



Psychotherapists' experiences of working with religion and spirituality in psychotherapy

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I declare that this research project is my own unaided work. It has not been submitted before for any other degree or examination at this or any other university.

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Abstract

Recent research indicates an increasing demand for psychotherapists to attend to the religious and spiritual needs of their clients in an ethical and growth-promoting way. This study's primary objective was to investigate the experiences of psychotherapists in navigating religion and spirituality in the therapy room. This research highlighted the complex nature of navigating religion and spirituality in therapy, foregrounding the need for spiritual competency, self-awareness and dialogue. This research was structured qualitatively, using open-ended semi-structured interviews to collect data. Psychologists registered with the HPCSA were asked to voluntarily participate in one-on-one interviews. Participants needed to have clinical experience of working with religion/spirituality in therapy, and were required to have practised for at least one year after fully qualifying. A sample of eight participants was interviewed. Transcribed interviews were analysed using Thematic Analysis (TA).

Significant themes that arose from analysis of the data included: areas of opposition and rapprochement between the domains of religion/spirituality and psychotherapy; ways in which religion/spirituality could be experienced as helping or hindering for psychological growth and the therapeutic process; ways of engaging with clients' religious/spiritual material that preserved the therapeutic relationship and honoured the clients' belief system; significant tension and discomfort between the personal and professional roles of the psychotherapist in relation to religion/spirituality in therapy. Findings further suggest that there is a need for more training in the realm of spiritual competency, particularly given the fraught historical relationship between psychology and religion, the professional taboo of engaging with it, and the multi-religious, multicultural context of South Africa.

Keywords: *South Africa; religion; spirituality; psychotherapy*

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Chapter 1: Introduction

Psychotherapy as a discipline has a long and complicated history with religion and spirituality, concepts which occupy an uneasy space in the therapeutic realm. Freud famously viewed religion as a delusion (Freud, 1927), and subsequent theorists extrapolated on this critical standpoint by focusing on it variously as a negative adaptation, a projection, or as pathology (Florence, 2009).

As a discipline, psychology has sought to distance itself from religion and philosophy, perhaps as a way to establish its credentials as a so-called hard science (Pargament, 2007). The longstanding diminution of this realm has had a lasting impact on its exclusion from the area of psychotherapy (Tummala-Narra, 2009). This theoretical distancing has frequently been echoed in the personal lives of psychologists who, literature suggests, often separate their professional domain from their own religious or spiritual beliefs with thickly drawn boundary lines (Florence, 2009; Tummala-Narra, 2009). Research indicates that this ‘disconnect’ plays out in the therapeutic space, where both clients and therapists may avoid the discussion of religious or spiritual content due to the discomfort which arises.

Increasingly, however, there has been a turn towards both investigating and appreciating the nuanced relationship between psychotherapy and religion/spirituality. More recently, in the light of post-positivistic paradigms, the World Health Organisation has acknowledged spirituality as a key factor of holistic health (WHO, 1998) and disciplines within the social and medical sciences are beginning to explore this dynamic interaction between belief systems and overall wellbeing. Within the realm of psychology, a similar openness towards a more holistic understanding of a person has emerged (Pargament, 2007) and the biopsychosocial-*spiritual* framework is increasingly validated and appreciated by experts in the field, including in the South African landscape (Brown et al., 2013; Elkonin et al., 2014). This framework also considers how a therapist positions their own beliefs or lack of beliefs, and how this has a bearing on the therapeutic relationship. More recent qualitative studies indicate that, regardless of

personal belief systems, therapists frequently avoid the topics of religion and spirituality with their clients (Elkonin et al., 2014; Haycock, 2014; Tummala-Narra, 2009). As noted by Tummala-Narra (2009): “In a therapeutic relationship, silence on issues of religion and spirituality indicate a tacit avoidance of core aspects of the client’s inner life” (p. 84). In contrast, a biopsychosocial-spiritual framework posits that authentic, holistically inclined care requires attention to all of the disturbances in a person’s relational experiences, including the relationship they have with the transcendent (Sulmasy, 2002, as cited in Elkonin et al., 2014).

The focus on religion in psychotherapy is of further import when the context of the South African landscape is considered. The International Religious Freedom Report (2006) indicates that not only are South Africans a religiously-inclined population as a whole, but that a rich diversity of beliefs and practices is represented. Moreover, religion is strongly connected to culture, identity and wellbeing. South African psychotherapists will thus inevitably face the challenges of navigating matters of a religious or spiritual nature (Elkonin et al., 2014).

This research thus aims to focus on the role that religion and spirituality play in the therapeutic dyad, exploring clinicians’ experiences of navigating such issues with their clients and how their own positioning impacts on this. In particular, the study hopes to focus on the impact of the above on the therapeutic relationship, including the specific issues of transference and countertransference. While emerging studies explore the relevance of religion and spirituality, they have focused largely on the client’s experience (Knox et al., 2005; Rose et al., 2001) and a dearth of therapist accounts is noted (Johnson et al., 2007; Strawn, 2007; Tummala-Narra, 2009). The topic as a whole remains largely underexplored in the South African context (Elkonin et al., 2014; Haycock, 2014). A further aim of the study is to explore the therapist’s experience of their own religious standpoint, and how this informs their experience of their client. This study also hopes to gain insight into how therapists perceive the role of religion/spirituality in the process of their client’s psychological growth or stagnation. The focus of the study is thus on

both the intrapsychic and interpersonal impacts of religion/spirituality being introduced into the therapy room, exploring the effects on both parties of the therapeutic dyad from the perspective of the psychotherapist.

Research aims

This research focuses on various aspects of psychotherapists' experience of engaging with religious beliefs. The first area focuses on views regarding the degree of compatibility of religion and psychotherapy, exploring this in the context of the historical dissonance between the spheres. This exploration further encompasses ways in which psychotherapists see complementarity and rapprochement between the fields. The study also aims to explore ways in which religious beliefs are seen to be psychologically harmful versus ways in which they support psychological growth. A further aim is to investigate psychotherapists' ways of working with religious content, particularly given the complex nature of such work. Lastly, this research hopes to offer insight into therapists' reflexive positioning, shedding light on both professional and personal stances towards religious beliefs. Overall, attention will be paid to issues of transference and countertransference linked to religious and spiritual issues. This is particularly pertinent as no relevant literature focusing specifically on this in the South African context could be found.

Research questions

This research asks the following questions: (1) How do therapists experience religion/spirituality in relation to psychotherapy, particularly when considering areas of compatibility or incompatibility? (2) How do therapists experience religion/spirituality as either growth-promoting or as inhibiting of psychological development? (3) How do psychotherapists engage with religious/spiritual content and work within their patients' religious worlds? (4) How do psychotherapists navigate their positionality, particularly with regards to tensions between their personal and professional identity with regards to religion/spirituality?

Rationale

Increasingly, clients seek therapists who will discuss the spiritual elements of their lives (Brown et al., 2013; Cunha & Scorsolini-Comin, 2021; Florence et al., 2019; Haycock, 2014; Knox et al., 2005; Tummala-Narra, 2009). While it is recognized that religion and spirituality are essential to the psychological identity and development of many individuals (Mayers, 2007; Sperry, 2012; Tummala-Narra, 2009; Zinnbauer & Pargament, 2000), there is still a dearth of research on the spirituality gap existing between psychologist and client. Furthermore, existing studies reflect an ongoing resistance on the part of psychotherapists to directly address it in their therapy rooms. Reasons for this avoidance may include their own discomfort levels with topics related to religion and spirituality, their own biases towards or against belief systems, and a sense of being undertrained for the task (Brown et al., 2013; Elkonin et al., 2014; Florence et al., 2019; Naicker, 2010; Patel & Shongo, 2006; Rupert et al., 2019). Cohen (1994) argues that if therapists themselves lack the self-awareness of the implication of their personal religious orientation and have themselves been reluctant to submit such content to their own analysis process, they will not be comfortable facilitating discussion of the disquieting and weighty existential issues that matters of belief can raise. This anxiety could then be projected onto clients. Greer (2005) supports this perspective, suggesting that if therapists – who are deemed to be psychologically sophisticated in their functioning – cannot integrate religion and spirituality for themselves, they will not be able to help their clients resolve similar tensions. Furthermore, authors such as Griffith (2006) posit the idea of religious transference as an underexplored area of impact on the therapeutic dyad.

While there is a growing body of literature surrounding religion and spirituality in the therapeutic space, there is a marked lack of research, both globally and in the South African context, into psychotherapist's perspectives and experiences of navigating this in sessions (Florence, 2009; Florence et al., 2019; Haycock, 2014; Johnson et al., 2007; Knox et al., 2005). Only four qualitative studies of psychologist perspectives in South Africa are known to the researcher. A

2013 study conducted by Brown et al. (2013) examines psychologists' perceptions of the concepts of religion and spirituality, as well as examining enablers and barriers to engaging with religion in therapy. A further study by the same researchers looked at the implications of the lack of training for South African psychologists in this area (Elkonin et al., 2014). A qualitative study which interviewed Hindu psychologists regarding their perceptions of mental illness was undertaken by Padayachee and Laher (2014). However, this study focused specifically on Hindu psychologists, and aimed to elicit content related to non-Western illness models. A 2010 Master's dissertation explored psychologists' perceptions of the use of religion and spirituality in therapy, focusing predominantly on religion's relationship to coping strategies (Naicker, 2010). Haycock's (2014) Master's level study highlighted therapists' perceptions of their own spiritual competency in their navigation of religious and spiritual content with clients. Both of these studies emphasized the underexplored nature of the terrain, and called for further research. Overall, there is a scarcity of research into how the introduction and exploration of religion and spirituality impacts the therapeutic relationship in general. No studies focusing specifically on the issue of religious transference and countertransference in the South African context is known to the researcher.

Whilst religion is certainly an area fraught with tensions in the psychotherapy space, it is also an area of clinical interest in that it undoubtedly colours the client-therapist relationship. The dearth of research in this area potentially contributes to a lack of understanding about the clinical implications for psychotherapists when working with clients' religious beliefs. An in-depth qualitative study could thus result in invaluable insights which could inform and enrich future discourse on the topic in the South African landscape, and which could prove useful in the future training of clinicians. The dearth of in-depth therapist accounts exploring their comprehensive experience in this regard is notable. Accordingly, this research aims to directly ask therapists about this experience.

Key Concepts

Along with this ‘spiritual turn’ in psychology, a reconceptualization of religion and spirituality in psychotherapy has emerged. For the purposes of this study, a discussion of these key concepts is needed. While no single definition is considered authoritative, recent theorists in the field of psychotherapy have articulated helpful conceptualisations.

Spirituality

The term ‘spirituality’ tends to have a broader scope compared to the term ‘religion’ and encompasses the feelings, thoughts, and actions of an individual seeking to engage with their version of the ‘sacred’ (Pargament, 2007). Furthermore, spirituality is generally conceived of as individualised and idiosyncratic, whilst still connecting the individual to something ‘beyond’ (Tummala-Narra, 2009). This conceptualisation is perhaps apt for more traditional incarnations of African spirituality in which interconnectedness and holism are central (Cilliers, 2009). In addition, spirituality may or may not incorporate religious elements and concerns, whereas religion tends to contain aspects of spirituality (Patel & Shikongo, 2006). Spirituality could also be construed as reflecting an intuitive element of human nature that is linked to phenomena such as reverence, awe, wonder, belonging and unconditional love (Gibson, 2003, as cited in Elkonin et al., 2014).

Religion

The term ‘religion’, on the other hand, is usually viewed as relating to a more structured and identifiable belief system (Zinnbauer & Pargament, 2000). In a similar vein, Lines (2006) views religion as a prescriptive and rigid societal construct aimed at providing structure. Tummala-Narra (2009) identifies religion as exhibiting elements of the communal and archaic, and adhering to more traditional God representations. It usually espouses codified value systems and has identified leaders. An important aspect to note is that religion is so often interwoven with culture as to be, at times, functionally indiscernible, and any

discussion of religion should take cognisance of this intimate connection (Tummala-Narra, 2009).

Despite the differences between the concepts, the terms are often used interchangeably in both clinical and theoretical literature (Tummala-Narra, 2009) and can be so hard to tease apart that for the purposes of this study, the combined term ‘religiosity/spirituality’ (RS) will be discussed as one entity encompassing all above aspects, denoting an individual’s sense of the ‘eternal’ and their ensuing relationship therewith. This is in keeping with recent psychological studies by researchers who question the practice of delineating between the two concepts due to the similarity of feelings and experiences involved, as well as the subjective, complex nature of such multidimension phenomena (Cunha & Scorsolini-Comin, 2019). At times, the terms ‘religion’ and ‘spirituality’ may be used interchangeably in this report. Additional terms such as ‘faith’ and ‘belief’ will also be used to broadly encompass the concept of religion and spirituality.

Furthermore, the terms ‘God’, ‘god-object’, ‘the sacred’ or ‘the divine’ will be used interchangeably to refer to a client’s or therapist’s personal representation of their perceived higher power. It should be noted that by using these terms, no value judgement is attached by the researcher. This study is not concerned with the so-called veracity of a client’s belief system, but only with how such belief impacts the therapeutic space and the client-therapist relationship.

Fundamentalism

As participants in this study refer to religious ‘fundamentalism’, it is important to note the way in which this term is conceptualized. Negative connotations in popular media frequently link the term ‘fundamentalism’ to religious extremism, often associating it with acts of violence or terrorism. However, for the purposes of this study, the term is used in a less political sense, referencing its theological origins. Vorster (2010) notes that fundamentalism can be active in all religions. The tenets of religious fundamentalism are conceived of

as follows: fundamentals of the historical faith are elevated to ‘absolutes’, leaving no room for relativity; a text or source is used in a literalist manner with little to no regard for its cultural, historical and contextual context; casuistic ethics are adopted which promote a legalistic lifestyle concerned with outward ways of conduct; a rigid, homogenous culture with strong leadership is present; a clear in-group and out-group predicated on an identifiable other is usually identified. Summers (2006) confirms the above representation of religious fundamentalism, noting its tendency towards literalism and a pervasive fear that the original tenets of the faith will be diluted. The act of interpretation of a text or set of tenets is thus regarded as an “attack” (p. 355). Summers further notes that:

The fundamentalist draws a sense of self not just from adherence to a belief system, but from the epistemological and ethical certainty of its doctrines. For the fundamentalist, the faith is not an incidental part of his life, but the very definition of who he is. (p. 337)

The importance of religion to identity and as a tether to an existential sense of positioning in the world is thus emphasized. While both researchers note the potential for violence arising from fundamentalism, it is not a necessary descriptor and many so-called moderately religious individuals in so-called ‘mainstream’ religions may subscribe to a form of fundamentalism without necessarily identifying with the term.

It is further important to note that the term ‘fundamentalism’ can be applied to secular movements too, denoting an approach to a practice or ideological system that eradicates alternate theories and areas of uncertainty, creating suspicion about those who hold different beliefs (Summers, 2006). This is of import when participants discuss forms of psychotherapeutic fundamentalism.

Structure of the thesis

This study uses a qualitative approach to explore the experiences of eight

South African psychologists as they reflect on how they encounter and respond to issues of religion and spirituality in the therapeutic relationship. This chapter has presented the aim, rationale and context of the study. Key concepts pertinent to the study were defined.

The second chapter encompasses a literature review, focusing on the contentious history between religion and psychotherapy. Historical views regarding areas of oppositionality, as well as potential rapprochement and complementarity are explored. Common issues related to religion and spirituality which arise in therapy will also be highlighted, as well as therapists' varying evaluations of healthy versus unhealthy spiritual frameworks. The South African context is given special consideration, highlighting the need for cultural and spiritual competence given the diverse population and the importance of indigenous and non-Western conceptualisations of mental health and healing. More recent literature on religion in psychotherapy is explored and differing approaches to working with such content are investigated, including intersubjective and relational psychoanalytic conceptualisations. In particular, Object Relations perspectives are discussed, with a focus on the impact of the perceived quality of relationship with the divine. An exploration of psychoanalytic literature highlights the key role of religious transference and countertransference in the therapeutic dyad.

The third chapter outlines the research methods used in this study. Firstly, the nature of the qualitative design and interpretive approach is delineated. Secondly, the purposive snowball sampling approach is explained and the inclusion criteria are clarified. Next, the methods of data collection and analysis, namely semi-structured interviews and thematic analysis, are discussed. An exploration of ethics considerations applicable to this study concludes the chapter.

Chapter Four present the results of the study and four main themes are highlighted: (1) Religion and psychotherapy: opposition and rapprochement; (2) Religion as growth-promoting or growth-inhibiting; (3) Engaging with patients' religious worlds in psychotherapy; (4) Psychotherapists' positionality: navigating the tension.

The fifth chapter allows an opportunity for discussion of the results in the context of existing literature. Areas for potential future research are identified and limitations of the study are noted.

Chapter 2: Literature review

This chapter aims to present the study's identified research problem in dialogue with relevant existing literature on the intersection of psychotherapy and religion/spirituality. Firstly, the centrality of RS to the psychotherapeutic project will be examined, followed by literature which highlights ways in which religious content emerges in therapy.

Next, literature pertaining to RS in psychotherapy within the specific socio-cultural context of South African is examined. This is important to highlight barriers and implications which may be more specific to the local context. Accordingly, differing models of illness and healing are considered.

Thereafter, barriers to working effectively with RS in the therapy room will be explored. This will focus on both psychotherapist and patient barriers, and both intrapsychic and external hindrances will be considered.

Following that, a survey of existing literature which evaluates the role of religion as either psychologically harmful or helpful will be undertaken, focusing on the therapeutic skill required to navigate this.

This is followed by an exploration of psychoanalytic approaches to RS which is considered key as Freud's antagonistic views of religion have been foundational to the development of psychoanalysis, and continue to permeate the practice of psychotherapy. An overview of the historically complex relationship between psychoanalytic approaches and RS will be presented, and the changing and diverse discourse surrounding the intersection of the two domains will be elucidated. This can be seen as important to understanding current clinical implications for psychotherapists, as well as providing a more comprehensive context in which barriers to practice emerge.

Lastly, contemporary conceptualisations and approaches to working with RS are foregrounded and their implications noted. This predominantly focuses on psychoanalytic ideas, as these have been most formative with regards to the existing tension between the realms of psychotherapy and religion. In addition, contemporary psychoanalytic approaches offer a variety of formulations that are potentially helpful for understanding the role of RS in the therapeutic encounter and which may offer insights into directions for future clinical practice.

2.1 The centrality of RS

Interest in the influence of RS in the therapeutic space has steadily risen in recent years (Bartoli, 2007; Cataldo, 2019; Cohen, 2019; Robertson, 2006; Shafranske, 2005; Tummala-Narra, 2009; Winton, 2013). Several theorists emphasise the key role that RS plays in an individual's identity, as well as in their relationship with their community, the divine and themselves (Cataldo, 2019; Heyer, 2016; Sperry, 2012; Tummala-Narra, 2009; Winton, 2013; Zinnbauer & Pargament, 2000). Issues of religion and spirituality are deeply entwined with all areas of an individual's identity construction (Tummala-Narra, 2009) and recent research emphasises that RS requires focused attention in psychotherapy (Cunha & Scorsolini-Comin, 2019; Sperry, 2012). This line of reasoning further suggests that attending to a client's beliefs should be a standard part of the therapy process (Kahle & Robbins, 2014). Furthermore, qualitative studies with psychotherapists in places such as Brazil (Cunha & Scorsolini-Comin, 2019), New Zealand (Florence et al., 2019) and South Africa (Elkonin et al., 2014) posit that RS content permeates psychotherapy, even when not explicitly addressed. Paying skillful attention to these issues thus demonstrates respect for the needs of the patient (Rupert et al., 2019). There is an increasing desire on the part of clients to address RS issues directly, and clients accordingly seek out practitioners who are willing to engage in this arena (Florence et al., 2019; Hage, 2006; Haycock, 2014). Florence et al. (2019) suggest that this uptick of interest in RS in psychotherapy could be partly attributed to an increasingly multi-cultural and religiously diverse society in a globalized world.

2.2 RS content in therapy

An overview of the reviewed literature, both locally and globally, indicates that psychotherapists commonly encounter religion-related problems which they hope to address in psychotherapy. This literature orients us to the frequency and thematic content of RS-related themes arising in therapy. For example, Johnson's (2007) qualitative study interviewed therapists about their experience of navigating aversive religious experiences in therapy, noting that 32% of clients had experienced distress relating to RS issues. Furthermore, this study found that spiritual concerns were often linked to clients' presenting problems, but that this was not directly addressed during intake and only came to light as therapy evolved. Johnson et al. (2007) identified common problems requiring therapeutic attention. A frequent theme was that of evolving spiritual beliefs resulting in doubt and inner conflict, sometimes related to the prescriptive nature of a religious belief system. Another area highlighted was that of arrested spirituality, whereby a client was mourning the loss of their spiritual connection and yearning to re-establish it. A third category involved client beliefs that therapists viewed as harmful, such as rigid beliefs and practices, or extreme moral scrupulosity. This was frequently connected to issues of guilt around prohibitive sexual mores. It could also be linked to internalized ideas touting submission and self-denial which negatively impacted on a client's relationships and self-esteem. A fourth area of distress involves clients who are in conflict with their God object or spiritual community. This too could be linked to expectations regarding sexuality or gender. Distress could also be as a result of a perceived broken relationship with God. Experiencing feelings of resentment towards the church community or God caused further anguish.

Haycock's (2014) South African study also noted excessive guilt and self-judgement to be a prominent presenting problem in need of therapeutic attention. A further area which therapists report is that of a client's struggle in moving away from a fundamentalist faith system, requiring a renegotiation of the way that they view and interact with the world (Florence et al., 2019). Literature also indicated the pervasiveness of existential matters concerning the purpose of existence, questions which often take on

a religious or spiritual nature (Barrett, 2009; Casement, 2020). However, despite this uptick in interest and surge of literature exploring RS and its relationship to psychotherapy, multiple studies emphasise that there is still a disconnect in practice, and that therapists and clients alike experience barriers and impingements to engaging in this manner (Barrett, 2009; Cohen, 2019; Florence et al., 2019; Haycock, 2014; Johnson et al., 2007; Tummala-Narra, 2009).

2.3 Understanding the South African context

According to Boston University's World Religion Database (2023), South African's population is overwhelmingly religious in nature, with approximately 82% of the population identifying as Christian, 7% following Indigenous beliefs, 6% identifying as atheistic or agnostic, 2.4% as Hindu, and 1.7% as Muslim. The pervasiveness of religious and spiritual beliefs, as well as the diversity of beliefs represented, serves to highlight the importance of a psychotherapeutic practice that is holistic and which attends to a client's emotional, psychological and spiritual needs (Brown et al., 2013; Elkonin et al., 2014; Haycock, 2014; Laher & Khan, 2011; Patel & Shongo, 2006). This is in keeping with global literature already discussed. (e.g. Tummala-Narra, 2009; Winton, 2013). A South African study with Muslim trainee psychologists found that participants recognized the deleterious effect of failing to engage with spiritual issues brought to therapy by clients (Patel & Shongo, 2006). Haycock's (2014) qualitative study with South African psychologists noted that many therapists viewed helping a client to find meaning in their lives as fundamental to the therapeutic project. Furthermore, this question of meaning was frequently linked to the client's spiritual beliefs, and participants believed that the most effective therapy approach was one that addressed both psychological and spiritual factors. However, studies also suggested that psychologists felt undertrained in this vital area (Elkonin, et al., 2012; Haycock, 2014; Patel & Shikongo, 2006).

