discuss ways that clients' experiences can be improved further, based on the findings of the present study.

A number of findings suggested that it might be beneficial for practitioners to ask clients whether they have religious/spiritual beliefs. Firstly, a significant majority of clients in this study (all whom identified as religious/spiritual) placed importance on their religion/spirituality being considered. While it may not be expected that clients who do not identify as R/S would place importance on this, a substantial number of clients in mental health care settings do identify as religious/spiritual. Secondly, asking clients about their religion/spirituality was associated with greater satisfaction because this behaviour was associated with practitioners who tended to be more likely to understand the relevance of their clients' R/S. Thirdly, once the topic of R/S was raised, most clients were satisfied with the way their R/S was considered.

Asking clients about their religious/spiritual beliefs may also be important because it appears that clients do not always broach this topic even when it is important to them, perhaps due to negative expectations that their practitioner will not consider their beliefs or understand their relevance. Helping clients to overcome this barrier by directly asking about R/S may help to ensure that a factor that can play an important role in clients' mental health is not missed. Although there is not yet any evidence to shed light on how non-religious/spiritual clients experience being directly asked about R/S, findings from the present study suggest that that religious/spiritual clients do not generally experience this in a way that negatively affects their satisfaction with the consideration of their beliefs.

The process of considering clients' religious/spiritual beliefs is one that needs to occur in tandem with checking clients' satisfaction with this process, particularly as clients' satisfaction with consideration and the extent of this consideration were so closely associated. Clients are active participants in the process of considering R/S and it is possible for clients to withdraw from practitioners' efforts to consider R/S if clients are dissatisfied with these efforts (cf. Gockel, 2011; Knox, et al., 2005; Mayers, et al., 2007; Stamogiannou, 2007). Initially checking clients' expectations of whether their religious/spiritual beliefs will be addressed may be an important part of this process as these expectations predicted how clients perceived and received practitioners' efforts (or lack thereof) to consider their religion/spirituality.

Developing a clear understanding of how R/S is relevant to clients' recovery appears to be an important factor in determining clients' satisfaction with the consideration of their religious/spiritual beliefs. Finding ways to do this needs to be the focus of additional research, but it is likely that assessing the relevance of clients' beliefs with regard to their difficulties and goals may assist this process. Including this assessment information in case conceptualisation could deepen this understanding further.

When considering how clients' religious/spiritual beliefs might be relevant to treatment, practitioners whose beliefs are dissimilar to their clients' can be reassured that for the most part, this dissimilarity does not put them at a disadvantage in terms of how their clients perceive their efforts to consider R/S. While the present study did not examine

why this is so, earlier qualitative work suggests that a collaborative approach that applies foundational therapeutic skills goes a long way in overcoming cultural differences between client and practitioner (Gockel, 2011; Knox, et al., 2005; Mayers, et al., 2007; Pope-Davis, et al., 2002; Stamogiannou, 2007).

Practitioners need to be aware of the possibility that their efforts to consider R/S may be perceived in a less favourable manner if their clients are unsure whether their practitioner holds religious/spiritual beliefs similar to their own. Findings from the present study suggest that a lack of transparency in this regard may affect clients' satisfaction with way R/S is considered. Practitioners may wish to consider self-disclosing their own R/S orientation, disclosing their view on the role of R/S in mental health care, and/or addressing any concerns clients might have regarding their practitioner's R/S orientation.

For practitioners, the implications of this study could be summarised as follows: strive to become aware, to understand, and to take collaborative action. Firstly, make efforts to become aware of clients' religious/spiritual beliefs, the importance placed on these, and the expectations and concerns religious/spiritual clients enter mental health care with. Secondly, understand how this information impacts upon the therapeutic process and clients' journey toward recovery. Thirdly, take action on the basis of this understanding, in a collaborative manner with the client while checking clients' satisfaction with the process.

Greater awareness, willingness, and competency to consider the religious/spiritual aspects of clients' lives could be assisted by a greater focus on finding effective ways to train practitioners, and by practitioners seeking out opportunities to improve their consideration of R/S. The findings of this study would suggest that one useful focus of training might be helping practitioners understand how to integrate clients' R/S into mental health assessment. It may also be valuable for practitioners to engage in a process of self-practice/self-reflection to identify and deal with particular concerns they may have with regard to considering clients' religious/spiritual beliefs. Universities may wish to review the presence or adequacy of their inclusion of R/S within cultural competency training. A useful approach may be to first instill basic principles of cross-

cultural practice (e.g., cultural safety, multicultural competencies, common factors approach), followed by additional training to address specific issues that pertain to the consideration of R/S in practice (e.g., including R/S in case conceptualisations, dealing with 'harmful' religious/spiritual beliefs).

Service providers, particularly those which are publically-funded, may wish to review their policies that pertain to the consideration of R/S. Policies which explicitly encourage the assessment of R/S as part of broader assessment practices are likely to be useful. Such policies may highlight this issue for practitioners' awareness, provide a mandate for further training, and assist practitioners' level of comfort in knowing that their employer endorses such practice.

Implications and recommendations for religious/spiritual clients

Research on the consideration of religion/spirituality has focused heavily on practitioners' views. In light of the consumer and recovery movements, the last decade has witnessed a shift toward eliciting clients' views as well. Nevertheless, even studies that focus on clients' views rarely discuss how clients can act upon their findings. Clients are increasingly recognised as being a partner in their care (Anthony, 1993; Papps & Ramsden, 1996); clients may be assisted in this partnership when research helps shed light on what they can do to work toward positive outcomes. Based on the findings of the present study, the following section outlines actions that clients themselves can take to improve the satisfactory consideration of R/S in their care.

This study found that practitioners do not always ask questions about religion/spirituality and until this changes, clients who believe it is important for their beliefs to be considered may need to initiate the topic themselves. Some clients may feel more comfortable doing this if they see a practitioner with similar beliefs to themselves, and this study suggests they are more likely to find these practitioners in services that are not provided by a government or public health service.

Clients who did not expect their practitioner to address their religious/spiritual beliefs, but discussed these anyway, often found they were satisfied with the way their religious/spiritual beliefs were considered. Clients who have concerns about whether

their practitioner will address their R/S may find that their concerns are not confirmed once they raise the topic. It may also be helpful for clients to discuss their concerns if they have any. This study also found that clients were less satisfied when they did not know the R/S orientation of their practitioner, so clients may wish to discuss this with their practitioner if this uncertainty concerns them.

Findings of this study suggest that clients who want their beliefs to be considered in their care are likely to find that R/S is considered to a greater extent when they see a practitioner who holds similar religious/spiritual beliefs to them. However, clients who see practitioners with beliefs that are different to their own can be assured that these practitioners often consider their clients' religious/spiritual beliefs, in a way clients are satisfied with. Clients may help their practitioner to better consider their R/S by providing feedback on this process; including what is working well and what could be improved. Clients may also find they are more satisfied with the way their beliefs are considered if they help their practitioner to understand how R/S is relevant to their mental health difficulties, strengths, and goals.

LIMITATIONS

The findings of the present study are limited by the use of a non-probability sampling approach, so females and New Zealand European participants were over-represented in the sample while a number of smaller ethnic and religious groups were under-represented. Part One of the analysis accounted for possible bias caused by disproportionate representations of these groups through the use of case weighting, and there were no empirical or theoretical reasons to believe that the findings of Part Two would differ according to gender, ethnicity or religious identification. Nevertheless, the results of the present study as a whole should be considered to be more representative of those who identify as New Zealand European and Christian and, to a lesser extent, Māori, Spiritual/Not Religious, and Buddhist, rather than the ethnic or religious groups not listed here. This study referred to R/S as being primarily defined by concepts that incorporate the sacred. Results should be considered more representative of individuals who include the sacred as part of their R/S identity than of those who do not.

Participants were self-selected, so it is possible that participants who held particularly strong views regarding their experience of mental health practitioners were more likely to participate. Mass advertising purposely provided as little information as possible so as not to attract particular types of participants. The distribution of the RCI and ISS scores were not unexpected for a mostly New Zealand-based sample, so it does not appear that the findings were biased toward those whose R/S was particularly central or non-central to their lives. Although there was no evidence of self-selection bias, this possibility cannot be excluded.

The use of single-item scales meant that the measurement of most variables may have been less precise than if multiple-item scales had been used (Bowling, 2005). Where possible, efforts were made to check the psychometric properties of these measures and the items received a substantial amount of input from stakeholders prior to dissemination of the questionnaire. No concerns were raised once these processes were complete.

The self-report and cross-sectional nature of the study meant that it was unknown if clients used their experience of their practitioner's consideration of R/S to determine the similarity of their practitioner's beliefs to their own, which may have inflated the relationships between Match Status and the outcome variables. Clients were provided a 'don't know' option for the Match Status question and it is hoped that clients used this rather than guessing. Future research may wish to assess client-practitioner match objectively. It is also unknown whether clients' experiences influenced recall of their expectations, although the reversed association between Expectations and Satisfaction suggests that this was not the case for many participants. In general however, temporal relationships between variables and causation could not be assumed.

The use of logistic regression required all continuous variables to be classified into ordinal groups. This may have led to less precise parameter estimates and predictions of associations between variables, and reduced power to detect statistically significant associations (Altman & Royston, 2006; J. Cohen, 1983). Because the aim of the present study was toward identifying patterns of relationships between variables rather than parsimonious prediction of outcome (cf. Royston & Sauerbrei, 2008), the effect of less

precise measurement on prediction ability (i.e., goodness of fit) was not overly concerning. The ability of the analysis to detect differences between countries and professions represented by fewer participants may have been affected, although standard errors of parameter estimates were not excessively large in proportion to group sizes.

CONTRIBUTIONS AND STRENGTHS

The present study has been able to contribute to the current literature in a number of ways. The most important of these was the investigation of two pertinent questions which had not been sufficiently investigated prior. Specifically, this study firstly provided an estimate of the extent to which R/S had been discussed and considered amongst a large sample of New Zealand clients who identified as religious/spiritual, and clients' satisfaction with this. Secondly, the study explored how eight factors predict the discussion and consideration of R/S, and clients' satisfaction with consideration, amongst a larger international sample. These contributions and others are discussed here.

The present study avoided several of the methodological limitations of previous surveys. Although one unpublished client-perspective study in New Zealand conducted an investigation similar to the first question of this study (de Beer, 1998), the ability of de Beer's study to provide an answer was limited by its scope and method. The present study surveyed a larger and more diverse sample of New Zealand mental health clients identifying as religious/spiritual compared with any previous studies. Using this sample, the study provided evidence that the majority of these clients discussed their religious/spiritual beliefs with practitioners. Amongst those who discussed their beliefs, most also perceived that these beliefs were considered in their care. It was significant to find, however, that half of those who placed importance on the consideration of their R/S had either not discussed these with their practitioner or were not satisfied with the way they had been considered.

A more comprehensive understanding of clients' experiences have been provided by the present study than what other quantitative studies have done. Whereas the majority of other studies only enquired whether clients were asked about R/S, discussed R/S, or perceived this was considered in their care (e.g., Awara & Fasey, 2008; Borras, Khazaal,

et al., 2010; de Beer, 1998), the present study enquired about all three, in addition to investigating clients' satisfaction with consideration. This contributes to a more comprehensive understanding of how frequently the topic of R/S is raised even when not asked about by practitioners, whether consideration of R/S is followed through once the topic is raised, and whether this consideration occurs in a way clients are satisfied with.

Participants in previous studies had not been asked about their satisfaction with the way their religious/spiritual beliefs had been considered. It appears this study was the first to have done so. On the whole, it was encouraging to find that those who discussed R/S were often satisfied with the consideration of their religion/spirituality. The results of the present study showed this satisfaction was not always determined by the extent that R/S was considered, suggesting that it may be important for future studies to evaluate client satisfaction rather than relying solely upon evaluations of whether R/S is considered.

Prior to this study, no surveys had directly compared the consideration of R/S in privately- and publically-provided services. This was also one of the few studies to have distinguished between clients who place importance on the consideration of their religious/spiritual beliefs and those who do not. As expected, estimates were more pessimistic when they included clients who did not place importance on the consideration of their religious/spiritual beliefs, and when estimates were confined to the experiences of those in the public sector. This highlighted the importance of accounting for contextual factors when making such estimates.

The present study was the first to identify factors that predicted (a) clients' reports that they discussed religion/spirituality with their mental health practitioner, (b) clients' perceptions that their beliefs were considered, and (c) clients' satisfaction with this. It was found that a range of factors influence these outcomes, and not all in the same manner. For example, client-practitioner matching predicts whether the topic of R/S is discussed and considered in clients' care, but it did not appear to provide an advantage in terms of clients' satisfaction when R/S *was* considered. It is hoped that this knowledge will assist stakeholders to better understand influences on the consideration of R/S in mental health care, and to take appropriate action.

Implications for clients are rarely outlined in the literature and it appears this is the first study on the consideration of R/S in mental health care to have outlined actions that clients can take to improve this consideration. These range from raising the subject of R/S themselves, to providing feedback to their practitioners. Perhaps future research could help to empower clients by doing the same and/or provide further discussion on the relative merits of doing so.

It appears that the present study is the first to have discusssed the application of cultural safety to the consideration of R/S in mental health care (Ramsden, 1990). Through the comparison of the concept of cultural safety to others, such as the multicultural competencies (D. W. Sue, et al., 1992), and the common factors model (Fischer, et al., 1998b), this concept was identified as an important addition to the conceptual foundation of considering R/S. The most important contributions of this concept to the consideration of R/S include its acknowledgement of sociopolitical issues and the importance of client participation (Papps & Ramsden, 1996). It is hoped that the application of this concept to R/S will be considered further by other researchers and practitioners.

The findings of this study support the consideration of R/S within the multicultural competencies model (D. W. Sue, et al., 1992). The statement 'strive to be aware, to understand, and to take collaborative action' fits broadly with D. W. Sue's characteristics of culturally competent mental health practitioners (Chapter Four). However, findings of the present study imply that awareness, understanding, and action need to encompass specific client-centred competencies, in addition to the generic knowledge-based competencies outlined by the MCC model. For example, 'understanding' could be extended beyond holding general knowledge of R/S and related issues, to include practitioners' ability to develop an idiographic understanding of how these are relevant to the recovery of particular clients. Likewise, 'awareness' could be extended beyond intellectual and self-awareness, to include awareness of specific clients' beliefs, preferences, expectations, and concerns. 'Action' could be extended beyond practitioners' ability to develop [generically] appropriate intervention strategies, to their ability to collaboratively tailor these strategies using their awareness and understanding of specific clients.

The application of the common factors approach to considering R/S is also supported by the present study (Chapter Four) (Fischer, Jome, & Atkinson, 1998a; Frank, 1971). The finding that clients' satisfaction with consideration did not depend upon whether their practitioner shared similar religious/spiritual beliefs was a strong indicator of this. A common factor experienced by both matched and unmatched clients, most likely a positive therapeutic alliance, may be more important than seeing a practitioner with similar religious/spiritual beliefs. Similarly, the findings support Fischer et al.'s assertion that mutual understanding of each other's worldview is an essential ingredient in culturally competent mental health care. Greater satisfaction was reported by clients who perceived that their practitioner understood aspects of their worldview (namely, the relevance of their religious/spiritual beliefs). In turn, clients who understood a little of their practitioner's worldview (namely, whether or not they shared similar religious/spiritual beliefs) also reported greater satisfaction. Findings from this study suggest that efforts by authors such as Padesky and Greenberger (1995) and Josephson (2004) to incorporate R/S within mainstream models of case conceptualisation are particularly important. These efforts 'sign-post' the need for practitioners to understand the clinical relevance of their clients' religious/spiritual beliefs, such as how they influence clients' strengths, difficulties, and recovery. It is hoped that future work will clarify how practitioners utilise case conceptualisation to develop an understanding of how their clients' religious/spiritual beliefs are relevant to recovery.

A contribution of this dissertation as a whole is that it has drawn together theory and research from a range of areas to explain how R/S is relevant to mental health and mental health care; what practitioners can do to consider their clients' religious/spiritual beliefs and some of the issues involved in doing so; provided an estimate of the extent this was occuring in a New Zealand sample, and used this theory and research to identify and investigate factors that are associated with the consideration of clients' religious/spiritual beliefs in mental health care. As such, this dissertation has offered some novel perspectives on each of these areas and identified opportunities for further research. This has ranged from providing an elaborated perspective on R/S as a predisposing, precipitating, perpetuating, and protective factor in the development of mental health difficulties, to examining the role of clients' perspectives in the definition and evaluation of cultural competence, including the consideration of their

religious/spiritual beliefs. This has uncovered gaps in the literature, such as the paucity of quality longitudinal, experimental and multivariate research on the links between religion, spirituality and mental health and the lack of such research with diverse religious and ethnic groups. It has also highlighted the need for stronger theoretical and empirical evidence with regard to the role of sociocultural and sociopolitical influences on the consideration of R/S in mental health care. It is hoped that these contributions have added to a stronger foundation for future investigations.

FUTURE RESEARCH

Two central questions and a number of hypotheses were posed by the present study. The process of investigating these uncovered a number of additional questions that can be investigated by future research.

Clients' uncertainty regarding the religious/spiritual beliefs of their practitioner was a main issue raised by the present study. This generated several further questions. First and foremost, why was this uncertainty unhelpful? Second, is it necessary for practitioners to disclose their R/S orientation, or is it sufficient for practitioners to disclose their view on the role of R/S in mental health care? Finally, in the absence of overt disclosure, what cues do clients use to determine the [dis]similarity of their practitioners' religious/spiritual beliefs and do the attributions clients make on the basis of these cues affect the therapeutic process, such as clients' engagement with their practitioner? Research to answer these questions would assist in better understanding the interactive and dynamic processes that occur between religious/spiritual clients and their practitioners.

As the present study demonstrated, there is a close (and likely bi-directional) relationship between the extent to which clients' religious/spiritual beliefs are considered and clients' satisfaction with consideration. It would be useful to better understand the dynamics that occur when the topic of R/S is first raised and how, as a result of this first discussion, the topic is then successfully or unsuccessfully negotiated through the course of therapy. How do practitioners and clients negotiate the therapeutic

relationship and alliance when a rupture is caused by unsatisfactory handling of R/S topics? Insights into this process may help practitioners to determine some useful ways to proceed when such ruptures occur.

Inter-profession and inter-country differences in the likelihood of discussing R/S require further examination. Firstly, it is important to determine whether the differences found in this study are replicated in other samples. Secondly, it would be useful to understand the factors that might contribute to these differences. For example, what factors other than personal religiousness/spirituality might explain the differences found between psychiatrists and psychotherapists with regard to discussion of R/S? Is the reduced focus on holism amongst psychiatrists a valid explanation for this finding? Do contextual factors, such as setting and role help to explain this and if so, what solutions might be implemented to ensure that an important part of a client's life is not missed? With regard to inter-country differences in the discussion of R/S, what impact do specific policy directives with regard to consideration of R/S have? Are certain types of practitioners, such as those who hold religious/spiritual beliefs, more likely to be open to such policy directives?

It is currently unclear exactly what impact the focus on Māori spirituality in mental health care policy and training in New Zealand has had on the consideration of R/S for non-Māori. Does the focus in New Zealand need to be broadened to include more diverse forms of religion/spirituality, or is the current focus sufficient for highlighting awareness of R/S for all ethnicities? Comparisons across ethnicities in this study could not be made because of the low proportions of non-Māori/non-New Zealand European participants. It would be useful for future studies to investigate this question using both quantitative and qualitative perspectives. It also appears important to develop a clearer understanding of the consideration of R/S in mental health care for Māori in particular, perhaps within a Kaupapa Māori framework.

A noteworthy finding of the present study was the strong effect of practitioners' understanding on clients' satisfaction with the way their religious/spiritual beliefs were considered. What specific practitioner behaviours led clients to perceive that their practitioner understood the relevance of their religious/spiritual beliefs to recovery?

Would improving the assessment of R/S suffice? Might the intentional inclusion of R/S in case conceptualisation help practitioners to further develop their understanding of how R/S is relevant to their client's recovery? Would training practitioners to incorporate R/S into case conceptualisations have a flow-on effect to clients' perceptions, and would this be reflected in clinical outcomes or therapeutic process measures?

As well as investigating questions arising from findings of the present study, a number of questions arose through the literature review that were outside the scope of this study and would be worthwhile subjects of future research.

First, no studies have yet published a set of practitioner attitudes and behaviours that clients themselves have generated and identified as being 'ideal' ways to consider their religious/spiritual beliefs. Such research would not only provide useful guidelines for practitioners but could also assist in the measurement of R/S consideration and clients' expectations. A set of recommendations such as this may also assist in evaluating the validity of researcher-generated practitioner attitudes and behaviours scales (e.g., Belaire & Young, 2002; Frazier & Hansen, 2009; Martinez, et al., 2007).

