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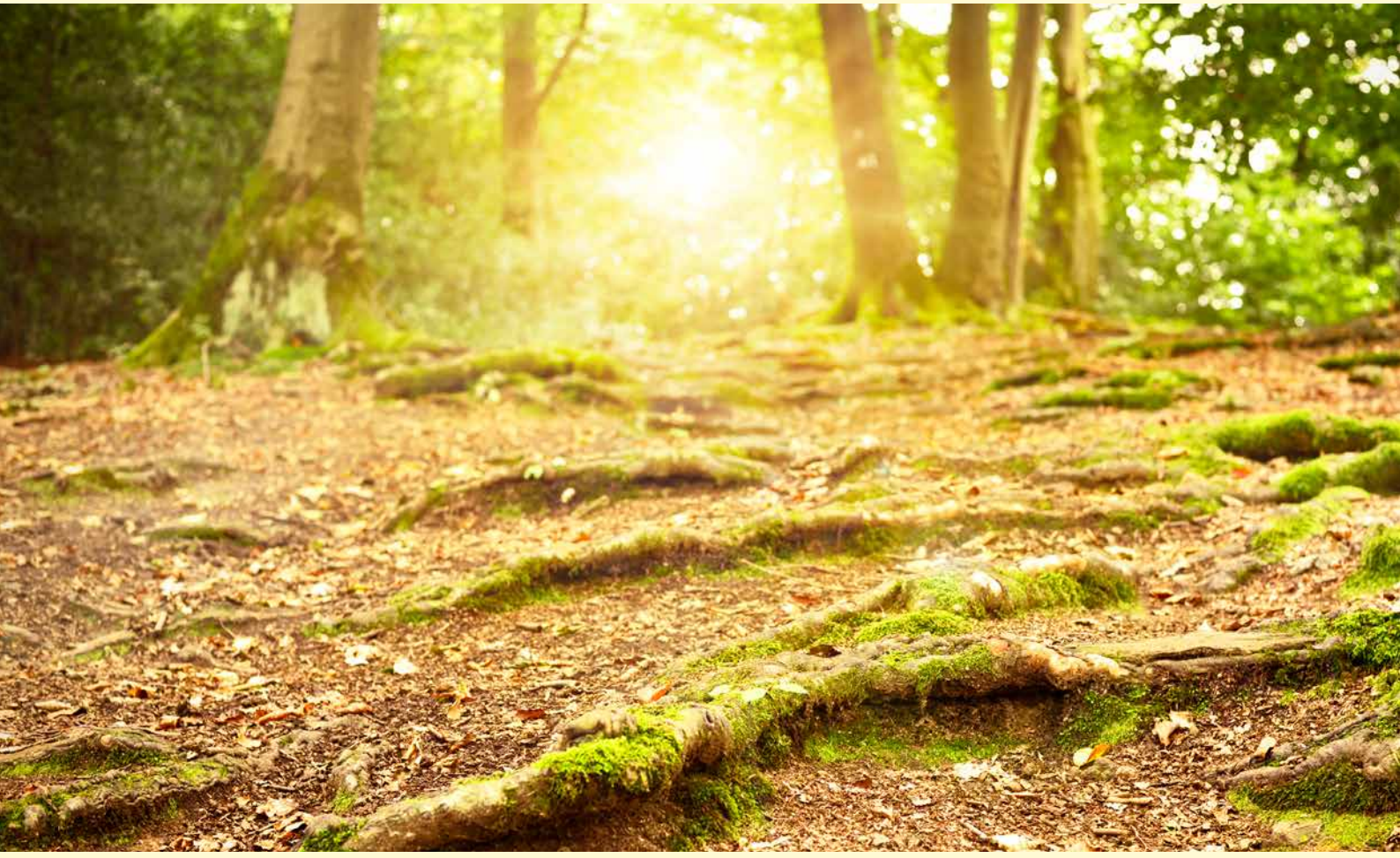
Race, culture and diversity

