IUL School of Social Sciences

Department of Social and Organizational Psychology

# Mental Health, Religiosity and Spirituality In Portugal: Towards the Development and Integration of Religious/Spiritual Competence for Mental Health Professionals

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Thesis presented in partial fulfilment of the requirements for the degree of Doctor in Psychology: Specialty in Clinical and Health Psychology

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[May, 2018]

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*To my dearest [and only]* ***Avó Yaya*** *who passed away last year...*

*I know you are not far, as I still see you in my dreams.*

(Maria Mendes Freire, born on December 20, 1920 and sleeping since October 18, 2017)

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**Abstract**

Mental health professionals are often ill-prepared to ethically and effectively deal with religious/spiritual dimensions in the psychotherapeutic settings, even though so much has been accomplished in this area lately. The general aim of this work is to explore and expand knowledge in this field, by using a transformative framework, based on the multicultural competence perspective. Firstly, a theoretical introduction is provided, emphasizing the numerous advances made in this field, contrasting the intertwined and tumultuous history between religion, spirituality and mental health. This chapter is followed by five empirical studies: Study 1 shows that religious members and clients desire to openly discuss religion/spirituality during mental health treatment, but they do have some concerns about whether mental health professionals are willing and competent to do so. Study 2 shows religious Leaders as important agents in promoting and preserving their congregants' mental health, as well as in their recovery processes; however this occurs without much referral to or collaboration with mental health professionals. In the remainder three studies, a sequential multistage mixed-methods design is used to understand the attitudes, beliefs and spiritual competence among mental health professionals. Major findings show that training and knowledge, in religious and spiritual topics, play an important role in these professionals' perceived level of comfort and preparedness to competently deal with religion and spirituality in clinical settings. However, results also show that their attitudes toward the integration of religion/spirituality and their personal religious/spiritual involvement also play an important role in this process. Finally, the discussion section of this work offers an integrative highlight of the main findings, reinforcing the need to consider all voices involved in a psychotherapeutic relationship. Furthermore, implications for practice and research are addressed on how to improve the process of an ethical and effective integration of religious/spirituality matters into clinical settings.

***Keywords*:** Spirituality; Religiosity; Mental Health; Professional Training; Spiritual Competence; Multistage Mixed-Methods Design; Transformative Paradigm.

**PsycINFO Classification Categories and Codes:**
**2920** Religion
**3310** Psychotherapy & Psychotherapeutic Counseling
**3410** Professional Education & Training
**3430** Professional Personnel Attitudes & Characteristics

**Resumo**

Os profissionais de saúde mental são muitas vezes inadequadamente formados/preparados para trabalhar, ética e eficazmente, com a religiosidade e espiritualidade em contextos psicoterapêuticos, apesar de todos os progressos científicos demonstrados nesta área. O principal objetivo deste trabalho doutoral é explorar e expandir o conhecimento nesta área, através do paradigma científico transformativo e com base na perspetiva teórica da competência multicultural. No primeiro capítulo -*introdução teórica*- enfatizam-se os inúmeros avanços realizados neste campo, em contraste à conflituosa história entre religião, espiritualidade e saúde mental no passado. Seguem-se cinco estudos empíricos: o Estudo 1, mostra que membros e clientes religiosos desejam discutir abertamente questões religioso-espirituais nos seus processos psicoterapêuticos; no entanto também referem algumas preocupações sobre se os profissionais de saúde mental estão abertos e são competentes para fazê-lo. O Estudo 2 mostra líderes religiosos como agentes importantes na promoção e manutenção da saúde mental de seus congregados, bem como nos seus processos de reabilitação; no entanto, isso ocorre sem muitas referências a colaboração/contacto com os profissionais de saúde mental. Nos restantes três estudos, utiliza-se uma metodologia sequencial *multifaseada*, para explorar as atitudes, crenças religiosas e competência religioso-espiritual dos profissionais de saúde mental. Os principais resultados demonstram que a formação e o conhecimento de temáticas religioso-espirituais têm um papel importante nos níveis de preparação e conforto dos profissionais de saúde mental para lidarem sensivelmente com as questões religioso-espirituais no contexto clínico. No entanto, os resultados também indicam que as atitudes e o envolvimento religioso-espiritual pessoal dos profissionais de saúde podem também influenciar estes processos. A discussão geral apresenta de forma integrativa os principais resultados obtidos, reforçando ser imprescindível considerar todas as vozes envolvidas numa equação psicoterapêutica. São ainda discutidas implicações para prática e investigação sobre como promover, de forma ética e efetiva, a integração das questões religioso-espirituais em contextos clínicos.

***Palavras-chave***: Espiritualidade; Religiosidade; Saúde Mental; Formação Profissional; Competências espirituais; Metodologia Mista e *Multifaseada*; Paradigma Transformativo.

**PsycINFO Classification Categories and Codes:**
**2920** Religion
**3310** Psychotherapy & Psychotherapeutic Counseling
**3410** Professional Education & Training
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# Contents


ACKNOWLEDGMENTS ..... 5

ABSTRACT ..... 11

RESUMO ..... 13

CONTENTS ..... 15

LIST OF ABBREVIATIONS AND ACRONYMS ..... 19

INDEX OF TABLES ..... 21

INDEX OF FIGURES ..... 22

**GENERAL INTRODUCTION ..... 23**

*Aims of the Present Thesis ..... 26*

*Selection and Justification of the Research Design ..... 28*

*Methodological Scope of this Thesis ..... 29*

*References ..... 30*

**CHAPTER 1 THEORETICAL INTRODUCTION ..... 33**

*Abstract ..... 35*

*Resumo ..... 36*

*Introduction ..... 37*

Religion (Religiosity) and Spirituality: Conceptualisations ..... 41

Religion (Religiosity) ..... 42

Spirituality ..... 43

Religiosity, Spirituality and Mental Health: Role and Impact ..... 44

Religion, Spirituality and Mental Health: A Developmental Perspective ..... 46

Religion, Spirituality and Mental Health: An Integrative View ..... 48

Multicultural Perspective ..... 51

Spiritual and Religious Competence: Guidelines for Integration ..... 53

Ethical considerations ..... 55

*Conclusion ..... 57*

*References ..... 58*

**THE PERSPECTIVES OF RELIGIOUS COMMUNITIES ..... 69**

**CHAPTER 2 PERSPECTIVES OF RELIGIOUS MEMBERS/CLIENTS ON RELIGION, SPIRITUALITY AND MENTAL HEALTH ..... 71**

*Abstract ..... 73*

*Resumo ..... 74*

*Introduction ..... 75*

Importance of Spiritual and Religious Issues in Mental Health: A Call for Awareness ..... 75

Clients' Perceptions of Spiritual and Religious Integration: A Call for Knowledge ..... 76
Mental Health in Portugal (a Brief Characterization) ..... 78
Religiosity and Spirituality in Portugal (a Brief Characterization) ..... 80
*Method* ..... *82*
*Sampling and Data Collection* ..... 82
*Participants* ..... 83
*Measures* ..... 85
*Data analysis* ..... 86
*Results* ..... *88*
*Religious/spiritual History of Participants* ..... 88
*Qualitative analysis* ..... 89
Religious/Spiritual Role ..... 89
Coping Mechanism ..... 90
Experience in the MHS ..... 91
Perceptions of Mental Health Professionals' Multicultural Competencies ..... 92
Perceived Quality of Service Received ..... 92
*Discussion* ..... *93*
*Limitations and Final Remarks* ..... 97
*References* ..... *98*

**CHAPTER 3 PERCEPTIONS OF RELIGIOUS AND SPIRITUAL LEADERS ON MENTAL HEALTH ..... 105**

*Abstract* ..... *107*
*Resumo* ..... *108*
*Introduction* ..... *109*
*Method* ..... *112*
*Sampling and Data Collection* ..... 112
*Participants* ..... 112
*Measures* ..... 113
*Data analysis* ..... 114
*Results* ..... *115*
*The Importance of Religion (Religiosity) and Spirituality in Mental Health* ..... 115
*The Experiences of Congregants in the Portuguese Mental Health System* ..... 117
*The (Perceived, Performed and/or Assigned) Role of Religious Leaders* ..... 119
*Relationships to Mental Health Professionals* ..... 120
*The Perceptions of Mental Health Professionals' Spiritual Competence* ..... 121
*Discussion* ..... *123*
*Limitations and Final Remarks* ..... 125
*References* ..... *127*

**THE PERSPECTIVES OF MENTAL HEALTH PROFESSIONALS ..... 131**

**CHAPTER 4 ATTITUDES, BELIEFS AND SPIRITUAL COMPETENCE AMONG PORTUGUESE MENTAL HEALTH PROFESSIONALS ..... 133**

*Abstract* ..... *135*

*Resumo* ..... *136*

*Introduction* ..... *137*

*Method* ..... *144*

*Study design* ..... 144

*Stage 1: Qualitative Study* ..... 146

Aims ..... 146

Procedures ..... 146

Participants ..... 146

Measures ..... 147

Data Analysis ..... 149

*Stage 2: Sequential Exploratory Study* ..... 149

Aims and Hypotheses ..... 149

Procedures ..... 150

Analytic Strategy ..... 150

Participants ..... 151

Measures ..... 151

*Stage 3: Sequential Explanatory Study* ..... 154

Aims ..... 154

Procedures ..... 155

Participants ..... 155

Measures ..... 156

Data Analysis ..... 157

*Results* ..... *157*

*Stage 1: A Qualitative Study* ..... 157

Personal Religiosity and Spirituality of Mental Health Professionals ..... 157

Definitions and Conceptualizations of Religion and Spirituality ..... 158

Attitudes toward Importance and Role of Religion and Spirituality ..... 162

Integration of Religion and Spirituality into Psychotherapy ..... 162

Integration of Religion and Spirituality as Therapeutic Strategies ..... 163

Religious and Spiritual Competence ..... 164

*Stage 2: A Sequential Exploratory Study* ..... 166

Personal Religiosity and Spirituality of Mental Health Professionals ..... 166

Training in Religious/Spiritual Issues and Mental Health ..... 168

Attitudes toward the Importance and Role of Religion and Spirituality ..... 169

Religious and Spiritual Competence ..... 171

Correlations and Mean Associations with Spiritual Competence ..... 173

Predictors of Spiritual Competence ..... 174

Mediation, Moderation and Conditional Process Analysis ..... 175
*Stage 3: A Sequential Explanatory Study* ..... 180
Polarization of Religion and Spirituality (and its impact on clinical practice) ..... 181
Impact of Mental Health Professionals' Personal Religiosity/Spirituality on Clinical Practice ..... 182
Religious and Spiritual Competence (the low levels of engagement) ..... 183
Integration of Religion and Spirituality into Psychotherapy ..... 185
Importance of Training and Knowledge in Religion/Spirituality on Clinical Practice ..... 186
*Discussion* ..... *187*
*Religious and Spiritual Competence* ..... 188
*Personal Religious/Spiritual Involvement* ..... 190
*Attitudes toward Religion/Spirituality in Clinical Practice* ..... 195
*Knowledge and Skills* ..... 196
*Training in Religious/Spiritual Matters* ..... 198
*Limitations and Final Remarks* ..... 202
*References* ..... *203*

**CHAPTER 5 GENERAL DISCUSSION ..... 211**

*Summary of the Major Findings – An Integrative View* ..... *215*
*Final Conclusions* ..... *223*

**CHAPTER 6 APPENDICES ..... 229**

*Appendix A (Paper 1)* ..... *231*
*Appendix B (Spiritual Competencies by ASERVIC)* ..... *233*
*Appendix C (Paper 2)* ..... *237*
*Appendix D (Interview Guide for Study 1)* ..... *239*
*Appendix E (Interview Protocol used for Study 1 and 2)* ..... *243*
*Appendix F (Codebook of Study 1)* ..... *249*
*Appendix G (Paper 3)* ..... *259*
*Appendix H (Interview Guide for Study 2)* ..... *261*
*Appendix I (Codebook of Study 2)* ..... *263*
*Appendix J (Paper 4)* ..... *273*
*Appendix K (Interview Guide for Study 3)* ..... *275*
*Appendix L (Descriptive Statistics of the items of the SCS, Study 4)* ..... *279*

## List of abbreviations and acronyms

Associations and Institutions

**ABCT** – Association for Behavioral and Cognitive Therapies

**ACA** – American Counseling Association

**AMCD** – Association for Multicultural Counseling and Development

**APA**[1] – American Psychiatric Association

**APA**[2] – American Psychological Association

**ASERVIC** – Association for Spiritual, Ethical and Religious Values in Counseling

**CIS-IUL** – Centro de Investigação e Intervenção Social

**CPLP** – Community of Portuguese Language Countries

**INE** – Instituto Nacional de Estatística

**ISCTE-IUL** – ISCTE-Instituto Universitário de Lisboa

Health and Mental health related abbreviations and acronyms

**MHP –** Mental Health Professionals

**MHS** – Mental health services

**PMHS** – Portuguese mental health system

**SNS** – *Sistema Nacional de Saúde* [Portuguese National Health System]

**DGS** – *Direção-Geral da Saúde* [Portuguese General Directorate of Health]

**CSP** – *Cuidados de Saúde Primários* [Portuguese Primary Health Care]

Religious Affiliation

**CC** – Catholic Church

**EC** – Evangelical Church

**JW** – Jehovah's Witnesses

**LDS** – Latter-day Saints

**LIC** – Lisbon Israelite Community

**OC** – Orthodox Church

**PBF** – Portuguese Baha'i Faith

**PBU** – Portuguese Buddhist Union

**PFI** – Pagan Federation International

**SDA** – Seventh Day Adventist Church

Measures

**SCS** – Spiritual Competency Scale

**SWBS** – Spiritual Well-being Scale

**EWB** – Existential Well-Being

**RWB** – Religious Well-Being

Methodologic and statistical related abbreviations and acronyms

**MAXQDA 11** – Software for qualitative, quantitative and mixed methods research, version 11

**IBM SPSS 20** – Statistical Package for the Social Sciences, version 20

**PROCESS** - free computational tool/procedure for SPSS and SAS that allows statistical analysis, such as moderation, mediation and integrated conditional process model (i.e. mediated moderation and moderated mediation)

**QUALTRICS** – online software designed for online data collection and analysis.

## Index of Tables

Table 1 - *Religious identification (affiliation) of Portuguese population* ..... 37
Table 2 - *Demographic characterization of the sample (N=40)* ..... 83
Table 3 - *Distribution of focus group interviews* ..... 84
Table 4 - *Religious and Spiritual characterization of the sample (N=40)* ..... 87
Table 5 - *Spiritual Well-Being Scale Statistics (N=40)* ..... 88
Table 6 - *Demographic characteristics of the participants (n=11)* ..... 113
Table 7 - *Information about the interviews and transcriptions.* ..... 114
Table 8 - *Core themes and code system of the thematic analysis* ..... 116
Table 9 - *Demographic Characterization of the Sample (Stage 1; n=17)* ..... 147
Table 10 - *Information about the interviews and transcriptions (Stage 1; n=17).* ..... 148
Table 11 - *Demographic Characterization of the Sample (Stage 2; n=208)* ..... 153
Table 12 - *Demographic characterization of the sample of the stage 3 (n=7)* ..... 157
Table 13 – *The Thematic Analysis for the Stage 1 (Core Themes and Code System)* ..... 159
Table 14 - *Religious and Spiritual Characterization of the Sample (Stage 1; n=17)* ..... 161
Table 15 - *Religious/Spiritual Characterization of the Sample (Stage 2; n=208)* ..... 167
Table 16 - *Training in R/S Issues and Mental Health of the Sample (Stage 2; n=208)* ..... 169
Table 17 - *Attitudes toward Religion/Spirituality, Mental Health, Treatment and Scientific Research of the Sample (Stage 2; N=208)* ..... 170
Table 18 - *Descriptive and psychometrics results of the revised Spiritual Competency Scale (Stage 2; n=208)* ..... 172
Table 19 - *Statistically significant correlations with Spiritual Competence (Stage 2)* ..... 173
Table 20 - *Unstandardized regression coefficients (B) of the pathways included in the proposed conditional process model.* ..... 178
Table 21 - *Conditional indirect effect(s) of Personal Religiosity/Spirituality on Spiritual Competence at -1$^{SD}$, Mean and +1$^{SD}$ values of the moderators (training and knowledge).* .. 180
Table 22 - *Thematic Analysis for the Stage 3 (Core Themes and Code System)* ..... 181
Table 23 - *Descriptive Statistics of the items of the Spiritual Competency Scale (means and standard deviations)* ..... 280

## Index of Figures

Figure 1 - *James Fowler's Stages of Faith (faith development theory)* ..... 47
Figure 2 - *Continuum of spiritual care in psychotherapy* ..... 50
Figure 3 - *Visual Model for the Multistage Mixed-Methods Design*..... 145
Figure 4 - C*onditional process model for potential interactions with spiritual competence*. 176

# General Introduction

I'm one of *those people* that many would say "*was born to be spiritual*" or "*was born with a talent for religion*". I always felt the need to connect with the transcendent, and although I've always been religious, I only felt a true spiritual and transcendental connection when I was 12 years and I became a 7th Day Adventist attendant. So, for all that I can remember, spiritual issues, faith, God, Jesus Christ, religion and so forth, have always been part of my life: a big and important part of my life. As a matter of fact, one of my first memories as a child, it is me sitting on a catholic altar step, looking at the congregants reaching out for God and thinking "*this is wonderful*".

And then I came to Portugal, to get my graduation in Clinical Psychology.

Religion and spiritual matters were never a problem in my life or my academic life, until my last year, the clinical internship. To be true, I do not remember ever discussing these issues in the classroom. And there I was: a clinical psychologist trainee in a hospital discussing my cases with my supervisor. Among them, two would always reappear for discussion and for the same exactly reason: I didn't know what to do with the religious and spiritual issues (my patients' or yet mine). Neither when they appeared to be positive dimensions to the patient, nor when the patient was struggling with them. In an attempt to appease my anxieties, I remember my supervisor saying "*Look, do not worry about that. You have much more to work with these patients*". I remember wishing to address religious-spiritual issues with these patients, but also feeling overwhelmed with so many dilemmas and doubts, but also with the fact that I almost felt compelled to find something *more* psychological to work with. And so, I did!!

I'm sharing this with you, firstly because what you have in your hands, right now, it is me agreeing with the statement that: "*the spiritual life is then part of the human essence. It is a defining-characteristic of human nature, without which human nature is not full human nature. It is part of the Real Self; of one's identity, of one's inner core, of one's species hood, of full humanness*" (Maslow, 1971, p. 314). How can we, as mental health professionals, look other way? I believe the spiritual life is part of the human essence. My essence and (my) patient's essence. Because of this, you will find the "*spiritual fingerprints*" of all the participants included in this work (whether is a highly religious member or client reaching out for help; a spiritual Leader willing to collaborate or yet a mental health professional ready to help). This work is filled with their beliefs, attitudes, expectations, experiences and needs.

But, it also has my own fingerprints; a researcher fingerprints, but in essence also my "*spiritual fingerprints*".

I'm also sharing this with you because I believe it is representative of what happens in many therapeutic relationships out there. On the one hand, we have clients (spiritual and/or religious clients) seeking professional help, in a moment of vulnerability yearning for the "*good old days*". On the other hand, we have good and well intentioned, but poorly trained mental health professionals working with religious and spiritual clients and issues every day. I believe some (but only a few) manage to handle the situation ethically and professionally; others struggle with it and look away, as they have many others things to worry about; others, not knowing what to do, decide to "*pôr a mão na massa*" anyway, since it is their job to help this patient; while others do not even notice the spiritual being in front of them. There are yet others that unconsciously (or maybe consciously) refuse to work with religious and spiritual matters, as they believe these matters belong to another world, another jurisdiction and under another domain. Now, two questions come to my mind: "*Which one of these professionals would you want to help you recover from a psycho-emotional problem?*" and "*To which one would you recommend someone close to your heart?*"

## Aims of the Present Thesis

Working with clients from different religious/spiritual backgrounds can be a challenge both for clients and therapists (Waller, Trepka, Collerton & Hawkins, 2010). This is mostly because in many aspects and occasions religion and mental health (psychotherapy, in particular) have often been perceived as separated worlds (Aukst-Margetić & Margetić, 2005). In part, this lead mental health professionals to held conflicting views about the role religion and spirituality play in mental health and clinical practice (Dailey, Robertson & Gill, 2015); and although, scientific literature suggest that clients are interested in having this area of their lives addressed in their psychotherapeutic process (Baetz, Griffin, Bowen & Marcoux, 2004; Knox, Catlin, Casper & Schlosser, 2005; Rose, Westefeld & Ansely, 2001; Rosmarin, Forester, Shassian, Webb & Björgvinsson, 2015), this wish (*or yet need*) is rarely matched (Baetz et al., 2004). This is due, not only, to the differences in the religious involvement between mental health professionals and clients (Baetz et al., 2004); or because some clients may fear being misunderstood or judged in secular settings (Knox et al., 2005; Martinez, Smith & Barlow, 2007; Gockel, 2011); but mostly, because mental health professionals lack

adequate training on how to integrate these dimensions into clinical practice or adjust psychotherapeutic interventions according to their clients' beliefs and practices (Hage, 2006).

The main purpose of this thesis is to contribute to the development of specific spiritual competencies of mental health professionals (i.e. Clinical Psychologists, Psychiatrists and Psychotherapists), aiming toward an ethical and effective integration of clients' religious/spiritual beliefs. Particularly, the present thesis was designed to approach three aims: 1) contribute to increase interest in these topics in the Portuguese research community; 2) characterize specific religious/spiritual communities represented in Portugal, regarding the role which religiosity and spirituality play in their mental health and their psychotherapeutic processes; and 3) describe the current clinical practice of Portuguese mental health professionals, regarding their attitudes, beliefs and spiritual competence when addressing religious/spiritual issues into psychotherapy.

This work is organized in five chapters, most of them based on published or submitted articles. In the first chapter, a theoretical introduction is provided. Starting with an overview of what has been described in the literature, topics such as the relationship between religion, religiosity, spirituality and mental health, highlighting the role and importance these dimensions have in the life of many people around the world are discussed. A brief review of the conceptualisation of religion (religiosity) and spirituality is also provided, as well as some areas of disagreement and contention. Theoretical guidelines for the integration and professional training are also included, as well as ethical considerations required in this field. The last section of this chapter, offers some reflections on why bringing religiosity and spirituality into mental health field is important, as well as some implications for clinical practice.

Following this theoretical introduction, three empirical chapters are presented (Chapter 2, 3 and 4), describing the results of five empirical studies. Chapter 2 presents a qualitative study conducted among religious/spiritual communities, showing the role religiosity and spirituality play in the religious/spiritual members' mental health status, how these dimensions shape their coping strategies and influence their experiences and/or expectations when seeking professional help. Chapter 3, also a qualitative study, presents the perspectives of religious Leaders regarding their role in the promotion, maintenance and recovery of their congregants' mental health, as well as the current relationship and collaboration with Portuguese mental health professionals. Chapter 4 (composed by three empirical studies)

presents the attitudes, beliefs and spiritual competence of mental health professionals in Portugal, when addressing religious and spiritual issues into psychotherapy. The chapters describing empirical studies are organized in four main topics: 1) the specific theoretical framework; 2) the research problems, aims and methodological plan; 3) presentation of results and 4) discussion of the results (which also includes limitations, implications and final remarks).

In the last chapter (Chapter 5) a general discussion is provided, integrating the results described across the studies and ending with research and clinical implications, with a particular focus on multicultural perspective and the Portuguese mental health context; as well as recommendations on how to bring religion, religiosity and spirituality into Portuguese mental health field.

## Selection and Justification of the Research Design

Considering the complex nature inherent to the process of seeking scientific answers, a mixed-methods approach was chosen to provide "*a more complete picture of the phenomenon under study"* on this particular research work (Mertens, 2012: 9). As such, a transformative framework was used (Creswell, Plano Clark, Gutmann & Hanson, 2003; Mertens, 2007; 2010; 2012; Sweetman, Badiee & Creswell, 2010), based on the multicultural competence theoretical perspective, which has been largely discussed in the scientific literature (Arredondo et al., 1996; Constantine, Gloria, & Ladany, 2002; Savage & Armstrong 2010; Sue, Arredondo & McDavis, 1992).

The transformative paradigm, as introduced by Donna M. Mertens, is a framework targeting marginalized culturally diverse communities; aiming to enhance social justice, furtherance of human rights and the respect for cultural diversity (Mertens, 2010). It has given to the context research "*an umbrella for researchers who view their roles as agents to further social justice*" (Mertens, 2012, p. 10). More specifically, it provides to the context of mixed methods research a new framework for addressing issues of inequalities, tensions, power differentials and privileges associated with economic status, migration and race/ethnicity issues, religious beliefs, gender, sexual orientations, disability, among a host of others (APA, 2003, p. 382; Mertens, 2007, 2012; Sweetman et al., 2010). On the other hand, it also provides a new perspective to researchers, leading them to: 1) focus on the strengths of the communities experiencing discrimination and oppression; 2) identify what are important to

them; 3) use the proper strategies for data collection and, most importantly, 4) use the information to stimulate social changes (Mertens, 2012).

Additionally, this methodological framework (mixed-methods, transformative and based on the multicultural competence theoretical perspective) was chosen to ensure that the views and perspectives of the main characters in the therapeutic relationship (clients, mental health professionals and privileged advisers) are represented and understood throughout the different stages of analysing, interpreting and reporting the data. This decision supports the ontological assumption of transformative research, in which: "*different versions of reality are given privilege over others and that the privileged views need to be critically examined to determine what is missing when the views of marginalized peoples are not privileged* (Mertens, 2012, p. 5). Finally, the choice of this methodological design also allows the proper integration of the Portuguese contextual and cultural in to the research (Harwell, 2011).

## Methodological Scope of this Thesis

Considering the selection and justification of the research design presented above, this present thesis aims to include different methodological ranges, according to Creswell et al. (2003), Duque (2014) and Ivankova, Creswell & Stick (2006):

- Overall, it assumes a *descriptive aim*, since it is intended to collect and measure independent information, not only from different samples, but also on different topics. This is aimed, specifically, to ensure a more complete characterization of the samples, in relation to their personal religious/spiritual experiences and specifically in relation to their experiences in the mental health field;
- It also adopts an *exploratory inquiry* (in the first three qualitative studies), emphasising the process of describing and understanding the phenomenon in study (religion, religiosity and mental health). As so, open-ended data collected through interviews (i.e. focus group and in-depth individual interviews) were used and thematic focus performed to analyse these databases and ensure a more detailed description of this phenomenon;
- Considering specifically the fourth study, a *correlational scope* is aimed, as distinct factors/variables are used to examine and determine whether and how they relate to each other. As so, statistical predictions, pathways and interactions are examined;

- In the last empirical study, a qualitative method is used (similarly to the first three studies), however an *explanatory inquiry* is used aiming to refine, explain and interpret the results obtained previously (focusing mostly on unexpected results).

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# Chapter 1

# Theoretical Introduction

**This chapter is based on the following published paper**

Freire, J. & Moleiro, C. (2015). Religiosity, Spirituality, and Mental Health in Portugal: a call for a conceptualisation, relationship, and guidelines for integration (a theoretical review). *Psicologia*. 29 (2), 17-32. http://dx.doi.org/10.17575/rpsicol.v29i2.1006 (**Appendix A**)

**Abstract**

In the Portuguese research society, particularly in the mental health field, little has been done regarding religiosity, spirituality and mental health. Thus, this paper strives to stimulate the interest in this area by providing an overview of the body of research on religiosity, spirituality and mental health, highlighting the role and importance these dimensions represent in the life of many people, whether in health or mental distress and illness. A brief review of the conceptualisation of religion (religiosity) and spirituality is provided, as well as some areas of disagreement and contention. Guidelines for the integration and professional training are also included, not discarding the ethical considerations inherent in this process. Finally, reflections are offered as to why bringing religiosity and spirituality into mental health field is important, as well as some implications for clinical practice, with particular focus on Portuguese mental health system.

***Keywords***: Religiosity; Spirituality; Mental Health; Conceptualisation; Integration; Guidelines; Ethical Challenges.

**Resumo**

Em Portugal, a investigação científica tem sido escassa no domínio do estudo da religiosidade, espiritualidade e saúde mental. Assim, este artigo propõe-se estimular o interesse pela área, fornecendo uma visão geral do corpo de investigação relativo a religiosidade, espiritualidade e saúde mental. Realça-se o papel e a importância que estas dimensões desempenham na vida de muitos indivíduos, quer estes sofram de doença ou mal-estar físico ou mental. É fornecido um resumo da conceptualização da religião (religiosidade) e espiritualidade, incluindo algumas áreas de desacordo e controvérsia. Incluem-se também orientações para a integração e formação profissional, tendo em consideração os aspetos éticos inerentes ao processo. Por fim, segue-se uma reflexão sobre a importância de integrar a religiosidade e a espiritualidade no campo da saúde mental, bem como algumas implicações para a prática clínica, com especial enfoque no sistema de saúde mental português.

***Palavras-chave:*** Religiosidade; Espiritualidade; Saúde Mental; Conceptualização; Diretrizes para Integração; Desafios éticos.

## Introduction

Portugal is predominantly a religious country tied not only to religious beliefs and practices, but also to several social and cultural aspects. In the last Portuguese Census, in 2012, almost 85% of the population identified as being religious, mostly Roman Catholic, and with a growing religiously diverse population representing up to 4% of Portuguese residents (INE, 2012; see **Table 1**). Although being a non-denominational state, Portugal (as a country, a society, and state) shares a particularly long and strong relationship with Roman Catholic Church (for a historical review, see Dix, 2010; Vilaça, 2006; Wiarda, 1994). Furthermore, as a society Portugal is quite advanced in terms of religious legislation. For instance, not only does Portuguese constitution forbid discrimination in any form, but it also constitutes religious and spiritual life as a right, as portrayed in the Art. 41 of the Constitution of the Portuguese Republic -*freedom of conscience, of religion and of form of worship*- and Law nº 16/2001 of June 22 -*Law of Religious Freedom*. Besides, in relation to health, the Portuguese State guarantees to any citizen the right to have their spiritual and religious needs understood and included when seeking medical care (Law nº 253/2009, regulating the spiritual and religious care in hospitals and other establishments of the National Health Service).

**Table 1** - *Religious identification (affiliation) of Portuguese population*

| | | No. | % |
|---|---|---|---|
| | **Portugal** | **8.989.849** | **100.00** |
| **Religion** | Catholic | 7.281.887 | 81.00 |
| | Orthodox | 56.550 | 0.63 |
| | Protestant | 75.571 | 0.84 |
| | Other Christian | 163.338 | 1.82 |
| | Jewish | 3.061 | 0.03 |
| | Muslim | 20.640 | 0.23 |
| | Other non-Christian | 28.596 | 0.32 |
| | **Not religious** | **615.332** | **6.84** |
| | **Did not answer** | **744.874** | **8.29** |

*Note*: Population aged 15 years and older (based on 2011 Census). Table reprinted and adapted from INE (2012, p. 530).

However, almost no research has studied this subject so far. For instance, in terms of previous work focusing on the integration of Religion and Spirituality into professional healthcare field, most of the work was conducted in nursing and end-of-life care (Caldeira, Castelo Branco & Vieira, 2011), whereas in mental healthcare research (Psychology, in particular) no academic research and publications were made, apart from a few masters

dissertations (e.g. Garrett, 2010; Taranu, 2011) and the research in the context of quality of life and well-being (e.g. Gouveia, Marques & Ribeiro, 2009; Pinto & Pais-Ribeiro, 2007; Pinto & Pais-Ribeiro, 2010).

More recently a few multicultural studies, with a focus on minority group issues, have been conducted to draw attention to this field (e.g. Freire & Moleiro, 2011; Moleiro, Pinto & Freire, 2013; Moleiro, Silva, Rodrigues & Borges, 2009). Yet, clearly these dimensions remain understudied in the field of mental health research in Portugal, which is also true for international research society, despite of the rapidly increasing interest in these topics (Hill & Pargament, 2003; Paloutzian & Park, 2005).

This gap in research between spirituality/religion and its implication on healthcare seems paradoxical given the historical relationship between psychiatry (the dominant science focusing on mental health at the time) and religion. As a matter of fact, the scientific research of religion and spirituality, whether in health or mental health has a long and tumultuous history: it has been long since these issues were considered to be completely outsiders of the health domain, to where it stands currently; In the meantime, these two dimensions were pathologized; considered to have a strong and negative effect on health, mental health and psychosocial functioning; *depathologized*; considered to have a slight, but positive impact on health and mental health; to what are believed today to be key dimensions in many peoples' lives, with practical and important repercussions on therapeutic outcomes.

As pointed by Koenig (2000, p. 386), "*religion and medicine are no strangers*" as these two worlds have been strongly linked for centuries. Not only in the past, healthcare institutions were built and staffed by religious organizations (Koenig, 2012), but physical diseases were perceived essentially in religious and/or spiritual terms and therefore the treatments applied were in many cases based on religious and/or spiritual practices and natural methods (Koenig, 2000). Likewise, mental healthcare was closely aligned with religious/spiritual care field. As aforementioned, mental healthcare facilities were also located in religious institutions (e.g. monasteries and convents) and the care was provided mostly by religious leaders and again based mostly in religious or spiritual terms (Koenig, 2009; 2012).

Even when considering specifically the psychological study of religion, this relationship dates back to the very beginning of the scientific foundation of psychology (Johansen, 2010). In fact, a clear number of the founding names of psychology, such as William James (1842–1910); Stanley Hall (1846-1924); Sigmund Freud (1856-1939); Alfred

Adler (1870-1937); Carl Gustav Jung (1875-1961); Jean Piaget (1896–1980); Carl Rogers (1902-1987), among many others, were influenced by their religious upbringing experiences, as many were sons of religious leaders; others themselves religiously devout; others fascinated with religion; whereas others were explicitly hostile toward religion and religious experience (Johansen, 2010; Nelson, 2009; Paloutzian & Park, 2005; Pargament, 2007; Richards & Bergin, 2004).

Although, the course of what is called "*the psychology of religion*" tend to differ across countries (Belzen, 2008), it seems consensual that the pioneer work of William James represent a remarkable part of what is known today as the study of psychological aspects of human religiousness (Emmons & Paloutzian, 2003; Johansen, 2010; Main, 2008; Vande Kemp, 1992). One of the great classics of the psychology of religion was written by William James, "*The Varieties of Religious Experience: A Study in Human Nature*" (1902)[1]. In this work, and in contrast with the current movement of understanding and studying religious experiences and behaviors from a quantitative perspective, William James endeavors to "*understand the uniqueness of religious practices and focused on peoples' religious and spiritual experiences in everyday life*" and "*portrays the need for the spiritual aspect of human consciousness as a natural and healthy psychological function*" (Johansen, 2010, p. 3).

One of the most prominent Portuguese examples, among many others, is São João de Deus, also named the Saint of Hospitality; the patron saint of hospitals, the sick, nurses, fire-fighters, etc. Nowadays, the legacy of this Portuguese-born soldier turned into health-care worker, is known around the world as the *Hospitaller Order of St. John of God* (HOSJG). Its presence in Portugal is under the St. John of God Institute, who provides a holistic health and social care, based on the Order's values of "*Quality, Respect, Responsibility and Spirituality*" (for historical review, please see HOSJG, 1997).

It is irrefutable that these worlds (health, mental health, religion and spirituality) represent powerful systems of healing across the globe (Koenig, 2000). In fact, for many and in several ways, these systems may also be much intertwined: as within the psychotherapeutic experience, the basis of the healing stance (such as empathy; hope; the search for meaning, love, peace and forgiveness) may also lead to spiritual growth and experience (Prasinos,

[1]This work is based on the prestigious Gifford Lectures on Natural Religion William James gave at the University of Edinburgh in 1901 and 1902.

1992). However, it is also true that on its way to become or to establish itself as a science, psychology (or yet the predominantly psychology as we know and coming from the highly developed nations) began to part paths with religion and spiritual related issues (Johansen, 2010; Koenig, 2012; Richards & Bergin, 2004).

As such, philosophers, scientists and health professionals started to see, understand and treat mental illness less with a religious approach and more with a bio-medical perspective (Thielman, 2009). Later, this separation was so profound that by the nineteenth century all terms and treatment related to religious issues were completely removed from the healthcare field (Thielman, 2009), religion being relegated only to hospital chaplains and clergy (Koenig, 2012).

Among many authors and scientists, one of the most prominent names contributing to the state of this gap is Sigmund Freud. Freud's hostility toward religion (and other factors, of course) led most of mental healthcare professionals, including psychologists, to avoid any contacts with the concept of religion, spirituality for a long time (Curry & Roach, 2012; Fallot, 1998; Hill & Pargament, 2003; Johansen, 2010; Koenig, 2012; Nelson, 2009; Plante, 2007), turning this it into a topic with little or no importance in the training of these professionals (Dein, 2004; Koenig, 2012).

However, times have changed. More recently, both mental health research and professionals have been claiming that religion and spirituality represent key dimensions when aiming a complete understanding of an individual (Fallot, 1998; Hill et al., 2000; Johansen, 2010; Tummala-Narra, 2009); as well as having a great and positive impact on both physical and mental health, and client's therapeutic process. It has been hypothesised that this impact is largely due to the meaning, meaning making and connection to the transcendent religion and spirituality may provide to one's life (Büssing, Ostermann & Matthiessen, 2005; Dein, 2004; Dein, Cook, Powell & Eagger, 2010; George, Ellison & Larson, 2002; Koenig, King & Carson, 2012; Park, 2005), mostly considering that these domains can influence one's core beliefs, goals, emotions or even the essential of human existence (Park, 2005).

Considering the above, the present paper aims to highlight some of the current perspectives on the relevance of religion and spirituality in mental health research and, most importantly, how to incorporate these life aspects in psychological treatment with religious and/or spiritual clients. Therefore, this theoretical review is organised according to the current trends of research on religiosity, spirituality and mental health; discussing firstly the

conceptualizations, ambiguities and confusions surrounding religion, religiosity and spirituality, as theoretical concepts. Then and briefly, the relationship between religion, spirituality and mental health will be addressed, focusing on the impact the former have across one's life spam, on mental health outcomes and to the psychological treatment process. Next, and from an integrative and multicultural point of view, some guidelines will be provided, along with the ethical issues the integration of religious and spiritual issues in psychological treatment requires.

## Religion (Religiosity) and Spirituality: Conceptualisations

When recognizing the different dimensions of "*religion*" and "*spirituality*", the understanding and definition of these phenomena is by nature complex and often these two are used interchangeably in the scientific research and clinical practice (Büssing et al., 2005; Koenig et al., 2012; Pargament, 1999; Zinnbauer, Pargament & Scott, 1999). This is essentially due to a great number of different perspectives, starting points and cultural contexts, as these terms can be seen as synonymous, overlapping, or completely different concepts (Hill et al., 2000; Tummala-Narra, 2009).

The ambiguity is so profound that, for some authors, religion should be considered as a broader and more general construct than spirituality (Hill et al., 2000; Pargament, 1999); whereas others see religion as a component falling into an "*umbrella*", of the spirituality (Dein, 2004; Miller, 1999). As mentioned before, it is commonly accepted, though, that both religion and spirituality emphasise the depth of meaning and purpose in life, and connection to the sacred (Büssing et al., 2005; Dein, 2004; Dein et al., 2010; Koenig et al., 2012); where some may be "*religious and spiritual*"; "*religious, but not spiritual*"; or yet again "*spiritual, but not religious*", without dismissing those who are "*neither religious nor spiritual*" (Koenig, George, Titus & Meador, 2004; Richards & Bergin, 2005; Saucier & Skrzypińska, 2006; Büssing, 2010; Worthington, Kurusu, McCollough & Sandage, 1996).

As a matter of fact, religion and spirituality as concepts do overlap, and in some regards, might also be similar (Fisher, 2011; Hadzic, 2011; Koenig et al., 2012; Richards & Bergin, 2005). However, one must also acknowledge they are not identical (Zinnbauer et al., 1999) and for that reason conceptualisations that focus or are narrowed to certain aspects of religion or spirituality might not be appropriate (Nelson, 2009; Saucier & Skrzypińska, 2006).

Obviously, this ambiguity and confusion have a great impact on the credibility and understanding of research and practice in this area (Koenig, 2009), leading for instance to: limited or otherwise too broad definitions of religion and spirituality, which results in a loss of their idiosyncratic characteristics (Hill et al., 2000; Zinnbauer et al., 1999); different forms of polarisation of religion and spirituality, the former being institutional/negative/harmful and the latter individualistic/positive/beneficial (Hill & Pargament, 2003; Pargament, 1999; Pargament, 2007; Mutter & Neves, 2008; Smith, 2007; Zinnbauer et al., 1999); and pathologization of religious and spiritual beliefs/practices in diverse or minority contexts (Adams, 2012; Fallot, 1998; Lukoff & Turner, 1998; Frame & Williams, 1996; Tummala-Narra, 2009).

Concerning this tendency for religious and spiritual pathologization, it is crucial to emphasise the weight a Western conceptualisation has put on this process of isolating, analysing, and defining both religion and spirituality (Smith, 2007). Indeed, Western conceptions of religion and spirituality have a tremendous impact on defining acceptable forms of approaching these concepts, with an interest in the realm of mental health; and undoubtedly a considerable progress has been made in this field. Yet again, it is important to emphasize the wide diversity of religious, spiritual, cultural and philosophical systems across the world and how these, idiosyncratically, impact and influence human life across the globe.

However, a complete discussion of this conceptual history, as important as it is, is beyond the purposes of this article (for extended discussions please see Fallot, 1998; Zinnbauer et al., 1999; Hill & Pargament, 2003; Hill et al., 2000; Smith, 2007; Koenig, 2009). Thus, this paper presents some of the most significant and recent inputs in this field, highlighting that special care must be taken to properly conceptualise these multidimensional concepts.

***Religion (Religiosity)***

One of the leading definitions of religion is provided by Argyle and Beit-Hallahmi (1975 as cited Argyle and Beit-Hallahmi, 2014). These authors define religion as "*a system of beliefs in a divine or superhuman power, and practices of worship or other rituals directed toward such a power*" (p. 6); This definition by nature emphasises the substance of religion, focusing primarily on institutionalised beliefs, emotions, practices, and relationships of individuals that are clearly related to the institutionalised sacred (Fallot, 1998; Lindridge, 2007; Pargament, 1999; Richards & Bergin, 2005; Zinnbauer et al., 1999). Pargament (1997,

as cited in Pargament, Magyar-Russell & Murray-Swank, 2005, p. 32) also defined religion as "*a search for significance in ways related to the sacred*", highlighting that the sacred here should be understood in a broader sense, rather than only limited to the traditional concepts of higher powers, divinity or God (Zinnbauer et al., 1999).

More recently, Koenig and colleagues suggested a more comprehensive definition of religion in an attempt to bridge, for instance, the gap between western and eastern traditions. Therefore, for these authors religion represents a "*multidimensional construct that includes beliefs, behaviours, rituals, and ceremonies that may be held or practiced in private or public settings, but are in some way derived from established traditions that developed over time within a community*" (Koenig et al., 2012, p. 45).

Moreover, religion has connection to other dimensions, such as a search for personal goals (i.e. meaning and purpose in life and good physical health) as well as having a social function (i.e. sense of belonging and closeness to others) (Zinnbauer et al., 1999; Johansen, 2010). Accordingly, *religious life*, *religiosity* or *religiousness* involve participation in a set of beliefs, rituals, and activities such as attending religious and church services, scripture reading, prayer, meditation, among others (Fallot, 1998; Haynes, 2009).

***Spirituality***

Compared to religious studies, the interest and research on spirituality are much more recent, yet there are numerous and diverse findings. In the health context across different fields, studies have been conducted in an attempt to define and distinguish spirituality from religion. Nonetheless, perhaps researchers might still be using personal definitions of spirituality, typically based on their own understanding of this dimension (Hadzic, 2011).

Also, spirituality is progressively being used to refer to the individual's subjective aspect of religious experience (Hill & Pargament, 2003). Therefore, research and society in general, have been witnessing a growing movement of its usage, shying away from the institutionalization of their beliefs (religion) toward its individualization. Therefore, more and more individuals identify themselves as being "*spiritual, but not religious*" (Baetz & Toews 2009; Miller, 2003; Saucier & Skrzypińska, 2006; Winslow & Wehtje-Winslow, 2007; Büssing, 2010; Zinnbauer et al., 1999), i.e. those who are "*committed to the spiritual dimension of life, but not be identified with any specific religion*" (Miller, 2003, p. 150).

Accordingly, spirituality is widely defined as a universal human trait (Fisher, 2011; Lindridge, 2007; Winslow & Wehtje-Winslow, 2007;) leading an individual toward knowledge, meaning, purpose and hope (Büssing et al., 2005; Smith, 2007; Winslow & Wehtje-Winslow, 2007), in an ultimate goal to find, transform and relate to the transcendent or sacred (Nelson, 2009; Pargament, 1999). To highlight that this journey may or may not include participation in a religious faith/community (Hill & Pargament, 2003; Koenig et al., 2004). And as Koenig et al., (2012, p. 46) added, it "*also extends beyond organized religion (and begins before it)*".

## Religiosity, Spirituality and Mental Health: Role and Impact

As aforementioned, it has been long since religious and spiritual related issues were considered to be outsider topics in the mental health domain. In the meantime, several developments in the mental health field have contributed to the changed interest in religion and spirituality. Research regarding religion, spirituality, and health (either physical or mental) is currently being much more encouraged and included in the literature, not exclusively but, in the fields such as: medicine, neuroscience, epidemiology, and psychology.

Generally, mental health field support the perspective that religion and spirituality (or yet the religious and spiritual experience) provide the needed guidelines, rules and paths many people can use to reach their ultimate goals and guide the course of their lives (Behere, Das, Yadav & Behere, 2013; Pargament et al., 2005); influencing their lives from everyday experiences such as what one eats, wears and behaves; to more significant matters, such as what one perceives as sacred; assumes to be true about the nature of reality; perceives psychological phenomenon and understands or copes with suffering and the experience of illness (Koenig, 2000; Pargament et al., 2005; Shafranske & Malony, 1990; Vieten & Scammell, 2015).

Concerning specifically the scientific research on the role and impact religion and spirituality have on health and mental health findings to date are unequivocal: the majority shows a positive and strong relationship between these dimensions. This is mostly because those who are religious and spiritual tend to present better indicators of physical and psychological well-being, in that they present lower rates of physical illnesses and psychological disorders, such as depression, suicide, anxiety, substance abuse, marital

problems (Büssing et al., 2009; Cohen & Koenig, 2004; Johansen, 2010; Koenig, 2000, 2001; Koenig, 2012).

Also, they seemed to present a greater sense of social support (Baetz & Toews, 2009; Fallot, 1998; Koenig, 2000, 2001, 2012); and experiencing much more positive emotions and acts, such as happiness, hope, optimism, meaning and purpose, altruism, gratitude and forgiveness (Baetz & Toews, 2009; Cohen & Koenig, 2004; Hackney & Sanders, 2003; Koenig, 2012; Rosmarin, Krumrei & Pargament, 2010). These positive connections seem to be closely linked to lifestyle habits, social support and coping strategies (e.g. prayer, meditation and religious rituals) often inherent to religious and spiritual daily life (Curry & Roach, 2012; Johansen, 2010; Koenig, 2012; Nelson, 2009).

There also seems to be a positive association between the onset and/or worsening of psychopathological symptoms and increased importance of religion and spirituality in the life of many patients/clients (Baetz & Toews, 2009; Gockel, 2011). Other studies indicate that, in psychological distress and suffering, religious clients tend to recover faster with better outcomes when mental health professionals seek the integration of their clients' religious beliefs and practices (Aukst- Margetić & Margetić, 2005; Baetz & Toews, 2009; Curlin et al., 2007; Fallot, 1998). This might be in response to clients' wishes that their religion or spirituality be included in psychological treatment (Hodge, 2011[a]; Knox, Catlin, Casper & Schlosser, 2005; Martinez, Smith & Barlow, 2007; Miller, 1999).

However, it is important to highlight that not all studies have found a positive relationship between religion, spirituality and mental health, and these should also be considered. Some researchers have indicated, for instance, that negative/harmful emotions such as dissatisfaction or anger toward God and/or a congregation and sense of guilt may arise; or yet a strict religious background or membership correlate with impaired mental health (Baetz & Toews, 2009; Cohen & Koeing, 2004; Curry & Roach, 2012; Fallot, 1998; Hadzic, 2011; Lindridge, 2007). It also seems true that when understood, used or manipulated in an unhealthy way, some religious and spiritual beliefs and practices may result in worse mental health and neurotic behaviour (Cohen & Koeing, 2004; Curry & Roach, 2012). For instance, among patients with obsessive-compulsive disorders (or even individuals in nonclinical samples), it is not uncommon to find beliefs or fear of sin/God, and consequently the use of daily practices such as church attendance or pray numerous times per day to try to

neutralise or decrease levels of distress (Abramowitz, Huppert, Cohen, Tolin & Cahill, 2002; Cohen & Koeing, 2004; Williams, Lau & Grisham, 2013).

Accordingly, the research and professional challenge here may require not only the recognition of the positive and negative impact that religion and spirituality might have on mental health, but most importantly the understanding of how this impact occurs; how it can be used as a resource; how it can be challenged; and how it can be integrated accurately into therapeutic settings, thus benefiting the client, the therapeutic relationship and the therapeutic process as a whole.

## Religion, Spirituality and Mental Health: A Developmental Perspective

From a developmental perspective, there is also little doubt that religion, religiosity and spirituality play an important role in the development across the human life span (Levenson, Aldwin & D'Mello, 2005). Innumerable models and theories have been developed to cover and explain how, across the human life span and accounting also with the influence of life events, learning, context and culture (Oser, Scarkett & Bucher, 2006), one sees oneself in relation to what is considered to be divine or transcendent (Dowling & Scarlett, 2006).

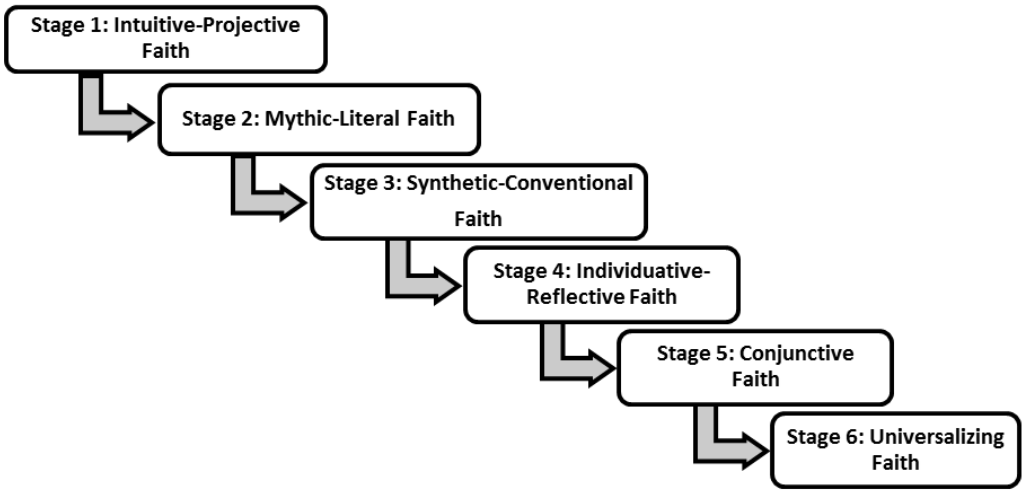
Even though, discussing religious and spiritual developmental models and theories is not the main interest of this work, it seems important to recognize the importance this topic has in this field, as this figures as one of the skills portrayed in the competencies for addressing religious/spiritual matters in counseling (Association for Spiritual, Ethical and Religious Values in Counseling - ASERVIC, 2009). This topic -*Spiritual and Religious Competence*- will be discussed with more details later.