With regard to improving the consideration of R/S, one suggestion advanced by this dissertation was that self-practice/self-reflection may be a particularly useful training tool in assisting practitioners to identify and modify their own assumptions, attitudes, and concerns regarding the role of R/S in practice. It would be useful for future research to determine whether this is indeed a useful tool by investigating whether such training improves (a) the likelihood of practitioners considering R/S in their work with clients, (b) practitioner effectiveness in integrating this domain into their practice, (c) client satisfaction with how this occurs, and (d) therapy outcomes.

CONCLUSION

This dissertation has explored the extent to which religion/spirituality is discussed and considered in New Zealand mental health care, in a sample of clients holding religious/spiritual beliefs. The study also examined clients' satisfaction with this process and utilised data from an international sample to investigate the factors that predicted these outcomes. The findings have challenged the oft-cited claim that R/S is largely neglected and minimised in mental health care, while they also identify opportunities for improvement. In particular, improvements in the extent to which clients' religious/spiritual beliefs are taken into account - and clients' satisfaction with this - may be achieved when practitioners improve their awareness of (a) clients' religious/spiritual beliefs, (b) the importance clients place on these, and (c) clients' expectations and concerns regarding how their beliefs are addressed. Efforts to understand the impact of these beliefs and concerns on the therapeutic process and clients' recovery may also contribute to the satisfactory consideration of R/S. Clients themselves may be able to help improve the consideration of their religious/spiritual beliefs by initiating conversation about their beliefs and providing feedback to their practitioner. Future research can contribute by further improving our understanding of the dynamic and interactive processes that impact upon and arise from the consideration of R/S.

Religion and spirituality are integral to the lives of a number of individuals who utilise mental health care services. To a certain extent, it appears that many practitioners are already aware of this, and have put this awareness into action in ways that are often well-received by clients. It is these practitioners, our colleagues, and our clients; such as those who have participated in this research, who can help us to work even more effectively with religious/spiritual issues in mental health care. Much progress is yet to be made, so let us continue in our efforts to ensure that religion, spirituality, and science communicate effectively toward the common goal of healing and in doing so, making sure that an essential aspect of many clients' lives is not missed.

REFERENCES

Abramson, L. Y., Seligman, M. E. P., & Teasdale, J. D. (1978). Learned helplessness in humans: Critique and reformulation. *Journal of Abnormal Psychology, 87*, 49-74. doi: 10.1037//0021-843X.87.1.49

Accreditation Council on Graduate Medical Education. (1994). *Special requirements for residency training in psychiatry*. Chicago, IL: Author.

Adalbjarnardottir, S., & Hafsteinsson, L. G. (2001). Adolescents' perceived parenting styles and their substance use: Concurrent and longitudinal analyses. *Journal of Research on Adolescence, 11*, 401-423. doi: 10.1037//0893-164X.15.1.25

Adhar, R. (2003). Indigenous spiritual concerns and the secular state: Some New Zealand developments. *Oxford Journal of Legal Studies, 23*, 611-637. doi: 10.1093/ojls/23.4.611

Ahdar, R. J. (2006, June). Reflections on the path of religion-state relations in New Zealand. *Brigham Young University Law Review*.

Ahn, Y. J., & Miller, M. M. (2010). Can MFTs address spirituality with clients in publically funded agencies? *Contemporary Family Therapy, 32*, 102-116. doi: 10.1007/s10591-009-9107-5

Alloy, L. B. (1997). Attributional style, daily life events, and hopelessness depression: Subtype validation by prospective variability and specificity of symptoms. *Cognitive Therapy & Research, 21*, 321-344. doi: 10.1023/A:1021878516875

Alloy, L. B., Abramson, L. Y., Whitehouse, W. G., Hogan, M. E., Tashman, N. A., Steinberg, D. L., . . . Donovan, P. (1999). Depressogenic cognitive styles: Predictive validity, information processing and personality characteristics, and developmental origins. *Behaviour Research & Therapy, 37*, 503-531. doi: 10.1016/S0005-7967(98)00157-0

Allport, G. W., & Ross, J. M. (1967). Personal religious orientation and prejudice. *Journal of Personality & Social Psychology, 5*, 432-443. doi: 10.1037/0022-3514.5.4.432

Altman, D. G., & Royston, P. (2006). The cost of dichotomising continuous variables. *British Medical Journal, 332*, 1080. doi: 10.1136/bmj.332.7549.1080

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

American Psychological Association. (2002). *American Psychological Association ethical principles of psychologists and code of conduct.* Washington, DC: Author.

American Psychological Association. (2003). *Guidelines on multicultural education, training, research, practice, and organizational change for psychologists*. Washington, DC: Author.

Anderson, R. E. (1973). Consumer dissatisfaction: The effect of disconfirmed expectancy on perceived product performance. *Journal of Marketing Research, 10*, 38-44. doi: 10.2307/3149407

Ano, G. G., & Vasconcelles, E. B. (2005). Religious coping and psychological adjustment to stress: A meta-analysis. *Journal of Clinical Psychology, 61*, 461-480. doi: 10.1002/jclp.20049

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal, 16*, 11-23.

Antonovsky, A. (1993). The structure and properties of the sense of coherence scale. *Social Science & Medicine, 36*, 725-733. doi: 10.1016/0277-9536(93)90033-Z

Antonovsky, H., & Sagy, S. (1986). The development of a sense of coherence and its impact on responses to stress situations. *The Journal of Social Psychology, 126*, 213-225.

Appelbaum, P. S., Robbins, P. C., & Roth, L. H. (1999). Dimensional approach to delusions: Comparison across types and diagnoses. *American Journal of Psychiatry, 156*, 1938-1943.

Arredondo, P., Toporek, R., Brown, S. P., Sanchez, J., Locke, D. C., & Stadler, H. (1996). Operationalization of the multicultural counseling competencies. *Journal of Multicultural Counseling & Development, 24*, 42-78. doi: 10.1002/j.2161-1912.1996.tb00288.x

Aten, J. D., & Leach, M. M. (Eds.). (2009). *Spirituality and the therapeutic process: A comprehensive resource from intake to termination*. Washington DC: American Psychological Association.

Atkinson, D. R., & Thompson, C. E. (1992). Racial, ethnic, and cultural variables in counseling. In S. D. Brown & R. W. Lent (Eds.), *Handbook of counseling psychology* (2nd ed., pp. 349-382). New York, NY: Wiley.

Australian Council on Healthcare Standards. (2010). *National standards for mental health services*. Barton, ACT: Australian Government.

Australian Psychological Society. (2007). *APS code of ethics*. Melbourne, VIC: Author.

Awara, M., & Fasey, C. (2008). Is spirituality worth exploring in psychiatric out-patient clinics? *Journal of Mental Health, 17*, 183-191. doi: 10.1080/09638230701498390

Babyak, M. A. (2004). What you see may not be what you get: A brief, nontechnical introduction to overfitting in regression-type models. *Psychosomatic Medicine, 66*, 411- 421. doi: 10.1097/01.psy.0000127692.23278.a9

Baetz, M., Griffin, R., Bowen, R., & Marcoux, G. (2004). Spirituality and psychiatry in Canada: Psychiatric practice compared with patient expectations. *The Canadian Journal of Psychiatry, 49*, 265-271.

Baetz, M., Larson, D. B., Marcoux, G., Bowen, R., & Griffin, R. (2002). Canadian psychiatric inpatient religious commitment: An association with mental health. *Canadian Journal of Psychiatry, 47*, 159-166.

Baker, M., & Wang, M. (2004). Examining connections between values and practice in religiously committed UK clinical psychologists. *Journal of Psychology & Theology, 32*, 126-136.

Baker, S. (November 25, 2010). Sombre church service for Pike River families. Retrieved March 30, 2011, from http://www.nzherald.co.nz/nz/news/video.cfm?c_id=1&gal_objectid=10689950&gallery_id=115407

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review, 84*, 191-215. doi: 10.1037//0033-295X.84.2.191

Barnett, J. E., & Johnson, W. B. (2011). Integrating spirituality and religion into psychotherapy: Persistent dilemmas, ethical issues, and a proposed decision-making process. *Ethics & Behavior, 21*, 147-164. doi: 10.1080/10508422.2011.551471

Barnette, J. J. (2000). Effects of stem and likert response option reversals on survey internal consistency: If you feel the need, there is a better alternative to using those negatively worded stems. *Educational & Psychological Measurement, 60*, 361-370. doi: 10.1177/00131640021970592

Bartholomew, K., & Horowitz, L. M. (1991). Attachment styles among young adults: A test of a four-category model. *Journal of Personality and Social Psychology, 61*, 226-244. doi: 10.1037//0022-3514.61.2.226

Bartz, J. D., Richards, P. S., Smith, T. B., & Fischer, L. (2010). A 17-year longitudinal study of religion and mental health in a Mormon sample. *Mental Health, Religion & Culture, 13*, 683-695. doi: 10.1080/13674670801944966

Baumeister, R. F. (1991). *Meanings of life*. New York, NY: Guilford Press.

Bayle, F. J., Caci, H., Millet, B., Richa, S., & Olie, J.-P. (2003). Psychopathology and comorbidity of psychiatric disorders in patients with kleptomania. *American Journal of Psychiatry, 160*, 1509 - 1513. doi: 10.1176/appi.ajp.160.8.1509

Beauchamps, T., & Childress, J. (2001). *Principles of biomedical ethics* (4th ed.). New York, NY: Oxford University Press.

Beck, A. T. (1967). *Depression: Causes and treatment*. Philadelphia: University of Pennsylvania Press.

Beck, A. T., Freeman, A. M., & Davis, D. D. (2004). *Cognitive therapy of personality disorders*. New York, NY: Guilford Press.

Beck, J. (1995). *Cognitive therapy: Basics and beyond*. New York, NY: Guilford.

Beck, R., & McDonald, A. (2004). Attachment to God: The attachment to God inventory, tests of working model correspondence, and an exploration of faith group differences. *Journal of Psychology & Theology, 32*, 92-103.

Belaire, C., & Young, J. S. (2002). Conservative Christians' expectations of non-Christian counselors. *Counseling & Values, 46*, 175-187. doi: 10.1002/j.2161-007X.2002.tb00211.x

Bellamy, C. D., Jarrett, N. C., Mowbray, O., MacFarlane, P., Mowbray, C. T., & Holter, M. C. (2007). Relevance of spirituality for people with mental illness attending consumer-centred services. *Psychiatric Rehabilitation Journal, 4*, 287-294. doi: 10.2975/30.4.2007.287.294

Bennett-Levy, J., Turner, F., Beaty, T., Smith, M., Paterson, B., & Farmer, S. (2001). The value of self-practice of cognitive therapy techniques and self-reflection in the training of cognitive therapists. *Behavioural and Cognitive Psychotherapy, 29*, 203-220. doi: 10.1017/S1352465801002077

Benning, T., & Broadhurst, M. (2007). The long case is dead - long live the long case: Loss of the MRCPsych long case and holism in psychiatry. *The Psychiatrist, 31*, 441-442. doi: 10.1192/pb.bp.107.014951

Bent-Goodley, T. B., & Fowler, D. N. (2006). Spiritual and religious abuse: Expanding what is known about domestic violence. *Affilia, 21*, 282-295.

Bergin, A. E. (1980). Psychotherapy and religious values. *Journal of Consulting & Clinical Psychology, 48*, 95-105. doi: 10.1037/0022-006X.48.1.95

Bergin, A. E. (1983). Religiosity and mental health: A critical reevaluation and meta-analysis. *Professional Psychology: Research and Practice, 14*, 170-184. doi: 10.1037//0735-7028.14.2.170

Bergin, A. E. (1991). Values and religious issues in psychotherapy and mental health. *American Psychologist, 46*, 394-403. doi: 10.1037/0003-066X.46.4.394

Biemer, P. P., & Christ, S. L. (2008). Weighting survey data. In E. D. d. Leeuw, J. J. Hox & D. D. Dillman (Eds.), *International handbook of survey methodology*. New York: Psychology Press.

Blake, M. (2012). Psychology and psychiatry: Rotten to the core. Retrieved November 28, 2012, from http://www.prophezine.com/index.php?option=com_content&view=article&id=665:psychology-and-psychiatry-rotten-to-the-core&catid=41:top-headlines

Block, J. H., Gjerde, P. F., & Block, J. H. (1991). Personality antecedents of depressive tendencies in 18-year-olds: A prospective study. *Journal of Personality and Social Psychology, 60*, 726-738. doi: 10.1037//0022-3514.60.5.726

Boomsma, D. I., de Geus, E. J. C., van Baal, G. C. M., & Koopmans, J. R. (1999). A religious upbringing reduces the influence of genetic factors on disinhibition: Evidence for interaction between genotype and environment on personality. *Twin Research, 2*, 115-125. doi: 10.1375/136905299320565988

Borders, T. F., Curran, G. M., Mattox, R., & Booth, B. M. (2010). Religiousness among at-risk drinkers: Is it prospectively associated with the development or maintenance of an alcohol-use disorder? *Journal of Studies on Alcohol and Drugs, 71*, 136-142.

Borras, L., Khazaal, Y., Khan, R., Mohr, S., Kaufmann, Y.-A., Zullino, D., & Huguelet, P. (2010). The relationship between addiction and religion and its possible implication for care. *Substance Use & Misuse, 45*, 2357-2410.

Borras, L., Mohr, S., Gillieron, C., Brandt, P.-Y., Rieben, I., Leclere, C., & Huguelet, P. (2010). Religion and spirituality: How clinicians in Quebec and Geneva cope with the issue when faced with patients suffering from chronic psychosis. *Community Mental Health Journal, 46*, 77-86. doi: 10.1007/s10597-009-9247-y

Bosworth, H. B., Park, K. S., McQuoid, D. R., Hays, J. C., & Steffens, D. C. (2003). The impact of religious practice and religious coping on geriatric depression. *International Journal of Geriatric Psychiatry, 18*, 905-914. doi: 10.1002/gps.945

Bottoms, B. L., Nielsen, M., Murray, R., & Filipas, H. (2003). Religion-related child physical abuse: Characteristics and psychological outcomes. *Journal of Aggression, Maltreatment and Trauma, 8*, 87-114. doi: 10.1300/J146v08n01_04

Bottoms, B. L., Shaver, P. R., Goodman, G. S., & Qin, J. (1995). In the name of God: A profile of religion-related child abuse. *Journal of Social Issues, 51*, 85-111. doi: 10.1111/j.1540-4560.1995.tb01325.x

Bowlby, J. (1977). The making and breaking of affectional bonds: I. Aetiology and psychopathology in the light of attachment theory. *British Journal of Psychiatry, 130*, 201-210. doi: 10.1192/bjp.130.3.201

Bowling, A. (2005). Just one question: If one question works, why ask several? *Journal of Epidemiology & Community Health, 59*, 342-345. doi: 10.1136/jech.2004.021204

Boyce, P., Parker, G., Barnett, B., Cooney, M., & Smith, F. (1991). Personality as a vulnerability factor to depression. *British Journal of Psychiatry, 159*, 106-114. doi: 10.1192/bjp.159.1.106

Braam, A. W., Hein, E., Deeg, D. J. H., Twisk, J. W. R., Beekman, A. T. F., & van Tilburg, W. (2004). Religious involvement and 6-year course of depressive symptoms in older Dutch citizens: Results from the longitudinal aging study Amsterdam. *Journal of Aging & Health, 16*, 467 - 489. doi: 10.1177/0898264304265765

Brandt, M. J., & Reyna, C. (2010). The role of prejudice and the need for closure in religious fundamentalism. *Personality & Social Psychology Bulletin, 36*, 715-725. doi: 10.1177/0146167210366306

Bray, J. (2010). Religiosity gap in psychiatry [letter]. *The Psychiatrist, 34*, 163 - 164. doi: 10.1192/pb.34.4.163b

Brechting, E. H., & Giancola, P. R. (2006). A longitudinal study of coping strategies and substance use in adolescent boys. *Journal of Child & Adolescent Substance Abuse, 16*, 51-65. doi: 10.1300/J029v16n02_03

Broger, B., & Zeni, M. B. (2005). Fathers' coping mechanisms related to parenting a chronically ill child: Implications for advanced practice nurses. *Journal of Pediatric Health Care, 28*, 83-95. doi: 10.1080/01460860590950863

Bronfenbrenner, U., & Ceci, S. J. (1994). Nature-nurture reconceptualized in developmental perspective: A bioecological model. *Psychological Review, 101*, 568-586.

Brosschot, J. F., Gebhardt, W. A., & Godaert, G. L. R. (1994). Internal, powerful others and chance locus of control: Relationships with personality, coping, stress and health.

Personality & Individual Differences, 16, 839-852. doi: 10.1016/0191-8869(94)90228-3

Brown, S. L., Nesse, R. M., House, J. S., & Utz, R. L. (2004). Religion and emotional compensation: Results from a prospective study of widowhood. *Personality & Social Psychology Bulletin, 30*, 1165-1174. doi: 10.1177/0146167204263752

Brown, S. L., Nesse, R. M., Vinokur, A. D., & Smith, D. M. (2003). Providing social support may be more beneficial than receiving it: Results from a prospective study of mortality. *Psychological Science, 14*, 320-327. doi: 10.1111/1467-9280.14461

Browne, M. A. (2006). Lifetime prevalence and lifetime risk of DSM-IV disorders. In M. A. O. Browne, J. E. Wells & K. M. Scott (Eds.), *Te Rau Hinengaro: The New Zealand mental health survey* (pp. 58-72). Wellington: Ministry of Health.

Bulkley, E. (1994). *Why Christians can't trust psychology*. Eugene, OR: Harvest House.

Bunevicius, A., Katkute, A., & Bunevicius, R. (2008). Symptoms of anxiety and depression in medical students and in humanities students: Relationship with big-five personality dimensions and vulnerability to stress. *International Journal of Social Psychiatry, 54*, 494-501. doi: 10.1177/0020764008090843

Cabin, R. J., & Mitchell, R. J. (2000). To Bonferroni or not to Bonferroni: When and how are the questions. *Bulletin of the Ecological Society of America, 81*, 246-248.

Calvert, S. (2010). *Attachment to God as a source of struggle and strength: Exploring the association between Christians' relationship with God and their emotional wellbeing.* (PhD dissertation), Massey University, Auckland, New Zealand.

Capital and Coast District Health Board. (2009). *Tikanga Guidelines.* Wellington, New Zealand: Author. Retrieved from http://www.ccdhb.org.nz/patient/docs/Tikanga_Guidelines_Jan09.pdf.

Carlson, E. A. (1998). A prospective longitudinal study of attachment disorganization/disorientation. *Child Development, 69*, 1107-1128. doi: 10.2307/1132365

Carone, D. A. J., & Barone, D. F. (2001). A social cognitive perspective on religious beliefs: Their functions and impact on coping and psychotherapy. *Clinical Psychology Review, 21*, 989-1003. doi: 10.1016/S0272-7358(00)00078-7

Carrier, R. (2005). *Sense and goodness without God: a defense of metaphysical naturalism*. Bloomington, IN: AuthorHouse.

Carroll, C. D. (2006). Convergence of service, policy, and science toward consumer-driven mental health care. *Journal of Mental Health Policy & Economics, 9*, 185-192.

Carter, P. (2008). Religion, psychiatry and professional boundaries [letter]. *Psychiatric Bulletin, 32*, 356 - 357. doi: 10.1192/pb.32.9.357b

Cederblad, M., Dahlin, L., Hagnell, O., & Hansson, K. (1995). Coping with life span crises in a group at risk of mental and behavioural disorders: From the Lundby study. *Acta Psychiatrica Scandinavia, 91*, 322-330. doi: 10.1111/j.1600-0447.1995.tb09789.x

Cervera, S., Lahortiga, F., Martinez-Gonzalez, M. A., Gual, P., De Irala-Estevez, J., & Alonso, Y. (2003). Neuroticism and low self-esteem as risk factors for incident eating disorders in a prospective cohort study. *International Journal of Eating Disorders, 33*, 271-280. doi: 10.1002/eat.10147

Chamberlain, J. (2005). User/consumer involvement in mental health service delivery. *Epidemiologia e Psichiatria Sociale, 14*, 10-14. doi: 10.1017/S1121189X00001871

Chan, C. S., Rhodes, J. E., & Perez, J. E. (2012). A prospective study of religiousness and psychological distress among female survivors of hurricanes Katrina and Rita. *American Journal of Community Psychology, 49*, 168-181. doi: 10.1007/s10464-011-9445-y

Chesner, S. P., & Baumeister, R. F. (1985). Effect of therapist's disclosure of religious beliefs on the intimacy of client self-disclosure. *Journal of Social & Clinical Psychology, 3*, 97-105. doi: 10.1521/jscp.1985.3.1.97

Chief Advisor Tikanga. (2003). *Board Guidelines: Tikanga Recommended Best Practice*. Auckland District Health Board. Retrieved from http://www.adhb.govt.nz/researchoffice/mrrc/tikanga_-_rbp.html.