A collection of articles



Edited by Dr Yetunde Ade-Serrano, Dr Ohemaa Nkansa-Dwamena & Dr Maureen McIntosh

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Contents

1 **Foreword**

2 **Introduction**

5 **Sense of self and the influence of culture: A psychological and personal perspective**
Dr Peter Martin

17 **Making sense of idioms of distress and cultural expression in psychotherapeutic practice**
Dr Maureen McIntosh

32 **Islam and counselling psychology: Soul to soul**
Dr Zakia Mahmood

56 **Modern feminism and counselling psychology: The danger of a single story – considering Black women in feminism**
Dr Ohemaa Nkansa-Dwamena

70 **The essence of spirituality and its applicability to practice – an alternative perspective**
Dr Yetunde Ade-Serrano

Foreword

We have produced this working booklet in the hope it will have some influence, contribute to the moving dialogue, and bring about a change in the thinking of and attitudes towards race, culture and difference, particularly within the areas of training, clinical practice and supervision. Addressing the issue of culture within counselling psychology (and applied psychology) is an enormous task and goes beyond the scope of this booklet. Nevertheless, critiquing this subject area is of utmost relevance and significance to us and has implications for professional development. We all have a culture that is both diverse and unique, and is at the core of our multi-cultural society within the UK.

Thus, the booklet is born out of illuminating areas of growth and a necessity to share in the cultural evolution of our current locality. The authors of this booklet have brought a wealth of experience and knowledge, offering contemplations, examining clinical work, and appraising topics that are of interest to them and meaningful for us all to reflect on.

We thank all the authors for their fidelity and perseverance during the production of this booklet.

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Introduction

'Be the change that you wish to see in the world.'
Mahatma Gandhi

Counselling psychology has grown over the decades, shaping its identity successfully, through its competencies, conscientiousness and the passion to make positive changes in the lives of people. Martin (2015) purports that cultural awareness is a central tenet of counselling psychology. Counselling psychologists are reflective and reflexive practitioners evolving both personally and professionally throughout the lifetime of their work with clients, within organisations, and communities. As scientist-practitioners the evidence we gain from these experiences informs the way we relate to all those we engage with.

There has been a transition over the last five years in the terminologies used in this area: equality, diversity, etc. Diversity as it is used within this booklet refers to a number of components including but not limited to gender, age, disability, sexuality, faith and/or religion, spirituality, race and ethnicity. Culture is a fluid enterprise between individuals and communities creating an environment of shared values, principles and systems of function through learning. Carriere (2014) believes that culture is cultivated; we propose that this phenomenon exists to bring together like-mindedness that is affirming. If the assertion that culture can be fluid is true, then, we could argue that culture cultivated in this way is not limited to the experience of cultural values within a specific ethnicity alone. Rather, culture can be across multi-ethnic groups including those from the dominant culture. We do acknowledge the silenced ethnicities and hope to give them a voice not just through our research or practice but also by our advocacy.

How can we as practitioners move the agenda forward for all marginalised individuals? How can *'we be that change we wish to see in the world'?* (Ghandi). How can we model acceptance and authenticity in our interactions when we work with clients from a different culture? How can we make sure that as well as culture, all aspects of a persons' life story is included within psychological formulations?

Unfortunately, and despite all the research about culture and diversity issues, racism, and cultural adaptations to therapeutic practice (e.g.: Rathod, Kingdon, Pinninti, Turkington & Phiri, 2015), certain ethnic minorities are still not accessing services, and are also more likely to be over represented within psychiatric hospitals. Is there unacknowledged bias and discrimination against some social groups because they represent a racial and cultural group different from the majority?

We postulate that in dialogue with colleagues on issues of equality, recognition and appreciation of difference, cognizance of our similarities and overlapping values of individuals/communities is needed. The colour of a person's skin, one's gender, disability, religious predisposition and language should not be used by others in making stereotypical assumptions about who, what or how the person is. In addition, awareness of one's own culture, biases, letting go of unhelpful assumptions being curious about the client history, and an openness to allow the client to teach us is the beginning of a worthwhile collaborative therapeutic relationship based on mutual respect. It is from this stance

that this booklet was developed, and every author who contributed, did so with a desire to explore and highlight the nuances of working with individuals who hold multiple identities.