Any discussion of the interface between RS and psychotherapy in South African needs to consider the specific religio-cultural context in which it is embedded. A growing body of South African literature highlights the importance of acknowledging and

integrating indigenous and non-Western explanatory models of illness into the mental health discourse (Ally & Laher, 2008; Bulbulia & Laher, 2023; Edwards, 2004; Laher, 2014; Laher & Khan, 2011; Marovic & Machinga, 2014; Sodi & Bojuwoye, 2011; Thompson-Assan & Ally, 2024). Emphasising the limitation of Western psychological practices in the South African context, these papers foreground the disconnect between the Western biomedical model, which tends towards body-mind dualism and compartmentalization, and an indigenous approach to health which is more holistic and inclusive of spirituality. This tension between conflicting paradigms is noted as extending to the divide between spiritual beliefs and ‘mainstream’ psychology (Bojuwoye & Sodi, 2010). Accordingly, many individuals would not feel comfortable seeking psychological help, preferring to seek the assistance of traditional or faith-based healers (Bojuwoye & Sodi, 2010; Bulbulia & Laher, 2013; Mkhize, 2004; Thompson-Assan & Ally, 2024).

South African studies emphasise the need for a broader understanding and cultural knowledge on the part of psychologists in order to avoid discriminating against spiritual ‘symptoms’ which may be construed as pathology (Ally & Laher, 2008; Laher, 2014). These papers provide an overview of illness conceptualization in African, Hindu, and Islamic traditions. Furthermore, it is noted that spiritually-based conditions presenting with features such as hallucinations and delusions may be forced into a Western diagnostic model and construed as pathology, instead of viewing them from the position of a cultural or spiritual formulation (Ally & Laher, 2008; Laher, 2014). For example, Laher (2014) draws attention to the process of *Ukuthwasa*, a traditional calling from the ancestors to become a healer, noting that it often presents with experiences such as hallucinations which, in a strictly western biomedical model, could be construed as illness. A study with Hindu South African psychologists similarly suggests that the intertwined nature of mental, physical and spiritual health in Hindu philosophy renders the line between ‘mental’ and spiritual illnesses less clear (Padayachee & Laher, 2014).

Padayachee and Laher’s (2014) study similarly emphasizes the need for expanding the bio-psychosocial conceptualization; in this instance, to include aspects of Hindu philosophy and practice. The study also highlights the inherent tension of drawing

from two different paradigms. Interviews with Hindu psychologists indicated that, in their formulation of mental illness, most participants drew from a traditional bio-psychosocial perspective in line with their clinical training in a Western epistemological framework. However, participants also referenced Hindu concepts such as *Karma* and the influence of astrological forces. In line with a more traditional indigenous cosmology, as discussed above, they also presented the belief that mental illness could result from a lack of balance between the mind, body and soul (p. 431). In addition, participants were comfortable with referring their clients to traditional or spiritual healers for concomitant treatment, thus exhibiting an openness to collaboration between spiritual forms of treatment with psychotherapy. Thus their relationship to what could be conceived of as competing domains was complex and nuanced. However, of note was the study's findings that the participants experienced a level of conflict between their personal and occupational ontological stance. The authors suggest that this points to an important area of research which is not adequately addressed in existing literature, that of the tension between the personal and the professional in the realm of RS beliefs. This is a gap which this research study hopes to address. In accordance with studies already discussed (Ally & Laher, 2008; Bodjuwoye & Sodi, 2010; Laher, 2014; Laher & Khan, 2011), this paper also called for greater religio-cultural competence in the realm of RS.

While the literature discussed already tends to highlight the disconnect between indigenous and psychological healthcare paradigms, Marovic and Machinga's (2022) paper forefronts areas of overlap between African cosmology and transpersonal psychology. Drawing on their experience as clinical psychologist and transpersonal psychotherapist respectively, they advocate for the integration of African indigenous perspectives with psychotherapy. They note that transpersonal psychology acknowledges aspects of the self which transcend the ordinary limits of the ego (Grof, 2008), correlating with a more traditional African cosmology which sees interconnectedness between the individual, family members, wider community, ancestors, and the environment (Marovic & Machinga, 2022). Furthermore, transpersonal psychology makes room for metaphysical experiences and the use of altered states of consciousness in therapeutic ways, a stance which coalesces with indigenous practices encompassing "mystical

experiences and altered states of consciousness” which have the potential to be “healing, educative, transformative and evolutionary” (Marovic & Machinga, 2022, p.33). Noting similar aims of achieving the highest human potential possible, they sound a call for further research into the corresponding dimensions of African indigenous wisdom and transpersonal psychology.

A common theme in the research output discussed in this section is the assertion that, linked to the imposition of western culture and paradigms, indigenous and non-Western religious systems have been denigrated and marginalized in the mental healthcare space (Marovic & Machinga, 2022; Padayachee & Laher, 2014; Sodi & Bojuwoye, 2010). Furthermore, it is suggested that traditional western psychology has shown little interest in indigenous psychological concepts because of an assumption that they are part of religious or “prescientific” worldviews, and thus irrelevant in Western scientific conceptualisations (Chakkarath, 2005, as cited in Padayachee & Laher, 2014, p. 434). Given the context of other forms of political and social oppression, it is pertinent to acknowledge the added impact of such dismissal and disregard on the healing practices and explanatory models which are located outside of the Western paradigm. However, a broad overview of literature points to a well-established discourse concerning the contentious relationship of psychotherapy with all religious systems, even those which could be considered the cultural home of early psychotherapeutic theorists (Florence et al., 2019; Tummala-Narra, 2009). Also of note is the fact that despite a large majority of South Africans adhering to some form of Christian religion, even if in conjunction with indigenous and traditional belief systems, very little literature exists which addresses an exploration of mainstream religion in psychotherapy in the context of South Africa.

2.4 Barriers to engagement with RS in psychotherapy

Global and local literature suggests that there are many reasons for therapist resistance to and avoidance of RS matters with clients, including their fear of overstepping ethical boundaries (Naicker, 2010), lack of spiritual competency (Rupert et al., 2019; Vieten et al., 2013), and concern about colleague’s judgement of them (Barrett, 2009; Florence et al., 2019; Johnson et al., 2007; Winton, 2013). Furthermore,

intrapsychic barriers, such as discomfort with their own religious and spiritual positioning (Cohen, 2019; Magaldi & Trub, 2018; Winton, 2013), or negative biases towards clients' faith frameworks (Hess, 2022; Vieten et al. 2013) also play an inhibitory role. Strawn (2007) noted that RS content was frequently only addressed when considered delusional. Such an approach reduced RS themes to an issue of medicalisation, and thus raises the danger of missing the key role that religion could play in a client's identity and meaning-making process.

2.4.1 Therapists as gatekeepers

A recent New Zealand study of how psychotherapists attend to RS foregrounded the fact that psychotherapists are the 'gatekeepers' who decided how much RS is allowed into the therapy room (Florence et al., 2019). This study found that some therapists simply avoided RS material, fearing judgement from their professional community. Similarly, Johnson's (2007) qualitative study with psychotherapists found that they were hesitant to acknowledge the use of explicitly RS-based treatment in the presence of their professional peers. A study with Brazilian psychotherapists similarly reported that they felt they had to overcome the professional taboo of directly addressing RS in therapy (Vanderberghe & Prado, 2012). South African studies point to similar barriers to practice (Brown et al., 2013; Elkonin et al., 2014; Haycock, 2014). Magaldi and Trub (2018) found that psychotherapists avoided RS material due to fears of impacting the therapeutic rapport.

Johnson et al.'s (2007) paper found that psychotherapists' strong judgmental reactions to religious content could be evoked by earlier memories of aversive religious experiences. This is significant as research suggests that the degree of comfort that a therapist has with regards to their own religious positioning has the potential to significantly affect the therapy process, and thus the client's psychological growth (Barrett, 2009; Haycock, 2014). Haycock's (2014) qualitative study with South African psychologists implies that therapist discomfort is frequently related to personal biases and judgements against clients' worldviews. Haycock further posits that when a client's spiritual inclination is not adequately identified and addressed, discomfort could be

experienced by both partners of the therapeutic dyad. In general, the biases, values and judgements of the therapists in the study were informed by their own spirituality or spiritual journey, and the effects of this filtered into the therapeutic relationship (Haycock, 2014). Haycock (2014) found that the degree of a therapist's openness to a client's spirituality appears to be contingent on the nature of the client's belief system (Haycock, 2014). The greatest area of discomfort was experienced when there was a clear RS-related value clash between therapist and client; for example, when the therapists had difficulty accepting a belief system that emphasises the silencing of women.

Qualitative studies with clients indicate that they may sense a therapist's avoidance of RS content, and through a process of pathological accommodation learn to edit their own content to avoid this area of discomfort (Cohen, 1994; Cohen, 2019; Strawn, 2007). Clients also fear that their faith might be pathologized (Florence, et al., 2019) or that their therapist might impose their own beliefs on them (Griffith, 2006; Knox, 2005). However, it should be noted that qualitative research also indicates that, in an atmosphere of acceptance and unconditional regard, RS issues can be addressed with no discomfort, much like any other topic area (Cunha & Scorsolini-Comin, 2021; Haycock, 2014). This highlights the importance of the therapist's stance towards the client's beliefs, foregrounding a stance of non-judgement and openness as key. These findings suggest that the area of psychotherapist's positioning in relation to their client's RS beliefs is an important area for clinical and research studies.

2.4.2 Spiritual competency

A commonly cited reason for avoidance of RS by therapists was a sense that they lacked the training and competence required to adequately meet the needs of their clients (Cunha & Scorsolini-Comin, 2019; Elkonin et al., 2014; Magaldi & Trub, 2018). Recent studies use the term 'spiritual competency' to refer to the need for practitioners to prioritise and respect their clients' religious or spiritual involvement (Vieten et al, 2013; Rupert et al., 2019). Building on existing ideas of multicultural competence (Sue & Sue, 2003), they argue that much of the work focusing on ethnic and racial diversity does not pay enough attention to spiritual and religious aspects (Vieten et al., 2013). A

practitioner's ability to distinguish between positive and dysfunctional RS beliefs is considered to be part of spiritual competency (Pargament, 1997; Vieten et al., 2013). Rupert et al. (2019) suggest that clinical training in RS is a key part of developing cultural competency, citing its relevance to mental health. They point out clients' desire to discuss RS or existential concerns. Furthermore, they note that committed religious or spiritual clients have better treatment outcomes when their RS paradigm is included, and more negative results if they experience their therapist as avoidant of or biased against their beliefs.

Many theorists have addressed the serious implications of the lack of training in RS matters and studies with therapists demonstrate a desire for further training and supervision in this area (Cunha & Scorsolini-Comini, 2021; Haycock, 2014; Patel & Shikongo, 2006; Plante, 2007; Tummala-Narra, 2009). Patel and Shikongo's (2006) study of Muslim trainee therapists in South Africa indicated that a lack of training led to insecurity and a hesitancy to engage with RS material. Naicker's (2010) study confirms that RS is largely ignored as a topic of importance in South African psychology training programmes.

Research suggests that therapists deal with their lack of spiritual competence in a number of different ways, for example, by referring clients to outsider experts, such as religious leaders or specialist therapists (Elkonin et al., 2014; Florence et al., 2019). Other therapists simply avoid the topic, thus conveying to the client that psychotherapy is not the place to attend to such issues (Florence et al., 2019). A particular area of lack identified in global literature is the competence of therapists in multicultural contexts, as many therapists from westernized backgrounds have a lack of familiarity with indigenous spiritual frameworks (Florence et al., 2019; Tummala-Narra, 2009). Florence et al.'s (2019) study suggested that it is crucial that further research be carried out on the relationship between indigenous Māori spirituality and psychotherapy, preferably "by Māori for Māori" (p. 335) in order to increase spiritual competence. Similar observations in the South African context have already been noted and discussed in detail (e.g. Ally & Laher, 2008).

2.4.3 Issues of self-awareness

A further hindrance to effectively addressing religion and spirituality in the therapeutic context is related to therapists' potential lack of insight into their own spirituality. Hague (2006) notes that this can create bias or reinforce stereotypical ideas about clients who hold differing spiritual views. Strawn (2007) points out that therapists may experience discomfort with religion-related material as they have not adequately explored it in their own therapy process. Simmonds (2004) suggests that if a supposedly psychologically sophisticated professional is unable to integrate or explore their own spirituality, it cannot be expected of 'lay' people. Some research suggests that the therapist's self-awareness and integration in such matters is the greatest predictor for their successful work with their clients' religious material (Strawn, 2007). One study found that great self-awareness is needed when a therapist is considering the issue of whether or not to disclose their RS positioning to a client (Magaldi & Trub, 2018). Florence et al. (2019) draw attention to the fact that educating psychotherapists in RS issues includes encouraging and facilitating their awareness of their own RS perspectives, an area which is lacking in psychotherapy education and training programmes (Barnett & Johnson, 2011; Magaldi & Trub, 2018; Tummala-Narra, 2009).

2.5 Religion as helpful or harmful

An exploration of existing literature demonstrates that religion can be conceived of as both helpful and harmful to psychological growth and maturation. Many theorists and practitioners acknowledge the protective role that religion can play, strengthening capacity to cope with and recover from stressors (Brown et al., 2013) strengthening self-esteem (Fallot, 2007, as cited in Haycock, 2014) and contributing to overall wellness (Padayachee & Laher, 2013; Tummala-Narra, 2009). Therapists have also expressed appreciation for the social support, resilience and traditional wisdom it can provide for clients (Vandenberghe & Prado, 2012).

However, an ever-growing body of literature also highlights RS that is not helpful to the client. Multiple studies with therapists indicate that clients' RS frameworks can be psychologically harmful, impinging on their psychological

growth in general, and their progress in the therapy room in particular (Cunha & Scorsolini-Comin, 2019; Florence et al., 2019; Haycock, 2014). It is important to note that a therapists' ability to differentiate helpful from harmful RS practice is invaluable, as is the need to be able to identify RS belief systems which promote "compassion and wholeness" versus those which encourage "fear, fragmentation, and harm" (Johnson et al., 2007, p. 458). Rigidity of religious views was observed to correlate with psychological suffering (Vandenberghe & Prado, 2012). A 2012 study with Brazilian psychotherapists highlighted the inner struggle experienced when they viewed clients' RS beliefs as harmful (Vandenberghe & Prado, 2012); for example, a rape survivor who believed her own sinfulness caused her assault. Similar themes and struggles were observed in a Brazilian study, where belief in divine judgement was seen to create psychological harm (Cunha & Scorsolini-Comin, 2019).

Sometimes it was observed that clients used religious principles to justify their passivity ('God will work it out') and to absolve them from owning their own problems. These findings were supported by Haycock's (2014) study in which some therapists reported that a client's religious framework served to 'block' the therapeutic process. South African psychologists report experiencing frustration with clients who abdicated responsibility for their life, relinquishing all control to a higher power (Haycock, 2014). Therapists also reported that the passivity resulting from this external locus of control was further aggravated by clients' avoidance of exploring emotional difficulties. Some papers refer to the concept of 'spiritual bypassing' (Hess, 2022; Vieten et al., 2013) as a way in which individuals seek to avoid grappling with difficult material by framing it in spiritual terms. Fundamentalist religion, in particular, was construed as obstructive to the therapeutic process, invoking unhealthy guilt in clients, and limiting them to cognitively simple ways of thinking (Haycock, 2014). Psychologists were also noted to differentiate between the type of religion embedded in a rigid, ritualized fundamentalism and one with a wider focus which emphasised interconnectedness and transcendence (Casement, 2020; Haycock, 2014). While these topics have been

identified in existing literature, further research is required in order to explore how practitioners evaluate the health of their client's religious beliefs, and how their own personal biases may impact this. Furthermore, how these issues are approached in training, professional development and peer interactions is also an area requiring more in-depth study.

An area of emerging interest is that of specific religion-related abuse (Cashwell & Swindle, 2018; McGraw et al., 2019; Panchuk, 2018; Park et al., 2017; Winell, 2011). The terms “religious trauma” (Panchuk, 2018) and “spiritual abuse” (Oakley, 2013; Winell, 2011) refer to a spectrum of conditions resulting from trauma connected to religious practices or teachings, such as enforced conformity, shaming, and misuse of religious texts with the intention of behavioural control. This results not only in ‘existential’ damage (Panchuk, 2018), but leaves the victim unable to counter the narrative of being at fault due to an internalised belief that the abuse is ordained by God (Winell, 2011). While common conceptions of religion-related abuse immediately call to mind sexual indiscretions, the existing body of literature takes a far broader view encompassing emotional abuse clothed in religious language (e.g. Cashwell & Swindle, 2018). In addition, individuals seeking to leave these systems struggle with the loss of access to the meaning-making aspects of their former faith system, experiencing a ‘shattering’ of their worldview and upheaval of their construction of reality. Panchuk (2018) refers to the epistemic effects of this as mirroring complex trauma and domestic abuse, particularly when one takes into account that an individual's god-figure can be conceived of, in object relation terms, as a relational object which threatens abandonment and punishment, thus rendering the very concept of ‘love’ as potentially abusive. These reflections also draw attention to the importance of psychotherapy as a space to work through experiences of oppression by internalised images of traumatic religious objects and related belief systems (Tummala-Nara, 2009).

2.6 Uneasy bedfellows: The history of psychology and religion

For the purposes of this study, an in-depth discussion of psychoanalytic concepts

was considered beneficial, as most of the research participants referred extensively to psychoanalytic concepts in their discussion of RS. Furthermore, an exploration of the contentious history of psychoanalysis and religion is considered important to contextualise the current debates and clinical implications. As psychotherapy was partly birthed from Freud's psychoanalytic concepts, his anti-religious stance could be considered to be woven into the fabric of the discipline's origins (Cohen, 2019; Frick, 2018; Litjmaer, 2009; Pargament & Saunders, 2007). In the South African context, this state of unease was discussed earlier in relation to indigenous and 'non-Western' forms of spirituality, which were considered 'pre-scientific', and accordingly dismissed (e.g. Naicker, 2010; Padayachee & Laher, 2014). This section hopes to put this finding in discussion with a longer history of tension, tracing the origins and development of the religion-psychotherapy divide, following different theoretical schools of thought as they emerge. Additionally, ways of conceptualizing potential complementarity, rapprochement and overlap will also be discussed. Historical developments will thus be put in dialogue with more recent perceptions. This serves not only to provide a richer understanding of current debates, but also opens up ways of thinking about how RS can be conceived of and worked with in current clinical practice.

2.6.1 Freud on religion

As the de facto founder of psychoanalysis, Freud's concept of God as an illusion and a universal obsessional neurosis (Freud, 1927) has cast a long shadow, setting up a conflictual relationship between religion and psychology. Based on this conflict, Frick (2018) refers to the "shame-cathected taboo" which has impacted the socialization of more recent psychoanalysts (p. 275). According to Freud, God is a human creation intended to buffer them against the harsh realities of existence, an oedipal fantasy (Cohen, 2019) and "psychological opiate" (Heyer, 2016, p. 436) which kept people away from the difficult work of their own inner mourning (Heyer, 2016). Furthermore, not only did Freud view God as a projection arising from wish fulfillment, he interpreted mystical experiences as illusory (Freud, 1927). He thus depicted religious beliefs as "fantasies that would eventually yield to scientific understanding and good analysis" (Cohen, 2019, p. 104).

Tummala-Narra (2009) has suggested that Freud's oppositional stance towards religion could have stemmed from his view of it as a competitor in the scientific` space which he hoped psychoanalysis would occupy. Cohen (2019) states that Freud and his followers depicted religious beliefs as parallel to scientific knowledge, a form of "false science" that served to divert neurotic individuals from facing reality (p. 104). Many more recent authors have noted the enduring impact of Freud's legacy, acknowledging the deleterious impact of such a reductionist interpretation of RS (Cataldo, 2019; Hoffman, 2019) and its exclusion from psychotherapy (Cohen, 2019). Cohen (2019), commenting on the clinical implications, posits that, at best, religious beliefs may be acknowledged as psychological constructs; at worst, seen as signs of immaturity or as injurious to psychological health. This seemingly irreconcilable divide has prompted practising therapists to reflect on their own experience of dissonance and struggles to mesh their two 'oppositional' identities as both an individual of faith and a mental health practitioner (Cohen, 2019; Florence, 2009; Rizzuto, 1979). This highlights this area of tension as an area of focus for further research, particularly as there is a dearth of such explorations in the South African context.

2.6.2 Challenges to Freud's views

Carl Jung diverged from Freud's views of RS in his acknowledgement of spiritual aspect of the psyche and his conception of a collective unconscious (Jung, 1938, as cited in Tummala-Nara, 2009). Critics of Jung, however, note that his attitude towards spirituality, while demonstrating more openness, could be interpreted as reductionistic, simultaneously exoticizing eastern spiritual traditions while confirming and elevating his own views of archetypal psychology (Parsons, 2001, as cited in Tummala-Nara, 2009).

Ensuing theorists and analysts challenged the perceived reductionism of both Freud and Jung. Erich Fromm explored a synthesis of psychoanalysis and Buddhist beliefs, centering notions such as self-actualisation (Suzuki et al., 1970). Fromm also drew a clear distinction between religion he viewed as authoritarian and submission-focused, versus a more humanistic-style religion which

foregrounded man's strength. A further challenge arose from Erikson's espousal that religion could be a conduit for personal healing and creativity (Simmonds, 2004; Erikson, 1958). Erikson acknowledged that some forms of religion could be adaptive in nature and serve to support both identity formation and self-cohesion (Erikson, 1993). He further linked religion to his proposed developmental stage of 'trust versus mistrust', thus viewing religion as adaptive in nature when the regression it evoked serve to return the individual to an earlier stage which was connected to a secure relational foundation.

Later humanistic theorists, including Maslow, Rogers and Frankl, also countered aspects of Freud's seemingly pessimistic determinism. Maslow and Rogers emphasized human potential, as well as the key role of human responsibility, freedom and greater consciousness (Tummala-Nara, 2009). This approach lent itself to a more accepting stance of religion and spirituality. Frankl's (1985) seminal concept of 'will to meaning' foregrounded the powerful human need to seek an ultimate and transcendent meaning in living, as opposed to the more simplistic 'pleasure principle' suggested by Freud.