Is also seems important to acknowledge that, although religious and spiritual development may overlap as theoretical frameworks, they are definitely not the same. Usually, religious development refers to ones identification with a particular religious tradition or community and its practices and beliefs; whereas spiritual development concerns the path of becoming *whole* as person and considering what defines and gives meaning to human beings (Dowling & Scarlett, 2006). Moreover, most of the work in this field has been done concerning the importance religion and spirituality has for adaptation in later life; however, lately the interest also covers early life, including childhood, adolescence and middle adulthood (Fowler & Dell, 2006; Levenson et al., 2005; McNamara Barry, Nelson, Davarya & Urry, 2010).

Unquestionably, one of the most influential theoretical and research frameworks in this field of human religious/spiritual development has been *the Faith Development Theory*, proposed by James Fowler's *Stages of Faith*, in 1981. Although over the years, this theory has been severely criticized, revised and reinterpreted (e.g. Coyle, 2011; Hoehn, 1983; Ivy, 1982; McDargh, 2001; Matise, Ratcliff & Mosci, 2017; Streib, 2001), it represented a major breakthrough in the study of religious and spiritual experience and in the integration of religion in psychology (Ivy, 1982; Jardine & Viljoen, 1992). This theory also brought lights of understanding from Erikson-Piaget-Kohlberg human development theories (e.g. psychosocial, cognitive-structural and moral perspectives) and contributed to the perspective that faith, as a dynamic process and a universal human concern, should be understood as going far beyond religious beliefs and behaviors (Hoehn, 1983).

Fowler initially defined faith as a *way of knowing, construing or interpreting* one's experience (Fowler, 1974, p. 211), relating "*a person or a community to power(s), boundaries (such as death and finitude), and source(s) of being, value and meaning which impinge on life in a manner not subject to personal control*" (Fowler, 1974, p. 207). Accordingly, faith development was defined as a sequential, structural and transformative process (broadly following a recognizable pattern of changes in six distinct stages, **Figure 1**), by which "*persons shape their relatedness to a transcendent center or centers of value*" and "*the self is constituted as it responds to questions of ultimate meaning*" (Fowler, Streib & Keller, 2004, p. 11).

**Figure 1 -** *James Fowler's Stages of Faith (faith development theory)*




*Notes*: Representation based on Fowler et al., (2004); Fowler & Dell (2006) and Oser et al. (2006).

Faith, as an integral and centring process behind the formation of one's core beliefs, values, and meanings, deeply influences the way a person: gives coherence and direction to her/his life; connects and trusts others on a daily basis; grounds her/his personal perspectives and bonds with others *in a sense of relatedness to a larger frame of reference*; shapes and transforms religious and/or spiritual attitudes, judgments, and feelings; and finally perceives and copes with the challenges of human life, such as pain, illness, suffering and death (Fowler & Dell, 2006; Oser et al., 2006).

As outlined above, religion, religiosity and spiritual matters directly relate to mental health and wellness outcomes, providing powerful sources of comfort, direction, and meaning for many people (Exline & Rose, 2005). Yet, they can also be sources of strain and struggle, as certain forms of religiousness and spirituality have different, and in some cases even harmful, implications for mental health and well-being (Abu-Raiya, Pargament & Exline, 2015; Exline & Rose, 2005): and these latter are often the main reason for seeking professional help.

As such, mental health professionals can help clients make positive developmental changes in many aspects of their life, including in religious and spiritual ways, by (for instance, but not limited to) helping a client sense what kind of conflict or crisis is blocking or pressing a resolution of a particular problem or her/his growth to a new stage of faith (Clendenen, 2006; Stauffer, Cook, Trippany-Simmons & Rush-Wilson, 2016). Furthermore, religious and spiritual developmental theories should also serve as frameworks enabling, for instance, the research field to understand, conceptualize and assess the evolution of how human beings perceive and conceptualize transcendent (God or Higher Beings) and how these impact their core values, beliefs, and meanings in their personal lives and in their relationships with others (Fowler & Dell, 2006; Fowler et al., 2004); becoming clear that, according to this theory, the focus should not be only on the notion of constructing *knowledge*, but mostly on the way a person constructs or reconstructs *meaning* throughout her or his life (Fowler et al., 2004).

## Religion, Spirituality and Mental Health: An Integrative View

Standing from an integrative point of view, Psychotherapy and Religion/Spirituality seem to share similar purposes, despite using different logics, methods, and strategies. Fundamentally, these worlds try to emphasise the importance of self-knowledge (resources, responsibilities

and difficulties); promote the acquisition of strategies to deal with the guilt and shame; guide the search for solutions to personal conflicts; seek to answer the questions of purpose and meaning of life, among others (Corey, 2001; West, 2004). Nonetheless, getting these two worlds together appears to be a complex and ethically challenging process (Martinez et al., 2007; Smith, Bartz & Scott Richards, 2007), starting with the clarification and definition of the boundaries between a religious and spiritual sensitive psychotherapeutic intervention from a spiritual care or counselling (Miller & Thoresen, 1999).

As mentioned earlier, international academia and professionals have been striving to demonstrate how important religion/spirituality can be in the life of many people, which lead to the understanding of its effects on health, emphasising both the advantages and disadvantages for mental health status. Nowadays, the focus has shifted toward understanding what role religion and spirituality play when integrated into therapeutic settings. It was not surprising to witness a rising tide of hypotheses, theories, researches and studies in the last years, concerning the development and integration of religious and spiritual perspectives and interventions into the mainstream of psychological practice (Richards & Bergin, 2004).

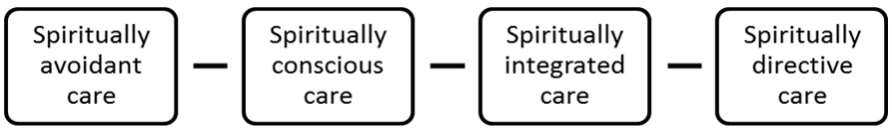
In Portugal, however, these dimensions are still poorly examined in its related scientific fields, intensifying the gap between research and practice. Few studies were conducted in mental health field researching religion and spirituality and to date no training programme (graduate or post-graduate) guides mental health professionals on how to integrate these issues into clinical practice. An important step, though, was taken by The Order of Portuguese Psychologists (OPP, 2011, p. 20) presenting religion as one of the dimensions to be taken into consideration when "*practice is aimed at minority populations, psychologists seek to obtain professional and scientific knowledge in order to intervene abiding by the ethics and efficiently, adapting their intervention to factors associated with sex, age, sexual orientation, gender identity, ethnicity, cultural origins, nationality, **religion**, language, socioeconomic level, capacity, or others*" [Section 5.6. Cultural Minorities].

Following this path, a small qualitative study was conducted by Freire and Moleiro (2011), which found that participants (members of religious minority groups) perceived religiosity/spirituality as a dominant factor in their lives. Even though they expressed openness and positive representations of the psychologists' work, this was not considered to be a first help-seeking option, since all participants agreed the primary help would be either within their family or their religious community (leaders and other members).

These steps raise a few questions related firstly to the fact that Portuguese society is predominantly religious and Catholic, being religious minority groups represented only by 4% of the population. Furthermore, as presented above, one must argue with the importance and impact religion and spirituality have on people's life and therapeutic processes (for a discussion see Koenig, 2012 and Vieten et al., 2013). What is certainly not known, so far, is what role religion and spirituality play on life and work of Portuguese mental health professionals. Or again the importance and impact religious and spiritual issues have when integrated into therapy.

In contrast to the Portuguese context, many studies have been conducted worldwide. As a matter of fact, international contributions range from approaches where religion and spirituality can be integrated (or not), to a continuum of spiritual care, as advanced by Saunders, Miller and Bright (2010). These authors conceived integration of a patient' spiritual or religious beliefs and practices – SRBP (credits to Saunders et al., 2010; **Figure 2**) from: *spiritually avoidant care*, where the mental health professionals avoid issues related to a patient's SRBP, even if the patient indicates a need or desire to discuss them; *to a spiritually conscious therapy* as a respectful and sensitive way of determining the impact that religious and spiritual matters have on the patient and the patient's problems; whereas *spiritually integrated care* focus on patients' SRBP, without explicitly seeking the maintenance or transformation of those; and finally *spiritually directive psychotherapy* where the goal of therapy is to help a patient resolve psychological problems either by maintaining or transforming SRBP (Saunders et al., 2010). To highlight that, the latter three approaches differ not only in content, but also on the level of the competence needed and ethical concerns inherent to each type of care.

**Figure 2** - *Continuum of spiritual care in psychotherapy*




*Note*: Figure reprinted from Saunders et al. (2010).

Examples of the latter three approaches range from those grounded and tailored on religious foundations, i.e. Buddhist (Nauriyal, Drummond & Lal, 2006); Christian (Jones &

Butman, 1991); Islamic (Dwairy, 2006); targeting specific religious or ethnic groups i.e. Jews (Rosmarin, Pargament, Pirutinsky & Mahoney, 2010); Mormons (Martinez et al., 2007; Lyon, 2013); Latinos (Cervantes, 2010); African-Americans (Constantine, Lewis, Conner & Sanchez, 2000; Frame & Williams, 1996); Asians (Hall, Hong, Zane & Meyer, 2011; Leong & Kalibatseva, 2011); targeting specific psychological disorders, i.e. depression (Agishtein et al., 2013; Pearce & Koenig, 2013); alcoholism and drug abuse (Hodge, 2011[b]; Lietz & Hodge, 2013); eating disorders (Kristeller & Hallett, 1999; Marsden, Karagianni & Morgan, 2007); founded on specific psychotherapeutic approaches, i.e. spiritually modified cognitive therapy (Hodge, 2006); religiously oriented cognitive behaviour therapy (Robertson, Smith, Ray & Jones, 2009); religious cognitive-emotional therapy (Rajaei, 2010); mindfulness-based cognitive therapy (Fresco, Flynn, Mennin & Haigh, 2011); Christian cognitive behavioural therapy (Pearce & Koenig, 2013); developed from the new forms of therapy such as *spiritually or religiously integrated, oriented, or accommodative psychotherapy* (McCullough, 1999; Pargament, 2007; Ripley et al., 2014; Sperry, 2012;); or again coming from the multicultural counselling field (Hage, Hopson, Siegel, Payton & DeFanti, 2006; Hall et al., 2011; Savage & Armstrong, 2010); among many other contributions.

Following the multicultural perspective and for the purpose of this paper, interventions aiming to provide specifically a *spiritual counselling or direction* are not covered. This includes all interventions aiming to: train religious and spiritual professionals (e.g. chaplains or religious leaders) with knowledge of psychology, psychotherapy or counselling; or yet train mental health professionals to exclusively work with religious and spiritual issues [*not discarding or questioning their value*]. Thus, a multicultural perspective of integration of religious and spiritual issues into clinical practice will be discussed below.

## Multicultural Perspective

Religion, spirituality and related matters are only explicitly outlined under the non-discrimination, boundaries and assessment affairs of the American Psychological Association (2010), American Psychiatric Association (2013) and American Counseling Association (2014)'s code of ethics. However, a remarkable step was taken previously in 2003, when a set of 6 extensive guidelines on multicultural education, training, research, practice, and organizational change for Psychologists were presented (APA, 2003). These guidelines intended to guide psychologist's work "*in the midst of dramatic historic socio-political*

*changes in U.S. society*" (APA, 2003, p. 377), and therefore help professional society embrace multiculturalism and diversity into psychological settings.

However, it is relevant to highlight that this absence of spiritual and religious reference can be also found within European code of ethics, being the Croatian (2004); British Psychological Society (2009); and Portuguese Order of Psychology (2011) the few mentioning religion or spirituality[2]. Another ground-breaking step was the work of the "S*pirituality and Psychiatry Special Interest Group*" (SPSIG), a group within The Royal College of Psychiatrists (United Kingdom), that recently published the "*Recommendations for psychiatrists on spirituality and religion*" (Cook, 2013). These recommendations are included in the discussion segment later.

According to the new edition of ACA's code of ethics (ACA, 2014, p. 20) a multicultural or diversity counselling "*recognizes diversity and embraces approaches that support the worth, dignity, potential, and uniqueness of individuals within their historical, cultural, economic, political, and psychosocial contexts*". From this point of view a [multi]*culturally competent mental health professional* must, first, be aware of his/her own cultural background, as well as its client's cultural background. Furthermore, this professional must also acquire specific knowledge and skills to accurately and effectively attend to client's needs and expectations (ACA, 2014; Arredondo et al., 1996; Hage et al. 2006; Metzger, Nadkarni & Cornish, 2010; Sue, Arredondo & McDavis, 1992; Vieten et al., 2013).

However, and once again, the Association for Multicultural Counseling and Development (AMCD), involved in the task force to develop the guidelines on multicultural issues, initially focused only on the five-major cultural/ethnic groups of the United States, namely African/Black, Asian, Caucasian/European, Hispanic/Latino and Native American or indigenous group (Sue et al., 1992; Arredondo et al., 1996).

Nonetheless, later works and in a much broader definition, understanding and view of a person, other dimensions were introduced to include age, sex/gender, sexual orientation, spiritual/religious identification, among others (APA, 2003; Hage et al., 2006; Metzger et al., 2010; Vieten et al., 2013). This inclusion allowed the emergence of new trends in the practice of psychology, such as psychological practice with older adults (APA, 2009; 2013); with girls

[2]Information retrieved from http://ethics.efpa.eu/ethics-around-europe, on November 14th, 2014.

and women (APA, 2007); with lesbian, gay and bisexual clients (APA, 2000) and the endorsement by ACA of the competencies for addressing spiritual and religious issues in counselling, as multicultural issues into clinical practice (Association for Spiritual, Ethical and Religious Values in Counseling [ASERVIC], 2009).

It is important to highlight, however, that this status was not earned only under the multiculturalism agenda. As a matter of fact, for the past four decades the APA's 36th Division, Society for the Psychology of Religion and Spirituality, has been promoting discussions aiming to understand the significance religion and spirituality have in people's lives and in the Psychology field. The Division latest achievement was the publication of APA's Handbook of Psychology, Religion, and Spirituality (2013), a two-volume handbook, introducing the most comprehensive analysis of the current state of the psychology of religion and spirituality[3].

## Spiritual and Religious Competence: Guidelines for Integration

[*First things first*] One must acknowledge that it is not necessary (or even possible) for mental health professionals to be specialists in all range of religious and spiritual perspectives represented in one society. As a matter of fact, even though, professionals' personal religious and spiritual views can serve as important components for expertise (meaning these views can influence their assessment of their patient's spiritual and religious issues, as well as the decision as to whether the use of religious and spiritual interventions is relevant), these are not sufficient or even necessary conditions for the competence (Gockel, 2011; Gonsiorek, Richards, Pargament & McMinn, 2009; Plante, 2007).

As behavioural scientists, expertise must be achieved through learning and training (Gonsiorek et al., 2009), therefore promoting (*multi*)culturally sensitive competencies may represent an effective way to achieve an accurate integration (Miller & Thoresen, 1999); in addition, of course, to an adequate education and ongoing training.

Therefore, it is important to highlight that this processes should always be conducted in a clinically and ethically competent manner with no exceptions. A psychologist should always "*provide services, teach, and conduct research with populations and in areas only*

[3]For more info please visit: http://www.apa.org/pubs/books/4311506.aspx

*within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience*" (APA, 2010, p. 5). This means not only are mental health professionals encouraged to become competent when working with religious and spiritual clients and issues, but are also compelled to act in accordance with the ethical guidelines in the field.

The development of religious and spiritual competence might, above all, strengthen the therapeutic relationship between mental health professionals and their patients; as well as allowing these professionals to be in a better position to distinguish the religious and spiritual issues (healthy and unhealthy beliefs, practices and behaviours) from psychopathology (Hage et al., 2006; Johansen 2010; Knox et al., 2005; Savage & Armstrong, 2010; Vieten et al., 2013).

With the increasing evidence that mental health professionals needed knowledge and skills to become competent in the area of spirituality and religion in therapy, ASERVIC, a division of ACA, convened a summit on spirituality aiming to discuss ideas on how to incorporate religious and spiritual issues into psychological treatment process (Miller, 1999). Thus, a set of 9 competencies were proposed to Accreditation of Counselling and Related Educational Programs (CACREP), which later were revised (Cashwell & Watts, 2010) and endorsed by the ACA. This new version of ASERVICs' guidelines for addressing spiritual and religious issues in counselling comprises now 14 competencies, divided into 6 categories (**Appendix B**). These competencies were firstly validated using a factor analysis research (Robertson, 2010); revisited by Reiner and Dobmeier (2014) and revised by Dailey, Robertson & Gill (2015).

The ASERVICs' steps toward the integration of spiritual and religious issues into clinical practice appear to be an important driving force. Consequentially it led (directly or indirectly) to new forms of competencies and integration, as outlined by Savage and Armstrong (2010). These authors presented a multicultural model (attitudes/values; knowledge; skills) based on ASERVIC' list of spiritual and religious competencies for psychotherapists. This chapter is so comprehensive (and recommendable) that it incorporates not only a rich amount of literature review and case vignettes illustrating *real* cases in therapy, but also (and most importantly) an extensive resource of practical guidelines supporting mental health practitioners. For instance, they provide important recommendations on how to assess, diagnose and conceptualise a case through multicultural and

religious/spiritual perspectives, as well as suggestions and resources to develop spiritual and religious skills through self-assessment and training activities.

More recently, Vieten and colleagues (2013) published the "*Spiritual and Religious Competencies for Psychologists*", a set of basic spiritual and religious competencies, based on attitudes, knowledge, and skills, in an attempt to overcome the lack of guidelines empirically validated or ultimately to be used in policy changes (Vieten et al., 2013). Therefore, these competencies might be another important resource guiding the mental health professionals in "*determining how and when to actively include religious or spiritual interventions into psychotherapy for those clients who request it and requires proficiency, rather than basic competence*" (Vieten et al., 2013, p. 138). However, what one must acknowledge as ground-breaking is the fact that these competencies were designed not only to help mental health professionals to provide care to those in need (e.g. religious and/or spiritual clients), but it also prepares mental health professionals to attend those clients lacking religious or spiritual involvement[4].

## Ethical considerations

Most of the mental health ethical guidelines (if not all) have as main assumption the respect and non-discrimination for the client as a person: a multicultural person (ACA, 2014; APA, 2010; APA[2], 2013; Barnett & Johnson, 2011; Cook, 2013; Hathaway & Ripley, 2009; Plante, 2007; Rosenfeld, 2011; Steen, Engels & Thweatt, 2006). However, most of them go beyond that.

For instance, in their paper, Steen and colleagues (2006) presented four topics addressed in the ACAs' code of ethics as a basis to explore the ethical challenges associated with integration of religious and spirituality matters into counselling. They highlighted the need for a mental health professional to be firstly aware of his/her own beliefs about religion and spirituality, by questioning how those beliefs might affect their work; and ensuring that he/she does not affect clients (Cook, 2013; Steen et al., 2006). For instance, *proselytism* (in an attempt to convert a client to engage or leave a religious or spiritual faith/community) is one practice involving ethical issues that need to be considered.

[4]These competencies are available in the paper or upon request from authors. Furthermore, a comprehensive approach of these 16 competencies was recently published: Vieten, C., & Scammell, S. (2015*). Spiritual and religious competencies in clinical practice: Guidelines for psychotherapists and mental health professionals*. New Harbinger Publications.

This issue was recognised to be particularly difficult to deal with, in cases when a mental health professional is either actively involved in a particular religious tradition or holds anti-religious and anti-spiritual beliefs, risking falling into some ethical pitfalls (Plante, 2007). For instance, one might fail to recognise the potential harm of specific religious and spiritual beliefs and practices or overestimating them by pathologising these beliefs and practices (Vieten et al., 2013).

Additionally, Plante (2007) proposed the RRICC model (that stands for Respect, Responsibility, Integrity, Competence, and Concern), composed by five main virtues considered to be common to the different professionals' codes of ethics. The importance of a mental health professional being proactive in overcoming the lack of adequate training for graduate and postgraduate programme is one of the virtues highlighted. Plante also cites Richards and Bergin's recommendations, such as the need for mental health professionals to: stay informed about the research in this area; attend workshops and seminars; seek for appropriate supervision and consultation; and personally, learn about the religious and spiritual traditions of their clients. Subsequently, these recommendations are encouraging mental health professionals not to avoid working with religious and spiritual issues due to the lack of adequate training, or doing so inappropriately, since many resources are available to start becoming competent in this area.

However, this leads to another important issue concerning service provision only within the boundaries of one's' competence, as APA (2010) established. When confronted with a religious and spiritual client or a client's wish to discuss religious and spiritual issues and problem, a mental professional should not proceed with the work when feeling uncomfortable, unprepared or holding negative feelings toward client's religiosity and spirituality, risking being more harmful than helpful for the therapeutic relationship and the client. Nevertheless, termination and/or referring to another professional are not supported by ACA (2014) when the reason is *simply* conflicting views. After all, mental health professionals are expected to be above all respectful and non-discriminatory. Therefore, recommendations are made in the following respects: seek for collaboration with a religious adviser, i.e. religious leader, clergy or chaplains; seek for consultation/supervision with a more competent mental health professional; or ultimately refer and/or terminate the therapeutic relationship (ACA, 2014; ASERVIC, 2009; Cook, 2013; Miller, 1999; Steen et al., 2006; Vieten et al., 2013).

## Conclusion

International academics and professionals have been working to advance the research on mental health, religion and spirituality. Portugal, however, might not hold equivalent standards concerning the research and proper integration of religious and spiritual issues into clinical practice. Much is unknown so far. Nonetheless, some researches focusing on multicultural aspects is being developed; OPP, in 2011, included religious and spiritual issues as a cultural minority characteristic that need to be considered; and overall Portugal, as state is advancing in terms of legislation. Furthermore, and following the Law nº 253/2009 on the spiritual and religious care in hospitals and other establishment of the National Health Service a practical manual was developed "*Manual de Assistência Espiritual e Religiosa Hospitalar*" (manual for the spiritual and religious care in hospital settings), and as the Directorate-General of Health presents:

> "*With this tool, health professionals have an advantage to develop an indispensable therapeutic complement to care with patients. Moreover, everyone realizes the therapeutic dimension of spirituality. The religious and spiritual support is essential to the healing and caring of a patient.*"[5]

This represents a ground-breaking step. However, this step was taken by the "*Grupo de Trabalho Religiões e Saúde*" (Religions and Health Working Group) in an attempt to make Portuguese chaplaincy more "*multicultural*"; and although it concerns health (mental) professionals as it promotes collaboration with religious advisers, it is not confined to mental health integration of religious and spiritual issues. For instance, it does not offer recommendations on how to use the information provided and again it appears to rely "*only*" on the respect and non-discrimination assumption. Also, other questions are yet to be answered: are, health (or mental) professionals aware of these (and other) techniques and opportunities of collaboration and its use? How have these impacted on professional work, therapeutic relationships and clients? Is there a need to go further? Here we would say inevitably: of course.

[5] Quotation retrieved from http://www.dgs.pt/?cr=21645

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# THE PERSPECTIVES OF RELIGIOUS COMMUNITIES

(Qualitative studies)

# Chapter 2

# Perspectives of Religious Members/Clients on Religion, Spirituality and Mental Health

**This chapter is based on the following paper published in the topical issue: Psychotherapy and Religious Values, edited by P. Scott Richards**

Freire, J., Moleiro, C., & Rosmarin, D. H. (2016). Calling for Awareness and Knowledge: Perspectives on Religiosity, Spirituality and Mental Health in a Religious Sample from Portugal (a Mixed-Methods Study). *Open Theology*, *2*(1), 681-699. https://doi.org/10.1515/opth-2016-0053 (**Appendix C**)

**Abstract**

Recent studies have demonstrated that when suffering or in psychological distress, religious clients tend to recover faster and with better outcomes when mental health professionals seek to integrate their clients' religious beliefs and practices in psychotherapy. As described in the literature and highly-recommended by the American Psychological Association (APA) guidelines, promotion of an accurate and sensitive integration of a client's religious and spiritual beliefs is implied among mental health professionals: the awareness of the particularities, the differences and barriers that religious clients might encounter when seeking help; the knowledge and respect of those specific characteristics and needs; and the development of specific competencies. A mixed-methods approach was used to conduct this study, with the aim of understanding the role which religiosity and spirituality play in mental health and the psychotherapeutic processes of religious members and clients in Portugal. Eight focus groups and three in-depth interviews were conducted, with a total of 41 participants. Participants stated their religiosity as vital aspects in their life and reported religious/spiritual practices as their primary coping strategies. They recognised that their religiosity should not be concealed or marginalised in the context of their psychological and/or psychiatric treatment, but revealed apprehensions, dilemmas and barriers prior to disclosure. Mental health professionals and services were seen as a possible source of help, but often as a last resort. Participants who sought professional help overall seemed to be satisfied with the service provided to them, although such treatment was mostly related to symptoms relief. Also, many concerns were shared; among them were both their wish for a religious match/ similarity with their mental health professional, and the perception of a lack of sensibility by their mental health professional toward religious and spiritual issues. Conclusions and implications for research are provided.

***Keywords:*** Psychotherapy; Religious Clients' Perspectives; Mixed-Methods Approach; Multicultural Competencies.

**Resumo**

Estudos recentes demonstraram que, quando em sofrimento psicológico, os clientes religiosos/espirituais tendem a recuperar mais rapidamente e com melhores resultados quando os profissionais de saúde mental integram as crenças e práticas religiosas dos seus clientes em psicoterapia. Conforme descrito na literatura e recomendado pelas diretrizes da *American Psychological Association* (APA), a promoção de uma integração efetiva e sensível das crenças religiosas e espirituais de um cliente é implícita ao trabalho dos profissionais de saúde mental, principalmente no que se refere à consciência das particularidades, diferenças e barreiras que estes clientes possam encontrar ao procurar ajuda profissional; ao conhecimento e o respeito dessas características e necessidades específicas e finalmente ao desenvolvimento de competências específicas. O presente estudo tem como principal objetivo compreender o papel que a religiosidade e a espiritualidade desempenham na saúde mental e nos processos psicoterapêuticos de clientes religioso-espirituais em Portugal. Utilizou-se uma abordagem de metodologia mista para realizar o estudo. Foram realizados oito grupos focais e três entrevistas individuas, totalizando 41 participantes. Os participantes deste estudo afirmaram a sua religiosidade/espiritualidade como um aspeto vital nas suas vidas e relataram práticas religioso-espirituais como sendo as principais estratégias de *coping*. Afirmaram ainda que a sua religiosidade não deveria ser ocultada ou marginalizada no contexto clinico, mas destacaram um conjunto de apreensões, dilemas e barreiras antes de se revelarem como religiosos. Os profissionais e serviços de saúde mental foram vistos como uma possível fonte de ajuda, mas muitas vezes como último recurso. No geral, os participantes com experiência em contexto clinico parecem satisfeitos com o serviço que lhes foi prestado, no entanto essa satisfação parece estar associada principalmente ao alívio dos sintomas. Entre as apreensões apresentadas surgem: o desejo de uma correspondência religiosa com o profissional de saúde mental e a perceção de falta de sensibilidade por parte dos profissionais da saúde mental quando trabalham com questões religioso-espirituais. Conclusões e implicações para a investigação são apresentadas.

***Palavras-Chave**:* Psicoterapia; Perspetiva dos Clientes, Metodologia Mista, Competências Multiculturais.

## Introduction

Despite of the historical and explicit tension between health sciences and religion, the interest in the role of religiosity and spirituality in health, and specifically in mental health, has increased significantly during the past few decades (Bartoli, 2007; Koenig, 2009; Post & Wade, 2009). While initially in research empirical studies of religiosity and spirituality were included as add-on variables in the context of other research agendas (Hill et al., 2000), they rapidly became a focus of research, mostly on the potential impact which religion and spirituality could have in peoples' lives (Bartoli, 2007).

More recently, the interest also covers their influence and effectiveness when integrated into psychological treatment (McCullough, 1999; Post & Wade, 2009; Wade, Worthington Jr & Vogel, 2007; Waller et al., 2010). However, these dimensions are still understudied in the scientific literature (Hill et al., 2000; Paloutzian & Park, 2005); and the educational and training programmes for (mental health professionals) (whether graduate or postgraduate) do not offer much guidance on how to accurately integrate these issues into clinical practice (Cates, 2009; Dein, 2004; Hage, 2006; Hill et al., 2000; Mayers, Leavey, Vallianatou & Barker, 2007).

Also, many studies have indicated that mental health professionals are usually less religious than other health professionals and the general population and are often ill-prepared to deal with their clients' religiosity and spirituality (Baetz & Toews, 2009; Coyle, 2001; Hill & Pargament, 2003; Gollnick, 2004; Hill et al., 2000; Miller & Thoresen, 1999; Moreira-Almeida, Lotufo Neto & Koenig, 2006; Rosmarin, Green, Pirutinsky & McKay, 2013). For these reasons (among others) religious and spiritual matters are often ignored, superficially considered or referred to other types of professional[6].

## Importance of Spiritual and Religious Issues in Mental Health: A Call for Awareness

Studies conducted aiming to understand the impact of spirituality; religiosity and faith related issues have suggested the existence of a positive relationship between religiosity/spirituality

[6]Although in this paper the authors did not specify (nor considered preferable) any type of mental health professional, nor a treatment modality, interventions aiming to provide specifically a spiritual counselling or direction were not covered (not discarding or questioning their value). In other words, religious and spiritual professionals trained with the knowledge of psychology, psychotherapy or counselling; or mental health professionals trained to work exclusively with religious and spiritual issues were not covered. However, in a previous paper (Freire & Moleiro, 2015) a multicultural training in spirituality and religiosity for mental health professionals was discussed and considered preferable.

and better indicators of physical and psychological well-being (Arveson, 2006; Miller & Thoresen, 2003; Nelson, 2009; Oman & Thoresen, 2005; Rosmarin, Krumrei & Pargament, 2010). Studies have reported that religious people tend to demonstrate not only much less physical illness and psychological disorders and a greater sense of social support (Agishtein et al., 2013; Baetz & Toews, 2009; Koenig, 2000, 2001, 2008), but also experience much more positive emotions (Cohen & Koenig, 2004; Hackney & Sanders, 2003; Rosmarin et al., 2010). This pattern seems to be closely linked to lifestyle habits, social support and religious coping strategies (e.g. prayer, meditation and religious rituals) often inherent to religious/spiritual daily life (Arveson, 2006; Nelson, 2009).

However, persons with faith-based worldviews (as with the general population) are not exempt from mental illness and suffer from a range of mental disorders and often having serious comorbid problems (Koenig, 2012). Also, studies have reported an association between the onset and/or aggravation of psychopathological symptoms and the increased importance of religion/spirituality in the life of many clients (Baetz & Toews, 2009; Gockel, 2011). Furthermore, when facing psychological distress (or even religious or spiritual struggles, as portrayed in DSM-V, 2013, p. 725), religious clients tend to recover faster and with better outcomes when mental health professionals seek the integration of their clients' religious beliefs and practices into treatment (Curlin et al., 2007; Baetz & Toews, 2009; Koenig, 2008), religiosity and spirituality also being part of the solution. Therefore, many clients wish their religiosity/spirituality to be respected and integrated into their psychological treatment (Baetz & Toews, 2009; Fridman, 2010; Knox, Catlin, Casper & Schlosser, 2005; Martinez, Smith & Barlow, 2007; Plante, 2007; Rose, Westefeld & Ansley, 2001), emphasising the importance these dimensions have in their personal development and healing process (Cates, 2009; Gockel, 2011; Knox et al., 2005; Rosmarin, Forester, Shassian, Webb & Björgvinsson, 2015).

### Clients' Perceptions of Spiritual and Religious Integration: A Call for Knowledge

The research field and clinical context have only recently begun to learn about client's views and experiences of religiosity/spirituality in the therapeutic relationship (Gockel, 2011). Clearly, such information would be essential to inform mental health professionals about the appropriateness of such integration, and also on "when" and "how" to include a client's spiritual and religious perspective into psychological treatment. Nevertheless, it seems

consensual that this process should always be conducted with caution; in a clinically, professionally competent and sensitive way (Arveson, 2006; Peres, Simão & Nasello, 2007; Sloan, 2001, cited by Plante, 2007).

This inclusion/integration appears to have a significant impact on the quality of the therapeutic relationship between clients and mental health professionals; meaning that clients seem satisfied with the perception of mental health professionals' openness and sensitivity toward discussion of religious/spiritual issues and perceived negative responses as risky to the therapeutic relationship (Fridman, 2010; Gockel, 2011; Knox et al., 2005; Martinez et al., 2007; Wade et al., 2007). This could be particularly important among (but not limited to) highly religious clients, who may fear being judged or misunderstood in secular settings (Dein, 2004; Gockel, 2011; Knox et al., 2005; Martinez et al., 2007; Richards & Bergin, 2005), or for those who need professional help but choose not to use mental health services (MHS) or consider it as a last resort (Leavey, 2004).

Many reasons have been highlighted to understand such patterns. It seems, for instance, that those who conceptualise their psychological problems primarily as spiritual or religious perceive seeking professional help as conflicting with their religious beliefs (Leavey, 2004; Mayers et al., 2007), and are concerned that the traditionally-secular practice might undervalue or misunderstand their spiritual/religious beliefs (Mayers et al., 2007; Myers, 2004), tend to turn initially –and often only– to religion or a religious sources, instead of seeking help from secular MHS (Leavey, 2004).

Related to this, several studies were conducted to understand the "*religiosity gap*" phenomenon between religious clients and their mental health professional (for review see: Crosby & Bossley, 2012; Mayers et al., 2007; Sørgaard, Sørensen, Sandanger, Ingebrigtsen & Dalgard, 1996), covering also the impact that religious (un)match would have on the (perceived) quality and effectiveness of psychological treatment. However, most of recent studies did not find clear evidence supporting the existence of such a gap when regarding treatment effectiveness (Cook, 2011; Crosby & Bossley, 2012; Dein, Cook, Powell & Eagger, 2010; Sørgaard et al., 1996).

However, one must acknowledge that many other aspects may play an important role prior to the evaluation of the treatment efficacy. From the client's perspective, it is important to consider: how they conceptualise their psychological problems, the role their faith community plays (whether mediating or obstructing) in their help-seeking process, their

perceptions of mental health professionals' openness and willingness to address religion/spirituality, their perceptions of mental health professionals' prejudices against religion/spirituality, and their attitudes about the helpfulness or usefulness of psychological treatment.

On the other hand, it also seems important to analyse how mental health professionals' personal religious/spiritual attitudes and commitment impact their religious/spiritually-related goals and interventions in psychological treatment (Kellems, Hill, Crook-Lyon & Freitas, 2010; Rosmarin et al., 2013). Specifically, it is imperative to understand how their religious and spiritual awareness, knowledge and training (or the lack of thereof) impact their willingness to engage in an accurate integration of these issues into clinical practice (Knox et al., 2005; Martinez et al., 2007).

Not only do the above-noted factors impact care, but also others (separately or combined) may be compromising, delaying or preventing religious clients from seeking professional help. On the other hand, it might also be contributing to maintaining the gap between clinical practice and clients' needs in psychological treatment (Hill & Pargament, 2003), as well as fostering the difficulty in developing skills and strategies to accurately work with religious clients (Arveson, 2006).

And this may be particularly true for the Portuguese mental-health field, where there is clearly a lack of scientific research. So far, only a few studies were conducted and most of them in the context of quality of life and well-being. Only more recently, and from a multicultural perspective, have issues related to ethnicity, race, sexual minorities, religion and spirituality been systematically investigated (e.g. Freire & Moleiro, 2011; Moleiro, Freire, Pinto & Roberto, 2014; Moleiro, Silva, Rodrigues & Borges, 2009).

## Mental Health in Portugal (a Brief Characterization)

Worldwide, epidemiological studies show that psychiatric and mental health problems have become one of the main causes of suffering and disability in present-day societies (Kessler et al., 2009) and Portugal is no exception! Although data in this field are still scarce, according to an epidemiological study published in 2013 Portugal has one of the highest prevalence

rates of mental disorders in adults in Europe[7] (surpassed only by Ireland) and worldwide[8] (surpassed only by the United States). Specifically, figures showed that, in the 12 months prior to the study, 22.9% of the Portuguese population reported suffering from a psychiatric disorder. The highest European rate was reported in Ireland, 23.1%. Worldwide, Portugal was surpassed only by the prevalence rates of United States (27.0%). The lifetime prevalence of any mental and psychiatric disorder in the Portuguese population was 42.7%, being the United States the only country with a higher rate, 47.4% (Almeida et al., 2013; Kessler et al., 2009). Anxiety disorders figured as having the highest prevalence (16.5%), followed by the group of mood disorders, with a prevalence of 7.9%. With much lower rates were externalizing disorders and substance abuse disorders, with a prevalence of 3.5% and 1.6%, respectively (Almeida et al., 2013).

The latest data produced by the General Directorate of Health (DGS) regarding the reports of mental health related issues in Portugal, showed that the proportion of patients with mental disorders accessing the Portuguese Primary Health Care (CPS) has been increasing in the last years; and although, the main nosological entities remain the same, this report showed that the highest prevalence rates were of those presenting depressive symptoms, followed by anxiety disorders and, finally by those presenting dementias (DGS, 2015).

Regarding the impact of health problems on the perceived quality of life (also designated as global burden of physical and mental diseases), in 2013 reports showed that mental health presented five of the top ten pathologies responsible for the greatest incapacity for productive and psychosocial activity, being depression in the first place, followed by alcohol related problems, schizophrenic disorders, bipolar diseases and dementias (DGS, 2013). In fact, mental and behavioural disorders is considered to be one of the most significant group of diseases contributing to the perception of years of health life lost due to ill-health, disability or early death (i.e. disability-adjusted life year), being surpassed only by the group of brain and cardiovascular diseases (Almeida et al., 2013).

In one hand, it is true that this tendency may be related to the increasing need of professional help that has occurred in the last years, mostly due to the impact of

[7]Countries participants in this study: Portugal, Germany, Belgium, Bulgaria, Spain, France, Netherlands, Northern Ireland, Italy, Romania. Data from 2008-2009; Source: World Mental Health Surveys Initiative (WMHSI-WHO).

[8]Countries participants in this study: Colombia, Mexico, United States, Nigeria, South Africa, Lebanon, Belgium, France, Germany, Israel, Italy, Netherlands, Spain, Ukraine, China, Japan, New Zealand. Source: World Mental Health Surveys Initiative (WMHSI-WHO).

economical/financial crisis, the progressive aging of the Portuguese population and some potential risk factors, such as gender inequalities and age (Almeida et al., 2013). However it is also important to highlight that, despite the many advances made in the Portuguese National Mental Health System lately, this tendency might also be a product of the long term crisis installed in the mental health field, an area that has long been considered to be the "*poor cousin to physical health in the SNS*" (Palha & Palha, 2016, p. 7) -which perhaps it is a phenomenon known worldwide. Furthermore, many other factors may be contributing to the increasing prevalence and negative impact of mental health problems in the Portuguese population, being the most serious: the deficits in the accessibility, equity, and quality of care of both non-specialized and specialized services (and perhaps also the lack of ability to appropriately diagnose and refer to the competent services) and the still present stigmatization and discrimination associated with mental illness (Beldie et al., 2012; Palha & Palha, 2016). In fact, the 2013 epidemiological study revealed that 65% of those living with a psychiatric disorder had no treatment in the previous 12 months, being perhaps the gap between those in need of a psychiatric/psychological treatment and those who actually had access to it, even more noticeable in cases of mental health problems with lower severity, such as anxiety disorders (Almeida et al., 2013).

## Religiosity and Spirituality in Portugal (a Brief Characterization)

As mentioned before, Portugal is a secular state; however, socially, historically and culturally it is undeniably tied to several religious beliefs and practices. The 2007 transnational comparative study between eight European countries[9], reported that more than 90% of the Portuguese population believes in God. More specifically, up to 78% of the participants reported belief in a 'personal God', whereas 15% articulated belief in a 'spirit, higher force or life force'. The percentage of non-believers was 3% (Menéndez, 2007). More recently, the results of the national census indicated that nearly 85% of the Portuguese population identified themselves as being religious (INE, 2012).

Historically, Portugal shares a particularly long and strong relationship with the Roman Catholic Church, the predominant religion of the country (81% of the population).

[9]Countries: Austria, Belgium, France, Ireland, Italy, Poland, Portugal and Spain; data from 2000; source: European Value Survey (EVS) and European Social Survey (ESS).

However, lately the group of non-Catholic, non-Christian and non-religious people has been growing rapidly, representing almost 11% of the population (INE, 2012 - **Table 1**, p. 37). On the other hand, as a civil society, Portugal has taken important legal steps in terms of religious protection and care. For instance, regarding the national health-care system, the Portuguese State guarantees any citizen the right to have his or her spiritual and religious needs understood and included when seeking health care (Decree Law nº 253/2009[10]).

However, and due to the lack of scientific research in this area, it is still unclear how this law has so far affected mental-health clinical practice. Actually, one must acknowledge that it is unclear what role religion and spirituality play in the Portuguese mental health field (apart from its role in the context of quality of life, as mentioned above). Particularly, the importance and impact that religious and spiritual issues have on people's lives and their therapeutic processes remains unknown. Related to this, we are only beginning to learn about the preferences, expectations and experiences religious people have in the Portuguese mental-health field.

Furthermore, it is still unclear what the current state of clinical practice is regarding the integration of religious and spiritual matter in psychotherapy. Especially considering that Portugal is a highly religious society and the educational and training programs do not prepare mental health professionals in how to accurately integrate these issues in clinical practice. Consequently, an important question arises: are the Portuguese mental health system and mental health professionals currently meeting their clients' religious/spiritual expectations and needs? This study was conducted aiming to address this question, contribute to the discussion of psychological treatment with individually and culturally diverse clients and ultimately to contribute to a more sensitive practice toward such diversity.

Therefore, the following aspects are discussed: (1) the role of spirituality and religiosity in the life and mental health setting of our participants; (2) the coping strategies used when suffering and in psychological distress; (3) the challenges/barriers (either internal or external) they may encounter when seeking MHS and professionals; (4) their experiences and/or expectations when accessing these services and professionals and finally (5) their

[10]Decree-Law nº. 253/2009 of 23 September, regarding the spiritual and religious assistance in hospitals and other establishments of the Portuguese National Health Service.

perceptions of a mental health professional' spiritual and religious competencies when working with religiously diverse clients.

## Method

Following a more pragmatic perspective about what is important when seeking knowledge – what are the problems and the solutions to the problems, rather than only the type of methods used to achieve the knowledge (Patton, 1990 cited by Creswell, 2003) – a mixed method approach was chosen to conduct this study. To maximise the advantages of both quantitative and qualitative methodologies (methodology triangulation), different forms of Sampling and Data Collection (data triangulation), and data analysis (investigator triangulation) were used (Creswell, 2003; Patton, 2002). The goal is to explore and provide both quantitative and qualitative information about participants' perceptions of religiosity, spirituality and mental health in Portugal and the context in which they experience these issues (Creswell, 2009). The analytic plan behind each process is presented below.

### *Sampling and Data Collection*

Regarding the sampling process, and in a first phase, participants were recruited through formal contact with religious institutions, according to their representation in the last national census (**Table 1**, p. 37). Therefore, invitation letters (via email) were sent to the institutions requesting the individual participation of a leader or representative (results will be presented in another paper). Since only three positive responses were received using this method (namely Jehovah's Witnesses, Latter-day Saints and Baha'i Faith), the strategy of 'snowball or chain sampling', as proposed by Patton (2002) was used. Key respondents/personal contacts were used, resulting in the participation of other religious groups (namely Catholic, Seventh Day Adventist, Orthodox, Pagan and Evangelical).

After the interviews with the leaders, they were invited to organise a group meeting. Interviews were conducted at worship places, before/after religious services/rituals. Each focus group member and in-depth interviewee was offered a gift card as a reward for their participation. All participants signed an informed consent form, agreeing, for instance, to be quoted. The study included the participation of a total of forty-one (41) members of different religious denominations (Baha'i Faith, Jehovah's Witnesses, Seventh Day Adventist Church, Orthodox Church, Evangelical Alliance, Pagan Federation International, Catholic Church and

Latter-day Saints). Of those, forty (40) participated in focus group interviews, and three (3) in in-depth individual interviews (two of them had previously participated in the focus groups interviews).

### *Participants*

Participants included 27 women and 13 men; aged between 25 and 71 years old (mean=41.40 years). Most of them were born in Portugal (25), but some had different ethnic backgrounds (e.g. Iran, Mozambique and Romania). While most participants had had some experience in the general health care system (public and private hospitals, local health centres, and private clinics), only 11 reported having (any) experience in the context of MHS (from a single session to a few sessions, to dropouts or years of therapy). For further information, a summary of demographic data is provided below (**Table 2**).

**Table 2** - *Demographic characterization of the sample (N=40)*

| | Freq. | % | | Freq. | % |
|---|---|---|---|---|---|
| **Age (N=39; 1 missing)**<br>Mean = 41,40 years old<br>Std. Deviation = 12,39<br>Minimum = 24<br>Maximum = 71 | | | **Gender** | | |
| | | | Female | 27 | 6 |
| | | | Male | 13 | 32 |
| **Marital Status** | | | **Educational attainments** | | |
| Single | 16 | 40 | Secondary degree or less | 17 | 43 |
| Civil union | 1 | 2 | Bachelor's Degree | 1 | 2 |
| Married | 20 | 50 | *Licenciatura* (BSc) | 14 | 35 |
| Divorced | 3 | 8 | Master's Degree | 6 | 15 |
| | | | Doctorate degree | 2 | 5 |
| **Citizenship** | | | **Native Language,** if not born in Portugal (N=15) | | |
| Portuguese | 25 | 63 | English | 1 | 6 |
| CPLP* | 11 | 27 | Portuguese | 8 | 54 |
| Other-EU | 3 | 8 | Creole | 2 | 14 |
| Other | 1 | 2 | Romanian | 3 | 20 |
| | | | Tetum | 1 | 6 |
| **Occupational status** | | | **Experience in (psycho)Therapy** | | |
| Studying (N=40) | 6 | 15 | Yes | 14 | 35 |
| Working (N=39) | 34 | 87 | Clinical Psychologist | 7 | 50 |
| | | | Psychiatrist | 4 | 29 |
| | | | Psychotherapist | 3 | 21 |
| | | | No | 26 | 65 |

*Note*: *Community of Portuguese-speaking countries in this sample: Angola; Brazil, Cape Verde, Mozambique and Timor.

*Focus group interviews*: Eight focus group interviews were conducted, each one representing a religious community. As mentioned before, a total of 40 adults participated, distributed as described in **Table 3**. Further details on duration and transcriptions are also included.

*In-depth individual interviews*: Of the 11 participants with experience in the MHS, two agreed to participate in an in-depth individual interview, in addition to another participant who did not participate in the focus groups. Participants were all female and Portuguese. Following are some further details about the causes for seeking help in MHS: **Participant 1** was a 34 years old, Pagan member, diagnosed with severe anxiety and psychosomatic symptoms. She reported several admissions to psychiatric emergency services. **Participant 2**, a 63 years old Catholic Nun; diagnosed with depression and suicidal attempts; she reported having been hospitalised in a psychiatric hospital for three weeks. **Participant 3** was 32 years old, belonging to the Evangelical Church, diagnosed with eating disorder (anorexia and bulimia).

All three participants reported they felt recovered and were maintaining good functioning. Concerning these three participants, and additionally to the study's objectives aforementioned, the importance/impact of religion on mental health status and quality of service received were also explored. The interviews lasted two hours with participant one (28 pages), one hour and a half with participant three (15 pages) and 30 minutes with participant two (10 pages).

**Table 3** - *Distribution of focus group interviews*

| Group | Participants | Duration | Pages |
|---|---|---|---|
| Catholic (members) | 10 | 1h27mins | 13 |
| Catholic (nuns) | 3 | 1h03mins | 19 |
| Baha'i Faith | 3 | 1h04mins | 16 |
| Jehovah's Witnesses | 7 | 40mins | 9 |
| 7$^{th}$ Day Adventist | 6 | 1h06mins | 16 |
| Orthodox | 3 | 19mins | 5 |
| Pagan Federation International | 3 | 2h33mins | 26 |
| Latter-day Saints | 4 | 56mins | 18 |

***Measures***

*Interview protocol*: For this paper two semi-structured interview protocols were developed (one for the focus group interviews and the other one for the individual interviews), covering themes arising from the literature review and in accordance with the proposed objectives (**Appendix D**). Thus, all participants were asked a standard set of questions (adjusted for each group of participants); however, the interviews were susceptible to change according to participants' responses, without compromising the goals.

The interview protocol for the focus group was developed to explore and understand general perceptions on religiosity, spirituality and mental health that could be generated in an interactive setting. Therefore, participants were encouraged to discuss and share their perspective on their sense of belonging to a religious community in Portugal (i.e. "What does being a Pagan mean to you?"); the coping strategies they use to overcome daily life problems (i.e. "When suffering, stressed out or in a difficult time in your life, what you usually do? Who do you seek help from?"); their experiences and/or expectations when seeking mental health professionals help and the spiritual competencies these professionals should have (i.e. "Imagine yourself visiting a Clinical Psychologist. What would you like to happen? Or not happen?"), and their knowledge and perception on the impact of the Law and Manual for spiritual and religious care in hospitals would have on their (hypothetical) psychological treatment (i.e. "*Do you think these tools could be an advantage when seeking help in the health care services in Portugal? How so?*").

As for the protocol used for the individual interviews, the main goal was to explore participants' experience as religious customers in the Portuguese mental health services. As with the focus group interviews, participants were asked to share their sense of belonging to a religious community in Portugal (referring also to the role and importance religion had in their daily life) and the coping strategies they used to overcome daily life problems. Concerning their clinical experiences, participants were asked to freely describe their personal experience ("I would like you to tell me about your experience when you felt you needed help…"), while some lead questions were introduced (i.e. "What role did your religiosity have throughout the treatment?"; 'What do you think about the treatment that was provided to you?"; "How sensitive do you think your therapist was when religious matters were brought to treatment?").

All interviews were audio taped, transcribed and analysed in their entirety. For further details on the transcriptions, see **Table 3** and the data analysis section below.

*Demographic form*: After the interview, participants were asked to complete a demographic form providing some basic information on age, sex, marital or relational status, educational attainments, employment, ethnic background and experience in MHS.

*Quantitative measures*: Also, two additional quantitative measures were used, the Spiritual Well-being Scale (SWBS), developed by Paloutzian and Ellison in 1982 (Ellison, 2006) and the Multidimensional Measurement of Religiousness and Spirituality (MMRS-Fetzer Institute, 1999) aiming to assess participants' religious/spiritual history, private/public religious practices and spiritual well-being (these measures were used previously in Moleiro, Pinto & Freire, 2013). The descriptive results are presented in **Table 4**. The interview protocol used in this study is available in the **Appendix E**.

***Data analysis***

Prior to the thematic analyses performed using the qualitative software MAXQDA 11, several stages and methodological efforts were involved in analysing and interpreting the data, so that the final result accurately represented the participants' perspectives. Thus, and firstly, all taped interviews were transcribed by a CIS-IUL intern, and afterwards transcriptions were read with their audios, by the first author, to check/correct mistakes and doubts, and to enable immersion in the data. Once transcription was completed, and in a first stage of thematic analyses (reflexivity), nine (9) different core themes were created in accordance with the interview guide questions, which later led to the categorisation in code (35) and sub-codes (90), in total 1563 units of analysis. A working draft of a codebook was developed throughout this stage (**Appendix F**).

In a second stage, data were analysed by an independent coder (PhD Researcher), using the *Intercoder Agreement* feature available on MAXQDA 11. Using this method and in a three-phase process, the final result of agreement between the two coders was 85.8%, (the option *Segment agreement* was used). Finally, all results were again analysed by the authors to present the reflections, commonalities, variations and new issues. A similar methodological approach is described in other studies (Carey, Morgan & Oxtoby, 1996). All measures, interviews, data analysis and the complete information on the coding process and results are available for external analysis within the limits of confidentiality.