Culture and diversity permeate every aspect of the work we do as psychologists, sometimes in the most subtle of ways. It is the presence of these which may facilitate themes of sameness and difference, a sense of belonging and otherness, and aspects of privilege and bias, all of which can affect the dynamic in therapeutic and supervisory work. Culture and diversity also feed into research stances and processes, and can open up exploration in such a way as to encourage growth and movement. However, in the same vein, where the subtleties and complexities of culture and diversity are engaged with from too subjective a standpoint, there is a risk of perpetuating the unhelpful cycles we try to distance ourselves from when working with culture and diversity. We risk creating harm even though the intention of our obligations to our clients and others come from a meaningful place.

As such, it is important to bear the following in mind when reading this booklet:

1. Culture is ever changing.
2. No one definition of culture encompasses what this will mean for any one individual at any given time.
3. Cultural knowledge is an integral and continuous process.
4. Culture is crucial and informs identity, attachment and engagement styles, it can be a template for recovery.
5. Culture is not language specific but is an expression of individual and or group experiences.
6. Lacking an awareness of race, culture and difference is unethical.

It is with the above that the papers in this booklet were curated, covering a wide range of experiences, research and clinical perspectives set within a counselling psychology context and narrative. It is hoped that in reading this booklet, readers will engage with a critical exploration of the meaning of culture and develop an understanding of its conscious and unconscious manifestations. Furthermore, the core aim of this booklet is to contribute to the development of awareness which can inform both clinical and research practice as well as consider different ways of engaging with individuals from a range of culturally diverse backgrounds.

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Sense of self and the influence of culture: A psychological and personal perspective

Peter Martin

What is this article about?

This article explores the 'self' as it may apply to theoretical, existential and clinical situations, using my experience as a case study in the mutable self. The purpose of this article in a booklet produced by the Black and Asian Counselling Psychologists' Group (BACPG) is to make a case for adventure, mistakes, the building of robust trust and respect, so that we can better serve and use our skills for the whole ever-changing community. That is my task.

I might seem to be the very last person to be writing for this important booklet. I am white, English (very) late middle-aged, and male, and nowadays sort of middle-class. But so are *you* the very last person to be suitable to know about someone else. For we are engaged in similarity and difference, and above all in how these factors affect change in a sense of self…and thanks for asking me.

I begin with a single case study, which explores cultural determinants and issues. I question the viability of any permanent sense of self, and eventually land on earth by adopting a pragmatic 'as if self-existed' position, although from a post-modernist perspective. This is followed by an exploration of the underlying thinking behind social-constructionism, and its clinical implications. The consequent need to be equipped for uncertainty and unknowing is illustrated by the nature of responses to a recent piece of my research. This is followed by short clinical vignettes illustrating the importance of provisionality and pragmatism. The piece concludes with an estimate of the human values needed to pursue this hazardous but worthwhile pathway. Increased toleration of uncertainty and of feeling 'unsafe' is promoted as most useful tools in navigating this sophisticated social ecology. There follows an exploration of consequent issues facing Counselling Psychologists in a many-layered and ever-changing society.

Keywords: self, structural-functionalism, social constructionism, cultural awareness, pragmatism, counselling psychology, post-modernism, intersubjectivity.

A construction of self: A workshop of the soul, or the constituents of constructionist analysis. A case study of a white male counselling psychologist's encounter with 'otherness'.