2.6.3 Object relations perspectives

Object relations theory facilitated a shift in psychoanalytic thinking away from a 'one person psychology' to a view of the primacy of relationships and the universal human need to have relational needs met (Cohen, 2019; Gurney & Rogers, 2007). Several key theorists used object relations as a way to reconceptualize the interface of religion and psychotherapy. Guntrip viewed religion as resulting naturally from the universal human desire for a 'good' object (Guntrip, 1961, as cited in Florence, 2009). He posited that religious belief and devotion could fall anywhere on the continuum from pathological to neurotic; unlike Freud, he did not see a primary issue with dependency, per se; instead, he saw only religious belief which encourage *infantile* dependency as problematic. He thus made space for the acceptance of more mature religion as a psychologically adaptive function (Guntrip, 1961, as cited in Florence, 2009, p 31). However, it

should be noted that Guntrip's stance towards religion was only concerned with God as a projection – an individual's longings projected onto the universe – not with God as a real person/entity (Tummala-Nara, 2009).

Winnicott's (1953) seminal ideas placed importance on the role of transitional objects. According to Winnicott, this object is both subjective (created) but also exists objectively in 'reality'. Winnicott viewed the dual nature of such an object is key to the development of a healthy psychic life, as it represents an individual's increased capacity to relate to reality (Meissner, 2009; Sorenson, 1994). Winnicott viewed 'God' as a transitional object which could aid an individual in their transition towards maturity. He thus allowed for a view of religion which included adaptive elements. However, he also critiqued the view of original sin espoused in Christian religion as ignoring the good in humankind and instead, attributing all that is good to the divine alone (Winnicott, 1990). According to Gabel (2020), arguing for the existence of an actual, external God was not key to Winnicott's framework. Instead, he viewed the *experience* of God in a psychological and spiritual way as significant (Gabel, 2020).

Building on Winnicott's ideas, Rizzuto (1979) and Meissner (1984) conceptualized religion as a phenomenon in a transitional space. They posited that an individual's representation of the divine object transforms as a person matures (Hess, 2022). Rizzuto (2004) saw parallel aspects in her Catholic upbringing and psychoanalytic approaches, including "an object-related universe in which people are never alone" (p. 441). Rizzuto further noted the similarity in self-inquiry, aims of transformation, and the importance of confronting both oneself and reality with honesty (Tummala-Narra, 2009, p. 88). It should be noted, however, that Rizzuto's (1979) concept of the God-representation is particularly tied to her understanding of the Western cultural context where the idea of a single, personal, God-figure is woven into the cultural context. Meissner (1986) furthered the application of object relations theory to RS issues, applying a developmental framework and incorporating aspects of ego psychology. According to Meissner, RS exists on a

continuum from pathology to maturation. Meissner also extended this example beyond the experience of an individual, suggesting that whole religious systems could be fixated at a certain developmental level (Meissner, 1984, as cited in Florence, 2009).

Finally, Bion contributed to psychoanalytic thinking about God, drawing on the experiences of mystics to inform his theory (Cohen, 2019; Florence, 2009; Simmonds, 2004;). Bion developed the concept of ‘O’, a reference to an abstract, ultimate sense of reality existing outside of the human mind, describing it as “absolute truth, godhead, the thing in itself, the infinite, ultimate reality (Bion, 1970, as cited in Hess, 2022, p. 26). More recent theorists point out ‘O’s’ approximation to an experience of God (Hess, 2022). Bion’s focus was on the process of psychoanalysis, as opposed to the content (Bion, 1970), emphasizing that the meditative reverie of analyst and patient could lead to ‘O’ and a kind of emotional connection from which something new is created. Drawing on Bion’s work, Hess (2022) suggests that sometimes the analytic process can lead to an awareness of infinity, and even “religious insight” (p. 578). Bion was opposed to the reduction of RS experiences to intrapsychic projections alone and emphasised the need for an analyst’s humility in the face of such vast and unknowable aspects of universal religious experience (Bion, 1970). Bion’s views thus allow for transcendence and mystery, refusing to turn God into an object of scientific enquiry or as something easily analysable. He effectively cautions psychoanalysts against making absolute and therefore reductionist statements about the divine, proposing instead that one must learn to be comfortable with the unknown and the transcendent (Gleig, 2012). This stance opened the way for a more intersubjective conceptualizing of RS in therapy.

Gurney and Rogers (2007) posit that an object relations approach to RS can be very constructive in the therapy room and may assist a client to explore their conceptions of the sacred as a way of evaluating and assisting their present day ways of relating and their self-esteem. However, despite acknowledging object

relations theory's more accommodating stance towards RS, they have also accused it of a reductionist approach. According to these critics, the concept of 'God' as an internal object and confined to psychic reality alone reduces religion to a subjective and purely intrapsychic experience, leaving no room for the transcendent or unexplained. However, it could be argued, as Rizzuto (1979) did, that by its very nature, psychoanalysis clearly delineates the intrapsychic as the field of exploration. While Spero (1992) accepted Rizzuto's concept of an internalized god image, acknowledging the potential influence of early childhood experiences on this, he broadened this idea to include the possibility that the internal "god image" might also contain traces of real spiritual encounters with the divine (Cohen, 2019, p. 106). Spero (2012) thus countered the view of God as only an aspect of psychic reality, suggesting that the relationship with the divine was as real as any other relationship in an individual's life.

2.6.4 Intersubjectivity and Relational psychoanalysis

More recent theorists impacted by relational psychoanalysis focus on a client's development of a more personal sense of reality. Intersubjectivity is a key concept and in this model, transference is co-constructed by both client and analyst (Tummala-Nara, 2009; Winton, 2013). Tummala-Nara (2009) emphasises the importance of addressing the sacred in the context of the therapeutic relationship, maintaining that the presence of the analytic third in psychotherapy – as represented by both the client's and therapist's respective images of God – is an area which must be explored for a rich therapeutic experience which assists the client in their move towards psychological and relational maturity. From this perspective, therapy creates the space in which a client may process their experience of a traumatic internalised object (or objects) linked to their related belief system. With this relational lens, it becomes apparent why the relationship between client and therapist may reflect the client's prior experience of the spiritual. Understanding the shared (therapist and client) and individual transferential reactions to RS is thus key, and unpacking the potentially shared or distinct transferential reactions to RS of both client and therapist, and addressing resistances, such as inner conflicts with

outdated or evolving self-images and spiritual beliefs, is part of the therapeutic process (Tummala-Nara, 2009). Accordingly, RS can be worked through both intrapsychically – such as through explorations of identity – and interpersonally in the transference relationships.

Drawing on Winnicott's ideas of transitional space, Winton (2013) highlights the importance of therapists' awareness of how religion sits in their own psyche, as well as that of their client's. As such, she suggests a need to step back from her own belief system to create space between her and her client. She draws a distinction between discussing religion in a factual way, which could lead to grappling with content, and that of a more therapeutic approach which looks rather at the meaning for the individual patient. She posits that her role as therapist is to find within her client's religious beliefs the personal meanings related to past experiences and relationships, including the transference relationship with the therapist. She further emphasizes the important role of analysing the transferential and counter-transferential material in the therapeutic dyad.

2.6.5 Spiritual currents in psychoanalysis

Some psychoanalytic theorists have also drawn parallels between psychoanalytic concepts and RS. For example, Stone's (2005) paper focuses not only on opening up the psychoanalytic space to an attempted rapprochement between psychoanalysis and spirituality, it further draws comparisons between the two, pointing out that both deal with the deepest longings and fears of the human endeavour. Stone (2005) also notes comparative aims, namely moving towards self-knowledge and the overcoming of narcissism. While she acknowledges that more fundamentalistic RS structures may be helpful 'containers' and sources of moral guidance, she posits that issues arise, both in society and within the individual, when 'frozen mythology' fails to evolve in order to meet the developmental needs of cultures or individuals. Such pathological religion serves to undermine the authentic self "through crushing impositions of demands, the erosion of selfhood by guilt, or the swallowing of self by an engulfing community"

(Jones, 1995, as cited in Stone, 2005, p. 422).

In his 2012 article, Gleig outlines what he believes to be a turn towards potential rapprochement between the domains of psychoanalysis and RS, using the term ‘psychospirituality’ to refer to the claims of contemporary analysts that psychoanalysis can function as “a modern secular spiritual practice” which possesses spiritual qualities (Gleig, 2012, p. 210). For example, Gordon (2004) suggests that a strong spiritual current has always been present in psychoanalysis, but that it was sidelined in order to render the discipline “palatable” to a discipline dominated by agnostic or atheist analysts (Gordon, 2004, as cited in Gleig, 2012, p. 218). Kirschner (1996, as cited in Gleig, 2012) suggests that psychoanalysis has its roots in and is shaped by the very religious and spiritual traditions it has historically undermined, viewing psychoanalytic theories as secular versions of narratives stemming from Greek mythology and biblical accounts. Kripal (2003) also draws structural parallels between psychoanalysis and religion, comparing aspects of psychoanalysis to Hindu tantric practice, suggesting that both are ritualized ways of confronting universal anxieties about “death, sexuality, pollution and the dissolution of the socialized self” (Kripal, 2003, as cited in Gleig, 2012, p. 220). Gleig (2012) links this spiritual turn to the cultural shift from modern to postmodern, resulting in a move away from concepts such as objective universal truth and a greater relational emphasis in psychoanalysis.

2.6.6 Contemporary discussions of RS and psychoanalysis

In the last five years, psychoanalytic authors have added to the discussion regarding the intersection of RS and psychotherapy, engaging with various aspects of key theorists in their creative responses to the oppositionality or rapprochement of the domains. There is agreement across the board regarding the centrality of the human need for spirituality, and on the importance of paying attention to RS in psychoanalysis (Casement, 2020; Cataldo, 2019; Cohen, 2019; Hess, 2022). Employing a largely intersubjective lens, the following papers explore current thinking around ideas of

religious identity, issues of transference and ‘thirdness’, fundamentalism, and RS-related dissociation.

Cohen (2019) acknowledges the centrality of RS, suggesting that for many, faith provides identity through shared history, beliefs and experiences, and this communal identity can be a positive cultural force. Through an examination of case studies, she highlights the importance of transference, suggesting that religious transference and countertransference provide insight into the intertwined areas of patients’ beliefs, wishes and fantasies about both the therapist and the patient’s divine object. Drawing on an object relations perspective, she demonstrates how working within the transference can allow for a softening of a harsh, internalised god image which is causing psychic suffering to a patient. Hess (2022) also points out the importance of skillful work with complicated transferential dynamics. In dialogue with Cohen’s (2020) paper, Hess (2022) acknowledges the questions that arise for a non-religious therapist who is confronted with patient espousing religion-related struggles. She outlines the potential questions as follows:

Should he offer concrete, practical suggestions? Should he avoid religious issues altogether? Should he refer the patient to a rabbi or teacher? (p. 592)

Hess (2022) recognises that different transferential dynamics may arise according to the therapist’s religious positioning. As a religious Orthodox Jew, she illustrates potential pitfalls in her clinical example of working with a similarly Orthodox patient in religious distress, drawing on Bion’s ideas of projection and containment. Hess (2022) further suggests that the religious therapist from the same background as their patient may find the work more challenging, emphasizing that they must refrain from offering practical advice or getting caught in matters of doctrine, but aim to “understand the topic behind the topic” (Hess, 2022, p. 592). According to Hess, referring a patient on to a spiritual leader for guidance would, at this point, suggest that the therapist is not able to contain the patient’s religious turmoil. This paper thus raises interesting questions concerning referral of patients to spiritual leaders.

Cataldo (2019) acknowledges that religious need is inherent to human beings, much like the forces of aggression and sexuality, and thus cannot be assigned to the realm of either ‘good’ or ‘bad’. Instead, she contends that religious need will be met in one of two ways; either “authentically and creatively” or in a “false-self promoting, defensive, or perverse way” (p. 130). Acknowledging the complexity of engaging with religious material in the therapeutic encounter, particularly when analyst-patient beliefs systems differ, she asks the key question: how can the analyst make room for the patients’ religious and spiritual experiences when they might diverge dramatically from the analyst’s? Drawing on intersubjective and relational ideas, she suggests that the ‘clinical third’ (Benjamin, 2017) can form a safe transitional space for religious experiences in a space of mutual recognition.

Cataldo (2019) posits that religious experience, like any relational encounter, can be either healthy or unhealthy, whether in the inner or outer dimension of experience. According to Cataldo (2019), in both RS and psychoanalysis, the feeling of being “touched by otherness” in both internal and external relationships is central (p. 120). In order to facilitate this recognition of the other, a process of decentering of the self is needed. In addition, a simultaneous process is needed which allows for the “destruction and creation of subjectivities that relativises the strictly personal in the context of a larger, more encompassing reality” (p. 122). Cataldo contends that in contemporary analytic theory, this encounter with otherness is framed in the language of the ‘third’. She concludes that what counts in analysts’ work with RS material is the willingness to be open to the third, allowing for patients to reach their creative and transformative potential in relation to their own RS. However, she also acknowledges that both religion and spirituality can be twisted into destructive forms of fundamentalism which pervert the human desire for surrender to a “transcendent other” and substitute it for submission to “human dictums” with their assurance of eternal blessing (Cataldo, 2019, as cited in Hoffman, 2019, p. 151). From this perspective, fundamentalism means that an immature sense of omnipotence is not given up, thereby blocking an encounter with a genuinely transcendent other (Cataldo, 2019; Hoffman, 2019). Cataldo (2019) also proposes that

there is hope for more dialogue between the differing yet interrelated disciplines of RS and psychoanalysis which would allow for their distinctness without “one discipline absorbing the other and collapsing the two into a single vehicle of meaning or truth” (Cataldo, 2019, p. 116).

Casement’s (2020) reflections on faith and psychoanalysis draw both from his personal experience and long career as a psychoanalyst. Casement notes similarities between psychoanalysis and RS, suggesting that they need not be adversaries. He states:

In each, we are confronted by the unknown. In each, we attempt to know the unfamiliar through the familiar ... In each, we find a restless wish to find answers to questions that trouble us. In each, we find an unease at not knowing. (p. 55).

Casement, however, also expresses suspicion of certain aspects of organized religion, which he sees as exercising forms of “social control” (p. 2) and which can be a fertile playground “for primitive defences” (p. 46). Casement’s (2020) perspective on the limitations of rigid or fundamental faith practices has been echoed by other recent theorists. Akhtar (2022), commenting on Casement’s views, resonates with the caution against avoiding the extreme of both “unbending religiosity” and “smug atheism” (Akhtar, 2022, p. 424). Akhtar further concurs with Casement’s suggestion that both mature RS and psychoanalysis must follow a path of “non-certainty” (Akhtar, 2022, p.423). From this stance, faith is no longer based in argument, and becomes, instead, an act of courage based in the unknown (Casement, 2020, p. 12). Further parallels between religion and psychoanalysis are drawn through conceptualizing analysis as leading to a process of rebirth after the loss of parts of the self, an analogy which links to Christian ideas of resurrection (Casement, 2020). Akhtar (2022) provides an additional interpretation of this concept, seeing this ‘rebirth’ through a Winnicottian lens as the “survival of the object” (Akhtar, 2022, p. 426).

Drawing on Winnicottian ideas of transitional space, Gabel's (2020) paper suggests a novel conceptualisation of experiences of religious and spiritual dissociation. Gabel argues that Winnicott's intermediate area, which refers to the space between the individual's internal and external world, can be understood as a 'dissociative' phenomenon. He further suggests that such dissociative experiences need not be pathologized. Using the example of a Balinese ritual, as well as an evangelical Christian movement, he proposes that voluntary dissociative states induced through religious ritual allows for greater responsiveness to particular types of information which is imbued with affective impact and meaning. This allows for psychological processes of a heavily "imaginative or creative nature" (p. 18) From this perspective, religious beliefs and expressions are not viewed as "immature or narcissistic", but simply as "a different system of appraisal and reactivity to internal and external stimuli" (p. 19). This perhaps puts Gabel's hypothesis in dialogue with literature around indigenous knowledge systems and practices discussed earlier (e.g. Marovic & Machinga, 2022) suggesting a non-reductionist way of viewing mystical experiences from a psychoanalytic perspective. Gabel's formulation seems to create space for a non-pathologising stance on spiritual experiences which have historically been denigrated or viewed as symptomatic of illness (e.g. Ally & Laher, 2008; Laher, 2014).

This review has attempted to place the current study in context by synthesising a broad array of both global and local literature examining current issues of debate related to the dialogue between RS and psychotherapy. It has done so by putting the study in the context of the origins and development of the field of psychotherapy with its tense, complex and ever-evolving relationship with RS. In doing so, it helps to provide a backdrop against which to understand the often contradictory experiences of present day psychotherapists when dealing with RS. An overview of this historical divide informs an understanding of South African literature which investigates the added dimension of the need for practising in sensitive and culturally informed ways that is cognisant of historically marginalised indigenous belief systems. An exploration of current psychoanalytic literature points to the thorny terrain that must be skillfully navigated with regards to RS, highlighting this as a topic worthy of deeper exploration, particularly in

the South African context where very few in-depth qualitative studies have been conducted. The disconnect between the professional and personal positioning of therapists when working with RS emerges as central, and suggests that this is an area for further exploration, particularly with regards to internal barriers and biases which may limit effective engagement. The literature also suggests that more recent conceptualisations of a psychoanalytic approach place it less at odds with non-Western belief systems, a finding which is of interest in terms of exploring the experiences of participants in this study. Novel ways of interpreting and working with RS are highlighted and suggest a burgeoning area of research worthy of further investigation.

2.7 Conclusion

This review has attempted to place the current study in context by synthesising a broad array of both global and local literature examining current issues of debate related to the dialogue between RS and psychotherapy. It has done so by putting the study in the context of the origins and development of the field of psychotherapy with its tense, complex and ever-evolving relationship with RS. An overview of this historical divide informs an understanding of South African literature which investigates the added dimension of the need for practising in sensitive and culturally informed ways that is cognisant of historically marginalised indigenous belief systems. An exploration of current psychoanalytic literature points to the thorny terrain that must be skillfully navigated with regards to RS, highlighting this as a topic worthy of deeper exploration, particularly in the South African context where very few in-depth qualitative studies have been conducted. The disconnect between the professional and personal positioning of therapists when working with RS emerges as central, and suggests that this is an area for further exploration, particularly with regards to internal barriers and biases which may limit effective engagement. The literature also suggests that more recent conceptualisations of a psychoanalytic approach place it less at odds with non-Western belief systems, a finding which is of interest in terms of exploring the experiences of participants in this study. Novel ways of interpreting and working with RS are highlighted and suggest a burgeoning area of research worthy of further investigation.

Chapter 3: Methods

3.1 Research design

A qualitative, interpretive approach has been utilized for this study. This aims to elicit and explore ‘experience near’ narratives gleaned from in-depth, one-on-one interviews. The purpose of the research is not generalisability, as the small sample size precludes this. Rather, the aim is to give voice to participants regarding their own experiences of navigating religious and spiritual content in the context of a therapeutic relationship, illustrating theoretical arguments with rich ‘insider’ narrative. As the focus of this study is ‘thick description’ (Geertz, 1973) and an understanding of human behaviour from the informant’s perspective, an exploratory qualitative research design was considered most appropriate.

Specifically, this study is governed by an interpretive paradigm whereby the focus is on participants’ subjective experiences as ‘the essence of what is real for them’ (Terre Blanche et al., 2016, p. 274). It aims to make sense of the experiences of individuals through empathic listening and attempting to enter the lived experience of participants. In keeping with the principles outlined by Terre Blanche et al. (2016), the interpretive approach relies on first-hand accounts, attempting to render the life world of the individual in rich detail. The researcher is the key instrument of data collection and interpretation in order to ‘recontextualise’ lived experiences through what researchers have referred to as ‘empathic reliving’ (p. 275). Key to understanding the individual’s narrative is understanding their experience in context. In this study, context refers not only to the broader multi-cultural, multi-religious South African landscape, but more specifically, to the space of the therapy room.

This approach is appropriate for a study which aims to both explore and understand participants’ lived experiences of specific phenomena and to understand the meaning which they ascribe to them (Creswell, 2014); in this instance, the phenomena of religious and spiritual content arising in and impact the therapeutic dyad. As this was an exploratory study, the researcher was open to other significant themes which arose during the research process. Creswell and Poth (2017) posit that the most meaningful aspect of a

qualitative approach is that it allows for themes and categories to emerge from the data itself, as opposed to being pre-established. The research tool of semi-structured interviews selected for this study helped to facilitate this process.

3.2 Sampling

The sample for this study consists of registered psychologists (counselling, clinical or educational) in South Africa who have had some exposure to working with a client's religious and spiritual content in the therapy room. Participants were recruited through the non-probability procedure of purposive sampling, followed by snowball sampling. Purposive sampling is a purposeful method of data collection and is advised when a researcher seeks participants from a large population who meet specific inclusion criteria necessary for the purposes of the study (Dawson, 2019). This sampling technique relies on the researcher to select participants that best serves the purpose of the study (De Vos et al., 2012). Purposive sampling was appropriate in this case as this study aims to specifically explore the experience of practising psychologists in South Africa who have experience working with religious and spiritual matters in psychotherapy.

The researcher was thus assisted by the supervisor of this research in sending out an invitation via email to a pre-existing database of qualified psychologists. This alerted recipients to the proposed research and invited them to participate voluntarily, thus avoiding any potential coercion or imposition. Respondents were then interviewed. The researcher utilized the voluntary participants to recommend other potential suitable participants who also met the inclusion criteria. and asked to recommend other potential participants. This snowballing technique (Fouche & Delport, 2011) was then implemented until the desired sample size was met. According to Terre Blanche et al. (2006), six to eight data sources proves sufficient where the focus is not on variation in the sample, but on in-depth interviewing and richness of data (p. 289). As data saturation was deemed to have been met once eight participants had been interviewed, no more participants were sought.

Inclusion criteria were stipulated for the participants which helped to ensure that the final sample was appropriate, allowing for generation of data relevant to the specific aims of this study. The following parameters were thus specified: the sample consisted of psychologists in South Africa registered with the Health Professions Council of South Africa (HPCSA). Initial inclusion criteria specified that only educational, clinical or counselling psychologists were eligible for the study. However, one respondent was registered with the HPCSA as both a Registered Counsellor and neuropsychologist, and had decades of experience in the counselling field. As this participant had a wealth of experience to share, she was also included in the study. The researcher focused on clinicians practicing in the greater Johannesburg area for convenience purposes, though one participant had recently relocated from Johannesburg to Cape Town. Participants were required to have practiced for at least one year post qualification, or, in the case of clinical psychologists, one year post community service. A further inclusion criterion stipulated that all participants must have had clinical experience of working with RS in therapy.