**Table 4** - *Religious and Spiritual characterization of the sample (N=40)*

| | Frequency | % |
|---|---|---|
| **Raised in a religious tradition** | | |
| Yes | 37 | 93 |
| Catholic | 24 | 65 |
| Jehovah's Witness | 4 | 11 |
| 7th Day Adventist | 2 | 5 |
| Baha'i | 2 | 5 |
| Other | 5 | 14 |
| No | 3 | 7 |
| **Current religious affiliation** | | |
| Catholic | 13 | 32.5 |
| Jehovah's Witnesses | 7 | 17.5 |
| 7th Day Adventist | 6 | 15 |
| Orthodox | 3 | 7.5 |
| Latter-day Saints | 4 | 10 |
| Pagan | 3 | 7.5 |
| Baha'i Faith | 3 | 7.5 |
| Evangelical Church | 1 | 2.5 |
| **Do you consider yourself to be a religious person? N=39 (1 missing)** | | |
| Moderately | 11 | 28 |
| Very | 17 | 44 |
| Completely | 11 | 28 |
| **Do you consider yourself to be a spiritual person? N=38 (2 missing)** | | |
| Slightly | 1 | 2.5 |
| Moderately | 12 | 31.5 |
| Very | 12 | 31.5 |
| Completely | 13 | 34.5 |
| **Public religious/spiritual participation (N=38, 2 missing)** | | |
| Nothing | 1 | 2.5 |
| Slightly | 1 | 2.5 |
| Moderately | 7 | 18 |
| Very | 20 | 53 |
| Completely | 9 | 24 |
| **Private religious/spiritual participation (N=39, 1 missing)** | | |
| Nothing | 1 | 2.5 |
| Moderately | 11 | 28 |
| Very | 18 | 46 |
| Completely | 9 | 23.5 |

## Results

### *Religious/spiritual History of Participants*

Most participants (n=37; 92.5%) reported that they had been raised in a religious tradition, among which 63% (n=25) indicated Catholicism as the main religion. Those who had experienced a religious change/conversion (n=21; 53%), reported belonging to the new religion/faith from 1 to 41 years. All participants claimed being "*moderately*" to "*completely*" religious when answering "*Do you consider yourself to be a religious person?*", whereas only one participant reported being "*slightly*" spiritual when asked "*Do you consider yourself to be a spiritual person?*". Concerning religious participation, more than 94% of participants reported being "*moderately*" to "*completely*" involved in public religious practices (n=36; 94%) and private religious practices (n=38; 97%).

*Spiritual Well-Being Scale (SWBS)*: Participants in the study scored positively and within the limits of the typical score for many religious groups[11], with an average score of SWBS for our sample of $102.27^{SD=4.87}$. As for the sub-scale, Existential Well-Being (EWB), participants scored $51.72^{SD=4.66}$ and for the Religious Well-Being (RWB) $50.55^{SD=8.53}$. Likewise, religious community was considered an important source of comfort and support (mean=19.40, of a possible total score of 24). A more detailed statistical presentation is provided below, in **Table 5**.

**Table 5** - *Spiritual Well-Being Scale Statistics (N=40)*

| | **RWB** | **EWB** | **SWBS** | **Religious Support** |
|---|---|---|---|---|
| Mean | 50.55 | 51.72 | 102.27 | 19.4 |
| Median | 52 | 52 | 103.5 | 19 |
| Mode | 54 | 51 | 103.00[a] | 19.00[a] |
| Std. Deviation | 4.87 | 4.66 | 8.53 | 2.81 |
| Min | 35 | 36 | 71 | 14 |
| Max | 54 | 60 | 114 | 24 |

*Note*: [a]. Multiple modes exist. The smallest value is shown

[11]Typical scores for many religious groups: SWB=82–109, out of 120; RWB=34–56, out of 60; EWB=46–53, out of 60.

***Qualitative analysis***

The themes emerging from the qualitative analysis were clustered into nine (9) core domains, namely: 1) *religious/spiritual role*; 2) *coping mechanism*; 3) *principles of health*; 4) *access to MHS*; 5) *experiences in MHS*; 6) *expectations when/if seeking professional help*; 7) *perceived barriers, difficulties and obstacles when/if seeking professional help*; 8) *perception of mental health professionals' competence*; 9) *religious laws and instruments*. All identifying information has been removed, and participants were named as follows: Religious Affiliation - Baha'i Faith [BF]; Jehovah's Witnesses [JW]; Seventh Day Adventist Church [SDA]; Orthodox Church [OC]; Pagan Federation International [PFI]; Catholic Church [CC or CNun] and Latter-day Saints [LDS]; Evangelical Church [EC] + Participant number (e.g. **JW_P1**). Extracts from transcripts (that have been translated and edited for readability) are also provided as examples.

***Religious/Spiritual Role***
[*Referring to the role – impact and importance – religion and spirituality play in participants' lives*].

When asked "*What does it mean being (e.g. Catholic)?*" participants reported their religiosity/spirituality as important dimensions in their life; seen mostly as a way of making sense of life and giving meaning/purpose to their life and understanding their roles and responsibilities in this world: "*…the fact that I have a religion in my life allows me to see my place in this world and realise that this world is much more than what I live every day and it goes far beyond my existence.*" [**LDS_P2**]. Also, being a religious person was often referred to as a way of life and mostly mentioned as "*a privilege*", "*a gift*"' or "*an honour*"': "*Being a Jehovah's Witness is one of the greatest privileges I have had… I'm one of the people who were gifted to be a Witness.*" [**JW_P4**].

Religiosity was often seen as a personal and close relationship with God (divinities or a Higher Power), and turning to God in search of comfort, hope, and the feeling of being loved and valued in the midst of difficulties, the often reported: "*Jesus for me isn't a distant person, is very close to me. I feel sometimes, when I am in prayer… when I pray, I talk to Jesus as if I'm talking to a real person and I feel, in fact, that is a dialogue, a relationship.*" [**CNun_P1**]. Participants reported using specific practices in their daily life (e.g. praying, meditation, reading sacred scriptures, attending worship services), not only to maintain or restore health, but also as a way of testifying their belongingness to a religious community:

"*The church also gives us doctrines, truths, and it asks me to practice them in my daily life… my life in church.*" [**CC_P10**].

Their faith community was often seen as, or compared to a (spiritual) family; providing a sense of belongingness, meaning and purpose; and also, giving support for enduring chaotic, stressful and suffering moments: "*Family is not just blood, I found here, in every brother a family that I didn't have.*" [**SDA_P4**]. Some participants also reported some negative aspects of their religion/religiosity, such as guilt, doubts and the negative impact these might have in life, mental health status or when suffering: "*There are lot of these situations… people who somehow couldn't deal with their guilt and that developed into a problem.*" [**CC_P1**].

***Coping Mechanism***

[*References to strategies used to cope with disease, suffering, pain, sadness and stress*]

Participants of this study often reported using religious and spiritual practices/strategies as coping mechanisms and as a resource in terms of comfort. The most common strategy was "*turning to*" or "*relying on*" God through prayer or reading the sacred scriptures: "*We are always praying, asking for God's help, and when we are really distressed we ask even more."* [**OC_P3**]. Participants also reported turning to their faith community, or receiving support to cope with their problems. Accordingly, relying on religious leaders would be a first step when seeking professional help: *"…we ask for help of our Lord; and the church leaders also have some answers for us. And they help us! Sometimes they are inspired and they tell us what we should do.*" [**LDS_P4**].

Also, participants often reported seeking (secular) professional help, but not as a first resort, since most stated seeking help first within their religious sources (God, religious leaders, family or community): "*So, my first thought would be to look for someone within my community. Not because there is a restriction in our faith, but because I think he/she would better understand what I'm going through.*" [**BF_P2**]. Another coping strategy reported was related to the way participants perceived or faced problems, i.e. having a more positive and hopeful view of suffering, illness and stress or understanding the problem: "*I think we look to suffering differently, to sacrifice, to pain, differently from those who don't believe, because we know suffering has a purpose.*" [CC_P1].

***Experience in the MHS***

[*Encompasses all references of having or not experience in the MHS, including their expectations and perceived barriers or difficulties*]

As previously mentioned only eleven participants reported having experience in the MHS. However, participants were able to share their relatives and friends' experiences. When asked "*When do you think you should seek professional help?*" participants reported "*So, we must fight cancer; fight depression; we go to psychologists, we seek friends.*" [**LDS_P5**]; "*If you lose sight of your own life, and you can't deal with it alone.*" [**OC_P2**]; "*As soon as it starts affecting me physically.*" [**PFI_P1**]; "*When there are cases of abuse, sexual violence, addiction… alcohol, drug… it is important to see a professional.*" [**LDS_P4**].

Some participants offered religious and spiritual explanations for experiencing distress or as a reason for not seeking (or delaying) professional help, whereas others integrated socio-psychological or biomedical explanations: "*I think mental illness, perhaps most of it, are spiritual disorders that can reach a point where it can cause physical problems, imbalances in your body that can interfere with your functioning as a person.*" [**BF_P2**]; "*It all happened when I was pregnant* (high-risk pregnancy) *…and right after my baby was born. I had many problems at work… with a very big belly; almost at time to give birth and I needed this psychiatric care. I had postnatal depression, and I learned a lot from this experience.*" [**LDS_P2**].

Participants reported that they may not encounter barriers when seeking professional help, but some concerns (e.g. fear, dilemma, doubts) were raised: "*I'm afraid that perhaps I won't be able to realise that what I really need is a different kind of help; that I can't see this as a mental problem, but rather as a religious or faith issue. And then is too late.*" [**CC_P2**]; "*I might resist a bit before going, because I wouldn't know if this person would be able to understand what is important to me, my priorities… well what is important to me.*" [**BF_P3**].

Participants also lacked information or hold preconceived ideas about the role of a mental health professional, especially regarding the work of a psychologist: "*Psychology uses hypnotism; reincarnation and these kinds of things that go against what we believe in. They prescribe allopathic medicines while we seek for homeopathic medicines.*" [**SDA_P2**]; "*You said that psychologists are not medical doctors. I always thought psychologists were physicians too.*" [**BF_P3**].

***Perceptions of Mental Health Professionals' Multicultural Competencies***
[*Encompasses all participants' references regarding their perception of a competent professional*]

Regarding participants' perception of a competent and helpful professional the most common competencies were: having an open, respectful and non-judgmental attitude "*Respect our beliefs, and if they don't know what we believe in, ask us.*" [**JW_P3**]; have knowledge and understanding of their patients' religion "*Especially our doctrines; what we believe in; our foundations; commandments. Yes, it is important to have this knowledge too. I think they will be better able to help us this way.*" [**LDS_P3**]; do not avoid, ignore, counteract or confront religious or spiritual beliefs "*If they ignore this issue or don't take it into account at all; thinking for instance that it doesn't influence our mental health state, and not consider it in our treatment… I mean; this wouldn't help me go there.*" [**JW_P5**]; be religious (belonging to the same or a different faith), or be a spiritual person "*this professional has to be a good Christian, I think. To know how important is to have a relationship with God… the spiritual part.*" [**OC_P2**].

Few participants agreed that mental health professionals should be able to accept and/or use practices, such as praying and meditation as strategies in treatment: "*For instance, one thing I wish we could do was to pray together, and it doesn't make sense to ask someone who doesn't believe in God. He/she won't be able to feel it.*" [**BF_1**]; while others stated that the clinical setting should not be a place to use such practices: "*I also know cases of Catholic psychologists, who are doing everything but psychotherapy, and this is also very serious. Having patients reading books of the saints, praying the rosary? I mean ... that's very important, but not in psychotherapy.*" [**CC_P1**].

***Perceived Quality of Service Received***
[*Encompasses all participants' reports regarding their evaluation of (satisfaction with) the service received in the Portuguese mental health system*]

For those who have had experience in MHS, most of them reported having a good to a very good experience, since only two of them dropped out. To be precise, four participants (three Catholics and one JW) would recommend their mental health professional unreservedly: "*I never had a single problem with my psychologist.*" [**CC_P1**]. Whereas two other participants interviewed individually (PFI_P1 and EC_P3), even though assessing their experience as positive (mostly related to symptomatic relief and the acquisition of strategies to cope with their problems), they would recommend their mental health professional with

some hesitation: "*From my experience the sensibility is zero. I mean as professionals they were excellent, except that sensibility (toward religious and spiritual issues) was zero. I heard things like – 'The less you believe in those magical things, the better for you'.*" [**PFI_P1**].

Additionally, these two participants reported seeking help from a mental health professional within their faith community, expecting a comprehensive approach. However, they also reported some concerns: "*when I was feeling better I saw an evangelical psychologist. He was a Pastor and it was very good. I mean I think technically the other one was better, but with him (evangelical psychologist) I felt that I could talk about everything… specially that missing part.*" [**EC_P3**]; "*I felt hurt with it (professional sleeping during therapy) ... so I thought it was time for me to get out. I mean, at the time I didn't know what was therapeutic intervention and what was channelling?*" [**PFI_P1**]. Likewise, three other participants also reported concerns whether psychological treatment was an appropriate context to discuss religious and spiritual matters: "*I mean, the psychologist would be working in an area and I would have my prayers and my faith to help me in another side… I mean, I might not need to reveal it because it might not be the place for doing so.*" [**BF_P3**].

Finally, some participants reinforced the need for further sensitivity, knowledge and skills when working with (but not restricted to) religious clients, while recommending religion and spiritually to be considered as important factors in clinical practice and training. In fact, the lack of specific knowledge and training were pointed out as one of the reasons for mental health professionals' lack of sensibility: "*I believe, as with most things, health professionals are not trained... maybe if you are Portuguese, you'll know what Catholicism is; but, for instance if a Muslim shows up I'm sure there are things that this psychologist won't use because he doesn't know it. I think there is no specific training, as in other areas, for this.*" [**CC_P2**].

## Discussion

The main focus of this study was to understand the role of religion (religiosity) and spirituality in the field of Portuguese mental health, from the client's perspective. As such, an exploratory approach was the most appropriate.

Religion and spirituality represent key dimensions in the lives of many people around the world, including mental health clients; emphasising the positive impact these dimensions may have, for example, in obtaining more stable and long-term psychotherapeutic results.

This fact was present in our participants' discourse, who recognised and reinforced that their religious or spiritual beliefs should not be concealed or marginalised within their psychotherapeutic process, but rather could be used complementarily or even as an integral factor toward a positive and long-lasting outcome. Similar results were found in other studies (Knox et al., 2005; Mayers et al., 2007; Rose et al., 2001).

When (or if) in psychological distress, participants in this study reported turning firstly to resources within their religious community (e.g. God, religious leaders, family), rather than to mental health professionals (seen as a possible help, but often as a last alternative). This help-seeking pattern is similar to what we found previously (Freire & Moleiro, 2011), as well as in other studies with minority groups (Abe-Kim, Gong & Takeuchi, 2004; Mayers et al., 2007; Moleiro et al., 2009).

It seems that the decision to seek help, by religious people, may involve many factors, including: the positive association between religiosity/spirituality and physical and mental health; the positive impact of social support; the use of appropriate and effective coping strategies, such as prayer and meditation; positive health behaviours; as well as preconceived ideas and prejudices about the role of mental health professionals (Arveson, 2006; Baetz & Toews, 2009; Dein et al., 2010; Freire & Moleiro, 2011; Hill et al., 2000; Vogel, Wester, Wei & Boysen, 2005). It also seems that religious people seek for religious leader and mental health professional help for different reasons (Sørgaard et al., 1996), in our study being the former for religious, personal and emotional problems and the latter when problems/symptoms were/are more severe or long lasting; or when in need of pharmacotherapy (although the latter was in some cases controversial).

Also, religious and spiritual clients may firstly face a dilemma between "*self-censoring these beliefs or risking further pathologization by mental health staff*" (Mayers et al., 2007, p. 318) or in a very best scenario seeing their religious foundations ignored or *just* recognized as important dimensions in life and/or the healing process, having a minor importance to the latter. Although, this was true for our participants who presented some level of fear, dilemma and doubt (e.g. of being judged, misunderstood, mistreated), it is important to highlight that these factors did not explicitly prevent participants from seeking professional help.

Also, not all participants felt compelled to conceal their religious identity in clinical settings. In fact, of the eleven participants who reported having had experience in MHS (and

excluding four who reported having only a couple of sessions or dropped out of therapy), the three Catholic and one Jehovah's Witness clients reported feeling very comfortable in the therapeutic setting, and also very satisfied with the service provided to them.

As presented previously, only the Pagan and Evangelical clients raised concerns regarding their therapeutic process and sensibility toward their religious background; whereas the Latter-day Saints client never revealed her religious identity (for unknown reasons). Most of the concerns raised by the Pagan and Evangelical clients were: having their religiosity or spirituality *regarded* as problematic and/unhelpful to treatment; a mismatch in language regarding their religious beliefs; and having therapists who were not sensitive enough to know how to address religion or spirituality in treatment or completely ignored these dimensions. In fact, these were the main reasons for seeking another mental health professional who matched their own religious and spiritual beliefs.

This last question was raised by our participants, who reinforced the importance of mental health professionals: 1) sharing their religious beliefs or being religious; 2) knowing their religious/spirituality beliefs and practices; 3) demonstrating openness to know and understand them; 4) or yet were trained to address spiritual and religious matters in treatment. These types of fears and wishes are not unfounded, given that studies tend to indicate that: mental health professionals' personal levels of religious or spiritual commitment can be related to their religious/ spiritual goals and interventions i.e. if therapists value religion and spirituality, they might place more importance on religious/spiritual goals and use more religious/spiritual interventions (Asselt & Senstock, 2009; Kellems et al., 2010).

However, many recent studies have suggested that similarity/match (either for gender, race, ethnicity, religion or sexual orientation) between therapist and client may not relate to the accurate integration of these multicultural features or affect the outcome of therapy (e.g. Kellems et al., 2010; Knipscheer & Kleber, 2004; Worthington & Sandage, 2001); or yet negatively influence the strength of the therapeutic relationship (Kellems et al., 2010; Knox et al., 2005; Wade et al., 2007).

Somehow religious/spiritual awareness and formal knowledge may play an important role in enhancing mental health professionals' work with religious clients or those presenting religious and spiritual issues in treatment (Bartoli, 2007; Schafer, Handal, Brawer & Ubinger, 2011). In fact, these may be particularly useful, leading mental health professionals to: learn more about different religious and spiritual traditions; know how to improve (and best fit)

their language/communication when dealing with religious and spiritual concerns, and perhaps define what techniques might be most effective with their religious clients. However, these alone do not necessarily mean religiosity/spirituality is being accurately and effectively integrated. Sometimes it can be quite the opposite, since the fear of imposing own values and beliefs; the discomfort in discussing a personal and private issue, and fearing compromise of the therapeutic relationship, may inhibit mental health professionals engaging in religious and spiritual discussions (Hodson, 2008; Kellems et al., 2010; Plante, 2007).

In contrast, the lack of self-awareness, knowledge and the disparity between how much clients value religion and spiritual issues (tending to be high among these clients) and how much mental health professionals tend to value religion and spirituality (lower than clients) may also create barriers and difficulties to religious and spiritual integration. Many authors have alerted that, in these cases, mental health professionals might tend to be unaware of the importance religiosity and spirituality might have in their clients' lives and in the worst-case scenario devalue, criticise, pathologize (explicitly or implicitly), their clients' religious/spiritual beliefs and practices (Plante, 2007; Vieten et al., 2013).

In fact, the ability to sensitively work with religious clients (with all its implications) needs to be acquired and learned (Hage, Hopson, Siegel, Payton & DeFanti, 2006; Richards & Bergin, 2005; Savage & Armstrong, 2010; Schafer et al., 2011; Vieten et al., 2013). Accordingly, studies have shown that mental health professionals' religious and spiritual training can contribute to their decision to engage in the integration of religious/spiritual issues into treatment and their self-perceived competence to help a client with religious/spiritual concerns (Asselt & Senstock, 2009; Kellems et al., 2010).

Therefore, a mental health professional must, not only, become aware of this new trend of research; be able to recognise this dimension as a key factor in many people's lives; be aware of the impact their personal religious/ spiritual matters might play in therapeutic settings; but also, and more importantly acquire knowledge and practical tools for a more sensitive intervention, applicable to each client and therapeutic orientation (Baetz & Toews, 2009). This could be particularly important to Portuguese mental health professionals, since nothing (or little) has been done in this area, neither in terms of scientific research, nor as regard to mental health professionals' training and education in religion/spirituality. Consequently, an important question arises: Is there a *religiosity gap* between the expectations and experiences of religious members/clients and what Portuguese mental health

professionals can or are providing to their clients in terms of religious and spiritual matters? Particularly when it concerns to religious minorities or yet unknown faith communities?

***Limitations and Final Remarks***

Although the results of this study contribute to our knowledge on the role and importance of religiosity and spirituality on mental health in Portugal, with different religious groups' inputs, and both from religious members (potential clients) and religious clients, it is important to acknowledge that this investigation was subject to certain limitations.

Firstly, all participants in the study were invited and/or chosen by their religious leader, who also organised most of the meetings. Therefore, one limitation might be the impossibility of preventing the effect of social desirability within some groups, due to the presence of participants with different religious hierarchies (i.e. members, ministers, deacons), which might have hindered some contrary ideas being raised. Furthermore, this study was restricted to: 1) religious members who had no experience of receiving mental health treatment and 2) were having or had completed psychological treatment. It would also be interesting and valuable to have the experience of those who did not choose to seek professional and secular help due to some (perceived) barriers.

As stated before, a mixed-methods approach was chosen to conduct this study in order to explore different methods of collecting data, different sources of information and different data analysis methodologies. Ultimately, the aim was to provide a pluralistic approach to participants' perceptions on religiosity, spirituality and mental health in Portugal, rather than a single-method or yet a competitive approach between methodological paradigms – quantitative and qualitative (Hiles, 2009).

Although this pluralistic approach allowed some interpretations and conclusions to be drawn on a non-competitive basis, many assumptions underlying qualitative and exploratory approaches should be considered. Firstly, the integration of different religious communities was intentional, according to the religious diversity in Portugal, however it is important to highlight that few idiosyncrasies were analysed in this paper. Secondly, and as is well-known, a qualitative approach can be a powerful way to generate rich descriptions and in-depth explorations of a phenomenon, however this method does not allow for generalisation beyond the sample (Donmoyer, 2009). As with most in-depth qualitative studies, this sample may be considered small and obviously, the results do not represent the experiences of individuals

within the general population or even from other religious groups. Yet again, it is important to highlight that *generalisation* was not (and it is not) the primary goal of this study. Rather, the aim was to provide the reader with a focused contextualisation of the problem; participants consistent with the research design (clients and prospects) and a solid research design, so that the question: "*will knowledge of a single or limited number of cases be useful to people who operate in other, potentially different situations*?" (Donmoyer, 2009, p. 372) could be answered affirmatively.

Furthermore, this study relied primarily on people's abilities and/or willingness to express (share) and/or remember, not only their religious daily life, but also and more importantly the kind of help they once received or considered to be ideal. This *willingness* and/or *capacity* has been found problematic elsewhere (Rogler et al. 1992, as cited by Sørgaard et al., 1996). Also, this study was based on people expressing attitudes, with the well-known discrepancy between behaviour and attitude as a consequence (Sørgaard et al., 1996).

Finally, from our results and as in previous researches, it seems clear that religious members (clients and prospects), wish their religiosity/spirituality not to be concealed in a clinical context, and wish these topics discussed and integrated. However, many factors may be compromising the achievement of an optimal result. It is also true that perceiving a mental health professional as open and not judgemental to spiritual/religious issues may help clients to freely disclose and adhere more to treatment and ultimately enhance its effectiveness. Additionally, and considering the impact religious and spiritual practices have on people's lives (e.g. as an important factor for health maintenance, or as coping strategies when suffering), mental health professionals are challenged to provide the best and most appropriate care to their religious/spiritual clients.

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# Chapter 3

# Perceptions of Religious and Spiritual Leaders on Mental Health

**This chapter is based on the following published paper**

Freire, J., Moleiro, C., Rosmarin, D. H., & Freire, M. (2018). A call for collaboration: Perception of religious and spiritual leaders on mental health (A Portuguese sample). *Journal of Spirituality in Mental Health*, 1-21. https://doi.org/10.1080/19349637.2017.1423001 (**Appendix G**)

**Abstract**

Aiming to explore the perspectives of religious Leaders regarding their role in the promotion, maintenance and recovery of their congregants' mental health, eleven local religious and spiritual leaders (from 10 different religious affiliations) participated in an exploratory qualitative study, involving in-depth and semi structured interviews. The referral processes and collaborations with mental health professionals and their perceptions of mental health professionals' competencies when working with religiously diverse clients were also examined. Theme content analysis of interview transcripts was performed and an *intercoder agreement* with an independent researcher was performed and 78% of agreement was achieved. Major findings reported in this study show that, although religious Leaders perceive themselves as important agents in promoting and preserving congregants' mental health, as well as in the recovery processes, this occurs without much referral to or collaboration with mental health professionals. We discuss these findings as well as why and how a healthy collaboration between mental health professionals and religious Leaders can positively impact the psychotherapeutic relationship and clinical outcomes with religious and spiritual clients, as recommended by several professional codes of ethics and reinforced by the extant scientific literature.

***Keywords**:* Religion; Spirituality; Mental Health; Collaboration; Religious and Spiritual Leaders; Mental Health Professionals.

**Resumo**

Com o objetivo de compreender o papel dos Líderes Religiosos em Portugal, no que se refere à promoção, manutenção e restabelecimento da saúde mental de seus congregados; as suas perceções sobre as competências dos profissionais de saúde mental no trabalho com clientes religioso-espirituais, bem como os processos de encaminhamento clinico e colaborações com profissionais de saúde mental, onze Líderes Religiosos (pertencentes a 10 afiliações religiosas diferentes) participaram neste estudo exploratório. Utilizou-se o método de análise de conteúdo para analisar as transcrições das entrevistas e foi realizado um acordo interjuízes, com recurso à funcionalidade *intercoder agreement* disponível no software MAXQDA 11. O índice de concordância total alcançado foi de 78%. Os principais resultados deste estudo indicaram que, apesar de os Líderes Religiosos se percecionarem como agentes importantes na promoção, manutenção e restabelecimento da saúde mental dos congregantes, esse trabalho ocorre na maioria das vezes sem muita referência ou colaboração com profissionais de saúde mental. Estes resultados são discutidos à luz da necessidade de se compreender porquê e como uma colaboração saudável entre profissionais de saúde mental e Líderes Religiosos pode impactar positivamente a relação psicoterapêutica e os resultados clínicos com clientes religioso-espirituais, conforme recomendado por vários códigos de ética e reforçados pela literatura científica existente.

***Palavras-chave**:* Religião; Espiritualidade; Saúde Mental; Colaboração; Líderes religioso-espirituais; Profissionais de Saúde Mental.

## Introduction

Over the past few decades, research on religion, spirituality and health has gone to great lengths to understand the nature of the relationship between these three dimensions. Although caution is advised when reading and interpreting the results (Seeman, Dubin & Seeman, 2003; Sloan, Bagiella, & Powell, 1999), overall the scientific literature consistently indicates positive associations between holding and practicing religious and spiritual beliefs and improved health mental outcomes (Koenig, 2012; Mills, 2002; Powell, Shahabi, & Thoresen, 2003; Rosmarin, Wachholtz, & Ai, 2011). That is, on the whole, religious people tend to present lower rates of psychological distress, and experience and show much more positive emotions and behaviours (Baetz & Toews, 2009; Hackney & Sanders, 2003; Koenig, 2012; Rosmarin, Krumrei, & Pargament, 2010); experience a greater sense of coherence and social support (Baetz & Toews, 2009; Fallot, 1998; Koenig, 2012); show improved and helpful coping strategies when facing physical or psychological suffering (Abu-raiya & Pargament, 2014; Koenig, 2012; Mueller, Plevak & Rummans, 2001; Rosmarin, Bigda-Peyton, Öngur, Pargament, & Björgvinsson, 2013; Thuné-Boyle, Stygall, Keshtgar, Davidson, & Newman, 2011); and benefit from religious factors which can motivate, sustain, and consolidate the recovery process (Fallot, 1998; Koenig, 2004). Because of these trends, studies have indicated that those regularly attending religious services, praying or meditating, reading religious literature and the like, are less likely to suffer from psychological disorders, such as depression, suicide, and anxiety compared with non-religious individuals (Cummings & Pargament, 2010; Koenig, 2012; Mueller et al., 2001).

These associations have been linked to lifestyle habits recommended and promoted by many faith communities (Anshel & Smith, 2013; Benjamins, Ellison, Krause & Marcum 2011; Campbell, Hudson, Resnicow, Paxton & Baskin, 2007; Nelson, 2009; VandeCreek, Carl & Parker, 1998). To this end, one particularly important agent in the process of disseminating and promoting healthy lifestyle behaviours is the religious leader[1] (Anshel & Smith, 2013). Religious Leaders are often the first source of help for those seeking religious/spiritual and social care within faith communities, and thus they are also the first professional called to assist believers during times of psychological-emotional suffering (Abe-Kim, Gong, & Takeuchi, 2004; Chalfant et al., 1990; Freire, Moleiro & Rosmarin, 2016; Leavey, Loewenthal & King, 2007; Mayers, Leavey, Vallianatou & Barker, 2007; Mitchell & Baker, 2000; Neighbors, Musick & Williams, 1998; Nelson, 2009; Pickard, 2012;

Wang, Berglund & Kessler, 2003; Weaver, Flannelly, Flannelly & Oppenheimer, 2003). For this reason, in particular, these professional are often referred to as "*frontline*" or "*gate-keepers*" to mental health issues (Neighbors et al., 1998; Nelson, 2009; Weaver, 1998). Given this proximity, religious Leaders often provide pastoral counselling, involving basic psychotherapeutic strategies, such as *active listening*, general support, and empathy (Young, Griffith & Williams, 2003), as well as more formal interventions such as cognitive restructuring and problem solving (Jorm, 2000; Leavey et al., 2007; Pickard, 2012). Several studies have shown that pastoral counselling represents an important and prominent part of a religious leader's work, taking 20% or more of their working time (Moran et al., 2005; Nelson, 2009; O'Connor, 2003; Weaver, 1998; Weaver et al., 2003; Young et al., 2003). It is important to note that people often seek help from religious Leaders for mental health concerns that are accompanied by religious and spiritual struggles (Sørgaard, Sørensen, Sandanger, Ingebrigtsen & Dalgard, 1996). Conversely, mental health professionals are seldom consulted for spiritual/religious problems (Sørgaard et al., 1996).

Consequently, several studies have been conducted and models were proposed to understand and foster an active and effective collaboration between mental health professional and religious Leaders (e.g. Breuninger, Dolan, Padilla & Stanford, 2014; Janse van Rensburg, Poggenpoel, Szabo & Myburgh, 2014; Moran et al., 2005; Thomas, 2012; Wang et al., 2003; Weaver et al., 2003). These studies emphasize the importance of a healthy relationship between these professionals, aiming to not only strengthen therapeutic relationships, but also to enhance therapeutic outcomes, with the ultimate goal of achieving what should be a culturally competent and effective work with religious and spiritual clients. And this could be particularly important for the Portuguese context, considering that, as a country, Portugal is highly religious and, as a society, is quite advanced in terms of religious laws.

Portugal is a secular State; however, socially, historically and culturally, it is undeniably tied to religious beliefs and practices, especially when it comes to the relationship with Catholicism. Specifically, more than 90% of the Portuguese population believes in God, 78% of which believe in a "personal God" and 15% in a "spiritual, higher force or life force" (Menéndez, 2007). In a trans-national comparative study between eight European countries[2], Portugal appeared as: one of the most religious countries in Europe (surpassed only by Poland); the society that most trusts the Church as an institution (Menéndez, 2007; Duque, 2014) and the only country where, between 1990 and 2008, the number of individuals

claiming to belong to a religious institution and to Catholic Church in particular increased (Duque, 2014). In the last Portuguese Census, the two later percentages were even higher, stating almost 85% of the population as religious, the majority belonging to the Roman Catholic Church, 81% (INE, 2012, p. 530, **Table 1**, p. 37).

Likewise, as a society, Portugal is quite advanced in terms of religious laws, and remarkable legal steps in terms of religious protection and care have been taken over the years. This includes the regulation of the spiritual and religious care in hospitals and other establishments of the National Health Service, which guarantees that any citizen has the right to have their spiritual and religious needs understood and included when seeking health care (Law nº 253/2009). Following this Law, a brief and practical manual for the spiritual and religious care in hospital settings was developed by the Religions and Health Working Group (GTRS, 2011). This manual -*Manual de Assistência Espiritual e Religiosa Hospitalar*- aimed, not only, to draw attention to the Portuguese chaplaincy and make it more "*multicultural*", but most importantly to promote collaboration between health professionals and religious advisers. As portrayed in the introduction text of the manual: "*with this tool, health professionals have an advantage to develop a therapeutic accompaniment that is indispensable to care. Besides, everyone is aware about the therapeutic dimension of spirituality. The religious and spiritual support is essential to the healing and caring of a patient.*" (GTRS, 2011, p. 5)

However, to the best of our knowledge, there is no empirical data concerning the extent and importance of the relationship between mental health professionals and religious Leaders in Portugal. Nor there are any studies aiming to specifically understand the role the latter one plays on their congregations' mental health status. Therefore, our research aims were twofold: (1) To address the scientific gap, by reaching religious Leaders in an attempt to understand their perspectives regarding their current relationship with a mental health professional, and (2) to discuss issues related to religious member's current mental health status. Specifically, we used a qualitative methodology to understand the perspectives of religious Leaders concerning: the main religious and spiritual principles, beliefs and practices related to psychological health and well-being; their religious members' specific characteristics and needs concerning mental health; the role religious Leaders play in the promotion, maintenance and recovery of their congregants' mental health; the possible barriers religious members might encounter when seeking professional help; perceptions of

their current relationship with a mental health professional (e.g. referral and consultation practices; facilitators and/or barriers), and perceptions of the mental health professional competencies when working with religiously diverse clients.

## Method

Given the paucity of previous research among Portuguese clergy on mental health, we used an exploratory and qualitative approach to generate interview data and to understand participants' perspectives, as these methods have been recommended for research in areas where little is known (Elliott, Fischer, & Rennie, 1999). Our approach also facilitated close contact with participants, to learn about their social and material circumstances, their experiences, perspectives and histories. This interactive and developmental process allows for emergent issues to be deeply explored (Snape & Spencer, 2003).

### *Sampling and Data Collection*

Participants of this study were recruited simultaneously with another study (Freire et. al, 2016), using a purposive sampling. As such, all participants were recruited through formal contact with the corresponding religious institutions. An invitation letter was sent out, via email, to the institution headquarters requesting the participation of a Leader or Representative, followed by phone calls to ensure invitations were received. Later on, the leaders were chosen and introduced to the first author by the religious institution. Face-to-face interviews were conducted in each participant's setting of choice, most of the time in their congregants' place of worship. All participants signed informed consent forms, agreeing for instance to be quoted.

### *Participants*

A total of eleven religious/spiritual leaders from ten religious institutions were interviewed. The affiliations were the following: Portuguese Baha'i Faith Community; Portuguese Buddhist Union; Catholic Church; Lisbon Israelite Community; Portuguese Hindu Community; Jehovah's Witnesses; Latter-day Saints Church; Orthodox Church; Pagan Federation International and Seventh-day Adventist Church. Two of the participants were female and nine were male; their age ranged from 39 to 64 years old. All participants were

Portuguese, except the Catholic and Jewish Leaders who were born and raised in Cape Verde and Italy, respectively. For further demographic information, see **Table 6**.

**Table 6** - *Demographic characteristics of the participants (n=11)*

| Institution | Age | Gender | Marital status | Education | Occupation/Role |
|---|---|---|---|---|---|
| **PBF** | 51 | Female | Married | Bachelor's degree | Administrative/R&S Leader |
| **PBU** | 55 | Male | n/r | Doctorate degree | Professor/R&S Leader |
| **CC** | 43 | Female | Single | Bachelor's degree | Nun/R&S Leader |
| **LIC** | n/r | Male | Married | n/r | Rabbi |
| **PHC** | 59 | Male | Married | n/r | Businessman/R&S Leader |
| **JW** | 64 | Male | Married | Doctorate degree | Professor/Minister |
| **LDS** | 47 | Male | Married | Bachelor's degree | Pastor |
| **OC** | 59 | Male | Single | Bachelor's degree | Priest/Chaplain |
| **PFI** | 53 | Male | Civil union | Bachelor's degree | Programmer/R&S Leader |
| **SDA_1** | 39 | Male | Married | Bachelor's degree | Pastor/Chaplain |
| **SDA_2** | 47 | Male | Married | Master's degree | Pastor |

*Notes*: n/r-no records; Religious affiliations: PBF-Portuguese Baha'i Faith; PBU-Portuguese Buddhist Union; CC-Catholic Church; LIC-Lisbon Israelite Community; PHC-Portuguese Hindu Community; JW-Jehovah's Witnesses; LDS- Latter-day Saints Church; OC-Orthodox Church; PFI-Pagan Federation International and SDA-Seventh-day Adventist Church.

### *Measures*

*Interview protocol*: For the purpose of this research, a semi-structured interview protocol was developed (**Appendix H**), covering themes arising from literature review and according to the proposed goals. Participants were asked a standard set of questions; however, the interviews were susceptible to change according to the participants' responses, without compromising the course of the goals. Interviews were conducted at the religious leaders' offices or/and worship places by the first author. Interviews lasted between 18 minutes, and 2 hours and 10 minutes (**Table 7**). All interviews were audio taped and transcribed in their entirety, and are available for external analysis within their corresponding confidentiality restrictions.

*Demographic form:* After the interview, participants were asked to complete a demographic form providing some basic information on age, gender, marital or relational status, educational qualifications, employment, ethnic background and experience in mental health services.

**Table 7** - *Information about the interviews and transcriptions.*

| Institution | Duration | Pages | Codes |
|---|---|---|---|
| **PBF** | 43mins | 10 | 43 |
| **PBU** | 18mins | 4 | 44 |
| **CC** | 1h 18mins | 15 | 89 |
| **LIC** | 26mins | 6 | 34 |
| **PHC** | 28mins | 6 | 37 |
| **JW** | 41mins | 9 | 69 |
| **LDS** | 2h 06mins | 28 | 135 |
| **OC** | 1h 06mins | 19 | 74 |
| **PFI** | 47mins | 12 | 71 |
| **SDA_1** | 38mins | 10 | 91 |
| **SDA_2** | 57mins | 13 | 102 |

***Data analysis***

Prior to the thematic analyses performed using the qualitative software MAXQDA 11, all taped interviews were transcribed by a CIS-IUL intern, and afterwards transcriptions were read with their audios by the first author, to check/correct any mistakes and doubts and also to enable immersion in the data. Once transcription was completed, the first stage of thematic analyses was performed by the first author (*reflexivity*), followed by a second stage, where data was analysed by another coder (the third Co-author), using the "*intercoder agreement*"[12] available on MAXQDA 11. The final agreement result between the two coders was 78%. The findings presently reported also include the reflections, commonalities, variations and new issues that arose from this methodological approach. Similar methodological approach is described in Carey, Morgan & Oxtoby (1996) and in the previously study conducted. Furthermore, this process of data analysis assisted by software was refined with the steps recommended in Lewins & Silver (2007).

All findings were analysed by the authors, totalling eight different core themes, distributed in 32 codes and 78 sub-codes, in a total of 789 analysis units (**Table 8)**. To ensure understanding of the codes created in this study, a codebook with definitions was developed (**Appendix I**). Finally, for the purpose of results presentation, the core themes were grouped into five categories, namely: a) *the importance of religion (religiosity) and spirituality in*

[12] Further information on this topic is available on the MAXQDA-Online Manual under the section "The Agreement Testing Concept in MAXQDA".

*mental health*; b) *the experiences of congregants in the Portuguese Mental Health System*; c) *the role of religious Leaders in mental health (perceived, performed and/or assigned)*; d) *the relationship and referral to mental health professionals;* and e) *perceptions of mental health professionals' competencies when working with religious clients*. All measures, interviews, data analysis and the complete information on the coding process and results are available for external analysis within their corresponding confidentiality restrictions.

## Results

### *The Importance of Religion (Religiosity) and Spirituality in Mental Health*

Across the board, religious Leaders stated that religion, religiosity and spiritually are important dimensions to the mental health of people around the world. Religion was often referred to as a source of meaning, purpose in life and sense of belonging, as well as an opportunity to have a personal relationship with God(s) and community support, which was referred to as a "way of being in life", a "privilege" or a "gift". Notably, few negative aspects of religion were mentioned, such as guilt, feelings of oppression and misinterpretations of beliefs, which could cause mental health problems:

> *"From the Buddhist' point of view, human existence is marked by an incessant desire for happiness"* [PBU]; *"But here it is based on something that is fundamental: knowing who God is… because I cannot have faith without knowing God.*" [LDS]; "*It helps in the same way that friendly relationships do. Profound relationships, from all the celebration and rituals we have together. It creates a very strong bond between the people that participate in them.*" [PFI]; "*And of course, if someone is in a situation in which they think that depression is just a problem of lack of faith, when they see a healthcare professional, they may help this person, but he/she will always have some sense of guilt. So he/she will never feel very happy or comfortable to open up in regards to this part of his/her life*" [SDA].

The use of religious and spiritual practices, such as prayer; meditation; reading sacred literature and attending religious rituals were also reinforced, as a way to maintain and restore mental and physical health:

> *"Baha'is members should work daily on their spiritual life and pray every day; they should read the scriptures every day* [PBF]; *"We advise our church members to be balanced in their diet... The principle is: anything which creates addiction is discouraged"* [LDS]; *"One of the greatest gifts Hindu religion gave to the world was yoga, meditation, which is now known worldwide. Meditation helps us to be 100% calm and in peace, both mentally and physically* [PHC].

**Table 8 -** *Core themes and code system of the thematic analysis*

| | Codes | % |
|---|---|---|
| **Importance of religion and spirituality** | **64** | **8.1%** |
| Meaning and purpose to life | 19 | |
| Sense of community/belonging | 13 | |
| Personal relationship with God(s) | 10 | |
| As a privilege, gift and/or honour | 5 | |
| Negative side of Religion and Spirituality | 12 | |
| As a lifestyle | 5 | |
| **The role of religion and spirituality** | **123** | **15.6%** |
| General (or unspecified) role | 5 | |
| "*Turning to*" or "*relying on*" God | 40 | |
| Community support | 18 | |
| Having a different view of problem | 19 | |
| Religious beliefs and practices | 17 | |
| Conventional medicine | 18 | |
| Other strategies | 6 | |
| **Religious principles related to health and mental health** | **97** | **12,3%** |
| Mental health structures within community | 40 | |
| Human traits | 9 | |
| As protective factors | 3 | |
| Religious practices and principles | 45 | |
| **Religious view of mental health** | **27** | **3.4%** |
| Mental health with/without religion and spirituality | 23 | |
| Role of faith vs their role | 4 | |
| **Access to Mental Health Services** | **185** | **23.4%** |
| When to seek for professional help | 9 | |
| Frequency of access | 34 | |
| Examples of disorders and situations | 23 | |
| Expectations when accessing MH services | 21 | |
| The experiences of using MH services | 21 | |
| (perceived) barriers and difficulties | 77 | |

**Table 8** – *Continuation*

| | Codes | % |
|---|---|---|
| **Professional competencies** | **142** | **18.0%** |
| General professional competencies | 16 | |
| Importance of specific competencies | 17 | |
| Specific competencies | 109 | |
| **The role of religious Leaders (RL)** | **111** | **14.1%** |
| The role of RL (perceived, performed or assigned) | 95 | |
| Relationship with MH professionals | 16 | |
| **Portuguese laws and instruments** | **40** | **5.1%** |
| Importance | 18 | |
| Knowledge | 22 | |
| **Total of the coded segments** | **789** | **100%** |

### *The Experiences of Congregants in the Portuguese Mental Health System*

This topic -*religious members' experiences when accessing mental health services*- was the most coded category and it included sub-topics such as: religious members' representation in the mental health system; the most recurrent situations and problems leading them to seek for professional help; the perceived barriers and difficulties religious members might encounter, amongst others.

When asked about the frequency of access of religious members in the mental health system, religious Leaders raised the issue of their underrepresentation and presented some explanations for such phenomenon. Firstly, religious Leaders stated that this underrepresentation is due to the combination of members' use of religious and spiritual practices and other factors, such as having a more "*positive and hopeful view on life and of difficulties*" [LDS; JW], the creation of health structures and psychological support for their church members [SDA; LDS; CC], resulting in a "*more quality of life*" [JW]. However, the "*lack of knowledge*" about the intervention of mental health professionals [LIC], along with some fears, dilemmas [PBF; OC; PFI] or even preconceived ideas about therapy [LIC; OC; CC] were also viewed as reasons for this underrepresentation.

All religious Leaders mentioned the importance of religious member seeking religious and spiritual help first, when in psychological suffering. However, none of the participants discarded professional help. Yet again, religious Leaders reported the use of mental health facilities when problems or symptoms are more severe and pharmacotherapy is needed, or when the problem is long lasting, and the religious support is/was not enough:

> *"In general, practitioners of the Buddha's life, when facing difficulties, anxieties, psychological and emotional problems, seek help first with their spiritual master, in a mentor in the community"* [PBU]; "*Obviously we seek Gods' help and guidance to give us strength to face difficulties; however, we do not despise medicine's progress, so we seek help there as well*" [JW]*; "There's a part that we can play, there is a part that we cannot play, nor should we try to"* [LIC]; "*When someone is sick, he/she should look for a competent doctor and seek healing. I pray and ask God's help to get better, but also seek a competent physician to be treated*" [PBF].

Most situations, problems or causes for seeking professional help reported were: marital or family conflicts; grief and bereavement; depression, anxiety and guilt; suicide; addictions; eating disorders; physical diseases causing mental health problems (e.g. cancer), being most of these problems also frequent among their congregants.

When questioned about the possible barriers and difficulties religious members may encounter when seeking professional help, some religious Leaders considered that there are no conflicts or barriers preventing religious people from seeking professional help: "*Hinduism has no barriers, it is a completely free religion. A person does what he/she wants, so there are no barriers when seeking the help of a psychologist or psychiatrist, or any other type of professional*" [PHC], while others pointed some general concerns and barriers, for instance: religious members' fears, dilemmas and preconceived ideas about mental health diseases and interventions: "*I mean, even me as a pagan; I would be very hesitant to say something about magic to a psychologist*" [PFI]; "*I think the barriers will appear if the psychotherapist is unaware of the patient' spiritual quest, or is unaware of the worldview and principles of his/her patient. I think it wouldn't be a relationship of fulsome understanding*" [PBU].

Furthermore some issues, concerning the ability of mental health professionals to work with a religiously client, were also raised:

> "*An Adventist patient has some beliefs and values that may cause some problems if they are ignored or unknown to the mental health professional; for instance, he/she can make suggestions that will challenge the way this patient thinks. So it is not productive at all if a mental health professional doesn't identify or recognize the patient's religious identity*" [SDA]; "*I imagine a patient saying - "I felt*

*better, because in my group we made a spell to improve my health and that made me better". The professional would get this look on their face like "you poor thing, do you really believe in that? You need therapy*" [PFI].

### *The (Perceived, Performed and/or Assigned) Role of Religious Leaders*

As expected, participants in this study believed that religious Leaders play an important role in promoting and maintaining their congregants' physical and mental health, as well as in aiding the recovery process. This role is mostly related to the dissemination of religious and spiritual beliefs and practices that are ultimately linked to physical and mental health:

"*My life as a pastor has been a little bit what we call medical-missionary work, trying to help people with their issues. But more recently, we have also been working hard in the healthy eating area… well of promoting a healthy lifestyle in general*" [SDA]; "*We want our members to have the best health conduct as possible*" [LDS]; "*We promote a healthy lifestyle so that we are not only physically, but also mentally, spiritually and socially healthy*" [SDA]; "*Our commandments are basically guidelines to make a man more of a man, and a woman more of a woman, in their integrity, in their wholeness, in their fullness. Humanly speaking, but also psychologically and spiritually*" [CC].

Regarding their religious members' recovery process from psychological suffering, stress or mental health issues, participants were asked: "*In these cases, what is your role as a religious/spiritual leader?*" the reports show that participants provided essentially three different types of responses: religious support (*pastoral care*); pastoral counselling and referral or recommendations to seek professional help. Other types of non-specific support were also mentioned, but less frequently.

As such, religious Leaders in this study mentioned offering mainly spiritual and religious support, in the form of pastoral care (e.g. visitations; meditation; prayers and blessings; reading scriptures, and seeking divine guidance), but also reported the use of therapeutic strategies such as "*listening*", "*supporting*"; "*caring*" and "*advising*", that in a way also represents the role of a pastoral counsellor. However, none of the participants reported having training in this last field specifically, while only a few reported previous contact with psychology/counselling as disciplines during their academic training to become a pastor or minister.

"*When someone is sick, his/her family comes to the temple, they talk to the priest and the priest says prayers in their behalf, asking God to help this person and this family overcome difficulties… overcome diseases*" [PHC]; "*I remind them about the Buddha's' teachings*" [PBU]; "*When you have a friend who*

*is going through a hard time, you help, communicate, listen, and make her/him see things more positively*" [JW]; "*I mean, as a pastor, sometimes I have to be, in a way, a psychologist, I do not know if it is a psychologist all the way, but I know that I have to use psychology to help them*" [SDA].

Furthermore, and regarding their experience identifying and dealing with their congregants' mental health problems, participants also reported some concerns and difficulties:

*"And I also have come across people with serious mental issues, which I don't even know the name of… but we can tell that it is serious stuff, and that I wouldn't be able to do anything. I couldn't even get this person to go to a doctor".* [SDA]; "*There are cases that we see where this person needs help and sometimes we don't even have the courage to talk about it*" [CC]; "*About losing someone, for instance… a child died. If they say to me "Father, what can you do for me?", "Nothing, I can cry with you, nothing else." I always say this because it's the only thing that occurs to me, to cry with them… that's so painful. What else can I say?*" [OC]

### *Relationships to Mental Health Professionals*

Regarding the current relationship between religious Leaders and mental health professionals, the few references made to referral and recommendations to seek professional help, often occurred within religious community, as interviewees of this study reported the creation of health structures and psychological support for church members. Those reporting relationships with mental health professionals outside their faith community stated having good-to-very good relationship [LIC; SDA; LDS], while one [OC] reported explicitly having a negative experience: "*A Priest, even a Catholic one has difficulties to work in chaplaincy… sometimes I feel like a stranger. With some exceptions, of course, especially at intensive care service where there is sometimes a good reception of our work*". The majority, however, reported *no* experience regarding referral to a mental health professional. Furthermore, no references were made by the participants that they were ever invited to collaborate, as an informant or adviser, with a mental health professional working with a religious client.

Concerning the areas of conflicts with mental health professionals, the most concrete examples reported were related to homosexuality, abortion, the use of pornography and masturbation, medication and referral to marriage counselling:

"*For instance, we are not concerned with young people* [seeking professional help], *what concerns us is a psychologist who says he/she does not see any problem with pornography. That's what worries me, because it is the opposite of what we teach*" [LDS]; "*In that situation, for instance* [marital problem, with no domestic violence], *imagine that the advice is to split or get a divorce. We make so much effort*

*so that the marriage can be a victory and not a defeat… and this advice could be very practical, saying "look, there are a lot of problems, you should leave for a while", but that might not be the best solution to the problem*" [JW].

### *The Perceptions of Mental Health Professionals' Spiritual Competence*

When asked about mental health professional' competencies when working with religious and spiritual people, leaders overall perceived professionals to be skilled, open and respectful of religious diversity:

"*I believe most professionals are competent; dedicated to their patients. And we do not normally feel much prejudice*" [JW]; "*Yes, that* [openness]. *As long as they are open to get to know the person in front of them… I mean in a serious way… at least they will get the necessary information*" [PFI]; *"A good professional knows or is willing to know the religion behind a patient"* [LDS]; "*Regarding prayers… a mental health professional should be able to say "may I pray with you?" Because, somehow, a physician cures, a psychologist heals, but the best healing attracts Gods' grace... we are channels through which it can move. When we ask for His help, His grace flows better, so it is a tool that is available to any professional*" [PBF]; "*I mean we do not like to be discriminated, and usually we aren't. I also see no reason to use discrimination when faced with a mental health professional, a secular or a member of our own religion or of any other religion. We look for competent professionals, who know what they are doing and, of course, to respect our religion*" [JW]; "*I'm talking about respecting the peculiarities of a culture"* [LIC].