My own sense of self is partly informed by age. I grew up while the embers of empire were still experienced not as the past, but as a kind of given 'reality'. When I looked at maps in school, there was a preponderance of red-coloured national entities, representing British colonies or Commonwealth countries. I assumed that important inventions would be made by British men. I did not, as a child, even consider that I was white: 'we' were white and the 'others' were like people in books or on travel films, or in what were deemed 'exotic' *National Geographic* magazines, who might be black, or Indian or Chinese. The fact that my

family was working-class and therefore 'other' to the majority of people who taught me, ran churches, or wrote books, was inconvenient to this view of self. We were financial pariahs since we lived on a council estate where credit was not awarded by major companies, yet we still clung to the idea of being 'better' than many others. My working-class sense of self was dictated by strong largely unspoken social norms, which in turn became a source of fascination for mainly middle-class researchers (e.g. Wilmott & Young, 2007). Then there was politics. My mother in her own words was 'Conservative by aspiration, but Labour by necessity', so there was another 'given'. But this 'given' was to be challenged and brought into conflict by my education (or should I say, by conflicting culture?).

The chance of a grammar-school place and the 'estrangement' from family culture that this experience enhanced, confirmed me in clinging on to whatever 'one-up' status I could find. Insecurity warps the mind! All of this cultural conflict could have been an invitation to retreat to polarisation of 'safe' but fragile permanent constructions fiercely maintained. What is my identity now? Is it uneasy working-class or uneasy middle-class? I am a hypocrite in either; or now, put more gently, I am discovering that cultural identity can sometimes be a place of temporary refuge, but for me never now my permanent domicile.

Alongside such conundrums were the paradoxical influences of Christian allegiance. On the one hand, these still placed a great emphasis on the work of missionaries, who were clearly on the 'right side', spreading the 'good news' and socialisation into 'civilising' practices. On the other, they sounded the constant call for personal humility and personal responsibility (I am a Protestant!). But this one-up stance as one of the 'winners' in my own mind then was confounded by my doubts about myself as an individual, intellectually, socially and as a man-to-be. It was indeed that interaction between the individual and the perceived dominant or prevailing culture, between the construction of a personal world and the wider, exterior construction of society that halted me in my tracks as potentially an out-and-out elitist.

My growing awareness of my (homo)sexuality, a cause for conflict in the context of almost uniformly sin-soaked sermons on this aspect of human experience, gave an inroad into and heightened awareness of 'otherness', the salvation from destructive belonging. Perhaps one of the products of the dialogue, or the intra-subjectivity engendered by a clash of cultures is what often transpires as intersubjectivity between others, and existential loneliness is thus assuaged? But the nature of this world, in which interaction between people, between external and what we see as internal, and between parts of sense of self, makes for a turbulent existence.

So when I seek to interact as authentically with people who are in some sense 'other', as culture might define them, I am aware of a maxim (whose origin I have sadly forgotten) which sums up difference in this case for a sexually 'other' person. It went something like 'Never forget that I am gay, and never treat me only as a gay person'. This impossible demand of someone who wants to relate to me is salutary. Moments of intersubjectivity arise when we each remember that the other occupies another cultural space in which we are a stranger. Sometimes, just sometimes, we find the commonality of strangers, when I/we experience the flash of intersubjectivity, but is a transcendent experience. The constant dialectic between the experience of self and that of others mediated at least

partially by culture illuminates what I am at that moment and may give me a glimpse of how that other person is in the same instant.

My experience as forever in potential is summarised by an old examination question for intending teachers: 'The adolescent advances to the future while retreating to the past'. For many of us, and for our clients of whatever age adolescent advance and retreat in the face of cultural mismatch is a continuous state. I have found that when cultural stance meets a variation it brings about a fecund cognitive dissonance (Festinger, 1957; Maertz et al., 2009). Meeting with others is always a potentially dissonant experience. The default position can be the convenient 'historic self' or the most chameleon-like 'as if' self. Maintenance of a rigid stance, however protective in the short-term, often involves what Melanie Klein calls 'splitting' (1946). We shun difference and change rationalising it as 'bad' while our accustomed norms are seen as 'good'. Alternatives to such polarisation involve living with uncertainty and unknowing with a degree of expectation and hope, as well as the liberating acceptance that we have no permanent self and that, whether we like it or not, we are altered by interaction with the 'other'.