Chubb, N. H. (1993). *Adolescent self-esteem and locus-of-control: A longitudinal study of gender differences and predictors of college plans and affect.* (PhD dissertation), University of Pittsburgh, PA.

Cigrang, J. A., Hryshoko-Mullen, A., & Peterson, A. L. (2003). Spontaneous reports of religious coping by patients with chronic physical illness. *Journal of Clinical Psychology in Medical Settings, 10*, 133-137.

Cobb, S. (1976). Social support as a moderator of life stress. *Psychosomatic Medicine, 38*, 300-314.

Cohen, A. B. (2009). Many forms of culture. *American Psychologist, 64*, 194-204. doi: 10.1037/a0015308

Cohen, J. (1983). The cost of dichotomization. *Applied Psychological Measurement, 7*, 249-253. doi: 10.1177/014662168300700301

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Mahwah, NJ: Erlbaum.

Cohen, S., & Wills, T. A. (1985). Stress, social support, and the buffering hypothesis. *Psychological Bulletin, 98*, 310-357. doi: 10.1037//0033-2909.98.2.310

Constantine, M. G. (2000). Social desirability attitudes, sex, and affective and cognitive empathy as predictors of self-reported multicultural counseling competence. *The Counseling Psychologist, 28*, 857-872. doi: 10.1177/0011000000286008

Constantine, M. G. (2002). Predictors of satisfaction with counseling: Racial and ethnic minority clients' attitudes toward counseling and ratings of their counselors' general and multicultural counseling competence. *Journal of Counseling Psychology, 49*, 255-263. doi: 10.1037//0022-0167.49.2.255

Constantine, M. G., & Ladany, N. (2000). Self-report multicultural conseling competence scales: Their relation to social desirability attitudes and multicultural case conceptualization ability. *Journal of Counseling Psychology, 47*, 155-164. doi: 10.1037//0022-0167.47.2.155

Cook, C. C. H., Powell, A., Sims, A., & Eagger, S. (2011). Spirituality and secularity: Professional boundaries in psychiatry. *Mental Health, Religion & Culture, 14*, 35-42. doi: 10.1080/13674676.2010.484935

Coyle, A., & Lochner, J. (2011). Religion, spirituality and therapeutic practice. *The Psychologist, 24*, 264-266.

Cronin, C., & Zuckerman, M. (1992). Sensation seeking and bipolar affective disorder. *Personality and Individual Differences, 13*, 385-387. doi: 10.1016/0191-8869(92)90121-5

Crossley, J. P., & Salter, D. P. (2005). A question of finding harmony: A grounded theory study of clinical psychologists' experience of addressing spiritual beliefs in therapy. *Psychology and Psychotherapy: Theory, Research, and Practice, 78*, 295-313. doi: 10.1348/147608305X26783

D'Andrea, M., Daniels, J., & Heck, R. (1991). Evaluating the impact of multicultural counseling training. *Journal of Counseling & Development, 70*, 143-150. doi: 10.1002/j.1556-6676.1991.tb01576.x

D'Souza, R. (2002). Do patients expect psychiatrists to be interested in spiritual issues? *Australasian Psychiatry, 10*, 44-47. doi: 10.1046/j.1440-1665.2002.00391.x

D'Souza, R. F., & Rodrigo, A. (2004). Spiritually augmented cognitive behavioural therapy. *Australasian Psychiatry, 12*, 148-152. doi: 10.1111/j.1039-8562.2004.02095.x

Dalgard, O. S., & Haheim, L. L. (1998). Psychosocial risk factors and mortality: A prospective study with special focus on social support, social participation, and locus of control in Norway. *Journal of Epidemiology & Community Health, 52*, 476-481. doi: 10.1136/jech.52.8.476

de Beer, W. A. (1998). *The 'religiosity gap': A New Zealand perspective.* (Royal Australian & New Zealand College of Psychiatrists, Section II Dissertation), Health Waikato, Hamilton, New Zealand.

Dein, S., Cook, C. C. H., Powell, A., & Eagger, S. (2010). Religion, spirituality and mental health. *The Psychiatrist, 34*, 63-64. doi: 10.1192/pb.bp.109.025924

Delaney, H. D., Miller, W. R., & Bisono, A. M. (2007). Religiosity and spirituality among psychologists: A survey of clinician members of the American Psychological Association. *Professional Psychology: Research and Practice, 38*, 538-546. doi: 10.1037/0735-7028.38.5.538

Delgado, C. (2007). Sense of coherence, spirituality, stress and quality of life in chronic illness. *Journal of Nursing Scholarship, 39*, 229-234. doi: 10.1111/j.1547-5069.2007.00173.x

Demmer, C. (2007). Coping with AIDS-related bereavement in KwaZulu-Natal, South Africa. *AIDS Care, 19*, 866-870. doi: 10.1080/09540120601090446

Denny, R. M., Aten, J. D., & Gingrich, F. C. (2008). Using spiritual self-disclosure in psychotherapy. *Journal of Psychology & Theology, 36*, 294-302.

Desai, K. M. (2006). *Predictors of growth and decline following spiritual struggles.* (Masters thesis), Bowling Green State University, OH.

Divett, D. (2011). *Refocussing and God Spaces: A holistic counselling theory and practice*. Saarbrücken, Germany: Lambert Academic Publishing.

Dougherty, S. G., & Worthington, E. L. (1982). Preferences of conservative and moderate Christians for four Christian counselors' treatment plans. *Journal of Psychology & Theology, 10*, 346-354.

Dudley, R., & Kuyken, W. (2006). Formulation in cognitive-behavioural therapy. In L. Johnstone & R. Dallos (Eds.), *Formulation in psychology and psychotherapy: Making sense of people's problems* (pp. 17-46). East Sussex, UK: Routledge.

Duncan, B. L., Miller, S. D., Sparks, J. A., Claud, D. A., Reynolds, L. R., Brown, J., & Johnson, L. D. (2003). The session rating scale: Preliminary psychometric properties of a 'working' alliance measure. *Journal of Brief Therapy, 3*, 3-12.

Durà-Vilà, G., & Dein, S. (2009). The dark night of the soul: Spiritual distress and its psychiatric implications. *Mental Health, Religion & Culture, 12*, 543-559. doi: 10.1080/13674670902858800

Durà-Vilà, G., Hagger, M., Dein, S., & Leavey, G. (2011). Ethnicity, religion and clinical practice: A qualitative study of beliefs and attitudes of psychiatrists in the United Kingdom. *Mental Health, Religion & Culture, 14*, 53-64. doi: 10.1080/13674676.2010.495111

Durie, M. (1994). *Whaiaora: Māori health development*. Auckland, New Zealand: Oxford University Press.

Dyslin, C. W., & Thomsen, C. J. (2005). Religiosity and risk of perpetuating child physical abuse: An empirical investigation. *Journal of Psychology & Theology, 33*, 291-298.

Edbom, T., Malmberg, K., Lichtenstein, P., Granlund, M., & Larsson, J.-O. (2010). High sense of coherence in adolescence is a protective factor in the longitudinal development of ADHD symptoms. *Scandinavian Journal of Caring Sciences, 24*, 541-547. doi: 10.1111/j.1471-6712.2009.00746.x

Edwards, L. C., Lim, B. R. K. B., McMinn, M. R., & Dominguez, A. W. (1999). Examples of collaboration between psychologists and clergy. *Professional Psychology: Research and Practice, 30*, 547-551. doi: 10.1037//0735-7028.30.6.547

Egan, R. (2009). *Spirituality in New Zealand hospice care.* (Doctor of Philosophy), Otago University, Dunedin, New Zealand.

Egan, R., MacLeod, R., Jaye, C., McGee, R., Baxter, J., & Herbison, P. (2011). What is spirituality? Evidence from a New Zealand hospice study. *Mortality, 16*, 307-324. doi: 10.1080/13576275.2011.613267

Elliott, C. H., & Lassen, M. K. (1997). A schema polarity model for case conceptualisation, intervention, and research. *Clinical Psychology: Science and Practice, 4*, 12-28. doi: 10.1111/j.1468-2850.1997.tb00095.x

Ellis, A. (1980). Psychotherapy and atheistic values: A response to A. E. Bergin's 'psychotherapy and religious values'. *Journal of Consulting & Clinical Psychology, 48*, 635-639. doi: 10.1037//0022-006X.48.5.635

Ellis, A. (2000). Can rational emotive behavior therapy (REBT) be effectively used with people who have devout beliefs in God and religion? *Professional Psychology: Research and Practice, 31*, 29-33. doi: 10.1037//0735-7028.31.1.29

Ellis, A., & Murray, J. G. (1980). *Case against religion: A psychotherapist's view and the case against religiosity* New York, NY: American Atheist Press.

Ellis, A., & Schoenfeld, E. (1990). Divine intervention and the treatment of chemical dependency. *Journal of Substance Abuse, 2*, 459-468. doi: 10.1016/S0899-3289(12)80006-X

Ellison, C. G., & Flannelly, K. J. (2009). Religious involvement and risk of major depression in a prospective nationwide study of African American adults. *Journal of Nervous & Mental Disease, 197*, 568-573. doi: 10.1097/NMD.0b013e3181b08f45

Ellison, C. G., & Lee, J. (2010). Spiritual struggles and psychological distress: Is there a dark side of religion? *Social Indicators Research, 98*, 501-517. doi: 10.1007/s11205-009-9553-3

Ellison, C. G., Musick, M., Levin, J., Taylor, R., & Chatters, L. (1997, August). *The effects of religious attendance, guidance, and support on psychological distress: Longitudinal findings from the National Survey of Black Americans*. Paper presented at the Annual Meetings of the Society for the Scientific Study of Religion, San Diego, CA.

Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science, 196*, 129-136. doi: 10.1126/science.847460

Enthoven, A. C., & Eccles, M. S. (2002). *Introducing market forces into health care: A tale of two countries.* Paper presented at the Fourth European Conference on Health Economics, Paris.

Ethics Committee of the British Psychological Society. (2009). *Code of ethics and conduct*. Leicester, UK: British Psychological Society.

Eysenck, M. W. (2001). *Principles of cognitive psychology* (2nd ed.). East Sussex, UK: Psychology Press.

Fallot, R. D. (1998). Spiritual and religious dimensions of mental illness recovery narratives. In R. D. Fallot (Ed.), *Spirituality and religion in recovery from mental illness* (Vol. 80, pp. 35-44). San Francisco, CA: Jossey-Bass.

Fallot, R. D. (2001). Spirituality and religion in psychiatric rehabilitation and recovery from mental illness. *International Review of Psychiatry, 13*, 110-116. doi: 10.1080/09540260120037344

Fallot, R. D., & Heckman, J. P. (2005). Religious/spiritual coping among women trauma survivors with mental health and substance use disorders. *Journal of Behavioral Health Services & Research, 32*, 215-226. doi: 10.1007/BF02287268

Field, A. (2009). *Discovering statistics using SPSS* (3rd ed.). London, UK: Sage.

Finch, W. H. (2010). Imputation methods for missing categorical questionnaire data: A comparison of approaches. *Journal of Data Science, 8*, 361-378.

Fiori, K. L., Brown, E. E., Cortina, K. S., & Antonucci, T. C. (2006). Locus of control as a mediator of the relationship between religiosity and life satisfaction: Age, race, and gender differences. *Mental Health, Religion & Culture, 9*, 239-263. doi: 10.1080/13694670600615482

Fischer, A. R., Jome, L. M., & Atkinson, D. R. (1998a). Back to the future of multicultural psychotherapy with a common factors approach. *The Counseling Psychologist, 26*, 602-606. doi: 10.1177/0011000098264004

Fischer, A. R., Jome, L. M., & Atkinson, D. R. (1998b). Reconceptualizing multicultural counseling: Universal healing conditions in a culturally specific context. *The Counseling Psychologist, 26*, 525-588. doi: 10.1177/0011000098264001

Fisher, R. M. (1999). *Patriarchy and punitiveness: Spouse abuse and protestant fundamentalism*. (PhD dissertation), The University of Nebraska, Lincoln.

Fitchett, G., Burton, L. A., & Sivan, A. B. (1997). The religious needs and resources of psychiatric inpatients. *Journal of Nervous & Mental Disease, 185*, 320-326. doi: 10.1097/00005053-199705000-00006

Flannery, R. B., & Flannery, G. J. (1990). Sense of coherence, life stress, and psychological distress: A prospective methodological inquiry. *Journal of Clinical Psychology, 46*, 415-420. doi: 10.1002/1097-4679(199007)46:4<415::AID-JCLP2270460407>3.0.CO;2-A

Frank, J. D. (1971). Therapeutic factors in psychotherapy. *American Journal of Psychotherapy, 25*, 350-361.

Frank, J. D., & Frank, J. B. (1991). *Persuasion and healing: A comparative study of psychotherapy*. Baltimore, MD: Johns Hopkins University Press.

Frazier, R. E., & Hansen, N. D. (2009). Religious/spiritual psychotherapy behaviors: Do we do what we believe to be important? *Professional Psychology: Research and Practice, 40*, 81-87. doi: 10.1037/a0011671

Frese, F. J., & Davis, W. W. (1997). The consumer-survivor movement, recovery, and consumer professionals. *Professional Psychology: Research and Practice, 28*, 243-245. doi: 10.1037//0735-7028.28.3.243

Freud, S. (2012 [1927]). *The future of an illusion* (G. C. Richter, Trans.). Peterborough, ON, Canada: Broadview.

Fuertes, J. N., Stracuzzi, T. I., Bennett, J., Scheinholtz, J., Mislowack, A., Hersh, M., & Cheng, D. (2006). Therapist multicultural competency: A study of therapy dyads. *Psychotherapy: Theory, Research, Practice, Training, 43*, 480-490. doi: 10.1037/0033-3204.43.4.480

Galanter, M. (1990). Cults and zealous self-help movements: A psychiatric perspective. *American Journal of Psychiatry, 5*, 543-551.

Galea, M. (2008). The impact of child abuse on the psycho-spiritual and religious status of Maltese college students. *Pastoral Psychology, 57*, 147-159. doi: 10.1007/s11089-008-0159-5

Galek, K., Krause, N., Ellison, C. G., Kudler, T., & Flannelly, K. J. (2007). Religious doubt and mental health across the lifespan. *Journal of Adult Development, 14*, 16-25. doi: 10.1007/s10804-007-9027-2

Gall, T. L. (2006). Spirituality and coping with life stress among adult survivors of childhood sexual abuse. *Child Abuse & Neglect, 30*, 826-844. doi: 10.1016/j.chiabu.2006.01.003

Gall, T. L., Basque, V., Damasceno-Scott, M., & Vardy, G. (2007). Spirituality and the current adjustment of adult survivors of childhood sexual abuse. *Journal for the Scientific Study of Religion, 46*, 101-117. doi: 10.1111/j.1468-5906.2007.00343.x

Gallup. (2012). Gallup WorldView. Retrieved 11th December, 2012, from https://worldview.gallup.com/default.aspx

Gamst, G., Dana, R. H., Der-Karabetian, A., Aragon, M., Arellano, L., Morrow, G., & Martenson, L. (2004). Cultural competency revised: The California brief multicultural competence scale. *Measurement and Evaluation in Counseling and Development, 37*, 163-183.

Gannoway, M. (1996). Delivery of therapy to religious individuals by religious and nonreligious therapists. *Journal of Psychological Practice, 2*, 31-39.

Gearing, R. E., Alonzo, D., Smolak, A., McHugh, K., Harmon, S., & Baldwin, S. (2010). Association of religion with delusions and hallucinations in the context of schizophrenia: Implications for engagement and adherence. *Schizophrenia Research, 126*, 150-163. doi: 10.1016/j.schres.2010.11.005

George, L. K., Ellison, C. G., & Larson, D. B. (2002). Explaining the relationships between religious involvement and health. *Psychological Inquiry, 13*, 190-200. doi: 10.1207/S15327965PLI1303_04

Gergen, K. J. (2009). *An invitation to social constructionism* (2nd ed.). London, UK: Sage.

Gibson, L. M. (2003). Inter-relationships among sense of coherence, hope, and spiritual perspective (inner resources) of African-American and European-American breast cancer suvivors. *Applied Nursing Research, 16*, 236-244. doi: 10.1016/S0897-1897(03)00053-3

Giglio, J. (1993). The impact of patients' and therapists' religious values on psychotherapy. *Hospital & Community Psychiatry, 44*, 768-771.

Ginsburg, M. L., Quirt, C., Ginsburg, A. D., & MacKillip, W. J. (1995). Psychiatric illness and psychosocial concerns of patients with newly diagnosed lung cancer. *Canadian Medical Association Journal, 152*, 701-708.

Glass, C. R., Arnkoff, D. B., & Shapiro, S. J. (2001). Expectations and preferences. *Psychotherapy, 38*, 455-462. doi: 10.1037//0033-3204.38.4.455

Gockel, A. (2011). Client perspectives on spirituality in the therapeutic relationship. *The Humanistic Psychologist, 39*, 154-168. doi: 10.1080/08873267.2011.564959

Goedde, C. (2000). *A qualitative study of the client's perspectives of discussing spiritual and religious issues in therapy.* (Psy.D dissertation), California School of Professional Psychology, San Diego, CA.

Goldenberg, H., & Goldenberg, I. (2012). *Family therapy: An overview* (8th ed.). Florence, KY: Cengage.

Gonsiorek, J. C., Richards, P. S., Pargament, K. I., & McMinn, M. R. (2009). Ethical challenges and opportunities at the edge: Incorporating spirituality and religion into psychotherapy. *Professional Psychology: Research and Practice, 40*, 385-395. doi: 10.1037/a0016488

Good, M., & Willoughby, T. (2011). Evaluating the direction of effects in the relationship between religious versus non-religious activities, academic success, and substance use. *Journal of Youth & Adolesence, 40*, 680-693. doi: 10.1007/s10964-010-9581-y

Gordon, T., Kelly, E., & Mitchell, D. (2011). *Spiritual care for healthcare professionals*. London, UK: Radcliffe.

Granqvist, P. (2006). On the relation between secular and divine relationships: An emerging attachment perspective and a critique of the 'depth' approaches. *International*

Journal for the Psychology of Religion, 16, 1-18. doi: 10.1207/s15327582ijpr1601_1

Granqvist, P., & Hagekull, B. (2003). Longitudinal predictions of religious change in adolescence: Contributions from the interaction of attachment and relationship status. *Journal of Social & Personal Relationships, 20*, 793-817. doi: 10.1177/0265407503206005

Granqvist, P., & Kirkpatrick, L. A. (2004). Religious conversion and perceived childhood attachment: A meta-analysis. *The International Journal for the Psychology of Religion, 14*, 223-250. doi: 10.1207/s15327582ijpr1404_1

Granqvist, P., & Kirkpatrick, L. A. (2008). Attachment and religious representations and behavior. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (2nd ed., pp. 906 - 933). New York, NY: Guilford.

Granqvist, P., Mikulincer, M., & Shaver, P. R. (2010). Religion as attachment: Normative processes and individual differences. *Personality & Social Psychology Review, 14*, 49-59. doi: 10.1177/1088868309348618

Green, J. E., Gardner, F. M., & Kippen, S. A. (2009). Healing of the soul: The role of spirituality in recovery from mental illness. *The International Journal of Psychosocial Rehabilitation, 13*, 65-75.

Greenberg, R. P. (1969). Effects of pression information on perception of the therapist and receptivity to influence in a psychotherapy analogue. *Journal of Consulting & Clinical Psychology, 33*, 425-429.

Greenberg, R. P., Constantino, M. J., & Bruce, N. (2006). Are patient expectations still relevant for psychotherapy process and outcome? *Clinical Psychology Review, 26*, 657-678. doi: 10.1016/j.cpr.2005.03.002

Griffith, J. L., & Griffith, M. E. (2002). *Encountering the sacred in psychotherapy: How to talk with people about their spiritual lives*. New York, NY: Guilford Press.