However, some concerns were raised regarding mental health professional's religious and cultural knowledge, training and secular values, and the importance of religious matching between professionals and patients, the use of medication, and other issues:

"*Hinduism is a religion that is unfamiliar to most people. For instance, people cannot distinguish between Hindu and Muslim or Islamist religion. This is one of the barriers I think psychologists might have*" [PHC]; "*I think that a psychotherapist who does not know Buddhism, or know at least theoretically what is supposed to happen in a meditative experience, I think will be at a disadvantage for a full understanding of the patient and therefore also for the treatment*" [PBU];

"*But also it depends on the mental health professionals' training; in case of a mental health professional who is averse to religion, certainly he/she will struggle when dealing with a religious person*" [LIC]; "*Also if this person has no training in this field. That's another challenge…. But well, that's understandable… you don't have to be trained in everything. It is hard to have the structure I have here*" [LDS];

"*It would be interesting if this person was an open person, for instance open to the practice of meditation personally. Someone who understands the principles of Buddhism and perhaps has an open view on the nature of mind*" [PBU]; "*I believe it would probably be easier for a person of a faith,*

*whatever that might be, to work with another person of faith, than an atheist or agnostic to work with a person of faith*" [LIC];

*"…specifically speaking about psychiatry… they work basically with drugs, and sometimes that's not useful if the rest of the person's life is not working. Well if you need an anti-depressant, take an anti-depressant. But if we can help* [with a religious practice] *this drug works better and instead of taking it for three years, you may end up taking it only the once*" [PFI];

"*But sometimes it worries me that the advice might be "leave religion because it makes no sense, it is fanaticism"; so this is what concerns me… that worries us*" [LDS]; "*I also think that most health professionals are so busy, always running around that, maybe, for them this would be just another thing to add to the pile "wait, now I have to read this regulation ..."* [JW]; "*There is no control* [of the work]. *You know, there are crazy people out there… opportunistic people… and professionals should be supervised… even in multidisciplinary teams in hospitals*" [OC].

Furthermore, some participants had recommendations for mental health professionals in how to improve their psychological intervention with religiously and spiritual clients:

"*Well it doesn't have to be different with a mental health professional. They should spend more time understanding the religion and spiritual connection of this patient, because that is very important to us*" [LDS];

"*A professional should know how a Jehovah's Witness, for example, thinks, see things, what is important to her/him or what is less important. This should be part of the information that helps establish the diagnosis and therapy*" [JW];

"*Health professionals should have an understanding of the patient's cultural and spiritual context. That way, they will definitely be in a better position to respect this patient's aspirations; and fully understand and correspond to this patient's expectations. That's all it takes: accept and respect their entire being, which also means their spiritual dimension, their beliefs, their deep convictions, and the practices they may enjoy having when they are, for example, hospitalized* [PBU];

"*Yes, I think that a psychologist or a psychiatrist with this dimension* [training]*… of course, I know it is not mandatory in your profession, but it would be an advantage for him/her and for patients too, of course. It would be an exceptional job… and sometimes we need support but it is so rare to find psychologists or psychiatrists who also take into account the religious part of the person*" [CC];

"*I think if they talk to Hindus, they could get to know our traditions... The most important thing is to know that patient, because we are talking about culture… religion and also know a little bit more about the patient's family* [PHC];

"*The mental health professional should be able to say "can I pray with you?" Because, somehow, a physician cures, a psychologist heals, but the best healing attracts Gods' grace...*

*we are channels through which it can move. When we ask for His help, this grace flows better, so it is a tool that is available to any mental health professional* [PBF];

"*So what we ask out of psychologists is for them to help a Mormon in a way that he/she doesn't become a drug addict* [to medication]*; because if that happens, than the problem remains*" [LDS].

## Discussion

Scientific literature recognizes the role religious Leaders play in the life of theirs congregants. In fact, the care they provide has once been called "*the ministry of the cure of souls*", referring to the acts of help aiming to heal, sustain, guide and reconcile a troubled one within a religious community (Clebsch & Jaekle, 1964, as cited by O'Connor, 2003, p. 5). As aforementioned, religious and spiritual leaders are expected to be, not only the first source of help for those seeking religious/spiritual and social care, but also, in most cases, the first professional called to assist believers in psychological-emotional distress.

In fact, in previous studies conducted with Portuguese religious members, results indicated that when (or if) in psychological distress, participants turn first to resources within their religious community, in which religious Leaders are the first contacted professional, over mental health professionals who were often seen as a possible help, but a last resort (Freire & Moleiro, 2011; Freire et al., 2016). However, to the best of our knowledge, there are no empirical studies in Portugal which have attempted to examine the perspectives of religious Leaders, regarding their engagement with mental health, mental health professionals and mental health illness.

Therefore, the overall goal of the study was to examine perceptions of Portuguese religious and spiritual leaders on mental health and the current relationship with mental health professionals. We used a qualitative methodology to inquire about: 1) the main religious and spiritual principles, beliefs and practices related to psychological health and well-being; 2) their congregants' specific characteristics and needs concerning mental health; 3) their (*perceived, performed and/or assigned*) role in the promotion, maintenance and recovery of their congregants' mental health; 4) the perceptions of their current relationship with the mental health professional and 5) their perceptions of a mental health professional competencies when working with religiously diverse clients.

Religious Leaders in this study perceived themselves as having an important role in the mental health of their congregants. In fact, this role (and its importance) was reinforced by the participants, who were aware and assumed this role and expectation and reported attending to the members' needs essentially in three different ways: religious support (pastoral care); pastoral counselling and referral or recommendations to seek professional help. Nonetheless, it is important to highlight that the interventions of religious Leaders in this study was not requested only when members were in distress, but often preventively; meaning they were also responsible for the dissemination and promotion of values and practices related to healthier lifestyle behaviours. Our results were consistent with the perspective that, in fact, religious and spiritual leaders can play an important role in providing and/or endorsing guidelines, initiatives and motivation aiming to increase health in the religious community, but also in assisting and counselling those facing psychological distresses (Anshel & Smith, 2013).

Related to this latter role of -*assistance and counselling*-, it should be highlighted that reports suggest that no participant intended to provide counselling *per se*. However, participants often reported dealing with mental health issues as an important part of their daily work and the use of strategies and techniques associated not only to pastoral counselling, but in some cases with mental health counselling. As such, participants reported assisting and counselling their congregants when dealing with distressing life events, mostly related to depressive symptoms and family problems. Yet, the precise amount of time spent in counselling care was not assessed in this study. These results are consistent with previous works (Young et al., 2003). Although it was not purposely aimed to assess the level of training and knowledge religious Leaders have on mental health/illness (i.e. mental health literacy) or yet on pastoral counselling/counselling, this study's participants admitted being untrained not only to accurately assess mental health problems, but also to provide the proper mental health care to the needs of a suffering member. Consequently, participants often reported lacking confidence and skills when dealing with issues related to psychological and mental disorders. Reports of lack of knowledge and training in mental health matters and counselling (as well as the impact thereof) were also discussed in others studies (Leavey et al., 2007; Moran et al., 2005; Pickard, 2012). This issue raises an important question, which for now still remains unclear. If religious Leaders are in fact the first professionals called to attend to people in distress in their communities, are the reported struggles (caused by the lack

of training, knowledge and confidence) delaying the recognizing the need for professional help?

Perhaps these struggles, along with the recognition of professional limitations help explain why the perception, or yet the image, of the mental health professional ability when working with religiously diverse clients was rather positive in this study. In fact, participants included in this study appear to be fully aware of the importance of proper care for mental health problems; often rejected the notions of spiritualization of mental health problems and resolution of these and also considered psychological help as a valid option. Participants were also aware of the principle and need of referral to mental health professionals and considered these crucial to the psychological well-being of their congregants. This awareness among clergy was also reported by Leavey et al. (2007).

It was also noticeable from participants' reports that they were open to dialogue and collaboration with mental health practitioners, as some in fact reported engaging in such practices in the past. However, evidence suggests that, not only most of the reports of referral occurred within their faith community (as was also reported by Moran et al., 2005), but in some cases participants seemed reluctant to refer congregants for secular psychological services. This occurred particularly in situations related to homosexuality, use of pornography and/or masturbation, abortion or marital problems, and/or when fearing that psychological constructs and interventions would contradict religious beliefs. Divergences and conflicts between religious Leaders and mental health professionals (as well as the consequences of thereof) were discussed previously by Breuninger et al. (2014), Koenig (2004). On the other hand, no references were made by the participants that they were ever invited to collaborate, as an informant or adviser, with a mental health professional working with a religious client. This was a rather surprising result, considering not only the discourse of participants throughout the interviews, but also the Portuguese cultural and religious context and the multiple legal advances occurred in the past years in Portugal.

### *Limitations and Final Remarks*

The present study is limited to the inherent characteristics of the qualitative methodology used to design, collect, analyse and discuss the data. Firstly, the recruitment process of this study was conducted simultaneously with another study, with religious members (Freire et. al, 2016); therefore, this sample may be considered small, since

participants were limited to the religious institutions that replied and accepted to participate. Furthermore, a purposive recruitment was applied, as most of the participants were nominated by their respective religious offices and/or superiors. Despite not knowing all the criteria used in the identification and selection of these religious Leaders, perhaps this was based on their knowledge and work experience in health and/or mental health. On the one hand, this could represent an advantage, in the sense that the information collected is in fact privileged, but on the other hand, biased and not representative of all religious Leaders' knowledge and experience. Therefore, the results cannot be generalized. Nonetheless, this particular limitation -representativeness and generalisation in qualitative studies- could be surpassed, with the religious and spiritual diversity represented in one study, as well as the several pertinent points raised, concerning the role and importance a healthy relationship and collaboration between religious Leaders and mental health professional might play (Janse van Rensburg et al., 2014).

By encouraging healthier relationships and collaborations with religious Leaders, mental health professionals would be better equipped to, in a more structured and professional communication, obtain different perspectives of particular faith traditions or belief systems on health and mental health. They would also have the opportunity to clarify or confirm definitions, terminology and scope of belief systems and religious practices, while providing specific information to clients and religious advisers, concerning the risk factors, symptoms, diagnoses and treatment plans (Janse van Rensburg et al., 2014). And this could also represent an opportunity to collaborate with religious advisers that are in a unique position to recognize people in distress, suffering and dealing with emotional and psychological problems (Moran et al., 2005). However, from the results it becomes clear that much more research is needed on religious and spiritual issues to better understand how mental health professionals and religious Leaders can engage in a more healthy and effective collaboration and therefore accommodate spiritual matters in psychotherapy (Leavey et al., 2007).

Considering all that has been discussed, so far, (*but not limited to*) it seems important to also bring these issues to the other part of this equation, the mental health professionals. Therefore, a subsequent multistage mixed methods study among Portuguese mental health professionals, will be presented expecting to describe how and when these professionals integrate and work (or not) with religious and spiritual issues in general and/or with their clients' religiosity and spirituality. Overall, the following topics await examination:

- mental health professionals' conceptualisations of religion (religiosity) and spirituality and the perceived role and importance in/to mental health;
- the integration of religion and spirituality in the psychotherapeutic process (knowledge, assessment and strategies);
- perceived difficulties or barriers to this integration;
- their perceptions and self-assessment of religious and spiritual competencies when working with religiously diverse clients;
- the perceived importance of specific religious and spiritual education and training.

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# THE PERSPECTIVES OF MENTAL HEALTH PROFESSIONALS

(a multistage mixed-methods design)

# Chapter 4

# Attitudes, Beliefs and Spiritual Competence among Portuguese Mental Health Professionals

**From this chapter the following paper was published:**
Freire, J., & Moleiro, C. (2017). Religious and Spiritual Competency of Mental Health Professionals in Psychological Care: Meeting Clients' Needs. In A. Thomas (Ed.), *Culture and Ethnic Diversity: How European Psychologists Can Meet the Challenges* (Chapter 16, p. 153–158). Hogrefe Publishing. http://doi.org/10.1027/00490-000 (**Appendix J**)

**And the following paper is been prepared:**
Freire, J., Moleiro, C., Matos, M. & Rosmarin, D. H. (*to be submitted*). Attitudes, Beliefs and Spiritual Competence among Mental Health Professionals: Moderated-Mediation Effects of Training and Knowledge.

**Abstract**

To understand the attitudes, beliefs and spiritual competence among MHPs, regarding the integration of religious/spiritual issues into psychotherapy, a multistage mixed-methods design was used, where three sequential studies were conducted. In the first stage, 17 mental health professionals were interviewed and the results informed/refined the instruments used in the next stage. In this cross-sectional study a total of 208 mental health professionals were surveyed, followed by a sequential explanatory study, where 6 former participants were again interviewed, aiming to explain the overall results and the preliminary analysis of the previous studies. Furthermore, explanations of two Portuguese academic specialists were included. Results indicated that participants' personal religiosity/spirituality; their attitudes toward the integration of religion/spirituality; their previous contact with these matters in their academic training and their frequency of reading scientific literature impacted their level of comfort and preparedness to engage to the integration of religion/spirituality into psychotherapy. Specifically, quantitative analyses showed that higher levels of these variables were significant predictors of higher levels of spiritual competence. These findings support the importance training and knowledge can have in the preparation of mental health professionals to sensitively deal with religious/spirituality matters in the clinical setting, while calling for attention to the impact individual features (such as personal attitudes and personal religious values and involvement) may also have in this process. Implications for practice and research are addressed on how to ethically and effectively integrate religious/spirituality matters into clinical settings.

***Keywords***: Religion; Spirituality; Mental Health; Spiritual Competence, Mixed Methods Approach.

**Resumo**

Com o objetivo de compreender as atitudes, crenças e competências espirituais dos profissionais de saúde mental no que diz respeito à integração de questões religioso-espirituais em psicoterapia, realizou-se o presente estudo empírico, com um quadro metodológico misto e desenvolvido em 3 diferentes etapas. Numa primeira etapa -*estudo qualitativo exploratório*- 17 profissionais de saúde mental foram entrevistados e os resultados informaram/refinaram o desenvolvimento dos instrumentos utilizados na etapa seguinte. Na segunda etapa -*estudo quantitativo descritivo*- 208 profissionais de saúde mental completaram um questionário online, seguido de um *estudo qualitativo explanatório*, em que 6 profissionais de saúde mental (participantes nos estudos anteriores) foram novamente entrevistados, com o principal objetivo de interpretar/explicar os resultados preliminares dos estudos anteriores. Além disso, nesta última etapa, foram também incluídas interpretações de dois especialistas académicos portugueses na área da religiosidade/espiritualidade. No geral, os resultados indicaram que as crenças religioso-espirituais dos participantes; as suas atitudes em relação à integração da religião e da espiritualidade no contexto clinico; o contato prévio com conteúdos religioso-espirituais na formação académica e o seu nível de conhecimento sobre estas temáticas têm impacto no seu nível de conforto e preparação para abordar estas temáticas na prática clinica. Mais especificamente, análises quantitativas indicaram que estas variáveis são preditores significativos de níveis mais elevados de competência espiritual. Assim, estes resultados corroboram a importância que a formação e o conhecimento adequados têm na preparação de profissionais de saúde mental para lidar sensivelmente com a religiosidade e a espiritualidade em contextos clínicos, mas realçam também o impacto que características individuais (como atitudes, crenças e envolvimento religioso-espiritual) podem também ter neste processo. Finalmente, são apresentadas implicações para prática e para a pesquisa sobre como integrar ética e eficazmente assuntos sobre religião/religiosidade e espiritualidade em contextos clínicos.

***Palavras-chave***: Religião; Espiritualidade; Saúde Mental; Competência Espiritual; Metodologia Mista.

## Introduction

Religion and spirituality can be core dimensions of a person's worldview and identity, and for many around the world, these are seen as one of the most important sources of strength and direction in their lives (Gockel, 2011; Koenig, 2012; Miller & Thoresen, 1999; Park, 2007). Overall, studies and reviews conducted over the past years have shown the existence of a strong and positive relationship between religious/spiritual beliefs and practices and better indicators of physical and psychological well-being (Koenig, 2012; Oman & Thoresen, 2005; Park, 2007; Powell, Shahabi & Thoresen, 2003).

More specifically, it seems that religious-oriented people tend to: have much less physical illness and psychological disorders (Koenig, 2012; Oman & Thoresen, 2005; Powell et al., 2003; Rosmarin, Krumrei & Pargament, 2010); have better lifestyle health behaviours (Beit-Hallahmi & Argyle, 1997; Powell et al., 2003); experience greater sense of social support, in forms of positive interactions and increased social integration (Baetz & Toews, 2009; Debnam, Holt, Clark, Roth & Southward, 2012; Nooney & Woodrum, 2002) and much more positive emotions, such as joy, hope, compassion and gratitude (Baetz & Toews, 2009; Oman & Thoresen, 2005; Rosmarin et al., 2010); have more effective ways of coping with stressful events (Nooney & Woodrum, 2002; Pargament, Ano & Wacholtz, 2005; Pargament & Raiya, 2007; Rosmarin, Bigda-Peyton, Öngur, Pargament & Björgvinsson, 2013) and some evidence suggests that patients recover faster and with better outcomes not only due to their religious/spiritual beliefs and practices (Jang & LaMendola, 2007), but also when these are taken into consideration in therapy (Aukst-Margetić & Margetić, 2005; Baetz & Toews, 2009; Curlin et al., 2007; Koenig, 2012; Smith, Bartz & Scott Richards, 2007; Wade, Worthington Jr & Vogel, 2007).

Nevertheless, is also true that religious/spiritual struggles can, sometimes, be a burden and a source of struggle for those facing stressful life events, adding another dimension to the pain and hardship of coping (Pargament et al., 2005). It is also important to highlight that this scientific field, as with any other one, is not exempt from controversy (e.g. results from King, Speck & Thomas, 1999); therefore, claims about the relationships between religion, spirituality, health and mental health should be always considered with caution (Powell et al., 2003; Sloan & Bagiella, 2002).

Less controversial is that when facing physical illness, psychological distress, suffering or stressful events in live, many patients actively turn to their religious/spiritual beliefs and practices (Freire, Moleiro & Rosmarin, 2016; Gockel, 2011); wish their religion/spirituality to be included in their psychotherapeutic process (D'souza, 2002; Freire et al., 2016; Knox, Catlin, Casper & Schlosser, 2005; Martinez, Smith & Barlow, 2007) and emphasize the importance of these dimensions have in their healing processes (Knox et al., 2005; Gockel, 2011). Although additional research is needed to reinforce this, it seems that clients also benefit when they learn how to apply their own religious/spiritual beliefs to their mental health or well-being concerns (Smith et al., 2007). Therefore, psychological interventions that facilitate client's understanding and application of ones' religious/spiritual teachings may be even more effective than other types of interventions (Martinez et al., 2007; Smith et al., 2007).

Patterson and colleagues have also suggested that clients who enter therapy with strong expectations that their therapist will be a directive expert will, not only, be more likely to form collaborative and productive bonds with the therapist during the early stage of therapy, but also these pre-treatment role expectations will positively facilitate clinical outcomes (Patterson, Anderson & Wei, 2014). Accordingly, paying attention to clients' expectations and experiences may ultimately enhance and strengthen the relational process of therapy, which consequently may also contribute to more positive therapy outcomes (Martinez et al., 2007; McLeod, 2012).

Following this, expertise (or know-how, competency or proficiency) is one of the core dimensions (if not the most important one) when incorporating religious/spiritual matters into therapy for those clients who request them or need them (Vieten & Scammell, 2015). Evidently, as behavioural scientists, any expertise must be achieved through learning and training (Gonsiorek, Richards, Pargament & McMinn, 2009) and, as stated by Miller and Thoresen, one way to achieve this is to "*provide health professionals with the knowledge, understanding, and skills to competently handle counselling*" with religious/spiritual issues (Miller & Thoresen, 1999, p. 9). As so, the promotion of multicultural sensitive competencies, specifically focused on religious/spiritual diversity, seems to be one of the most effective ways to achieve an accurate integration (Hage, Hopson, Siegel, Payton & DeFanti, 2006; Miller & Thoresen, 1999; Savage & Armstrong 2010; Sue & Sue, 2008).

However, the tumultuous relationship between religion and health sciences and particularly with mental health (Koenig, 2012), caused a conflict that persists to the present day. In fact, the separation between these two worlds was so profound that by the 19th century all terms and treatments related to religious issues were completely removed from the healthcare field (Thielman, 2009). From that moment on, religion and religious related issues were relegated only to hospital chaplains and clergy (Koenig, 2012). This created a "*border region*" where neither a mental health professional intervenes -who lacks the needed diversity training- nor does the religious/spiritual specialist -who lacks the psychological expertise- (Miller & Thoresen, 1999, p. 9). Consequently, a "*No-Man's-Land*" emerged where many times clients get lost (Wick, 1985 as cited by Miller & Thoresen, 1999).

This *no man's land* was empirically portrayed in a study conducted by Balboni and colleagues, in which participants, cancer patients, reported that their spiritual needs were minimally or not at all supported, neither by their religious community (47%), nor by the medical system (72%) (Balboni et al, 2007). And this inadequate support seems to have a great impact on the well-being of both patients and bereaved caregivers, while being also associated with higher costs at the end of life medical care, particularly among those belonging to a racial/ethnic minority (i.e. African American and Latino patients) and high religious coping patients (Balboni et al., 2011).

The times when religious/spiritual issues were complete outsider domains in the mental health field has long passed, though. There is an increasing awareness across academia and professions about the importance and impact religion and spirituality have in the lives of many patients. Still, many barriers and factors have interfered with the process of developing competency in spiritual and religious aspects for mental health professionals, leading them to often feel ill-prepared to deal with these aspects.

One of the most rooted barriers/factors is the reluctance on the part of faculties to systematically incorporate content related to religious/spiritual diversity into training for mental health professionals (Cashwell & Young, 2004; Dailey, Robertson & Gill, 2015; Hage et al., 2006; Vogel, McMinn, Peterson & Gathercoal, 2013; Wiggins, 2009). Actually -apart from pastoral counsellors- only a few mental health professionals receive formal training on how to work with religious/spiritual issues in clinical practice (Curlin et al., 2007; Dailey et al., 2015; Hage et al., 2006; Miller & Thoresen, 1999; Richards & Bergin, 2005; Rosmarin, Green, Pirutinsky & McKay, 2013; Vogel et al., 2013; Young, Wiggins-Frame & Cashwell,

2007). In fact, even among spiritually competent samples, many still indicate a desire for more training in this area (Dailey et al., 2015; Young, Cashwell, Wiggins-Frame & Belaire, 2002).

Another important barrier that may impact mental health professionals' ability to provide a sensitive service to their religious clients is that often these professionals feel uncomfortable to deal with these topics due to their own attitudes, beliefs and lack of self-awareness on how these impinge on professional practice (Wiggins, 2009). As some studies indicated, mental health professionals are measurably less religious than the general population, their clients and other health professionals (Baetz, Griffin, Bowen & Marcoux, 2004; Curlin et al., 2007; Delaney, Miller & Bisonó, 2007; Neeleman & King, 1993). Also, those holding belief systems that greatly differ from their clients' may find challenging to support certain religious/spiritual views or even may avoid addressing these aspects in therapy (Constantine, Lewis, Conner & Sanchez, 2000; Savage & Armstrong 2010; Wiggins, 2009). Even those who believe that it is important to incorporate religious/spiritual issues into clinical practice engage in these behaviours less frequently than one would expect (Frazier & Hansen, 2009; Neeleman & King, 1993; Rosmarin, Green et al., 2013).

It is unquestionable that mental health practitioners also bring their cultural perspectives and personal experiences of religion and spirituality into the clinical setting (Wiggins, 2009) and these may greatly influence therapeutic issues, such as their conceptualizations of clients' presenting concerns, the therapeutic relationship, and the choice of clinical interventions (Constantine et al., 2000; Young et al., 2002). However, it also should be unquestionable that "*whatever behavioral scientists and health care professionals may themselves believe, the spiritual side of human nature remains important to many or most clients*" (Miller & Thoresen, 1999, p. 6). Thus, the increase of self-knowledge and self-awareness of the positive and negative religious/spiritual associations and experiences (and the impact of these on professional practice) will better prepare mental health professionals to keep the focus only on clients' goals and needs, as well as in the general purpose of the psychotherapeutic process (Wiggins, 2009).

As mentioned earlier, expertise in this filed is acquired mainly through learning and training, thus the multicultural competence perspective, specifically focused on religious/spiritual diversity, seems to be one of the most effective ways to accurately promote the awareness (attitudes and beliefs), knowledge and skills needed when working with

individuals from a variety of cultural groups (as originally proposed by Sue, Arredondo & McDavis, 1992).

According to the multicultural perspective in the counselling profession, a competent (or skilled) counsellor is the one who: a) *is aware of his or her own assumptions about human behaviour, values, biases, preconceived notions, personal limitations,* and how these may impact counselling – Awareness; b) *has good knowledge and understanding of his or her own worldview, has specific knowledge of the cultural groups he or she works with, and understands socio-political influences* without negative judgments – Knowledge and c) seek to *develop and practice appropriate, relevant, and sensitive intervention strategies and skills in working with his or her culturally different clients* – Skills (Sue et al., 1992, p. 481).

Although initially the multicultural framework focused primarily on aspects related to ethnicity, race, and culture, a broader understanding of personal culture was later embraced, encompassing the term *diversity*, which "*refers to other individual, people differences including age, gender, sexual orientation,* ***religion****, physical ability or disability, and other characteristics by which someone may prefer to self-define*" (Arredondo et al., 1996, p, 44).

However, one must acknowledge that it is not necessary (or even achievable) for mental health professionals to be specialists in all range of religious/spiritual perspectives represented in one society (Plante, 2007; Gonsiorek et al., 2009; Gockel, 2011). Nor it is possible to, in one single document (i.e. Multicultural Counseling Competencies) include all the nuances associated with all the aspects of diversity. Also, being multiculturally competent does not necessarily means to have competence in all areas of diversity (Constantine, Gloria, & Ladany, 2002; Robertson, 2010). Therefore, the development of a given competency can be best described by guidelines that are specific to that specific aspect of diversity (Constantine et al., 2002).

Accordingly, a set of 14 guidelines for addressing spiritual and religious issues in counselling were developed by The Association for Spiritual, Ethical and Religious Values in Counselling[13] (ASERVIC, 2009), and later endorsed by The American Counseling Association (ACA). These competencies were developed to, firstly, help professionals understand how to address religious/spiritual issues in therapy (Dailey et al., 2015), and to be

[13]These guidelines/competencies are available here: https://www.aservic.org/resources/spiritual-competencies/

used in the context of a "*counselling that recognizes diversity and embraces approaches that support the worth, dignity, potential, and uniqueness of individuals within their historical, cultural, economic, political, and psychosocial*" (ACA, 2014, p. 20). The religious and spiritual competencies address four main domains, namely: the general knowledge of the spiritual phenomena; the awareness of one's own spiritual views and experiences; the understanding of clients' spiritual views, and the acquisitions and use of interventions and strategies that are appropriate and acceptable to a client's viewpoint (ASERVIC, 2009; Young et al., 2002).

The development of the ASERVIC' competencies represents a milestone in the history of the integration of religious/spiritual issues in counselling, as it: 1) guides professionals on how to effectively and ethically include religious and spiritual material in counselling; 2) helps them meet professionals' code of conduct to both address religious/spiritual and become competent before doing so and 3) informs educators of the material that should be included in counsellor training (Robertson, 2010). Furthermore, these competencies informed the development of the Spiritual Competency Scale (SCS – Robertson, 2010; Dailey et al., 2015), used as a valid and reliable measure of spiritual competence, and to assess professional's attitudes/beliefs toward spirituality-related matters in counselling and how they address these issues with their clients (Dailey et al., 2015).

Considering all the above presented, the development of religious and spiritual competence might, not only allow mental health professional be in a better position to recognize the types of religious/spiritual issues infused in the client's life and therapy process (healthy and/or unhealthy beliefs and practices), but also distinguish them from psychopathology (Knox et al., 2005; Hage et al., 2006; Savage & Armstrong, 2010; Vieten et al., 2013). Besides, and as mentioned before, it might strengthen the therapeutic relationship between mental health professionals and their clients, and even positively facilitate positive clinical outcomes.

This could be a particularly important step for the Portuguese mental health field (both for the research society and mental health practitioners), where little research has been done regarding religion, spirituality and mental health, so far. To be precise, much is unknown concerning (for instance) the role religion and spirituality play on the life and work of Portuguese mental health professionals; or yet, the importance and impact these dimensions have when (if) integrated into therapy. Thus, this study conducted among Portuguese Mental

Health Professionals (namely clinical psychologists, psychiatrists and psychotherapists), aims to explore and describe these professionals' current clinical practice. More specifically, it is intended to explore the mental health professionals' attitudes and beliefs, knowledge and spiritual competence when addressing religious/spiritual issues in Psychotherapy.

This has been discussed early! However, it is important to recall that the terms "*religion*" (*religiosity*) and "*spirituality*" were used interchangeably throughout this work. We acknowledge that "religion" and "spirituality" are not the same (Miller & Thoresen, 1999), although accepting that in some aspects they may overlap (Hage et al., 2006; Koenig, 2012). Also, we acknowledge that the understanding and definition of these phenomena are by nature complex, and the ambiguity could affect the interpretation of research results (Koenig, 2009). As so, and for the purposes of this chapter, *religion* is defined as an organized system of beliefs, practices, rituals and symbols related to or to facilitate closeness to the sacred or transcendent (Koenig, 2012; Koenig, George, Titus & Meador, 2004; Savage & Armstrong, 2010). Accordingly, *religiosity* relates to the set of beliefs and behaviours such as attending religious and church services, scripture reading and prayer, and involvement in religious activities, among others, associated to a specific religious institution (Fallot, 1998). *Spirituality*, on the other hand, refers to the pursuit of an understanding of meaning, purpose, and significance of life or existence in general, while emphasizing an individual experience that may or may not lead to participation in a community (Hage et al., 2006; Koenig et al., 2004). We will (continue) to use the terms "religion" and "spirituality" together (e.g. religion/spirituality; religious/spiritual; religiosity/spirituality), except when citing the results related specifically to one or domain other.

Furthermore, *attitudes* refers to the implicit and explicit perspectives (and also biases) mental health professionals may hold about religiosity and spirituality as it relates to the practice of psychotherapy; *knowledge* refers to information, facts, concepts, and awareness of research mental health professionals possess (or should possess) about religion and spirituality, while *skill/competence* refers to the ability of mental health professionals to actively and effectively utilize religion and spirituality in their clinical work with clients (as portrayed in Savage & Armstrong 2010 and Vieten & Scammell, 2015).

## Method

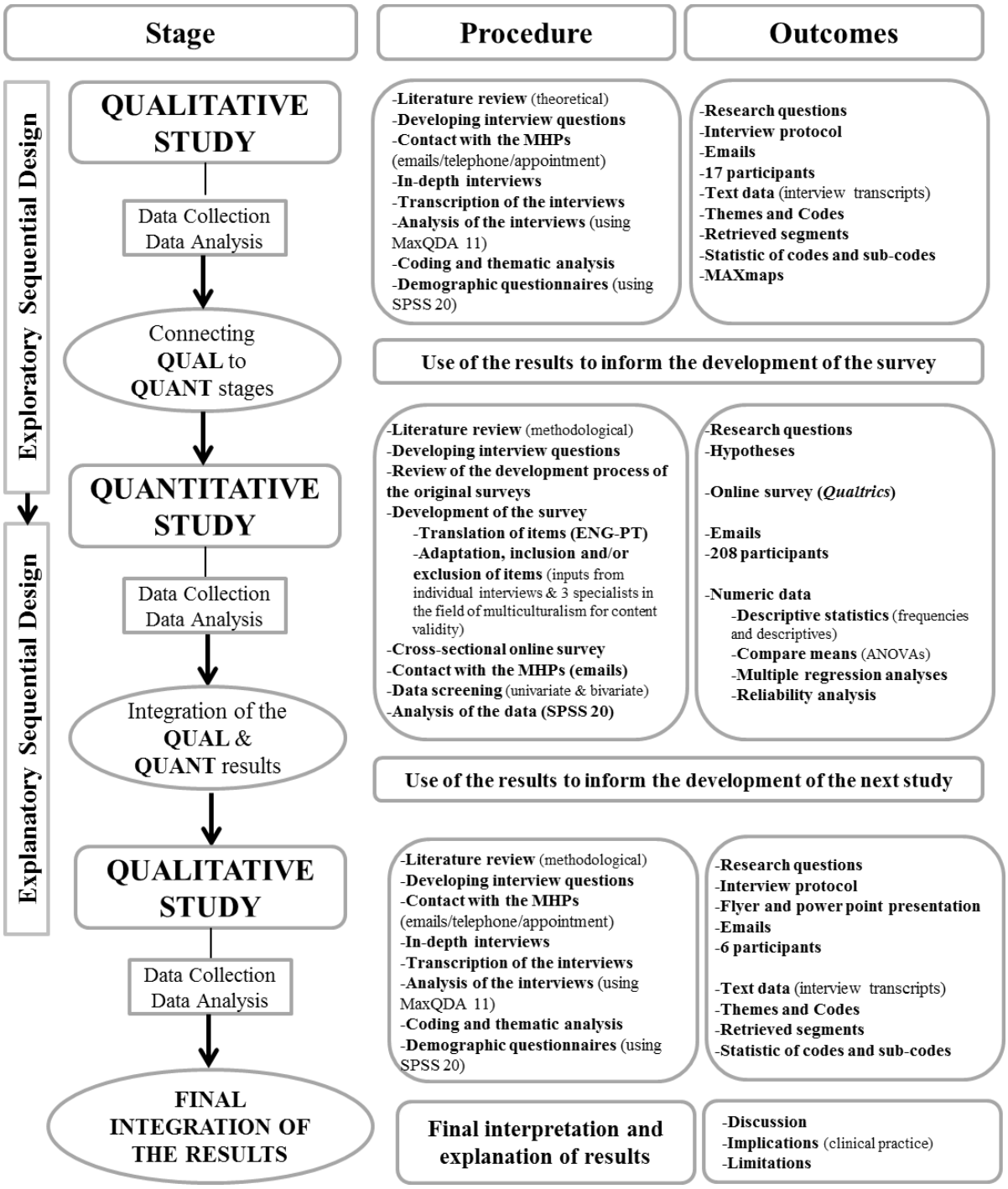
### *Study design*

For the past few years, the number of empirical studies aiming to understand mental health professionals beliefs/practices, attitudes and competency when working with religious/spiritual issues in mental health in general (particularly psychotherapy), has been increasing (e.g. Dailey et al., 2015; Magaldi-Dopman et al., 2011; Rosmarin, Green et al., 2013; Vieten et al., 2013). However, we are unaware of any previous research on this topic that -*intending to analyse the predictors of spiritual competence*- uses a sequential transformative design to approach concerns of religious diversity in clinical practice and integrates the multicultural perspective, focused on religious/spiritual diversity, as an advocacy lens.

As so, this study was developed in three sequential phases. In the first phase, a qualitative inquiry was used to explore the general perspectives of Portuguese mental health professionals about religiosity, spirituality and mental health in Portugal. In-depth individual interview was used as a method of collecting data and content analysis was performed to analyse the data (the software MAXQDA 11 was used in this stage). This study was also used to inform specific cultural and professional aspects of the Portuguese sample and refine the developmental process of the quantitative measures used in the next stage, following an *exploratory sequential design* (Fetters et al., 2013; Leech & Onwuegbuzie, 2009). An online survey, allocated in the platform *Qualtrics*, was used as a method of collecting data, which was analysed using the statistical software SPSS 20. Following this, the results and the preliminary analysis and interpretations were presented to a small group of previous participants, in an *explanatory sequential design* (Fetters et al., 2013; Ivankova, Creswell & Stick, 2006).

All methods and results in this research have equal weight; all data sets were analysed separately; the results of the first study informed the following and the mixing process was conducted, firstly after the quantitative stage and at the final data interpretation stage (Leech & Onwuegbuzie, 2009). Finally, the present study was reviewed and approved by the Ethics Committee of the Garcia de Orta Hospital (Lisbon). Further details are presented in the *Data analysis* section of each stage. The **Figure 3** portrays the diagram of this research design.

**Figure 3** - *Visual Model for the Multistage Mixed-Methods Design*




*Notes*: Graphical representation based on Ivankova et al. (2006).

### *Stage 1: Qualitative Study*

#### *Aims*

The overall goal of this stage was to explore the attitudes, beliefs and clinical practices of Portuguese mental health professionals. Expecting to describe how and when these professionals integrate and work (or not) with religion/spirituality in general and/or with their patients' religion/spirituality, the following goals were explored: 1) mental health professionals' conceptualizations of religion (religiosity) and spirituality; 2) the role and importance they attribute to these dimensions in/to mental health; 3) their general attitudes toward the integration of religion/spirituality in the psychotherapeutic process; 4) the knowledge and strategies used when working with religious or spiritual clients; 5) the perceived difficulties or barriers to this integration; and finally 6) their perceptions and self-assessment of competencies when working with religious or spiritual diverse clients.

#### *Procedures*

Between November, 2013 and January, 2014 two separate invitation emails were sent to a list of 120 email contacts of *LinkedIn* public profile of mental health professionals. Eighteen mental health professionals replied (response rate 15%). One declining the invitation; 13 participated and four did not continue the conversation. One mental health professional was invited by a college and the remaining 3 Psychologists were invited through a religious community office in Lisbon. A semi structured protocol was used to conducted the face-to-face interviews (see the section *Measures*).

#### *Participants*

Participants were 17 mental health professionals: 13 clinical psychologists, of which eight were also psychotherapists and four psychiatrists. Participants were 11 females and 6 males, aged between 26 and 57 years old. Most of them were born in Portugal (14), but some had different ethnic backgrounds (Angola and Mozambique). Concerning their theoretical training models most participants were trained in clinical and health psychology, being cognitive-behavioural and humanistic the perspectives most used in clinical practice. Although less frequently, mindfulness and existential perspectives were also mentioned, but no participant reported having specific training in religious/spiritual issues in clinical practice (**Table 9**).

**Table 9** - *Demographic Characterization of the Sample (Stage 1; n=17)*

| **Age** | | | **Country** | | **%** |
|---|---|---|---|---|---|
| Min. | | 26 | Portugal | 14 | 82 |
| Max. | | 57 | Other-Not EU | 3 | 18 |
| Mean | | 35.2 | | | |
| **Sex** | | **%** | **Mental Health Professionals** | | **%** |
| Female | 11 | 65 | Clinical Psychologist | 13 | 29 |
| Male | 6 | 35 | Psychiatrist | 4 | 24 |
| **Work context** | | **%** | **Membership status*** | | **%** |
| Public practice | 9 | 53 | Full member | 15 | 88 |
| Private practice | 13 | 76 | Trainee member | 2 | 12 |
| IPSS | 1 | 6 | Not registered | - | - |
| **Educational degree** | | **%** | **Clinical experience (in age)** | | |
| Bachelor's | 7 | 41 | Min | 3 | |
| Integrated Master's | 4 | 24 | Max | 12 | |
| Master's | 2 | 12 | Mean | 6 | |
| Doctorate | 1 | 6 | | | |
| Psychotherapy | 8 | 47 | | | |
| **Area of psychology (n=13)** | **%** | | **Theoretical orientations** | | **%** |
| Clinical/Health | 8 | 62 | | | Used often/always |
| Clinical/Cognitive | 3 | 23 | CBT** | | 16 |
| Counselling/Cognitive | 2 | 15 | Eclectic/Integrated | | 28 |
| | | | Humanistic | | 34 |
| | | | Psychodynamic/Psychoanalytic | | 9 |
| | | | Other (e.g. Mindfulness; Existential) | | 13 |

*Note*: *Membership to Portuguese Order of Psychologists and Portuguese Order of Physicians; **Cognitive behavioural therapy.

***Measures***

A semi-structured interview protocol was purposely developed for this stage, covering themes arising from literature review and in accordance with this research's goals (**Appendix K**). Questions were related to: 1) mental health professionals' personal, academic and professional background (e.g. "*I would like to ask you to tell me little about your personal story and how you became a psychologist/psychotherapist*"); 2) their conceptualizations of "religion"; "religiosity" and "spirituality" in mental health field (e.g. "*According to your personal and professional experience how would you define religion; religiosity and spirituality*?"; 3) mental health professionals' knowledge, strategies and perceived barriers when dealing with religion/spirituality in clinical practice (e.g. "*From your clinical experience how and when do these issues occur/appear?*"); 4) mental health professionals'

self-assessment of the competencies needed to accurately integrate religious/spiritual matters (e.g. "*How comfortable [or how prepared] do you feel when exploring and working on these issues?*" and 5) the importance of specific training and scientific research on religious/spiritual issues (e.g. "*How important a specific training would be for you and your clinical practice?*").

After the interview participants were also asked to complete a demographic form, providing basic demographic information, such as age, sex, ethnicity, educational qualifications, personal spirituality and religiousness. Participants signed an informed consent form, agreeing for instance to be quoted. Interviews were conducted at mental health professionals' clinical offices or at ISCTE, by the 1st author and lasted between 22 minutes and 1 hour and 25 minutes. Details are presented below.

**Table 10** - *Information about the interviews and transcriptions (Stage 1; n=17).*

| Participant | Age | Sex | Professional | Pages | Codes |
|---|---|---|---|---|---|
| **P1** | 34 | Male | Psychiatrist | 6 | 95 |
| **P2** | 31 | Male | Psychiatrist | 6 | 86 |
| **P3** | 57 | Female | Clinical Psychologist* | 10 | 134 |
| **P4** | 35 | Female | Clinical Psychologist* | 8 | 78 |
| **P5** | 27 | Female | Clinical Psychologist* | 14 | 141 |
| **P6** | 39 | Male | Psychiatrist | 11 | 103 |
| **P7** | 26 | Female | Clinical Psychologist | 8 | 83 |
| **P8** | 27 | Female | Clinical Psychologist | 15 | 149 |
| **P9** | 33 | Female | Clinical Psychologist * | 9 | 105 |
| **P10** | 32 | Male | Clinical Psychologist* | 11 | 125 |
| **P11** | 49 | Female | Clinical Psychologist | 13 | 143 |
| **P12** | 50 | Female | Clinical Psychologist | 7 | 91 |
| **P13** | 34 | Male | Clinical Psychologist* | 8 | 105 |
| **P14** | 34 | Male | Psychiatrist | 6 | 60 |
| **P15** | 31 | Female | Clinical Psychologist* | 14 | 128 |
| **P16** | 30 | Female | Clinical Psychologist* | 9 | 91 |
| **P17** | 30 | Female | Clinical Psychologist | 15 | 166 |

*Note*: *also a Psychotherapist.

***Data Analysis***

Audiotaped interviews were transcribed by a CIS-IUL intern and read with their audios by the 1st author, to check/correct mistakes and doubts and to enable immersion in the data. Two interviews were reconstructed from notes, by the 1st author, due to a recording failure. Thematic analysis was performed using the qualitative software MAXQDA 11, in which segments of the interviews were clustered into 10 core themes and 49 codes (Braun & Clarke, 2006). The interviews were analysed, firstly, per interview guide questions, resulting in 1279 units. Later, all units were again analysed, this time using the 14 competencies developed by ASERVIC (2009). From this analysis 604 units were added, most of the time in co-occurrence with previous units, totalizing 1883 units of analysis. A detailed table is presented in the "*Results*" section. All measures, interviews and results of the data analysis are available for external analysis within the limits of confidentiality.

For results presentation, the core themes were composed into five categories, namely: a) *the attitudes toward religion/spirituality (importance; role and integration into psychotherapy)*; b) *the definitions and conceptualizations of religion/spirituality*; c) *the integration of religion/spirituality into psychotherapy process (frequency, perceived barriers and difficulties and the strategies used)*; d) *mental health professionals' self-assessment of their competencies when working with religious clients.*

***Stage 2: Sequential Exploratory Study***

***Aims and Hypotheses***

The purpose of this study was to explore the predictors of spiritual competence and ultimately describe the current clinical practice regarding mental health professionals attitudes, beliefs and spiritual competence when addressing religious/spiritual issues in Psychotherapy. Therefore, a cross-sectional study was conducted and the following topics were assessed: 1) the religious/spiritual commitment of participants; 2) the importance and role attributed to religion/spirituality in mental health and clinical practice; 3) participants' level of academic contact and previous training in religious/spiritual issues and desire for further training; 4) their attitudes toward religiosity, spiritually, mental health and scientific research; 5) their level of spiritual competence and 6) the interactions between participants'

personal religiosity/spirituality, their attitudes toward religious/spiritual integration, religious/spiritual training and knowledge and spiritual competence.

More specifically, it is hypothesized that: (1) the group with higher levels of religious/spiritual commitment will have higher scores in Spiritual Competency Scale; likewise, (2) the group with more positive attitudes toward religiosity, spiritually, mental health and scientific research will also have higher scores in Spiritual Competency Scale; (3) the group with higher levels of religious/spiritual knowledge, higher frequency of contact with religious/spiritual matter in academic training and those having specific postgraduate training in religion/spirituality will report higher scores of spiritual competence. Finally, interactions between participants' personal religiosity/spirituality, their attitudes toward the integration of religion/spirituality, their training and knowledge on religious/spiritual issues and spiritual competence were also investigated.

***Procedures***

Between October, 2015 and January, 2016, a total of 1786 mental health professionals were invited to participate in the study. Firstly, an invitation-email containing the link to the online survey was sent, followed by a friendly reminder email a month later. Of all attempted e-mails, 18 (324) were returned as undeliverable; 21 (313) individuals accessed the survey available in the *Qualtrics* platform, but 81 failed to complete the survey in its entirety. Eight respondents declined to participate and 16 were excluded from the participant' pool, they failed to meeting the criteria of being a clinical psychologist and/or psychotherapist. Thus, the final sample totalled 208 participants (participation rate around 12%).

***Analytic Strategy***

A complete set of analyses was conducted using the IBM Statistical Package for the Social Sciences (SPSS) version 20. Additionally, a freely computational tool for SPSS, PROCESS (Hayes, 2012) was used. Firstly, descriptive analyses were conducted for frequencies' purpose, intending to determine the occurrences of the variables within the sample. Next, a series of variables were transformed, using the function "Compute Variables", to create new scales, sub-scales and summed scores (index). With these, reliability analyses were performed determining the Cronbach's Alpha of the scales created. Following this step, a series of univariate analyses of variance (ANOVAs), bivariate correlations, and regression analyses were performed to test the interactions between participants reported

levels of personal religiosity/spirituality; their attitudes toward religion/spirituality and mental health; previous training and knowledge in religious/spiritual issues and their level of spiritual competence. These latter analyses were conducted using the computational tool for SPSS, PROCESS (Hayes, 2012).

***Participants***

Participants of this stage were 164 women (79%) and 44 men (21%); aged between 24 to 77 years old ($M_{age}$=38.40 years old; $SD_{age}$=10.696). Most of the participants was born in Portugal (95%, n=196) and half of them were currently living in the capital city, Lisbon (54%, n=112). Regarding their academic training, 69% (n=142) had the equivalent of five years of academy training; most of them were clinical psychologists (95%, n=196) and almost half of the respondents had a postgraduate psychotherapy training (46%, n=96). In response to the question "*To what extent your clinical practice is guided by each of the following theoretical approaches?*" and in a scale of 5-point Likert (ranging from 0=nothing and 4=always), the following percentages were reported at 2 or more: humanistic=59% (n=121); CBT=58% (n=120); eclectic/integrative=55% (n=114); psychodynamic or psychoanalytical=53% (n=109) and other theoretical approaches=12% (n=25). Half of the sample reported currently working in a private setting (52%, n=103) and respondents had an average of 11 years of experience in clinical practice ($SD_{years}$= 9.023) (**Table 11**).

***Measures***

An online survey was used to collect data. The original surveys were in English (Rosmarin, Green et al., 2013 and Dailey et al., 2015), therefore a translation to Portuguese was conducted and, prior to the mail-out, the entire survey was filled and revised by three researchers in the field of multiculturalism for a face validity. Also, and following the results of the 1st stage, some adjustments were made in the content, wording and the order of some questions[14]. The final survey was composed by 56 single-items, and it included items assessing: 1) participants' demographic information, 11 items; 2) their general religious/spiritual involvement, 12 items; 3) their level of training in religious/spiritual issues and mental health, 3 items; 4) their attitudes toward religion, spiritually, mental health and scientific research, 5 items); their level of engagement into the integration of

[14]The final survey, in Portuguese language, (link and/or copy) is available upon request to the corresponding author.

religious/spiritual issues in the psychological treatment they provide, 4 items; and their level of spiritual competence, 21 items. Overall, the survey required 10-15 min to complete.

In the demographic section, participants were asked to report their personal information (such as age, sex, residence area) and information regarding their academic and clinical training (e.g. educational degree, training in psychotherapy and years of experience in clinical practice).

The following 4 sections were based on the online survey used to assess the attitudes of members of the Association for Behavioral and Cognitive Therapies (ABCT, Rosmarin, Green et al., 2013). In the 1st section, general religious/spiritual involvement, a series of questions were asked to assess the religious/spiritual commitment of the respondents (e.g. the perceived importance of religion/spirituality in their life; their religious affiliation; the frequency of their public and private religious/spiritual practices and their beliefs about God).

The 2nd section, training in religious/spiritual issues and mental health, is composed by items assessing participants' level of training in religious/spiritual issues and mental health, namely: "*How often was religious/spirituality incorporated into your clinical training?*"; "*Have you ever taken a course/workshop/training session on religion, spirituality and mental health?*" and "*How often do you read a journal article/book chapter/book related to religion or spirituality?*". In the next section, attitudes toward religion/spirituality, mental health and scientific research, participants were asked five questions, among others: "*How important do you think issues of religion/spirituality in mental health is?*" and "*Would you be interested in furthering your training in religion/spirituality?*". The last section, engagement to the integration of religion/spirituality in treatment, was composed by items aiming to assess the level of engagement to the integration of religious/spiritual issues in the treatment mental health professionals provide (e.g. "*How often are spiritual or religious issues relevant in the treatment you provide?*" and "*How often do you inquire about or assess your clients' religion or spirituality?*"). All descriptive reports are presented in the "*Results*" section.

**Table 11** - *Demographic Characterization of the Sample (Stage 2; n=208)*

| Age | | Country of Origin *(n=206)* | | % |
|---|---|---|---|---|
| Min | 24 | Portugal | 196 | 95 |
| Max | 77 | Other-Not Portugal | 10 | 5 |
| Mean | 38.40 (SD=10.696) | | | |

| Sex | | % | Type of Professional *(n=207)* | | % |
|---|---|---|---|---|---|
| Female | 164 | 79 | Clinical/Health Psychology | 196 | 95 |
| Male | 44 | 21 | Other Psychology | 7 | 3 |
| | | | Other-Not Psychology | 4 | 2 |
| | | | Psychotherapist | 96 | 46 |

| Residential Area | | % | Work context *(n=200)* | | % |
|---|---|---|---|---|---|
| North | 42 | 20 | Private practice | 103 | 52 |
| Centre | 34 | 16 | Public practice | 24 | 12 |
| Lisbon | 112 | 54 | IPSS | 25 | 13 |
| South | 15 | 7 | Public & Private Practice | 22 | 11 |
| Azores & Madeira | 5 | 3 | Other | 26 | 13 |

| Educational degree | | % | Theoretical orientations | | % |
|---|---|---|---|---|---|
| Bachelor's | 66 | 32 | | Used often/always | |
| Integrated Master's | 76 | 37 | CBT *(n=206)* | 120 | 58 |
| Master's | 37 | 18 | Eclectic/Integrated *(n=206)* | 114 | 55 |
| Doctorate and Postdoc | 23 | 11 | Humanistic *(n=206)* | 121 | 59 |
| Other | 6 | 3 | Psychodynamic *(n=207)* | 109 | 53 |
| | | | Other | 25 | 12 |

| Years of experience in clinical settings | | Membership status* | | % |
|---|---|---|---|---|
| Min | 0 | Full member | 176 | 85 |
| Max | 45 | Trainee member | 12 | 6 |
| Mean | 10.60 (SD=9.023) | Not registered | 10 | 5 |
| | | Did not mention | 10 | 5 |

*Notes*: Percentages were rounded to the nearest whole number. *Order of Psychologists and Order of physicians.