So does 'self' exist in any meaningful sense?

Many clients coming to us are deemed to lack a 'sense of self'. Or in the case of trauma, geographical, or spiritual dislocation their sense of self is threatened or seems lost. I want to pose the question: 'Is our task to restore what is lost: or is it to work with the change and build the ability to be a self that matches what is now the context of a life?'

As counselling psychologists (CoP) in any context, we tend to work from ourselves outwards and as many a CoP will attest there are two aspects of changing and adapting: one is the interpersonal, and the other is intellectual. It was social constructionism that was the end to certainty for me. Discovering the 'truth' both about myself and the universe was subject to internal dispute, new perspectives which were uncomfortable brought inevitable disjunction and re-grouping. Ideas that a sense of self could be an illusion, or at best a temporary and somewhat ramshackle apparition, were deeply disturbing, but in the way of these things simultaneously invigorating.

It began for me with broad-brush Sociology at teacher-training college. Then, at its structural-functionalist stage, where the science identified and illuminated rather prescribed patterns across cultures owed much to a certain form of Anthropology. Durkheim's famous study of suicide (Durkheim, 1951) proposed that social conditions, time and place could determine (and I mean *determine*) suicidality, the individual miserable person in their own right. My opportunistic Calvinistic Protestant origins took to this let-out from the weight of individual responsibility, as I perceived it: plusses and minuses but not ontological certainty. I can to a degree empathise with a person presenting themselves for therapy in a centre in the UK fairly directly related to North American liberalism, but coming from something quite different, possibly a matrilineal, deeply embedded society where what counts is the community that takes priority, not the individual. The word 'ontology' means something and we are required to hold our world view loosely while we stumble towards another's.

Structural-Functionalism mercifully gave way to Symbolic Interactionalism a more fluid model for the study of groups, among other social phenomena, in which relationship,

perception, and interaction were keys to epistemology. The publication in the mid-1960s of *The Social Construction of Reality: A Treatise in the Sociology of Knowledge* (Berger & Luckmann, 1967), for instance, offered more width – and therefore also uncertainty – to epistemology, but also afforded a pathway to present-day approaches to a post-modernist critique and understanding of the self. So far, so wobbly! Is it any wonder that in training, in supervision, and in practice we tend to find reassurance in what might be called 'schoolism' in terms of our model, or an assumed but (to other members of the group) unrecognisable cultural or political 'norm'?

For me it was a paradoxical problem amplified by clinical training. My newly acquired perception of a mêlée of paradigms, temporary resting places, sheer abject fear, and the temptation to hide in dogmatism, was countered by concerted and worthy theory that 'a strong sense of self' was deemed important to mental health (Erikson, 1959; Karkouti, 2014). The work of such theorists as G.H. Mead (1925) and Cooley (1998), located the mechanism of the 'Looking Glass Self' and the relationship between 'I and me'. Their ideas were echoed by the attachment theorists and clinicians – notably Bowlby (1953) and Ainsworth (1964), and later by such luminaries as Daniel Stern (1985).

But from their extensive work I gained awareness that a sense of self is dynamic, not fixed. Whether the archaic source of identity is the mother, or the wider society, the shaping forces of the 'other' become the basis of a social-constructionist view of 'self'.
A movement between selves can be driven by social pressures as well as 'chosen' by what we may understand as a 'core self'. It seems to me that the human being in search of self is stepping forward and stepping back as a kind of 'dance of awareness', sometimes internally, and sometimes in terms of status, survival and economics.