Gunnoe, M. L., Hetherington, E. M., & Reiss, D. (1999). Parental religiosity, parenting style, and adolescent social responsibility. *The Journal of Early Adolescence, 19*, 199-225. doi: 10.1177/0272431699019002004

Gwaltney, C. J., Shields, A. L., & Shiffman, S. (2008). Equivalence of electronic and paper-and-pencil administration of patient-reported outcome measures: A meta-analytic review. *Value in Heath, 11*, 322-333. doi: 10.1111/j.1524-4733.2007.00231.x

Haarhoff, B., Gibson, K., & Flett, R. (2011). Improving the quality of cognitive behaviour therapy case conceptualization: The role of self-practice/self-reflection. *Behavioural & Cognitive Psychotherapy, 39*, 323-339. doi: 10.1017/S1352465810000871

Hackney, C. H., & Sanders, G. S. (2003). Religiosity and mental health: A meta-analysis of recent studies. *Journal for the Scientific Study of Religion, 42*, 43-55. doi: 0.1111/1468-5906.t01-1-00160

Hage, S. M. (2006). A closer look at the role of spirituality in psychology training programs. *Professional Psychology: Research and Practice, 37*, 303-310. doi: 10.1037/0735-7028.37.3.303

Hankin, B. L. (2005). Childhood maltreatment and psychopathology: Prospective tests of attachment, cognitive vulnerability, and stress as mediating processes. *Cognitive Therapy & Research, 29*, 645-671. doi: 10.1007/s10608-005-9631-z

Hankin, B. L., Kassel, J. D., & Abela, J. R. Z. (2005). Adult attachment dimensions and specificity of emotional distress symptoms: Prospective investigations of cognitive risk and interpersonal stress generation as mediating mechanisms. *Personality & Social Psychology Bulletin, 31*, 136-151. doi: 10.1177/0146167204271324

Hansen, N. D., Randazzo, K. V., Schwartz, A., Marshall, M., Kalis, D., Frazier, R., . . . Norvig, G. (2006). Do we practice what we preach? An exploratory survey of

multicultural psychotherapy competencies. *Professional Psychology: Research and Practice, 37*, 66-74. doi: 10.1037/0735-7028.37.1.66

Hanson, B. S., Isacsson, S.-O., Janzon, L., & Lindell, S.-E. (1989). Social network and social support influence mortality in elderly men. The prospective population study of 'men born in 1914', Malmo, Sweden. *American Journal of Epidemiology, 130*, 100-111.

Hanson, J. (2005). Should your lips be zipped? How therapist self-disclosure and non disclosure affects clients. *Counseling & Psychotherapy Research, 5*, 96-104. doi: 10.1080/17441690500226658

Hardy, M. A. (1993). *Regression with dummy variables*. Newbury Park, CA: Sage.

Harrow, M., Hansford, B. G., & Astrachan-Fletcher, E. B. (2008). Locus of control: Relation to schizophrenia, to recovery, and to depression and psychosis - A 15-year longitudinal study. *Psychiatry Research, 168*, 186-192. doi: 10.1016/j.psychres.2008.06.002

Hartog, K., & Gow, K. M. (2005). Religious attributions pertaining to the causes and cures of mental illness. *Mental Health, Religion & Culture, 8*, 263-276. doi: 10.1080/13674670412331304339

Harvey, P. (2000). *An introduction to Buddhist ethics*. UK: Cambridge University Press.

Hatcher, R. L. (2010). Alliance theory and measurement. In J. C. Muran & J. P. Barber (Eds.), *The therapeutic alliance: An evidence-based guide to practice* (pp. 7-28). New York, NY: Guilford Press.

Hathaway, W. L., & Ripley, J. S. (2009). Ethical concerns around spirituality and religion in clinical practice. In J. D. Aten & M. M. Leach (Eds.), *Spirituality and the therapeutic process: From intake to termination* (pp. 25-52). Washington DC: American Psychological Association.

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*, 97-104. doi: 10.1037/0735-7028.35.1.97

Havighurst, S. S., & Downey, L. (2009). Clinical reasoning for child and adolescent mental health practitioners: The mindful formulation. *Clinical Child Psychology & Psychiatry, 14*, 252-272. doi: 10.1177/1359104508100888

Hays, P. A. (2008). *Addressing cultural complexities in practice: Assessment, diagnosis, and therapy* (2nd ed.). Washington, DC: American Psychological Association.

Hays, P. A. (2009). Integrating evidence-based practice, cognitive-behavior therapy, and multicultural therapy: Ten steps for culturally competent practice. *Professional Psychology: Research and Practice, 40*, 354-360. doi: 10.1037/a0016250

Hazan, C., & Shaver, P. (1987). Romantic love conceptualized as an attachment process. *Journal of Personality & Social Psychology, 52*, 511-524. doi: 10.1037//0022-3514.52.3.511

Heaven, P. C. L., & Ciarrochi, J. (2007). Personality and religious values among adolescents: A three-wave longitudinal analysis. *British Journal of Psychology, 98*, 681-694. doi: 10.1348/000712607X187777

Heinz, A. J., Disney, E. R., Epstein, D. H., Glezen, L. A., Clark, P. I., & Preston, K. L. (2010). A focus-group study on spirituality and substance-user treatment. *Substance Use & Misuse, 45*, 134-153. doi: 10.3109/10826080903035130

Her Majesty's Government. (2012). *No health without mental health: Implementation framework*. London, UK: Department of Health.

Hera, J. (2011). Cultural competence and patient-centred care. In I. S. George (Ed.), *Cole's Medical Practice in New Zealand* (10th ed., pp. 41-47). Wellington, New Zealand: Medical Council of New Zealand.

Heubel, F. (2000). Patients or customers: Ethical limits of market economy in health care. *Journal of Medicine & Philosophy, 25*, 240-253. doi: 10.1076/0360-5310(200004)25:2;1-O;FT240

Hicks, D., & Gwynne, M. A. (1996). *Cultural anthropology* (2nd ed.). New York, NY: HarperCollins.

Hill, E., Terrell, H. K., Cohen, A. B., & Nagoshi, G. T. (2010). The role of social cognition in the religious fundamentalism-prejudice relationship. *Journal for the Scientific Study of Religion, 49*, 724-739. doi: 10.1111/j.1468-5906.2010.01542.x

Hill, L., & Smith, N. (1990). *Self-care nursing: Promotion of health* (2nd ed.). Norwalk, CT: Appleton & Lange.

Hill, P., & Hood, R. W. (1999). *Measures of religiosity*. Birmingham, AL: Religious Education Press.

Hill, P., & Pargament, K. I. (2003). Advances in the conceptualization and measurement of religion and spirituality: Implications for physical and mental health research. *American Psychologist, 58*, 64-74. doi: 10.1037/0003-066X.58.1.64

Hill, P., Pargament, K. I., Hood, R. W., McCullough, M. E., Swyers, J. P., Larson, D. B., & Zinnbauer, B. J. (2000). Conceptualizing religion and spirituality: Points of commonality, points of departure. *Journal for the Theory of Social Behaviour, 30*, 51-77. doi: 10.1111/1468-5914.00119

Hilton, C. (2008). Religion, psychiatry and professional boundaries [letter]. *Psychiatric Bulletin, 32*, 356-357. doi: 10.1192/pb.32.9.357

Hodge, D. R. (2001). Spiritual assessment: A review of major qualitative methods and a new framework for assessing spirituality. *Social Work, 46*, 203-214. doi: 10.1093/sw/46.3.203

Hodge, D. R. (2003). The intrinsic spirituality scale: A new six-item instrument for assessing the salience of spirituality as a motivational construct. *Journal of Social Service Research, 30*, 41-61. doi: 10.1300/J079v30n01_03

Hodge, D. R. (2006a). Spiritually modified cognitive therapy: A review of the literature. *Social Work, 51*, 157-166. doi: 10.1093/sw/51.2.157

Hodge, D. R. (2006b). A template for spiritual assessment: A review of the JCAHO requirements and guidelines for implementation. *Social Work, 51*, 317-326. doi: 10.1093/sw/51.4.317

Hofmann, L., & Walach, H. (2011). Spirituality and religiosity in psychotherapy - A representative survey among German psychotherapists. *Psychotherapy Research, 21*, 179-192. doi: 10.1080/10503307.2010.536595

Holahan, C. (1987). Self-efficacy, social support, and depression in aging: A longitudinal analysis. *Journal of Gerontology, 42*, 65-68. doi: 10.1093/geronj/42.1.65

Holahan, C., & Moos, R. H. (1981). Social support and psychological distress: A longitudinal analysis. *Journal of Abnormal Psychology, 90*, 365-370. doi: 10.1037//0021-843X.90.4.365

Hollins, S. (20008). Understanding religious beliefs is our business. Invited commentary on.... Religion and mental health. *Psychiatric Bulletin, 32*, 204. doi: 10.1192/pb.bp.108.021311

Homan, K. J., & Boyatzis, C. J. (2010). The protective role of attachment to God against eating disorder risk factors: Concurrent and prospective evidence. *Eating Disorders, 18*, 239-258. doi: 10.1080/10640261003719534

Hosmer, D. W., & Lemeshow, S. (1989). *Applied logistic regression*. New York, NY: Wiley.

Houts, A. C., & Graham, K. (1986). Can religion make you crazy? Impact of client and therapist religious values on clinical judgements. *Journal of Consulting & Clinical Psychology, 54*, 267-271. doi: 10.1037//0022-006X.54.2.267

Hoverd, W. J., & Sibley, C. G. (2010). Religious and denominational diversity in New Zealand 2009. *New Zealand Sociology, 25*, 59-87.

Howsepian, B. A., & Merluzzi, T. V. (2009). Religious beliefs, social support, self-efficacy and adjustment to cancer. *Psycho-Oncology, 18*, 1069-1079. doi: 10.1002/pon.1442

Huguelet, P., Mohr, S., Betrisey, C., Borras, L., Gillieron, C., Marie, A. M., . . . Brandt, P. Y. (2011). A randomized trial of spiritual assessment of outpatients with schizophrenia: patients' and clinicians' experience. *Psychiatric Services, 62*, 79-86. doi: 10.1176/appi.ps.62.1.79

Huguelet, P., Mohr, S., Borras, L., Gillieron, C., & Brandt, P.-Y. (2006). Spirituality and religious practices among outpatients with schizophrenia and their clinicians. *Psychiatric Services, 57*, 366-372. doi: 10.1176/appi.ps.57.3.366

Hussain, Z. (2010). *A gift for the bereaved parent: A remedy for grief from the Islamic perspective using quotes from the Quran and Hadith*. London, UK: Summer.

Hustoft, H., Hestad, K. A., Lien, L., Moller, P., & Danbolt, L. J. (2013). If I didn't have my faith I would have killed myself! Spiritual coping in patients suffering from schizophrenia. *International Journal for the Psychology of Religion, 23*, 126-144. doi: 10.1080/10508619.2012.688003

Hwang, W.-C. (2006). The psychotherapy adaptation and modification framework: Application to Asian Americans. *American Psychologist, 61*, 702-715. doi: 10.1037/0003-066X.61.7.702

Hyman, C., & Handal, P. J. (2006). Definitions and evaluation of religion and spirituality items by religious professionals: A pilot study. *Journal of Religion & Health, 45*, 264-282. doi: 10.1007/s10943-006-9015-z

International Social Survey Program Research Group. (2008). International social survey programme: Religion III. Retrieved 22nd June, 2010, from http://sacat.gesis.org/webview/index.jsp

Jaccard, J. (2001). *Interaction effects in logistic regression*. Thousand Oaks, CA: Sage.

James, A., & Wells, A. (2003). Religion and mental health: Towards a cognitive-behavioural framework. *British Journal of Health Psychology, 8*, 359-376. doi: 10.1348/135910703322370905

James, W. (1902). *The varieties of religious experience*. New York, NY: Random House.

Jenks, G. F. (1967). The data model concept in statistical mapping. *International Yearbook of Cartography, 7*, 186-190.

Jensen, J. P., & Bergin, A. E. (1988). Mental health values of professional therapists: A national interdisciplinary survey. *Professional Psychology: Research and Practice, 19*, 290-297. doi: 10.1037//0735-7028.19.3.290

Joint Commission on the Accreditation of Healthcare. (2008). Spiritual assessment. *Standards - Frequently asked questions.* Retrieved December 15, 2012, from http://www.jointcommission.org/standards_information/jcfaqdetails.aspx?StandardsFaqId=290&ProgramId=1

Joint Commission on the Accreditation of Healthcare. (2012a). *Comprehensive accreditation manual for behavioral health*. Oakbrook Terrace, IL: Author.

Joint Commission on the Accreditation of Healthcare. (2012b). *Hospital accreditation standards*. Oakbrook Terrace, IL: Author.

Josephson, A. M., & Peteet, J. R. (2004a). Worldview in diagnosis and case formulation. In A. M. Josephson & J. R. Peteet (Eds.), *Handbook of spirituality and worldview in clinical practice* (pp. 31-46). Alington, VA: American Psychiatric Publishing.

Josephson, A. M., & Peteet, J. R. (Eds.). (2004b). *Handbook of spirituality and worldview in clinical practice*. Washington DC: American Psychiatric Publishing.

Josephson, A. M., & Wiesner, I. S. (2004). Worldview in psychiatric assessment. In A. M. Josephson & J. R. Peteet (Eds.), *Handbook of spirituality and worldview in clinical practice*. Alington, VA: American Psychiatric Publishing.

Jung, C. (1938). *Psychology and religion*. New York, NY: Vail-Ballou.

Kane, D., Cheston, S., & Greer, J. (1993). Perceptions of God by survivors of childhood sexual abuse: An exploratory study in an underresearched area. *Journal of Psychology & Theology, 21*, 228-237.

Kark, J. D., Shemi, G., Friedlander, Y., Martin, O., Manor, O., & Blondheim, S. H. (1996). Does religious observance promote health? Mortality in secular vs. religious Kibbutzim in Israel. *American Journal of Public Health, 86*, 341-346. doi: 10.2105/AJPH.86.3.341

Kay, J. (2002). *An evaluation of clients' experiences of Refocussing Therapy.* (Masters thesis), University of Auckland, New Zealand.

Kazantzis, N., & Deane, F. P. (1998). Theoretical orientations of New Zealand psychologists: An international comparison. *Journal of Psychotherapy Integration, 8*, 97-113. doi: 10.1023/A:1023236406807

Keating, A. M., & Fretz, B. R. (1990). Christians' anticipations about counselors in response to counselor descriptions. *Journal of Counseling Psychology, 37*, 293-296. doi: 10.1037//0022-0167.37.3.293

Kelley, M. M. (2003). *Bereavement and grief related to a significant death: A psychological and theological study of attachment styles and religious coping.* (PhD dissertation), Boston University, MA.

Kelly, T. A., & Strupp, H. H. (1992). Patient and therapist values in psychotherapy: Perceived changes, assimilation, similarity, and outcome. *Journal of Consulting & Clinical Psychology, 60*, 34-40. doi: 10.1037/0022-006X.60.1.34

Kendler, K. S., Gatz, M., Gardner, C. O., & Pedersen, N. L. (2006). Personality and major depression: A Swedish longitudinal, population-based twin study. *Archives of General Psychiatry, 63*, 1113-1120. doi: 10.1001/archpsyc.63.10.1113

Kendler, K. S., Myers, J., & Prescott, C. A. (2005). Sex differences in the relationship between social support and risk for major depression: A longitudinal study of opposite-sex twin pairs. *American Journal of Psychiatry, 162*, 250-256. doi: 10.1176/appi.ajp.162.2.250

Kennedy, G. J., Kelman, H. R., Thomas, C., & Chen, J. (1996). The relation of religious preference and practice to depressive symptoms among 1,855 older adults. *Journal of Gerontology: Psychological Sciences, 51B*, 301-308. doi: 10.1093/geronb/51B.6.P301

Kersten, M. (November 21, 2010). Pike River blast: Praying for a miracle. Retrieved March 30, 2011, from http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10689122

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*, 593-602. doi: 10.1001/archpsyc.62.6.593

Kessler, R. C., Birnbaum, H., Demler, O., Falloon, I. R. H., Gagnon, E., Guyer, M., . . . Wu, E. Q. (2005). The prevalence and correlates of non-affective psychosis in the National Comorbidity Survey Replication (NCS-R). *Biological Psychiatry, 58*, 668-676. doi: 10.1016/j.biopsych.2005.04.034

Kidwai, A. R. (2012). *Daily wisdom: Selections from the Holy Qur'an*. Markfield, UK: Kube.

King, D. E., Cummings, D., & Whetstone, L. (2005). Attendance at religious services and subsequent mental health in midlife women. *International Journal of Psychiatry in Medicine, 35*, 287-297. doi: 10.2190/DEB0-B55Y-7EW6-8D7B

King Jr, R. R. (1978). Evangelical Christians and professional counseling: A conflict of values? *Journal of Psychology & Theology, 6*, 276-281.

King, M., Speck, P., & Thomas, A. (2001). The Royal Free interview for spiritual and religious beliefs: Development and validation of a self-report version. *Psychological Medicine, 31*, 1015-1023. doi: 10.1017/S0033291701004160

Kingsbury, S. J. (1987). Cognitive differences between clinical psychologists and psychiatrists. *American Psychologist, 42*, 152-156. doi: 10.1037//0003-066X.42.2.152

Kirkpatrick, L. A. (1997). A longitudinal study of changes in religious belief and behavior as a function of individual differences in adult attachment style. *Journal for the Scientific Study of Religion, 36*, 207-217. doi: 10.2307/1387553

Kirkpatrick, L. A. (1998). God as a substitute attachment figure: A longitudinal study of adult attachment style and religious change in college students. *Personality & Social Psychology Bulletin, 24*, 961-973. doi: 10.1177/0146167298249004

Kirkpatrick, L. A., & Shaver, P. R. (1992). An attachment-theoretical approach to romantic love and religious belief. *Personality & Social Psychology Bulletin, 18*, 266-275. doi: 10.1177/0146167292183002

Kirmayer, L. J., Thombs, B. D., Jurcik, T., Jarvis, G. E., & Guzder, J. (2008). Use of an expanded version of the DSM-IV outline for cultural formulation on a cultural consultation service. *Psychiatric Services, 59*, 683-686. doi: 10.1176/appi.ps.201100280

Kish, L. (1990). Weighting: Why, when, and how? A survey for surveys *Proceedings of the Section on Survey Research Methods* (pp. 121-130): American Statistical Association.

Kivimaki, M., Feldt, T., Vahtera, J., & Nurmi, J.-E. (2000). Sense of coherence and health: Evidence from two cross-lagged longitudinal samples. *Social Science & Medicine, 50*, 583-597. doi: 10.1016/S0277-9536(99)00326-3

Kline, R. B. (2011). *Principles and practice of structural equation modeling* (3rd ed.). New York, NY: Guilford Press.

Knapp, S., Lemoncelli, J., & VandeCreek, L. (2010). Ethical responses when patients' religious beliefs appear to harm their well-being. *Professional Psychology: Research and Practice, 41*, 405-412. doi: 10.1037/a0021037

Knox, S., Catlin, L., Casper, M., & Schlosser, L. Z. (2005). Addressing religion and spirituality in psychotherapy: Clients' perspectives. *Psychotherapy Research, 15*, 287-303. doi: 10503300500090894

Koch, J. R., & Ramirez, I. L. (2010). Religiosity, Christian fundamentalism, and intimate partner violence among U.S. college students. *Review of Religious Research, 51*, 402-410.

Koenig, H. G. (1999). Does religious attendance prolong survival? A six-year follow-up study of 3,968 older adults. *Journals of Gerontology - Series A Biological Sciences and Medical Sciences, 54*, 370-376. doi: 10.1093/gerona/54.7.M370

Koenig, H. G. (2007). Religion and remission of depression in medical inpatients with heart failure/pulmonary disease. *The Journal of Nervous & Mental Disease, 195*, 389-395.

Koenig, H. (2008a). Concerns about measuring 'spirituality' in research. *Journal of Nervous & Mental Disease, 196*, 349-355. doi: 10.1097/NMD.0b013e31816ff796

Koenig, H. G. (2008b). Religion and mental health: What should psychiatrists do? *Psychiatric Bulletin, 32*, 201-202. doi: 10.1192/pb.bp.108.019430

Koenig, H. G. (2012). Religious versus Conventional Psychotherapy for Major Depression in Patients with Chronic Medical Illness: Rationale, Methods, and Preliminary Results. *Depression Research and Treatment, 2012*, 11. doi: 10.1155/2012/460419

Koenig, H. G. (Ed.). (1998). *Handbook of religion and mental health*. San Diego, CA: Academic Press.

Koenig, H. G., Hays, J. C., George, L. K., Blazer, D. G., Larson, D. B., & Landerman, L. R. (1997). Modeling the cross-sectional relationships between religion, physical health, social support, and depressive symptoms. *American Journal of Geriatric Psychiatry, 5*, 131-143. doi: 10.1097/00019442-199700520-00006

Koenig, H. G., King, D. E., & Carson, V. B. (Eds.). (2012). *Handbook of religion and health* (2nd ed.). New York, NY: Oxford University Press.