To perform statistical analyses two sub-scales were created, namely: "*mental health professionals' personal R/S*" and "*mental health professionals' attitudes toward R/S*". Methodological steps recommended by Rosmarin, Green et al. (2013) were adopted. The sub-scales were composed by summed indexes of the single-items and standardized values were used prior to entry analyses. The sub-scale "*mental health professionals' personal R/S*", measuring participants' level of religiousness and spirituality, was created using items of the section "General R/S involvement" (i.e. importance of religion; importance of spirituality; participants' belief in God; frequency of religious public religious practices and frequency of private religious practices). The resulting scale was internally consistent (α=.87). The sub-scale "*mental health professionals' attitudes toward R/S*", assessing participants' attitudes toward religion/spirituality and mental was composed by 4 items (i.e. perceived importance of religion/spirituality to mental health; perceived importance of religion/spirituality to research; perceived relevance of religion/spirituality to treatment provided; frequency of inquiry about religious/spiritual issues), and it was also internally consistent (α=.83).

Finally, and aiming to assess participants' level of spiritual competence and understand how mental health professionals perceived religion/spirituality, the revised Spiritual Competency Scale was used (Dailey et al., 2015). This validated scale is composed by 21 items (loaded onto six factors), and it is based on the 14 competencies presented by ASERVIC (2009). This scale was also internally consistent (α=.90) and the six factors had the following psychometrics results: Factor 1 (Assessment), α=.82; Factor 2 (Counsellor Self-Awareness), α=.79; Factor 3 (Diagnosis and Treatment), α=.78; Factor 4 (Human and Spiritual Development), α=.70; Factor 5: Culture and Worldview, five items, α=.77 and Factor 6: Communication, three items, α=.65. Descriptive reports of the SCS are also presented in in the "*Results*" section.

### *Stage 3: Sequential Explanatory Study*

#### *Aims*

After the two previous studies were conducted and data were analysed, the results and the preliminary analysis and interpretations were presented to a small group of previous participants, in an explanatory sequential design. Considering that the first two studies provided a general understanding of the research problem, this study was design to refine and explain the results obtained, by exploring participants' views in more depth (Ivankova et al.,

2006). Although, no explicit question was brought to the participants, some concerns lead to the development of this study: 1) the tendency to polarize "religion" and "spirituality" (being attributed a more negative connotation to religion when compared to spirituality, as well as the mental health professionals' openness toward their integration and their impact in the therapeutic process); 2) the impact of personal religiosity/spirituality in the clinical practice, along with the impact of religious/spiritual match between professional and client; 3) the low levels of engagement, preparedness and spiritual competence reported by the participants and finally 4) the importance (impact) of training and knowledge in religion/spirituality on clinical practice.

***Procedures***

Firstly, and following some methodological recommendations (Caracelli & Greene; 1993; Creswell et al., 2003; Ivankova et al., 2006), the extreme cases selection methodology was used to select participants. Accordingly, and from the pool of participants of both previous stages, 70 participants were identified (i.e. those who showed interest in participating in another study of this project **AND** provided their email address). Using a specific criterion determined by the authors[15], 14 participants were selected and invited to participate in the study. Of all attempted contacts, only two mental health professionals agreed to participate. To increase the number of participants the criteria was adjusted and the remaining participants were also invited and more three participants were interviewed.

***Participants***

Thus, the final sample included seven participants, five former participants of the 2nd study (all females) and two Portuguese academic specialists (one female and one male). The former participants were aged between 31 and 61 years old; four were clinical psychologists and one was a psychiatrist (being three also psychotherapists) and currently living in the North, Centre and Lisbon areas. Furthermore, all of them scored above the group mean on the Spiritual Competency Scale (85 to 107 points) and three within the range for spiritual competence. As for the two Portuguese academic specialists, they were interviewed aiming to enrich the interpretations of the results. They were both PhD faculty members, one in the field of "nursing and spirituality" and the other one in "psychotherapy and religious science". A

[15]Initial criteria: participants who scored 20 points (above or below) the total mean score of the Spiritual Competency Scale (SCS, Dailey et al., 2015).

semi-structured protocol was used to conduct face-to-face interviews; all of them conducted at participants' respective offices and interviews lasted approximately 45 minutes (**Table 12**).

***Measures***

Although, no explicit question was brought to the participants of this study, some general questions were presented (e.g. *"What meanings have these results for you?"*; *"To what extent do you identify with them?"*; *"Why do you think we had these results?*"). Also, a flyer with the results was purposely developed and presented to the participants. Firstly, participants were asked a general question assessing their willingness and interest to participate again in the study, followed by the presentation of the results. After participants read the results and declared they were ready to start the interview, an introductory sentence was presented to participants: "*As you could see – in the first study – we interviewed 17 mental health professionals and we explored their experience in the clinical practice regarding the integration of the religion/spirituality. The main results seem to indicate that… As so, we would like to ask you to share with us your opinion: "what meaning have these results for you?"; "to what extent do you identify with them?"; "why do you think we had these results?*"). As for the second study, the questions were the same, but the background sentence was adjusted, i.e. "*In the second study, we wanted to describe, in quantitative terms, the attitudes, beliefs and competencies of mental health professionals when working with religion/spirituality in clinical practice. We used an online survey and 208 mental health professionals participated. The results suggest that..."*. To end the interview participants were asked to complete a demographic form providing basic information on age, sex, ethnicity; educational qualifications, employment; theoretical orientations and personal spirituality and religiousness. To include the interpretations of specialists in this explanatory study, a power point presentation (ppt) was developed with more detailed information and was presented to the specialists. Although the phrasing of the questions was adjusted, the content remained the same.

**Table 12 -** *Demographic characterization of the sample of the stage 3 (n=7)*

| Participant | Age | Professional | SCS Score | Duration | Pages | Codes |
|---|---|---|---|---|---|---|
| **P1** | 37 | Clinical Psychologist | 105 | 42mins | 7 | 73 |
| **P2** | 35 | Clinical Psychologist* | 85 | 36mins | 6 | 44 |
| **P3** | 31 | Clinical Psychologist* | 93 | 1h10mins | 11 | 65 |
| **P4** | 35 | Clinical Psychologist | 107 | 41mins | 7 | 52 |
| **P5** | 61 | Psychiatrist* | 107 | 49mins | 9 | 64 |
| **Specialist_1** | Nr | Assistant Professor/Nurse | N/A | 47mins | 9 | 33 |
| **Specialist_2** | Nr | Associate Researcher* | N/A | 34mins | 6 | 45 |

*Note*: *also Psychotherapist. Nr=Not recorded; N/A=Not Applicable

***Data Analysis***

As with the first stage, all audiotaped interviews were transcribed verbatim by a CIS-IUL intern and read with their audios by the 1st author, to check/correct mistakes and doubts and to enable immersion in the data. The qualitative software MAXQDA 11 was used for data storage, coding, and theme development. Thematic analysis was performed, where segments of the interviews were analysed (per interview guide questions) and clustered into 4 core themes and 13 codes, totalizing 376 units of analysis. For results presentation, the core themes were composed into five categories, namely: 1) *polarization of religion/spirituality (and its impact on clinical practice)*; 2) *the impact of mental health professionals' personal* religiosity/spirituality *on clinical practice*; 3) *religious and spiritual competence (the low levels of engagement)*; 4) *integration of religion/spirituality into psychotherapy* and 5) *the importance of training and knowledge in religion/spirituality on clinical practice*. The specific interpretations and explanations of participants were integrated in the respective categories.

## Results

### *Stage 1: A Qualitative Study*

***Personal Religiosity and Spirituality of Mental Health Professionals***

The results of qualitative analysis and the code system created are presented in the **Table 13**. Throughout the interviews, and as portrayed in **Table 14**, participants of this 1st stage, reported higher levels of personal spirituality when compared to religiosity. Eight

participants (almost half of the sample) declared being affiliated to a religious institution (mostly to a Christian faith), however most of them reported being only moderately (or lower) religious, whereas all participants reported being moderately (or higher) spiritual. Spirituality also seems to have more importance when compared with Religion. In accordance, religious/spiritual private practices (such as private communication with God and/or, meditation, etc.) occur more frequently in comparison to religious/spiritual public practices (most of the times associated with religious institutions). Regarding participants' personal beliefs about God, only three participants reported believing in a personal God and having no doubts, while the majority reported believing in Gods or Higher Power, or never believed in God, Gods or Higher Power at all.

> "*I am a Christian. I believe in God's creation and all of that*" [**P1**]; "*I think I'm a little spiritual. I mean, I do not have a religion, but I feel that I'm spiritual.*"[**P6**]. "I do not have a religion, although I have been baptized in the Catholic religion, I have no religion, but I do not have antibodies against it also. I just do not belong to any religion in particular." [**P16**]

### *Definitions and Conceptualizations of Religion and Spirituality*

When asked to define, and conceptualize religion and spirituality, most participants could, not only define both terms as it is commonly accepted in the literature and was provided in page 9, but also conceptualize them as distinct concepts with overlapped features. Also, participants could recognize the different forms of religiosity and spirituality, where one can be "*religious and spiritual*"; "*religious, but not spiritual*"; "*spiritual, but not religious*" or "*neither religious nor spiritual*".

> "*…religiosity I think is a belief or set of beliefs that have to do with a God, or that God exists*" [**P2**]; "*…religion is a specific group that shares a particular belief system. Religion has to do with belonging… a sense of belonging or being part of a particular religious group*" [**P13**]; "*…spirituality is when we experience something greater than ourselves, and many times people may not realize that… but it is a bond or a belief in something bigger, which may not be linked to an institution or a formalized spirituality*" [**P5**]; "*Spirituality is something different from religion because someone may not have a religion and be spiritual*" [**P9**]; "*I mean, I think religion exists in some way to help structure spirituality, but meanwhile, maybe for some people, it suddenly became just a ritual and they forgot the spiritual part.*" [**P3**]

**Table 13** – *The Thematic Analysis for the Stage 1 (Core Themes and Code System)*

| | Codes | % |
|---|---|---|
| **Sample characterization** | **107** | **8** |
| Participant's R/S life/history | 9 | |
| Participant's type of profession | 16 | |
| Academic training and extra trainings | 46 | |
| Work setting | 36 | |
| **R/S Conceptualizations** | **132** | **10** |
| Religion/Religiosity | 34 | |
| Spirituality | 34 | |
| R/S as same concept | 0 | |
| R/S as distinct concepts | 17 | |
| R/S as overlapping concepts | 22 | |
| Polarization of R/S | 25 | |
| **R/S Role and Importance** | **105** | **8** |
| Positive impact/important (life and health) | 72 | |
| Negative impact/unimportant (life and health) | 24 | |
| In therapy | 9 | |
| **Integration of R/S in clinical practice** | **579** | **45** |
| General perspectives about the integration of R/S in mental health | 67 | |
| Influence of mental health professionals' personal R/S in clinical practice | 78 | |
| Influence of R/S match between mental health professional and client | 13 | |
| Barriers/difficulties to the integration | 54 | |
| Are R/S being integrated in clinical practice? | 367 | |
| Frequency? | 64 | |
| How? When? Why? By whom? | 303 | |
| **Experiences of integration of R/S** | **146** | **11** |
| Reports of successful integration | 21 | |
| Reports of unsuccessful integration | 12 | |
| What helped? And what hampered? | 61 | |
| Considered or used R/S practices as therapeutic strategies | 52 | |
| **Mental Health Professional' Self-assessment on the integration of R/S** | **39** | **3** |
| How prepared they feel when addressing R/S issues? | 18 | |
| How comfortable they feel when addressing R/S issues? | 21 | |

**Table 13 -** *(continuation)*

| | Codes | % |
|---|---|---|
| **Mental Health Professionals' Education/Training/Supervision** | **124** | **10** |
| Training in multicultural issues (Yes = 6; No = 6) | 12 | |
| Training in R/S issues (Yes = 7; No = 11) | 18 | |
| Lack of academic training | 17 | |
| Importance of religious/spiritual training | 21 | |
| Resources professionals use to effectively address R/S matters | 56 | |
| Never needed help | 2 | |
| Religious sources (literature; R/S members or Leaders) | 15 | |
| Literature research | 34 | |
| Supervision/Intervision | 5 | |
| **Importance of research on R/S** | **22** | **2** |
| **Portuguese laws and instruments** | **25** | **2** |
| Knowledge (Yes = 2; No = 6) | 8 | |
| Openness | 4 | |
| Importance (Important = 10; Not important = 3) | 13 | |
| **Total units of analysis** (without ASERVIC's Competencies codes) | **1279** | **100** |
| **ASERVIC's Competencies** | **604** | |
| Competence 1-Definition of R/S | 108 | |
| Competence 2-Awareness of clients' R/S | 64 | |
| Competence 3-Exploration of personal R/S | 20 | |
| Competence 4-Evaluation of personal R/S | 49 | |
| Competence 5-Recognition of self-limitations | 24 | |
| Competence 6-Description and application of R/S models | 1 | |
| Competence 7-Respondes to client R/S communications | 45 | |
| Competence 8-Use of R/S concepts | 15 | |
| Competence 9-Recognition of R/S in client's communication | 31 | |
| Competence 10-Gathering of R/S information | 16 | |
| Competence 11-Recognition of R/S as a multi factor | 80 | |
| Competence 12-Setting goals in consistency with client R/S | 13 | |
| Competence 13-Specific skills | 50 | |
| Competence 14-Application of theory and research in clinical practice | 6 | |
| Lack of competence* | 82 | |
| **Total units of analysis** | **1883** | |

*Note*: The code "Lack of competence" was later divided into 14 sub-codes, in accordance with the 14 competencies of ASERVIC (2009).

**Table 14 -** *Religious and Spiritual Characterization of the Sample (Stage 1; n=17)*

| **How religious?** | | **%** | **How spiritual?** | | **%** |
|---|---|---|---|---|---|
| Nothing | 5 | 29 | Nothing | - | - |
| Little | 3 | 18 | Little | - | - |
| Moderately | 6 | 35 | Moderately | 5 | 29 |
| Very | 3 | 18 | Very | 6 | 35 |
| Completely | - | - | Completely | 6 | 35 |
| **Religion: Importance** | | **%** | **Spirituality: Importance** | | **%** |
| Nothing | 4 | 24 | Nothing | - | - |
| Little | 4 | 24 | Little | - | - |
| Moderately | 2 | 12 | Moderately | 4 | 24 |
| Very | 4 | 24 | Very | 7 | 41 |
| Completely | 3 | 18 | Completely | 6 | 35 |
| **Religion: Institution** | | **%** | **Beliefs about God** | | **%** |
| 7th Day Adventist | 3 | 17.5 | I believe (no doubts) | 3 | 18 |
| Agnostic | 2 | 12 | I believe (with doubts) | 1 | 6 |
| Buddhist | 1 | 6 | I believe (Some of the time) | 1 | 6 |
| Catholic | 3 | 17.5 | I believe in a Higher Power | 7 | 41 |
| *Espirita* | 1 | 6 | I don't know | 3 | 18 |
| No religion | 7 | 41 | I don't believe in God. | 2 | 12 |
| **R/S public practice*** | | | **R/S private practice*** | | |
| Never/rarely | | 64 | Never/rarely | | 58 |
| Up to twice a week | | 24 | Up to twice a week | | 18 |
| Up to once a day | | 12 | Up to once a day | | 24 |

*Note*: Percentages were rounded to the nearest whole number. *Frequency during last year.

Participants also demonstrated a tendency to polarize religion and spirituality in this matter. Religion and/or religiosity were often seen more negatively (or having more negative impact) than spirituality, leading them to demonstrate more openness toward spiritual integration. In some cases, this tendency was influenced by participants' personal views and religious/spiritual experiences.

> "*…regarding spirituality, I really see it as having a positive impact. I have more difficulties seeing it as something negative… But in fact, I think in this case*[16] *I would probably be prejudicial, as I would be with the Jehovah's Witnesses and this feeling I have that they must knock on peoples' door, which I think is a very personal and harmful thing… and constantly hear "leave me alone, I don't want to hear." This is a terrible thing. Maybe is harder for me to show empathy with this patient's religion*" [**P3**]; "*I*

[16]Participant referring to Western Wall or Wailing Wall in Jerusalem;

*have more difficulties in seeing spirituality's negative side… how can it have a more disadvantageous side? I cannot conceive that way. But religion, yes*" [**P5**]; "*I would almost dare to say that religion is spirituality with dogma and spirituality is a dimension in its purest state.*" [**P11**]

### *Attitudes toward Importance and Role of Religion and Spirituality*

Results for this stage showed that the sample have positive attitudes toward religion/spirituality. In fact, participants not only recognized religion/spirituality as important dimensions in the everyday life of their clients (e.g. providing a sense of meaning, purpose, belonging and social support; used as positive coping strategies), but also often considered these dimensions as having a positive impact on clients' mental health status, therapeutic process and in some cases on recovery outcomes. Even though less frequently, negative impact of religion/spirituality were also reported (24 units out of 105). Most of these references were associated to religion and religious experiences, mostly related to some psychopathologies, feelings of guilt and shame or depression.

"*…I believe my work is very focused on acquiring some personal spirituality and helping others acquiring it too, because I think this is, and answering your question, very important to well-being*" [**P2**]; "*…I think probably a person becomes more resilient, because somehow it [religion] helps you cope better with suffering, because it gives you a meaning that eventually helps you go through live with more tranquillity or at least there is potential to experience thing with more tranquillity*" [**P3**]; "*Some people who already have a mental disorder, read bible and instead of getting better they become even sicker, because they lose the ability of understanding what is writing. They take it literally and sometimes this is worse for their mental health.*" [**P4**]

### *Integration of Religion and Spirituality into Psychotherapy*

Participants of this study reported openness and often (*if not always*) stated they would "*feel comfortable*" discussing religious/spiritual issues with their clients. Yet, when asked "*How often do you usually address issues related to religion (religiosity) and spirituality when conceptualizing your psychotherapeutic cases?*" many participants reported having *integrated* religion/spirituality only a few times or rarely, while some of them explicitly stated: "*No, no, not at all*"; "*Spirituality, with that name? No*" or "Do y*ou mean professionally? In the professional relationship, never*". This was mostly due to their self-perceived lack of knowledge and training or yet because participants expected clients to be the ones bringing up religious/spiritual issues. Therefore, participants reported "*felling prepared*" less frequently when deciding to engage to the integration of religion/spirituality

compared to "*feeling comfortable*". Also, participants reinforced the need for specific training, both for multicultural issues in general or particularly in religious/spiritual matters.

> "*But yes… only few people talked me directly about religion*" [**P15**]; "*I cannot say it was very often*" [**P16**]; "*I feel quite comfortable… prepared… I think I have some lack of knowledge. To work a religious crisis, for example, or a technical matter in which religion is not a protective factor... because I think it's easier for me to be prepared to work if it is protective factor. If it is positive, I support it 100%, so let's keep it... If you live it with anxiety and stress, then it is harder for me if I don't know [this religion]. I mean, I feel prepared if it is something I know… that I know minimally or have resources*" [**P5**]; "*Currently, in our academic curriculum there is nothing regarding these issues, there is no kind of training*" [**P4**]; "*If you ask me if I feel prepared to potentiate it, no I don't. I would need... is not uncomfortable, but to potentiate it I would need specific training in this area*" [**P9**].

Another important aspect influencing the decision to engage to the integration of religious/spiritual issues into psychotherapy seems to be mental health professionals' personal religious/spiritual experience. In fact, many participants stated they would feel more comfortable and/or prepared to work with religious/spiritual matters when: a) their own religious/spiritual issues are resolved; b) there is a religious/spiritual match with a client; or at least when c) they are familiarized or have knowledge about the specific religion or spiritual faith.

> "*I think sometimes it has some potential, other times, and especially when it also touches us and our barriers or struggles, for instance when I don't like certain things in that religion, it can be problematic… For me it's hard to understand that [JW missionary work] … it is almost an incentive to be mistreated and that's hard for me. In these situations, it is harder to me to be empathically with this patient's religion.*" [**P3**]; "*It is very useful and it is always present [*religion/spirituality*], but it is not always easy to work with it, because sometimes I happen to be going through my own doubts or at a moment of great questioning about a particular experience I lived or also with my patients...*" [**P7**]; "*With religion I feel comfortable… very comfortable indeed, mostly because of my own religious practice [Buddhism], and this helps me deal with this issue in clinical practice. I don't impose my visions, but I do not remove them from the relationship as well. I think in this relationship [with clients] we must be authentic and if we disagree with something, well, we must accept it, we cannot just hide it or run from it.*"[**P17**]

### *Integration of Religion and Spirituality as Therapeutic Strategies*

When reporting the integration of religion/spirituality, participants seemed divided in their use of religion/spirituality as therapeutic intervention or the strategies used. In other words, when asked "*How*" and "*When*" religion/spirituality were integrated, participants reported some strategies (e.g. questioning at intake clients' religious commitment; supporting

and/or encouraging religious practice; praying for/with clients; using relaxation techniques). Furthermore, most participants regarded spiritual or religious development as one form of psychotherapy, rather than an explicit therapeutic technique.

> "*…this work more connected to spirituality, is often not explicit, as I said, is almost inherent to my work… I do not say «now we are going work to gain greater spirituality». It doesn't come up that way*" [**P2**]; *"Spirituality, with this name, I don't work, unless the client also brings it…. I think, somehow, the therapeutic process is also a work of personal achievement, personal development, so I think we'll be always working with spiritual matters, but not necessarily calling it spirituality"* [**P3**]; *"I usually don't ask if this person is religious, I think this is a personal matter. But of course, I try to understand a little bit in the clinical history, how and when the symptoms appeared and I also try to understand this patient' personality before getting sick"* [**P13**]. "*It is possible to talk about spirituality without mentioning it one single time. We are talking about the lives of real people, and it appears all the time*" [**P17**].

***Religious and Spiritual Competence***

This section was not explicitly included in the interview protocol, however after the first round of thematic analysis it was possible to assess participants' level of religious/spiritual competence when engaging to the integration of religious/spiritual issues in psychotherapy, in accordance with the 14 competencies of ASERVIC (2009).

As so, it was possible to note that participants of this stage appear to have acquired competencies related to the awareness of clients' religiosity/spirituality and the impact their own attitudes, beliefs, and values about religion/spirituality have on psychotherapeutic process. Most participants recognize "*that the client's beliefs (or absence of beliefs) about spirituality and/or religion are central to his or her worldview and can influence psychosocial functioning*" (**Competence 2**); are aware of the need to actively explore own religiosity/spirituality (**Competence 3**); seem to understand "*the influence of his or her own spiritual and/or religious beliefs and values on the client and the counseling process*" (**Competence 4**); are aware of the personal and professional limits and seems to be acquainted with resources for consultation (individual research, supervision or religious resources) and are, if needed, open to refer a client to a more competent professional (**Competence 5**). It also seems consensual between participants that, to fully understand a client perspective and accurately make a diagnosis, religion/spirituality must be regarded as multidimensional factor, contributing to enhance client's well-being, problems or yet to exacerbate symptoms (**Competence 11**).

Although being one of the most categorized codes, the **first competence** (definition of religion/spirituality) seems to be acquired only partly. Reports indicate that participants can conceptually *"describe the similarities and differences between spirituality and religion*". However, most of them reports regarding the second part show a lack basic knowledge about the beliefs of various spiritual systems, major world religions, as participants reported feeling more comfortable to deal competently with Catholicism or system of beliefs similar to their own.

Similarly, and even though most participants recognize religious/spiritual issues were not addressed or integrated explicitly throughout their clinical experience, nor were introduced by them, they seem to be aware of the need to respond "*to client communications about spirituality and/or religion with acceptance and sensitivity*" (**Competence 7**), as well as being able to recognize religious/spiritual themes in a client communication and respond to these when therapeutically relevant (**Competence 9**). However, fewer references were made to **Competence 8**, which is related to professional ability to use religious/spiritual "*concepts that are consistent with the client's spiritual and/or religious perspectives and that are acceptable to the client*".

Few segments were also categorized as **Competence 10**, regarding participants' ability to, at the intake and assessment processes; gather clients' religious/spiritual information. In most cases this is due to mental health professionals' clinical practice of waiting for clients to initiate conversations about religion/spirituality or using "*clues*" from the communication of the clients to address these issues. Other reports seem to indicate, that participants' theoretical orientation (e.g. psychodynamic or psychoanalytic) also influences the assessment competence, as no questions or directions are imposed to clients during therapeutic sessions. Another competence that was also categorized a few times was the **Competence 12** (setting goals in consistency with a client' religion/spirituality). However, the few references made to this competence seem to indicate, that participants are aware of the need to set "*goals with the client that are consistent with the client's spiritual and/or religious perspectives*".

One of the most controversial competence appears to be the **Competence 13** ("*The professional counselor is able to a) modify therapeutic techniques to include a client's spiritual and/or religious perspectives, and b) utilize spiritual and/or religious practices as techniques when appropriate and acceptable to a client's viewpoint.*"). In fact, this competence was one of the two competencies to be present in the discourse of all participants

(as was the first competence). The controversial side of this competence is most related to the item b. In one hand, it seems to be consensual among participants that the therapeutic strategies should be modified and acceptable to clients' perspectives, including religious and spiritual. However, when it concerns to the utilization of religious/spiritual practices as techniques, participants seem to have more questions and doubts.

Throughout the interviews and specifically when participants were asked: "*To what extent would you consider using religious-spiritual practices (e.g., meditation, pray silently or out loud, reading sacred scriptures, etc.) as strategies in the clinical context?*", it was possible to note some resistances among participants concerning praying and reading religious/spiritual literature, while no negative responses were reported for practices associated with meditation (e.g. relaxation or mindfulness). As so, participants reported the willingness to: a) attend or follow clients' desire to pray, read religious/spiritual literature and/or meditate; b) encourage or validate clients to engage in religious/spiritual practices, but as mental health professionals, they would only engage personally in such practices if they were familiar to them; c) encourage or validate clients to engage in religious/spiritual practices, but as mental health professionals, they would not engage personally in these practices. Finally, some participants reported they would not use or promote explicit religious/spiritual practices, such as prayer or religious/spiritual readings, mostly due to the lack of training or knowledge, but also because these as are consider to be personal matters of a client and/or yet outside the field of psychotherapy.

The remaining two competencies (**Competence 6** and **14**) were the two least categorized codes. Although, some participants recognized religion, religiosity and spirituality as developmental dimensions on human life no models or theories were mentioned or introduced in the interviews.

### *Stage 2: A Sequential Exploratory Study*

#### *Personal Religiosity and Spirituality of Mental Health Professionals*

As with the results of the Stage 1, participants of this study reported higher levels of personal spirituality when compared to religiosity. More than half of the sample (55%; n=114) declared affiliation to a religious institution, mostly to Christian faith (n=103). Of those, 89% reported belonging to Catholic Church (n=92). However, only 37% (n=77) of the participants reported being more than moderately religious. By contrast, 72% (n=149)

participants reported being moderately (or higher) spiritual. Spirituality also seems to have more importance for this sample when compared to Religion, as less than 40% (n=79) considered religion to have more than moderate importance in their life, by comparison with the 70% (n=146) who considered spirituality to be moderately (or higher) important (**Table 15)**. The difference between endorsed levels of spirituality versus religiosity in this sample was significant $t_{(207)}$=10.667, $p$<.000, as well as with the importance given to these dimensions $t_{(207)}$=11.206, $p$<.000. However, these items were moderately correlated ($r$=.41, $p$=.01) and ($r$=.45, $p$=.01), respectively.

**Table 15** - *Religious/Spiritual Characterization of the Sample (Stage 2; n=208)*

| **How religious?** | | **%** | **How spiritual?** | | **%** |
|---|---|---|---|---|---|
| Not at all | 77 | 37 | Not at all | 17 | 8 |
| Slightly | 54 | 26 | Slightly | 42 | 20 |
| Moderately | 58 | 28 | Moderately | 77 | 37 |
| Very | 16 | 8 | Very | 59 | 29 |
| Completely | 3 | 1 | Completely | 13 | 6 |
| **Religion: Importance** | | **%** | **Spirituality: Importance** | | **%** |
| Not at all | 77 | 37 | Not at all | 17 | 8 |
| All most unimportant | 8 | 4 | All most unimportant | 4 | 2 |
| Of little importance | 44 | 21 | Of little importance | 41 | 20 |
| Moderately | 35 | 17 | Moderately | 46 | 22 |
| Important | 26 | 12 | Important | 45 | 22 |
| Very important | 18 | 9 | Very important | 55 | 26 |
| **Religion: Institution** | | **%** | **R/S public practice * *(n=100)*** | | **%** |
| Christian | 103 | 59 | Never/rarely | 76 | 76 |
| Catholic Church | 92 | | Up to twice a week | 24 | 24 |
| Other Not Catholic | 5 | | Up to once a day or more | - | - |
| Did not mention | 6 | | | | |
| Other NOT Christian | 3 | 2 | **R/S private practice * *(n=168)*** | | % |
| No religion | 62 | 35 | Never/rarely | 64 | 38 |
| Other religion | 8 | 5 | Up to twice a week | 56 | 33 |
| Did not mention** | 32 | - | Up to once a day or more | 48 | 29 |

| **Beliefs about God** | | **%** |
|---|---|---|
| I never believed in God (Gods or Higher Power). | 32 | 17 |
| I don't know whether there is a God, and I don't believe there is any way to find out. | 21 | 11 |
| I don't believe in a personal God, but I do believe in a Higher Power of some kind. | 58 | 32 |
| I find myself believing in God some of the time, but not at others. | 8 | 4 |
| While I have some doubts, I do believe in God. | 32 | 17 |
| I know that God exists and I have no doubts about it. | 33 | 18 |
| None of the statements presented** | 24 | - |

*Notes*: Percentages were rounded to the nearest whole number. *Frequency during last year. **For statistical analyses these values were coded as "*Missing*".

Private religious/spiritual practices (such as private communication with God and/or, meditation, etc.) were also endorsed to a higher extent than public religious/spiritual practices (such as religious services attendance). Of the 208 participants, only 100 answered the item "*During the past year, how often did you participate in religious services at a place of worship?*". Of those, 76% (n=76) reported "*rarely* or *never*" attending religious services, whereas the remaining 24% (n=24) of respondents reported attending religious services no more than twice a week. In contrast, 168 participants answered the item "*During the past year, how often have you prayed, meditated or communicated with God in any way?*". Of those, 38% (n=64) reported praying, meditating or communicating with God "*rarely* or *never*", while 62% (n=194) reported up to daily private religious/spiritual practices (or greater). Similarly, the difference between these two types of religious/spiritual practices was significant in the sample $t_{(99)}$=10.667, $p$<.000, and again these were found to be moderately correlated ($r$=.47, $p$=.01). Concerning participants' personal beliefs about God, 67% (n=123) of the respondents reported certain beliefs, being "*I don't believe in a personal God, but I do believe in a Higher Power*" endorsed by 32% (n=58); "*I know that God really exists and I have no doubts about it*" endorsed by 18% (n=33), and "*I never believed in God (Gods or Higher Power)*" by 17% (n=32). The remaining 33% (n=61) of the participants reported believing, but with doubts.

***Training in Religious/Spiritual Issues and Mental Health***

Of the 205 participants who answered to the item "*How often was religious/spirituality incorporated into your academic and clinical training?*", 76% (n=155) reported that religious/spiritual topics were incorporated "*never* or *rarely*". An even greater percentage of participants (82%; n=170) reported never attended a specific course, workshop or training in religious/spiritual matters. Concerning participants' reading habits (n=177), 45% (n=79) reported reading scientific journal articles, books, or chapters related to religion/spirituality, "*Sometimes*" (or more). These reports are described in **Table 16**.

**Table 16 -** *Training in R/S Issues and Mental Health of the Sample (Stage 2; n=208)*

| How often was R/S incorporated into your clinical training? *(n=205)* | | | % |
|---|---|---|---|
| | Never | 60 | 29 |
| | Rarely | 95 | 46 |
| | Sometimes | 36 | 18 |
| | Often | 14 | 7 |
| Have you ever taken a course/workshop/training session on R/S? | | | |
| | No | 170 | 82 |
| | Yes | 38 | 18 |
| How often do you read scientific literature about R/S and mental health? *(n=177)* | | | |
| | Never | 51 | 29 |
| | Rarely | 47 | 27 |
| | Sometimes | 57 | 32 |
| | Often | 21 | 12 |
| | Always | 1 | <1 |

*Note*: Percentages were rounded to the nearest whole number.

***Attitudes toward the Importance and Role of Religion and Spirituality***

All frequencies of the items used to assess participants' attitudes toward the integration of religious and spiritual dimensions into mental health, research and clinical practice are presented in **Table 17**. Reports showed that most participants consider religion/spirituality to have moderate (or greater) importance to mental health and clinical psychology. Specifically, more than 65% of the participants considered religion/spirituality to be "*Very*" to "*Completely*" important to mental health (66%) and to clinical psychology (67%). Similarly, 68% of the participants agreed (whether *partly* or *strongly*) that "*a separate course on religion/spirituality should be incorporated into psychologists/mental health professionals training programs*". Furthermore, almost 75% participants (n=150) showed interest in furthering their religious/spiritual training. However, a disparity was noted regarding how much participants valued religion/spirituality in the treatment they provided. Although 72% (n=149) of participants considered religion/spirituality to be relevant in some way, only 28% (n=58) considered it be more than "*Sometimes*" relevant. The percentage of those who considered religion/spirituality to have little or no relevance was also 28% (n=58). Likewise, the percentage of those systematically inquiring or explicitly assessing their clients' religiosity/spirituality was rather low, as only 25% reported doing so more than "*Sometimes*" ("*Often*" =18%, n=37 and "*Always*" =7%, n=14). The percentage of those who *never* or *rarely* inquire about religious/spiritual issues in treatment was 45% (n=93).

**Table 17** - *Attitudes toward Religion/Spirituality, Mental Health, Treatment and Scientific Research of the Sample (Stage 2; N=208)*

| Question | Not at all | | Slightly | | Moderately | | Very | | Completely | |
|---|---|---|---|---|---|---|---|---|---|---|
| | *n* | *(%)* | *n* | *(%)* | *n* | *(%)* | *n* | *(%)* | *n* | *(%)* |
| How important do you think issues of R/S in mental health is? | 4 | (2) | 11 | (5) | 56 | (27) | 69 | (33) | 68 | (33) |
| How important do you think research on religious/spiritual issues is to clinical psychology? | 5 | (2) | 13 | (6) | 50 | (24) | 69 | (33) | 71 | (34) |

| | Def. Not | | Prob. Not | | Probably | | Very Prob. | | Def. Yes | |
|---|---|---|---|---|---|---|---|---|---|---|
| | *n* | *(%)* | *n* | *(%)* | *n* | *(%)* | *n* | *(%)* | *n* | *(%)* |
| Would you be interested in furthering your training in religion/spirituality? (n=206) | 8 | (4) | 44 | (22) | 73 | (36) | 47 | (23) | 30 | (15) |
| Would you include R/S as a specialty or personal attribute on your professional card, etc.? (n=206) | 75 | (37) | 82 | (41) | 26 | (13) | 14 | (7) | 5 | (2) |

| | St. Disagree | | Disagree | | Pt. Disagree | | Pt. Agree | | Agree | | St. Agree | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *n* | *(%)* | *n* | *(%)* | *n* | *(%)* | *n* | *(%)* | *n* | *(%)* | *n* | *(%)* |
| Do you think a separate course on R/S should be incorporated into psychologists/mental health professionals training programs? (n=206) | 7 | (3) | 37 | (18) | 22 | (11) | 66 | (33) | 52 | (26) | 18 | (9) |

| | Never | | Rarely | | Sometimes | | Often | | Always | |
|---|---|---|---|---|---|---|---|---|---|---|
| | *n* | *(%)* | *n* | *(%)* | *n* | *(%)* | *n* | *(%)* | *n* | *(%)* |
| How often are religious/spiritual issues relevant in the treatment you provide? (n=207) | 15 | (7) | 43 | (21) | 91 | (44) | 52 | (25) | 6 | (3) |
| How often do you inquire about or assess your clients' R/S? | 32 | (15) | 61 | (29) | 63 | (30) | 37 | (18) | 14 | (7) |

*Notes*: Percentages were rounded to the nearest whole number; Def.= Definitely; Prob.= Probably; St.= Strongly; Pt.= Partly

***Religious and Spiritual Competence***

To assess participants' levels of spiritual competence, the revised Spiritual Competency Scale was used (Dailey et al., 2015). The descriptive and psychometrics results for this study are presented in **Table 18**. Psychometrics results of the original scale (whether the extended or the revised version) can be found in Robertson (2010) and Dailey et al., (2015), respectively. In the latter publication, a cut-off score for spiritual competence was hypothesized at 105 points (i.e. a minimum of 5 points for each of the 21 items), based on the notion that when participants "*Agree*" (5 points) or "*Strongly Agree*" (6 points) to items would strongly suggest spiritual competence. Accordingly, a lack of spiritual competence is indicated by a lesser level of agreement (i.e., "*Partly Agree*" at 4 or fewer points per item).

Concerning the results for this study, the mean score of spiritual competence for this sample was 81 points $^{(SD=15.856)}$, 24 points below the hypothesized cut-off score for spiritual competence, i.e. 105 out of a possible 126 points. In fact, the results showed that 94% (n=195) of the participants scored below this cut-off score ($t_{(207)}$=-21,856, $p < .000$). Furthermore, results showed that 25% of the participants scored below 73 points, 50% scored up to 82 points, while 75% of the sample scored below 93 points. The mean scores of the SCS' sub-scales are also reported in the **Table 18**. Similarly, all sub-scales' mean scores were below the range of the expected scores score for spiritual competence. The results showed that the highest mean scores were obtained in the 4$^{th}$, 5$^{th}$ and 6$^{th}$ factors "*Human and Spiritual Development*" ($M_{score}$=13$^{SD=3.010}$), "*Culture and Worldview*" ($M_{score}$=23$^{SD=3.629}$) and "*Communication*" ($M_{score}$=13$^{SD=2.756}$). In contrast, the 3$^{rd}$ factor (*Diagnosis and Treatment*) was endorsed to a lesser extent ($M_{score}$=8$^{SD=3.370}$), followed by the Factor 1 (*Assessment*, $M_{score}$=10$^{SD=3.615}$) and Factor 2 (*Counsellor Self-Awareness*, $M_{score}$=15$^{SD=4.809}$). Accordingly, the five highest mean scores were obtained in three items from the Factor 5 (Culture and Worldview) and two from the Factor 6 (Communication) (e.g. "*Spiritual/religious beliefs impact a client's worldview*." –$M_{score}$=5.21$^{SD=.782}$; "*Cultural practices are influenced by spirituality.*" –$M_{score}$=4.76$^{SD=.996}$ and "*Addressing a client's spiritual or religious beliefs can help with therapeutic goal attainment*" –$M_{score}$=4.55$^{SD=1.010}$). The items producing the lowest mean scores were all from the Factor 3 (Diagnosis and Treatment), namely: "*Including religious figures in guided imagery is an appropriate counseling technique.*" ($M_{score}$=2.70$^{SD=1.337}$); "*Prayer is a therapeutic intervention.*" ($M_{score}$=2.68$^{SD=1.469}$) and "*Sacred scripture readings are appropriate homework assignments.*" ($M_{score}$=2.23$^{SD=1.209}$). Further descriptive details of the SCS items are presented in the **Appendix L**.

**Table 18 -** *Descriptive and psychometrics results of the revised Spiritual Competency Scale (Stage 2; n=208)*

| | Min. | Max. | Mean | Expected Scores* | Skewness | | Kurtosis | | α |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | St. | SE | St. | SE | |
| Total Score for the SCS (sum of all 21 items) | 24 | 112 | 81$^{(SD=15.856)}$ | 105-126 | -.811 | | 1.242 | | .90 |
| Median & Mode=82 points | | | | | | | | | |
| Percentiles 25=72 points | | | | | | | | | |
| 50=82 points | | | | | | | | | |
| 75=92 points | | | | | | | | | |
| Theoretical cut-off score for spiritual competence=105 points | | | | | | | | | |
| Participants **below** cut-off=94% (n=195) | | | | | | | | .336 | |
| Participants **above** cut-off=6% (n=13) | | | | | | | | | |
| Factor 1: Assessment (∑ of items 1; 7; 13) | 2 | 18 | 10$^{(SD=3.615)}$ | 15-18 | -.138 | | -.759 | | .82 |
| Factor 2: Counsellor Self-Awareness (∑ of items 2; 8; 14; 19) | 3 | 24 | 15$^{(SD=4.809)}$ | 20-24 | -.393 | 0.169 | -.503 | | .79 |
| Factor 3: Diagnosis and Treatment (∑of items 3; 9; 15) | 1 | 15 | 8$^{(SD=3.370)}$ | 15-18 | .127 | | -1.131 | .337 | .78 |
| Factor 4: Human and Spiritual Development (∑of items 4; 10; 16) | 3 | 18 | 13$^{(SD=3.010)}$ | 15-18 | -1.194 | | 1.772 | | .70 |
| Factor 5: Culture and Worldview (∑ of items 5; 11; 17; 20; 21) | 5 | 30 | 23$^{(SD=3.629)}$ | 25-30 | -1.128 | | 3.315 | .336 | .77 |
| Factor 6: Communication (∑ of 6; 12; 18) | 3 | 18 | 13$^{(SD=2.756)}$ | 15-18 | -.94 | | 1.713 | | .65 |

*Notes*: Min.= Minimum; Max.= Maximum; St.=Statistic; SE=Std. Error; SD= Std. Deviation; ∑=Summation. *Range of the expected scores score for spiritual competence.

***Correlations and Mean Associations with Spiritual Competence***

Results of statistically significant correlations (*Spearman's rho*), are presented in **Table 19**. Results indicated that spiritual competence had a small but positive association with: participants' birth place, i.e. if born in Portugal or not ($r_s$=.15, $p$=.03); their level of religious/spiritual involvement ($r_s$=.27, $p$=.01); their religious identification, i.e. if religious or not religious ($r_s$=.22, $p$=.03) or if belonging to a Christian faith or not ($r_s$=.23, $p$=.00); their level of previous contact with religion/spirituality in academic training ($r_s$=.14, $p$=.04) and their habits of reading religious/spiritual scientific literature ($r_s$=.27, $p$=.00). Finally, the correlation between participants' spiritual competence and their attitudes toward religion/spirituality, mental health and integration of religion/spirituality in clinical was also positive, but strong ($r_s$=.58, $p$=.00).

No significant correlations were found based on age, sex, current residence area, type of professional (if Clinical Psychologist, Psychiatrist or Psychotherapist), preferable or used theoretical orientation in clinical practice, current work context, years of clinical experience and those who reported having specific training in religious/spiritual issues.

**Table 19 -** *Statistically significant correlations with Spiritual Competence (Stage 2)*

| Spearman's Correlations | | | | | | | |
|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 1-Country of Origin[1] | - | | | | | | |
| 2-Religious identification[2] | .049 | - | | | | | |
| 3-Christian Faith[3] | .075 | .876** | - | | | | |
| 4-Integration of R/S in academic training | -.113 | .138 | .159* | - | | | |
| 5-Frequency of R/S reading | -.001 | -.068 | -.061 | .162* | - | | |
| 6-Personal R/S[4] | .024 | .604** | .508** | .259** | .154* | - | |
| 7-Attitudes toward the integration of R/S[5] | .047 | .239** | .230** | .154* | .368** | .330** | - |
| 8-Spiritual Competence | **.145*** | **.222**** | **.233**** | **.143*** | **.268**** | **.256**** | **.584**** |

*Notes***:** [1]Measured as following: 1=Portugal and 2=Other NOT Portugal; [2]Measured as following: 0=No Religion and 1-Have a religious affiliation; [3]Measured as following: 0-Not Christians and 1=Christians; [4]Sub-scale of personal religiosity and spirituality; [5]Sub-scale of attitudes toward religion and spirituality integration; *Correlation is significant at the .05 level (2-tailed); **Correlation is significant at the .01 level (2-tailed).

Following this step, a series of significant mean associations with participants' level of spiritual competence was conducted. Significant differences in mean scores were noted between those born in Portugal and those who reported other country of origin ($t_{204}$= -2.098; $p$=.037; $d$=-.77). The group born outside Portugal[17] produced significantly higher mean in comparison with those born in Portugal ($90.90^{SD=11.318}$<M<$80.26^{SD=15.813}$). The only statistical difference based on theoretical orientations was noted among who reported using Psychodynamic orientation ($t_{205}$=2.390; $p$<.020; $d$=.32). Those who reported preferring or using this orientation on a regular basis produced lower means ($78.67^{SD=18.02}$) compared with those who reported *Never* or *Rarely* using it (M=$83.78^{SD=12.457}$). Statistical differences in scores based on participants' religious identification were also noted ($t_{174}$=-3.651; $p$=.000; $d$=.54). The group who reported having any religious affiliation produced significantly higher mean scores compared with those identifying as "No-Religion" ($84.34^{SD=13.447}$<M<$75.50^{SD=18.354}$). Similarly, statistical differences in scores based on participants' religious affiliation were also reported ($t_{174}$=-3.687; $p$=.000; $d$=.55). Those having a Christian based affiliation produced significantly higher mean scores in comparison with other participants ($84.82^{SD=13.328}$<M<$76.16^{SD=17.798}$). No significant difference in mean scores were found based on age, sex, current residence area, type of professional (if Clinical Psychologist, Psychiatrist or Psychotherapist), preferable or used theoretical orientation in clinical practice (except for Psychodynamic orientation), current work context, years of clinical experience and those who reported having specific training in religious/spiritual issues.

***Predictors of Spiritual Competence***

Following the significant correlations and mean scores comparisons analysis, a series of linear regression analyses were conducted, testing the relationships and interactions between: participants reported levels of personal religiosity/spirituality; their attitudes toward religion/spirituality and mental health; their knowledge and previous training in religious/spiritual issues (predictor variables) and participants' level of spiritual competence (outcome variable). Regarding participants reported level of religious/spiritual involvement, greater personal religious/spiritual involvement significantly predicted higher scores in the Spiritual Competency Scale [$F_{(1,\ 206)}$=19.17; $p$<.000; $R^2$=.09, $B$=1.41, $SE$=.32, β=.29],

[17]Country of origin rather than Portugal: Angola=1; Brazil=2; Cape Verde=1; Germany=1; Italy=1; Mozambique=; Switzerland=1; Venezuela=2).

suggesting that participants who reported higher levels of personal religiosity/spirituality would, more likely, "*Agree*" or "*Strongly agree*" with the statements presented in the SCS and consequently reporting higher levels of spiritual competence.

More contact with religious/spiritual matters in the academic training also predicted higher scores in the SCS [$F_{(1, 203)}$=5.84; $p$=.017; $R^2$=.03, $B$=3.07, $SE$=1.27, β=.17], suggesting that higher frequency of contact with religion/spirituality in academic training predicts higher level of agreement with the statements of SCS, suggesting higher levels of spiritual competence. It also seems that higher frequency of religious/spiritual reading also predicted higher scores in the Spiritual Competency Scale [$F_{(1, 175)}$=16.93; $p$<.000; $R^2$=.09, $B$=4.67, $SE$=1.14, β=.30], suggesting that those reading religious/spiritual scientific literature more frequently would also report higher levels of spiritual competence.

Finally, more positive attitudes toward religion/spirituality, mental health and integration of religion/spirituality in clinical practice also predicted higher scores in the SCS [$F_{(1, 206)}$=136.62; $p$<.000; $R^2$=.40, $B$=3.09, $SE$=.26, β=.63]. This is also indicative that those endorsing more positive/favourable attitudes toward religion/spirituality would produce higher levels of spiritual competence.

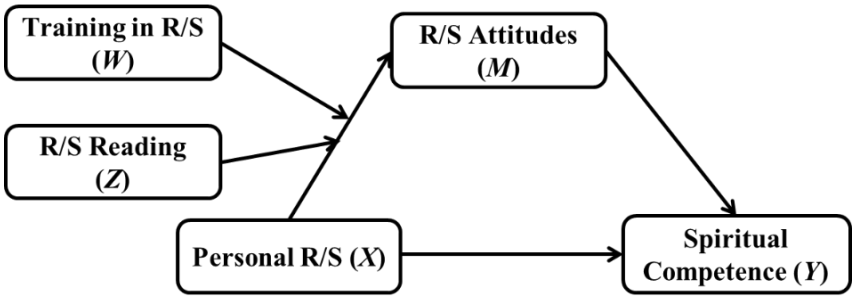
***Mediation, Moderation and Conditional Process Analysis***

Considering the results presented above, it was also intended in this study to closely assess and understand the pathways and interactions through which previous contact with religion/spirituality in academic training and knowledge in religious/spiritual issues (measured as the frequency of reading religious/spiritual scientific matters) may be influencing participants reported level of spiritual competence. As so, a conditional process model is proposed, more specifically a moderated-mediation model, as portrayed in **Figure 4**. In accordance to Hayes (2013, p. 327), a conditional process analysis, is used when the research goal is to "*understand and describe the conditional nature of the mechanism or mechanisms by which a variable transmits its effect on another and testing hypotheses about such contingent effects*".

The proposed conditional process model contains a mediation model in which mental health professionals' personal religious/spiritual involvement (*X*) directly influences participants' attitudes toward the integration of religion/spirituality in clinical settings (*M*), which in turn affects spiritual competence (*Y*). It also contains two moderation models showing: 1) the role training (*W*) and knowledge (*Z*) might have on regulating the impact of

participants' personal religiosity/spirituality on their attitudes toward religion/spirituality and 2) on their competence to integrate religious/spiritual issues in clinical practice.

**Figure 4** - C*onditional process model for potential interactions with spiritual competence*




*Notes*: Based on the moderated-mediation analysis, PROCESS MODEL 9 (Hayes, 2013).

Therefore, it is hypothesized in this model that, despite the impact personal religious/spiritual involvement might have on participants' attitudes and self-reported spiritual competence, previous contact with religion/spirituality in academic training, as well as frequent reading of religious/spiritual literature will have a significant effect on participants' attitudes toward religion/spirituality, which in turn will mediate the relationship between personal religiosity/spirituality experiences and spiritual competence. And, it is expected that these effects will occur over and above participants' personal religiosity/spirituality (Rosmarin, Green et al., 2013).

To conduct these tests the computational tool for SPSS, PROCESS (Hayes, 2012) was used and statistical recommendations by Preacher and Hayes (2004) and Hayes (2012, 2013, and 2015) were followed. The proposed model was introduced and calculated as Model 9 of PROCESS model templates, being the mediation model with "Personal R/S" as predictor of both "R/S Attitudes" and "Spiritual Competence" and "R/S Attitudes" as the mediator of this last relationship ("Personal R/S" and "Spiritual Competence"). The moderations tested the effects of the interaction of "Personal R/S" with "Training in R/S" on the relationship between "Personal R/S" and "R/S Attitudes" (int_1, *XW* on *M*), as well as the effect of the interaction of "Personal R/S" with "R/S Reading" in this same relationship (int_2, *XZ* on *M*).

For both mediation and moderated-mediation procedure, bootstrapping approach was used to test the indirect effects from a 5000 estimate and 95% bias corrected confidence intervals, using the cut-offs for the 2.5% highest and lowest scores of the empirical distribution (as defined by default in PROCESS). The indirect effects were considered

significant when the confidence interval did not include zero. Regarding the moderated-mediation, the interpretation was done: by (1) analysing the significance of the unstandardized regression coefficients ($B^{SE}$) of the indirect effects at different values of the moderators (i.e., $-1^{SD}$, Mean, $+1^{SD}$); and (2) by confirming the significance of the index of the two moderated-mediations, as recommended by Hayes (2013, 2015). Again, the coefficients (B estimates and the index of moderated-mediation) were considered significant when zero was not included in the confidence interval (between the lower and upper bound). The socio-demographic variables presented before as correlated with spiritual competence (i.e. country of origin; religious identification and Christian affiliation) were introduced in the model as covariates ($U_1$, $U_2$ and $U_3$ respectively), aiming to statistically remove their potential confounder influence on the paths in the process model (Hayes, 2013, p. 172). All detailed results are presented in **Table 20** and **Table 21**.