An instructively titled journal article 'Champ or Chump' – a study of the social-identity of Jamaican-born, Canadian sprinter, Ben Johnson (Stelzl, 2008) – is a good illustration of forceful public social-construction. This research demonstrated how, through the use of language, an image of this man was influenced strongly by convenient perception by the 'in' group. When portrayed as an Olympic winner, this man was adjectively portrayed usually as 'Canadian': when exposed for having taken illegal steroids he was usually identified as a 'Jamaican'. I have no idea how Johnson himself handled his 're-classification,' but I can identify with the conforming strictures of fear and my own view of self when not belonging to a socially approved group, or what sociologists call a 'reference group'. As CoPs we need to be constantly aware of our power as a seemingly dominant in group: simply working together in an agency, or the kind of neighbourhood we run a practice, can create the impression of a desired entity, as opposed to the one currently experienced by the client. It is no accident that so many clients become therapists!

More internally, the construction of self can be evidenced by your own history or mine. It provides an archive of how we formed a sense of self (or selves). My working-class origins were a good grounding in developing the sense of when one construction of self, needed to be sacrificed for one that was more attuned to survival (for instance in bullying situations). This 'switch' is more than clever adaptation: it calls evolutionarily for a sense of self suited to survival. I am aware that as a child I was unable to understand why my elders

had allowed six million Jews to be exterminated. Yet I stood by as the same happened on a small but no less horrific scale at Srebrenica, and later in Rwanda. I look at the earlier interpretations of Milgram's experiments (see Jolanda & Frank, 2014, for useful extrapolations of this classic study) with a greater understanding, and a greater humility (and sometimes horror) wondering where I would be in such a situation and whether my sense of self would be unrecognisably changed.

So which does have priority in the way we construct ourselves: mothering or societal norms? Perhaps it doesn't matter. Anthony Giddens' tellingly titled study *Modernity and Self Identity: Self and Society in the Late Modern Age* (1991) takes us straight to the heart of what does matter. As CoPs we major on phenomenology and particularly on one aspect of it, intersubjectivity (and thus the nature of reflexivity). We need to use our professional and presumably personal emphases to face the facts and live in a world of the tacitly understood. What Giddens says of Wittgensteinian existential phenomenology is highly relevant:

> *'Self-consciousness has no primacy over the awareness of others, since language, – which is intrinsically public – is the means of access to both. Intersubjectivity does not derive from subjectivity, but the other way round.'* (p.51)

So here he is talking about the urgent, pragmatic need to communicate as one to another, using whatever means available to us in our static dynamic sense of self in order to meet up with and mutate in an encounter with the static/dynamic of the client. It involves letting the 'other' have some sense of meaning beyond our own narcissistic directive. For this to happen, one needs at least a provisional sense of self so that in any given moment of encounter the basis for exchange exists, rather than movement within just one organism. This generosity is, in my view the counter to any kind of colonialism, of spirit, as well as geography and resources. This is never as true as in a culturally diverse setting. It is here with a person, massively different from us in every way that our assumptions will release, that letting go of the self is so necessary and productive.

An 'as if' pragmatic way of engaging with the 'other'

So whether or not I exist in any semi-permanent form, the only possible position for me is to develop an 'as if' stance. This position is probably a version of the Platonic allegory (Rouse, 1956) of shadows in the cave. There is also probably something of the existentialist 'Dasein' relational focus (Heidegger, 1962). Neither perspective answers the question of 'Do I exist as a separate entity?' but instead offers another way of assessing reality. For me, the Buddhist understanding of the Dharmic middle-way further illuminates these ideas through inviting us to see the tree in the forest (Khong, 2009). An 'as if' position allows me to privilege the present moment and present relationships whilst remaining agnostic about the nature of reality and the ultimate divisibility of self from others. So my chosen option is to live 'as if' I am a self and 'as if' others have their beings as separate entities, with a certain humility that understands that we are just 'getting by': we know far less than we don't know. That way I can have some sense of identity, at least on a case-by-case, moment by moment, situation-by-situation basis.

I intuit that this is what happens to a sense of self in rapidly changing situations such as the current movement of refugees, moving from one culture to another, sense of self always

on the line in an effort to survive and to attain the goal of safety. I imagine that the upper reaches of Maslow's triangle are unimportant when security and hope are so important (see Smith, 2008 for a human ecology-based update on Maslow as applied to the refugee population in Upstate New York). It may be important to adapt to what aids survival. A counter understanding is that at such times ethnic and cultural identities become more important as a driver of survival, rather than as its apotheosis. These considerations are very important clinically since we may not assume that any individual with whom we are in therapeutic relationship relies on their cultural heritage for the same reason as we may.