Koenig, H. G., & Larson, D. B. (2001). Religion and mental health: Evidence for an association. *International Review of Psychiatry, 13*, 67-78. doi: 10.1080/09540260124661

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

Koenig, H. G., Pargament, K. I., & Nielsen, J. (1998). Religious coping and health status in medically ill hospitalized older adults. *Journal of Nervous & Mental Disease, 186*, 513-521. doi: 10.1097/00005053-199809000-00001

Koenig, H. G., Siegler, I. C., & George, L. K. (1989). Religious and non-religious coping: Impact on adaptation in later life. *Journal of Religious Gerontology, 5*, 73-94. doi: 10.1300/J491v05n04_07

Kohls, N., Walach, H., & Wirtz, M. (2009). The relationship between spiritual experiences, transpersonal trust, social support, and sense of coherence, and mental distress: A comparison of spiritually practising and non-practising samples. *Mental Health, Religion & Culture, 12*, 1-23. doi: 10.1080/13674670802087385

Koszycki, D., Raab, K., Aldosary, F., & Bradwejn, J. (2010). A multifaith spiritually based intervention for generalized anxiety disorder: A pilot randomized trial. *Journal of Clinical Psychology, 66*, 430 - 441. doi: 10.1002/jclp.20663

Kouvonen, A. M., Vaananen, A., Vahtera, J., Heponiemi, T., Koskinen, A., Cox, S. J., & Kivimaki, M. (2010). Sense of coherence and psychiatric morbidity: A 19-year register-based prospective study. *Journal of Epidemiology and Community Health, 64*, 255-261. doi: 10.1002/jclp.20663

Kramer, C. H. (2000). Revealing ourselves. In M. Baldwin (Ed.), *The use of self in therapy* (pp. 61-96). New York, NY: Haworth Press.

Krause, N. (2011). Religion and health: Making sense of a disheveled literature. *Journal of Religion & Health, 50*, 20-35. doi: 10.1007/s10943-010-9373-4

Krause, N., & Ellison, C. G. (2009). The doubting process: A longitudinal study of the precipitants and consequences of religious doubt in older adults. *Journal for the Scientific Study of Religion, 48*, 293-312. doi: 10.1111/j.1468-5906.2009.01448.x

Kuczewski, M. G. (2007). Talking about spirituality in the clinical setting: Can being professional require being personal? *The American Journal of Bioethics, 7*, 4-11. doi: 10.1080/15265160701399545

Kunda, Z. (1999). *Social cognition: Making sense of people*. Cambridge, MA: MIT Press.

Kuyken, W., Padesky, C. A., & Dudley, R. (2009). *Collaborative case conceptualization: Working effectively with clients in cognitive-behavioral therapy*. New York, NY: Guilford Press.

Kvarfordt, C. L., & Sheridan, M. J. (2009). Understanding the pathways of factors influencing the use of spiritually based interventions. *Journal of Social Work Education, 45*, 385-405. doi: 10.5175/JSWE.2009.200800071

La Torre, M. A. (2002). Spirituality and psychotherapy: An important combination. *Perspectives in Psychiatric Care, 38*, 108-110. doi: 10.1111/j.1744-6163.2002.tb00664.x

Laireiter, A.-R., & Willutzki, U. (2003). Self-reflection and self-practice in training of cognitive behaviour therapy: An overview. *Clinical Psychology & Psychotherapy, 10*, 19-30. doi: 10.1002/cpp.348

Lamb, H. R., & Bachrach, L. L. (2001). Some perspectives on deinstitutionalization. *Psychiatric Services, 52*, 1039-1045. doi: 10.1176/appi.ps.52.8.1039

Lammers, J., & Bappell, B. (2003). Consumer participation in mental health services: Looking from a consumer perspective. *Journal of Psychiatric and Mental Health Nursing, 10*, 385-392. doi: 10.1046/j.1365-2850.2003.00598.x

Lawrence, R. M., Head, J., Christodoulou, G., Andonovska, B., Karamat, S., Duggal, A., . . . Eagger, S. (2007). Clinicians' attitudes to spirituality in old age psychiatry. *International Psychogeriatrics, 19*, 962-973. doi: 10.1017/S1041610206004339

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. New York, NY: Springer.

Leach, M. M., Aten, J. D., Wade, N. G., & Hernandez, B. C. (2009). Noting the importance of spirituality during the clinical intake. In J. D. Aten & M. M. Leach (Eds.), *Spirituality and the therapeutic process: A comprehensive resource from intake to termination* (pp. 75-92). Washington DC: American Psychological Association.

Leibrich, J. (2002). Making space: Spirituality and mental health. *Mental Health, Religion & Culture, 5,* 143-162. doi: 10.1080/13674670210144095

Lepping, P. (2008). Religion, psychiatry and professional boundaries [letter]. *Psychiatric Bulletin, 32*, 357. doi: 10.1192/pb.32.9.357a

Like, R. (2001). Clinical Cultural Competency Questionnaire (CCCQ). Retrieved December 4, 2012, from http://rwjms.umdnj.edu/departments_institutes/family_medicine/chfcd/grants_projects/documents/Pretraining.pdf

Linden, S. C., Harris, M., Whitaker, C., & Healy, D. (2010). Religion and psychosis: The effects of the Welsh religious revival in 1904-1905. *Psychological Medicine, 40*, 1317-1323. doi: 10.1017/S0033291709991917

Lindenthal, J. J., Myers, J. K., Pepper, M. P., & Stern, M. S. (1970). Mental status and religious behavior. *Journal for the Scientific Study of Religion, 9*, 143-149. doi: 10.2307/1384980

Lindgren, K. N., & Coursey, C. D. (1995). Spirituality and serious mental illness: A two-part study. *Psychosocial Rehabilitation Journal, 18*, 93-111.

Liraud, F., & Verdoux, H. (2000). Which temperamental characteristics are associated with substance use in subjects with psychotic and mood disorders? *Psychiatry Research, 93*, 63-72. doi: 10.1016/S0165-1781(99)00120-1

Little, R. J., & Rubin, D. B. (1987). *Statistical analysis with missing data*. New York, NY: Wiley.

Lockenhoff, C. E., Ironson, G. H., O'Cleirigh, C., & Costa, P. T. (2009). Five-factor model personality traits, spirituality/religiousness, and mental health among people living with HIV. *Journal of Personality, 77*, 1411-1436. doi: 10.1111/j.1467-6494.2009.00587.x

Loewenthal, K. M., Cinnirella, M., Evdoka, G., & Murphy, P. (2001). Faith conquers all? Beliefs about the role of religious factors in coping with depression among different cultural-religious groups in the UK. *British Journal of Medical Psychology, 74*, 293-303. doi: 10.1348/000711201160993

Lomax, J. W., Karff, R. S., & McKenny, G. P. (2002). Ethical considerations in the integration of religion and psychotherapy: Three perspectives. *Psychiatric Clinics of North America, 25*, 547-559. doi: 10.1016/S0193-953X(01)00015-6

Lovin, R. W. (2000). *Christian ethics: An essential guide*. Nashville, TN: Abingdon Press.

Lukoff, D., & Lu, F. G. (1999). Cultural competence inclues religious and spiritual issues in clinical practice. *Psychiatric Annals, 29*, 469-472.

Magaldi-Dopman, D., & Park-Taylor, J. (2010). Sacred adolescence: Practical suggestions for psychologists working with adolescents' religious and spiritual identity. *Professional Psychology: Research and Practice, 41*, 382-390. doi: 10.1037/a0020941

Magaldi-Dopman, D., Park-Taylor, J., & Ponterotto, J. G. (2011). Psychotherapists' spiritual, religious, atheist or agnostic identity and their practice of psychotherapy: A grounded theory study. *Psychotherapy Research, 21*, 286-303. doi: 10.1080/10503307.2011.565488

Mahalik, J. R., & Kivlighan Jr., D. M. (1988). Self-help treatment for depression: Who succeeds? *Journal of Counseling Psychology, 35*, 237-242. doi: 10.1037//0022-0167.35.3.237

Manthei, R. J. (2005). What can clients tell us about seeking counselling and their experience of it? *International Journal for the Advancement of Counselling, 4*, 541-556. doi: 10.1007/s10447-005-8490-3

Martin, D. (2005). *On secularization: Towards a revised general theory*. Hants, UK: Ashgate.

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting & Clinical Psychology, 68*, 438-450. doi: 10.1037//0022-006X.68.3.438

Martinez, J. S., Smith, T. B., & Barlow, S. H. (2007). Spiritual interventions in psychotherapy: Evaluations by highly religious clients. *Journal of Clinical Psychology, 63*, 943-960. doi: 10.1002/jclp.20399

Mathieson, F., Mihaere, K., Collings, S., Dowell, A., & Stanley, J. (2012). Māori cultural adaptation of a brief mental health intervention in primary care. *Journal of Primary Health Care, 4*, 231-238.

Mattis, J. S. (2000). African American women's definitions of spirituality and religiosity. *Journal of Black Psychology, 26*, 101-122. doi: 10.1177/0095798400026001006

Mays, N., & Pope, C. (2000). Qualitative research in health care: Assessing quality in qualitative research. *British Medical Journal, 320*, 50-52.

Maydeu-Olivares, A., & Garcia-Forero, C. (2010). Goodness of fit testing. *International Encyclopedia of Education, 7*, 190-196. doi: 10.1016/B978-0-08-044894-7.01333-6

Mayers, C., Leavey, G., Vallianatou, C., & Barker, C. (2007). How clients with religious or spiritual beliefs experience psychological help-seeking and therapy: A qualitative study. *Clinical Psychology & Psychotherapy, 14*, 317-327. doi: 10.1002/cpp.542

Mazaheri, M., & Theuns, P. (2009). Effects of varying response formats on self-ratings of life-satisfaction. *Social Indicator Research, 90*, 381-395. doi: 10.1007/s11205-008-9263-2

McConnell, K. M., Pargament, K. I., Ellison, C. G., & Flannelly, K. J. (2006). Examining the links between spiritual struggles and symptoms of psychopathology in a national sample. *Journal of Clinical Psychology, 62*, 1469-1484. doi: 10.1002/jclp.20325

McCullagh, P. (1980). Regression models for ordinal data. *Journal of the Royal Statistical Society: Series B (Methodological), 42*, 109-142.

McCullough, M. E., Tsang, J.-A., & Brion, S. (2003). Personality traits in adolescence as predictors of religiousness in early adulthood: Findings from the Terman

longitudinal study. *Personality and Social Psychology Bulletin, 29*, 980-991. doi: 10.1177/0146167203253210

McCurdy, D. B. (1998). Personhood, spirituality and hope in the care of human beings with dementia. *Journal of Clinical Ethics, 9,* 81-91.

McDonald, A., Beck, R., Allison, S., & Norsworthy, L. (2005). Attachment to God and parents: Testing the correspondence vs. compensation hypotheses. *Journal of Psychology & Christianity, 24*, 21-28.

McIntosh, D. N., Silver, R. C., & Wortman, C. B. (1993). Religion's role in adjustment to a negative life event: Coping with the loss of a child. *Journal of Personality & Social Psychology, 65*, 812-821. doi: 10.1037//0022-3514.65.4.812

McMinn, M. R. (1984). Religious values and client-therapist matching in psychotherapy. *Journal of Psychology and Theology, 12*, 24-33.

McMinn, M. R., Aikins, D. C., & Lish, R. A. (2003). Basic and advanced competence in collaborating with clergy. *Professional Psychology: Research and Practice, 34*, 197-202. doi: 10.1037/0735-7028.34.2.197

Menard, S. (2002). *Applied logistic regression analysis* (2nd ed.). Thousand Oaks, CA: Sage.

Mendes de Leon, C. F., Seeman, T. E., Baker, D. I., Richardson, E. D., & Tinetti, M. E. (1996). Self-efficacy, physical decline, and change in functioning in community-living elders: A prospective study. *The Journals of Gerontology: Social Sciences, 51*, S183-S190. doi: 10.1093/geronb/51B.4.S183

Menezes, A., & Moreira-Almeida, A. (2010). Religion, spirituality, and psychosis. *Current Psychiatry Reports, 12*, 174-179. doi: 10.1007/s11920-010-0117-7

Meredith, P., Murray, J., Wilson, T., Mitchell, G., & Hutch, R. (2012). Can spirituality be taught to health care professionals? *Journal of Religion & Health, 51*, 879-889. doi: 10.1007/s10943-010-9399-7

Meyer, J. (2004). *The secret power of speaking God's word*. New York, NY: Warner Faith.

Miller, C., & Hedges, D. W. (2008). Scrupulosity disorder: An overview and introductory analysis. *Journal of Anxiety Disorders, 22*, 1042-1058. doi: 10.1016/j.janxdis.2007.11.004

Miller, G. (2003). *Incorporating spirituality into counseling and psychotherapy*. New York, NY: Wiley.

Miller, L., & Kelley, B. S. (2008). Relationships of religiosity and spirituality with mental health and psychopathology. In R. F. Paloutzian & C. L. Park (Eds.), *Handbook of the psychology of religion and spirituality* (pp. 460-478). New York, NY: Guilford Press.

Miller, W. R., & Rollnick, S. (2013). *Motivational interviewing: Helping people change* (3rd ed.). New York, NY: Guilford Press.

Miller, W. R., & Thoresen, C. E. (2003). Spirituality, religion, and health: An emerging research field. *American Psychologist, 58*, 24-35. doi: 10.1037/0003-066X.58.1.24

Millon, T. (2004). *Masters of the mind: Exploring the story of mental illness from ancient times to the new millennium*. Hoboken, NJ: John Wiley & Sons.

Ministry of Health. (1995). *A guide to effective consumer participation in mental health services*. Wellington, New Zealand: Author.

Ministry of Health. (2002). *He Korowai Oranga: Māori Health Strategy*. Wellington, New Zealand: Author.

Ministry of Health. (2006). *Whakatataka Tuarua: Māori Health Action Plan 2006 - 2011*. Wellington, New Zealand: Author.

Ministry of Health. (2010a). *Mental health: Service use in New Zealand 2007/08*. Wellington, New Zealand: Author.

Ministry of Health. (2010b). Mental health: Service use in New Zealand 2007/08 tables. Retrieved 16 March, 2012, from http://www.health.govt.nz/system/files/documents/publications/mh2007-08-app-final.xls

Mitchell, J. R., & Baker, M. C. (2000). Religious commitment and the construal of sources of help for emotional problems. *British Journal of Medical Psychology, 73*, 289-301. doi: 10.1348/000711200160471

Mohr, S., Borras, L., Betrisey, C., Pierre-Yves, B., Gillieron, C., & Huguelet, P. (2010). Delusions with religious content in patients with psychosis: How they interact with spiritual coping. *Psychiatry, 73*, 158-172. doi: 10.1521/psyc.2010.73.2.158

Mohr, S., Perroud, N., Gillieron, C., Brandt, P.-Y., Rieben, I., Borras, L., & Huguelet, P. (2011). Spirituality and religiousness as predictive factors of outcome in schizophrenia and schizo-affective disorders. *Psychiatry Research, 186*, 177-182. doi: 10.1016/j.psychres.2010.08.012

Monod, S., Brennan, M., Rochat, E., Martin, E., Rochat, S., & Bula, C. J. (2011). Instruments measuring spirituality in clinical research: A systematic review. *Journal of General Internal Medicine, 26*, 1345-1357. doi: 10.1007/s11606-011-1769-7

Morrison, E. F., & Thornton, K. A. (1999). Influence of southern spiritual beliefs on perceptions of mental illness. *Issues in Mental Health Nursing, 20*, 443-458. doi: 10.1080/016128499248420

Morrison, J. K. (1978). The client as consumer and evaluator of community mental health services. *American Journal of Community Psychology, 6*, 147-155. doi: 10.1007/BF00881036

Morrison, J. Q., Clutter, S. M., Pritchett, E. M., & Demmitt, A. (2009). Perceptions of clients and counseling professionals regarding spirituality in counseling. *Counseling & Values, 53*, 183-194. doi: 10.1002/j.2161-007X.2009.tb00124.x

Morrow, D., Worthington, E. L., & McCullough, M. E. (1993). Observers' perceptions of a counselor's treatment of a religious issue. *Journal of Counseling & Development, 71*, 452-456. doi: 10.1002/j.1556-6676.1993.tb02664.x

Mullen, P., Smith, R., & Hill, E. (1994). Sense of coherence as a mediator of stress for cancer patients and spouses. *Journal of Psychosocial Oncology, 11*, 23-46. doi: 10.1300/J077V11N03_02

Murray, S. (2007). *Recovery and rehabilitation for those found not guilty by reason of insanity (NGRI) for homicide: Patient and clinician perspectives.* (DClinPsych dissertation), University of Auckland, New Zealand.

Mushtaq, I., & Hafeez, M. A. (2008). Psychiatrists and the role of religion in mental health [letter]. *Psychiatric Bulletin, 32*, 395. doi: 10.1192/pb.32.10.395b

Musick, M. A., Blazer, D. G., & Hays, J. C. (2000). Religious activity, alcohol use, and depression in a sample of elderly Baptists. *Research on Aging, 22*, 91-116. doi: 10.1177/0164027500222001

Musick, M. A., House, J. S., & Williams, D. R. (2004). Attendance at religious services and mortality in a national sample. *Journal of Health & Social Behavior, 45*, 198-213. doi: 10.1177/002214650404500206

Myers, J., & Baker, M. (1998). Religiously committed clinical psychologists, talking. *Clinical Psychology Forum, 117*, 30-32.

Naeem, F., Gobbi, M., Ayub, M., & Kingdon, D. (2009). University students' views about compatibility of cognitive behaviour therapy (CBT) with their personal, social and religious values (a study from Pakistan). *Mental Health, Religion & Culture, 12*, 847-855. doi: 10.1080/13674670903115226

Nagelkerke, N. J. D. (1991). A note on the general definition of the coefficient of determination. *Biometrika, 78*, 691-692. doi: 10.2307/2337038

Nairn, R. C., & Merluzzi, T. V. (2003). The role of religious coping in adjustment to cancer. *Psycho-Oncology, 12*, 428-441. doi: 10.1002/pon.654

Nakagawa, S. (2004). A farewell to Bonferroni: The problems of low statistical power and publication bias. *Behavioral Ecology, 15*, 1044-1045. doi: 10.1093/beheco/arh107

National Health Service. (1999). *National service framework for mental health: Modern standards and service models*. London, UK: Department of Health.

Needleman, L. D. (1999). *Cognitive case conceptualization: A guidebook for practitioners*. Mahwah, NJ: Lawrence Erlbaum.

Neeleman, J., Bijl, R., & Ormel, J. (2004). Neuroticism, a central link between somatic and psychiatric morbidity: Path analysis of prospective data. *Psychological Medicine, 34*, 521-531. doi: 10.1017/S0033291703001193

Neeleman, J., & Lewis, G. (1994). Religious identity and comfort beliefs in three groups of psychiatric patients and a group of medical controls. *The International Journal of Social Psychiatry, 40*, 124-134. doi: 10.1177/002076409404000204

Neeleman, J., & Persaud, R. (1995). Why do psychiatrists neglect religion? *British Journal of Medical Psychology, 68*, 169-178. doi: 10.1111/j.2044-8341.1995.tb01823.x

Nelsen, H. M., & Kroliczak, A. (1984). Parental use of the threat 'God will punish': Replication and extension. *Journal for the Scientific Study of Religion, 23*, 267-277. doi: 10.2307/1386041

Nelson-Becker, H. B. (2003). Practical philosophies: Interpretations of religion and spirituality by African American and European American Elders. *Journal of Religious Gerontology, 14*, 85-99. doi: 10.1300/J078v14n02_01

New Zealand Association of Psychotherapists. (2012). Accessed October 13, 2012, from http://nzap.org.nz/

New Zealand Psychologists Board. (2002). *Code of ethics for Psychologists working in Aotearoa/New Zealand*. Wellington, New Zealand: Author.

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

Newcomb, M. D., Madahian, E., & Bentler, P. M. (1986). Risk factors for drug use among adolescents: Concurrent and longitudinal analyses. *American Journal of Public Health, 76*, 525-531. doi: 10.2105/AJPH.76.5.525

Ng, F. (2007). The interface between religion and psychosis. *Australasian Psychiatry, 15*, 62-66. doi: 10.1080/10398560601083118

Nolen-Hoeksema, S., Girgus, J. S., & Seligman, M. E. P. (1986). Learned helplessness in children: A longitudinal study of depression, achievement, and explanatory style. *Journal of Personality and Social Psychology, 51*, 435-442. doi: 10.1037//0022-3514.51.2.435

Nunn, C. Z. (1964). Child control through a 'coalition with God'. *Child Development, 35*, 417-432. doi: 10.2307/1126705

O'Connor, S., & Vandenberg, B. (2005). Psychosis or faith? Clinicians' assessment of religious beliefs. *Journal of Consulting & Clinical Psychology, 73*, 610-616. doi: 10.1037/0022-006X.73.4.610

O'Connor, S., & Vandenberg, B. (2010). Differentiating psychosis and faith: the role of social norms and religious fundamentalism. *Mental Health, Religion & Culture, 13*, 171-186. doi: 10.1080/13674670903277984

O'Hagan, M. (2001). *Recovery competencies for New Zealand mental health workers*. Wellington, New Zealand: Mental Health Commission.