Firstly, and as depicted in **Table 20**, results indicated that participants reported level of religious/spiritual involvement and their religious/spiritual reading habits predicted more positive attitudes toward religion/spirituality and mental health ($a_1$=.512$^{.156}$, 95% CI=.203 to .820, $p$<.000 and $a_3$=1.217$^{.251}$, 95% CI=.719 to 1.714, $p$=.000, respectively); whereas previous contact with religious/spiritual issues in the academic training did not show a significant direct effect on participants' attitudes ($a_2$=.208$^{.316}$, 95% CI=-.416 to .831, $p$=.511).

However, when examining the interactions included in the model results indicated that, in one hand, the interaction between participants' personal religiosity/spirituality and their previous contact with religion/spirituality, presented as int_1 (*XW* on *M*) on **Table 20**, had a significant effect on participants' attitudes ($a_4$=-.193$^{.088}$, 95% CI=-.367 to .019, $p$=.030). This result was corroborated by the index of partial moderated mediation presented in **Table 21** ($B_W$=-.553$^{.299}$, 95% CI=-1.186 to -.0217, $p$=.000).

On the other hand, the interaction between participants' personal religiosity/spirituality and their religious/spiritual reading habits, presented as int_2 (*XZ* on *M*) on **Table 20**, produced a nonsignificant result on participants' attitudes ($a_5$=-1019$^{.076}$, 95% CI=-.252 to .048, $p$=.182). This result was also corroborated by the index of partial moderated mediation presented in **Table 21** ($B_Z$=-.292$^{.237}$, 95% CI=-.783 to .148). This model accounted for 32% of the variance of participants reported attitudes toward religion/spirituality and mental health ($F_{(8, 135)}$=7.906, $p$<.000).

**Table 20** - *Unstandardized regression coefficients (B) of the pathways included in the proposed conditional process model.*

| | | R/S Attitudes (*M*) | | | | Spiritual Competence (*Y*) | | |
|---|---|---|---|---|---|---|---|---|
| | Path | Coeff. | *p* | 95% CI LLCI-ULCI | Path | Coeff. | *p* | 95% CI LLCI-ULCI |
| Personal R/S (*X*) | $a_1$ | **.512$^{(.156)}$** | **.001** | **.2033, .8202** | $c_1$' | .241$^{(.386)}$ | .624 | -.5224, 1.0038 |
| R/S Attitudes (*M*) | | | | | $b_1$ | **2.863$^{(.338)}$** | **.000** | **2.1942, 3.5329** |
| Training in R/S (*W*) | $a_2$ | .208$^{(.316)}$ | .511 | -.4161, .8319 | | | | |
| R/S Reading (*Z*) | $a_3$ | **1.217$^{(.251)}$** | **.000** | **.7198, 1.7141** | | | | |
| int_1 (*XW* on *M*) | $a_4$ | **-.1930$^{(.088)}$** | **.030** | **-.3671, -.0190** | | | | |
| int_2 (*XZ* on *M*) | $a_5$ | -.1019$^{(076)}$ | .182 | -.2523, .0484 | | | | |
| Country of Origin ($U_1$) | $a_6$ | 1.864$^{(1.329)}$ | .163 | -.7648, 4.4927 | $b_2$ | 9.540$^{(5.844)}$ | .104 | -2.0155, 21.0955 |
| Religious Identification ($U_2$) | $a_7$ | .537$^{(1.093)}$ | .491 | -1.6247, 2.6981 | $b_3$ | -1.880$^{(4.732)}$ | .691 | -11.2385, 7.4780 |
| Christian Affiliation ($U_3$) | $a_7$ | .826$^{(.9657)}$ | .394 | -1.0842, 2.7357 | $b_4$ | 3.2902$^{(4.245)}$ | .439 | -5.1034, 11.6838 |
| Constant | $i_M$ | -4.0919$^{(1.533)}$ | .008 | -7.123, -1.060 | $i_Y$ | **70.217$^{(6.191)}$** | **.000** | **57.9756, 82.4595** |
| | | **$R_2$=.32** | | | | **$R_2$=.42** | | |
| | | **$F_{(8, 135)}$=7.906, *p*=.000** | | | | **$F_{(5, 138)}$=19.978, *p*=.000** | | |

*Notes*: int_1 and int_2=interaction 1 (*XW* on *M*) and interaction 2 (XZ on *M*); Coeff=unstandardized regression coefficients, *B*; Standard errors are presented in parentheses and in superscript style; CI= Confidence Interval; LLCI=Lower Limit of the Confidence Interval; ULCI=Upper Limit of the Confidence Interval. Significant effects are depicted in bold.

As for the final moderated-mediation model, the results indicated that participants' attitudes (and accounting with all the interactions mentioned before), fully mediated the relationship between participants' personal religiosity/spirituality and their reported level of spiritual competence ($b_1$=2.863$^{.338}$, 95% CI=2.194 to 3.533, $p$<.000), as personal religiosity/spirituality showed no significant direct effect on spiritual competence ($c_1$'=.241$^{.386}$, 95% CI=-.522 to 1.004). Overall, this model accounted for 42% of the variance of participants reported level of spiritual competence ($F_{5,138}$=19.98, $p$<.000). In both procedures, no covariates introduced in the model yield a significant result (**Table 20**).

The results of the conditional indirect effects of "Personal R/S" (*X*) on "Spiritual Competence" (*Y*) are presented in **Table 21**. As seen, the effects of the proposed interactions (training and knowledge), significantly moderated the relationship of personal religiosity/spirituality on spiritual competence (through the mediating role of participants' attitudes) **only** on the following three levels: **1)** when both moderators were low, being the effect of personal religiosity/spirituality on spiritual competence at its highest level in the model (-1$^{SD}$; $B_W$=.235, $B_Z$=.221, *X* on *Y*=1.271$^{.510}$, 95% CI=.352, 2.362); **2)** when previous contact with religion/spirituality in academic was low and participants' reading habits were at mean level, being the effect of personal religiosity/spirituality on spiritual competence also high, but lower than previously (-1$^{SD}$ $B_W$=.235, Mean $B_Z$=1.229, *X* on *Y*=.977$^{.459}$, 95% CI=.140, 1.931); **3)** when previous contact with religion/spirituality in academic was at its mean level, but participants' reading habits was low, being the effect of personal religiosity/spirituality on spiritual competence moderate (Mean $B_W$=1.049, -1$^{SD}$ $B_Z$=.221, *X* on *Y*=.821$^{.417}$, 95% CI=.098, 1.727).

Finally, and as mentioned before, only the moderation effect of previous contact with religion/spirituality in academic was supported by the index of moderated mediation ($B_W$=-.553$^{.299}$, 95% CI=-1.186 to -.0217, $p$=.000). Furthermore, and since this confidence interval did not include zero, and with the upper bound negative, the conclusion is that the indirect effect of participants' personal religiosity/spirituality on spiritual competence, through participants' attitudes, is significantly and negatively moderated by participants' previous contact with religion/spirituality in academic training, but not by their reading habits ($B_Z$=-.292$^{.237}$, 95% CI=-.783 to .148).

**Table 21** - *Conditional indirect effect(s) of Personal Religiosity/Spirituality on Spiritual Competence at -1$^{SD}$, Mean and +1$^{SD}$ values of the moderators (training and knowledge).*

| | Training in R/S (*W*) | R/S Reading (*Z*) | Effect of *X* on *Y* | BootLLCI | BootULCI |
|---|---|---|---|---|---|
| R/S attitudes (*M*) | **.235 (-1$^{SD}$)** | **.221 (-1$^{SD}$)** | **1.271$^{(.510)}$** | **.352** | **2.362** |
| | **.235 (-1$^{SD}$)** | **1.229 (Mean)** | **.977$^{(.450)}$** | **.140** | **1.931** |
| | .235 (-1$^{SD}$) | 2.238 (+1$^{SD}$) | .683$^{(525)}$ | -.291 | 1.752 |
| | **1.049 (Mean)** | **.221 (-1$^{SD}$)** | **.821$^{(.417)}$** | **.098** | **1.727** |
| | 1.049 (Mean) | 1.229 (Mean) | .527$^{(.305)}$ | -.014 | 1.170 |
| | 1.049 (Mean) | 2.238 (+1$^{SD}$) | .233$^{(.356)}$ | -.479 | .942 |
| | 1.862 (+1$^{SD}$) | .221 (-1$^{SD}$) | .372$^{(.453)}$ | -.500 | 1.286 |
| | 1.862 (+1$^{SD}$) | 1.229 (Mean) | .077$^{(.306)}$ | -.540 | .667 |
| | 1.862 (+1$^{SD}$) | 2.238 (+1$^{SD}$) | -.217$^{(.309)}$ | -.899 | .351 |
| IMM | **-.553$^{(.299)}$, -1.186, -.022** | -.292$^{(.237)}$, -.783, .147 | | | |

*Notes***:** BootLLCI=Lower limit of the bootstrap confidence interval; BootULCI= Upper limit of the bootstrap confidence interval; IPMM=Index of Moderated Mediation; Standard errors are presented in parentheses and in superscript style; Significant indirect effects are depicted in bold.

### *Stage 3: A Sequential Explanatory Study*

As mentioned before, this study was designed to refine and explain the results obtained in the previous two studies. As so, some concerns lead to the development of this study, namely: the participants' tendency to polarize the concepts "*religion*" and "*spirituality*" (attributing a more negative connotation to religion when compared to spirituality); the perceived impact of personal religiosity/spirituality in the clinical practice, along with the impact of religious/spiritual match between mental health professionals and their client; the low levels of engagement, preparedness and spiritual competence reported by the participants and, finally the importance of training and knowledge in religion/spirituality on clinical practice. Apart from some general questions (e.g. *"What meanings have these results for you?"*; *"To what extent do you identify with them?"*; *"Why do you think we had these results?*"), no explicit question was brought to the participants, at first. However, whenever needed, specific questions were presented to participants, to ensure that the concerns mentioned above would be discussed. The results of the qualitative analysis and the code system created for this stage are presented below, in the **Table 22**.

**Table 22 -** *Thematic Analysis for the Stage 3 (Core Themes and Code System)*

| | **Codes** | **%** |
|---|---|---|
| **Personal interest in R/S** | **6** | **2** |
| **Training in R/S** | **61** | **16** |
| Academic training | 3 | |
| Specific training | 10 | |
| (perception) Need of training | 22 | |
| Consequences of the lack of training | 22 | |
| Readings habits of R/S literature | 4 | |
| **Use of R/S in clinical practice** | **156** | **41** |
| Why? | 34 | |
| When? | 5 | |
| How? | 104 | |
| Importance of the use of R/S | 13 | |
| **Interpretations and explanations** | **153** | **41** |
| Polarization of R/S | 24 | |
| Importance (and impact) of personal R/S and R/S match | 52 | |
| Low levels of SCS | 77 | |
| **Total units of analysis** | **376** | **100** |

*Notes*: Percentages were rounded to the nearest whole number.

***Polarization of Religion and Spirituality (and its impact on clinical practice)***

Apart from one participant, all others consider the result, mental health professionals' tendency to polarize "*religion*" and "*spirituality*", attributing a more negative connotation to religion when compared to spirituality, not surprising and in accordance to the socio-cultural context of Portugal. In fact, the socio-cultural and religious context was the most cited explanation for such phenomenon. Participants of this stage considered that, since most Portuguese mental health professionals are born and raise in a Christian/Catholic tradition, some of them might have preconceived beliefs about religion, leading them to perceive this as mystical, dogmatic, closed-mind or even fundamentalist. Considering those reasons, it was not surprising to participants that religion could be perceived as more harmful to mental health than spirituality, and many times unrelated or separated from Psychology, as a science:

> "*There is this thing, almost established in our society, from generation to generation, which goes from grandparents, parents, children, grandchildren… descendants, until today, that religion is related with*

*the mystical. And since it is a very mystical thing... I mean, psychology is a science and science does not mix up with religion*" [**P1**]; "*From what I understand of psychological well-being and mental health, I consider that the more flexible someone is, the healthier psychologically he/she can be. And, in fact, I see more psychological flexibility among those with a greater spiritual dimension than a religious one. Perhaps because religiosity, or at least most of it, or perhaps it is only my understanding and does not mean that it is so, but from what I know religion it is more dogmatic, more closed, it has more limitations in terms of beliefs. And this can affect one's psychological adaptability and the interpretations, what they feel…*" [**P2**]; "*I believe the issue of polarizing these concepts, this negative connotation to religion compared to spirituality ... I can understand this, since in Portugal, I think, religion can be a prison, because of its dogmas, its more rigid rules…*" [**P3**]; "*Religion, the institution, are very limiting to individuality. For instance, in the case of Portuguese Catholicism, one cannot use condoms or it has a lot of sexual morals... I mean, they are considered obsolete and limiting and we know that Catholic do not observe many of these principles. Therefore, in a sense, spirituality is seen more as liberation, as having more beneficial effects when compared to institutionalized religion. So, no wonder these results*" [**Specialist_2**].

### *Impact of Mental Health Professionals' Personal Religiosity/Spirituality on Clinical Practice*

Throughout the interviews, participants of this stage were unanimous when discussing the impact a mental health professional' religious and/or spiritual experiences might have on his/her clinical practice. They reported that their personal religious/spiritual experiences can, in fact, interfere with their work (positively or negatively) depending on: their level of personal religiousness and spirituality; their past religious/spiritual experiences, but most importantly, depending on their level of religious/spiritual self-awareness. Furthermore, they perceived the result of stage 2 ("*greater personal religious/spiritual involvement significantly predicted higher scores in the Spiritual Competency Scale*") as representative of Portuguese context, nevertheless they also stated that personal religious/spiritual involvement should not be a criterion for spiritual competence. As so, participants reported that professionals who experience a self-growth process, actively explore their own religious/spiritual beliefs and experiences (for instance, through personal psychotherapy) and are trained in religious/spiritual issues would be better prepared, not only to work with their patients' religious/spiritual issues, but also to regulate the impact their personal religiosity/spirituality will have on the therapeutic process:

"*We [mental health professionals] are always influenced by our story, the one we carry and that we are often very afraid to talk about it*" [**P1**]; "*It was uncomfortable to have to directly explain to the patient that we did not correspond in our beliefs and I was afraid that this would negatively impact on our relationship. But, it did not*" [**P2**]; "*There are many people mad at religion out there. Both professional*

*and patients. A patient can have a belief, be sensitive, well-educated, but if he/she thinks we talk too much about religion, that we are trying to indoctrinate him/her, hm… If we question anything, anyway… they project the anger they have toward God or religion over us, and this can damage the bond we are trying to create*" [**P3**]; "*Well, I think it is very important for the therapist to have a lot of self-awareness, to be aware if, in fact, he/she is being genuine or not* [when asking about religious/spiritual matters in practice] [**P4**]; "*It is impossible from me to separate my clinical practice from my conception of the divine, I always look at a human being as a body, as a conscious and unconscious mind, I go to the bottom of what the person allows me to go*" [**P5**]; "*Many times, from my experience, they* [the mental health professionals] *devalue, I mean they devalue a patient's belief, religion or spirituality, when he/she does not agree or when they don't have the knowledge*" [**Specialist_1**]; "*Well, I think this result makes sense, but it shouldn't. I mean, this result should not be so, in my opinion. And maybe here comes the role of this investigation and the role of training, because I think that a therapist's religiosity, or spirituality, should not influence its openness to talk about these themes*" [**P4**].

***Religious and Spiritual Competence (the low levels of engagement)***

Following the results presented before, participants were also able to discuss and interpret the low levels of engagement, preparedness and spiritual competence reported by the participants. Firstly, most participants were not surprised with these results; considered them also as representative of Portuguese context and several explanations were reported. As so, and in accordance with what was presented above, the lack of mental health professionals' self-awareness, training, knowledge, as well as lack of alternatives to acquire such competence were pointed as explanations reported for these results:

"*I think this fear also comes from a lack of knowledge. And as reported in this study, the participants said they had little knowledge about the religious/spiritual profile in Portugal ... and it also has to do with academic training, for sure*" [**P1**]; "*I believe that it is very important to alert mental health professionals about the importance of religiosity and spirituality, both as a protective factor of mental illness, or as a symptom, I mean, as a negative factor. But also as a therapeutic strategy that can be used*" [**P4**]; "*Well, first, first, it is knowing yourself, as a person. That is, knowing yourself before being a psychoanalyst... before any training. We are people above all, who should be curious and must have love for each other. And then there is training. And, having his/her own therapeutic process*" [**P5**].

As already mentioned above, another explanation was the separation of Psychology from religion, many times portrayed as a "*grey zone*", not belonging to the scientific field of mental health:

"*I really don't think these results [low scores in the SCS] are surprising. I mean, tin his field [mental health] we work with beliefs and behaviours and if we think it is overlapping with religion... I think psychologists tend to think that it is not a scientific area to work with a patient' religiosity and they also have some prejudice in addressing religion/spirituality in this area. So, they try to it separated from*

*psychotherapy, because they think that these questions are not supposed to be included in therapy, which we might be stepping away from the scientific basis of the psychotherapy* [**P2**]; "*It is true. In fact, we want to separate the waters. What is science, is science and what is not, is set apart*" [**P3**].

Participants of this stage also reported the Portuguese socio-cultural and religious context as another reason for the low levels of spiritual competence:

"*We also have this cultural thing... I mean, not only culturally, but I think we are also very... we tend to devalue our work, devalue our knowledge. We self-depreciate us, a lot. I mean... I'm not sure if these 94% are exactly true, because of our self-evaluation, we are very punitive, we punish ourselves a lot, we do not value ourselves as often as we should've*" [**P1**]; "*I think since in Portugal there is still not much work on this topic… perhaps due to this lack of religious diversity. We are still a very Catholic country. For instance, the USA is much more diverse. Not Portugal. So, focusing on this religious field, I think that with the rise diversity, especially, as I said, in spirituality, things will change*" [**P4**].

The limitations inherent to the scale used to measure spiritual competence were also pointed as explanation for such low levels of spiritual competence. In fact, participants not only pointed the limitations of a self-reported measure, but also the fact that the participants of stage 2 were not trained to demonstrate such competence:

"*Yes, mostly when we compare… I was just thinking that it is a self-perceived competence, it is not… the competence to be really measured one must have a referential of what is competence and since these issues were not addressed in the training, they might not know what it is supposed to do*" [**P2**]; "*Yes, that was the part that confused me, because it is a self-evaluation. Competence is something that is measured externally, that is observed. That's why I was confused*" [**P3**].

Other explanations, such as: clinical experience; work context (if in a public or private practice or yet in a religious-based institution); fear of being misunderstood or perceived as invasive by the patient; lack of awareness concerning the importance of religious/spiritual issues at the organizational level, among others, were also reported:

"*This sensitivity, we perfect with what clinical practice dictates us, like with everything in life. We end up knowing if what we are doing is the right thing, in the right moment, and if that patient will feel invaded or not, if he/she will be receptive or not* [**P1**]; "*But this is also a matter of work context. For instance, if we are in a private office that is a neutral place, it is harder to work with religion/spirituality… in this context, a Catholic religious institution, it was easier*" [**P3**]; "*There is also a very important question, which is the time. Not having time to deal with these issues. There are a lot of overwhelmed professionals. And this is also something to take into consideration, especially in a hospital setting*" [**Specialist_1**]; "*I don't want people to think that I'm indoctrinating them or I'm imposing my own beliefs. Because this is basically how religion works: to shape our way of thinking. I mean, I do not want this at all... this is why we approach religion/spirituality with such a care, I do not want people to feel that I am trying to make them think in a certain way*" [**P3**]; "*Because the important*

*people here in Portugal are not prepared to consider the spiritual dimensions at this level, for example, in the public hospitals, or when it concerns to mental health professionals training*" [**P5**].

### *Integration of Religion and Spirituality into Psychotherapy*

By reading the preliminaries results through their own professional experiences, participants could report several examples, illustrating why or/and when to use and integrate religion/spirituality in clinical practice. Most of the references (units) reporting *why* or *when* to use/integrate religion/spirituality were made by the Participant 1, who currently works in a public palliative care institution. As so, bereavement (grief or mourning, or yet the anticipatory processes of grief and end-of-life care) was one of the most mentioned reasons to engage to the integration of religion/spirituality in clinical practice. Nevertheless, other examples were reported, such as rehabilitation therapies; when patients face depression, marital/familial or sexual related problems; when a patient requests for this integration and when religion/spirituality is the cause of the psychological disorder (e.g. guilt, fear, anxiety). Participants also reinforced the importance to use/integration of religiosity/spirituality in clinical practice as therapeutic tool to: help enhance therapeutic alliance; promote motivation to attitudinal or behavioural change; help patients engage more deeply into religious/spiritual experiences and ultimately to improve therapeutic outcome:

"*But, yes, it was a positive challenge. That's why I approached it naturally and explained how it would be… always having in mind the patient's need, of course. Then our psychotherapy evolved in another direction, with a greater level of complexity, but more importantly in our therapeutic alliance*" [**P2**]; "*We can also create a sense of hope, which will serve as a motivation - a realistic thing, of course – toward change, so this person can walk* to *the other side, to try alternative solutions*" [**P3**]; "*It has an impact, as I said, in the guilt issue, and also in the symptoms a patient presents, but it also has a great impact on recovery. There are many factors that help, for example, prayer is pointed as having an impact, as with other strategies…*" [**P4**]; "*They [the religious patients] can go to God more easily, mostly because they are in a relationship with someone, and that someone is the therapist*" [**P5**].

Furthermore, participants were also able to report several practical examples, illustrating how they used or engaged to the integration of religion/spirituality into their clinical practice, as presented below:

"*If in a certain moment, I notice any resistance from that patient, for example concerning this issue, but if I see that this will help the therapeutic process, I do it, of course. Always focused on the need of that patient, but I do it*" [**P1**]; "*It was clear to the patient where were my limits in terms of approaching religion in therapy. She knew exactly when she needed a complementary help from someone who shared the same beliefs as her*" [**P2**]; "*Now I am comfortable to integrate the strategies of mindfulness, meditation... to be true, I already unknowingly combined a series of spiritual strategies with patients*

*who were more sensitive to it or even with those who were not explicitly connected to religion, but needed this component in their lives and were open to it*" [**P3**]; "*I think it is important to talk about this* [religion/spirituality], *to ask they beliefs, to try to address this issue and not to think that this is a waste of time, because it is not, these beliefs are rooted, often consciously, but many times they are unconsciously passed by their parents* [**P4**]; "*I'm constantly trying to make these values to exist, but in the sense that they can grow, mature, as this patient grows and matures. Because, most of the times, what I find are values of their early infancy, second childhood and those values… well, they don't help us at all*" [**P5**]; "*What it is really important, is to be aware and get to know the patient we have in front of us. Because even if this patient tells me that he/she does not believe in anything, he/she does not believe in God, he/she does not believe in anything, he/she does not have a belief that usually relates to a religion, you always have a spiritual experience, you must have*" [**Specialist_1**]; "*I think the ideal is that the mental health professionals to be tolerant, accepting… unconditionally a patient's religion and spirituality; and to respect the patient, above all*" [**Specialist_2**].

### *Importance of Training and Knowledge in Religion/Spirituality on Clinical Practice*

Participants of this study also agreed with the importance and impact training and knowledge in religious/spiritual issues have on mental health professionals' competence to integrate religion/spirituality into clinical practice (whether in academic training or as a post-graduate specific course). Furthermore, they also validated the fact that there is a lack of integration of religious/spiritual matters during a mental health professional' academic training, as well as a lack of alternatives to find and enrol in a post-graduate specific course. Another factor pointed as a barrier to the integration of religion/spirituality into clinical practice was a generalized lack of awareness concerning the need, importance and impact religious/spiritual matters have on therapeutic processes (whether socially, politically, administratively or even among mental health professionals).

Accordingly, some consequences of the lack of training were reported: no recognition of the signs to engage to a needed integration of religion/spirituality into clinical practice; being perceived by a patient as judgemental; loss of crucial opportunities to enhance the therapeutic alliance or even therapeutic outcomes; impose their own religious/spiritual ideologies or lack of them; or even a loss of a patient (whether those who withdraw from therapy or those who consciously choose not to bring the issue again). As so, participants also reported personal initiatives to overcome these barriers and avoid such consequences (e.g. engage more deeply to a religious or spiritual experience; reading of religious/spiritual literature; or complement their academic training with another type of training):

"*For instance, about my academic training, I don't remember, I mean very vaguely… that we ever talked about religious or spiritual. It was more on a philosophical level. Maybe philosophy,*

*anthropology… but not much. Which for young adults who are neither ready, nor trained to give answers at this level is almost nothing*" [**P1**]; "*In my psychotherapeutic training, we talked about religion/spirituality… well more focused on cultural differences, but still. We talked about self-disclosure and the numerous cultural issues that we have and how these should be addressed in psychotherapy. But yes, about self-awareness*" [**P2**]; "*It would be interesting to have the integration of religion/spirituality in the mental health professionals' training at universities or even in postgraduate training, but I guess this is something that people don't think about, I do not know why*" [**P3**]; "*Regarding my training, since I think this is an important part of psychotherapeutic process, I studied by myself… I was interested in spiritualist philosophies, other religions, so I informed myself*" [**P4**]; "*About our training, we have our academic training and after that we try to go as far as we want. in our own way, that's what I did*" [**P5**].

## Discussion

The scientific mental health field is filled with the argument that religious/spiritual beliefs, values and practices are vital dimensions for many people around the world. No wonder, these dimensions are one of the most important source of strength and direction in the lives of many (Gockel, 2011; Koenig, 2012; Miller & Thoresen, 1999; Park, 2007). As mentioned before, most studies conducted in the mental health field have shown the existence of a strong and positive relationship between religion, spirituality and mental health outcomes. As a matter of fact, these results enabled a great shift in the professional mental health context. If initially, the main question was only "*why*" bringing religious/spiritual into mental health field was important, nowadays "*how*" to best integrate these contents into psychotherapeutic settings is also a question on the agenda (Richards & Bergin, 2005).

Despite the rapidly increasing interest in such topics, these dimensions studies are still understudied in the field of mental health research, -and even in the multicultural field- which is also true for Portugal, where clearly these dimensions are still poorly examined, enhancing the gap between research and practice. Thus, the present multistage mixed-method study was designed to explore and describe the mental health professionals' current clinical practice, regarding the integration of religious/spiritual issues into psychotherapy. More specifically, it is intended to explore mental health professionals' attitudes, beliefs, knowledge and spiritual competence when addressing religious/spiritual issues in psychotherapy.

Considering the methodological framework and the study design used in this multistage study, it is important to emphasize that, although other connecting points were used in intermediate stages, -for instance, when results of the first stage informed data collection in the second stage or when both results were integrated guiding the development

of a third stage- the most important connection point will be presented below. The results of the three stages were integrated in a single discussion section, always focusing on a multicultural perspective (Hage et al., 2006) and the ASERVIC guidelines (2009). However, it should be highlighted that a complete discussion of the religious/spiritual competence -*as important as it is*- is beyond this chapter's scope (for detailed information on religious/spiritual competency, please see: Young et al., 2002; Robertson, 2010; Savage & Armstrong 2010; Vieten et al., 2013; Cashwell & Young, 2005[18]; Vieten & Scammell, 2015).

Thus, this section discusses some of the most significant results attained in this study, with input from recent researches in this field, highlighting that this topic should be analysed with special care. For discussion presentation, all core themes analysed throughout this study will be presented considering the following categories: 1) *religious and spiritual competence among Portuguese mental health professionals* 2) *their personal religious/spiritual involvement and its impact in the clinical practice;* 3) *their stance toward religion/spirituality in clinical practice; 4*) *their knowledge and skills when addressing religious/spiritual matters in psychotherapy* and finally 5) *the importance of religion/spirituality training to clinical practice.*

***Religious and Spiritual Competence***

*[Reminding that]* The origins of religious/spiritual competencies (as outlined by ASERVIC, 2009) can be traced back to the multicultural competencies literature, but it also reflects the needs from the medical, psychiatric, social work, counselling, nursing, and psychological literature and professional practice (Savage & Armstrong, 2010), or even all those interested in providing a spiritually sensitive therapy (Cashwell & Watts, 2010). One of the major contributions of the multicultural perspective [*besides the opportunity to expand the understanding of human diversity, of course*] has been to provide baseline competencies essential to all psychotherapeutic transactions, from academic preparedness of a mental health professional, to the practice of any psychological therapy (Arredondo et al., 1996). As such, the development of attitudes, knowledge and skills with a multicultural focus has become essential to a more competent psychotherapeutic practice (Savage & Armstrong, 2010).

[18]Reference only: Cashwell, C. S., & Young, J. S. (Eds.). (2005). *Integrating spirituality and religion into counseling: A guide to competent practice.* Alexandria, VA: American Counseling Association.

As mentioned above, the development of religious and spiritual competencies (whether the ASERVICs' guidelines or any other set of guidelines developed in this area) was ground-breaking, as it became clear that common sense, personal interests, mainstream clinical expertise and even general cultural competence were not enough to adequately attend to the religious/spiritual matters presented by many clients seeking psychological assistance (Vieten & Scammell, 2015). Above all, this competency, or even the guidelines to know-how, guides mental health professionals on how to ethically and effectively include religious/spiritual matters into clinical practice (Robertson, 2010; Vieten & Scammell, 2015). These guidelines also serve to inform researches to develop valid and reliable measures to assess mental health professionals' attitudes, beliefs and clinical practices when addressing these domains with their clients (Dailey et al., 2015). Finally, it also advises Faculties and educators on the material that should be included in mental health professional training (Cashwell & Young, 2004; Robertson, 2010).

Overall, results of this current study showed that Portuguese mental health professionals may be lacking in most of the basic religious and spiritual competencies that mental health professionals should possess to be able to work at a baseline level of competence (*but still ethically and effectively*) with their clients' religious and spiritual diversity issues.

In the first stage, for instance, Portuguese mental health professional explicitly reported lacking basic knowledge on religious and spiritual diversity, while also reporting being acquainted or comfortable to deal competently merely with Catholicism and/or religious beliefs similar to their own. There was also a trend to negatively polarize religion when compared to spirituality, as well as greater openness towards spiritual integration. Furthermore, most participants recognized that religious/spiritual issues were not addressed or integrated explicitly throughout their clinical experience, nor were they introduced by them. The lack of knowledge, and adequate training in religious/spiritual matters and, in some cases, the fear of overstepping psychotherapeutic boundaries, were pointed as some of the barriers to integrating religion/spirituality in clinical practice. In the second stage, the mean score of the sample was far below the desirable one for what would be indicative of spiritual competence. In fact, all mean scores of the 6 sub-scales were found to be below the range of the expected score for spiritual competence and participants scored within this range in only 5 out of 21 items (see **Appendix X**). In the third stage, results were analysed, and validated as representative of the Portuguese context; some were considered to be challenging to the

therapeutic processes and some explanations were provided (again the lack of knowledge, inadequate training in religious/spiritual matters and lack of familiarity with these competencies).

However, it should be highlighted that, although this sample was relatively non-religious, most participants were highly spiritual and had a considerably favourable posture toward religion/spirituality, mental health, treatment and scientific research of religion/spirituality. Furthermore, it also seems that respondents of this study might have indeed acquired one of the foremost spiritual competence, i.e. "*recognizing that the client's beliefs (or absence of beliefs) on spirituality and/or religion are central to his or her worldview and can influence psychosocial functioning*" (**Competence 2** of ASERVIC, 2009), along with the fact that they also appeared to be empathetic, respectful and appreciative of clients with diverse religious/spiritual backgrounds and beliefs (Vieten & Scammell, 2015).

These might seem like obvious competencies, -as they are essential to the practice of any psychological therapy- however, one must also acknowledge that not all mental health professional can effectively work with clients who hold certain religious/spiritual beliefs (Constantine et al., 2000). Also, being religiously and spiritually competent goes far beyond being "*purely*" empathetic, respectful, and appreciative of clients' religious/spiritual beliefs, experiences, and practices. In fact, being religiously and spiritually competent begins with these competencies. However, there is a need to go beyond that. The following are specific results.

***Personal Religious/Spiritual Involvement***

There are no Portuguese data for comparison with the combined measures used to assess participants' religious/spiritual experiences in this study. However, when considering the Portuguese religious profile -most Portuguese people profess to believe in God or a higher power (93%); those believing in a personal God make up almost 80% of the population; 85% identified as belonging to a religious entity, 81% of which to the Roman Catholic Church and most Portuguese people (78%) seem to greatly trust their church (INE, 2012; Menéndez, 2007)- it is possible to conclude that Portuguese mental health professionals have lower rates of religious identification, beliefs and practices when compared to the general Portuguese population. In contrast, Portuguese mental health professionals showed significantly higher levels of spirituality, importance given to spirituality and spiritual practices when compared to their level of religiousness.

Considering that a clear majority of the Portuguese population identifies as belonging to a religious entity (most of them Catholic Church), only half of the participants reported religious identification. Yet, most of these were, in fact, Catholics. Portuguese mental health professionals also reported low rates of religious practices, with roughly one-third of respondents reporting attending public religious services on a regular basis. The national rate of regular participation in public religious activities is almost half of the population (Dix, 2009). Regarding participants' beliefs on God, less than half of the respondents said they believed in God, while it is estimated that most of the Portuguese population does so (Menéndez, 2007). In contrast, the percentages of those believing in a "*spiritual, higher force or life force*" and non-believers are significantly higher than the general population. At least one-third of respondents reported believing in a Higher Power and almost 15% stressed they never believed in God, Gods or a Higher Power, while the national rates are 15% and 7%, respectively (Menéndez, 2007; INE, 2012). Similar patterns -i.e. the tendency for mental health professionals to be much less religious than the general population- was also reported in studies conducted in Brazil (Menegatti-chequini, Gonçalves, Leão & Peres, 2016); Canada (Baetz et al., 2004); United Kingdom (Neeleman & King, 1993); and United States (Delaney et al., 2007; Rosmarin, Green et al., 2013).

As aforementioned, Portuguese mental health professionals endorsed higher levels of spirituality, more importance given to spirituality and spiritual practices when compared with their religiousness levels. This corroborates similar results reported by Shafranske and Malony in the early 90s and by most of the above reported studies (e.g. Baetz et al., 2004; Delaney et al., 2007; Menegatti-chequini et al., 2016; Rosmarin, Green et al., 2013). This pattern was described in the first stage of this study, confirmed in the second stage and explained in the last stage. On the one hand, this pattern might be illustrative of a conceptual distinction between religion and spirituality that has emerged in contemporary societies (Hill & Pargament, 2003; Miller & Thoresen, 2003), but on the other, also due to the developmental changes experienced throughout mental health professionals' journey, where old frameworks are, due to several circumstances, challenged and new systems of values are adopted and/or reconstructed (Magaldi-Dopman et al., 2011).

Another explanation might also be the growing interest in spiritual identities among Portuguese mental health professionals. Although, overt belonging to more spiritual faith traditions were scarce in all stages, some participants in the first stage did report a "special sympathy" toward Eastern faiths (mostly, Buddhist philosophy and practices), as well as

toward psychotherapeutic approaches that foster spiritual growth among clients, such as existential perspectives, mindfulness and meditation (Rosmarin, Green et al., 2013). Accordingly, many participants (in the first stage) meaningfully described themselves as being "*spiritual but not religious*" and able to also make this distinction in their clinical practice. Perhaps, it should be presently noted that the religious/spiritual experiences of mental health professionals may be more complex than a simple distinction between being secular and/or religious, as an international study among psychotherapists from New Zealand, Canada, and the United States showed (Smith & Orlinsky, 2004).

Following this, an important question discussed in the first stage of this study was the ability to define and conceptualize "*religion*", "*religiosity*" and "*spirituality*". This is also the **first competence** presented in the guidelines for addressing religious/spiritual issues in counselling, by ASERVIC (2009). Although most participants of this study recognized their shortcomings in [the knowledge of] "*basic beliefs of various spiritual systems, major world religions, agnosticism, and atheism*", it is important to highlight that most of them was, in fact, able to demonstrate competence regarding the first part (i.e. "*The professional counsellor can describe the similarities and differences between spirituality and religion*"). As mentioned before participants were not only able to see themselves in a more complex way regarding their religiosity and/or spirituality, but they were also able to view their clients as spiritual and religious beings, recognizing the peculiarities of being "*religious and spiritual*"; "*religious, but not spiritual*"; "*spiritual, but not religious*" or "*neither religious nor spiritual*".

This ability to recognize and differentiate levels and forms of religious/spiritual experiences appears as an important factor to the integration of religion/spirituality, since it enables mental health professionals to be in a better position to decide what is more appropriate for their clients and their practice. It also helps them recognize the signs and/or assess the needs to engage in the integration of religious/spiritual issues in therapy. Furthermore, it also encourages them to understand that spirituality can transcend religious involvement (Vieten et al., 2013). And this is of utmost importance!

Considering that this dimension is a significant part of life of many people around the world, by embracing new perspectives on spirituality (rather than reducing its meaning), mental health professionals would be able to elevate this to a higher dimension of human potential, allowing them to look beyond traditional religious experiences and manifestations (Pargament, 2007). In fact, one must agree that "*the sacred can take many forms and people can take many paths to the sacred, both traditional and non-traditional*" (Pargament, 2007, p.

32). However, following this, there was also a trend to polarize religion and spirituality in this matter: a phenomenon well described in many works (Pargament, 1999; Zinnbauer, Pargament & Scott, 1999; Hill & Pargament, 2003; Pargament, 2007; Smith, 2007). Religion and/or religiosity were often viewed in a more negative light (or having more of a negative impact) than spirituality, leading them to demonstrate more openness toward spiritual integration. In some cases, this tendency was influenced by participants' personal views and religious/spiritual experiences.

As a matter of fact, the impact of mental health professionals' personal religious/spiritual involvement was another important question discussed throughout this study. Based on the assumption that *spirituality is part of the human essence, without which human nature is not full human nature* (Maslow, 1971, p. 314) and that everyone has some spiritual and/or religious background (whether it is due to one's upbringing in a religious/spiritual manner, or by having a devoutly religious nature, or yet by having no religious/spiritual upbringing, beliefs, or practices) (Pargament, 2007; Vieten & Scammell, 2015). If so, one must also agree that personal religious/spiritual values (as with any other value system) may, in fact, operate as one of the foundations that significantly influences one's life: from what we eat, wear, assume to be true about the nature of reality, to how we perceive psychological phenomenon and even psychotherapeutic processes in both implicit and explicit ways (Shafranske & Malony, 1990; Vieten & Scammell, 2015). No wonder Constantine and colleagues once stated "*because counseling is not a value-free process mental health professionals' attempts to completely isolate their personal values from therapeutic relationships may be generally futile and may lead to unsuccessful therapeutic outcomes*" (Constantine et al., 2000, p. 32).

Many first stage participants corroborate this by asserting that their level of comfort and preparedness to work with religious/spiritual matters was influenced by their level or state of personal religiosity and/or spirituality (e.g. if their own religious/spiritual issues were sorted or not) or by their knowledge about religious/spiritual traditions. Some studies have suggested that among those for whom religion/spirituality personally represents an important dimension, they may in fact be in a better position to recognize when this domain is also relevant to their clients (Rosmarin, Green et al., 2013). They are also more likely to try attaining more knowledge and skills to effectively integrate religious/spiritual matters into their clinical practice, in comparison to the less interested ones (Dailey et al., 2015). However, participants of this stage also suggested that their personal conflicts or their

personal opinions on certain religious groups may have acted as biases, and therefore influenced their level of comfort and willingness to engage in the integration of religion/spirituality in clinical practice. This was also reported in Magaldi-Dopman et al. (2011) and evidenced by Gonsiorek and colleagues (2009) and Wiggins (2009).

In the 2nd stage study higher levels of personal religiosity/spirituality were associated, not only with more positive attitudes toward religion/spirituality and mental health (dimension composed, for instance, by items measuring mental health professionals' perception of the relevance religion/spirituality has in mental health and treatment they provided), but also with higher levels of perceived spiritual competence. Similarly, greater personal religious/spiritual involvement also significantly predicted more favourable attitudes toward the integration of religious/spiritual issues into clinical practice and reflected higher levels of spiritual competence. These interactions, though, revealed relatively low effect sizes. Even so, similar results were reported by other studies (Baetz et al., 2004; Dailey et al., 2015; Delaney et al., 2007; Frazier & Hansen, 2009; Menegatti-chequini et al., 2016; Rosmarin, Green et al., 2013).

In the last stage participants not only validated these last results (as being representative of the Portuguese context), but also considered them problematic to therapeutic processes, mostly among those lacking self-awareness concerning their own religious/spiritual values. For instance, those identifying as atheists, agnostics or even religiously ambivalent may not be able to recognize potential countertransference reactions to their clients' problems, or yet may overlook or under-estimate the importance of their clients' religious/spiritual beliefs (Robertson, 2010; Savage & Armstrong, 2010). Even those who are devoutly religious may experience difficulties in working with certain clients if their reference point remains their own personal beliefs. In this case, they may over identify with their clients' beliefs, or fail to see their clients' pathological use of spirituality or religion (Constantine et al., 2000).

It is true that being a member of a particular faith does not mean being expert in that faith or that you can accurately integrate religion/spirituality into professional psychological practice (Pargament, 2007, Plante, 2007). In fact, these professionals must be even more cautious to avoid ethical pitfalls, such as *proselytism* (trying to convert a client into engaging or abandoning a religious/spiritual belief, practice or faith), or yet to intervene in areas outside the boundaries of their competence (Plante, 2007). Perhaps the common denominator here lays on the level of psychotherapists' awareness of their own religious/spiritual value system,

the impact this might have on the client and psychotherapeutic process and, lastly, the recognition of one's professional limitations (as portrayed in the **Competence 3**, **4** and **5** of the ASERVIC guidelines) (ASERVIC, 2009).

In fact, regardless of what a mental health professional may believe in, religion/spirituality still represents an important dimension to many or yet most clients (Miller & Thoresen, 1999). As so, acquiring expertise in this field (know-how, competence or proficiency) must be carried out via learning and training (Gonsiorek et al., 2009). These topics –knowledge, skills and training in religion/spirituality- will be discussed later; however, it is important to highlight how psychotherapist's self-awareness of religion/spirituality can influence one's attitudes and spiritual competence when addressing religious/spiritual matters in therapy (ASERVIC, 2009; Wiggins, 2009; Vieten & Scammell, 2015). As Wiggins stated "*the more they* [therapists] *are aware of their stance vis-a-vis spirituality and religion, including both positive and negative associations, the better prepared therapists will be in serving clients for whom these issues are paramount*" (Wiggins, 2009, p. 53).

***Attitudes toward Religion/Spirituality in Clinical Practice***

Hand in hand with mental health professionals' personal religious/spiritual involvement are the attitudes they hold toward the relevance of religion/spirituality to mental health and the practice of psychotherapy. In fact, several studies have been conducted on religious/spiritual beliefs, practices and attitudes toward religion/spirituality and mental health among mental health practitioners, as mentioned above (e.g. Magaldi-Dopman et al., 2011; Rosmarin, Green et al., 2013; Vieten et al., 2013).

It was notable throughout this study -in all stages- how Portuguese mental health professional participants in the current study appeared to hold considerably positive attitudes toward religion/spirituality, mental health, treatment and scientific research of religious/spiritual matters. For instance, starting with the first stage, participants not only recognized religion/spirituality as an important dimension in their clients' everyday life, but also often reported these dimensions as having a positive impact on clients' mental health status, therapeutic process and in some cases on recovery outcomes. However, a disparity was found when comparing these first reports with the perceived relevance and role respondents gave to the treatment they provided to their clients.

Similarly, the items used in the second stage to assess participants' explicit perceived relevance of religion/spirituality to mental health, training and research were also highly endorsed, in contrast with those used to assess perceived relevance of religion/spirituality to the treatment they provided to their clients. This contrast was also reported in the Spiritual Competency Scale (Dailey et al., 2015), where items assessing more *theoretical* contents and relevance of religion/spirituality to mental health, development and treatment (e.g. "*Culture and Worldview*", "*Communication*" and "*Human and Spiritual Development*") were more highly endorsed when compared to items/subscales assessing more *practical and explicitly* religious/spiritual contents and relevance (such as the items of Factor 3, 2 and 1, "*Diagnosis and Treatment*" "*Counselor Self-Awareness*" and "*Assessment*", respectively). These results were discussed in the third stage, as participants validated them, also considering them as representative of the Portuguese context and several explanations were provided. These findings are also consistent with other studies, where reports of positive attitudes toward religion/spirituality were shown, however contrasting with low levels of preparedness, comfort and engagement (Frazier & Hansen, 2009; Neeleman & King, 1993; Rosmarin, Green et al., 2013). Despite these findings, mental health professionals' attitudes did act as the strongest predictor of spiritual competence. Those holding more positive/favourable attitudes toward religion/spirituality significantly produced higher levels of spiritual competence (Rosmarin, Green et al., 2013).

***Knowledge and Skills***

If mental health professionals' approaches to clients are guided by their personal beliefs, practices and the attitudes they hold toward religion/spirituality, one must also recognize the relevance knowledge may have in the clinical practice (Vieten & Scammell, 2015). Although mental health professionals are not expected to be experts in the entire range of religious/spiritual faith traditions represented in one society (unless it is of ones' personal interest), this proved to be particularly true for this study. In fact, knowledge -or yet lack of knowledge- was one of the most cited barriers to an effective integration of religion/spirituality into clinical practice in the first stage (this is also described in others studies, such as Curlin et al., 2007 and Magaldi-Dopman et al., 2011 and discussed by Pargament, 2007 and Plante, 2007). Yet, and unsurprisingly, individual literature research was also one of the most cited personal initiatives to overcome this barrier.

This could also be corroborated by the results of the second stage of this study, as a relatively high percentage of participants reported reading scientific journal articles, books, or chapters related to religion/spirituality on a regular basis. Of a great interest is that, in this stage where relationships and interactions were tested, results indicated that a higher frequency of religious/spiritual reading predicted more favourable attitudes toward religion/spirituality and mental health, as well as higher scores in the Spiritual Competency Scale. This suggests that those reading religious/spiritual scientific materials more frequently would also hold more positive attitudes toward religion/spirituality and report higher levels of spiritual competence when dealing with these issues in clinical settings.

This is remarkable, since mental health professional are encouraged to be proactive in overcoming the lack of knowledge and the lack of adequate training present in most graduate and postgraduate programs (Plante, 2007). In fact, mental health professionals are called to: stay informed about the research in this area; attend workshops and seminars; seek appropriate supervision and consultation; personally and actively learn about the religious/spiritual traditions and aspects of their clients with which they are unfamiliar and most importantly seek to understand how these operate in the life of a particular client (Pargament, 2007; Plante, 2007; Richards & Bergin, 2005; Vieten & Scammell, 2015). As such, these recommendations are encouraging mental health professional not to avoid working with religious/spiritual issues due to lack of knowledge and adequate training -or doing so inappropriately- but to be proactive in seeking resources that are available to start becoming proficient in this area.

By acquiring knowledge of the beliefs and practices of major religious traditions, psychotherapists will be able to recognize and understand the elements within those belief systems that are considered normative and healthy within a client's religious/spiritual tradition (e.g. commandments, rules, practices and ceremonies); as well as the concepts (such as perspectives on divinity, human nature, morality, and life after death) and vocabulary used in these traditions (e.g., faith, forgiveness, reincarnation, karma, meditation, sin and guilt) (Hage et al., 2006; Knox et al., 2005; Savage & Armstrong, 2010; Vieten et al., 2013). And these acquisitions are of crucial importance in what concerns for instance the demonstration of communication, assessment and diagnostic skills, which in turn will influence mental health professionals' choices regarding case formulation, treatment planning, and intervention strategies (Vieten & Scammell, 2015).

As mentioned above, some of the competencies requiring mental health professionals to attain information, facts, concepts, and awareness of the research conducted in this field were in fact present in the respondents' reports. Participants of both first and second stages could demonstrate skills regarding "*Culture and Worldview*", which highlights the relationship between cultural factors and religion/spirituality, as well as the need to consider these concepts within a multicultural framework. Some competencies of the "*Communication*" factor -which addresses awareness of the religious/spiritual nuances expressed through clients' language and mental health professionals' openness to these expressions-, were also present in participants' reports. However, competencies regarding the fourth Factor "*Human and Spiritual Development*" (which includes items describing the relationship between these two aspects of development) were only reported in the second stage (as only one segment was coded in this category in the first stage).

However, more practical competencies -*skills*- were reported and endorsed to a lesser extent in this study. These types of competencies are present in factors such as "*Assessment*" (which includes items about the inquiry of clients' beliefs during the intake process); "*Diagnosis and Treatment*" (containing items related to identifying the influence religious/spiritual beliefs have on a client's concerns, as well as how to including these beliefs in treatment) or even in the "*Counsellor Self-Awareness*" factor (which includes items that address the importance of the psychologists' self-exploration and understanding of their own beliefs and value systems). This pattern was also reported in the Frazier and Hansen study, where they identified and used 29 recommended religious and spiritual psychotherapeutic behaviours from literature to assess psychologists' perceived importance and use of these behaviours. Overall, results indicated that psychologists assessed these dimensions as important, but engaged in these behaviours less frequently than their ratings suggested they would (Frazier & Hansen, 2009).

### *Training in Religious/Spiritual Matters*

Scientific literature in this field is conclusive regarding the preparation programs for mental health professionals. Firstly, it became apparent that training programs that seek the integration of religious/spiritual issues into academic curricula may increase trainees' level of competence in addressing religious/spiritual matters with their clients (Constantine et al., 2000). However, it is also true that graduate programs have been rather slow in adapting their training programs to meet these new educational demands, mostly due to the fact that faculty

members themselves lack adequate competency in these areas (Hage et al., 2006). Consequently, most mental health professionals do not receive adequate training in how to -*ethically and effectively*- tend to the religious/spiritual domains in clinical practice (Hage, 2006; Hage et al., 2006; Miller & Thoresen, 1999; Richards & Bergin, 2005). Even among those providing specific training in religion/spirituality, results indicated the absence of an unifying model for teaching religious/spiritual topics (Young et al., 2002; Cashwell & Young, 2004), as well as training programs relying on informal and non-systematic sources of teaching (Vogel et al., 2013) leading to a significant variation in the goals and content of the training programs in religion/spirituality.

Unsurprisingly, results of this current study showed that Portuguese mental health professionals lack formal training in religious/spiritual matters. Most of the respondents of the first stage expressed a sense of inadequacy, comfort or as mentioned above a lack of enough knowledge to address religious/spiritual concerns in the clinical setting due to a lack of training in this matter. Furthermore, respondents also reported lack of alternatives to acquire such competence. Similarly, in the second stage over three-quarters of the participants reported that religious/spiritual topics were "*never* or *rarely*" incorporated into their academic training. An even greater percentage of participants (82) reported never having attended a specific course, workshop or training in religious/spiritual matters, even though most of these were interested in furthering their training in religious/spiritual matters (74%). Furthermore, many agreed that a separate course on religion/spirituality should be incorporated into psychologists/mental health professionals training programs (68%). In the third stage, participants supported these results; discussed the importance and impact training/knowledge has on mental health professionals' preparedness and competence to integrate religion/spirituality into clinical practice and reinforced the need for further training in these matters as one way to overcome these barriers.

This lack of specific training in religious/spiritual matters was also reported in previous studies conducted amongst mental health professionals (e.g. Curlin et al., 2007; Dailey et al., 2015; Menegatti-Chequini et al., 2016; Rosmarin, Green et al., 2013; Vogel et al., 2013; Young et al., 2002). Although not specifically about religious/spiritual issues, these findings are also consistent with a previous study conducted in Portugal. In this study, aiming to define and assess cultural and individual diversity competencies, 84% of the participants reported having no specific training on diversity issues, while 96% of them indicated that receiving further training on cultural and individual diversity would be useful (Moleiro,

Freire, Pinto & Roberto, 2014). Despite these findings, a higher frequency of contact with religion/spirituality in the academic training was positively associated with more a favourable stance toward the integration of religious/spiritual issues into clinical practice and also predicted higher levels of perceived spiritual competence amongst the respondents, whereas specific post-graduated training did not show significant associations.