While the researcher hoped to attract a diverse sample of participants encapsulating a wide variety of racial, cultural and religious backgrounds, only White and Indian participants responded. Furthermore, certain religious affiliations were not represented either; for example, Islam. The study thus includes a reflection on this area of limitation. The final sample was comprised of one male and seven females. Participants ranged in age from 34 to 72 years. In terms of participant experience, a wide variety was represented with the least inexperienced practitioner having been in practice for one year post community service, while the most experienced participant noted over thirty years of practice. One participant identified as Hindu, one as Orthodox Jewish, and one as broadly spiritual but unaffiliated to any specific religious creed. The remaining five participants were raised in contexts of Christianity including Lutheranism, Catholicism and non-denominational charismatic churches. However, other than retaining a cultural link to the religion, these participants did not necessarily feel any current affiliation. As such, three described themselves as agnostic, one as atheist, and one as agnostic but with Buddhist leanings. In terms of registration categories, as already discussed, one participant was

registered as both a Registered Counsellor and as a neuropsychologist. The remainder of the sample was comprised of a counselling psychologist, an educational psychologist, and five clinical psychologists. All of the participants worked in private practice, and one participant worked in both private practice and in a clinical state setting.

3.3 Data collection

Semi-structured, one-on-one individual interviews were employed in this study at a time and place convenient to the participant. Participants were given the option of meeting in person or online via an electronic platform of their choice. Two of the eight participants opted to meet online via Zoom. The interviews were approximately one hour in length. Interviews were recorded and then transcribed verbatim by the researcher.

One-on-one interviews were deemed to be most suitable to facilitate trust and rapport between the researcher and participants, thus encouraging participants to share more freely. As a method of data collection, interviews are experienced as more ‘natural’ and are therefore more suited to the interpretive approach in that they “create an environment of openness and trust within which the interviewee is able to express herself or himself authentically” (Terre Blanche et al., 2006, p. 297). As the aim of this research study required a degree of introspection and self-awareness on the part of the interviewee, this approach was deemed suitable. Furthermore, the researcher anticipated that the interview questions had the potential to evoke a degree of self-consciousness or anxiety about a participant’s professional competence. As such, sensitivity and attunement were required by the researcher and one-one-interviews are best designed to accommodate this (Terre Blanche et al., 2006).

A semi-structured interview schedule (Appendix A) comprised largely of open-ended questions was employed, as this allowed room for flexibility, as well as facilitating further probing where needed in order to gather rich, nuanced data (Qu & Dumay, 2011). Semi-structured interviews, through scripted open-ended

questions and exploratory questions arising during the interview process, are well suited to eliciting authentic and unique insights from participants (Crouch & McKenzie, 2006; Newcomer et al., 2015) While serving as a guide for the interview process, the interview schedule did not limit the researcher's questioning, and when the interviewer felt a pertinent theme had been raised, additional prompting questions were sensitively utilized to elicit more in-depth data. The researcher was thus able to explore the meanings that participants attached to their experiences of working with religion and spirituality in psychotherapy.

An initial interview schedule was developed which hoped to address the aims and research questions of the study. The questions were guided by significant issues flagged in the literature surveyed. The research supervisor and an expert reader reviewed the interview schedule and minor adjustments were made. Once initial interviews had taken place, the supervisor and researcher re-examined the interview schedule to assess its suitability. This allowed for reflection on the interview agenda. No modifications were needed at this stage.

3.4 Data analysis

The analysis of the data was undertaken using thematic analysis (Braun & Clarke, 2006) to highlight key themes. This qualitative data analysis method aims to identify, analyse and report patterns appearing within data (Braun & Clarke, 2006). This qualitative data analysis method can be used to identify patterns within and across data in relation to participants' lived experience, including participant perspectives, behaviours and practices (Clarke & Braun, 2017).

Its flexibility as a method is well-suited to an exploratory, qualitative study (Clarke & Braun, 2017). Furthermore, it allows for the researcher to analyse rich, detailed, complex data, such as will be rendered through the one-on-one interviews. It also allows the researcher to further interpret the data. In keeping with this method of

analysis, this researcher implemented Braun and Clarke's (2006) recommended process for identifying, extracting and codifying core themes, namely:

1) The researcher familiarised herself with the data, immersing herself in it through repeated listening, transcribing and reading. The process of listening to and transcribing audio-recordings verbatim allowed the researcher to develop a thorough familiarity with the data. It also allowed for ongoing reflection on the researcher's impact on interviewees, allowing for adjustments to interviewing style in future interviews. This was done in conjunction with feedback from the researcher's supervisor, who was able to highlight that the researcher was initially too directive at times in her interviewing style.

2) The researcher then read the transcripts several times, enabling a generation of initial codes to identify features of the data that were prominent. Repeated patterns appearing in the data were taken note of.

3) The researcher then looked for broader themes and organised the different codes into potential themes. Different codes, where appropriate, were thus grouped together under a single theme. This allowed for preliminary identification of main and sub-themes. Themes at first were divided between helpful and harmful, rapprochement and opposition, but as analysis deepened, it became apparent that these themes were not separate but were actually in conversation with one another.

4) The researcher reviewed the themes, seeking connection across emergent these. This led to refinement of themes, merging of themes, or elimination of themes. The process of thinking about the personal versus the professional positioning of therapists with regards to RS proved to be a difficult but prominent part of the analysis, but it required immersion in the data to refine it in a way that did not just focus on individual stories, but highlighted what that might mean for therapists working with RS in therapy in overall.

5) The researcher attempted to further define and name themes. Attention was given to identifying the core of each theme, noting salient features. At this stage, clarifying and

refining of sub-themes was helpful in analysing longer, complex themes. This enabled the researcher to refine sub-themes under the theme of ‘Psychotherapist’s positionality’, drawing out the nuance between the related yet distinct areas.

6) Finally, the researcher attempted to write a coherent, logical and well-supported analysis of the themes in the form of a research report. Relevant and representative extracts were drawn from the data and related to the research question. Finally, the prioritized themes were tabulated as depicted in Table 1 (Chapter 4).

Trustworthiness

In qualitative research, trustworthiness refers to the process of guaranteeing the credibility, transferability, dependability and confirmability of the study. The researcher aims to ensure trustworthiness of the research through the following approach:

Credibility entails ensuring that the point of view of a participant is accurately represented by the researcher. In this instance, the researcher aimed to include thick descriptions of participants’ accounts, making use of verbatim phrasing from transcripts where necessary. Where the researcher was unsure of the exact meaning of a participant’s words, the researcher clarified this with the participant (Babbie & Mouton, 2011). Should a participant request it, they will be sent a copy of the transcript of their interview to check, allowing them to confirm that their experience has been accurately captured (Given & Saumure, 2012). The researcher further immersed herself in literature pertinent to this study in order to ensure that she was conversant with salient issues and that the research approach was well suited to the overall research aims. Ongoing supervisory feedback enhanced this study’s credibility.

Dependability refers to the extent to which the research study can be replicated by another researcher (Given & Saumure, 2012). The close guidance of a research supervisor further added to the dependability of this study.

Transferability of the study was ensured through dense descriptions of procedures

and processes and “detailed and rich descriptions of contexts” (Terre Blanche et al., 2006, p. 91), allowing these understandings to subsequently be transferred to new contexts. However, it should be noted that the small scope and qualitative nature of this study is not intended to lead to generalizability (applying the findings to other contexts).

Lastly, confirmability refers to the corroboration between participant responses and the researcher’s resultant interpretations and findings (Terre Blanche et al., 2006). This was aided by external moderation from a research supervisor. The researcher’s own commitment to reflexive practice here aimed to avoid the pitfalls of unconscious biases or interpretations that may arise. A consideration of reflexivity follows.

3.6 Reflexivity

According to Finlay (2002), current theorists accept that reflexivity is a key feature of qualitative research, and that a skilled researcher should aim to be aware of and make explicit their role in co-constructing the ‘knowledge’ of the research study. This contemporary approach does not seek to deny the researcher’s role in knowledge construction; instead, it acknowledges the centrality of the researcher who actively shapes the “collection, selection and interpretation” of data (Finlay, 2002, p. 212). This researcher aimed to take into account two specific types of reflexivity as discussed by Finlay, namely: introspection and intersubjective reflection. Introspection, according to this understanding, requires an ongoing process of self-dialogue and self-discovery on the part of the researcher. This was especially important for me as my personal history is intimately intertwined with a deeply religious upbringing, and subsequent exploration of religious and spiritual material in the therapeutic context. Many of these religious experiences I would now consider aversive in nature, and therapy facilitated my moving away from the constrictive, stunting elements of my worldview. It is thus incumbent for me to acknowledge my prior experience of oppressive religious structures, combined with a respect for the deep meaning with which such traditions and beliefs systems can imbue one’s existence. I am also aware that despite departing from the more fundamentalist and prescriptive elements of my belief system, I still identify with a Judeo-Christian faith tradition, both culturally and spiritually, and retain a respect for it.

Furthermore, I have been on the receiving end of pastoral counselling where a directive, faith-based and judgmental stance was taken towards counselees. I thus need to be aware of assuming that a therapist with a strong faith position would automatically be inflicting psychological harm. Reflexivity about how this informs my perceptions of other's faith experiences is therefore important and requires of me that I do not impose an assumption of similar experiences on to those of a similar faith tradition.

Intersubjective reflection highlights the role that unconscious processes play in shaping the relational exchange between researcher and participant (Finlay, 2002). It extends the concept of self-reflectiveness to include an awareness of 'self-in-relation-to-others' (p. 216). This frequently means that a researcher needs to be aware of their perceived power as a professional carrying an associated sense of authority. In this study, however, I interviewed already established practitioners, which perhaps lessened this particular aspect of power imbalance. However, I differed in race, age, gender and religion from some participants, and an awareness of how differences and sameness contributed to the researcher-participant relationship needs to be noted. Reflexivity here required of me an openness to converging and diverging experiences of participants from all (or no) religious and spiritual contexts. I reflected on how I am affected by, and simultaneously affect, the participant, paying particular attention to transferences which may be mutually shaping the relationship. Considering my appearance as a white, South African female, some participants made assumptions about my faith affiliation. When assumptions of sameness were at play, it was noted that participants felt freer to express their stance. However, when participants were from a different religious or cultural background from me, there was more of a noted hesitancy in taking strong standpoints and opinions were sometimes expressed more cautiously with added disclaimers. This perhaps suggests that participants feared offending me, given the affective and value-laden domain which we were discussing. Reflexivity was required of me in order to be aware of these dynamics and to manage them as best as possible. Additionally, given that participants were required to reflect on their own practice as psychotherapists, a marked self-consciousness arose during the interview process as participants feared judgement not only from me, the researcher, but from peers who would read the research. Despite

participants being made aware of assured anonymity in the resultant research, fear of being perceived to have handled a patient ‘incorrectly’ led, at times, to editing or strong affect. Continued focus on reflexivity, openness and a non-judgemental stance were thus key for me. Opportunities to discuss this reflexive position with my supervisor also allowed for processing of this material and greater self-awareness. However, despite a dedicated commitment to reflexivity, this researcher acknowledges that she played an implicit role in the research process, noting the co-constructing nature of the study (Brown, 2006).

3.7 Ethics

Ethical considerations for this research encompassed: informed consent, voluntary participation, confidentiality and non-maleficence. The study was explained to participants in full and all participants were given participant information handouts (Appendix B) and informed consent forms (Appendix C) to sign prior to the commencement of interviews. The informed consent form also alerted them to the fact that interviews would be recorded and their permission was sought.

In keeping with principle of non-malevolence, no emotional harm was caused to participants. The participants themselves were not deemed vulnerable or at risk. Instead, as mental health professionals, it was assumed that they possessed a degree of psychological maturity which should support them in navigating any questions which may invoke emotional responses. Furthermore, it was also assumed that such participants would have access to networks of psychological support of their own. While the topic in question (religion and spirituality in the therapy room) does not necessarily denote an area of emotional sensitivity, it was assumed that some practitioners might experience discomfort around disclosing examples of times where they feel they may have failed to implement the best approach towards their clients. Sensitivity was thus practised regarding all questions which may have evoked anxiety or self-consciousness in the participant. Participants were also made aware that they may withdraw from the study at any time, and that no negative consequences would ensue therefrom.

Interviews were recorded on a password encrypted iPhone which only the researcher had access to, and audio files were saved under pseudonyms. In order to preserve the participant's right to confidentiality, pseudonyms were assigned during the transcription process. Anonymised transcripts were shared only with the researcher's supervisor and were also password protected. When writing up the results, pseudonyms were used and any potentially identifying details were omitted or disguised. In addition, the researcher ensured that when discussing specific examples taken from the therapy room, any potential mention of clients was also anonymised. Participant's private details were not disclosed to anyone and digital transcripts were kept on a secure laptop with encrypted software.

Prior to the commencement of the interview process, ethical clearance was sought from and granted by the Human Research Ethics Committee at the University of Witwatersrand (Appendix D). Participants were asked to consent to approximately one-hour one-on-one interviews. Before being interviewed, participants were given a participant information sheet (Appendix B) outlining the scope and purpose of the research; this was also explained verbally to participants. The voluntary aspect of participation was pointed out to the participant at numerous points throughout the research process, both verbally and in writing on the participant information sheet (Appendix B). Further ensuring the voluntary nature of the study, participants needed to indicate their willingness through signing consent forms (Appendix C) denoting their awareness of the purposes of the study and how their interview information would be utilised. Participants were also invited to provide consent for the audio recording of the interviews (Appendix C).

Chapter 4: Results

The results of this research highlighted four major themes. The first theme examines participants' views on the incompatibility or compatibility of RS with psychotherapy, noting areas of oppositionality and areas of rapprochement. The second theme explores participants' views of RS that hinders or promotes patients' psychological growth, commenting on when it is both helpful and harmful in psychotherapy. Thirdly, participants' reflections on how they work with RS content in the therapy space is explored. The final theme underscores therapists' own reflections on their personal religious and spiritual positioning, the impact this may have on the therapeutic dyad, and the complexity of navigating this in a professional context. The themes and sub-themes are represented in the table below:

Table 1: Overview of themes and sub-themes

Theme 1	RS and psychotherapy: opposition and rapprochement
	1.1 Religion and psychotherapy as incompatible 1.2 Potential for complementarity 1.3 Aims of RS and psychotherapy 1.4 Psychotherapy as religion/spirituality 1.5 Psychotherapists as 'priests'
Theme 2	RS as growth-promoting versus growth-inhibiting
	2.1 Religion as defence 2.2 Impact on self-worth 2.3 Religious abuse 2.4 Agency 2.5 Religion as protective
Theme 3	Engaging with patients' religious worlds in psychotherapy
	3.1 Stance of openness 3.2 Object relations 3.3 Working within the patient's religious framework

	3.4 Psychosis
Theme 4	Psychotherapists' positionality: navigating the tension
	4.1 Personal versus professional 4.2 Difficulties of disclosure 4.3 Sameness versus difference 4.4 Feelings of incompetence

4.1 Theme One: RS and psychotherapy: opposition and rapprochement

This section highlights the heterogeneity of views among participants with regards to the degree of compatibility between RS and psychotherapy. It also explores the complex and sometimes contradictory nature of individual participant's perspectives as it pertains to areas of oppositionality and overlap between the psychotherapeutic and faith domains.

4.1.1 Religion and psychotherapy as incompatible. Carin, Dana and Jana all initially expressed their views that psychotherapy and RS were antithetical. Dana, who describes herself as “agnostic”, explained that:

I do not subscribe to a religion myself but even if I did, psychology is a science and an art and actually has no relationship at all with religion, and so irrespective of who you choose [as a therapist], they shouldn't be framing their intervention and treatment of you in those terms. I don't subscribe to any religion but it's not the point; the point is that what you are looking for is a specific kind of intervention and that is areligious by definition. (Dana)

She expressed distress at practitioners who framed themselves as “Christian psychologists” or subscribed to overtly religious ideas in their practice. She further explained that in working with religious patients, she asked them to “hold them [religious belief and therapy] as separate”. Dana expanded on this by noting:

I'm not atheist – I just don't understand any of it, but I do think that there is an essence and there is a soul and there is the spiritual domain, and then there is the psychological, mental, intellectual

domain, and a limbic system. So, you have emotions, you have a mind, and you have a spiritual reality, and I just don't think we should merge them all into one. (Dana)

Carin, who describes herself as an “atheist”, expressed her struggle with reconciling religion with psychotherapy, noting that she views religion as “delusional” and potentially a form of “brainwashing”. Like Dana, she emphasised that psychology’s position as a science set it up as antithetical to religious belief:

My view is, we're supposed to be scientists. And to me, science and faith – I don't get it... I struggle to come to terms with somebody who's a scientist – because as psychologists we're supposed to be scientists – believes in this great, omnipotent being. A lot of psychologists I know are religious. (Carin)

Three of the participants noted that their patients also expressed difficulty in integrating the two areas. Clare explained how her patient felt that she was unable to marry her religious faith with psychotherapy:

[My patient] went to church one weekend prior to our session and saw a religious counsellor there and they were counselling her saying, Bipolar isn't a real thing. If you pray it will go away and it's a crisis of faith. And that made her feel like she's not strong enough in her faith ... that she cannot have a relationship with God if she takes the meds. So she felt very pathologized. (Clare)

Dana also described patients' difficulty in reconciling faith with psychotherapy, recalling that, as a young woman of faith herself, she had been told that “psychologists are evil”. Of her patients, she also noted:

A lot of religious people say, you know, my church doesn't really subscribe to this because of your ideas, your new-age ideas – you know, you won't give us the right advice. (Dana)

She thus linked her own memory of being warned about the dangers of psychologists with experiences of her religious patients who also struggled with the perceived incompatibility of their faith with psychotherapy.

4.1.2 Potential for complementarity. While acknowledging the different roles of religion and psychotherapy, Kyla thought that they could complement one another, stating:

It's important to respect their [the patient's] values, their beliefs. I would always try and tell patients that it's not mutually exclusive, that you can go and see your traditional healer and consult but you can also come to therapy or come and get your psychiatric medication. (Kyla)

Similarly, Clare felt that an inherent clash did not necessarily exist, explaining:

Mental health is still health, the same as if you have flu and the doctor gives you meds. It doesn't mean necessarily that you can't have a relationship with God at the same time as you're taking meds. (Clare)

As interviews with participants progressed, even those who had initially taken a strong stance with regards to the irreconcilable nature of religion and psychotherapy voiced sentiments indicating nuance in their viewpoint. Jana observed that she drew a distinction between narrowminded religion, and a faith that allowed its adherents to “think for themselves” and exercise intellectual rigour, remarking that the latter allowed for more of a rapprochement between the domains of religion and psychotherapy. She demonstrated this by referring to both a therapist and a patient who, for her, encapsulated possessing both religious faith and the capacity for mental rigour:

I have no problem with people who are more broader-minded ... I have had Jewish patients who might go to their Rabbi and talk, and I have no problem with that. (Jana)

There's a Jewish Orthodox psychoanalyst in New York and I've done a few seminars with him ... I have no problem with that. But that's because he is so free and he has a 'proper mind' – in the way that we talk about a 'mind' in psychoanalysis. (Jana)

You know, there was a monastery where the abbot said he would only take monks who have had a full analysis. He knew what he was talking about. If your spirituality or religion is truthful, it should hold, it should withstand questioning. (Jana)

Dana similarly reflected that, despite her initial feelings of resistance when encountering religious patients, she found that the perceived quality of the patient's belief could impact this:

[On when RS can be integrated into therapy] When it can be used healthily and it's authentic for them and full of meaning and purpose for them. And in my clinical insight does not feel like, and I'm sorry to sound arrogant, but doesn't feel like a delusion or a hallucination or is something that is a barrier to intimacy to access them. (Dana)

Of further note is that several participants drew a distinction between organized religion and the idea of 'spirituality'. Jana, for example, expressed the following:

I have no problem with meaningful spiritual ritual. If you look around the room, you'll see Buddhas. And this is my Buddha [points to a traditional African mask on the wall] – she protects us, my work with my patients. (Jana)

Jana thus expressed an acceptance of both her patients' and her own spirituality, despite her earlier feelings of anger towards organized religion.

4.1.3 Aims of RS and psychotherapy. Participants reflected on areas of convergence and divergence in the aims of both psychotherapy and RS. In particular, several interviewees noted how therapy concerned itself with the same overarching existential themes as religion. For example, Tim explained:

I understand religion as a human construct that is across the board, across cultures. And common to all of that [psychotherapy and religion] is understanding castrated-ness or lack, incompleteness or mortality. We're not omnipotent, we're not omniscient, and we will die, and these are terrible things to think about. We can't really think about them in their bigness so we construct a something that helps us to live with the sting of being human. We all need that, whether we believe in Jesus or Krishna or Freud or Marx or Science. We need a belief (Tim).

In the above quote, Tim highlights the common work of both religion and psychotherapy in facing and symbolising the painful limitations and fears of the human experience. Tim suggests that humans, at their core, require a meaning-making system in

order to navigate the overwhelming nature of issues such as mortality. Exploring the work of therapy as echoing aspects of religious practice, particularly with regards to the work and process of mourning, he stated:

I think that Freud's notion of mourning and melancholia is tied up in religious practice. So if you don't engage in mourning, you are tied to a dead body and you drag it around. And religious practice is very good at helping with mourning. (Tim)

Tim drew parallels with the Jewish religious practice of 'sitting shiva' which requires the mourner to sit with, ritualise and make overt their grief over the loss of a loved one. By linking this to Freud's seminal work on mourning and melancholia, Tim noted the converging roles of working through loss, whether of a person or an idea, and the centrality of mourning in therapy. He expanded this comparison by noting that the Jewish mourning rituals "helped the deceased's soul move into the next realm", likening this to the work of therapy as enabling the patient to separate from lost internal objects or "dead bodies". Tim thus highlighted the therapeutic importance of "working through" loss in the realm of the intra and interpersonal. He further linked this to the "psychoanalytic notion" of being "haunted by the past", with unsuccessful mourning resulting in patients being stuck in a state of melancholia.

While Tim noted mourning as a central task of both religion and therapy, other participants proposed a similarity in the aims of self-growth and self-reflection, for example:

Inevitably there is an overlap because... they're both about trying to be the best that you can be. (Anne)

I think a lot of what Judaism is about is a lot of introspection, a lot about growth and development and kind of sitting and thinking and actually struggling with the thinking. I think it's supposed to be something that you're meant to think about and reflect about and be in touch with yourself about. So for me, I think they [psychotherapy and religion] actually go quite nicely together. (Kyla)

While Anne commented on the aims of personal development more generally, Kyla linked this more specifically to her Jewish faith, pointing out that a commitment to introspection was a core value in both domains.

4.1.4 Psychotherapy as religion/spirituality. Despite some participants feeling antipathy towards certain forms of religion and spirituality, some viewed the two areas as simply a different way of approaching the same human problems. Most of the participants reflected on their perception of therapy itself as inherently spiritual in nature. For example:

I don't think religion and psychoanalysis are different things. I think that they are different ways of talking about the human condition. (Tim).

[On the distinction between therapy and RS] I don't know whether one can entirely compartmentalise it because I think the very nature of therapy invites the spiritual (Shani).