Olson, B. F. (2008). *Evaluating the error of measurement due to categorical scaling with a measurement invariance approach to confirmatory factor analysis.* (Masters Thesis), University of British Columbia, Vancouver, Canada.

Orcutt, H. K. (2006). The prospective relationship of interpersonal forgiveness and psychological distress symptoms among college women. *Journal of Counseling Psychology, 53*, 350 - 361. doi: 10.1037/0022-0167.53.3.350

Ormel, J., & Wohlfarth, T. (1991). How neuroticism, long-term difficulties, and life situation change influence psychological distress: A longitudinal model. *Journal of Personality & Social Psychology, 60*, 744-755. doi: 10.1037//0022-3514.60.5.744

Orth, U., Berking, M., Walker, N., Meier, L. L., & Znoj, H. (2008). Forgiveness and psychological adjustment following interpersonal transgression: A longitudinal analysis. *Journal of Research in Personality, 42*, 365-385. doi: 10.1016/j.jrp.2007.07.003

Orzech, K. M., Shapiro, S. L., Brown, K. W., & McKay, M. (2009). Intensive mindfulness training-related changes in cognitive and emotional experience. *The Journal of Positive Psychology, 4*, 212-222. doi: 10.1080/17439760902819394

Overholser, J. C. (1998a). Cognitive-behavioral treatment of depression, Part IX: Confronting predisposing factors. *Journal of Contemporary Psychotherapy, 28*, 289-305. doi: 10.1023/A:1022934008276

Overholser, J. C. (1998b). Cognitive-behavioral treatment of depression, Part X: Reducing the risk of relapse. *Journal of Contemporary Psychotherapy, 28*, 381 - 396. doi: 10.1023/A:1022970527103

Owen, J., Leach, M. M., Wampold, B., & Rodolfa, E. (2011). Client and therapist variability in clients' perceptions of their therapists' multicultural competencies. *Journal of Counseling Psychology, 58*, 1-9. doi: 10.1037/a0021496

Owen, J. J., Tao, K., Leach, M. M., & Rodolfa, E. (2011). Clients' perceptions of their psychotherapists' multicultural orientation. *Psychotherapy, 48*, 274-282. doi: 10.1037/a0022065

Padesky, C. A., & Greenberger, D. (1995). *Clinician's guide to mind over mood*. New York, NY: Guildford Press.

Pain, C. M., Chadwick, P., & Abba, N. (2008). Clients' experiences of case formulation in cognitive behaviour therapy for psychosis. *British Journal of Clinical Psychology, 47*, 127-138. doi: 10.1348/014466507X235962

Palmer, G. B. (1996). *Toward a theory of cultural linguistics*. Houston: University of Texas Press.

Paloutzian, R. F., & Park, C. L. (Eds.). (2005). *Handbook of the psychology of religion and spirituality*. New York, NY: Guilford Press.

Pampel, F. C. (2000). *Logistic regression: A Primer*. Thousand Oaks, CA: Sage.

Papps, E., & Ramsden, I. (1996). Cultural safety in nursing: The New Zealand experience. *International Journal for Quality in Health Care, 8*, 491-497. doi: 10.1093/intqhc/8.5.491

Pargament, K. I. (1997). *The psychology of religion and coping: Theory, research, and practice*. New York, NY: Guilford Press.

Pargament, K. I. (1999). The psychology of religion *and* spirituality? Yes and no. *The International Journal for the Psychology of Religion, 9*, 3-16. doi: 10.1207/s15327582ijpr0901_2

Pargament, K. I. (2007). *Spiritually integrated psychotherapy: Understanding and addressing the sacred*. New York, NY: Guilford Press.

Pargament, K. I. (2009). The psychospiritual character of psychotherapy and the ethical complexities that follow. *Professional Psychology: Research and Practice, 40*, 391-393.

Pargament, K. I., & Brant, C. R. (1998). Religion and coping. In H. G. Koenig (Ed.), *Handbook of religion and mental health* (pp. 111-128). San Diego, CA: Academic Press.

Pargament, K. I., Ensing, D. S., Falgout, K., Olsen, H., Reilly, B., Van Haitsma, K., & Warren, R. (1990). God help me: (I): Religious coping efforts as predictors of the outcomes to significant negative life events. *American Journal of Community Psychology, 18*, 793-824. doi: 10.1007/BF00938065

Pargament, K. I., Koenig, H. G., Tarakeshwar, N., & Hahn, J. (2004). Religious coping methods as predictors of psychological, physical and spiritual outcomes among medically ill elderly patients: A two-year longitudinal study. *Journal of Health Psychology, 9*, 713-730. doi: 10.1177/1359105304045366

Pargament, K. I., & Krumrei, E. J. (2009). Clinical assessment of clients' spirituality. In J. D. Aten & M. M. Leach (Eds.), *Spirituality and the therapeutic process* (pp. 93-120). Washington DC: American Psychological Association.

Pargament, K. I., Magyar-Russell, G. M., & Murray-Swank, N. A. (2005). The sacred and the search for significance: Religion as a unique process. *Journal of Social Issues, 61*, 665-687. doi: 10.1111/j.1540-4560.2005.00426.x

Pargament, K. I., Murray-Swank, N. A., Magyar, G. M., & Ano, G. G. (2005). Spiritual struggle: A phenomenon of interest to psychology and religion. In W. R. Miller & H. D. Delaney (Eds.), *Judeo-Christian perspectives on psychology: Human nature, motivation, and change* (pp. 245-268). Washington, DC: American Psychological Association.

Pargament, K. I., Murray-Swank, N. A., & Mahoney, A. (2008). Problem and solution: The spiritual dimension of clergy sexual abuse and its impact on survivors. *Journal of Child Sexual Abuse, 17*, 397-420. doi: 10.1080/10538710802330187

Pargament, K. I., Smith, B. W., Koenig, H. G., & Perez, L. (1998). Patterns of positive and negative religious coping with major life stressors. *Journal for the Scientific Study of Religion, 37*, 710-724. doi: 10.2307/1388152

Park, C. L. (2005a). Religion and meaning. In R. F. Paloutzian & C. L. Park (Eds.), *Handbook of the psychology of religion and spirituality* (pp. 295-314). New York, NY: Guilford Press.

Park, C. L. (2005b). Religion as a meaning-making framework in coping with life stress. *Journal of Social Issues, 61*, 707-729. doi: 10.1111/j.1540-4560.2005.00428.x

Passmore, N. L. (2003). Religious issues in counselling: Are Australian psychologists 'dragging the chain'? *Australian Psychologist, 38*, 183-192. doi: 10.1080/00050060310001707197

Penninx, B. W. J. H., van Tilberg, T., Kriegsman, D. M. W., Deeg, D. J. H., Boeke, A. J. P., & van Eijk, J. T. M. (1997). Effects of social support and personal coping resources on mortality in older age: The longitudinal aging study Amsterdam. *American Journal of Epidemiology, 146*, 510-519. doi: 10.1093/oxfordjournals.aje.a009305

Pérez, J. E., Little, T. D., & Henrich, C. C. (2009). Spiritualty and depressive symptoms in a school-based sample of adolescents: A longitudinal examination of mediated and moderated effects. *Journal of Adolescent Health, 44*, 380-386. doi: 10.1016/j.jadohealth.2008.08.022

Perkins, C. (2009). *Spirituality and mental health: An audit of a mental health service for older people*. Paper presented at the 4th International Conference on Ageing and Spirituality, Auckland. http://www.selwyncare.org.nz/Resources/library/PDFs/SCAS/Perkins__Dr_Chris_-_Presentation.pdf

Perneger, T. V. (1998). What's wrong with Bonferroni adjustments. *British Medical Journal, 316*, 1236. doi: 10.1136/bmj.316.7139.1236

Petersen, L. R., & Roy, A. (1985). Religiosity, anxiety, and meaning and purpose: Religion's consequences for psychological well-being. *Review of Religious Research, 27*, 49-62. doi: 10.2307/3511937

Peyrot, M. (1996). Causal analysis: Theory and application. *Journal of Pediatric Psychology, 21*, 3-24. doi: 10.1093/jpepsy/21.1.3

Pfeffermann, D. (1996). The use of sampling weights for survey data analysis. *Statistical Methods in Medical Research, 5*, 239-261. doi: 10.1177/096228029600500303

Pfeifer, S. (1994). Belief in demons and exorcism in psychiatric patients in Swizerland. *British Journal of Medical Psychology, 67*, 247-258. doi: 10.1111/j.2044-8341.1994.tb01794.x

Phillips, R. E., & Stein, C. H. (2007). God's will, God's punishment, or God's limitations? Religious coping strategies reported by young adults living with serious mental illness. *Journal of Clinical Psychology, 63*, 529-540. doi: 10.1002/jclp.20364

Pieper, J. (2004). Religious coping in highly religious psychiatric inpatients. *Mental Health, Religion & Culture, 7*, 349-363. doi: 10.1080/13674670410001719805

Pieper, J., & van Uden, R. (1996). Religion in mental health care: Patients' views. In P. J. Verhagen & G. Glas (Eds.), *Psyche and faith: Beyond professionalism* (pp. 69-83). Zoetermeer, Netherlands: Boekencentrum.

Pilkington, A., Msetfi, R. M., & Watson, R. (2011). Factors affecting intention to access psychological services amongst British Muslims of South Asian Origin. *Mental Health, Religion & Culture, 15*, 1-22. doi: 10.1080/13674676.2010.545947

Pirutinsky, S., Rosmarin, D. H., Pargament, K. I., & Midlarsky, E. (2011). Does negative religous coping accompany, precede, or follow depression among Orthodox Jews? *Journal of Affective Disorders, 132*, 401-405. doi: 10.1016/j.jad.2011.03.015

Plante, T. G. (2007). Integrating spirituality and psychotherapy: Ethical issues and principles to consider. *Journal of Clinical Psychology, 63*, 891-902. doi: 10.1002/jclp.20383

Podolska, M. Z., Bidzan, M., Majkowicz, M., Podolski, J., Sipak-Szmigiel, O., & Ronin-Walknowska, E. (2010). Personality traits assessed by the NEO Five-Factor Inventory (NEO-FFI) as part of the perinatal depression screening program. *Medical Science Monitor, 16*, 77-81.

Polaschek, N. R. (1998). Cultural safety: A new concept in nursing people of different ethnicities. *Journal of Advanced Nursing, 27*, 452-457. doi: 10.1046/j.1365-2648.1998.00547.x

Ponterotto, J. G. (2008). Theoretical and empirical advances in multicultural counseling and psychology. In S. D. Brown & R. W. Lent (Eds.), *Handbook of counseling psychology* (4th ed., pp. 121-140). Hoboken, NJ: John Wiley & Sons.

Ponterotto, J. G., Sanchez, C. M., & Magids, D. M. (1990). *The multicultural counseling awareness scale (MCAS): Form B; Revised self-assessment*. New York, NY: Fordham University.

Poole, R., & Higgo, R. (2011). Spirituality and the threat to therapeutic boundaries in psychiatric practice. *Mental Health, Religion & Culture, 14*, 19-29. doi: 10.1080/13674671003746845

Poole, R., Higgo, R., Strong, G., Kennedy, G., Ruben, S., Barnes, R., . . . Mitchell, P. (2008). Religion, psychiatry and professional boundaries [letter]. *Psychiatric Bulletin, 32*, 356-357. doi: 10.1192/pb.32.9.356

Pope-Davis, D. B., Liu, W. M., Toporek, R. L., & Brittan-Powell, C. S. (2001). What's missing from multicultural competency research: Review, introspection, and recommendations. *Cultural Diversity & Ethnic Minority Psychology, 7*, 121-138. doi: 10.1037/1099-9809.7.2.121

Pope-Davis, D. B., Toporek, R. L., Ortega-Villalobos, L., Ligiero, D. P., Brittan-Powell, C. S., Liu, W. M., . . . Liang, C. T. H. (2002). Client perspectives of multicultural counseling competence: A qualitative examination. *The Counseling Psychologist, 30*, 355-395. doi: 10.1177/0011000002303001

Posadzki, P., & Glass, N. (2009). Self-efficacy and the sense of coherence: Narrative review and a conceptual synthesis. *The Scientific World Journal, 9*, 924-933. doi: 10.1100/tsw.2009.107

Propst, L. R., Ostrom, R., Watkins, P., & Dean, T. (1992). Comparative efficacy of religious and nonreligious cognitive-behavioral therapy for the treatment of clinical depression in religious individuals. *Journal of Clinical & Consulting Psychology, 60*, 94-103. doi: 10.1037//0022-006X.60.1.94

Psychotherapy and Counselling Federation of Australia. (2012). Accessed October 12, 2012, from http://www.pacfa.org.au/

Ramsden, I. (1990). Cultural safety. *The New Zealand Nursing Journal, 83*, 18-19.

Rasic, D., Robinson, J. A., Bolton, J., Bienvenu, O. J., & Sareen, J. (2011). Longitudinal relationships of religious worship attendance and spirituality with major depression, anxiety disorders, and suicidal ideation and attempts: Findings from the Baltimore epidemiologic catchment area study. *Journal of Psychiatric Research, 45*, 848-854. doi: 10.1016/j.jpsychires.2010.11.014

Reber, J. S. (2006). Secular psychology: What's the problem? *Journal of Psychology & Theology, 34*, 193-204.

Reed, P. (1987). Spirituality and well-being in terminally ill hospitalized adults. *Research in Nursing & Health, 10*, 335-344. doi: 10.1002/nur.4770100507

Reifman, A., & Windle, M. (1995). Adolescent suicidal behaviors as a function of depression, hopelessness, alcohol use, and social support: A longitudinal investigation. *American Journal of Community Psychology, 23*, 329-354. doi: 10.1007/BF02506948

Reinert, D. F. (2005). Spirituality, self-representations, and attachment to parents: A longitudinal study of Roman Catholic college seminarians. *Counseling & Values, 49*, 226-238. doi: 10.1002/j.2161-007X.2005.tb01025.x

Reinert, D. F., & Edwards, C. E. (2009). Attachment theory, childhood maltreatment, and religiosity. *Psychology of Religion & Spirituality, 1*, 25-34. doi: 10.1037/a0014894

Ribaudo, A., & Takahashi, M. (2008). Temporal trends in spirituality research: A meta-analysis of journal abstracts between 1944 and 2003. *Journal of Religion, Spirituality & Aging, 20*, 16-28. doi: 10.1080/15528030801921972

Richards, P. S. (2009). Toward religious and spiritual competence for psychologists: Some reflections and recommendations. *Professional Psychology: Research and Practice, 40*, 389-391.

Richards, P. S., & Bergin, A. E. (1997). *A spiritual strategy for counseling and psychotherapy* (1st ed.). Washington, DC: American Psychological Association.

Richards, P. S., & Bergin, A. E. (2005). *A spiritual strategy for counseling and psychotherapy* (2nd ed.). Washington, DC: American Psychological Association.

Richards, T. A., & Folkman, S. (1997). Spiritual aspects of loss at the time of a partner's death from AIDS. *Death Studies, 21*, 527-552. doi: 10.1080/074811897201769

Ridley, C. R., & Kelly, S. M. (2007). Multicultural considerations in case formulation. In T. Eells (Ed.), *Handbook of psychotherapy case formulation* (2nd ed., pp. 33-64). New York, NY: Guilford Press.

Ridley, C. R., & Kleiner, A. J. (2003). Multicultural counseling competence: History, themes, and issues. In D. B. Pope-Davis, H. L. K. Coleman, W. M. Liu & R. L. Toporek (Eds.), *Handbook of multicultural competencies in counseling and psychology* (pp. 3-20). Thousand Oaks, CA: Sage.

Riso, L. P., Froman, S. E., Raouf, M., Gable, P., Maddux, R. E., Turini-Santorelli, N., . . . Cherry, M. (2006). The long-term stability of early maladaptive schemas. *Cognitive Therapy & Research, 30*, 515-529. doi: 10.1007/s10608-006-9015-z

Rose, E. M., Westefeld, J. S., & Ansley, T. N. (2001). Spiritual issues in counseling: Clients' beliefs and preferences. *Journal of Counseling Psychology, 48*, 61-71. doi: 10.1037//0022-0167.48.1.61

Rosen, G. (1968). *Madness in society: Chapters in the historical sociology of mental illness*. IL: University of Chicago Press.

Rosenfeld, G. W. (2011). Contributions from ethics and research that guide integrating religion into psychotherapy. *Professional Psychology: Research and Practice, 42*, 192-199. doi: 10.1037/a0022742

Rosmarin, D. H., Auerbach, R. P., Bigda-Peyton, J. S., Bjorgvinsson, T., & Levendusky, P. G. (2011). Integrating spirituality into cognitive behavioral therapy in an acute psychiatric setting: A pilot study. *Journal of Cognitive Psychotherapy, 25*, 287-303. doi: 10.1891/0889-8391.25.4.287

Rosmarin, D. H., Pargament, K. I., & Flannelly, K. J. (2009). Do spiritual struggles predict poorer physical/mental health among Jews? *The International Journal for the Psychology of Religion, 19*, 244-258. doi: 10.1080/10508610903143503

Rotter, J. B. (1966). Generalized expectancies for internal vs. external control of reinforcement. *Psychological Monographs, 80*, 1-28. doi: 10.1037/h0092976

Royston, P., & Sauerbrei, W. (2008). *Multivariable model-building: A pragmatic approach to regression analysis based on fractional polynomials for modelling continuous variables*. West Sussex, UK: Wiley.

Russinova, Z., Wewiorski, N. J., & Cash, D. (2002). Use of alternative health care practices by persons with seriious mental illness: Perceived benefits. *American Journal of Public Health, 92*, 1600-1603. doi: 10.2105/AJPH.92.10.1600

Ryan, L., & Golden, A. (2006). 'Tick the box please': A reflexive approach to doing quantitative social research. *Sociology, 40*, 1191-1200. doi: 10.1177/0038038506072287

Ryan, M. E., & Francis, A. J. P. (2012). Locus of control beliefs mediate the relationship between religious functioning and psychological health. *Journal of Religion & Health, 51*, 774-785. doi: 10.1007/s10943-010-9386-z

Sallquist, J., Eisenberg, N., French, D. C., Purwono, U., & Suryanti, T. A. (2010). Indonesian adolescents' spiritual and religious experiences and their longitudinal relations with socioemotional functioning. *Developmental Psychology, 46*, 699-716. doi: 10.1037/a0018879

Saradjian, A., & Nobus, D. (2003). Cognitive distortions of religious professionals who sexually abuse children. *Journal of Interpersonal Violence, 18*, 905-923. doi: 10.1177/0886260503253881

Saroglou, V. (2002a). Beyond dogmatism: The need for closure as related to religion. *Mental Health, Religion & Culture, 5*, 183-194. doi: 10.1080/13674670210144130

Saroglou, V. (2002b). Religion and the five factors of personality: A meta-analytic review. *Personality & Individual Differences, 32*, 15-25. doi: 10.1016/S0191-8869(00)00233-6

Saunders, S. M., Miller, M. L., & Bright, M. M. (2010). Spiritually conscious psychological care. *Professional Psychology: Research and Practice, 41*, 355-362. doi: 10.1037/a0020953

Sax, L. J., Gilmartin, S. K., & Bryant, A. N. (2003). Assessing response rates and nonresponse bias in web and paper surveys. *Research in Higher Education, 44*, 409-432. doi: 10.1023/A:1024232915870

Schafer, J. L. (1997). *Analysis of incomplete multvariate data*. New York, NY: Chapman & Hall.

Schafer, J. L., & Graham, J. W. (2002). Missing data: Our view of the state of the art. *Psychological Methods, 7*, 147-177. doi: 10.1037//1082-989X.7.2.147

Schafer, R. M., Handal, P. J., & Brawer, P. A. (2011). Training and education in religion/spirituality within APA-accredited clinical psychology programs: 8 years later. *Journal of Religion and Health, 50*, 232-239. doi: 10.1007/s10943-009-9272-8

Schmidt, F. L. (1996). Statistical significance testing and cumulative knowledge in psychology: Implications for training of researchers. *Psychological Methods, 1*, 115-129. doi: 10.1037//1082-989X.1.2.115

Schuster, M. A., Stein, B. D., Jaycox, L. H., Collins, R. L., Marshall, G. N., Elliott, M. N., . . . Berry, A. H. (2001). A national survey of stress reactions after the September 11, 2001, terrorist attacks. *New England Journal of Medicine, 345*, 1507-1512. doi: 10.1056/NEJM200111153452024

Schuurmans-Stekhoven, J. B. (2011). Is it God or just the data that moves in mysterious ways? How well-being research may be mistaking faith for virtue. *Social Indicators Research, 100*, 313-330. doi: 10.1007/s11205-010-9630-7

Sevensky, R. L. (1984). Religion, psychology, and mental health. *American Journal of Psychotherapy, 38*, 73-86.