This study also aimed to understand the pathways and interactions through which previous contact with religion/spirituality in academic training and knowledge in religious/spiritual issues may be influencing the participants' reported level of spiritual competence. As such, a conditional process model -a two moderated mediation model- was proposed. Furthermore, all interactions between these variables, mental health professionals' personal religious/spiritual involvement and spiritual competence would be regulated by the mediating role of participants' attitudes toward religion/spirituality.

Unexpectedly, the first set of results indicated that training did not show a significant direct effect on the participants' attitudes in this model, whereas mental health professionals' personal level of religious/spiritual involvement and the frequency of their literature reading were significant factors. However, when analysing the interaction with participants' religious/spiritual involvement, previous training appeared to have a significant and negative effect (i.e. a decreasing role) on the impact personal religious/spiritual involvement has on participants' attitudes. This result was also reported in the previous work of Rosmarin, Green et al. (2013[b]). Interestingly, the participants' reading habits did not produce such an effect.

Of even greater interest is that this same role was also reported in the conditional indirect effects training has on spiritual competence (through the mediating role of participants' attitudes). Although in some cases, training **AND** participants' reading habits had this effect, participants' reading habits *alone* did not have this effect on spiritual competence. As such, it seems that among those with low religion/spirituality contact levels, personal religiosity/spirituality is in fact a significant factor contributing to their perceived level of spiritual competence. However, this effect decreases when a mental health professional reports higher contact levels with religious/spiritual contents. This is of utmost importance, since it suggests that regardless of what a mental health professional may profess, with adequate training anyone in this professional field can -*ethically and effectively*- deal with religious/spiritual clients and issues in the clinical practice (Rosmarin, Green et al., 2013).

This result may also be suggestive of the structural effect specific training might have on religion/spirituality, not only in regulating the impact personal religiosity/spirituality has on mental health professionals' attitudes and spiritual competence, but most importantly on the role of shaping attitudes and acquiring competencies that these professionals can efficiently use with any patient at any time. And this effect may not work the same way with knowledge. In other words, it seems that when a mental health professional turns to individual literature research, they do so seeking a resource to overcome a specific difficulty or barrier they encounter in a specific situation. Although it seems that this pattern is in fact helping them overcome isolated situations, [*otherwise this would not be one of the most reported resources, nor would it produce any effect whatsoever*] this may not be enough.

In a recent study conducted amongst Social Work professionals in Spain regarding the elements to improve intercultural sensitivity, results indicated that theoretical knowledge appeared to be one of the most important aspects in correlation with dimensions of intercultural sensitivity. However, a further examination of the results showed that this type of knowledge was not linked to appropriate interventions (Álvarez-Pérez, Fernández-Borrero & Vázquez-Aguado, 2014). As a matter of fact, the authors asserted that *knowledge should not be limited to a technical dimension, but should also relate to experiential learning* (p. 364). Additionally, they emphasized the "*need to redirect the training received on cultural diversity, shifting from theoretical principles to a more practical approach*" (Álvarez-Pérez et al., 2014, p. 364). And here we agree!

Perhaps here it becomes important to recognize that acquiring knowledge must transcend becoming a specialist in a particular set of religious/spiritual tradition, beliefs, practices or teachings. In fact, being religiously and spiritually competent must be more than the sum of the acquired knowledge on religion/spirituality and the knowledge once acquired on psychological interventions. As Pargament described *it rests on wisdom about how to put the two together* (Pargament, 2007, p. 190). As such, all these insights must be cultivated and demonstrated in the form of skills (such as relational, assessment, interventional, referral, supervision and training ones) critical to the provision of a multiculturally sensitive service to clients with a wide range of religious/spiritual worldviews (Savage & Armstrong 2010; Vieten & Scammell, 2015).

***Limitations and Final Remarks***

The results of the current study should be examined with caution, mostly due to its limitations. Although some of them have already been mentioned in the qualitative studies presented before, it should be highlighted that most participants of the first stage, if not all, agreed to participated in this study due to their personal interest in this topic (either because they are personally involved in some form of religious/spiritual practice; or because at some point in their professional career they were challenged to deal with these dimensions; or yet *simply* because they might hold a positive view toward this topic). On the one hand, this could be considered as not constituting an issue, since the information reported was collected from an open, interested and yet ill trained sample. However, this could also be biased and not representative of all mental health professionals providing psychotherapy aid in Portugal.

It remains unknown how professionals who chose not to participate in this study may differ from those who have indeed participated, yet it is possible that those who received the invitation and were less supportive of the inclusion of religious/spiritual matters in mental health decided to decline the invitation. As such, it would also be of great value (and interest) to have the experience of those holding more negative attitudes toward the integration of religious and spiritual matters into clinical practice, or yet those who have never dealt with these dimensions in their professional settings. This concern was also discussed by Young and colleagues (2007).

Another important limitation of this study is that it relies primarily on participants' abilities and/or willingness to express, share, and/or remember, not only their daily life experiences, but also and most importantly to analyse and assess their attitudes and competencies when working with religious/spiritual clients or issues. As mentioned above, this *willingness*/*ability* has been found problematic by Rogler and colleagues (Rogler et al., 1992, as cited by Sørgaard et al., 1996), mostly when considering the well-known discrepancy between what one might think and consider to be ideal/ethical and the attitudes and behaviours that are demonstrated in the clinical settings (Sørgaard et al., 1996).

Similar concerns were discussed by Moleiro and colleagues, where self-report measures were considered limiting when assessing mental health professionals with openness to cultural issues, but little awareness and knowledge (Moleiro et al., 2014). As such, the use of distinct methods for assessing participants' level of spiritual competence (i.e. response to case vignettes; reports from clients; direct observation of therapeutic sessions or analysis of

therapeutic sessions' records) would be preferable in future research, to enable more irrefutable results.

The current research has contributed to the understanding of the importance and impact factors such as mental health professionals' personal religious/spiritual involvement, their attitudes towards the integration of religious/spiritual issues into clinical practice, but also their training and knowledge might have on their level of preparedness and comfort to deal with these matters. Although past studies have researched these factors, to the best of our knowledge, no previous research has studied the correlations between these factors as a whole. Much of what was found and reported was hypothesized based on previous research and theory. However, some surprising results were reported (i.e., that previous contact with religion/spirituality in academic training did not have a significant effect on participants' attitudes, but its interaction with a personal level of religiosity/spirituality had a significant effect; as well as the fact that knowledge alone significantly impacted participants' attitudes, but its interaction with a personal level of religiosity/spirituality did not). These are important contributions since they can inform clinical practice and promote further research on the importance of developing specific training on religious/spiritual matters, precisely tackling the needs and idiosyncrasies of each professional context. Particularly, results of this study support the need to extend training on religious/spiritual matters beyond the self-awareness component. This is of utmost importance since it provides mental health professionals the opportunity to know the trends of recent empirical research findings, as well as to understand conceptual models and also acquire more directive and effective intervention techniques to address religious/spiritual issues within the therapeutic relationship and, ultimately, provide sensitive and effective care to those seeking psychological help.

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# Chapter 5

# General Discussion

It is remarkable to think that for so long religion and mental health sciences were, not only, completely alienated from each other, but also the relationship between them was built "*on mistrust, misunderstanding, and missed opportunities, leading to a schism from both sides*" (Aten & Leach, 2009, p. 14). As several influential historical figures in the field of mental health presented religion and spirituality as factors contributing, if not causing, psychopathology (Aten & Leach, 2009; Fallot, 1998), religion and spiritual related issues were completely removed from the healthcare field (Thielman, 2009). These dimensions were then relegated only to hospital chaplains and clergy (Koenig, 2012) and education and training of mental health professionals on how to integrate religious and spiritual topics into psychotherapy became scarce (Shafranske & Malony, 1990). It is not surprising that this tumultuous relationship created what E. Wick called a "*No-Man's-Land*" (Wick, 1985, as cited by Miller & Thoresen, 1999), where many times clients -*willing to address their religious/spiritual issues in therapy* (Rose, Westefeld & Ansley, 2001)- get lost!

However, over the past years, mental health field witnessed a shift, as great strides have been made aiming to understand the relationships between religion, spirituality and mental health. This *awakening* trend lead both mental health research and professional fields to recognize religion and spirituality as key dimensions of a person's identity and worldview, being these one of the most important source of strength and direction in the life of many people around the world (Gockel, 2011; Koenig, 2012; Miller & Thoresen, 1999; Park, 2007). It also made possible to understand and determine the impact these dimensions have on physical and mental functioning, and more recently, the interest also covers their influence and effectiveness when integrated or accommodated into psychological treatment (McCullough, 1999; Wade, Worthington Jr & Vogel, 2007; Worthington, Hook, Davis & McDaniel, 2011).

Overall, results are consistent indicating that religious and spiritual people tend to present better indicators of physical and psychological well-being (e.g. Koenig, 2012), greater sense of social support (e.g. Baetz & Toews, 2009) and experiencing much more positive emotions and acts (e.g. Rosmarin, Krumrei & Pargament, 2010), being these positive connections often linked to the lifestyle habits, social support and coping strategies inherent to religious and spiritual daily life (e.g. Curry & Roach, 2012). It also seems that for many patients' religion and spirituality become even more important when facing psychological distress and suffering (Gockel, 2011), being these dimensions also important factors, contributing to faster and more stable clinical recoveries (e.g. Curlin et al., 2007).

Even when reporting the negative impact religion and spirituality also have on mental health (e.g. Baetz & Toews, 2009; Curry & Roach, 2012), researchers are congruent indicating that this might be an important step toward a better understanding of how these influences occur; how these can be challenged or used as a resource; and most importantly how to accurately address these dimensions into clinical settings, always aiming the benefit of the client, the therapeutic relationship and the therapeutic process, as a whole.

These developments in research also contributed for the increasingly awareness among mental health professionals of the need for a more sensitivity intervention with clients coming from a wide variety of cultural backgrounds, including religious and spiritual backgrounds (Watts, 2001); and even though faculties have been rather slow following these changes (Hage, Hopson, Siegel, Payton & DeFanti, 2006), many professionals in this field also recognize the need to develop greater competency in religious and spiritual diversity (Watts, 2001).

In Portugal, though, and because of the scarcity of studies in this field, there is still a lack of an overall understanding of the role and impact religion and spirituality have in the Portuguese mental health field. Therefore, the main goal of this Ph.D. project was to contribute to the development of specific spiritual competencies of mental health professionals (i.e. Clinical Psychologists, Psychiatrists and Psychotherapists), ultimately aiming an ethical and effective integration of clients' religious/spiritual beliefs in therapeutic settings. Specifically, the purpose of this work was threefold: (1) contribute to the discussion of religious and spiritual topics in the Portuguese research field, bringing this conversation also to the clinical practice; (2) understand what role religion, religiosity and spirituality play in the lives of religious/spiritual members, as well in their psychotherapeutic processes and 3) describe the current clinical practice of Portuguese mental health professionals, as regards to their attitudes, beliefs and spiritual competence when addressing religious/spiritual issues in psychotherapy.

A transformative paradigm was used in this work -*based on the Multicultural Competence theoretical perspective*- to ensure that, not only, the voices of the main characters are used to determine the proper strategies to collect, analyse, interpret and report data, but that these information are used to stimulate respect for cultural diversity (Mertens, 2010) and ultimately lead to the needed social changes (Mertens, 2012). The Multicultural Competence perspective was used as theoretical background for this work, firstly as a response to the "*urgent and necessary*" need for multiculturalism in the mental health profession (Sue,

Arredondo & McDavis, 1992, p. 480), but also to ensure that the discussion about the integration of religious and spiritual topics in the Portuguese mental health field "*recognizes diversity and embraces approaches that support the worth, dignity, potential, and uniqueness of individuals within their historical, cultural, economic, political, and psychosocial*" (ACA, 2014, p. 20).

As so, this work, organized in five main chapters, started with a contextual introduction to religion, spirituality and mental health and presented five empirical studies (Chapters 2, 3 and 4). These studies were developed with different groups and covering a diversity of perspectives and topics, aiming a more complete understanding of the phenomenon addressed in this work. This last chapter integrates the main contributions of each study, as a brief general discussion is provided, also integrating the potential implications the results of the empirical studies may have for clinical practice and research. We believe that overall, the results obtained in this work will contribute to discussion and understanding of the importance religious and spiritual matters -*as multicultural dimensions*- have in the mental health field, based above all on the perspectives, needs and recommendations of the main characters involved in the therapeutic relationship.

## Summary of the Major Findings – An Integrative View

Considering the scarcity of studies and discussion on religion, spirituality and mental health in the Portuguese research this field, the first step of this Ph.D. project was to provide a theoretical framework and an overview of the current state of literature on religiosity, spirituality and mental health, aiming to encourage a scientific conversation on these topics. Thus, the first chapter -*the theoretical introduction*- started to emphasize this remarkable lack of studies in this field, although Portugal, as a country, society and state shares a particularly long and strong relationship with the Roman Catholic Church, the main religious institution in the country. This research gap is then discussed considering the tumultuous relationship established between religion, spiritual related topics and health care field, with a particular focus on mental health.

As firstly mentioned in this chapter, as well as several times throughout this work, the relationship established between these worlds over the years, not only decided their separation, but also left deep *marks* even to the current thinking about religion and spirituality. One of the most prominent of these marks is the fact that most mental healthcare professionals avoided any contact with religion and spirituality for a long time (Curry &

Roach, 2012; Fallot, 1998; Koenig, 2012; Plante, 2007), turning these topics of little or no importance in the education and training of these professionals (Dein, 2004; Koenig, 2012), as well as in their personal live (e.g. Baetz, Griffin, Bowen & Marcoux, 2004; Delaney, Miller & Bisonó, 2007). However, it is also true that misunderstandings came from both sides, as many religiously and spiritually committed people also assumed that mental health professionals "*at best reduce religious conviction and practice to psychological processes and at worst actively derogate spirituality in its entirety*" (Fallot, 1998, p. 3).

This topic was explicitly addressed in the third chapter -in which the current relationship and collaboration between religious Leaders and mental health professionals was assessed- however, the relationship between religion, spirituality and mental health, through the eyes of a Portuguese sample, was gradually addressed throughout the studies. For instance, in the first study conducted among religious members and clients it was possible to notice that, although participants viewed mental health professionals as a possible source of help, most of the time this type of help was only considered as a last resource. Participants often reported turning primarily to religious and spiritual-based sources, being relying on God or seeking help from their religious leaders the most cited sources of help. Accordingly, only a few participants had any previous experience in the mental health system, whether in public or private practice. Similar help-seeking pattern was found in other studies (e.g. Abe-Kim, Gong & Takeuchi, 2004; Mayers, Leavey, Vallianatou & Barker, 2007), as well in a previous study we conducted (Freire & Moleiro, 2011).

As a matter of fact, most of the religious members participants of the first study stated only resorting to professional help when problems/symptoms were/are more severe or long lasting, or yet when in need of pharmacotherapy (even though this last was in some cases controversial). Interestingly, the issues related to the use of pharmacotherapy for mental illness was found to be controversial, not only by religious members and religious Leaders, but in some cases also by the mental health professionals. In this last group of participants, though, reports were scarce, and most of these were reported as a potential barrier to the adherence to psychotherapy, thus influencing the outcomes. Presently, this is also a controversial topic in the Portuguese mental health system, since the last Evaluation Report of the National Mental Health Plan for 2007-2016 (*Relatório da Avaliação do Plano Nacional de Saúde Mental*) revealed that, in 2016 alone, more than 20 million packages of psychoactive drugs were sold in Portugal (DGS, 2017). On this matter, the Order of the Portuguese Psychologists asserted that, although the SNS co-payments ascended to more than 56% of the

costs, this significant increase in the consumption of psychoactive drugs and the exorbitant expenses with these -almost 140 000 000€- are clearly indicative of a "*lack of strategy and concerted intervention*" that often "*only promote the symptoms relief*" (OPP, 2017[19]).

Furthermore, a small number of religious members also reported some level of discomfort, doubts and dilemmas prior to (or when) seek professional help; lacked information or held preconceived ideas about the role of a mental health professional; offered religious and spiritual explanations for their suffering and psychological distress; considered religious match/similarity with their mental health professional an important factor when seeking professional help, and in some occasions perceived mental health professionals as lacking sensitivity when addressing religious and spiritual issues in therapy. These reports were also found in the speech of the religious Leaders participants in the second study. As so, it seems plausible from these reports to consider that these factors (or the combination thereof) can influence one's willingness to reach out for professional help; their level of adherence to the therapeutic relationship and therefore impact the therapeutic outcomes, as reported or discussed previously (e.g. Abe-Kim et al., 2004; Dein, 2004; Knox, Catlin, Casper & Schlosser, 2005; Mayers et al., 2007).

These reports are an important beginning, as they inform mental health specialists, not only of a detailed understanding of religious members' (and prospects clients) interests and opinions, but also their expectations, experiences and conceptualizations of religion and spirituality in relation to mental health, that are essential to or can affect the therapeutic relationship (Gockel, 2011; Mayers et al., 2007). And these might be of such importance considering, for instance, the current Portuguese mental health scenario -being one of the countries with the highest prevalence rates of mental disorders in Europe and worldwide (Almeida et al., 2013); having a high percentage of people living with untreated psychiatric disorders (Almeida et al., 2013); where there is still a lack of specialized professionals (DGS, 2017) and social stigma is still very prevalent (DGS, 2016; Palha & Palha, 2016), and where scientific knowledge about the effectiveness and efficiency of psychotherapy is still very limited (Vasco, Santos & Silva, 2003).

On the other hand, more positive roles and influences of religion, religiosity and spirituality were also highly reported. In fact, it was unanimous among participants and

[19]Press Release of the Order of the Portuguese Psychologists regarding the last World Mental Health Day celebrations (October 10th 2017): https://www.ordemdospsicologos.pt/pt/noticia/2072

reported in all studies that religion, religiosity and spirituality represent key dimensions of human life, contributing to: better indicators of both physical and mental health; promote better lifestyle health behaviours: greater sense of social support; the experience of much more positive emotions; as well as the use of more effective coping strategies to deal with stressful live events. Even among mental health professionals, these dimensions were considered to have a positive impact on clients' mental health status, therapeutic process and in some cases also in their recovery outcomes.

Although, the sample of mental health professionals was religiously unlike the general Portuguese population (being, for instance, significantly less religious and less connected to a personal God), they held considerably favourable attitudes toward religion, religiosity and spirituality in mental health, treatment and scientific research. In fact, most of them were, not only, highly spiritual (as they endorsed higher levels of spirituality, importance given to spirituality and spiritual practices), but also considered the promotion of spiritual or religious development as one form of psychotherapy, rather than only an explicit therapeutic technique. This tendency for mental health professionals to be much less religious than the general population they serve was also reported in other studies (Baetz et al., 2004; Delaney et al., 2007; Menegatti-chequini, Gonçalves, Leão & Peres, 2016; Neeleman & King, 1993; Rosmarin, Green, Pirutinsky & McKay, 2013; Shafranske, 2000).

In one hand, this could explain the fact that Portuguese mental health professionals showed a tendency, not only to conceptually polarize religion and spirituality (being religion and religious related issues often perceived more negatively or having more negative impact than spirituality), but also to demonstrate more openness toward spiritual integration. This is also a phenomenon well discussed in the scientific literature -called "*The Dangers of Polarization*", being the work of Kenneth I. Pargament one of the leading references (Pargament (1999, p. 8).

Remarkably, and related to this tendency, another phenomenon well discussed in the scientific literature, is the impact mental health professionals' personal religious/spiritual involvement has on their level of comfort, willingness and competence to engage to the integration of religion/spirituality in clinical practice. And in this work mental health practitioners' personal religiously and spirituality revealed to be an important factor to the integration of religion/spirituality in clinical practice.

Overall, results of this work showed that Portuguese mental health professionals [although highly spiritual and holding considerably favourable attitudes toward religion,

religiosity and spirituality] may be lacking most of the basic religious and spiritual competencies that mental health professionals should possess to be able to work at a baseline level of competence (*but still ethically and effectively*) with their clients' religious and spiritual diversity and issues.

If we start, for instance, from the perspectives of the religious members who sought professional help, although most of them seemed overall satisfied with the service provided to them, this satisfaction was mostly related to symptoms relief. In fact, in many occasions throughout the interviews participants stated: "*…as professionals they were excellent*"; "*…technically the other one* [secular therapist] *was better*"; "*I never had a single problem with my psychologist*". However, as regard to their perception of their mental health professionals' competencies to *ethically and effectively* work with their religious and spiritual issues the whole picture is: "*From my experience the sensibility is zero. I mean as professionals they were excellent, except that sensibility (toward religious and spiritual issues) was zero. I heard things like – 'The less you believe in those magical things, the better for you'.*" or yet "W*hen I was feeling better I saw an evangelical psychologist. He was a Pastor and it was very good. I mean I think technically the other one was better, but with him (evangelical psychologist) I felt that I could talk about everything… specially that missing part*". Even among those only considering the possibility of seeking professional help, the speech was: "*I might resist a bit before going, because I wouldn't know if this person would be able to understand what is important to me, my priorities… well what is important to me.*"

Similarly, from the perspectives of religious Leaders, mental health professionals represent an important source of help when religious members face psychological problems. However, it was unanimous among these participants the importance of seeking religious and spiritual help first and resorting to mental health facilities when problems or symptoms are more severe and long lasting; when pharmacotherapy is needed or yet when religious support is not enough. Furthermore, religious Leaders while perceiving themselves as important agents to their congregants' mental health status, little to no collaboration with or referral to mental health professionals were reported outside their community faith.

This lack of basic competencies to *ethically and effectively* address religious and spiritual matters in clinical practice was also reported among mental health professionals themselves. Among other results, participants of the first sequential study stated, for instance, lacking basic knowledge about the religious and spiritual diversity in Portugal; feeling more comfortable to work competently with religious and spiritual issues, when it came to

Catholicism and/or religious beliefs similar to their own; or yet suggested how their personal conflicts or their personal impressions about some religious groups may have impacted their level of comfort and willingness to engage to the integration of religion/spirituality in clinical practice. In fact, generally, participants reported being more comfortable than prepared to deal with religious and spiritual issues in their clinical practice, while some statements of no integration whatsoever were also reported.

Results of the cross-sectional study revealed that, not only mental health professionals' scores for the SCS were substantially below the cut-off score for what was hypothesized or considered to be spiritual competent (Dailey, Robertson & Gill, 2015), but also showed that mental health professionals perceived religion and spirituality to have more relevance to mental health, training and research in general than when it comes to their clinical practice and to the treatment they provided to their clients. Apparently, mental health professionals assess these dimensions as important but fall short in incorporating them. This discrepancy was also discussed in previous studies, such as Neeleman & King, 1993 and Rosmarin et al., 2013. Furthermore, results indicated that higher levels of religious/spiritual involvement significantly predicted more favourable attitudes (Rosmarin et al., 2013) and also predicted higher levels of spiritual competence (Dailey et al., 2015).

Finally, results indicated that in an interaction with mental health professionals' attitudes, their previous contact with religious and spirituality matters in academic training and their knowledge about these dimensions, training seems to have a more *structural effect*, not only on regulating the impact personal religiosity/spirituality have on mental health professionals' attitudes and spiritual competence, but most importantly on the role of shaping attitudes and acquiring competencies that these professionals can use efficiently with any patient and at any time.

Highlighting that as important as one's religious and spiritual experiences might be [and this was discussed in the study with mental health professionals], this should not represent a criterion for the provision of a spiritually sensitive therapy. It is also true that clients in several occasions reported their wish/preference for a religious and spiritual values match with their therapist (whether by sharing their religious beliefs or by being religious; by knowing their religious/spirituality beliefs and practices or demonstrating openness to know and understand them or yet by acquiring competencies to address spiritual and religious matters in treatment).

This topic has been explored for decades now, aiming to understand the effects matching between clients and therapists (for instance those sharing the same race, ethnicity, gender, sexual orientation or religious beliefs) have on clients' perceptions of therapists and ultimately on therapeutic outcomes (e.g. Beutler, Clarkin, Crago & Bergan, 1991; Cabral & Smith, 2011; Jones, Botsko & Gorman, 2003; Karlsson, 2005; McMinn, 1984). Results in this matter have been conclusive: although, client-therapist match can improve mutual understanding, strengthen the therapeutic alliance and decreases premature termination -*as it accommodates patient preferences/demands*- (Swift, Callahan, & Vollmer, 2011); data indicate that this does not necessarily mean that the outcomes of mental health treatment will differ *only* because clients and therapists share the same characteristics (Cabral & Smith, 2011). We must acknowledge that many other aspects/factors may influence the therapeutic alliance, outcomes, efficacy and effectiveness. Furthermore, other types of matching have been proposed (for instance, matching psychotherapy to a disorder or presenting problem), but were also found to be incomplete and not always effective (Wampold & Imel, 2015).

Bruce E. Wampold, the author of the Contextual Model of Psychotherapy[20], once stated: "*that some therapists consistently produce better outcomes than other therapists in clinical trials, where therapy is manualized, therapists are trained and supervised, and adherence is monitored, suggests that* ***how*** *therapy is conducted is more important than* ***what*** *therapy is delivered*"[21] (Wampold, 2005). And here we cannot but agree! In fact, we believe that this is where *multicultural competency perspective* really makes a difference.

First, let's recall what is written on pages 53 and 54 of this work: [A psychologist should always "*provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience*" (APA, 2010, p. 4, Section 2.01 Boundaries of Competence)]. In the next paragraph of this code of conduct the following is asserted:

> "*Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status is essential for effective implementation*

[20]For more information, please see: Wampold, B. E., & Imel, Z. E. (2015). *The Great Psychotherapy Debate: The Evidence for What Makes Psychotherapy Work*. Routledge.
[21]Bold style was used to highlight the words "*how*" and "*what*", originally presented only in italic style.

*of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals*" (APA, 2010, p. 5, Section 2.01 Boundaries of Competence).

So, we wonder: if someone of a certain *age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status* is a diverse client; couldn't this *someone* be also *a* client? A human being? And isn't this what psychotherapy is all about? A primarily interpersonal type of treatment; based on psychological principles; that involves a trained therapists and a client who seeks for professional help; a client who is suffering from a mental disorder, problem or complaint? (Wampold & Imel, 2015) Is the psychotherapy ultimate goal *only* to remove or ameliorate a client's distress or is it to help this client? So, in order to go one step forward toward a more [multi]culturally sensitive psychotherapy we will also rely on the American Counseling Association "Boundaries of Competence" Section where is clearly stated that:

"*Counselors practice only within the boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience. Whereas multicultural counseling competency is required across all counseling specialties, counselors gain knowledge, personal awareness, sensitivity, dispositions, and skills pertinent to being a culturally competent counselor in working with a diverse client population*" (ACA, 2014, p. 8, Section C.2.a Boundaries of Competence)

So, the proposal that ***how*** therapy is conducted being more important than ***what*** therapy is delivered stands; in fact, we agree that culturally sensitive psychotherapy works because psychotherapy itself -*as a therapeutic healing practice*- was created from and was intended to help the healing process of a client in a specific cultural contexts. As so, we agree that *all psychotherapy is culturally adapted* (Benish, Quintana & Wampold, 2011, p. 287). If so, shouldn't all psychotherapists, or yet all mental health professionals, aspire and strive to become culturally competent?

## Final Conclusions

In an ideal scenario, religious and spiritual issues in the mental health field would "*require more than just passive acceptance*" from mental health professionals (Breuninger et al., 2014, p. 151). In fact, psychological interventions with people and groups culturally and individually diverse imply the development of specific competencies, which ultimately would lead to a sensitive integration of a client's religious and spiritual experiences (Miller, 1999).

We are aware that this work does not qualify for the actual preparation or as a training manual for mental health professionals when working with religious people or religious matters in therapy. However, we do believe that based on the multicultural competence perspective -which also includes spiritual and religious aspects of diversity-, the acknowledgement of the need for the development of specific competencies in the field of religion, spirituality and mental health -Spiritual Competency- it is a first step toward a more culturally skilled mental health professional. As so, this work should be seen as a "*wake-up call*" or another helper (*so to speak*), guiding mental health professionals to search and define what to do prior to beginning working with these issues.

To sum, this work strived to demonstrate, not only the need to acknowledge the importance of religion and spirituality in people's lives, but also how important it could be when properly integrated and addressed in clinical practice. By showing: 1) how much has been done internationally; 2) how clients' preferences, expectations and experiences can influence their perception of a competent professional and an effective and efficient psychological intervention; 3) how a healthy collaboration between mental health professionals and religious Leaders could positively impact the psychotherapeutic relationship and clinical outcomes and 4) how important is to acknowledge the impact mental health professionals' personal religious and spiritual involvement, their attitudes, training and knowledge play in their preparation to sensitively deal with religion and spirituality in clinical settings; this work intended to provide mental health professionals an opportunity to consciously "*choose*" to engage to the integration of religious and spiritual issues into therapy, choosing to go as far as one think might be suitable for his/her practice. And this might be by engaging in approaches that explicitly integrate religious and spiritual issues, or legitimately eschew them, but providing a spiritually and culturally sensitive care (Vieten et al., 2013). What is definitely not adequate to the standards required in mental healthcare is to "*deny*" a proper care by avoiding these issues to be part of a client's therapeutic process or to merely refer them to other professionals or domains claiming: "*this is no longer my jurisdiction*".

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# Chapter 6 Appendices

**Appendix A (Paper 1)**

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# Religiosity, Spirituality, and Mental Health in Portugal: a call for a conceptualisation, relationship, and guidelines for integration (a theoretical review)

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**Abstract:** In the Portuguese research society, particularly in the mental health field, little has been done regarding religiosity, spirituality and mental health. Thus, this paper strives to stimulate the interest in this area by providing an overview of the body of research on religiosity, spirituality and mental health, highlighting the role and importance these dimensions represent in the life of many people, whether in health or mental distress and illness. A brief review of the conceptualisation of religion (religiosity) and spirituality is provided, as well as some areas of disagreement and contention. Guidelines for the integration and professional training are also included, not discarding the ethical considerations inherent in this process. Finally, reflections are offered as to why bringing religiosity and spirituality into mental health field is important, as well as some implications for clinical practice, with particular focus on Portuguese mental health system.

***Keywords***: Religiosity; Spirituality; Mental Health; Conceptualisation; Integration; Guidelines; Ethical challenges

**Religiosidade, Espiritualidade e Saúde Mental: da conceptualização, à relação e às orientações para a integração (revisão teórica):** Em Portugal, a investigação científica tem sido escassa no domínio do estudo da religiosidade, espiritualidade e saúde mental. Assim, este artigo propõe-se estimular o interesse pela área, fornecendo uma visão geral do corpo de investigação relativo a religiosidade, espiritualidade e saúde mental. Realça-se o papel e a importância que estas dimensões desempenham na vida de muitos indivíduos, quer estes sofram de doença ou mal-estar físico ou mental. É fornecido um resumo da conceptualização da religião (religiosidade) e espiritualidade, incluindo algumas áreas de desacordo e controvérsia. Incluem-se também orientações para a integração e formação profissional, tendo em consideração os aspectos éticos inerentes ao processo. Por fim, segue-se uma reflexão sobre a importância de integrar a religiosidade e a espiritualidade no campo da saúde mental, bem como algumas implicações para a prática clínica, com especial enfoque no sistema de saúde mental português.

***Palavras-chave***: Religiosidade; Espiritualidade; Saúde Mental; Conceptualização; Diretrizes de integração; Desafios éticos.

Portugal is predominantly a religious country tied not only to religious beliefs and practices, but also to a number of social and cultural aspects. In the last Portuguese Census, in 2012, almost 85% of the population identified as being religious, mostly Roman Catholic, and with a growing religiously diverse population representing up to 4% of Portuguese residents (INE, 2012. See Table 1). Although being a non-confessional secular state, Portugal (as a country, a society, and state) shares a particularly long and strong relationship with Roman Catholic Church (for a historical review, see Wiarda, 1994; Vilaça, 2006; Dix, 2010).

Furthermore, as a society Portugal is quite advanced in terms of religious legislation. For instance, not only does Portuguese constitution forbid discrimination in any form, but it also constitutes religious and spiritual life as a right, as portrayed in the Art 41 - *freedom of conscience, of religion and of form of worship*. More specifically in relation to health, the Portuguese State guarantees to any citizen the right to have their spiritual and religious needs understood and included when seeking for health care (Law nº 253/2009, regulating the spiritual and religious care in hospitals and other establishments of the National Health Service).

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**Appendix B (Spiritual Competencies by ASERVIC)**


# SPIRITUAL COMPETENCIES by ASERVIC

**Endorsed by the American Counseling Association (ACA)**

***Preamble***

The Competencies for Addressing Spiritual and Religious Issues in Counseling are guidelines that complement, not supersede, the values and standards espoused in the ACA Code of Ethics. Consistent with the ACA Code of Ethics (2014), the purpose of the ASERVIC Competencies is to "*recognize diversity and embrace a cross-cultural approach in support of the worth, dignity, potential, and uniqueness of people within their social and cultural contexts*" (p. 3). These Competencies are intended to be used in conjunction with counseling approaches that are evidence-based and that align with best practices in counseling.

**Culture and Worldview**

1. The professional counselor can describe the similarities and differences between spirituality and religion, including the basic beliefs of various spiritual systems, major world religions, agnosticism, and atheism.
2. The professional counselor recognizes that the client's beliefs (or absence of beliefs) about spirituality and/or religion are central to his or her worldview and can influence psychosocial functioning.

**Counselor Self-Awareness**

3. The professional counselor actively explores his or her own attitudes, beliefs, and values about spirituality and/or religion.
4. The professional counselor continuously evaluates the influence of his or her own spiritual and/or religious beliefs and values on the client and the counseling process.
5. The professional counselor can identify the limits of his or her understanding of the client's spiritual and/or religious perspective and is acquainted with religious and

spiritual resources, including leaders, who can be avenues for consultation and to whom the counselor can refer.

**Human and Spiritual Development**

6. The professional counselor can describe and apply various models of spiritual and/or religious development and their relationship to human development.

**Communication**

7. The professional counselor responds to client communications about spirituality and/or religion with acceptance and sensitivity.
8. The professional counselor uses spiritual and/or religious concepts that are consistent with the client's spiritual and/or religious perspectives and that are acceptable to the client.
9. The professional counselor can recognize spiritual and/or religious themes in client communication and is able to address these with the client when they are therapeutically relevant.

**Assessment**

10. During the intake and assessment processes, the professional counselor strives to understand a client's spiritual and/or religious perspective by gathering information from the client and/or other sources.

**Diagnosis and Treatment**

11. When making a diagnosis, the professional counselor recognizes that the client's spiritual and/or religious perspectives can a) enhance well-being; b) contribute to client problems; and/or c) exacerbate symptoms.
12. The professional counselor sets goals with the client that are consistent with the client's spiritual and/or religious perspectives.
13. The professional counselor is able to a) modify therapeutic techniques to include a client's spiritual and/or religious perspectives, and b) utilize spiritual and/or religious practices as techniques when appropriate and acceptable to a client's viewpoint.
14. The professional counselor can therapeutically apply theory and current research supporting the inclusion of a client's spiritual and/or religious perspectives and practices.

https://www.aservic.org/resources/spiritual-competencies/

**Appendix C (Paper 2)**

DE GRUYTER OPEN Open Theology 2016; 2: 681–699

Psychotherapy and Religious Values Open Access

Jaclin' Freire*, Carla Moleiro, David H. Rosmarin

# Calling for Awareness and Knowledge: Perspectives on Religiosity, Spirituality and Mental Health in a Religious Sample from Portugal (a Mixed-Methods Study)

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**Abstract:** Recent studies have demonstrated that when suffering or in psychological distress, religious clients tend to recover faster and with better outcomes when mental health professionals (MHPs) seek to integrate their clients' religious beliefs and practices in psychotherapy. As described in the literature and highly-recommended by the American Psychological Association (APA) guidelines, promotion of an accurate and sensitive integration of a client's religious and spiritual beliefs is implied among MHPs: the awareness of the particularities, the differences and barriers that religious clients might encounter when seeking help; the knowledge and respect of those specific characteristics and needs; and the development of specific competencies. A mixed-methods approach was used to conduct this study, with the aim of understanding the role which religiosity and spirituality play in mental health and the psychotherapeutic processes of religious members and clients in Portugal. Eight focus groups and three in-depth interviews were conducted, with a total of 41 participants. Participants stated their religiosity as vital aspects in their life and reported religious/spiritual practices as their primary coping strategies. They recognised that their religiosity should not be concealed or marginalised in the context of their psychological and/or psychiatric treatment, but revealed apprehensions, dilemmas and barriers prior to disclosure. MHPs and services were seen as a possible source of help, but often as a last resort. Participants who sought professional help overall seemed to be satisfied with the service provided to them, although such treatment was mostly related to symptoms relief. Also, many concerns were shared, among them were both their wish for a religious match/similarity with their MHP, and the perception of a lack of sensibility by their MHP towards religious and spiritual issues. Conclusions and implications for research are provided.

**Keywords:** psychotherapy; religious clients' perspectives; mixed-methods approach; multicultural

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**Appendix D (Interview Guide for Study 1)**

# GUIÃO DE ENTREVISTA – GRUPO FOCAL

**Pertença**

1. O que significa para cada um/a ser **denominação X**?

**Estratégias de Coping (lidar com o sofrimento e o stress)**

2. Quando em sofrimento, em stress ou num momento mais difícil da vossa vida, o que costumam fazer? (Quem procuram?)
3. Nestas situações, qual o papel da vossa religião/espiritualidade? O que a vossa **denominação X** aconselha?
4. Em que situações procurariam apoio junto dos serviços de saúde (nomeadamente, saúde mental, psicólogos/as, etc…)?
5. Que princípios ou restrições específicas na **denominação X** poderão entrar em conflito com as indicações dos profissionais de saúde psicológica?

**Experiências e expectativas no acesso aos serviços de saúde mental**

6. Qual a vossa percepção da sensibilidade que os técnicos de saúde mental (Psicólogo; Psicoterapeuta; Psiquiatra; Enfermeiro especializado) têm para trabalharem/ajudarem um **membro da denominação X**? (Eles conhecem as vossas necessidades específicas enquanto grupo religioso? Se não, o que seria importante saberem?)
7. Imagine-se numa consulta um(a) Psicólogo(a):
    - O que gostaria que acontecesse?
    - E que não acontecesse? Que barreiras ou dificuldades acham que têm (teriam) de enfrentar quando vão a um(a) Psicólogo(a)?

    Não sei se estão familiarizados com a Lei da Assistência Espiritual e Religiosa e o recente Manual de Assistência Espiritual e Religiosa Hospitalar (se não explicar do que se trata brevemente).
8. Em que medida esses instrumentos são (poderão ser) uma mais-valia no acesso e tratamento dos membros da "**denominação X**" aos serviços de saúde em Portugal?

# GUIÃO DE ENTREVISTA INDIVIDUAL

## Introdução ao estudo

Introduções e apresentação do estudo:

- Confidencialidade;
- Formato da entrevista (gravação e transcrição);
- Dúvidas iniciais dos participantes.

## 1-Papel e importância da R/E

**1.** Qual o papel e importância da religião e espiritualidade na sua vida? E no seu bem-estar psicológico e mental?

**2.** Quando em sofrimento, em stress ou num momento mais difícil da sua vida, o que costuma fazer?

## 2-Experiência nos serviços de saúde mental

**3.** Gostava que me falasse da sua experiência quando procurou ajuda num Profissional de saúde mental, nomeadamente:

**3.1.** Quando sentiu/percebeu que precisava de ajuda;

**3.2.** As suas expectativas (o que esperava que acontecesse); Que receios tinha?

**3.3.** O que mais o(a) ajudou? E o que menos ajudou?

**4.** [Como avalia] Qual a sua opinião sobre o acompanhamento que lhe foi proporcionado?

**5.** Que papel (influência/importância) a sua religião/espiritualidade teve ao longo do acompanhamento?

**Procurar saber:**

**1.** O que o(a) levou a procurar ajuda?
**2.** Que opções de ajuda tinha? (apoio espiritual; acompanhamento psicológico)
**2.1.** Foi por iniciativa própria; indicação de familiares; encaminhamento médico; amigos; lideres religiosos…?
**2.2.** Houve conhecimento da problemática por parte do grupo de suporte (família; amigos, comunidade religiosa)?
**2.3.** Procurou outro tipo de ajuda antes, enquanto ou depois de estar em acompanhamento psicológico?

## 3-Competências Integração das crenças

**6.** Como caracteriza o(a) profissional que o(a) acompanha(ou) quanto à sensibilidade que tem (teve) ao abordar as questões da religiosidade/espiritualidade?

**7.** (Caso tenha acontecido) Que questões religiosas/espirituais foram exploradas?

**7.1.** Que razões o(a) levaram a explorar (ou não) estas questões com o profissional?

**7.2.** De que forma sentiu (ou não sentiu) abertura da parte do(a) profissional para trazer as questões da religiosidade/espiritualidade (ex: trazer praticas religiosas/espirituais, como a meditação; oração/rezas em alta voz e/ou silenciosa; a leitura das escrituras sagradas, etc.) na ajuda que recebeu?

**8.** Recomendaria este(a) profissional a um familiar/amigo/membro da sua comunidade religiosa? Porquê?

**9.** Como seria um(a) profissional (um acompanhamento) ideal no trabalho com pessoas religioso/espirituais?

**Procurar saber:**

**3.** Como foi a experiência do "DISCLOSURE":
**3.1.** Quão fácil/difícil foi expor a sua religião e a importância desta dimensão na sua vida?
**3.2.** Quem e quando acha que deveria ser responsável por trazer as questões da religião e da espiritualidade às sessões de psicoterapia (o cliente ou o profissional)?

**Appendix E (Interview Protocol used for Study 1 and 2)**

## TERMO DE CONSENTIMENTO INFORMADO

O presente questionário enquadra-se num estudo no âmbito do Projeto de Doutoramento: "*Saúde Mental, Religiosidade e Espiritualidade"* (SFRH/BD/84066/2012), a decorrer no Centro de Investigação e Intervenção Social (CIS-IUL) do ISCTE-IUL.

Este questionário pretende compreender as questões relativas ao bem-estar psicológico e espiritual das pessoas religiosas, e o significado que atribuem à vida. Trata-se de um questionário de preenchimento voluntário, confidencial e anónimo, e a eventual publicação dos dados aqui recolhidos só poderá ter lugar respeitando essa confidencialidade e em revistas e congressos da especialidade. Salientamos que não há respostas certas ou erradas relativamente a qualquer das afirmações. Pedimos-lhe que indique como se sente, e não como acha que se deveria sentir. Não é necessário pensar muito sobre cada questão. Responda a cada pergunta de acordo com a sua reação inicial, e depois passe à seguinte.

**Tendo tomado conhecimento sobre a informação disponível do estudo, declaro aceitar participar.**

___/____/ _____

_____
(Assinatura)

Agradecemos desde já a sua colaboração, sem a qual este estudo não seria possível.

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**Por favor, passe à página seguinte.**

**INFORMAÇÕES GERAIS:**

**Idade:** _____

**Sexo:** Feminino O Masculino O

**Estado civil ou relacional:**

Solteiro(a) O União de Facto O Casado(a) O Divorciado(a) O Viúvo(a) O

**Nível de Escolaridade Obtido:** _____

**Estuda atualmente?** Sim O Não O Especifique _____

**Trabalha atualmente?** Sim O Não O Profissão _____

**Qual a sua nacionalidade:** Portuguesa O Outra O **_____**

Caso não tenha nascido em Portugal, por favor indique:

**O seu País de origem? _____ Há quanto tempo reside Portugal? _____ (meses/anos)**

**Língua materna:** _____

**Alguma vez procurou ajuda nos Serviços de Saúde Mental** Sim O Não O

**Se sim, a que profissional recorreu?**

Psicólogo(a) Clinico O Psiquiatra O Psicoterapeuta O

**MMRS** (Fetzer Institute, 1999, traduzido por Moleiro *et al*., 2011)

**Durante a sua infância ou adolescência, foi educado(a) em alguma tradição religiosa?**

Sim O Não O Se sim, qual? _____

**Actualmente pertence a que Instituição Religiosa e/ou Espiritual?**

Budismo O Fé Baha'í O Adventista do 7º Dia O Igreja Católica O Igreja Ortodoxa O

Igreja Universal do Reino de Deus O Igreja de Jesus Cristo dos Santos dos Últimos Dias O

Hinduísmo O Islão O Judaísmo O Testemunhas de Jeová O

Outra: _____ **Há quanto tempo? _____(meses/anos)**

**Considera-se uma pessoa religiosa?**

Nada ○ Pouco ○ Moderadamente ○ Muito ○ Extremamente ○

**Considera-se uma pessoa espiritual?**

Nada ○ Pouco ○ Moderadamente ○ Muito ○ Extremamente ○

**Por favor classifique seu envolvimento religioso actual:**

**Na sua participação em serviços religiosos**

Nada ○ Pouco ○ Moderadamente ○ Muito ○ Extremamente ○

**Na sua participação em práticas religiosas privadas (ex. oração, meditação e estudo de materiais religiosos).**

Nada ○ Pouco ○ Moderadamente ○ Muito ○ Extremamente ○

**EBE** (Paloutzian e Ellison, 1982) e **RS-SF** (Fetzer Institute, 1999) traduzidos por Moleiro *et al*. 2011.

A seguir encontrará um conjunto de afirmações relativas ao seu bem-estar e ao significado que atribui à vida. Neste conjunto de questões o termo "Deus" poderá não representar perfeitamente a sua experiência religiosa e/ou espiritual. No entanto, e por conveniência, utilizaremos este termo para descrever uma força superior ou divina, que poderá estar ou não associada a uma organização religiosa. Para cada uma das seguintes afirmações, assinale a resposta que melhor se adequa à sua actual experiência. No entanto, se alguma não se aplicar a si, por favor deixe em branco.