So for us and for our clients the 'self' is also dependent on an awareness that my context in a sense is me; that 'I' form a part of another construction called 'society'. I draw my sense of self from society and I also contribute, albeit infinitesimally to that entity. That might be depressing and unsatisfactory if it were a static state, but it is not. Moment by moment we do enjoy participation in the environment, often unconscious of the forces that guide our response. That process is called experiencing. If we miss experiencing by confusing it with essence, then we are indeed in a cul-de-sac. If there is no essential self, then we are free to travel the byways of our many brief selves without fear of descent into madness for ourselves or for our clients.

I respect a robust and respectable defence of a sense of core self in, for instance Allan (1997), who argues that the concept of 'fragmented' self depends on over-reliance on certain linguistic assumptions. I respect also the struggle that we as CoPs experience when as a client seems to have no sense of self, even in a provisional way; the human distress emanating from this is palpable, and a 'settled' state is often clinically necessary before any theory of mind can take enough control for everyday living to be possible.

Yes at the heart of it all I am not convinced. A post-modernist concept of 'selves' in a moment, rather than a static self, is what my own experience suggests. The 'shifting sand' identified by the participants of my study (in relation to one another, as well as in relation to me as researcher) is evident as the tide comes in and out and the shoreline changes character throughout the day and seasons.

Self, culture and counselling psychologists: From noun to verb

So where does all this theorising lead us? We are thinking about cultural mixes in our day-to-day lives and in particular in our lives as practising CoPs. Well for a start it offers us a rich opportunity to fully embrace and explore, and to expand our much-trumpeted phenomenologist stance. (For a summary of this see the excellent article by Larsson, Loewenthal & Brooks, 2012). If we are talking about the experienced-life with all its vulnerable edges, so called 'cultural awareness' is right at the heart of the aware, mutable self. Culture is not '*right-on*' *add-on* to persons relating to other persons therapeutically, but a touchstone of intersubjectivity.

The process aspect of phenomenology is operationalised in intersubjectivity. Ellis and Flaherty (1992) justify subjectivity as a *natural and authentic locus of human phenomenology* (my italics). Crossley (1996) examines extensively what he calls 'the fabric of social becoming', the matrix in which subjectivity becomes intersubjective.

In thinking of the self, particularly as it relates to cultural or contextual collision or elision, intersubjectivity is the essential locus of 'community' in which emotional and intellectual information is understood and integrated into the healing that comes from relationship. It is the kitchen of the home.

We as CoPs major on intersubjectivity as an outworking of a phenomenological positioning, but how to *do* it? It is not just a matter of willingness to listen, to be open, to be disturbed but also a matter of basic personality. I have a potential difficulty in my work as a CoP who is open to cultural awareness. I see myself as a socially-skilled introvert (which I share with only a percentage of my colleagues). I do not naturally subscribe to a community-sense of self (extroversion as amplified by Rowe, 2003) which is so important to many other wider cultures, and indeed to many people who share the same demographic descriptors as I do. Introversion can be a disadvantage when trying to achieve intersubjectivity with people who see themselves as primarily defined by belonging and community. I am defined at least partially by my Protestant sense of individual self, and only secondarily by the approval of significant others. A Northern European or American construction of selfhood or the techniques of 'treatment' are not something that can necessarily be exported. It is well for people like me to constantly monitor this assumption if I want to get to communicate well with community-based individuals.