Shafranske, E. P. (1996). Religious beliefs, affiliations, and practices of clinical psychologists. In E. P. Shafranske (Ed.), *Religion and the clinical practice of psychology* (pp. 149-162). Washington, DC: American Psychological Association.

Shafranske, E. P. (2005). The psychology of religion in clinical and counseling psychology. In R. F. Paloutzian & C. L. Park (Eds.), *Handbook of the psychology of religion and spirituality* (pp. 496-515). New York, NY: Guilford Press.

Shafranske, E. P., & Malony, H. N. (1990). Clinical psychologists' religious and spiritual orientations and their practice of psychotherapy. *Psychotherapy, 27*, 72-78. doi: 10.1037/0033-3204.27.1.72

Shahabi, L., Powell, L. H., Musick, M. A., Pargament, K. I., Thoresen, C. E., Williams, D., . . . Ory, M. A. (2002). Correlates of self-perceptions of spirituality in American adults. *Annals of Behavioral Medicine, 24*, 59-68. doi: 10.1207/S15324796ABM2401_07

Sharkey, J. (2005). *Refocussing therapy: The effectiveness and uniqueness of a God-based therapy method.* (Masters thesis), Massey University, Auckland, New Zealand.

Shaw, A., Joseph, S., & Linley, P. A. (2005). Religion, spirituality, and posttraumatic growth: A systematic review. *Mental Health, Religion & Culture, 8*, 1-11. doi: 10.1080/1367467032000157981

Shea, M., Yang, L. H., & Leong, F. T. L. (2010). Loss, psychosis, and chronic suicidality in a Korean American immigrant man: Integration of cultural formulation model and multicultural case conceptualization. *Asian American Journal of Psychology, 1*, 212-223. doi: 10.1037/a0020951

Sheridan, M. J. (2004). Predicting the use of spiritually-derived interventions in social work practice: A survey of practitioners. *Journal of Religion & Spirituality in Social Work, 23*, 5-25. doi: 10.1300/J377v23n04_02

Sherman, A. C., Plante, T. G., Simonton, S., Latif, U., & Anaissie, E. J. (2009). Prospective study of religious coping among patients undergoing autologous stem cell transplanation. *Journal of Behavioral Medicine, 32*, 118-128. doi: 10.1007/s10865-008-9179-y

Shipley, B. A., Weiss, A., Der, G., Taylor, M. D., & Deary, I. J. (2007). Neuroticism, extraversion, and mortality in the UK health and lifestyle survey: A 21-year

prospective cohort study. *Psychosomatic Medicine, 69*, 923-931. doi: 10.1097/PSY.0b013e31815abf83

Shrauger, J. S., & Silverman, R. E. (1971). The relationship of religious background and participation to locus of control. *Scientific Study of Religion, 10*, 11-16. doi: 10.2307/1385313

Shucksmith, J., Hendry, L. B., & Glendinning, A. (1995). Models of parenting: Implications for adolescent well-being within different types of family contexts. *Journal of Adolescence, 18*, 253-270. doi: 10.1006/jado.1995.1018

Siddle, R., Haddock, G., Tarrier, N., & Faragher, E. B. (2002). Religious delusions in patients admitted to hospital with schizophrenia. *Social Psychiatry & Psychiatric Epidemiology, 37*, 130-138. doi: 10.1007/s001270200005

Silverman, A. B., Reinherz, H. Z., & Giaconia, R. M. (1996). The long-term sequelae of child and adolescent abuse: A longitudinal community study. *Child Abuse & Neglect, 20*, 709-723. doi: 10.1016/0145-2134(96)00059-2

Skinner, B. F. (1953). *Science and human behavior*. New York, NY: The Free Press.

Smith, D., & Orlinsky, D. E. (2004). Religious and spiritual experience among psychotherapists. *Psychotherapy: Theory, Research, Practice, Training, 41*, 144-151. doi: 10.1037/0033-3204.41.2.144

Smith, K. A. (2010). *Correlates of perceived multicultural competence: Experience and ethnic identity.* (PhD dissertation), California State University, Sacramento.

Smith, L., Riley, S., & Peters, E. R. (2009). Schizotypy, delusional ideation and well-being in an American New Religious Movement population. *Clinical Psychology & Psychotherapy, 16*, 479-484. doi: 10.1002/cpp.645

Smith, T. B., McCullough, M. E., & Poll, J. (2003). Religiousness and depression: Evidence for a main effect and the moderating influence of stressful life events. *Psychological Bulletin, 129*, 614-636. doi: 10.1037/0033-2909.129.4.614

Smith, T. L., & Meyers, L. S. (1997). The sense of coherence: Its relationship to personality, stress, and health measures. *Journal of Social Behavior & Personality, 12*, 513-526.

Sodowsky, G. R., Kuo-Jackson, P. Y., Richardson, M. F., & Corey, A. T. (1998). Correlates of self-reported multicultural competencies: Counselor multicultural social desirability, race, social inadequacy, locus of control, racial ideology, and multicultural training. *Journal of Counseling Psychology, 45*, 256-264. doi: 10.1037//0022-0167.45.3.256

Sodowsky, G. R., Taffe, R. C., Gutkin, T. B., & Wise, S. (1994). Development of the multicultural counseling inventory: A self-report measure of multicultural competencies. *Journal of Counseling Psychology, 41*, 137-148. doi: 10.1037//0022-0167.41.2.137

Southall, D., & Roberts, J. E. (2002). Attributional style and self-esteem in vulnerability to adolescent depressive symptoms following life stress: A 14-week prospective study. *Cognitive Therapy & Research, 26*, 563-579. doi: 10.1023/A:1020457508320

Spataro, J., Mullen, P. E., Burgess, P. M., Wells, D. L., & Moss, S. A. (2004). Impact of child sexual abuse on mental health: Prospective study in males and females. *British Journal of Psychiatry, 184*, 416-421. doi: 10.1192/bjp.184.5.416

Sperry, L. (2010). *Core competencies in counseling and psychotherapy: Becoming a highly competent and effective therapist*. New York, NY: Routledge.

Spilka, B., Hood, R. W. J., Hunsberger, B., & Gorsuch, R. (2003). *The psychology of religion: An empirical approach* (3rd ed.). Boulder, CO: Westerview Press.

Stallard, P. (1996). The role and use of consumer satisfaction surveys in mental health services. *Journal of Mental Health, 5*, 333-349. doi: 10.1080/09638239619257

Stamogiannou, I. (2007). *Psychologists' and clients' experiences of addressing spirituality in cognitive-behavioural therapy.* (Doctor of Psychology dissertation), University of Surrey, Guildford, UK.

Standards New Zealand. (2008). *Health and disability services (core) standards*. Wellington, New Zealand: Ministry of Health.

Stanford, M. S. (2007). Demon or disorder: A survey of attitudes toward mental illness in the Christian church. *Mental Health, Religion & Culture, 10*, 445-449. doi: 10.1080/13674670600903049

Statistics New Zealand. (2006). New Zealand's 2006 census of population and dwellings Retrieved 26th of February, 2009, from http://www.stats.govt.nz/census/2006-census-data/quickstats-about-culture-identity/quickstats-about-culture-and-identity.htm

Statistics New Zealand. (2013). New Zealand's 2013 census of population and dwellings Retrieved 3rd of December, 2013, from http://www.stats.govt.nz/Census/2013-census/data-tables/population-dwelling-tables.aspx

Stein, C. H., & Wemmerus, V. A. (2001). Searching for a normal life: Personal accounts of adults with schizophrenia, their parents and well-siblings. *American Journal of Community Psychology, 29*, 725-746. doi: 10.1023/A:1010465117848

Sternthal, M. J., Williams, D. R., Musick, M. A., & Buck, A. C. (2010). Depression, anxiety, and religious life: A search for mediators. *Journal of Health & Social Behavior, 51*, 343-359. doi: 10.1177/0022146510378237

Stevenson, M. (2008). *An introduction to logistic regression*. Course notes for Analysis and Interpretation of Animal Health Data. EpiCentre, Massey University. Palmerston North.

Stewart, C., Koeske, G. F., & Koeske, R. D. (2006). Personal religiosity and spirituality associated with social work practitioners' use of religious-based intervention practices. *Journal of Religion & Spirituality in Social Work, 25*, 69-85. doi: 10.1300/J377v25n01_05

Stirling, B., Furman, L. D., Benson, P. W., Canda, E. R., & Grimwood, C. (2010). A comparative survey of Aotearoa New Zealand and UK social workers on the role of religion and spirituality in practice. *British Journal of Social Work, 40*, 602-621. doi: 10.1093/bjsw/bcp008

Strauser, D. R., Ketz, K., & Keim, J. (2002). The relationship between self-efficacy, locus of control and work personality. *Journal of Rehabilitation, 68*, 20-26.

Strawbridge, W. J., Shema, S. J., Cohen, R. D., & Kaplan, G. A. (2001). Religious attendance increases survival by improving and maintaining good health behaviors, mental health, and social relationships. *Annals of Behavioral Medicine, 23*, 68-74. doi: 10.1207/S15324796ABM2301_10

Studenmund, A. H. (2010) *Using econometrics: A practical guide* (6th ed.). Upper Saddle River, NJ: Prentice Hall.

Sturmey, P. (2009). Case formulation: A review and overview of this volume. In P. Sturmey (Ed.), *Clinical case formulation: Varieties of approaches* (pp. 3 - 32). West Sussex, UK: John Wiley & Sons.

Suchower, L. J., & Copenhaver, M. D. (1997, October). *Using logistic regression to test for interaction in the presence of zero cells.* Paper presented at the Northeast SAS Users Group Conference, Baltimore, MD.

Sue, D. W., Arredono, P., & Davis, M. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling & Development, 70*, 477-486. doi: 10.1002/j.2161-1912.1992.tb00563.x

Sue, D. W., Bernier, J. E., Durran, A., Feinberg, L., Pedersen, P., Smith, E. J., & Vasquez-Nuttall, E. (1982). Position paper: Cross-cultural counseling competencies. *The Counseling Psychologist, 10*, 45-52. doi: 10.1177/0011000082102008

Sue, D. W., Ivey, A. E., & Pedersen, P. (1996). *A theory of multicultural counseling and therapy*. Stamford, CT: Brooks/Cole.

Sue, S. (1998). In search of cultural competence in psychotherapy and counseling. *American Psychologist, 53*, 440-448. doi: 10.1037//0003-066X.53.4.440

Sullivan, W. P. (1993). 'It helps me to be a whole person': The role of spirituality among the mentally challenged. *Psychosocial Rehabilitation Journal, 16*, 125-135.

Sulmasy, D. (2002). A biopsychosocial-spiritual model for the care of patients at the end of life. *The Gerontologist, 42*, 24-33.

Sun, B. C., Adams, J., Orav, E. J., Bucker, D. W., Brennan, R. A., & Burstin, H. R. (2000). Determinants of patient satisfaction and willingness to return with emergency care. *Annals of Emergency Medicine, 35*, 426-435. doi: 10.1016/S0196-0644(00)70003-5

Surtees, P. G., Wainwright, N. W. J., Luben, R., Khaw, K.-T., & Day, N. E. (2006). Mastery, sense of coherence, and mortality: Evidence of independent associations from the EPIC-Norfolk prospective cohort study. *Health Psychology, 25*, 102-110. doi: 10.1037/0278-6133.25.1.102

Svanberg, P. O. G. (1998). Attachment, resilience and prevention. *Journal of Mental Health, 7*, 543-578. doi: 10.1080/09638239817716

Swanson, P. B., Kane, R. T., Pearsall-Jones, J. G., Swanson, C. F., & Croft, M. L. (2009). How couples cope with the death of a twin or higher order multiple. *Twin Research & Human Genetics, 12*, 392-402. doi: 10.1375/twin.12.4.392

Sweet, S. A., & Grace-Martin, K. (2003). Multivariate analysis with logistic regression. In S. A. Sweet & K. Grace-Martin (Eds.), *Data analysis with SPSS: A first course in applied statistics* (2nd ed., pp. 157-168). Boston, MA: Allyn & Bacon.

Swift, J. K., Callahan, J. L., & Vollmer, B. M. (2011). Preferences. *Journal of Clinical Psychology, 67*, 155-165. doi: 10.1002/jclp.20759

Tabachnick, B. G., & Fidell, L. S. (2007). *Using multivariate statistics* (5th ed.). Boston, MA: Pearson.

Tan, S.-Y. (1996). Religion in clinical practice: Implicit and explicit integration. In E. P. Shafranske (Ed.), *Religion and the clinical practice of psychology* (pp. 365-387). Washington, DC: American Psychological Association.

Tanyi, R. A. (2002). Toward clarification of the meaning of spirituality. *Journal of Advanced Nursing, 39*, 500-509. doi: 10.1046/j.1365-2648.2002.02315.x

Taylor, C. Z. (2002). Religious addiction: Obsession with spirituality. *Pastoral Psychology, 50*, 291-315. doi: 10.1023/A:1014074130084

Tepper, L., Rogers, S. A., Coleman, E. M., & Malony, H. N. (2001). The prevalence of religious coping among persons with persistent mental illness. *Psychiatric Services, 52*, 660-665. doi: 10.1176/appi.ps.52.5.660

Thielman, S. B. (1998). Reflections on the role of religion in the history of psychiatry. In H. G. Koenig (Ed.), *Handbook of religion and mental health* (pp. 3-20). San Diego, CA: Academic Press.

Thoits, P. A. (1995). Stress, coping, and social support processes: Where are we? What next? *Journal of Health & Social Behavior, 35*, 53-79. doi: 10.2307/2626957

Thomas, J., & Ashraf, S. (2011). Exploring the Islamic tradition for resonance and dissonance with cognitive therapy for depression. *Mental Health, Religion & Culture, 14*, 183-190. doi: 10.1080/13674676.2010.517190

Trice, P. D., & Bjorck, J. P. (2006). Pentecostal perspectives on causes and cures of depression. *Professional Psychology: Research and Practice, 37*, 283-294. doi: 10.1037/0735-7028.37.3.283

Tummala-Narra, P., Singer, R., Li, Z., Esposito, J., & Ash, S. E. (2012). Individual and systemic factors in clinicians' self-perceived cultural competence. *Professional Psychology: Research and Practice, 43*, 165-174. doi: 10.1037/a0025783

Turbott, J. (1996). Religion, spirituality and psychiatry: Conceptual, cultural and personal challenges. *Australian & New Zealand Journal of Psychiatry, 30*, 720-727. doi: 10.3109/00048679609065037

Turk, D. C., & Salovey, P. (1985). Cognitive structures, cognitive processes, and cognitive-behavior modification: I. Client issues. *Cognitive Therapy & Research, 9*, 1-17. doi: 10.1007/BF01178747

ULCA Statistics Consulting Group. (2011). What are pseudo R-squareds? Retrieved October 12th, 2012, from http://statistics.ats.ucla.edu/stat/mult_pkg/faq/general/Psuedo_RSquareds.htm

Ullman, C. (1982). Cognitive and emotional antecedents of religious conversion. *Journal of Personality & Social Psychology, 43*, 183-192. doi: 10.1037//0022-3514.43.1.183

United Kingdom Council for Psychotherapy. (2012). Accessed October 12, 2012, from http://www.psychotherapy.org.uk/index.html

Unruh, A. M., Versnel, J., & Kerr, N. (2002). Spirituality unplugged: A review of commonalities and contentions, and a resolution. *Canadian Journal of Occupational Therapy, 69,* 5-19. doi: 10.1177/000841740206900101

Unterrainer, H.-F., Ladenhauf, K. H., Moazedi, M. L., Wallner-Liebmann, S. J., & Fink, A. (2010). Dimensions of religious/spiritual well-being and their relation to personality and psychological well-being. *Personality and Individual Differences, 49*, 192-197. doi: 10.1016/j.paid.2010.03.032

Utts, J. M., & Heckard, R. F. (2007). *Mind on statistics* (3rd ed.). Belmont, CA: Thompson Brooks/Cole.

Valentine, H. (2009). *Kia Ngäwari ki te Awatea: The relationship between Wairua and Mäori well-being - A psychological perspective.* (DClinPsych dissertation), Massey University, New Zealand.

Valentine, L., & Feinauer, L. L. (1993). Resilience factors associated with female survivors of childhood sexual abuse. *American Journal of Family Therapy, 21*, 216-224. doi: 10.1080/01926189308250920

van Teijlingen, E. R., Rennie, A.-M., Hundley, V., & Graham, W. (2001). The importance of conducting and reporting pilot studies: the example of the Scottish Births Survey. *Journal of Advanced Nursing, 34*, 289–295. doi: 10.1046/j.1365-2648.2001.01757.x

van Voorhees, B. W., Paunesku, D., Kuwabara, S. A., Basu, A., Gollan, J., Hankin, B. L., . . . Reinecke, M. (2008). Protective and vulnerability factors predicting new-onset depressive episode in a representative of U.S. adolescents. *Journal of Adolescent Health, 42*, 605-616. doi: 10.1016/j.jadohealth.2007.11.135

Vasegh, S. (2011). Cognitive therapy of religious depressed patients: Common concepts between Christianity and Islam. *Journal of Cognitive Psychotherapy, 25*, 177-188. doi: /10.1891/0889-8391.25.3.177

Verhagen, P. J. (2010). The case for more effective relationships between psychiatry, religion and spirituality. *Current Opinion in Psychiatry, 23*, 550-555. doi: 10.1097/YCO.0b013e32833d8b04

Wade, N. G., Worthington, E. L., & Vogel, D. L. (2007). Effectiveness of religiously tailored interventions in Christian therapy. *Psychotherapy Research, 17*, 91-105. doi: 10.1080/10503300500497388

Wade, P., & Bernstein, B. L. (1991). Culture sensitivity training and counselor's race: Effects on black female clients' perceptions and attrition. *Journal of Counseling Psychology, 38*, 9-15. doi: 10.1037//0022-0167.38.1.9

Waitemata District Health Board. (2010). *Waitemata District Health Board mental health and addictions plan 2009 - 2015* Auckland, New Zealand: Author.

Walker, D., Gorsuch, R. L., & Tan, S.-Y. (2004). Therapists' integration of religion and spirituality in counseling: A meta-analysis. *Counseling & Values, 49*, 69-73. doi: 10.1002/j.2161-007X.2004.tb00254.x

Walker, D., Reid, H. W., O'Neill, T., & Brown, L. (2009). Changes in personal religion/spirituality during and after childhood abuse: A review and synthesis. *Psychological Trauma: Theory, Research, Practice, and Policy, 1*, 130-145. doi: 10.1037/a0016211

Walker, D., Worthington, E. L., Gartner, A. L., Gorsuch, R. L., & Hanshew, E. R. (2011). Religious commitment and expectations about psychotherapy among Christian clients. *Psychology of Religion & Spirituality, 3*, 98-114. doi: 10.1037/a0021604

Walker, L., & Pitts, R. C. (1998). Naturalistic conceptions of moral maturity. *Developmental Psychology, 34*, 403-419. doi: 10.1037//0012-1649.34.3.403

Waller, G., Meyer, C., Ohanian, V., Elliott, P., Dickson, C., & Sellings, J. (2001). The psychopathology of bulimic women who report childhood sexual abuse: The mediating role of core beliefs. *Journal of Nervous & Mental Disease, 189*, 700-708. doi: 10.1097/00005053-200110000-00007

Wang, P. S., Berglund, P. A., & Kessler, R. C. (2003). Patterns and correlates of contacting clergy for mental disorders in the United States. *Health Services Research, 38*, 647-673. doi: 10.1111/1475-6773.00138

Warnock, C. J. P. (2009). Who pays for providing spiritual care in healthcare settings? The ethical dilemma of taxpayers funding holistic healthcare and the first amendment requirement for separation of church and state. *Journal of Religion & Health, 48*, 468-481. doi: 10.1007/s10943-008-9208-8

Weerasekera, P. (1993). Formulation: A multiperspective model. *Canadian Journal of Psychiatry, 38*, 351-358.

Wesselmann, E. D., & Graziano, W. G. (2010). Sinful and/or possessed? Religious beliefs and mental illness stigma. *Journal of Social & Clinical Psychology, 29*, 402-437. doi: 10.1521/jscp.2010.29.4.402

White, B., Driver, S., & Warren, A. M. (2010). Resilience and indicators of adjustment during rehabilitation from a spinal cord injury. *Rehabilitation Psychology, 55*, 23-32. doi: 10.1037/a0018451

White, H. (2000). A reality check for data snooping. *Econometrica, 68*, 1097-1126. doi: 10.1111/1468-0262.00152

White, K., Lehman, D. R., Hemphill, K. J., Mandel, D. R., & Lehman, A. M. (2006). Causal attributions, perceived control, and psychological adjustment: A study of chronic fatigue syndrome. *Journal of Applied Social Psychology, 36*, 75-99. doi: 10.1111/j.0021-9029.2006.00004.x

Whitley, R. (2012). Religious competence as cultural competence. *Transcultural Psychiatry, 49*, 245-260. doi: 10.1177/1363461512439088

Widom, C. S., DuMont, K., & Czaja, S. J. (2007). A prospective investigation of major depressive disorder and comorbidity in abused and neglected children grown up. *Archives of General Psychiatry, 64*, 49-56. doi: 10.1001/archpsyc.64.1.49

Wiggins, M. I. (2009). Therapist self-awareness of spirituality. In J. D. Aten & M. M. Leach (Eds.), *Spirituality and the therapeutic process: From intake to termination* (pp. 53-73). Washington DC: American Psychological Association.