**Assinale (com um X) as afirmações de acordo com a escala:**

**1.Discordo totalmente** **2.Discordo** **3.Discordo parcialmente** **4.Concordo parcialmente** **5.Concordo** **6.Concordo totalmente**

| | |
|---|---|
| Não encontro muita satisfação na oração. | (1)(2)(3)(4)(5)(6) |
| Não sei bem quem sou, de onde vim ou para onde vou. | (1)(2)(3)(4)(5)(6) |
| Creio que Deus me ama e se preocupa comigo. | (1)(2)(3)(4)(5)(6) |
| Sinto que a vida é uma experiência positiva. | (1)(2)(3)(4)(5)(6) |
| Acredito que Deus é impessoal e não se interessa pelas minhas situações quotidianas. | (1)(2)(3)(4)(5)(6) |

| | |
|---|---|
| Se adoeço posso contar com ajuda dos membros da minha congregação. | ①②③④⑤⑥ |
| Sinto-me inquieto(a) quanto ao meu futuro. | ①②③④⑤⑥ |
| Tenho uma relação pessoal significativa com Deus. | ①②③④⑤⑥ |
| Sinto-me bastante realizado(a) e satisfeito(a) com a vida. | ①②③④⑤⑥ |
| Não recebo muita força pessoal e apoio de Deus. | ①②③④⑤⑥ |
| Tenho uma sensação de bem-estar a respeito do rumo que minha vida está a tomar. | ①②③④⑤⑥ |
| Acredito que Deus se preocupa com meus problemas. | ①②③④⑤⑥ |
| Os membros da minha congregação proporcionam-me conforto quando preciso. | ①②③④⑤⑥ |
| Não aprecio muito a vida. | ①②③④⑤⑥ |
| Não tenho uma relação pessoal satisfatória com Deus. | ①②③④⑤⑥ |
| Sinto-me bem acerca do meu futuro. | ①②③④⑤⑥ |
| O meu relacionamento com Deus ajuda-me a não me sentir sozinho(a). | ①②③④⑤⑥ |
| Sinto que a vida está cheia de conflito e infelicidade. | ①②③④⑤⑥ |
| Sou muitas vezes criticado(a) na minha comunidade por aquilo que sou e faço. | ①②③④⑤⑥ |
| Sinto-me plenamente realizado(a) quando estou em íntima comunhão com Deus. | ①②③④⑤⑥ |
| A vida não tem muito sentido. | ①②③④⑤⑥ |
| A minha relação com Deus contribui para minha sensação de bem-estar. | ①②③④⑤⑥ |
| Acredito que existe um verdadeiro propósito para minha vida. | ①②③④⑤⑥ |
| As pessoas da minha congregação exigem muito de mim. | ①②③④⑤⑥ |

**Agradecemos a sua colaboração.**

**Appendix F (Codebook of Study 1)**

| Study 1 – Religious groups (Memo Manager) | | | |
|---|---|---|---|
| **Core Theme** | **Code** | **Sub-Code** | **Memo text** |
| **01-Religious/Spiritual Role**<br>O papel (impacto/importância) da R/S na vida dos participantes: no geral e /ou no dia-a-dia.<br>*Componente teórica do papel da R/S, sendo que as estratégias de *coping*, "**2-Coping mechanism**", representam a parte prática. | **1-*Meaning and purpose to life*:** Todas as referências à religião e espiritualidade como sendo uma forma de dar significado e propósito à vida. Podem ser referências às crenças religiosas ou às atribuições que os próprios participantes fazem em função da sua religiosidade. | Way of making sense | Crenças ou cognições descritas como uma forma de ver o mundo e de dar significado à vida, aos acontecimentos, ao sofrimento... |
| | | Place in the world (role & responsibilities) | Todas as formas encontradas para perceberem o lugar, papel, responsabilidade que desempenham, tendo sido atribuído pela R/S ou sentido em função da sua religiosidade/espiritualidade. |
| | **2-Community role:** Papel da comunidade religiosa | Support & belongingness | Sentimento de pertença ao grupo religioso; demonstrações de orgulho por pertencerem ao grupo. |
| | | (spiritual) family | Equiparar a comunidade/grupo à família... |
| | **3-Personal relationship with God*:** todas as referências à importância e papel que a relação intima com *Deus/Deuses/Divindades/Seres superiores tem na vida dos participantes… | God as person; close relationship | Deus/Divindade vista como uma pessoa real; salvador, numa relação pessoal... |
| | | Guidance | A relação com a Divindade vista como uma forma de reger os comportamentos e o modo de vida (ORIENTAÇÃO)... |
| | | Faith; Hope; Peace | Referencias à fé, esperança e tranquilidade que a relação com Deus* ou com a religião/grupo dão à vida dos participantes |
| | | Sons of God; Being chosen | Considerarem filhos de Deus* ou chamados filhos de Deus; a vocação ou chamamento para pertencerem ao grupo religioso. |
| | **4-Privilege; Gift; Honor:** Religião ou relação com Deus* vista como um privilégio, uma honra; | | |
| | **5-Negative side of R/S:** Aspectos negativos da religião (lideres; comunidade; crenças e práticas...) apontadas pelos participantes. | Dissatisfaction with R/S | Insatisfação demonstrada relativamente à religião (divindade) do participante; à religião dos outros, ou à R&S no geral. |
| | | Beliefs or practices | Crenças e práticas consideradas mal adaptativas. |
| | | Community | Aspectos negativos da comunidade R/S a que se pertence. |
| | | Doubts&Guilt | A culpa, a dúvida e o peso destas na vida em geral ou no momento do sofrimento. |
| | **6-Lifestyle:** Equiparar a vida religiosa a um estilo de vida, e as referencias a práticas para a manutenção da vida R&S. | "Daily" life practices | Práticas diárias como forma de cultivar a religiosidade/espiritualidade |
| | | Way of life | Referencias à religiosidade/espiritualidade como modo e/estilo de vida! |

| Core Theme | Code | Sub-Code | Memo text |
|---|---|---|---|
| **02-Coping mechanism**<br>Referência à religião como uma forma para lidar com os problemas. Todas as estratégias utilizadas para lidar com a doença; sofrimento, dor, tristeza, stress... | **0-General approach:** Referência geral à R/S como uma forma para lidar com os problemas | | |
| | **1-"Turning to" or "relying on" God:** A forma prática como a relação com Deus/Divindade/Poder Superior servem como estratégias para lidar com o sofrimento/stress/doenças... | Forgiveness | PERDÃO: Pedir perdão, sentir-se perdoado(a), perdoar... |
| | | God's help/guidance | Buscar a ajuda e orientação de Deus ou de um ser superior (santos; profetas; mensageiros...) sem especificar como... |
| | | Hope/Faith<br>Reading scriptures<br>Prayer | Fé ou esperança no futuro; outra vida…<br>Referencias à escritura/leitura das escrituras sagradas como forma de lidar<br>Orar, rezar, falar com Deus* |
| | **2-Community faith:** A forma como a comunidade religiosa serve como estratégias para lidar com o sofrimento/stress/doenças... | Religious leaders | Recorrer aos líderes religiosos, ou apoio recebido destes como forma de ultrapassar/lidar com o sofrimento. |
| | | Social support | O suporte/apoio/ajuda dado ou sentido na comunidade religiosa perante situações de doença, sofrimento... |
| | **3-Different view of the problema:** A forma prática como o significado e o propósito de vida que têm (crenças, pensamentos, ideiais…) servem como estratégias para lidar com o sofrimento/stress/doenças... | Positivity | Encarar os problemas com positividade; atitudes positivas. |
| | | Understand the meaning | Compreender (e aceitar) a razão/propósito/significado do (de um) sofrimento em concreto |
| | **4-Religious "stuff":** Tudo o que esteja relacionado com a religião e que não esteja directamente ligado a Deus(es) ou *higher power*, comunidade... | Religious models | Olhar para pessoas religiosas (santos, personagens bíblicas…), histórias, mitos, experiências como modelo para ultrapassar as dificuldades. |
| | | Magical/Alternative therapy<br>Religious beliefs<br>Religious services | Referencias a práticas mágicas e terapias alternativas;<br>Crenças religiosas específicas (por ex. citações bíblicas; mandamentos…);<br>Cultos, encontros religiosos; |
| | **5-Conventional medicine (physical & mental):** Referencias de que procurariam ajuda dos serviços e profissionais de saúde, caso necessário (já que referencias à procura efectiva esta na categoria "**2-Frequency of Access**". **INCLUI "REFERRAL"**: Todas as referências feitas ao **reencaminhamento** (FEITO) para o MHS ou o aconselhamento para a procura de ajuda profissional. | | |
| | **6-Other strategies** | Family role<br>Helping others<br>Other | O papel e o apoio familiar<br>Referências específicas de como ajudar os outros os ajudou.<br>Todas as outras estratégias sem categoria. |

| Core Theme | Code | Sub-Code | Memo text |
|---|---|---|---|
| **03- Health Principles** Princípios dos grupos religiosos para se manterem saudáveis ou direcionados a um estilo de vida mais saudável. | **1-Protective factors:** Factores que os participantes indicam como sendo benéficos (ou contribuiriam) para a manutenção da saúde. | | |
| | **2-(mental) Health structures:** Estruturas de saúde/saúde mental criadas para responder às necessidades dos membros. | | |
| | **4-Religious practices and principles:** Referências a todas as práticas específicas que ajudam na manutenção da saúde: física; mental e espiritual. | Healthier behaviors | Referências gerais à promoção ou adopção de comportamentos saudáveis |
| | | Food diet & physical activity | Referências à alimentação, atividade física como fatores para a manutenção da saúde (quer física, quer mental). |
| | | | |
| **04-Acess to Mental Health Services:** Todas as referências ao facto de terem (ou não) experiencia nos serviços de saúde mental e as referentes aos familiares/amigos/conhecidos... Desde uma sessão até acompanhamentos prologados no tempo. | **1-When to seek for professional help** | Help-seeking path | O padrão de procura de ajuda (a tendência para procurar determinadas pessoas/profissionais primeiro e só depois profissionais de saúde mental) |
| | | Severe/Worsening/Medication | Worsening of symptoms/In need of medication: perante doença psiquiátrica grave ou quando os sintomas estão exacerbados ou são físicos ou quando é necessária a medicação! |
| | | Examples of disorders&situations | Doenças/perturbações/problemas que os participantes apontam como importantes serem tratados por profissionais de saúde. |
| | **2-Frequency of Access:** Todas as experiências (ou não experiências!!) nos MHS reportadas pelos participantes (próprias, de familiares, de conhecidos...) | No experience | Referências ao não acesso aos MHS, Nunca terem ido a um psiqc! |
| | | Experience in therapy | Todas as experiências pessoais reportadas (nas entrevistas) pelos participantes. |
| | | Others experiences | A experiencia no MHS de pessoas conhecidas, familiares, amigos, membros... |
| | | Under representation | Referências à sub-representação. |
| | **3-Religious view of MH:** A forma como vêm a doença mental; o seu papel individual e responsabilidade na procura de soluções; O papel da religião no momento do *distress*; | Role of faith vs their role | O papel que a R/S tem na manutenção da saúde mental e no processo de recuperação (referências gerais)! Papel dos participantes (das pessoas religiosas). |
| | | MH with/without Religion +Concerns | Olhar holistico do problema (mental e religioso) sem fazer a separação dessas dimensões E/OU participantes que demonstram vontade para integrar R/S:<br>Formas de categorizar: WITH e WITHOUT+Concerns<br>**Ps CONCERNS**: Referência à possibilidade de não ser necessário trabalhar ou integrar a religião consoante/dependendo a problemática! |
| | | R/S satisfaction & support | Satisfação com a religião no geral ou em momentos em especifico (ex. ao longo do acompanhamento) |

| Core Theme | Code | Sub-Code | Memo text |
|---|---|---|---|
| **05-Experiencies:** TODAS as referências dos participantes que tiveram "toda e qualquer" experiência no SNSM. | **1-Mental distress:** Referencias à problemática, causas, diagnóstico (oficial, feita pelo profissional ou referenciada pelo participante), profissional e tipo de tratamento a que foi submetido, ou que o participante refere ter procurado. | Causes of mental distress | As causas apontadas para os problemas mentais/psicológicos E/OU para a procura de ajuda |
| | | Diagnosis | Distúrbio; diagnóstico feito (pelo participante, ou pelos MHP) |
| | | Type of MHP | INCLUI:<br>*tipo de acompanhamento e/ou tratamento realizado (ex: psicoterapia; psiquiatria; acompanhamento psicológico individual ou familiar; CBT; sistémica; medicação.....)<br>*tipo de profissional (psicólogo clinico, psiquiatra, psicoterapeuta...)<br>*o que o cliente procurou (ex. alivio da sintomatologia, medicação...) |
| | **2-Integration of R/S:** A forma como a R/S foram ou não integradas e trabalhadas em contexto de terapia | Disclosure + Concerns | Todas as referências ao facto do participante (paciente) revelar (quer por iniciativa própria, quer quando questionado) a sua identidade religiosa durante o processo terapêutico! + Referências ao facto de "depender" da problemática/procura para se fazer o *disclosure* da religiosidade. |
| | | Integrated (how & when) | Quando e a forma como a R/S foram integradas no processo psicoterapêutico.<br>+*With no avaliation* =Quando se refere à integração da R/S sem se avaliar o impacto ou a importância<br>+*Positive* = quando se faz uma avaliação positiva da integração ou da forma como o profissional integrou R&S (sem ser avaliar o acompanhamento/serviço prestado)<br>+*Negative* = INCLUI Negative integration OU "Oppose to religion principles" OU "R/S pathologisation by MHP" |
| | | No integration/No disclosure | Todas as referências ao facto do 1) participante (paciente) preferir (ou não poder) revelar a sua identidade religiosa OU 2) referências do participante em como o MHP não tenha questionado ou integrado a R/S. |
| | **3- Quality of service received:** A avaliação do (satisfação com o) serviço prestado. | Drop outs | Desistências do acompanhamento, relacionado ou não com a questão da religiosidade! |
| | | Dissatisfaction + R&S related | Toda e qualquer referência sobre o facto de não se estar satisfeito com o tratamento/acompanhamento…<br>- *R&S related* = Insatisfações relacionadas com a integração (ou não) da R&S |
| | | Satisfaction<br>+ R&S related<br>+ With concerns | Toda e qualquer referência sobre o facto de se estar satisfeito com o tratamento/acompanhamento…<br>+ R&S related = satisfações relacionadas com a integração (ou não) da R&S<br>CONCERNS = Quando o(a) participante refere que ficou satisfeita com o serviço mas levanta algumas questões |

| Core Theme | Code | Sub-Code | Memo text |
|---|---|---|---|
| **06-Expectations** Todas as expectativas relativamente à procura de ajuda profissional. | **1-General expectations:** Espectativas gerais sobre o papel do MHP; o tratamento; as respostas e melhorias... | | |
| | **2-R/S integration:** Expectativas relativamente à forma como R/S poderiam ser integradas (ou não); reação do MHP; *disclosure*. | Negative! | A expectativa que os MHP sejam preconceituosos, incompetentes, pouco sensíveis<br>+R/S pathologisation by MHP = expectativas que o disclosure (o conhecimento do participante ser religioso) leve a que os MHP associem os sintomas/doença à religiosidade.<br>+Religious unmatch with MHP = Quando se espera que os MHP seculares não sejam capazes de perceber um cliente religioso |
| | | Positive! | A expectativa que os MHP sejam sensíveis na integração ou que não sejam preconceituosos, incompetentes, pouco sensíveis! |
| **07-Barriers/Difficulties/Obstacles:** Percepção de barreiras ou dificuldades no acesso; adesão; estabelecimento da relação terapêutica... | **1-No barriers:** Referências ao facto de não haver barreiras/conflitos/dificuldades no acesso aos serviços de saúde mental (quer da parte dos profissionais, quer da parte das pessoas religiosas/religião); | | |
| | **2-Fear; dilemma; doubts:** Medos, dilemas e dúvidas experienciados ao longo do processo psicoterapêutico e que atrasaram, impossibilitaram, quer a procura de ajuda, quer o processo de "disclosure" sobre a R/S. | YES! or NO! | Existência (ou não) de referências sobre dilemas e medos antes de procurarem ajuda, ao longo do acompanhamento ou que os fizesse desistir da ajuda ou mesmo de pedir ajuda. |
| | | Spiritualization by R/S people (YES! Or NO!) | Casos em que não se procura ajuda profissional por se considerar que se trata de um problema religioso/espiritual ou que a cura será do foro R/S. |
| | | Illness: physical vs. mental | Diferenças entre a doença fisica vs doença mental e a forma como essa visão pode influenciar a procura de ajuda profissional. |
| | | R/S and MH boundary | Participantes reconhecerem ser "difícil" perceber/reconhecer as fronteiras que separam um aconselhamento/psicoterapia de aconselhamento espiritual/religioso (e isso representar uma barreira). |
| | **3-Oppose to religious principles:** Indicações ou terapêuticas que se oponham (contrariam) os princípios e regras da religião. | Conflicts | Conflitos entre as crenças/práticas R/S e a Psicologia! Entre as prescrições terapêuticas que entram em contradição com os princípios religiosos |
| | | Use of medication | Reservas dos participantes relativamente à utilização "*excessiva*" da medicação para resolver problemas emocionais... reservas relativamente à toma da medicação! |

| Core Theme | Code | Sub-Code | Memo text |
|---|---|---|---|
| | **5-Preconceived ideas about therapy:** Informações erradas e preconceitos sobre o papel e o trabalho dos MHP. | Lack of information | Falta de informação (ou informação errada) sobre o papel e o trabalho de um MHP. |
| | | Prejudices about seeking help | Estigmas, preconceitos |
| | **6-Resistence/Difficulty to seek PH:** A resistência de determinadas pessoas para procurar ajuda profissional, sem causa ou razão descrita. | | |
| | **7-Other barriers** | | |
| **08-Professional competence:** Referências às competências que os MHP devam ter no trabalho com pessoas religiosas; Referências ao que os MHP devem ou não fazer! | **1-MH Professional competence:** A forma como vêm um profissional competente para trabalhar com pessoas religiosas. | General professional competence | A forma como vêm os profissionais de saúde em geral. |
| | | Importance of specific competencies | A importância dada ao desenvolvimento das competências (awareness; knowledge; skills) |
| | | Presentation of MHP | Critério para procurar profissionais tendo em conta a sua biografia; informações encontradas na internet (algo importante para encontrar profissionais especializados). |
| | | Female vs Male MHP | Diferenças entre ser acompanhado por UMA ou UM MHP! |
| | | Physician vs Psychologist | Comparação feita entre médicos, psicólogos e/ou psiquiatras. |
| | | Other factors | Outros factores que influenciam as competências e o trabalho dos PSM. |
| | **4- Specific competencies:** Competências especificas e direccionadas ao trabalho com pessoas religiosas/espirituais; Referências a "Awareness; Knowledge & Skills" | Awareness | Estar ciente da componente religiosa/espiritual do paciente; ser sensivel; aberto; imparcial; respeitador; confiável:<br>**Being aware:** Estar ciente da componente religiosa/espiritual do paciente, mesmo que este não o diga explicitamente... ser capaz de "juntar as peças"<br>**Impartiality & Equality:** Ser imparcial e tratar a todos de forma igual.<br>**Openness:** Estar aberto e disponível para ouvir e perceber... com uma atitude positiva!<br>**Respect:** Respeitar a posição, crenças e decisões dos pacientes religiosos.<br>**Sense of security:** Ser capaz de tornar a terapia/relação terapêutica num "lugar" seguro; que transmita segurança/confiança. Tornar o ambiente seguro e confortável à partilha/disclosure.<br>**Sensibility:** Ser sensível... tacto para trabalhar as questões da R&S. |

| Core Theme | Code | Sub-Code | Memo text |
|---|---|---|---|
| | | Knowledge | Ter conhecimentos específicos sobre: religião; espiritualidade; práticas e crenças; importância da religião...<br><br>**Importance of Knowledge:** Importância dada ao conhecimento especifico que os MHP deveriam ter sobre questões religioso/espirituais;<br>**What to know**: O que seria importante o profissional saber sobre a R/S do paciente… referências a:<br>-Quem são e o que isso envolve;<br>-Crenças (básicas e relativas à doença, sofrimento, morte...), visão de vida;<br>-Como leva a vida (estilo de vida; regras; proibições);<br>-Importância da R/S na vida das pessoas religiosas;<br>-O que as ajuda (estratégias; práticas);<br>-A dinâmica familiar. |
| | | Strategies/Skills | Estratégias apontadas como importantes para trabalhar com pessoas R&S.<br><br>**Things to avoid:** Alguns exemplos que do que os MHP deveriam evitar fazer quando têm um paciente à frente;<br><br>**Use of religious practices:** Utilizar/incentivar/recomendar (ou NÃO) práticas religiosas no contexto clinico!<br><br>**What skill:** conjunto de estratégias recomendadas pelos participantes:<br><br>Questionar sobre a religiosidade/espiritualidade explicitamente;<br><br>Ter em conta a religião quando faz recomendações;<br><br>Despender mais tempo para saber sobre a religião;<br><br>Encorajar/validar a prática da R&S |
| | | Lack of specifics competencies | As referências relativamente à falta de competências específicas (quer seja em casos hipotéticos; quer da experiencia) |
| | | Religious match | Os que concordam ou gostariam (ou NÃO) de ter um MHP da mesma religião; religioso ou conhecedor da sua religião:<br><br>YES! or NO!<br><br>**Matching issue & concerns** = Importância/impacto do match visto pelos participantes e todas as questões levantadas! |

| Core Theme | Code | Sub-Code | Memo text |
|---|---|---|---|
| **09-Religious Leaders issue** Questões relacionadas ao trabalho do LR (função; intervenção) e a sua relação com os MHP | **1. Leaders role:** Papel do líder religioso no lidar com os problemas dos membros | 1. **Counseling**: Referências ao suporte psicológico que é prestado aos membros... Utilização de estratégias de counseling...<br>a. **Conserns**: TODAS as outras referências. Em específico a incapacidade para lidar com questões da saúde/doença mental;<br>2. **General help**: Referências à ajuda prestada sem especificar de que tipo OU com referência à saúde fisica, estilo de vida, mudança de comportamentos...<br>3. **Referral**: Todas as referências feitas ao reencaminhamento (FEITO) para o sistema nacional de saúde mental ou o aconselhamento dado para a procura de ajuda profissional.<br>4. **Religious support**: Especificações relativa à ajuda espiritual e religiosa prestada (orações, visitas...) | |
| | **2. Relationship MHP-RLeaders:** Relação entre os profissionais de saúde mental e os líderes religiosos. | 1. **Good relationship**: Referências ao facto de terem tido uma boa experiência no relacionamento com MHP;<br>2. **Problematic**: Incluindo a insatisfação demonstrada/sentida/percebida na com o relacionamento com os MHP. | |
| **10-Laws and instruments** Conhecimento e utilização dos instrumentos disponíveis (leis; panfletos...) | **1-Importance of the investigation:** Referências à importância do surgir de investigações nesta área. | | |
| | **2- Importance of the laws and instruments:** Importância dada ao conhecimento e utilização dos instrumentos disponíveis (leis; panfletos...), quer para os MHP, quer para os participantes; | | |
| | **3-Knowledge of the Law and Manual de Assistência (YES! Or NO!)** | | |

**Appendix G (Paper 3)**

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# A call for collaboration: Perception of religious and spiritual leaders on mental health (A Portuguese sample)

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**ABSTRACT**

To assess the relationship and collaborations between mental health professionals and religious and spiritual leaders, eleven representatives of ten different religious affiliations in Portugal participated in this qualitative study. Major findings reported showed that religious leaders perceive themselves as important agents in promoting and preserving their congregants' mental health, as well as aiding their recovery processes; however this occurs without much referral to or collaboration with mental health professionals. These findings are discussed, as well as why and how a healthy collaboration between mental health professionals and religious leaders can positively impact the psychotherapeutic relationship and clinical outcomes with religious/spiritual clients.

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## Introduction

Over the past few decades, research on religion, spirituality, and health has gone to great lengths to understand the nature of the relationship between these three dimensions. Although caution is advised when reading and interpreting the results (Seeman, Dubin, & Seeman, 2003; Sloan, Bagiella, & Powell, 1999), overall the scientific literature consistently indicates positive associations between holding and practicing religious and spiritual beliefs and improved health mental outcomes (Koenig, 2012; Mills, 2002; Powell, Shahabi, & Thoresen, 2003; Rosmarin, Wachholtz, & Ai, 2011). That is, on the whole, religious people tend to present lower rates of psychological distress, and experience and show much more positive emotions and behaviors (Baetz & Toews, 2009; Hackney & Sanders, 2003; Koenig, 2012; Rosmarin, Krumrei, & Pargament, 2010); experience a greater sense of coherence and social support (Baetz & Toews, 2009; Fallot, 1998; Koenig, 2012); show improved and helpful coping strategies when facing physical or psychological suffering (Abu-raiya & Pargament, 2014; Koenig, 2012; Mueller, Plevak, & Rummans, 2001; Rosmarin, Bigda-Peyton, Öngur, Pargament, & Björgvinsson, 2013; Thuné-Boyle, Stygall, Keshtgar, Davidson, & Newman, 2011); and benefit from religious factors

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**Appendix H (Interview Guide for Study 2)**

# GUIÃO DE ENTREVISTA – LÍDERES RELIGIOSOS

## Identidade; Pertença e consciência da saúde

1. Gostaria que nos descrevesse brevemente o seu percurso como **Líder/Ministro/Pastor/Padre**?
2. Que princípios ajudam os membros da **denominação X** na manutenção da saúde?

## Estratégias de Coping (lidar com o sofrimento e o stress)

3. Quando em sofrimento, em stress ou num momento mais difícil o que os membros da **denominação X** costumam fazer? Quem procuram?
4. Nestas situações, qual o papel da vossa religião/espiritualidade? O que a vossa **denominação X** aconselha? E qual o seu papel enquanto Líder Religioso e/ou Espiritual?
5. Que princípios ou restrições específicas na **denominação X** poderão entrar em conflito com as indicações dos profissionais de saúde psicológica?

## Acesso aos serviços de saúde (fisica e mental)

6. Tendo em conta a sua experiencia como Líder: Com que frequência acha que os membros da "**denominação X**" procuram os serviços de saúde (física e mental)?

   Tentar perceber o porquê da sub-representação das pessoas religiosas nos serviços de saúde:
   - Passam despercebidas?
   - Não adoecem física/psicologicamente com frequência?
   - Têm outros recursos que os ajudam na recuperação?
   - Preferem não pedir ou receiam pedir ajuda nos serviços laicos?

7. Em que situação consideraria importante encaminhar um membro a um serviço de saúde mental (Psicólogo; Psicoterapeuta; Psiquiatra; Enfermeiro especializado) … para apoio psicológico? (Procurar saber se tem alguma experiencia de encaminhamento?). Que entraves ou barreiras (receios) acha que os membros da "**denominação X**" encontram nos serviços de saúde física e mental?
8. Qual a sua percepção da sensibilidade que os técnicos de saúde mental (Psicólogo; Psicoterapeuta; Psiquiatra; Enfermeiro especializado) têm para trabalharem/ajudarem um **membro da denominação X**? (Eles conhecem as vossas necessidades específicas enquanto grupo religioso? Se não, o que seria importante saberem?)
9. No seu entender, o que faria um profissional de saúde mental competente ou preparado para trabalhar/ajudar um membro da "**denominação X**" a recuperar de um problema psicológico?
10. Quais acha serem as principais barreiras que os membros da "**denominação X**" têm de enfrentar?
11. Não sei se estão familiarizados com a Lei da Assistência Espiritual e Religiosa e o recente Manual de Assistência Espiritual e Religiosa Hospitalar (se não explicar do que se tratar brevemente).
12. Em que medida esses instrumentos são (poderão ser) uma mais-valia no acesso e tratamento dos membros da "denominação X" aos serviços de saúde em Portugal?

**Appendix I (Codebook of Study 2)**

| Study 2 – Religious Leaders (Memo Manager) | | | |
|---|---|---|---|
| **Core Theme** | **Code** | **Sub-Code** | **Memo text** |
| **00-Formação do RL** | | | Quando a formação do RL tem ligações às questões da saúde, saúde mental, psicologia... |
| **01-Religious/Spiritual Role:** O papel (impacto/importância) da R/S na vida dos participantes: no geral e /ou no dia-a-dia. *Componente teórica do papel da R/S, sendo que as estratégias de *coping*, "**2-Coping mechanism**", representam a parte prática. Face à vida no geral (teórico) | ***Meaning and purpose to life*:** Todas as formas como a R/S proporciona-lhes significado e propósito à vida, quer seja uma atribuição (na forma de crenças, por exemplo) ou que os próprios participantes atribuem em função da sua religiosidade. | Way of making sense | Crenças ou cognições descritas como uma forma de ver o mundo e de dar significado à vida, acontecimentos... |
| | | Place in the world | Todas as formas encontradas para perceber o lugar/papel/responsabilidade que desempenham, tendo sido atribuído pela R/S ou sentido em função da sua religiosidade/espiritualidade. "role & responsibilities" e "Testify" |
| | **Community role:** Papel da comunidade religiosa | Sense of belongingness | Sentimento de pertença ao grupo religioso; demonstrações de orgulho por pertencerem ao grupo. |
| | | Support | O suporte/apoio/ajuda dado ou sentido na comunidade religiosa (componente teórica) |
| | | (spiritual) family | Equiparar a comunidade/grupo à família... |
| | **Personal relationship with God*:** todas as referências à importância e papel que a relação intima com *Deus/Deuses/Divindades/Seres superiores tem na vida dos participantes… | Personal and close relationship | Deus/Divindade vista como uma pessoa real; salvador, numa relação pessoal... |
| | | Guidance | A relação com a Divindade vista como uma forma de reger os comportamentos e o modo de vida (ORIENTAÇÃO)... |
| | | Faith; Hope; Peace | Referencias à fé, esperança e tranquilidade que a relação com Deus* ou com a religião/grupo dão à vida dos participantes |
| | **Privilege; Gift; Honor:** Religião ou relação com Deus* vista como um privilegio, uma honra; | Sons of God; Being chosen | Considerarem-se filhos de Deus ou chamados filhos de Deus; a vocação ou chamamento para pertencerem ao grupo religioso. |
| | **Negative side of R/S:** Aspectos negativos da religião (lideres; comunidade; crenças e práticas...) apontadas pelos participantes. | Beliefs or practices | Crenças e práticas consideradas mal adaptativas. |
| | | Community | Aspectos negativos da comunidade R/S a que se pertence. |
| | | Doubts&Guilt | A culpa, a dúvida e o peso destas na vida em geral ou no momento do sofrimento. |
| | **Lifestyle:** Equiparar a vida religiosa a um estilo de vida, e as referencias a práticas para a manutenção da vida R&S. | "Daily" life practices | Práticas diárias como forma de cultivar a religiosidade/espiritualidade |
| | | Way of life | Referencias à religiosidade/espiritualidade como modo e/estilo de vida! |

| Core Theme | Code | Sub-Code | Memo text |
|---|---|---|---|
| **02-Coping mechanism**<br>Referência à religião como uma forma para lidar com os problemas. Todas as estratégias utilizadas para lidar com a doença; sofrimento, dor, tristeza, stress... Face ao sofrimento, doença e problemas | **General approach** | | Referência geral à R/S como uma forma para lidar com os problemas |
| | **"Turning to" or "relying on" God:** A forma prática como a relação com Deus/Divindade/Poder Superior servem como estratégias para lidar com o sofrimento/stress/doenças... | Forgiveness | PERDÃO: Pedir perdão, sentir-se perdoado(a), perdoar... |
| | | God's help/guidance | Buscar a ajuda e orientação de Deus ou de um ser superior (santos; profetas; mensageiros...) sem especificar como... |
| | | Hope/Faith | Fé ou esperança no futuro; outra vida… |
| | | Meditation | Referencias à meditação como uma prática utilizada para lidar com os problemas |
| | | Prayer | Orar, rezar, falar com Deus* |
| | | Reading scriptures | Referencias à escritura/leitura das escrituras sagradas como forma de lidar com os problemas |
| | **Community faith:** A forma como a comunidade religiosa serve como estratégias para lidar com o sofrimento/stress/doenças... | Religious leaders (+ geral) | Recorrer aos líderes religiosos, ou apoio recebido destes como forma de ultrapassar/lidar com o sofrimento. |
| | | Social support | O suporte/apoio/ajuda dado ou sentido na comunidade religiosa perante situações de doença, sofrimento... |
| | **Different view of the problema:** A forma prática como o significado e o propósito de vida que têm (crenças, pensamentos, ideiais…) servem como estratégias para lidar com o sofrimento/stress/doenças... | Positivity | Encarar os problemas com positividade; atitudes positivas. |
| | | Understand the meaning | Compreender (e aceitar) a razão/propósito/significado do (de um) sofrimento em concreto |
| | **Religious "stuff":** Tudo o que esteja relacionado com a religião e que não esteja directamente ligado a Deus(es) ou *higher power*, comunidade... | Magical/Alternative therapy | Referencias a práticas mágicas e terapias alternativas; |
| | | Religious beliefs | Crenças religiosas específicas (por ex. citações bíblicas; mandamentos…); |
| | | Religious models | Olhar para pessoas religiosas (santos, personagens bíblicas…), histórias, mitos, experiências como modelo para ultrapassar as dificuldades. |
| | | Religious services | Cultos, encontros religiosos; |
| | **Conventional medicine (physical & mental):** Referencias de que procurariam ajuda dos serviços e profissionais de saúde, caso necessário (já que referencias à procura efectiva esta na categoria "**2-Frequency of Access**". | | |
| | **Other strategies:** Todas as outras estrategias que não se incluem nas outras categorias. | Alternative therapies | Referencias a terapias alternativas como forma de lidar/ultrapassar os problemas. |
| | | Helping others | Referências específicas de como ajudar os outros os ajudou. |
| | | Other | Todas as outras estratégias sem categoria. |
| | **R/S satisfation & support:** Satisfação com a religião no geral ou em momentos em especifico (ex. ao longo do acompanhamento) | | |

| Core Theme | Code | Sub-Code | Memo text |
|---|---|---|---|
| **03- Health Principles:** Princípios dos grupos religiosos **para se manterem saudáveis ou direcionados a um estilo de vida mais saudável.** | **(mental) Health structures:** Estruturas ou serviço de saúde/saúde mental criadas para responder às necessidades dos membros (clinicas) | | |
| | **Human traits:** (Desenvolvimento de) Traços ou características humanas que os ajudam a manterem-se saudáveis: amor, justiça, colaboração, vida familiar | | |
| | **Protective factors:** Factores que os participantes indicam como sendo benéficos (ou contribuiriam) para a manutenção da saúde. | | |
| | **Religious practices and principles:** Referências a todas as práticas específicas que ajudam na manutenção da saúde: física; mental e espiritual. | Food diet & physical activity | Referências à alimentação, atividade física como fatores para a manutenção da saúde (quer física, quer mental). |
| | | Healthier behaviors | Referências gerais à promoção ou adopção de comportamentos saudáveis |
| | | Religious beliefs | Crenças religiosas que promovem (ou ajudam na promoção da) a saúde |
| | | Sacred Scriptures | Referencias às sagradas escrituras (Bíblia, tora, livros religiosos) como guias e conselhos para a manutenção da saúde (física; mental; espiritual). |
| | | Other practices | Jejum; Meditation; Prayer; Religious services; Relationship with God; Traditional medicine; |
| **04-Religious view of MH:** A forma como vêm a doença mental; o seu papel e responsabilidade; O papel da religião no momento do distress; | **MH with/without Religion:** Olhar holístico do problema (mental e religioso) sem fazer a separação dessas dimensões. E/OU Participantes que demonstram vontade para que R/S seja integrado (OU NÃO). Formas de categorização: WITH (com religião) WITHOUT (separação da R/S e saúde mental). | | |
| | **Role of faith vs their role:** O papel que a R/S tem na manutenção da saúde mental e no processo de recuperação (referências gerais)!<br>Papel dos participantes (das pessoas religiosas). E a relação entre estes dois papeis! | | |

| Core Theme | Code | Sub-Code | Memo text |
|---|---|---|---|
| **05-Acess to Mental Health Services:** Todas as referências ao facto de terem (ou não) experiencia nos serviços de saúde mental e as referentes aos familiares/amigos/conhecidos... Desde uma sessão até acompanhamentos prologados no tempo. | **When to seek for professional help:** Referencias à FORMA como procuram ajuda (a quem procuram primeiro...); QUANDO procurar ajuda; e os MOTIVOS da procura. | Help-seeking path | O padrão de procura de ajuda (a tendência para procurar determinadas pessoas/profissionais primeiro e só depois profissionais de saúde mental) |
| | | Severe/Worsening/Medication | Worsening of symptoms/In need of medication: perante doença psiquiátrica grave ou quando os sintomas estão exacerbados ou são físicos ou quando é necessária a medicação! |
| | | Examples of disorders&situations | Doenças/perturbações/problemas que os participantes apontam como importantes serem tratados por profissionais de saúde + o reconhecimento da doença mental. |
| | **Frequency of Access:** Todas as experiências (ou não experiências!!) nos MHS reportadas pelos participantes (próprias, de familiares, de conhecidos...) | Others experiences | A experiencia no MHS de pessoas conhecidas, familiares, amigos, membros... |
| | | Under representation | Referências à sub-representação das pessoas religiosas no Sistema Nacional de Saude e as causas apontadas para tal **(CAUSES FOR)** |
| **06-Experiencies:** TODAS as referências dos participantes que tiveram "toda e qualquer" experiência no Sistema Nacional Saúde Mental. | **Causes of mental distress** | | As causas apontadas para os problemas mentais/psicológicos E/OU para a procura de ajuda |
| | **Integration of R/S:** A forma como a R/S foram ou não integradas e trabalhadas em contexto de terapia | Disclosure | Todas as referências ao facto do participante (paciente) revelar (quer por iniciativa própria, quer quando questionado) a sua identidade religiosa durante o processo terapêutico! |
| | | Negative | Quando se faz uma avaliação negativa da integração ou da forma como o profissional integrou R&S (sem ser avaliar o acompanhamento/serviço prestado). |
| | | No integration/No disclosure | Todas as referências ao facto do 1) participante (paciente) preferir (ou não poder) revelar a sua identidade religiosa OU 2) referências do participante em como o MHP não tenha questionado ou integrado a R/S. |
| | **Quality of service received:** A avaliação do (satisfação com o) serviço prestado. | Drop outs | Desistências do acompanhamento, relacionado ou não com a questão da religiosidade! |
| | | Dissatisfaction | Toda e qualquer referência sobre o facto de não se estar satisfeito com o tratamento/acompanhamento… |
| | | Satisfaction | Toda e qualquer referência sobre o facto de se estar satisfeito com o tratamento/acompanhamento… |

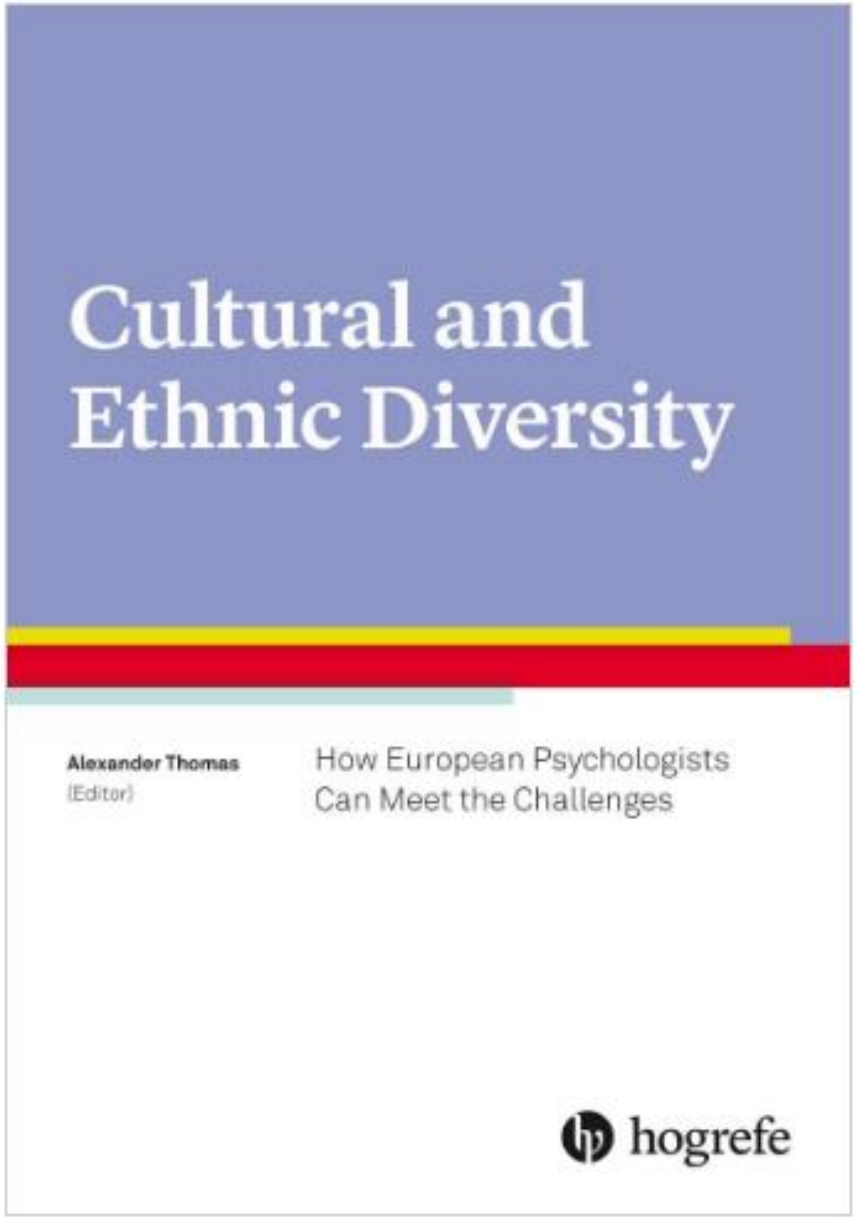
| Core Theme | Code | Sub-Code | Memo text |
|---|---|---|---|
| **07-Expectations** Todas as expectativas relativamente à procura de ajuda profissional. | **R/S integration:** Expectativas relativamente à forma como R/S poderiam ser integradas (ou não); reação do MHP; *disclosure*. | Negative! | A expectativa que os MHP sejam preconceituosos, incompetentes, pouco sensíveis<br>+R/S pathologisation by MHP = expectativas que o disclosure (o conhecimento do participante ser religioso) leve a que os MHP associem os sintomas/doença à religiosidade.<br>+Religious unmatch with MHP = Quando se espera que os MHP seculares não sejam capazes de perceber um cliente religioso |
| | | No need for integration or disclosure | Considerarem não haver necessidade/importancia/abertura para se revelarem (ou membros revelarem) a sua identidade religiosa quando em tratamento. |
| | | Positive! | A expectativa que os MHP sejam sensíveis na integração ou que não sejam preconceituosos, incompetentes, pouco sensíveis! |
| **08-Barriers/Difficulties/Obstacles:** Percepção de barreiras ou dificuldades no acesso; adesão; estabelecimento da relação terapêutica... | **No barriers:** Referências ao facto de não haver barreiras/conflitos/dificuldades no acesso aos serviços de saúde mental (quer da parte dos profissionais, quer da parte das pessoas religiosas/religião); | | |
| | **Fear; dilemma; doubts:** Medos, dilemas e dúvidas experienciados ao longo do processo psicoterapêutico e que atrasaram, impossibilitaram, quer a procura de ajuda, quer o processo de "disclosure" sobre a R/S. Existência (ou não) de referências sobre dilemas e medos antes de procurarem ajuda, ao longo do acompanhamento ou que os fizesse desistir da ajuda ou mesmo de pedir ajuda. | | |
| | **Oppose to religious principles:** Indicações ou terapêuticas que se oponham (contrariam) os princípios e regras da religião. | Conflicts | Conflitos entre as crenças/práticas R/S e a Psicologia! Entre as prescrições terapêuticas que entram em contradição com os princípios religiosos |
| | | Use of medication | Reservas dos participantes relativamente à utilização "*excessiva*" da medicação para resolver problemas emocionais... reservas relativamente à toma da medicação! |
| | **Perspectives on illness:** A forma como a perspectiva sobre a doença pode influenciar a procura de ajuda profissional. | Spiritualization by R/S people | Casos em que não se procura ajuda profissional por se considerar que se trata de um problema religioso/espiritual ou que a cura será do foro R/S. |
| | | Illness: physical vs. mental | Diferenças entre a doença fisica vs doença mental e a forma como essa visão pode influenciar a procura de ajuda profissional. |

| Core Theme | Code | Sub-Code | Memo text |
|---|---|---|---|
| | **Preconceived ideas about therapy:** Informações erradas e preconceitos sobre o papel e o trabalho dos MHP. | Lack of information | Falta de informação (ou informação errada) das pessoas religiosas sobre o papel e o trabalho de um MHP. |
| | | Prejudices about seeking help | Estigmas, preconceitos |
| | **Resistence/Difficulty to seek PH:** A resistência de determinadas pessoas para procurar ajuda profissional, sem causa ou razão descrita. | | |
| | **Percepção de discriminação:** Referências ao facto de se sentirem discriminados (quer pessoalmente, quer em grupo) por pertencerem à sua comunidade religiosa | | |
| | **Other barriers** | | |
| **09-Professional competence:** Referências às competências que os MHP devam ter no trabalho com pessoas religiosas; Referências ao que os MHP devem ou não fazer! | **MH Professional competence:** A forma como vem um profissional competente. | General professional competence | A forma como vem os profissionais de saúde em geral. |
| | | Importance of specific competencies | A importância dada ao desenvolvimento das competências (awareness; knowledge; skills) |
| | | Physician vs Psychologist/MHP | Comparação feita entre os médicos e os psicólogos e/ou psiquiatras. |
| | | Other factors | Outros factores que influenciam as competências e o trabalho dos MHP. |
| | **Specific competencies:** Competências especificas e direccionadas ao trabalho com pessoas religiosas/espirituais; Referências a "Awareness; Knowledge & Skills" | Equality | Tratar a todos de forma igual |
| | | Knowledge: Ter conhecimentos específicos sobre: religião; espiritualidade; práticas e crenças; importância da religião... | **Importance of Knowledge:** Importância dada ao conhecimento especifico que os MHP deveriam ter sobre questões religioso/espirituais;<br>**What to know**: O que seria importante o profissional saber sobre a R/S do paciente… referências a:<br>-Quem são e o que isso envolve;<br>-Crenças (básicas e relativas à doença, sofrimento, morte...), visão de vida;<br>-Como leva a vida (estilo de vida; regras; proibições);<br>-Importância da R/S na vida das pessoas religiosas;<br>-O que as ajuda (estratégias; práticas);<br>-A dinâmica familiar. |

| Core Theme | Code | Sub-Code | Memo text |
|---|---|---|---|
| **09-Professional competence:** Referências às competências que os MHP devam ter no trabalho com pessoas religiosas; Referências ao que os MHP devem ou não fazer! | **Specific competencies:** Competências especificas e direccionadas ao trabalho com pessoas religiosas/espirituais; Referências a "Awareness; Knowledge & Skills" | Openness | Estar aberto e disponível para ouvir e perceber... com uma atitude positiva! |
| | | Religious match | Os que concordam ou gostariam (ou NÃO) de ter um MHP da mesma religião; religioso ou conhecedor da sua religião:<br>YES! or NO!<br>**Matching issue & concerns** = Importância/impacto do match visto pelos participantes e todas as questões levantadas! |
| | | Respect & sense of security | Respeitar a posição, crenças e decisões dos pacientes religiosos e tornar o ambiente seguro e confortavel à partilha/disclosure |
| | | Sensibility | Ser sensível... tacto para trabalhar as questões da R&S. |
| | | Strategies/Skills | Estratégias apontadas como importantes para trabalhar com pessoas R&S.<br>**Use of religious practices:** Utilizar/incentivar/recomendar (ou NÃO) práticas religiosas no contexto clinico!<br>**What skill:** conjunto de estratégias recomendadas pelos participantes:<br>Questionar sobre a religiosidade/espiritualidade explicitamente;<br>Ter em conta a religião quando faz recomendações;<br>Despender mais tempo para saber sobre a religião;<br>Encorajar/validar a prática da R&S |
| | | Lack of specific competencies | As referências relativamente à falta de competências específicas (quer seja em casos hipotéticos; quer da experiencia)<br>Lack of Knowledge: Falta de conhecimento<br>Lack of Respect/Openness: Falta de respeito e abertura<br>Lack of Sensibility: Falta de sensibilidade<br>Reasons for lack of Sensibility |

| Core Theme | Code | Sub-Code | Memo text |
|---|---|---|---|
| **10-Religious Leaders issue** Questões relacionadas ao trabalho do LR (função; intervenção) e a sua relação com os MHP | **Leaders role:** Papel do líder religioso no lidar com os problemas dos membros | 5. **Conversão**: Papel/trabalho na conversão dos novos membros... (não tem a ver com a saude mental)...<br>6. **Counseling**: Referências ao suporte psicológico que é prestado aos membros... Utilização de estratégias de counseling...<br>a. **Conserns**: TODAS as outras referências. Em específico a incapacidade para lidar com questões da saúde/doença mental;<br>7. **General help**: Referências à ajuda prestada sem especificar de que tipo OU com referência à saúde fisica, estilo de vida, mudança de comportamentos...<br>8. **Referral**: Todas as referências feitas ao reencaminhamento (FEITO) para o sistema nacional de saúde mental ou o aconselhamento dado para a procura de ajuda profissional.<br>9. **Religious support**: Especificações relativa à ajuda espiritual e religiosa prestada (orações, visitas...) | |
| | **Relationship MHP-RLeaders:** Relação entre os profissionais de saúde mental e os líderes religiosos. | 3. **Good relationship**: Referências ao facto de terem tido uma boa experiência no relacionamento com MHP;<br>4. **Problematic**: Incluindo a insatisfação demonstrada/sentida/percebida na com o relacionamento com os MHP. | |
| **11-Laws and instruments** Conhecimento e utilização dos instrumentos disponíveis (leis; panfletos...) | **Importance of the investigation:** Referências à importância do surgir de investigações nesta área. | | |
| | **Importance of the laws and instruments:** Importância dada ao conhecimento e utilização dos instrumentos disponíveis (leis; panfletos...), quer para os MHP, quer para os participantes; | | |
| | **Knowledge** (Conhecimento da lei e do manual de assistencia religiosa e espiritual em contexto hospitalar)<br>**YES (conhecem a lei e/ou o manual)**<br>**NO (não conhecem nem a lei; nem o manual)**<br>**Unsatisfied or have concerns (os que se mostram insatisfeitos ou levantam questões acerca da lei ou do manual)** | | |

**Appendix J (Paper 4)**






Chapter 12 Reframing Human–Computer Interaction Based on Cross-Cultural and Cultural Psychology: A Review of Key Research Questions . . . . . 107
*Torkil Clemmensen*

Chapter 13 Effects of Cultural Diversity in Various Fields of Industrial and Organizational Psychology . . . . . 121
*Stefan Kammhuber and Douglas L. Morse*

**Part V Clinical and Counselling Psychology** . . . . . 133

Chapter 14 Aspects of Transcultural Counselling and Psychotherapy . . . . . 135
*Ulrike de Ponte and Hans van Eck*

Chapter 15 Cultural Differences in Illness Beliefs, Coping, and Motivation for Psychotherapy as Predictors of Treatment Outcome . . . . . 143
*Luisa Bockel and Ricarda Mewes*

Chapter 16 Religious and Spiritual Competency of Mental Health Professionals in Psychological Care: Meeting Clients' Needs . . . . . 153
*Jaclin Freire and Carla Moleiro*

Chapter 17 Intermarried Couples Negotiating Mixedness in Everyday Life in Denmark: Lessons for Psychologists . . . . . 159
*Rashmi Singla*

**Part VI Migration/Immigration** . . . . . 169

Chapter 18 A Professional Qualification Framework of Working with (Im)migrants and Refugees (WIRE) . . . . . 171
*Heike Abt*

Chapter 19 Culture in Resilience Processes: Looking at the Meaning of Narratives of Those Who Migrate . . . . . 179
*Sandra Roberto and Carla Moleiro*

**Part VII Psychology of International Youth Exchange** . . . . . 185

Chapter 20 Developmental-Psychological Contributions to International Youth Exchanges . . . . . 187
*Ulrike de Ponte*

Chapter 21 Effects of International Youth Exchanges on Openness and Mobility in Professional Careers . . . . . 193
*Heike Abt and Siegfried Stumpf*

Chapter 22 Effects of International Youth Exchanges on Young People in Need of Special Support . . 203
*Alexander Thomas and Ulrike de Ponte*

Chapter 23 Development of Multicultural Identity in International Youth Exchange Experiences . . 211
*Alexander Thomas*

Contributors . . . . . 221

**Appendix K (Interview Guide for Study 3)**

# GUIÃO DE ENTREVISTA – PROFISSIONAIS DE SAÚDE MENTAL

## 1-Introdução do estudo e história profissional do(a) participante

1. Introduções e apresentação do estudo:
    a. Confidencialidade;
    b. Formato da entrevista (gravação e transcrição);
    c. Dúvidas iniciais dos participantes.
2. Gostaria que começasse por me contar um pouco a sua história pessoal e de como se tornou Psicólogo (a) clínico (a)/Psicoterapeuta.

## 2-Conceptualização: Religião (religiosidade) e Espiritualidade; Saúde Mental

3. De acordo com a sua experiência pessoal e profissional como definiria Religião; religiosidade e espiritualidade?
    a. Considera que estes conceitos são distintos; complementares ou se sobrepõem?
4. Que papel acha que a religião (religiosidade) e espiritualidade (poderão) desempenham na saúde e bem-estar das pessoas, especificamente no que se refere à saúde mental?

## 3-Integração (avaliação; estratégias; conhecimento)

5. Com que frequência costuma abordar questões relacionadas com a religião (religiosidade) e espiritualidade nas conceptualizações dos seus casos psicoterapêuticos?
    a. Geralmente **como** e **quando** surgem essas questões? [são levantadas por si ou pelo(a) cliente]

        Especificamente costuma questionar acerca da religião; religiosidade; espiritualidade ou sistema de crenças aos seus pacientes/clientes? Com que frequência?

    b. Sente alguma barreira na obtenção destas informações? [quer da parte do profissional, como do cliente]
6. [Caso tenha] Gostava de lhe pedir que se recordasse de 2 experiências em que a religião, a religiosidade e/ou espiritualidade foram abordadas e trabalhadas: uma com sucesso e outra sem sucesso.
    c. O que acha que ajudou a que a abordagem e trabalho fossem um sucesso?

d. O que poderá ter dificultado? O que faria diferente?

7. [Alguma vez o fez?] Ate que ponto consideraria utilizar práticas religioso-espirituais (ex: meditação; oração/rezas em alta voz e/ou silenciosa; a leitura das escrituras sagradas, etc.) como estratégias no contexto clinico?

**4-Avaliação da competência pessoal**

8. Quão preparado(a) [confortável] se sente em explorar e trabalhar estas questões?
9. No que se refere às questões da religião (religiosidade) e espiritualidade que tipo de formação e/ou treino teve antes e durante a sua formação académica e profissional?
    a. Se NÃO questionar se teve formação específica sobre a diversidade cultural e individual?
10. Que tipo de apoio adicional considera ser necessário [ou precisaria] para que possa integrar e trabalhar questões religiosas e espirituais ao longo de um acompanhamento psicológico?
    b. A quem se dirigiria ou o que faria para conseguir esse apoio?
    c. [Se aplicável] De que forma uma formação específica sobre religião/espiritualidade [questões da multiculturalidade, no geral] poderia ser importante? [Lic.? MA? Ph.D.? Pós graduações? Cursos de formação?]
11. Quão importante acha ser a pesquisa sobre as questões da religião/espiritualidade no contexto da Psicologia?

**NOTA: Preenchimento do questionário demográfico e formulário de consentimento.**

**Appendix L (Descriptive Statistics of the items of the SCS, Study 4)**

Table 23 - *Descriptive Statistics of the items of the Spiritual Competency Scale (means and standard deviations)*

| | *Mean* | *SD* |
|---|---|---|
| Religious beliefs should be assessed at intake. (N=206) | 3.41 | 1.424 |
| If counselors do not explore their own spiritual beliefs, they risk damaging the therapeutic alliance. (N=206) | 3.18 | 1.590 |
| Sacred scripture readings are appropriate homework assignments. (N=207) | 2.23 | 1.209 |
| Understanding human development helps a counselor work with spiritual material. (N=206) | 4.48 | 1.184 |
| Spiritual/religious beliefs impact a client's worldview. (N=208) | 5.21 | .782 |
| Addressing a client's spiritual or religious beliefs can help with therapeutic goal attainment. (N=208) | 4.55 | 1.011 |
| Inquiry into spiritual/religious beliefs is part of the intake process. (N=207) | 3.27 | 1.401 |
| Counselors who can describe their own spiritual development are better prepared to work with clients. (N=208) | 3.84 | 1.404 |
| Including religious figures in guided imagery is an appropriate counseling technique. (N=205) | 2.70 | 1.337 |
| There is a relationship between human development and spiritual development. (N=208) | 4.21 | 1.213 |
| Coping strategies are influenced by religious beliefs. (N=207) | 4.33 | 1.115 |
| A counselor's task is to be in tune to spiritual/religious expressions in client communication. (N=206) | 3.77 | 1.367 |
| It is essential to determine a client's spiritual functioning during an intake assessment. (N=208) | 3.19 | 1.330 |
| Counselors are called by the profession to examine their own spiritual/religious beliefs. (N=206) | 3.88 | 1.435 |
| Prayer is a therapeutic intervention. (N=205) | 2.68 | 1.469 |
| It is essential to know models of human development before working with a client's spiritual/religious beliefs. (N=205) | 4.24 | 1.235 |
| A client's perception of God or a higher power can be a resource in counseling. (N=208) | 4.16 | 1.201 |
| Spiritual/religious terms are infused in clients' disclosures. (N=205) | 4.50 | 1.096 |
| Counselors who have not examined their spiritual/religious values risk imposing those values on their clients. (N=207) | 3.96 | 1.579 |
| Cultural practices are influenced by spirituality. (N=206) | 4.76 | .996 |
| A client's worldview is affected by religious beliefs. (N=208) | 4.90 | .854 |