The majority of participants also felt that elements of the interchange in the therapeutic dyad held a sacred quality:

There are times when we are sort of sitting in silence, and he [the patient] is just thinking, thinking, thinking. We're not saying anything to each other but something's happening and I feel a spiritual connection to him that's not something I can touch or see, but I feel it in my body and I feel it in the room and it's with a lot of clients. (Clare)

I honestly feel like through therapy or through that vulnerability, whatever the hell happens in this space, there's a spiritual element to it as well. (Clare)

Where people experience a real epiphany [in therapy], there is a sense of mystique and beauty to that that can feel that it's so profound that God has spoken to them. (Dana)

Clare and Dana thus emphasise moments of transcendence in the therapy room that can feel, for both patient and therapist, akin to a spiritual experience, linking these moments to both vulnerability and insight. Shani corroborated this feeling in describing “numinous” moments with her own patients. Both Shani and Dana found themselves

thinking of Psychologist M. Scott Peck's book *The Road Less Travelled* which speaks to their experience of therapy as spiritual. Dana expounded on this link by saying of the book:

[The book] speaks about that mystery that Psychology and science can't account for – it's just those moments where you're so in flow connected to this person that there is a sense of wonder. I mean, I'm not an atheist, but I just don't know how it all fits together. (Dana)

Dana drew comparisons with this sense of “holding space” in therapy with her own memories of transcendent moments in a church setting:

When churches dim the lights, soft music, get reflective, deep breaths – and suddenly you're in this different space and the 'Lord has come'. But actually, you've just connected with the moment and nothing exists in history or in the future because just for this moment, now, while we sing a song, we're with ourselves. And that's what you get in therapy anyway, that 'holding space'. (Dana)

Spaces of worship and contemplation were thus compared to the therapy room, with the qualities of presence, timelessness and moment-to-moment awareness key to both.

4.1.5 Psychotherapists as ‘priests’. Almost all of the participants felt that the roles of religious leaders and psychotherapists, while serving different purposes in some ways, also had enough in common to evoke comparisons. Dana referred to therapists as potential “secular shamans”. Dana, Tim, Clare and Carin all felt that therapists inhabited the role of “priests” in some way. With regards to the role of therapists, Tim stated:

Therapists are secular priests. There was a time when we went to speak to the priest. And there's a time now where people will go and speak to the priest or the rabbi or imam to hear some way of how to navigate life. You come to the therapist to help you navigate the struggles of life and our job is to help people live more easily with who they are in the in the world they find themselves in. (Tim)

Tim expanded on this point by noting that both priest and therapist may be viewed as a listening ear and companion, accompanying an individual through the potential loneliness and confusion of experience. Tim encapsulated his thinking thus:

Basically the point [of a priest and a therapist] in this instance is the same. I'm suffering in life, I'm struggling with this living thing, I want to find a way. I want to speak to somebody about that. (Tim)

Both Tim and Carin's reflections led them to draw analogies with the Catholic church confessional experience, underscoring the human need to confess. Carin stated:

I do think that people come to us as "priests" in a way. They tell us everything and they know it's safe, you know. There's the sanctity of the confessional. (Carin).

However, Tim also expressed a clear view about the difference in approaches to guilt and absolution. Observing that while both religion and psychotherapy address the individual's guilt-induced suffering, they approach it very differently:

If you're a Catholic priest, you would be able to absolve guilt. The idea is that if one confesses then one is freed of that, because Jesus died for your sins. If you're psychoanalytic, you'll say, well, it's inherent to the human condition that you're guilty. If you're a Freudian or a Kleinian in particular. So guilt is inherent to the story. And you don't get to be absolved of the guilt. You might get to work *through* your guilt and integrate it in a way that is less burdensome. But you have to bear it! (Tim)

Dana alluded to a similar idea, commenting on the fact that some patients might hold the view that a religious response of absolution is preferable to the hard work of facing consequences, tolerating feelings of guilt, and making difficult choices in psychotherapy:

The people who want the religious counsel have cheated on their wife and they know that the religious answer is grace and mercy and forgiveness and long-suffering, whereas the secular answer [for the wronged partner] might be, you have options, you don't have to do this. (Dana)

Tim perhaps captured the complexity of the therapist's position in comparison to that of a religious leader. He reflected on the fact that, while not overtly directive or prescriptive, therapists do not necessarily come empty handed either, stating:

I can't bring them [patients] the solace of Jesus. I can't bring them the wisdom of Mohammed in terms of, these are the ways in which you must live. But I bring you the tools of "science", and I mean that in inverted commas. I bring you these ways we have learned of how one navigates anxiety and depression and whatever. I say "science" tongue in cheek because I also bring you the belief of psychotherapy and I bring you *me*. (Tim)

The above reflection seems to showcase the often contradictory nature of psychotherapy as experienced by practitioners, in that it highlights the conflicting conceptualisations of the theory and practice of psychotherapy as a science, a belief system and a healing relationship.

4.1.6 Psychotherapy as fundamentalism. Lastly, participants noted the potential for psychotherapy, like certain forms of religious practice, to become dangerously fundamentalist. Tim elucidated that:

Psychoanalysis is set up along the terms of a religion. It is profoundly belief based and then potentially carries a dogma and an orthodoxy and a 'get in line with it'. As in, 'There will be no salvation outside of this and you cannot stray!' (Tim)

Tim thus noted a potential rigidity, intolerance and purism which might manifest in the profession, adding that:

In some ways, the psychoanalytic community can be very dogmatic and very authoritarian and oppressive. (Tim)

Shani also alluded to a negative experience of psychotherapeutic practice which mirrored an unhealthy form of fundamentalist religion, recalling the feeling of being zealously indoctrinated into a certain 'denomination' of psychotherapy in her Master's

training. She linked this to her appreciation for her own former therapist who had not imposed any particular dogmatism on her:

There wasn't this *fundamentalist* feeling of [my therapist's] a "Jungian" or a "Kleinian". Which I think is quite lovely, you know, that you transcend that stuff. So you're *informed* by it, but your client's not having to come into a space where they can almost feel a modality. It's the *connection* that matters.

Shani thus foregrounded the importance of the quality of relationship in the therapist-patient dyad, observing that it could be negatively impacted by a rigid, almost religious adherence to a particular school of psychological thought.

4.2 Theme Two: RS as growth-promoting versus growth-inhibiting

This theme explores therapists' perceptions of how patients' use RS in ways that could impact their psychological health in both helpful and harmful ways.

4.2.1 Religion as defence. All eight of the participants acknowledged that RS could be used as a psychological defence. Shani recounted that some of her patients used their beliefs as an "intellectualising defence". Tim, Shani and Dana acknowledged the role of faith in defending against the "unknown". Dana noted that:

In a world of uncertainty, there is so much certainty and if you just block out all the noise of the secular and subscribe fully to that, then you can be safe, as long as you don't put your head out.
(Dana)

Similarly, Carin reflected on religion providing many people with a sense of "control" to defend against the terror of unpredictability. She explained the nature of this unpredictability by referencing three of her patients' traumatic experiences:

I think a lot of people turn to religion to feel like they have a modicum of control. We cannot control that we fell asleep at the wheel and ended up with a traumatic brain injury, or that the horse bolted and we fell off the horse, or that the robbers came into the shop and decided to shoot you. (Carin)

Specifically, she referred to a patient coping with the aftermath of a Traumatic Brain Injury (TBI). Carin noted that while she found her patient's beliefs to sometimes be "self-limiting", religion positively impacted her patient's capacity to deal with trauma:

I think [religion] gives her a sense of order. Because when you've had a trauma, or a TBI, it must feel overwhelming all the time because you lose your ability to filter... Like, everything comes at you at full speed. So in that kind of chaos, being quite religious gives a sense of order. It works for her. And although at times it is self-limiting, the benefit is greater than the harm. (Carin)

Tim also reflected on the role that RS plays in defending against fear and vulnerability. To illustrate his stance, he recounted the case of a religious patient who had survived an attempted shooting. The patient in question turned to his faith as a means of comfort and reassurance, drawing on his belief that God had saved him. While Tim noted the helpful role that this played in his patient's ability to face the trauma, he also noted that it rendered the patient in question unable to engage with the vulnerability and fear of his child, who had been present with him when the shooting occurred. Tim explained:

For my patient, okay, God is at his side and protects him in that moment and I'm good with that. I can go with that. One can speak into that. How fortunate and how lucky that was the case. But, when I then try to engage in relation to the child and to my patient in his role as parent ... he couldn't engage the child, because it would mean to engage his vulnerability. Because even though the bullets had missed him, he would have to engage with the child's vulnerability. He has to step through the trauma. And go into the trauma. And so it's both a useful defence and it's a defence against something else. (Tim)

Tim's above reflection captures the complexity and contradictory nature of religion as a defence, noting that while it can be psychologically protective and provide an individual with a sense of a more stable world, it can also block therapeutic work that requires an openness to vulnerability and uncertainty. Kyla similarly encapsulated the contradictory nature of religion as defence:

People speak [critically] of religion as a defence. You know, we all have defences – we wouldn't survive if we didn't – it's just about ascertaining which defences are healthier than others, which are not helpful for us anymore... All humans need defence mechanisms. Can you imagine if we didn't have them? I think [therapy] is about sometimes just challenging the defence mechanisms that are counterintuitive to your growth. So if you're going to say: I'm not going to work on myself because God love me, that might be counterintuitive ... if religion is a barrier for you, if it goes against having these honest conversations with yourself or avoiding your own development or self-growth. (Kyla).

Kyla thus notes that the idea of RS being used defensively cannot be neatly categorised as either helpful or harmful. She also draws attention to the role that RS might play in defending against painful self-exploration. This connects to a further thread that arose during the interview process, namely the impact of RS beliefs on a patient's sense of self.

4.2.2 Impact on self-worth. Participants reflected that RS could have a significant impact on a patient's self-esteem, manifesting in both helpful and harmful ways. Shani noted that highly religious patients sometimes experienced "levels of an internalised sort of badness." Dana expressed a negative view of the role of RS on self-worth, drawing on both her personal experience and that of her patients. In particular, she referenced Christian ideas of "impurity" and "original sin", linking this to the potentially damaging feelings of guilt and self-loathing:

I don't think there are many people that feel *as* condemned as orthodox religious people (Dana).

When you're in the Church, you just always feel wrong, you always feel bad ... and by default you *are* fundamentally sinful, flawed. (Dana)

Dana thus drew a direct link between certain religious beliefs and poor self-worth. Conversely, Dana also acknowledged that religion could be utilised to defend against feelings of worthlessness:

. [Religion] can defend against chronically low self-esteem because you've got this inherent superpower. And I think that's actually how a lot of these fanatical religions draw people in.

Certainly, I was drawn in by having a low self-esteem because it gives you a belonging, it gives you a family, it gives you these superpowers, and you can justify everything along religious lines. (Dana)

Dana explained her personal difficulty in working with an extreme version of this defence which she referred to as a kind of “Christian narcissism”, explaining it as follows:

Religion gives the illusion of personal specialness ... like [everyone’s] going to die of Covid but you’re going to pray and you’re going to be okay, and we’re all going to go down together except *that* person because that person fasts. (Dana)

Dana’s vignettes thus highlight her experience of religion as both helpful and harmful to a psychologically mature sense of self-worth. In the above quote she notes that even when utilised to improve self-esteem, it can lead to an unhealthy sense of exceptionalism.

4.2.3 Religious abuse. Jana and Dana further explored the potential harmful impact of abuse which they saw as legitimised by religious belief systems. Jana described working with a patient whose father exerted control over her in his role as a church pastor. In the following quote, Jana comments on the damage caused by an internalised sense of badness connected to the religious concept of inherent sinfulness:

She was so abused religiously; it was beyond disgusting ... She first had to understand that her father was not all knowing and that perhaps original sin - perhaps she was not bedevilled. They exorcised her at age 4! That’s a sin! A *deep* sin! That’s ridiculous. And it was horrible because she was convinced [of her inherent badness]. (Jana)

And then when her father discovered that she’d just kissed or maybe slept with somebody ... she had to walk down the aisle in the church where he was the pastor to apologise for her sexual [behaviour]... now that’s sexual abuse for me, even if it wasn’t with touching, that’s sexual abuse. (Jana)

Dana also commented on the deleterious psychological impact of what she described as “religious abuse”. Reflecting on working with patients who were recovering from being raised in extreme religious communities or self-described “cults”, Dana spoke of the difficulty they experienced in trusting their own perceptions:

They believe that their minds are broken as a result, and everything that they’ve ever believed was true, they have to sort of reconstitute when they leave [the religion]. And that takes an enormous amount of ego strength. (Dana)

In addition to the intrapsychic harm described above, Dana also acknowledged that the effects of religious abuse could manifest in the therapist-patient relationship, noting:

They [the patients] latch quite readily onto therapy and the therapist, but also have those undertones of: but aren’t we just doing the same thing here? And what makes *this* [therapy] right and *that* [the former belief system] wrong? (Dana)

Dana’s observations were that patients who had suffered a form of ‘existential’ wounding due to religious abuse were either quick to latch on to the therapist as a substitute for a religious authority, or conversely, were wary that psychotherapy was just a new religious belief system that might similarly ensnare them.

4.2.4 Agency. A further sub-theme acknowledged by all eight participants was in the area of personal agency. Several participants recounted instances where patients used their religious beliefs to avoid taking ownership of difficult choices. For example, Clare remembered a patient who, despite being treated poorly by a former love interest, viewed their bumping into each other on campus as a “divine, meant-to-be thing”. Shani similarly reported religion being used as a way to outsource personal agency, noting that it could become a useful “scapegoat” when “one doesn’t want to interrogate your motives”. She recounted the following about a patient who had written to their guru asking for guidance about moving cities:

Then you don't have to engage with the pain of making a hard decision. You don't have to engage with the pain of having a hard conversation with your parents... the guru said it's okay. (Shani)

Dana noted that religious belief could legitimise a sense of passivity in certain patients, viewing excessively religious patients as being in an almost "childlike position". Carin called this relinquishing of agency and personal responsibility "pull [ing] the god card". She elaborated on this concept with the following analogy:

I don't know if you ever heard the joke about the lottery ticket? There was this guy who prayed every night, "Please God, I want to win the lottery". And then one day this voice booms down and says, "Meet me halfway! Buy a ticket!" And sometimes I use that little analogy with my clients when they say, "Well, it's God's will". I go, whoa, God gave you freedom of choice. (Carin)

Carin's example points out an extreme position of handing over important outcomes to the divine object while neglecting to realise that the onus to implement change lies with the individual.

4.2.5 Religion as protective. All participants, even those who had expressed their difficulty with RS being utilised in unhealthy ways, were unequivocal in their acknowledgement that patients could psychologically benefit from their beliefs. For example, despite her expressed personal antithesis towards organised religion, Carin reflected that religion had mostly emerged as "benevolent" in the therapy room and stated it as providing "a sense of grounding" and "community" for some of her patients. Clare acknowledged the complexity of designating RS as either helpful or harmful by explaining that she viewed it as giving her patient "a reason to live" while simultaneously serving as both a "protective factor" as well as a "barrier" in certain areas of psychological growth. Anne felt that it imparted a sense of "resilience". All of the participants expressed the belief that RS could offer patients hope, meaning and a sense of belonging. Clare explained her sense of direct relief when encountering a patient's supportive faith:

I've also seen how much spirituality can have such a healing component. There was a point in therapy where if someone told me they were religious, I was almost relieved for them, because,

okay, thank goodness, they're going to have hope, they're going to see a bigger picture, they're going to accept things that happened to them that were bad because they're going to see it as meant to be. (Clare)

Clare recounted working with a patient with treatment-resistant depression who only experienced relief when reconnecting to her faith:

I'm thinking back to a woman I saw in her fifties and when she reconnected with God, her depression basically disappeared, and I mean, she did struggle very much with low self-esteem and it was like this acceptance came in – “I am still loved”. (Clare).

The above quote speaks to the perceived power of a faith system to mitigate a sense of despair. It also points to the positive impact that a religious belief can have on a patient's sense of value; a point which is pertinent to the area of self-worth highlighted earlier in this discussion. Clare further noted that sometimes, a patient's *lack* of faith could be growth inhibiting, exacerbating existing depression and lack of meaning. She described an already “pessimistic” patient whose absence of belief robbed him of the comfort that there was a “higher being looking out for [him]”.

Kyla felt that RS was mostly helpful for her patients, describing it as providing a “sense of belonging, support and meaning”. Working specifically in a state setting with limited resources, Kyla stressed the valuable role that faith communities could play for patients:

People use their belief in God or a higher being ... as a meaning-making experience to help them get through. I think also working where I do, the church is a big support system for a lot of our patients ... and I think that their belief in their particular religion – which is mostly Christianity – it comes up in a lot of ways as their coping mechanism that allows an access to feeling part of something, feeling supported, trying to make sense of difficulties that they've been through. (Kyla)

All participants thus acknowledged that religion could either enhance or hinder mental health. These reflections perhaps point to the skill and complexity required to

work with religious content therapeutically. How therapists approach working with religious content will be explored in the next section.

4.3 Theme Three: Engaging with patients' religious worlds in psychotherapy

Closely linked to therapists' evaluation of the impact of a patient's belief system on their psychological wellbeing is the complexity of working with RS content in the therapy room. Participants reflected on their experiences of how to engage with material that was, variously, culturally sensitive, core to identity, and powerfully reflective of a patient's inner world.

4.3.1 Stance of openness. Most of the participants relayed that they were aware of needing to step over their own beliefs or non-beliefs in order to engage with the religious world of the patient. While acknowledging that this could be challenging, participants placed high value on 'suspending disbelief' in order to explore the meaning of a patient's relationship with the divine. Shani, for example stated:

... it's not for us to superimpose or project our stuff onto the other. I think that's what's most exciting is that it's what *that* patient is going to find. (Shani)

In a similar vein, Carin explained that she did not "negate" her patient's beliefs saying, "I try and go with them". Clare reaffirmed this sentiment by noting the importance of "just explor[ing]" the patient's experience related to religious content, and noting what it brought up for them specifically. Most participants acknowledged the importance of the patient feeling safe enough to bring their own beliefs, and the potential relief it could provide, underscoring how crucial it was that therapists refrain from judgement. Clare reflected:

Just having that thing of not being judged about whatever your beliefs are is really helpful to people. (Clare)

Clare expanded the idea of non-judgement even further, describing a therapeutic stance of suspending her own disbelief in order to enter into the inner world of her

patient. With regards to a patient who reported visits from spirits, Clare expressed the view that it was not her place to decide if they “exist or not”. She described her experience as follows:

And I can’t say that I sit there and don’t believe her experience, because I feel like when she’s talking to me about it, I’m becoming immersed in her experience and how she makes sense of stuff, so in that way, it almost strengthens rapport when patients are able to bring spirituality in because it is such a part of who they are. (Clare)

Most of the participants noted this potential for the exploration of religious content to strengthen rapport and to provide deeper insight into a patient’s inner world.

4.3.2 Object relations. Object relations emerged as a common thread for several participants. Specifically, participants acknowledged the work of differentiating a patient’s more idiosyncratic view of the divine from a broader religious creed. Kyla, for example, described her therapeutic stance as viewing the patient’s relationship to the divine as a window into their internal world:

I would never attack someone’s beliefs or challenge someone’s beliefs. I think I would challenge their internal object relations, rather than the religious system. (Kyla)

Participants mused on the multi-directional relational impact of conceptions of God. For example:

I’m thinking of one or two people where their internalized image of God was this scary, punitive figure, and sometimes it shows up in the transference around feeling like *I’m* punitive or judgmental. (Shani)

[On the book *The Road Less Travelled*] It’s worthwhile reading that last chapter on God in therapy – something like that – where he speaks about how people will view their intimate partner or their therapist the way that they view their God. And so, if their God is punitive and harsh and judgmental, all they key men in their lives will be. If they have a loving, gentle “daddy” [God], then all of those key players will be that way also. (Dana)

I stand to be corrected, but there is no difference between an extreme idealization of the therapist and taking him for God... it's all templates. (Jana)

All of the above reflections suggest that an individual's perception of God can, even if unconsciously, be coloured by experiences with parental or other significant figures. Conversely, someone's view of the divine may form a matrix through which they view, for example, figures of authority. Furthermore, in a therapeutic context, patients may then project those same relational templates onto their psychotherapist. This then has significance for working not only with a patient's elicited object relations, but can also be observed as playing a role within the transferential relationship.

4.3.3 Working within the patient's religious framework. Tim and Kyla both posited that the role of the psychotherapist was not to work with the *content* of a patient's belief system, but rather to tease out the *meaning* for a patient. Tim emphasised that it was not his place to make a judgement on the 'objective' truth value of any belief. Tim viewed working with religious beliefs much like working with the contents of a dream:

If somebody speaks to you about a dream, you're using what's happening in the dream as something they are scripting. [It's the same] with the religious belief I just mentioned. I'd use it like that. The person's just giving you material that they may have put into the idea of 'God' or whatever. I don't need to hear that as "truth". (Tim)

Tim's observation reflects participant's general approach of working with the individual meaning of religious content as opposed to grappling with ideas of 'veracity'. He elaborated on his viewpoint by offering case examples related to two different patients, one presenting their dilemma within the framework of their traditional ancestral beliefs, the other characterising her psychological position in terms of her particular Christian doctrine. He described the following in relation to the first patient:

You say that the ancestors are saying something to you: What are they saying? Why might they say that? What's that about? What was your ancestor's story? I mean, the ancestors are not arbitrary things. They are family, essentially. And they're telling a story. Now, if the ancestors are speaking, well then, that's what's in play, and so that gets spoken. And if there aren't [objectively]

ancestors and this is a projection, the patient is speaking the projection as if they were ancestors. It doesn't really matter [to the therapeutic process]. What matters is, how does the individual feel influenced by what has been? (Tim)

In the above example, Tim decentralises the role of religious “truth” in the therapy room. Tim does not view his role as being to evaluate the supposed ‘validity’ of an individual’s cultural beliefs, likening that approach to a potential form of psychoanalytic “colonisation”. Instead he views spiritual content as an opportunity to mine for deeper, more personalised meanings for the individual. This vignette could also be linked to the object relations approach discussed earlier as Tim describes engaging with ancestors as reflections of internalised working models of relating.