Willemsen, G., & Boomsma, D. I. (2007). Religious upbringing and neuroticism in Dutch twin families. *Twin Research & Human Genetics, 10*, 327-333. doi: 10.1375/twin.10.2.327

Wink, P., Ciciolla, L., Dillon, M., & Tracy, A. (2007). Religiousness, spiritual seeking, and personality: Findings from a longitudinal study. *Journal of Personality, 75*, 1051-1070. doi: 10.1111/j.1467-6494.2007.00466.x

Woods, T. E., & Ironson, G. H. (1999). Religion and spirituality in the face of illness: How cancer, cardiac, and HIV patients describe their spirituality/religiosity. *Journal of Health Psychology, 4*, 393-412. doi: 10.1177/135910539900400308

Worthington, E. L. (1988). Understanding the values of religious clients: A model and its application to counseling. *Journal of Counseling Psychology, 35*, 166-174. doi: 10.1037//0022-0167.35.2.166

Worthington, E. L., Hook, J. N., Davis, D. E., & McDaniel, M. A. (2011). Religion and spirituality. *Journal of Clinical Psychology, 67*, 204-214. doi: 10.1002/jclp.20760

Worthington, E. L., Kurusu, T. A., McCullough, M. E., & Sandage, S. J. (1996). Empirical research on religion and psychotherapeutic processes and outcomes: A 10-year review and research prospectus. *Psychological Bulletin, 119*, 448-487. doi: 10.1037//0033-2909.119.3.448

Worthington, E. L., & Scott, G. C. (1983). Goal selection for counseling with potentially religious clients by professional and student counselors in explicitly Christian or secular settings. *Journal of Psychology & Theology, 11*, 318-329.

Worthington, E. L., Wade, N. G., Hight, T. L., Ripley, J. S., McCullough, M. E., Berry, J. W., . . . O'Conner, L. (2003). The religious commitment inventory-10: Development, refinement, and validation of a brief scale for research and counseling. *Journal of Counseling Psychology, 50*, 84-96. doi: 10.1037//0022-0167.50.1.84

Worthington, R. L., Soth-McNett, A. M., & Moreno, M. V. (2007). Multicultural counseling competencies research: A 20-year content analysis. *Journal of Counseling Psychology, 54*, 351-361. doi: 10.1037/0022-0167.54.4.351

Wulff, D. H. (1996). *Psychology of religion: Classic and contemporary*. Hoboken, NJ: Wiley.

Yangarber-Hicks, N. (2004). Religious coping styles and recovery from serious mental illnesses. *Journal of Psychology & Theology, 32*, 305-317.

Young, J. E., Klosko, J. S., & Weishaar, M. E. (2003). *Schema therapy: A practitioner's guide*. New York, NY: Guilford Press.

Young, J. S., Wiggins-Frame, M., & Cashwell, C. S. (2007). Spirituality and counselor competence: A national survey of American Counseling Association members. *Journal of Counseling & Development, 85*, 47-52. doi: 10.1002/j.1556-6678.2007.tb00443.x

Young, S. L., & Ensing, D. S. (1999). Exploring recovery from the perspective of people with psychiatric disabilities. *Psychiatric Rehabilitation Journal, 22*, 219-232.

Zane, N., Sue, S., Chang, J., Huang, L., Huang, J., Lowe, S., . . . Lee, E. (2005). Beyond ethnic match: Effects of client-therapist cogntive match in problem perception, coping orientation, and therapy goals on treatment outcomes. *Journal of Community Psychology, 33*, 569-585. doi: 10.1002/jcop.20067

Zinnbauer, B. J., & Barrett, J. J. (2009). Integrating spirituality with clinical practice through treatment planning. In J. D. Aten & M. M. Leach (Eds.), *Spirituality and the therapeutic process: A comprehensive resource from intake to termination* (pp. 143 - 165). Washington DC: American Psychological Association.

Zinnbauer, B. J., & Pargament, K. I. (2000). Working with the sacred: Four approaches to religious and spiritual issues in counseling. *Journal of Counseling & Development, 78*, 162-171. doi: 10.1002/j.1556-6676.2000.tb02574.x

Zinnbauer, B. J., & Pargament, K. I. (2002). Capturing the meanings of religiousness and spirituality: One way down from a definitional tower of Babel. *Research in the Social Scientific Study of Religion, 13*, 23-54.

Zinnbauer, B. J., & Pargament, K. I. (2005). Religiousness and spirituality. In R. F. Paloutzian & C. L. Park (Eds.), *Handbook of the psychology of religion and spirituality* (pp. 21-42). New York, NY: Guilford Press.

Zinnbauer, B. J., Pargament, K. I., Cole, B., Rye, M. S., Butter, E. M., Belavich, T. G., . . . Kadar, J. L. (1997). Religion and spirituality: Unfuzzying the fuzzy. *Journal for the Scientific Study of Religion, 36*, 549-564. doi: 10.2307/1387689

Zinnbauer, B. J., Pargament, K. I., & Scott, A. B. (1999). The emerging meanings of religiousness and spirituality: Problems and prospects. *Journal of Personality, 67*, 889-919. doi: 10.1111/1467-6494.00077

APPENDICES

APPENDIX A: PARTICIPANT RECRUITMENT

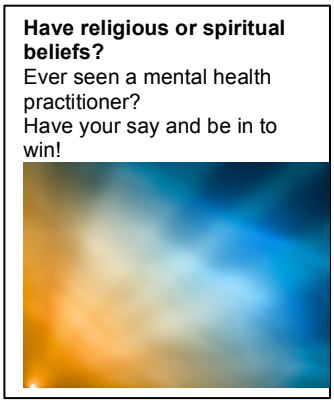

Figure 1. *Facebook advertisement.*

Figure 2. *Letterbox flyer.*

Email to religious organisations

Hi there,

This is just a quick email to see whether you allow notices to be placed in your weekly notices, notice board, magazine, or on your website.

I am a PhD student from Massey University in Auckland, New Zealand and currently undertaking my clinical psychology training. My PhD research is investigating how people's religious/spiritual beliefs are taken into consideration in mental health care (i.e., by counsellors, psychologists, and other mental health professionals).

I am looking for people in England, N.Z., Australia, and the U.S., to take part in the research who:
a) hold some form of religious/spiritual belief,
b) have seen a counsellor, psychologist, or other mental health practitioner, and
c) are over the age of 16
Anyone who meets these criteria can participate by completing a 10 minute questionnaire online at www.beliefs-survey.co.nz. This website is secure and anonymous.

If there is any opportunity to place a notice about the research in your notices, please email me to let me know how this can be done. Otherwise, I have attached a brief notice (below) that can be copied into a newsletter.

Thank you so much for your help, and please let me know if you have any questions (including whether you would like a copy of the research results). Feel free to pass on this info to any of your friends or colleagues who might be interested.

Kind regards,

Bronwyn Castell.

(attached notice)

International PhD Study: Religious and Spiritual Beliefs in Mental Health Care
Have you ever seen a counsellor, psychologist, or other mental health professional?
If so, you are invited to take part in a 10-15 minute online survey investigating how people's religious/spiritual beliefs are taken into consideration in mental health care.
Go to www.beliefs-survey.co.nz to take part and go into the draw to win a $300 camera.

APPENDIX B: PARTICIPANT INFORMATION SHEET

MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGA TANGATA

Clients' Expectations and Perceptions of how Spiritual and Religious Beliefs and Practices are Addressed by Mental Health Practitioners

Who is conducting the research, and what is the research about?
My name is Bronwyn Clark, and I am currently working toward a PhD in Psychology. I would like to invite you to take part in a survey developed to gather information about people's spiritual and/or religious beliefs, particularly in relation to experiences with a mental health practitioner.

What does taking part involve?
You are being invited to take part if you identify as having some form of spiritual or religious belief, have seen a mental health practitioner (either in the past or currently), and are over the age of 16.

If you choose to participate, you can go to the website **www.beliefs-survey.co.nz** to complete a questionnaire consisting of three parts. Not all parts will be relevant to you, in which case you can skip them.

The questionnaire should take about 10-15 minutes to complete. You are welcome to fill it at your own leisure. Completion and submission of the questionnaire implies that you consent to participate. You have the right to decline to answer any particular question.

You may experience some discomfort answering questions of a personal nature. If you are concerned by any discomfort these questions cause you, support is available from Lifeline (0800 543 354 in NZ, or 13 11 14 in Australia).

What will happen to the information I provide?
The information you provide will not be used to identify you in any way, will be kept confidential, and will not be used for any purpose other than research. Your responses will be stored in a secure location; only I and my supervisors will be able to see them. The data will be securely destroyed after ten years.

If you choose to participate, you will be entered into a prize draw to win a digital camera worth $300. You will also have the opportunity to receive feedback on the results of the study and take part in further research if you wish. To indicate your interest in any of these, enter your contact details at the end of the questionnaire. These details will not be associated with your responses.

Contacts
If you have any questions or concerns about this study, please contact me at b.d.clark@massey.ac.nz, phone 0064 9 414 0800 ext. 41243, or my supervisor Jennifer Stillman at j.a.stillman@massey.ac.nz, phone 0064 9 414 0800 ext. 41218.

Thank you very much for your help.

Yours sincerely,

Bronwyn Clark.

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application 10/008. If you have any concerns about the conduct of this research, please contact Dr Denise Wilson, Chair, Massey University Human Ethics Committee: Northern, telephone 0064 9 414 0800 x9070, email humanethicsnorth@massey.ac.nz.

Te Kunenga ki Pūrehuroa

School of Psychology – Te Kura Hinengaro Tangata
Private Bag 102904, North Shore Mail Centre, Auckland 0745, New Zealand T +64 9 414 0800 extn 41244 F +64 9 414 0831
www.massey.ac.nz

APPENDIX C: QUESTIONNAIRE

SPIRITUALITY, RELIGION, AND MENTAL HEALTH SERVICES: QUESTIONNAIRE

SECTION ONE

Please circle the answer that best applies to you:

1. Are you: Male Female

2. What is your age? _____

3. Which ethnic group do you most strongly identify with?

   a. New Zealand European
   b. Māori
   c. Chinese
   d. Samoan
   e. Indian
   f. Cook Island Maori
   g. Tongan
   h. English
   i. Korean
   j. Dutch
   k. Other *(please specify)* _____

4. Which religious group or organisation do you identify with?

   a. Buddhist
   b. Christian
   c. Hindu
   d. Jewish
   e. Muslim
   f. Ratana
   g. Ringatū
   h. No religion
   i. Other *(please specify)* _____

   If you circled any option in the first column (a-e), please specify which denomination, division, or branch you identify with (if any): _____

Some people consider there to be a difference between being 'religious' and being 'spiritual'. To assist you in answering some of the questions in this survey, general definitions of 'religious' and 'spiritual' are provided below:

Religious: Being religious sometimes involves adhering to the beliefs and practices of a formal religion. Often it involves a commitment to sacred rules or laws.
Spiritual: Being spiritual sometimes involves having a belief in, experience of, or connection with a God, spiritual being, ancestor, or realm outside of ordinary human experience. This can also include oneness with nature.

5. My spirituality is most closely represented by: *(circle all that apply)*

   a. I do not have any spiritual beliefs
   b. Belief in a realm that exists outside of ordinary human experience
   c. Belief in spiritual beings that exist outside of ordinary human experience
   d. Belief in God
   e. Belief in a deity higher than oneself
   f. Belief in more than one God or deity
   g. Communication or connection with a God or deity
   h. Communication or connection with a spiritual being
   i. Wairua Māori
   j. A spiritual connection with ancient ancestors (Tupuna)
   k. A belief than Tapu can affect me
   l. Having a spiritual association with the land
   m. Enlightenment
   n. A close connection with nature
   o. I have spiritual beliefs but none of these apply to me

6. Are there any other ways you would define your spirituality?

_____

_____

_____

7. Using the definition of 'religious' provided earlier, to what extent do you consider yourself to be religious?

1	2	3	4	5	6	7	8	9	10
not religious at all									highly religious

8. Using the definition of 'spiritual' provided earlier, to what extent do you consider yourself to be spiritual?

1	2	3	4	5	6	7	8	9	10
not spiritual at all									highly spiritual

SECTION TWO

The next ten questions are about your religious beliefs and practices. Please indicate the extent to which the following statements are true of you *at the moment*.

If you do not have any religious beliefs or practices you can go directly to question 19

	1	2	3	4	5
9. I often read books and magazines about my faith.	not at all true of me	somewhat true of me	moderately true of me	mostly true of me	totally true of me
10. I make financial contributions to my religious organisation.	not at all true of me	somewhat true of me	moderately true of me	mostly true of me	totally true of me
11. I spend time trying to grow in understanding of my faith.	not at all true of me	somewhat true of me	moderately true of me	mostly true of me	totally true of me
12. Religion is especially important to me because it answers many questions about the meaning of life.	not at all true of me	somewhat true of me	moderately true of me	mostly true of me	totally true of me
13. My religious beliefs lie behind my whole approach to life.	not at all true of me	somewhat true of me	moderately true of me	mostly true of me	totally true of me
14. I enjoy spending time with others of my religious affiliation.	not at all true of me	somewhat true of me	moderately true of me	mostly true of me	totally true of me
15. Religious beliefs influence all my dealings in life.	not at all true of me	somewhat true of me	moderately true of me	mostly true of me	totally true of me
16. It is important to me to spend periods of time in private religious thought and reflection.	not at all true of me	somewhat true of me	moderately true of me	mostly true of me	totally true of me
17. I enjoy working in the activities of my religious organisation.	not at all true of me	somewhat true of me	moderately true of me	mostly true of me	totally true of me
18. I keep well informed about my local religious group and have some influence in its decisions.	not at all true of me	somewhat true of me	moderately true of me	mostly true of me	totally true of me

The next six questions are about your spiritual beliefs and practices. Please indicate how you feel about each statement *at the moment*. **Note that some of the scales are reversed.**

If you do not have any spiritual beliefs or practices, you can go directly to section three (below)

19. In terms of the questions I have about life, my spirituality answers…

0 (no questions) 1 2 3 4 5 6 7 8 9 10 (absolutely all my questions)

20. Growing spiritually is…

10 (more important than anything else in my life) 9 8 7 6 5 4 3 2 1 0 (of no importance to me)

21. When I am faced with an important decision, my spirituality…

0 (plays absolutely no role) 1 2 3 4 5 6 7 8 9 10 (is always the overriding consideration)

22. Spirituality is…

10 (the master motive of my life, directing every other aspect of my life) 9 8 7 6 5 4 3 2 1 0 (not part of my life)

23. When I think of the things that help me to grow and mature as a person, my spirituality…

0 (has no effect on my personal growth) 1 2 3 4 5 6 7 8 9 10 (is absolutely the most important factor in my personal growth)

24. My spiritual beliefs affect…

10 (absolutely every aspect of my life) 9 8 7 6 5 4 3 2 1 0 (no aspect of my life)

SECTION THREE

The next few questions are about your expectations and experiences of a mental health practitioner

Important: If you have seen both public (provided by a district health board or government health service) *and* private mental health practitioners, please answer the following questions in relation to the **public practitioner** that you saw **most recently.**

If you have *only* seen a private mental health practitioner, please answer in relation to the private practitioner that you saw most recently.

25. Is the practitioner you are answering these questions about: *(please circle one)*

Public Private

26. What is the *job title* of the mental health practitioner you are answering these questions about?

a. Care co-ordinator*
b. Psychotherapist
c. Psychologist
d. Psychiatrist
e. Mental health nurse
f. Maori mental health worker
g. Pacific mental health worker
h. Social worker
i. Occupational therapist
j. Don't know
k. Other *(specify):* _____

**If you circled 'care co-ordinator', please also circle their profession, if you know it.*

27. In which country did you consult with this mental health practitioner? _____

28. Did your mental health practitioner identify with similar religious or spiritual beliefs as yourself? *(please circle one)*

Yes No Don't know

29. At the time that you saw this mental health practitioner, to what extent would you have considered yourself to be religious?

1 (not religious at all) 2 3 4 5 6 7 8 9 10 (highly religious)

30. At the time that you saw this mental health practitioner, to what extent would you have considered yourself to be spiritual?

1 (not spiritual at all) 2 3 4 5 6 7 8 9 10 (highly spiritual)

To what extent do you agree with the following statements?

31. Prior to contact with my mental health practitioner, I expected to be asked about any religious or spiritual beliefs that I had

1 (do not agree at all) 2 3 4 5 6 7 8 9 10 (completely agree)

32. Prior to contact with my mental health practitioner, I…

a. Expected that my *religious* beliefs would be taken into consideration

1 (do not agree at all) 2 3 4 5 6 7 8 9 10 (completely agree)

b. Expected that my *spiritual* beliefs would be taken into consideration

1 (do not agree at all) 2 3 4 5 6 7 8 9 10 (completely agree)

33. Prior to contact with my mental health practitioner, I expected they would understand how my religious or spiritual beliefs were relevant to my recovery

1 (do not agree at all) 2 3 4 5 6 7 8 9 10 (completely agree)

34. Did your mental health practitioner ask you whether you had any religious or spiritual beliefs?

Yes *(go to the next question)* No *(go to question 35)*

34.a. When were you asked?

i. During the first two meetings with my mental health practitioner

ii. Later than this

34.b. How in-depth was the discussion?

i. Brief (I was only asked one or two questions about religious or spiritual beliefs)

ii. More in-depth than this

35. Did you discuss your spiritual or religious beliefs at all with your mental health practitioner?

Yes *(go to the next question)* No *(go to question 41)*

To what extent do you agree with the following statements?

36. My mental health practitioner allowed me to feel comfortable discussing my spiritual or religious beliefs with them.

37. I felt comfortable *initiating* a discussion about my spiritual or religious beliefs with my mental health practitioner.

1 (do not agree at all) 2 3 4 5 6 7 8 9 10 (completely agree)

If you like, you can use this space to explain your answers to questions 36-37:

_____

_____

_____

38. My mental health practitioner understood how my spiritual or religious beliefs were relevant to my recovery

39. During their work with me, my mental health practitioner…

    a. Took my *religious* beliefs into consideration.

    b. Took my *spiritual* beliefs into consideration.

40. I am satisfied with the <u>*way*</u> in which my mental health practitioner took my religious or spiritual beliefs into consideration.

1 (do not agree at all) 2 3 4 5 6 7 8 9 10 (completely agree)

If you like, you can use this space to explain your answers to questions 38-40:

_____

_____

_____

41. It was important to me for my religious/spiritual beliefs to be taken into consideration

1 (do not agree at all) 2 3 4 5 6 7 8 9 10 (completely agree)

If you like, you can use this space to explain your answer to question 41:

_____

_____

_____

42. My mental health difficulties were wholly or partly a result of spiritual or religious factors.

43. My spiritual or religious beliefs could have helped me to recover from my mental health difficulties.

1 (do not agree at all) 2 3 4 5 6 7 8 9 10 (completely agree)

If you like, you can use this space to explain your answers to questions 42-43:

44. Using the space below, please answer one of the following questions: *(circle one)*

    a. If your religious and/or spiritual beliefs were *not* taken into consideration, how would you have liked this to happen? OR……

    b. If your religious and/or spiritual beliefs *were* taken into consideration, what did you find the most helpful, and what could have been improved? OR…….

    c. If you would *not* want your religious and/or spiritual beliefs to be taken into consideration, why?

You have reached the end of the questionnaire. Thank you very much for your time

Place this survey in the large freepost envelope it came in, and put it in any NZ Post post box.

Entry for the prize draw, and request for the results of the questionnaire, are attached to the back

PRIZE DRAW ENTRY FORM / REQUEST FOR RESULTS

Tick the boxes that are relevant to you (you don't have to tick any of them if you don't want to):

☐ I would like to be entered into the prize draw for a digital camera worth $300

☐ I would like to know the results of the study

☐ I would like to take part in another research study similar to this one (this may involve an interview)

If you ticked any of the above, please provide your details below so you can be contacted:

To protect your privacy, you may use a pseudonym (false name) in place of your real name. Please ensure that it is a name that you will remember (e.g., a pet's name).

Name: _____

Phone: _____

Email: _____

Postal Address: _____

_____

_____

Detach this form from the questionnaire and send it in the small freepost envelope, separate from your survey