With his second example, Tim once again viewed the religious content as a way of entering into a patient’s internal dynamics. In this case, Tim considered how he would engage with a devoutly Christian patient who was holding potentially limiting views about her own agency, stuck in a state of passivity and dependence while she waited for God to instruct her:

I would want to be curious about that: “You seem to have a clear idea about what God wants from you, and about what God is going to bring and not bring. So you have an idea that God holds the power and that you don’t have any power and you’re waiting to receive this. Let’s explore that idea. Why is God keeping you waiting? Why would God want this or that?” To speak to that as if, in a sense, it were true. And to use that to try and understand. (Tim)

Along similar lines, Anne discussed working within her patients’ religious frameworks, noting that she used their own metaphor to engage with what they might be trying to communicate. Anne was reminded of an adolescent patient who had been told by her church leadership that she was “possessed” by evil spirits and had undergone subsequent “exorcism”. Anne described her way of working with this content as follows:

I would just be open to ask them: what does this mean for you? Is it literal? Metaphorical? ... But it would be difficult for me. It depends on what it means for *that* person. If it gave them a release

and they felt like the demon's being released, I don't know how harmful it would be. If they felt that they were evil, or that [possession] could excuse bad behaviour, I'd have to address it. (Anne)

Anne's wrestling with the above example highlights that working within a patient's religious framework can be complicated, and at times, it can be difficult to know whether or not to challenge a particular view that might be construed as 'harmful'. This links to the theme explored earlier with regards to the impact of patient's beliefs on their psychological health. However, the above quote also reveals Anne's choice to focus on the individual *meaning* of a religious belief – in this case, the patient's exorcism – in order to determine what role it might be playing for them.

While taking a different approach, Carin also reflected a tension with regards to working with religious content. She described taking a potentially more active role in challenging beliefs, perhaps in line with her use of Cognitive Behavioural Therapy as a modality. She noted that she might ask a patient to look for "evidence" regarding an unhelpful perspective; for example, their view of themselves as only "sinful". She explained that she viewed her work as a form of "refram[ing] their beliefs in such a way that they can "empower themselves". In line with the examples already discussed, Carin also described engaging with a patient's beliefs 'as if' they were true:

Researcher: How do you respond to your patient when she tells you that God spoke to her in her coma?

Carin: I say, how interesting. What did he say? Then she tells me what God told her... You just go with it, go with it, go with it. It's like working with somebody who's psychotic. You don't want to say, no there's no spiders crawling all over your body, you empathise with them and say, gosh that must be really awful and scary.

Carin describes an approach of remaining within the realm of the patients' spiritual experience in order to illuminate and expand on individual meaning.

4.3.4 Psychosis. In the above example, while demonstrating her intention of working with the underlying meaning contained in her patient's religious experience,

Carin references psychosis, foregrounding a tension reported by most of the participants as they grappled with how to distinguish psychosis from so-called ‘normal’ RS beliefs and experiences. This struggle was also attested to by Dana, Carin and Kyla, who expressed their own experience of wrestling with the limit of ‘suspension of disbelief’ in the therapy room. When asked to reflect on an area of difficulty in working in the realm of religion and spirituality, they responded as follows:

Where do we draw the line between mental illness and real spiritual experience? (Clare)

Coming as someone with different spiritual beliefs [what’s difficult is] to know how to ascertain – especially when you’re working in an acute setting – is what is psychosis, and what is actually culturally appropriate. (Kyla)

I think knowing what is psychotic and needs a psychiatrist and what is existential and what is just a general lived experience. Because it is often the most flagrantly mentally unwell people or profoundly traumatised who have the strongest need for a religious experience. (Dana)

Clare was reminded of a case she had worked with which epitomised her own lack of clarity on the matter:

I was working at the mood disorder and substance rehab ward at the time and he [my patient] was hyper-religious, Christian, enthusiastic about Jesus in his life, born again and all of that, and it’s so interesting when we sat in MDT [multidisciplinary team] meetings, they said: “This guy’s having a manic episode.” And I just thought, take this guy, put him in a church on Sunday and he’s completely normal, so where do we then draw the line? Just because we are now seeing him in a ward, are we saying that he’s having a manic episode? (Clare)

Clare thus posed a difficult question as she struggled to distinguish for herself where the line between religious belief and psychosis should be drawn. Her dilemma, echoed by other participants, perhaps illustrates the enormous skill required of a psychotherapist in navigating the complex intersection of psychological health and religious beliefs.

4.4 Theme Four: Psychotherapists' positionality: navigating the tension

A common thread running through all participant accounts was of the tension felt between their personal and professional stance. Participants expressed awareness of balancing their own beliefs, biases and socio-religious identity with their psychotherapist role.

4.4.1 Personal versus professional. During the interview process, participants consistently highlighted the tension inherent in navigating their personal and professional identity with regards to religion and spirituality.

Carin, Dana and Jana all explored how their personal negative experiences with religion contributed to their professional challenge of 'stepping over' their own triggers and biases. All of them acknowledged strong personal aversion towards certain types of religious expression:

They can say what they like, religion [in my experience] is punitive and cutthroat and mercenary and therapists are like: can we just be a bit kinder? Can we just find a middle ground? And I would never have been able to do the kind of work I do as a therapist if I still subscribed to that version of religion. (Dana)

From a deeply personal level, I find people who are hooked up in Christianity far harder to bear than perhaps those who are Jewish or Islam. I was brought up in a so-called Christian household. When I get Christianity thrown at me, I find it far more distasteful than if somebody would throw Buddhism or Islam or Deism at me. It's probably because it was ingrained in me and I reject it. It's more personal. It's kind of like, piss off! (Carin)

[After describing a 'cleansing ceremony' her devout Catholic mother had to undergo after childbirth to rid her of 'uncleanness'] Now you know why religion makes me super angry, livid beyond ... [mimes grabbing her throat]. (Jana)

These excerpts capture a sense of aversion rooted in negative personal experiences of religion. They further reflected on their initial visceral response to patients bringing religious material:

The minute they [start talking about] their religious beliefs, I almost want to move it out the way. I almost want to say: can we just take that and put it over there so that I can deal with *you*? (Dana)

At the back of your brain, you're seeing certain things as codswallop, but I know I have to be present for my clients. (Carin)

Despite detailing their grappling with this aspect of their work, the above participants also discussed being aware of how their own religious background was informing this, an awareness which helped them to create a gap between their personal and professional responses. Participants further stressed that their initial felt response did not reflect how they actually engaged with patients. Carin acknowledged that despite wanting “to close off from it”, she “ma[de] a conscious cognitive effort not to.” Contrasting her personal response with her professional demeanour she explained:

[in her role as therapist] I'm more open and it's a professional setting. I have to accept what my clients say, I have to be Rogerian, I have to be at one with my clients. (Carin)

Reflecting on her career as a psychoanalytic therapist, Jana commented that her own “deeply entrenched” atheism had perhaps, at times, inhibited her from productive therapeutic work:

I have kind of calmed down a bit, although [my stance] is still very strong on the anti-religious side... I do know that I had probably one patient who was very religious for whom I didn't do justice. (Jana)

She acknowledged that religious material could feel “difficult” and “uncomfortable”. However, she was reminded of successful work with a self-described religious patient, foregrounding the quality of connection above all. This led her to muse:

Maybe the more important thing is how much I relate to a person rather than the religious side. (Jana)

Other participants who, despite not feeling a strong personal dislike for religion, also grappled with the near impossibility of navigating positionality. Kyla, for example, pondered the challenge of balancing her Orthodox Jewish and psychotherapist identities:

I really do try and keep these different parts of myself separate – I know it’s easier said than done. And when I’m in the room, I’ve got my therapist hat on, I’m not the religious Kyla... so I do try and keep those identities kind of separate. Even though, I mean, ultimately you can’t. You just look at me and you can see that I’m wearing a wig and I’m wearing a skirt, so just looking at me you can already assume things about me. But I think it’s trying to maybe use my therapist brain in thinking about the patient, not thinking from a spiritual point of view. (Kyla)

All of the participant thus acknowledged the need to be aware of their own religious positioning and potential biases in order to be of service to their patients.

4.4.2 Difficulties of disclosure. Closely linked to the issue of professional versus personal identities, participants also noted the discomfort that arose when patients asked them directly about their religious affiliation, relaying the struggle of whether to disclose their own stance or not. For example:

Often patients will ask me what my beliefs are. That I find very awkward. (Carin)

What’s tricky is when [patients] ask. And that’s tricky because I want to be boundaried, but I also want to, for me in general in my practice, I’d rather just answer the question and move forward. But because I ... I have so many questions around it *myself* I don’t want to be more confusing to the client. (Anne)

Clare felt that her patients generally appreciated honesty with regards to her religious positioning, feeling that it then allowed them to “focus back on themselves”. From Clare’s perspective, it was more important for patients to feel her acceptance and openness than to receive an affirmation of her holding a similar religious stance. However, she recalled an exception to this approach with a particularly religious patient:

The only time I've felt it [potential disclosure] would damage rapport was with the guy who asked me directly if I'm a Christian because I knew he would judge me and not want me as his therapist anymore. (Clare)

These excerpts speak to participants' struggles when navigating issues of faith-related disclosure, highlighting the centrality of rapport and the need for awareness of each patient's specific needs.

The process of reflecting on their therapeutic role also allowed participants to consider their own experience as patients, specifically how their therapists' stance on faith impacted the space. Describing her first therapist as "seriously atheistic", Jana recalled feeling that she would have been "judged" for any religious material that she might bring. Clare similarly pondered the role that their former therapists' resistance towards religion had on precluding such content from the therapy room:

I very much got the sense that my therapist wasn't religious whatsoever... there was an underlying thing of, no, it's all bullshit kind of a thing. (Clare)

Clare went on to recall that her therapist had explicitly delineated religious belief as limiting, noting its impact on her:

I didn't like it because it didn't sit well with me. I felt it was judgmental, and I felt it was a bit, who are you to say there is or isn't a God? How do you know? (Clare)

Because now I sit there and I'm thinking, so if I decide tomorrow that I'm deeply spiritual or religious, then I know that [my therapist is] going to sit across from me and think, wow, this person is defending against xyz and look at how they're using God as an excuse ... so it didn't add to the therapy process in a good way. (Clare)

Here, Clare notes how her therapist's disclosure of her anti-religious positioning impacted the therapeutic process negatively. In contrast to the above, Clare referenced a more recent therapy experience where she felt comfortable bringing her religious longings and conflicts to the therapist. Linking it to her own role as psychotherapist, she

expressed the belief that allowing for her own patients' religious material brought her "closer" to her patients, and "deepened" their work together.

Anne similarly described an appreciation for the space her therapist made for the spiritual in the therapy process, particularly with regards to the processing of grief around her mother's passing:

Now that I've had a baby, we spoke a lot about my mom dying. What did that mean? Where's the spiritual aspect? Is she still with me? The fact that [my therapist] would go there makes me feel safe to go there. (Anne)

Anne felt that her therapist's comfort level with exploring the spiritual assuaged certain aspects of her own anxiety about engaging likewise with her own patients.

About therapist's advertent or inadvertent self-disclosure. Add a sentence to orient it like that. The other example counterpoints the disclosure of anti-religious sentiment, suggesting something about anti-religious disclosure too.

4.4.3 Sameness versus difference. Participants expressed different perspectives on the impact of similarity to a patients' beliefs. Clare, for example, acknowledged that some patients may choose a therapist with the same religious affiliation as them because it might make them feel "safer". However, she also acknowledged the opposite, noting that patients sometimes intentionally sought out therapists from a different background:

I would have thought initially if someone comes to see me from a different religious background, they're going to feel like I can't relate or understand, but a lot of clients specifically seek out a therapist who's not from the same background because they feel too much judgement if they see people in their same community. (Clare)

Almost all of the participants acknowledged the benefits of working with patient's whose belief systems were radically different from the therapist's own religious upbringing. This is captured in the following reflections:

[on working with traditional ancestral beliefs] I find myself more respectful of his experiences than I would of ones that mimic my own. (Dana)

It's probably easier for me when I have someone who's Hindu or Muslim or Jewish because I don't share those beliefs, whereas the Christian beliefs I shared at some stage and when I get that thrown at me, I find it offensive. (Carin)

When it's the same, it's more difficult. Having those assumptions about the person and not really allowing the openness for exploration and curiosity. It really shuts down a lot because you're assuming a lot about this person's external and internal world. (Tim)

Participants thus highlighted that difference could make it easier to suspend disbelief and sidestep their own triggers, further noting that their curiosity and stance of 'not-knowing' allowed for deeper exploration, helping them to avoid the assumptions they might have made about a more familiar religious worldview.

4.4.4 Feelings of incompetence. Of the eight participants, six described feelings of anxiety and incompetence when working with RS content. Clare specifically referenced her own uncertainty in a situation where she strongly identified with a patient's religious struggles:

[My patient was] having a crisis of faith and I was sitting there constantly just thinking, because I'd been through a similar experience, and I was thinking: how do I handle this without influencing her in any way? I didn't want to direct her to "religion is bullshit" or whatever... I had the exact same concerns as her. (Clare)

Clare also commented on her concerns that she might be invested in her patient holding on to some part of her faith, fearing that she might "unconsciously" be "directing the conversation". She elaborated on this:

I had to say to myself: there's not going to be a resolution to this. I need to just let it be for what it is. I don't actually need to steer her to "keep the faith" or "no don't". So that, I suppose, is anxiety-provoking. That was more my internal process. (Clare)

Several participants felt that their anxiety was exacerbated by a potential gap in training, commenting that they had either received inadequate training in working with RS, or had received very contradictory messages. Commenting on her Master's level training, Anne explained the confusing messaging about the role of RS in psychotherapy:

All the lecturers had different beliefs but were all adamant that their beliefs were right, so there wasn't much room for this topic. (Anne)

When given space to reflect at the end of the interview, several participants indicated that the process of speaking about their work with RS had brought to the fore a sense of incompetence, closely linked to fear of doing something 'wrong'. Kyla and Clare expressed similar fears of scrutiny and feelings of self-consciousness. When asked about what had been most difficult in the interview process, they stated the following:

I guess it's those questions where, thinking about my impact in the room, or dealing with how patients respond to me. (Kyla)

Where I had to think about, how did I respond in therapy, there I was afraid of also what you might think. (Clare)

All of the participants appreciated being able to grapple with the topic in the interview, noting that it alerted them to the importance of religion in psychotherapy. Clare felt that the whole interview had been "surprising". Both Clare and Anne noted that they had not spent much time thinking about or discussing the topic before:

[It made me think about] ... things I haven't thought of in as much detail or to this extent. But I think that maybe even just talking about it has opened my eyes a bit. Like, maybe I'll be a bit more aware of it when it does come up in therapy now. (Clare)

You know, I think about this so much in my personal life. Why haven't I thought of it in my work? That bothers me. I feel like I should have. (Anne)

Tim felt that the “space to talk” about the topic in the course of the interview allowed for “new links” and “elaborations on links” to be made. All of the participants expressed that the interviewer’s curiosity and openness to different views helped them to feel that they could speak more freely. This could possibly be linked to earlier discussion of the importance of providing a non-judgemental space for patients with regards to religion. Kyla’s reflection at the end of the interview perhaps encapsulates several of the sub-themes already discussed:

It’s a challenging topic because the role of the therapist is to keep yourself kind of neutral within the therapy space and reflecting on yourself is not always an easy thing to do, but it is a *necessary* thing to do. We *must* do it. We sometimes need that little push to do it. And there’s a lot of sensitivity about being accepting of other people’s religions and you don’t want to say something that someone might find offensive, intentionally or unintentionally. (Kyla)

Here, Kyla refers back to the challenge of marrying a professional and personal identity, acknowledging the discomfort of it while also emphasising the importance of being willing to self-reflect, and of having spaces that encourage such discussion. She also notes the sensitive nature of religion as it is so deeply tied to identity, culture and meaning.

Chapter 5: Discussion

This research undertook to investigate psychotherapists' experiences of working with religion and spirituality in psychotherapy. This chapter seeks to synthesise and analyse the key findings within the context of existing literature. The findings will be presented thematically, focusing on the aims which guided the research study. These aims include an exploration of the following: 1). How do therapists understand the relationship between RS and psychotherapy? 2). How are RS beliefs experienced as either psychologically harmful or as supportive of psychological growth? 3). How do therapists work with religious content, particularly given the complexity of such work? 4). How do therapists understand their reflexive positioning, particularly with regards to potential discord between their professional and personal selves in the area of RS?

5.1 RS and psychotherapy: opposition and rapprochement

The accounts captured from the sample highlighted the tension experienced by several participants when considering the intersection of the realms of RS and psychotherapy. Some participants strongly expressed their view that religious beliefs and psychotherapy should be kept separate, linking this perception to their positioning of psychology as a science, thereby rendering it as irreconcilable with religious belief. They further advocated that both practitioners and patients should keep these areas of their lives separate. Accounts of patient's discomfort with the perceived oppositionality of the realms of psychotherapy and religion were also relayed. This expressed tension reverberates with an extensive body of literature capturing psychotherapy's uneasy history with religion, tracing this opposition to Freud's stance that religion represented a form of delusion and psychological immaturity (e.g. Cohen, 2019; Florence, 2009; Freud, 1927; Frick, 2018;). Pargament (2007) and Tummala-Nara (2009) hypothesise that historically, the discipline of psychology sought to distinguish itself from religion in order to shore up credibility in an era of scientism, thus creating a template whereby the personal meaning of faith for patients was left unexplored. The legacy of this is that modern psychotherapists have tended to demarcate sharply between the RS and therapeutic domains. This division is enforced with regards to separating out their own faith stance from their therapeutic practice, as well as – whether consciously or

unconsciously – encouraging patients to do the same (Brown et al., 2013; Cunha & Scorsolini-Comin, 2021; Florence et al., 2019; Tummala-Nara, 2009). Research conducted with South African psychotherapists supports this finding, noting that therapists may avoid such content due to discomfort, and when concerned about how to navigate religious material, frequently referred patients to outside religious leaders to address such matters (e.g. Haycock, 2014; Patel and Shikongo, 2006).

Therapists also offered their perspectives on being patients in psychotherapy. They expressed a sense that their religious life did not belong in psychotherapy, and vice versa. Notably, patients feared that their religious beliefs would be pathologized by practitioners. Conversely, they feared that their religious leaders would view any discussion of ‘mental illness’ or their seeking out of psychotherapy as undermining of their faith. This correlates with research which foregrounds clients’ reluctance to submit their religious beliefs to therapeutic intervention due to fear of judgement (e.g. Florence et al, 2019; Griffith, 2006). Patients further feared that psychotherapists would offer directives which contradicted their faith perspective. Simmonds’ (2004) research with psychoanalysts found that many participants felt that spiritual matters were vulnerable and precious, and expressed anxiety that their own therapists might respond to the attempted exploration of this complex material by interpreting away their dearly held beliefs and experiences. Cohen (2019) similarly notes that analysands confronted with ‘non-believing’ therapists may feel that they should “protectively” exclude their religious life from the analytic dialogue (p. 107).

However, in counterpoint to the above, other participants expressed openness to the notion of RS having a place in psychotherapy, conceiving of the domains as potentially playing complementary roles whereby mutual respect allowed room for both. Some viewed exploration of RS material in psychotherapy as inevitable and important. Expanding on the idea of complementarity, participants in this study also expressed the view that the actual practice and process of psychotherapy could be a spiritual experience. Participants further referenced a sense of something ‘holy’ in their work with patients, noting moments of transcendence that could be construed as a form of

unconscious communication. Even those participants who had initially expressed their stance that psychology was a science noted that there was mystery in the process of psychotherapy. The therapeutic relationship itself was also seen to be sacred. This reverberates with wider literature which forefronts an intangible, spiritual connection in the therapeutic dyad (Field, 2005; Haycock, 2014; Rizzuto, 2004; Stone, 2005). Sperry (2012) referred to the therapeutic relationship as a “sacred resource” in the process of change (p. 140). In a similar vein, Pargament (2002) viewed psychotherapy as the “process of soul meeting and soul making” (cited in Barrett, 2009, p. 9). Thus, the quality of the relationship between therapist and patient was placed at the centre of the healing project. Stone (2005) similarly contends that the holding environment of the analytic space, particularly in its facilitation of the analytic practices of silent reverie and unconscious communication, is akin to a spiritual practice and is “steeped in the meaningful unknown [and] pregnant mysteries” (p. 424). This calls to mind Bion’s (1970) concept of ‘O’ to describe the unquantifiable emotional connection and transformational process of psychoanalysis, a process which Hess (2022) has described as a potentially spiritual experience capable of producing a transcendent awareness.

A finding of particular interest was participant’s articulation of an evolving perspective through the interview process. Those participants who had initially expressed the view that RS and psychotherapy were antithetical indicated a shifting stance through the course of interviews; this led to an acknowledgement of a more nuanced approach. It emerged that participants viewed the *nature* of a patient’s religious beliefs as a key determinant in its potential complementarity and rapprochement with psychotherapy. When patients were seen to possess open-mindedness and were able to interrogate their own belief systems with intellectual rigour, participants who had initially expressed a strong sense of the antithetical nature of religious and psychotherapeutic domains displayed more acceptance. Religious views that were perceived as rigid, defensive, narrow-minded and devoid of personal meaning were viewed as contrary to the therapeutic project.

Even those participants who embraced the idea of complementarity emphasised that their perception of rapprochement between religion and psychotherapy depended on the type of faith adhered to by patients. Rigid or fundamentalist beliefs were viewed as being the most difficult to work with, enforcing a sense of incompatibility between the domains. Conversely, faith or spirituality that was experienced as psychologically mature was viewed as easier to incorporate in the therapeutic process. This perspective reverberates with literature which distinguishes between approaches to religious belief that can either stifle spontaneity and authenticity, or promote self-awareness and psychological growth (e.g. Guntrip, 2009; Haycock, 2014; Johnson et al., 2007; Tummala-Narra, 2009). Haycock's (2014) research with South African psychotherapists similarly noted that practitioners drew a distinction between a spirituality embedded in fundamentalism versus one with a broader focus on interconnectedness. This perspective is widely echoed in literature which notes the psychologically stunting impact of rigid religious beliefs; using developmental conceptualisations of psychological maturity, literature distinguishes between 'mature' belief and immature, limiting, 'frozen' approaches to faith (Florence et al., 2019; Haycock, 2014; Johnson, 2007; Stone, 2005).

This distinction between the levels of maturity and rigidity of belief systems has implications for its potential complementarity with psychotherapy. Stone (2013), for example, highlights the difficulty of integrating rigid religious frameworks into a psychoanalytic practice. As fundamentalist belief systems frequently conflate thoughts with actions – for example, equating lustful thoughts with the sin of adultery – Stone (2013) suggests that patients embedded in this worldview find psychoanalysis to be morally threatening as it encourages them to give voice to a full range of their fantasies, thoughts and feelings. Furthermore, dogmatic belief systems tend to view thoughts and emotions hierarchically, thus encouraging adherents to feel guilt about so-called 'negative' emotions, such as anger and envy. With no outlet for these affective states, such individuals could be prone to utilizing defensive coping strategies such as denial, repression, projection and splitting in order to minimize these 'sinful' components, making them unavailable to the exploratory process of therapy through an "impenetrable" spiritual defense strategy (Stone, 2013, p. 327). These findings suggest that the discussion

around complementarity is layered and complex, and that the type of religion, as well as the type of psychotherapy being practiced, may play a role.

Expanding on comparisons between the spiritual and psychotherapeutic processes, some participants viewed psychotherapy itself as a form of religion, complete with psychoanalytic correlates for doctrine, ‘religious leaders’, tenets of belief, and even forms of fundamentalism. This concurs with literature that acknowledges the potential ‘religious’ structure of psychotherapy at large, and psychoanalysis in particular (e.g. Carveth, 2008; Cataldo, 2019; Field, 2005; Gleig, 2012; Rizzuto, 2004; Stone, 2005). This comparison was particularly noted in reference to existential themes such as grief, guilt, fear and purpose – issues which were construed as core human concerns focused on in both domains. Literature similarly notes the centrality of attending to existential questions with patients in psychotherapy (Barrett, 2009; Brown et al., 2013; Haycock, 2014; Rupert et al., 2019). More specifically, this research pointed to the work of both psychotherapy and religious ritual in assisting individuals to “mourn”, thereby liberating their libidinal energy to be invested in the project of their lives. This was linked to Freud’s (1917) seminal paper on ‘Mourning and Melancholia’, which posits that unsuccessful mourning of lost objects results in a ‘stuckness’ in a state of melancholy and in which psychotherapy was viewed as a way of helping patients to separate themselves from lost internal objects. This could be put in dialogue with Carveth and Forster’s (2009) assertion that the work of mature religion, much like the work of psychotherapy, is to bring the individual out of the paranoid-schizoid position, characterised by splits, into the more integrated depressive position where imperfection and nuance are tolerated. Lastly, the comparison of religion and psychotherapy also led participants to muse about the dangers of falling into fundamentalism in both spheres. It was noted that excessive purism, rigidity of thinking, and suspicion of the ‘other’ could manifest in psychotherapeutic schools of thought, potentially harming therapeutic rapport and closing down avenues of exploration. Carveth’s (2008) essay exploring the similarities between religion and psychoanalysis perhaps expresses this idea most succinctly. He observed:

For fundamentalism, in either field, is psychopathology; it entails foreclosure of the gap that the healthy version of each seek to open or reopen and keep open. (p.53)

Aims of authenticity, self-awareness and transformation were also highlighted by participants as shared goals in the domains of faith and psychotherapy (e.g. Haycock, 2014; Marovic & Machinga, 2022). This finds resonance with psychoanalytic literature which notes the common search for one's real or true self in both spheres (Carveth, 2008; Rizzuto, 2004; Stone, 2005; Tummala-Nara, 2009). This could further be linked to Winnicott's seminal idea of the true and false self (Winnicott, 1960). Winnicott viewed the false self as an adaptive layer of personality that developed around a person's true self in response to environmental failures, resulting in impeded authentic self-expression (Parker & Davis, 2009). Certain forms of spirituality, much like psychotherapy, prioritise the search for self. Stone (2005), for example, sees striving towards authentic self-knowledge as core to both projects. Continuing with Winnicottian ideas of the true and false self, psychoanalyst Donald Carveth (2004) also sees similarities in the concerns of both religion and psychoanalysis in this regard, noting that the death of the false self in order that resurrection might occur is key to both.

A further area of overlap identified in this research was that of the negotiation of guilt and the concept of confession, noted by participants as key concepts in Catholicism in particular. Similar comparisons exist in psychoanalytic literature (e.g. Carveth, 2004; Rizzuto, 2004; Tummala-Narra, 2009). In this conceptualisation, psychotherapists were compared to religious and spiritual leaders, such as priests and shamans. Referencing Boehnlein's ideas, Brown et al. (2013) echoed this sentiment, stating that:

... spirituality and therapy are linked because the process of repentance and the process of psychotherapy both require clients to embark on a journey of transformation that involves painful introspection (p. 118).

While the universal human need to confess to a safe, non-judgemental other was seen as a commonality between domains, it was noted that guilt was approached differently. Whereas religion was viewed as potentially offering absolution, participants felt that psychotherapy required individuals to tolerate and work through guilt feelings, noting that some types of religion might offer an easier ‘out’ in this regard. However, the human need for alleviation from suffering caused by guilt bound the two spheres together in a common aim. These findings seem to clinically illustrate Carveth’s (2008) assertion that both psychoanalysis and religion – at least those religions which are Judeo-Christian in origin – stress the key role of the internal conflict between conscience and impulse.

5.2 Growth-inhibiting versus growth-promoting religion

Identifying aspects of religion that could be either growth-promoting or growth-inhibiting was another area of therapeutic work that was foregrounded by the sample. The research findings revealed that patients utilised religious and spiritual beliefs in ways that both sustained and protected them, as well as in ways that stunted personal growth and psychological maturity. These findings are echoed in literature which acknowledges the dual role of religion as both helping and harmful in the therapeutic process (e.g. Cunha & Scorsolini, 2019; Haycock, 2014; Johnson, 2007; Pargament et al., 2005; Patel & Shikongo, 2006; Tummala-Narra, 2009). Stone (2005), for example, acknowledges that religion can be “a treasure house of still-valid wisdom” or a “prison house of confining rules and required beliefs” (p. 420). Participants reported that religion could be used defensively, allowing patients to avoid distressing material and to outsource their sense of agency. Patients were noted to turn to religion as a way of gaining a sense of certainty and control when faced with trauma. While this was acknowledged as providing some protective functioning, it was also observed to counter-productively exclude feelings of fear and vulnerability from therapeutic investigation. This correlated with research highlighting the therapeutic impasse created by patients whose religion promoted an external locus of control, thus absolving them from owning and navigating their own problems (Haycock, 2014; Patel & Shikongo, 2006; Vandenberghe & Prado, 2012). Hess’s (2020) psychoanalytic paper explored patients’ defensive use of RS through

‘spiritual bypassing’ – a term used to denote a patient’s use of their belief system to avoid difficult material.

Of note is that both the literature and the research participants acknowledged the need to hold a nuanced understanding of how to work with defensive religion in psychotherapy. Simmonds (2004) foregrounds the multifaceted, complex character of RS, acknowledging that it can hold enormous value, as well as be defensively misused. Simmonds (2004) goes on to suggest the therapist’s ability to discern what is perverse from what is life-enhancing in a patient’s RS paradigm is key, further positing that with skillful work, a patient’s defensive usage of RS can be analysed and thus mature and change. This once again highlights the importance of spiritual competency and self-awareness when working with RS material.

The positive and negative impact of religious beliefs on self-worth was also viewed as therapeutically pertinent. Some faith-related beliefs were seen to buoy up a sense of value, particularly when connected to the idea of being loved by a benevolent God-figure. This has resonance in existing literature (e.g. Haycock, 2014). Accordingly, an individual’s perception of the divine impacts their view of themselves. For example, an individual who conceives of God as loving and present tends to develop a more secure internal working model; this in turn suggests to the individual that they are worthy of care (Gurney & Rogers, 2007). On the other hand, certain fundamentalist belief systems were viewed as potentially harmful to self-esteem. Frequently linked with the doctrine of ‘original sin’ held by some Christian denominations, a sense of inherent and intractable ‘badness’ was observed in patients with fundamentalist outlooks. One participant reflected with deep emotion on the devastating impact of this sense of faultiness that had been instilled in her by her own conservative Christian upbringing. She further lamented the guilt and self-loathing she saw in patients with similar belief systems. This correlates with literature which notes the potential harmful effects of such beliefs (e.g. Johnson, 2007). Vanderberghe and Prado (2012) connect a patient’s inherent sense of sinfulness to their viewing of trauma as a form of punishment. The authors further see a correlation between the rigidity of religious views and psychological suffering. This stance is

corroborated by Johnson (2007) who similarly connected rigidity in religious belief and practice with excessive moral “scrupulosity” (p. 455), leading to harmful internalised ideas about the need to deny the self, a lack of assertiveness, and shame about sexual matters. Literature also points to belief in divine punishment as a source of potential psychological suffering (e.g. Cunha & Scorsolini, 2019; Johnson, 2007). This research thus highlights the extensive psychological suffering that can result from religious beliefs, thereby emphasising the importance of therapist competence in engaging in this realm.

The above findings related to religion-related psychological suffering also link to participant reflections on the impact of ‘religious abuse’ as an area of interest. Two of the participants recounted working with abusive religion, speaking with passion about the harm inflicted on patients by prescriptive faith systems. The terms *religious trauma* (Panchuk, 2018) and *spiritual abuse* (Oakley, 2013; Winell, 2011) are used to refer to pervasive psychological damage as a result of religion-related beliefs, messages and experiences (Stone, 2013). Winell (2011) highlights the harm of an internalized belief of ‘badness’ and the related notion that suffering is thus a divinely orchestrated consequence. Winell (2011) also contends that this type of religious trauma can create lasting damage in social, emotional, cognitive and physical domains.

Stone (2013) views religion which uses the fear of God, divine punishment or social ostracism as a way to control as psychologically violent and harmful. Furthermore, Stone (2013) suggests that such deeply ingrained terror can produce lifelong fear. Drawing on the work of Griffith, Stone (2013) further suggests that the repressive measures inherent in abusive religious systems lead to “dissociative self-silencing” (Griffith, 2010, as cited in Stone, 2013, p. 325). Panchuck (2018) highlighted the devastating existential impact for individuals attempting to extricate themselves from such a religious context. Panchuck (2018) emphasizes the impact of a shattered worldview and the confusion inherent in reconstructing a meaning-making universe in the wake of losing one’s entire grounds of existence. In terms of its clinical implications, participant reflections and corroborating studies illuminate this as an area of burgeoning

interest and specialised practice which requires further research (Cashwell & Swindle, 2018; McGraw et al., 2019; Panchuk, 2018; Park et al., 2017; Winell, 2011). The same literature further suggests that the long-term effects of religious trauma are akin to those of posttraumatic stress disorder (PTSD), a concept about which few practitioners are informed. According to Stone (2013), such trauma may go unrecognized, particularly as it is not acute, but gradually accrues via relentless long-term exposure to traumatizing messages couched in the language and tenets of a frequently socially sanctioned religious system. These reflections also draw attention to the importance of psychotherapy as a space to work through experiences of oppression by internalised images of traumatic religious objects and related belief systems (Tummala-Nara, 2009). The literature as a whole advocates for a deeper understanding of the effects of this trauma, and highlights the need for therapist competency when engaging in such complex work. Of note is that no research on spiritual abuse or religious trauma has been conducted in the South African context.

While this research has foregrounded the devastating psychological impact of harmful religious beliefs, it should be noted that all participants also acknowledged that religion and spirituality could serve a psychologically protective role, connecting patients not only to internal sources of succour, but also to supportive community structures. This can be seen as particularly relevant for a country such as South Africa, where access to mental health care is limited and community resources play a critical role. Religion was seen to aid a patient's ability to cope, particularly in relation to finding meaning in trauma and a sense of life purpose. This is in keeping with existing studies both in South Africa (e.g. Brown et al., 2013; Nkoana et al., 2022; Patel & Shongo, 2006; Thompson-Assan & Ally, 2024) and internationally (e.g. Hess, 2022; Pargament et al., 2005; Vandenberghe & Prado, 2012) which note the potential helpful role of religion in this regard. This links to an issue highlighted earlier in this discussion, namely the type of religious belief in question. This is articulated by Johnson (2007) who distinguishes between religion that engenders "compassion and wholeness" from religion which promotes "fear, fragmentation and harm" (Johnson et al., 2007, p. 458). Casement (2020) similarly distinguishes between RS frameworks that are rigid and inhibitory versus those that

embrace openness, flexibility and connectedness. As suggested by Cohen (2019), religion appears to be a central need of humanity; however, that need may be met in ways that are authentic and creative, or in ways that are defensive and perverse (p. 130). The skill required to make this distinction and to work sensitively with it cannot be underestimated (Rupert et al., 2019; Vieten et al., 2013). This study has seemingly highlighted a lack of guidelines for practising psychotherapists who encounter the need for such professional discernment. This is a striking consideration given the complexity of the task and the implications for the psychological health of affected patients.

5.3 Working with patients' religious worlds in psychotherapy

As discussed, existing literature points to the importance of skillful work with religious content. Both participant accounts and the surveyed research output underscore the desire of many patients to discuss religious material in psychotherapy. Furthermore, their religious and spiritual beliefs are construed as central to their identity and wellbeing (e.g. Cunha & Scorsolini, 2019; Florence et al., 2019; Haycock, 2014; Rupert et al., 2019). This section thus considers participant accounts of how they engage with a patient's religious world.

A stance of openness and non-judgement was seen as key to successful therapeutic engagement, a view which existing research strongly corroborates (Johnson, 2007; Plante, 2007; Rupert et al., 2019). Studies suggest that patients will 'edit' religious content in direct relation to how receptive and comfortable they experience their therapist to be, pointing to potential counter-transference implications which could hinder a fuller meeting of the patient's needs (Hess, 2022; Johnson, 2007; Mayers et al., 2004; Simmonds, 2004; Winton, 2013). This issue then becomes one imbued with ethical weight, as the needs of the patient should be prioritised over that of a psychotherapist's potential discomfort or existing biases. Participants referenced suspending their own beliefs in order to enter the worldview of their patients, noting the powerful positive effect this could have on the rapport of the dyad. This therapeutic stance then allowed participants to explore the *meaning* of an individual's beliefs, as opposed to wrestling with the objective 'truth' claims of any system, an approach validated in existing studies

(Sorenson, 1994; Stone, 2005; Tummala-Nara, 2009; Winton, 2013). Casement (2020) advocates for a psychoanalytic approach that is rooted in acceptance of non-certainty and humility, thus moving away from the need to engage with religious content from a position of argument or defence of supposed truth claims. Stone (2005) conceptualises this as allowing for an exploration of the intrapsychic and intrapersonal dimensions connected to religious belief rather than making any comment on an article of faith. Participants similarly expressed the view that directly challenging items of faith was counterproductive and unethical. Working *within* a patient's religious framework was noted as key to successful engagement. Different ways of working with religious themes were identified by various participants, potentially related to their modality of choice.

An object relations approach emerged as a potential way of engaging with patients' religious content, whereby the objects of the god-figure, ancestor, or divine presence were engaged with much like any other relational object. Participants reflected that patients' developmental experiences could be projected onto their divine object. This approach is echoed in literature which similarly views an individual's internal God-representation as paralleling development of other object relations (e.g. Jones, 1991; Rizzuto, 1979; Stone, 2005; Stone, 2013; Tummala-Nara, 2009; Winton, 2013). Stone (2005) notes that patients' experiences of God are complex and can be both adaptive and defensive. Studies suggest that individuals' internalized images of the divine will impact their psychological health and internalized worlds profoundly (e.g. Gurney & Rogers, 2007; Rizzuto, 2004; Stone, 2013). Both existing research and participant accounts suggest that openness to the object relations approach when working with RS preserves the integrity of an individual's belief system while allowing for meaningful therapeutic work. This could be considered especially important in the multi-racial, multi-cultural, multi-religious context of South Africa, whereby practitioners engage with a wide variety of belief systems (e.g. Ally & Laher, 2008). Furthermore, it could be hypothesised that such an approach avoids the pitfalls of psychological 'colonisation', an area of great importance given the country's history of oppression and diminution of indigenous practice (e.g. Marovic & Machinga, 2022). Tummala-Nara's (2009) case study outlines how the intersection between ethnic identity and religion are especially important for

individuals and communities who have been subjected to oppression, and this could be extrapolated to apply to indigenous belief systems in the South African landscape. These findings suggest potential value in further studies specifically investigating psychotherapists' use of object relations in their work with RS.

However, it should also be acknowledged that some literature suggests that an object relations approach to RS could be construed as reductionist, as it confines the divine or ancestral objects to projections existing only in the realm of the intrapsychic, thus failing to allow for the consideration of 'real' interaction beyond the psychological realm (e.g. Gurney & Rogers, 2007). Perhaps the call for cultural humility in the face of the unknown (e.g. Cohen, 2019), and a willingness to embrace non-certainty (e.g. Casement, 2020) could serve, at least partially, to address this critique. Furthermore, some psychoanalytic writers have argued that such an object relations approach needs to be broadened to include the possibility that internal 'god images' may contain traces of 'real' encounters with the divine (e.g. Spero, 1992, as cited in Cohen, 2019). This highlighted area of tension suggests it is a rich field for further research.

A further related area of interest to emerge was related to transference, with participants noting a potential correlation between how patients viewed the divine and their transference towards the therapist. This is in line with literature which notes religious transference as an important concept which may manifest as an idealising of the therapist as omniscient, benevolent or punitive (e.g. Lijtmaer, 2009; Sperry, 2012; Strawn, 2007). Heyer (2016) contends that, when working psychoanalytically, much rich information can be gleaned from religious countertransference, suggesting that ignoring it means missing opportunities to learn about the patient's inner world, including learning about existential issues, perceptions of suffering, the use of defences, personality structure and object relations. Cohen (2019) similarly foregrounds the importance of transference and counter-transference material when working with RS, pointing out that it contains information about patients' fantasies about the therapist and the divine. This is an important area to note as almost no South African studies focusing on this area has

been conducted, although it has arisen incidentally in limited existing studies (e.g. Haycock, 2014; Patel & Shikongo, 2006).

Working in the realm of the ‘as if’ was also described as key to successful engagement with religious content. This allowed participants to enter more fully into their patient’s worlds. This could be linked to Winnicott’s views on therapy as a transitional space or ‘third’ area which allows for transcending the dichotomy between objectivity and subjectivity (Winnicott, 1971). These accounts find resonance in Winton’s (2013) case study of working with religious material in which she unpacks how, in her role as both a psychoanalyst and as a Dominican Sister with deeply ingrained spiritual beliefs, she navigates the therapeutic play space. Utilising a Winnicottian perspective, she noted her task of stepping back from her own religious and political beliefs, including the attendant emotional reactions, in order to create a gap through which projections could enter the therapy. Winton connected this to Ogden’s (1990) concept of prying open a “space between symbol and symbolized” (p. 241). She thus demonstrates the therapy space to be a ‘play space’ or relational space “in which religious and other material may be approached in a way that attends to its psychic, personal or relational meanings” (p. 350). This fleshes out an approach to working with religious content whereby the therapist’s and the patient’s belief are approached as being neither in the realm of the literal, nor as purely imaginary, but as existing in the minds of both. As demonstrated in both the aforementioned case study and in participant accounts, approaching religious beliefs in play mode involves freeing them from the need to be replicas of reality, thus allowing them to become more creative and flexible. Winton (2013) suggests that failure to engage with RS material in this way can lead to the therapist being ‘lured’ in to engaging with religious problems on a “religious level”, rather than a therapeutic level which considers the meaning behind the content (p. 349).

However, it should also be acknowledged that participants also expressed grappling with the limits of ‘suspension of disbelief’ with regards to potential psychosis and delusion. This suggests that this is a topic which is worthy of greater investigation, as participants noted the difficulty of distinguishing between mental illness and spiritual

afflictions or experiences. This perhaps puts participants' dilemma in dialogue with the South African literature discussed which emphasized the importance of taking indigenous knowledge systems and other non-Western religious beliefs into account in the assessment and treatment of psychological health (e.g. Ally & Laher, 2008; Laher & Kahn, 2011; Marovic & Machinga, 2014; Thompson-Assan & Ally, 2024). It also highlights the need for appropriate professional training, and increased cultural and spiritual competency for psychologists, a finding which aligns similar calls in the existing literature (e.g. Ally & Laher, 2008; Laher, 2014). From a psychoanalytic perspective, Gabel's (2020) paper provides an interesting counterpoint to historically pathologizing interpretations of religion-related disassociative states. Drawing on Winnicottian ideas of transitional space, Gabel (2020) suggests that voluntarily induced states of religious dissociation can be construed as intermediate areas of experiencing in which the boundaries between self and other, and internal and external reality, are temporarily suspended. This liminal space facilitates an unmediated experience of reality leading to an experience of creativity and mysticism which allows for different forms of insight. Gabel's (2020) hypothesis perhaps puts his views in dialogue with existing literature which suggests that altered states of consciousness in traditional African religion and indigenous spiritual practices have the potential for personal healing, transformation and growth (Marovic & Machinga, 2022). This dialogue between psychoanalysis, transpersonal psychology and indigenous knowledge systems seems to counter the long-entrenched narrative of the irreconcilable divide between psychology and religion, and presents itself as an area for potential future research.

5.4 Therapists' positionality: navigating the tension

Participants were noted to share generously and with vulnerability regarding their therapeutic work with RS content. However, it was evident that the exploration of such themes was not without its challenges. In the realm of religious belief, a clear tension between participants' personal and professional selves emerged. Almost all acknowledged grappling with separating their professional views from existing beliefs and biases that might negatively impact the patient-therapist rapport, thus pointing out the potential role of countertransference which could impact the therapeutic work. This

emerged as an underexplored area for most participants, as they reported that it was sometimes challenging to overcome existing biases. In addition, this challenge seemed to be amplified when participants held their own negative experiences of religion. This suggests a potential correlation between their personal religious experience and their degree of difficulty in navigating related content with their own patients. Furthermore, this led participants to reflect meaningfully on their own experiences as patients, recalling how their own therapists had welcomed or excluded RS content from the therapeutic space. This suggests the powerful impact that therapists play as ‘gatekeepers’, whether through overtly dismissing a particular belief, or simply through avoidance of engagement with RS material. Of note were participants’ observations that the desire to avoid religious material was sometimes conveyed unconsciously, but was felt in the transference. Such an observation seems to emphasise the importance of therapist’s self-awareness in this regard, pointing to the need for practitioners to have worked through their own religion-related struggles (e.g. Kahle & Robbins, 2004; Stone, 2013; Winton, 2013).

The above accounts all find resonance in the broader literature reviewed. Difficulty in marrying the personal and professional selves in the realm of RS has been noted in both international literature (e.g. Tummala-Nara, 2009; Winton, 2013) and in more recent South African studies (e.g. Brown et al., 2013; Padayachee & Laher, 2013). At times, this manifests in questions of whether or not to disclose one’s own religious positioning. While participants noted the discomfort evoked when issues of self-disclosure arose, overall their accounts seemed to indicate that discernment and clinical judgement was key when navigating the choice. This finding perhaps speaks to literature which raises the questions of the hypothesised helpfulness of religious disclosure (e.g. Magaldi & Trub, 2018; Tummala-Narra, 2009). When handled skillfully and with the individual needs of the patient in mind, therapist disclosure which centres the therapeutic relationship and which pays careful attention to the possible meaning of disclosure for a patient can be used to strengthen rapport and enrich therapeutic work. However, great self-awareness of the therapist’s own religious positioning and reactions is needed when navigating the issue of religious disclosure (Magaldi & Trub, 2018). Overall, it was

evident that RS in therapy is a challenging and uncomfortable area for many practitioners. They expressed anxiety that they were not handling the content correctly, and verbalised fears of judgement and criticism from the interviewer, as well as from their professional peers at large. This fear of judgement is broadly reflected in existing literature too (e.g. Barrett, 2009; Florence et al., 2019; Hage, 2006; Johnson, 2007). Overall, this research suggests that religion in psychotherapy is an underexplored area in professional spaces, and several participants reported absent, inadequate or confusing training on the matter in the process of their Master's studies. This is corroborated by studies in both South Africa (Brown et al., 2013; Haycock, 2014; Naicker, 2010) and internationally (e.g. Cunha & Scorsolini, 2019; Florence et al., 2019; Vieten et al., 2016) which also note a dearth of adequate training and the need for a more proactive approach to clinician awareness.

5.5 RS in the South African context

As the reviewed literature had highlighted the inclusion of indigenous cosmology and non-Western illness models as so key, it was striking how little discussion of local RS arose in participant interviews. Furthermore, when it was mentioned, it was not the focus of discussion but arose tangentially. In addition, considering topical political issues in the Middle East and South Africa's institutional support for Palestine, there was minimal discussion regarding the relationships between Judaism, Christianity and Islam. It was notable that participants referred very little to indigenous healing practices, and there was a distinct lack of discussion regarding the complex relationship between Christianity and indigenous beliefs that many South Africans routinely navigate. There was also limited discussion regarding the array of diverse religions found in the South African context. As the majority of participants' work is in the realm of private practice, it could be hypothesised that these findings are partly attributable to the kinds of patients with whom therapists are working, which may remain predominantly white or Western in their worldview. However, it is also possible that therapists are particularly ill equipped to think through issues of indigenous spirituality and that participants did not address it because they did not know how to engage with it. A third hypothesis suggests that their racial and cultural location made local and indigenous knowledge less proximal to them,

and thus was simply not at the forefront of their minds. This again reinforces the findings of this study in terms of the importance of developing spiritual competency in general, and in South Africa in particular. Lastly, it is also possible that the lack of reference to this material is due to the fact that the clients of the research participants have themselves engaged in the practise of transference editing, limiting the degree of openness to sharing due to apprehension of how their spiritual content will be handled. Overall, this finding serves to illustrate the potentially uncomfortable relationship between religion and mental health in South Africa, stressing the importance of therapists paying more attention to this area in future.

5.6 Implications for clinical practice

Overall, this research posits that RS presents therapists with an affect and value-laden area replete with potential ethical minefields, and thus require specific competency to navigate it. The term ‘spiritual competency’ is used by Rupert et al. (2019) to denote a level of familiarity, comfort and skill with religious material. This is closely connected to the need for practising psychotherapists to pay attention to their own unresolved RS-related issues, as a lack of self-awareness in this realm could lead to deleterious counter-transference responses to patients. Peteet (2014) posited that there is increasing evidence that RS commitments influence the work of psychotherapists. Not only can this affect capacity for therapeutic empathy (e.g. Morrison & Borgen, 2010), but unresolved anxiety related to RS can also be projected onto patients (e.g. Cohen, 1994; Winton, 2013). The issue of spiritual competency thus becomes an ethical one as it is closely related to the ability to meet patients’ needs. Furthermore, existing literature suggests that self-awareness is the greatest predictor for successful work with religious content, and that if practitioners are unwilling to subject their own personal religious beliefs to analytical investigation, there is more of a danger than they might infringe in unhelpful ways on the potentially psychologically unsophisticated beliefs of their patients (e.g. Strawn, 2007; Winton, 2013) potentially disrupting treatment through avoidance of religious material (e.g. Hess, 2022) or anti-religious bias based on assumptions (e.g. Cohen, 2019; Griffith, 2006; Vieten et al., 2013). It is further suggested that understanding their own spiritual journey helps therapists to better understand their clients’ struggles.

Issues of countertransference also emerged with participants in the form of expressing a vested interest in their patient's ultimate religious choices. Participants noted fearing that they might want to influence their patient's path, particularly when they felt overidentified with someone's particular spiritual struggle. Overidentification with a client's spiritual journey (e.g. Cohen, 2019; Peteet, 2009), and strong affect related to therapist's own aversive religious experiences (Florence et al., 2019), is also noted in existing studies to be an area of importance. Tummala-Nara's (2009) case study underscores the need for the examination of one's own religious beliefs and related meanings as it is triggered by work with a client's religious material. She describes this interaction of the respective God images of the therapist and patient as requiring an understanding of the shared and transferential reactions of the therapeutic dyad to religion and spirituality. For the research participants, exploration of religious countertransference emerged as a critical yet fairly underrepresented area of discussion.

Thus issues of personal discomfort, unexplored bias, fear of professional judgement, and avoidance of religious themes can all lead to therapeutic failure. Florence et al. (2019) perhaps sum up the core of the matter by acknowledging that therapists are 'gatekeepers', and that a personal reflective stance is therefore a non-negotiable for ethical practice. Writing in the context of New Zealand, Florence et al. (2019) further connected gatekeeping to a potential danger of minimising traditional Maori spirituality in the therapy space. It could be hypothesised that this has resonance in a multi-cultural, multi-faith context such as South Africa where the discipline of psychology has had not only an uncomfortable history with religion as a whole, in line with international accounts, but is presented with particular challenges when the worlds of traditional African belief systems and psychotherapy overlap. Her case example highlights the need for modern practitioners to focus on expanding beyond Westernised, Judeo-Christian conceptualisations of God, which have tended to dominate the historical discourse on religion and psychotherapy, to make understandings of indigenous healing practices a priority (Tummala-Nara, 2007). This has particular relevance for the South African context which suggests it is an area worthy of further research. Citing Nsamengang

(2007), Marovic and Machinga (2022) advocate for the importance of integrating African shamanic knowledge into models of psychology, positing that Western psychology “cannot flourish and serve the African continent without integrating local indigenous reality and context” (p. 38).

Finally, participants expressed their appreciation for the interview process which allowed them to think about and discuss a largely underexplored area, leading them to reflect that this would alter the way that they perceived their patient’s religious content in the future. This seems to corroborate research findings, discussed above, on the importance of creating more professional spaces to engage with religious material. Opening up the discussion on RS in psychotherapy may help to normalise it, perhaps mitigating some of the attendant anxiety highlighted in this study. Furthermore, participants commented on the ‘non-judgemental’ stance of the interviewer which allowed them more freedom to delve into uncomfortable material. This perhaps mirrors the importance of the therapist’s non-judgemental stance towards their patients, an area already highlighted as critical for successful work with religious material.

Chapter 6: Conclusion

6.1 Limitations

Limitations of this current study need to be considered along with the findings. Firstly, limitations with regards to the research sample should be noted. The participants who responded to the call for interviews were overwhelmingly in private practice, with only one participant holding dual roles in a state clinical setting and private practice. This is perhaps unsurprising, given that the majority of South African psychologists work in private practice due to limited public health posts. It is thus likely that the issues emerging in these vastly differing environments may not be adequately addressed due to the overrepresentation of psychotherapists working in the private sphere. Related to this is that no distinction is made between short and long-term therapy processes, as it can be hypothesised that patients in state settings would have access to a shorter therapeutic process. This may impact the way that religious and spiritual content is engaged with. Furthermore, while the researcher hoped to have participants from many different races, cultures and religious beliefs represented, the demographics of respondents meant that practitioners aligned to some religious beliefs were not represented, for example, Islam. The additional use of snowball sampling as a methodology meant that participants frequently suggested other interview participants with a similar worldview to their own. In the same vein, while this study hoped for a racially diverse sample, the participants who volunteered were White or Indian. The perspective of Black South African psychotherapists is therefore missing from this research. It could be hypothesised that the composition of the sample thus led to the exclusion of significant exploration of the role of traditional ancestral beliefs, an area which is key in a country such as South Africa.

The sample was, however, heterogenous in terms of years of practice and therapeutic modalities represented. While this added richness to the research, it also brought certain limitations. For example, due to the broad array of therapeutic modalities represented, no one particular modality was explored in depth, thus leading to a loss of opportunity of honing in on one specific approach to religious and spiritual material, such as a psychoanalytic approach. As such approaches could appear very different in their

formulation and execution, research which delineates more clearly and in depth in this regard could be helpful. In addition, there may be differences in perceived ‘spiritual competency’ related to years of experience, with newly trained psychotherapists exhibiting more anxiety in this area. However, as this was not the focus of the study, such issues remain unexplored.

In addition, the concepts being explored in this study, namely religion and spirituality, are very broad and can be difficult to delineate from one another or to operationalise. The polysemic nature of these concepts means that the objectives of the study were broad and opportunities to focus more specifically on one particular type of religious belief was not present. The above places limits on the generalisability and transferability of the research.

Another aspect to consider is the fear of judgement expressed by many of the participants. As religion and spirituality in psychotherapy is a relatively underexplored topic, historically connected to a sense of taboo within the profession, participants may have edited their responses to avoid feeling too exposed in the interview process. Selection bias may also be relevant here, as participants who chose to respond to the research call are perhaps more open to discussing the topic of religion, albeit not exempt from some personal discomfort. Thus psychotherapists whose level of discomfort in this area is perhaps even greater may have chosen not to respond to the call for research, and their perspectives may therefore be missing from the accounts.

Lastly, the interviewer’s own subjectivity and societal positioning possibly limited the research. Though a reflexive stance was intentionally engaged, the researcher’s own history with the topic may have impacted the way that the data was collected, analysed and presented. Closely related to this is the researcher’s position as a white South African female. Participants were noted to make certain assumptions about the researcher’s religious affiliation and history, and may have, whether consciously or unconsciously, consequently attempted to tread with care around issues they perceived to be value-laden with the potential to cause offence. Participants may have edited their

responses according to their perceived similarity or difference from the researcher's imagined stance with regards to religion and spirituality.

6.2 Recommendations for future research

Existing literature indicates that there is a marked lack of research into psychotherapists' perspectives of working with RS (Florence, 2009; Florence et al., 2019; Haycock, 2014; Johnson et al., 2007). This indicates that broad research in this area is pertinent as a whole. However, given the findings of this study in particular, several areas for potential study emerge as key. Future research could focus on a racially and culturally heterogeneous South African sample population which could investigate the experiences of voices not included in this research, for example Muslim psychotherapists and Black psychotherapists. Given the current political climate in which religious identity and political affiliations are fraught with tension, exploration of the intersection of political, cultural and religious beliefs and the resultant impact on both the therapeutic dyad and therapeutic process could be useful.

An area of great importance for future research is a deeper exploration of how psychotherapists engage with traditional African belief systems. While participants in this study touched on working with ancestral beliefs, on the whole, this sample did not forefront traditional African cosmology, focusing largely on Judeo-Christian faith systems. Given the historical context of the discipline of psychoanalysis and psychotherapy, such a focus is perhaps not unexpected. However, this study has indicated that there is room for more research on psychotherapists' spiritual competency when working with indigenous belief systems. Given the largely religious nature of the South African population, the potential for dialogue between psychotherapists and religious/spiritual leaders and healers is also a rich area to be mined in order to increase complementarity of practice, particularly given areas of overlap in aims (e.g. Marovic & Machinga, 2022).

As issues of spiritual competency, anxiety, and lack of training emerged as consistent themes in this study, research into how religion and spirituality in

psychotherapy is engaged with in Master's training programmes, ongoing professional development forums, and supervisory spaces could prove to be valuable.

The challenging area of working with psychosis when it overlaps with religious and spiritual beliefs was also highlighted as an area of importance. Participants largely expressed being unable to answer their own questions with regards to how to walk the line between entering into the religious framework of a patient while also remaining alert to clinically significant issues such as delusion and psychosis. Future research could explore this area more fully and perhaps connect this to the question of training psychotherapists in spiritual competency. Important to this discussion is the call for greater religio-cultural competency and an inclusive stance towards non-Western and indigenous spirituality, thus avoiding the pitfalls of pathologizing spiritual conditions and experiences.

Although participants in this study were noted to reference the experiences of their patients, the focus of this research was particularly on the experience of psychotherapists. As literature indicates that clients increasingly seek therapists who will engage with their religious and spiritual concerns, research that focuses on patient accounts, or studies that consider patient and therapist experiences in tandem, could be a valuable source of insight.

Of particular interest is the issue of religious transference and countertransference, which emerged in this study as central to practitioner accounts. While this study's focus was broad in terms of psychotherapist's experiences of working with RS, it is suggested that future research could focus more specifically on therapist and patient experiences of religious transference/countertransference, particularly as there is a dearth of such research in general, and in South Africa specifically. As discussed in this study, the issue of rapport and religious transference is crucial when considering a successful therapeutic outcome, and including a focus on religious transference could be seen as an ethical obligation for the profession. The significant tensions between the

personal and professional stance of practising therapists also emerged as worthy of exploration.

6.3 Conclusion

This research highlights the important role that religion and spirituality plays in the lives of both psychotherapists and their patients. This is in keeping with a burgeoning body of research which highlights increasing interest in and demand for psychotherapists with ‘spiritual competence’. Religion and spirituality are demonstrated to be an integral part of human identity and experience, and neglecting this area in psychotherapy could be seen as an ethical neglect of a patients’ needs. The importance of research in this area is thus paramount. Furthermore, despite the historical tensions between the two domains which was also reflected in participant accounts of unease, this study demonstrates areas of similarity and rapprochement between religion and psychotherapy, thus underlining the complex, nuanced relationship between the domains. This research has thus sought to explore psychotherapists’ experiences of working with religious and spiritual themes in the therapy room.

Participants in this study acknowledged both the healing and harmful aspects of religious beliefs encountered in their practice and in their personal lives. The therapeutic skill required to discern and work with these potentially polar opposite aspects of faith systems was highlighted as particularly important. Given the deleterious effects of psychologically damaging tenets of belief discussed by participants, it is evident that religious abuse and religious harm is an area of relevance. The area of religious abuse also emerged as an unexplored topic in the South African context. Ironically, it was noted that a ‘fundamentalist’ application of psychoanalytic beliefs could also be harmful to patients, mirroring a rigidity of thinking and purism highlighted in both the literature and in participant accounts as a growth-inhibiting aspect of certain forms of religiosity.

This study also explored ways of working with religious beliefs that prioritises respect for diverse worldviews, while still allowing the practitioner to examine individual psychological mechanisms linked to expressions of faith. Working with the meaning of

patients' beliefs, as opposed to engaging with 'truth claims', was foregrounded by participants as key. However, the difficulty of this work was also highlighted. This is particularly pertinent given the multi-cultural, multi-racial South African setting in which psychotherapists can expect to encounter diverse belief systems which require skill, understanding and empathy to navigate. Overall, this study hoped to respond to Cataldo's (2019) challenge of conceiving of ways to explore RS that honors "both its otherness and its embeddedness in human psychology, culture and history" (p. 115).

The current study highlights the difficulties faced by psychotherapists, underscoring a tension between their personal and professional identities when it comes to faith, frequently linked to the aforementioned historical tension between the domains built into the foundations of the discipline of psychology. This manifests in complex and often contradictory perspectives on the place of religious beliefs in psychotherapeutic work. This research also suggests that fears of incompetence and a lack of exposure to models of working with religious material, both in participants' own experiences of therapy as well as in professional training contexts, contributes to potential anxiety and avoidance of religious material. Participants expressed strong emotional reactions to certain beliefs and practices, frequently linked to their own religious backgrounds, thus foregrounding the importance of psychotherapists having worked through their own affective responses and biases in order to meet their patients with empathy and openness. This study also demonstrated that the place of religion in psychotherapy seems to be a largely unthought through aspect of therapeutic practice, and participant accounts suggest that this has implications in areas of religious transference and countertransference which could impact the quality of the therapeutic alliance and the therapeutic outcomes. A call for greater self-reflection and awareness in this area is thus sounded. This also foregrounds the lack of training in areas of spiritual competency in professional training settings.

This study has offered a unique perspective on psychotherapists' experiences of engaging with religious and spiritual content. In particular, it explored the personal and professional challenges faced by psychotherapists when encountering therapeutic content

embedded in religious and spiritual worldviews, noting the value-laden and affect-rich nature of such content. It thus offers opportunities for future exploration into spiritual competence as a core skill needed for effective practice.

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Appendix A: Interview schedule

Demographic Information

Gender:

Age:

Years of Experience:

Religious Affiliation (if any):

Registration category:

Questions:

1. What experiences have you had working with participants who bring religious and spiritual content to therapy?
2. How frequently does RS content arise in therapy?
 - When and how is it introduced to the session?
3. What RS related themes arise most frequently in therapy?
 - How (if at all) is it linked to the presenting problem?
 - What kind of psychologically growth-inhibiting issues arise?
 - How (if at all) is RS helpful in the therapy process?
4. How do you respond to a client when they first introduce their RS in therapy?
 - Do you avoid it or pursue it?
 - How do you decide what is relevant to pursue in therapy?
5. What is your perception of the role that RS plays in psychotherapy?

6. How (if at all) do you perceive psychotherapy/psychoanalysis and RS as overlapping/converging or diverging?
7. What is evoked in you when a client introduces RS-themed content?
8. What impact does a client's RS beliefs have on your therapeutic rapport?
 - For example, if a client's beliefs are the same as or different from your own.
 - For example, if a client's beliefs and experiences connect to something meaningful related to RS in your own upbringing.
9. How do you respond to a client who brings RS beliefs which you perceive as harmful/a barrier to psychological growth?
 - For example, when a client is using RS as a defence or justification for passivity.
 - For example, when a client's beliefs are seen as directly harmful (e.g., the self is inherently 'bad')
 - For example, when the religious system which a client defers to is seen as oppressive (e.g., certain genders or sexual orientations are denigrated).
10. How did you (or do you), if at all, explore RS content in your own therapy (when you were a client)?
 - How has your own exploration of RS in therapy impacted how you navigate similar content with your client?

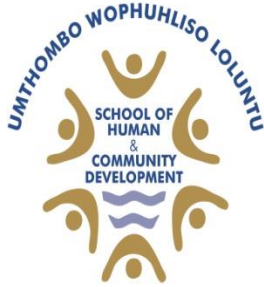
11. What is your experience of transference/countertransference related to RS content and relational dynamics?
 - For example, what resonance is there between a client's perception of the divine/divine authorities and their relationship with you as therapist?
12. How, if at all, do you help clients integrate the psychological and spiritual dimension of their experience?
13. What, if any, is the most rewarding aspect of working with a client's RS content?
14. What is the biggest challenge that you face in navigating RS material with a client?

At the conclusion of the interview, the following questions regarding the experience of the interview process will be posed:

Debrief and Reflective Questions:

1. Is there anything else that we not discussed today that is important to you?
2. What was it like talking about this topic?
3. What did you find to be the most difficult to talk about?
4. Looking back on the interview, are you surprised by anything that came up today?
5. What was it like talking to me in particular?

Appendix B: Participant information sheet



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Dear Sir / Madam

My name is Linda Filmer, and I am a Master's student in Clinical Psychology at the University of the Witwatersrand, Johannesburg. As part of my studies, I am required to undertake a research project, and I am investigating therapists' experiences of working with religion and spirituality in psychotherapy under the supervision of Professor Carol Long. The aim of this research project is to find out how psychologists perceive the impact of such content on the therapy process and on the therapeutic relationship.

As part of this project, I would like to invite you to take part in an interview. This activity will involve conversing with myself as the researcher about the topic and will take around 60 minutes. The interview can be on an online platform of your choosing or face-to-face at a time and place convenient for you. With your permission, I would also like to audio record the interview using a digital device. This recording will be saved as a password-protected audio file and stored on my password-protected computer. Only I, the researcher, will have access to these recordings. The audio recordings will be transcribed verbatim by the researcher. Quotes and content from the interview will be used for research purposes and included in the final report; however, the identity of the participants will be kept confidential. Identifying details of participants, organisations, and/or participants' clients will be omitted or disguised. Pseudonyms (false names) will be used for participants. Apart from myself, only my research supervisor will be allowed to view transcripts, and they will already be anonymized.

There will be no personal costs to you if you participate in this project. You will also not receive any direct benefits from participation. There are no disadvantages or penalties if you do not choose to participate or if you withdraw from the study. You may withdraw at any time or not answer any question if you do not want to, without any negative consequences. In the unlikely event that you experience any distress or discomfort at any point in this process, we will stop the interview or resume another time.

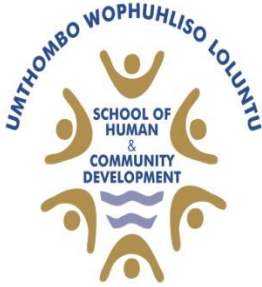
If you have any questions during or afterwards about this research, feel free to contact me on the details listed below. This study will be written up as a research report which will be available online through the university library website. If you wish to receive a summary of this report, I will be happy to send it to you. Anonymised and confidential research publications may be in the form of journal articles and / or conference presentations. With your permission, the data collected from this research project will be stored and may be used by other researchers for future analysis in an anonymised format.

If you have any concerns or complaints regarding the ethical procedures of this study, you are welcome to contact the University of the Witwatersrand's Human Research Ethics Committee (Non-Medical), telephone +27(0) 11 717 1408, email hrecnon-medical@wits.ac.za.

Yours sincerely, Researcher
Linda Filmer; lindafilmer@gmail.com; 0823852532

Supervisor
Prof Carol Long, Carol.Long@wits.ac.za; 011 7174510

Appendix C: Combined consent form



Psychology
School of Human & Community
Development
University of the Witwatersrand
Private Bag 3, Wits, 2050
Tel: 011 717 4503 Fax: 011 717
4559



Psychotherapists' perceptions of working with religion and spirituality in psychotherapy

I, agree to participate in this research project. The research has been explained to me and I understand what my participation will involve. I agree to the following:

(Please circle the relevant options below).

I agree that my participation will remain confidential

YES NO

I agree that the researcher may use anonymous quotes in his / her research report

YES NO

I agree that the interview may be audio recorded

YES NO

I agree that the information I provide may be used in an anonymised format after this project has ended, for academic purposes by other researchers, subject to their own ethics clearance being obtained.

YES NO

----- (signature)
----- (name of participant)
----- (date)

----- (signature)
----- (name of person seeking consent)
----- (date)

Appendix D: Ethics clearance certificate



SCHOOL OF HUMAN AND COMMUNITY DEVELOPMENT ETHICS COMMITTEE
CONSTITUTED UNDER THE UNIVERSITY HUMAN RESEARCH ETHICS COMMITTEE (NON-MEDICAL)

CLEARANCE CERTIFICATE:

PROTOCOL NUMBER: MCLIN/22/05

PROJECT TITLE:

Therapists' experiences of working with religion and spirituality in psychotherapy.

INVESTIGATOR

Filmer Linda (2451075)

SCHOOL/DEPARTMENT OF INVESTIGATOR

SHCD/Psychology

DATE CONSIDERED

12 August 2022

DECISION OF THE COMMITTEE

Approved unconditionally

RISK LEVEL

Minimal Risk

EXPIRY DATE

31 December 2024

ISSUE DATE OF CERTIFICATE

24 August 2022

CHAIRPERSON

C Harvey
(Dr Clare Harvey)

Cc: Prof. Carol Long (Supervisor)

DECLARATION OF INVESTIGATOR

To be completed in duplicate and **ONE COPY** returned to the Chairperson of the School/Department ethics committee.

I fully understand the conditions under which I am authorized to carry out the abovementioned research and I guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee.

[Signature]
Signature

Date

24 / 08 / 2022