Schlösser (2009) investigating the transportability of psychoanalysis to China concludes its concepts may be adopted but the manner of its use will be moulded by the culture:

> *'Chinese society will probably take over the theory of neurosis because the psyche seems to work on ubiquitous principles. Yet it will reshape the therapeutic techniques derived from this theory so that they fit into the country's culture.'* (p.224)

This 'reshaping' applies also to the individual, both in private and professionally. When I encounter something that does not fit with my view of the universe, or my present construction of self I am disconcerted, unsure and sometimes defensive. As a practitioner in spite of my values and aspirations there is a large part of me that wants to retain a sense of competence, ease and effectiveness. These are some of the stances that have to be surrendered if a CoP is to enter the state of ever increasing cultural awareness. Assumptions are useful psychological 'shorthand' but the pursuit of wider perspectives and sensitivity often renders them inaccurate.

Some of my assumptions were severely tested (and I was found wanting) when I conducted some research around cultural awareness in CoP initial training and supervision (Martin, 2015). The work was a minefield! The very definition of what was a 'cultural issue' was shifting sand. Almost every issue especially in the supervision questionnaire seemed to marginalise some self or cultural identity. One participant, for instance described her frustration with 'hegemonic therapeutic discourse' (p.109) presumably embodied in my perceived assumptions!

One possible response for a CoP is to try to airbrush out the issues altogether. There was considerable anecdotal evidence in the study that cultural influences and dilemmas are avoided in supervision, to the detriment of both the supervisee and the unseen client. Once again the cosy safety of a 'model' of therapy with all its ontological and

epistemological underpinnings can stand in the way of seeing what is there in the client, perhaps obscured by both therapist and supervisory presuppositions.

I found also that responses to cultural issues by trainers and by supervisors demanded a universal, joined-up approach, not isolating some aspects of culture from others. Discussing perhaps, ethnicity, without seeing where this affects and is affected by gender, race, sexuality etc., can be distorting. Responses to the questionnaires called for a more sophisticated sense of what culture may mean in an *individual* life. 'Our clinical experience teaches us that cultures do not come along in "ones". *How can we empathise collectively and individually with multiple identities e.g. a Muslim lesbian who is poor?'* (p.110). Further responses reminded me forcefully that such issues cannot be divorced from even wider issues of power and authority, and that social change is an important outcome of increased cultural awareness.

Looking back at this recent research in the light of the present focus of this article, I have learned a lot, not only about the process of research, but also about the nature of the task for the CoP who seeks to be aware, who wants to position herself usefully in the unknown, and who is prepared to allow vulnerability in the interests of an intersubjective encounter. Part of the interrogation of this experience, and of the autobiographical case study above, is rather like an ever-moving Yin-Yang symbol. How much of myself, at any given moment, is 'I', and how much is a straight 'outworking' of my own cultural history? I do not even know how to define myself, let alone allow someone else to make judgements based on a single strand of a complex life. The research questions response evoked in me rage and sense of being misunderstood. Some contributors told me that my very question makes them experience being again 'unseen'.

Living with and thriving on uncertainty: A way forward?

A proud tradition in counselling psychology is a relative emphasis on personal therapy for the trainee (Kumari, 2011; Rizq, 2008). Perhaps, given our diverse roles (Moore & Rae, 2009), such personal therapy and indeed continuing professional development (CPD) and supervision should have as its focus the toleration of uncertainty and not knowing. Rather than concentrating on problem-solving or the undoing of more specific neuroses, such an existential requirement is often a by-product of training in its requirements and administration, rather than a conscious choice (Kumari, 2011).

An overall stance of developing toleration of uncertainty is well established in the Existential (post-existential) traditions and paradigms (Loewenthal, 2010). Perhaps this might be a way forward in better understanding of tackling both a community and individual challenges thrown up by encounter with other cultures which are unfamiliar, and importantly also with intra-cultural dissonance and rebalancing when our sense of self is mutated once again by new experience, new input, new learning?

One frequent recommendation made by participants in my 2015 research was that more knowledge should be provided for the CoP in order to enable a better encounter between cultures. I wonder! There is a danger that the individual CoP may bolster their existing sense of self with an 'expert' stance rather than with the spirit of enquiry. Openness to the potential of a sense of threat, and a convinced position of seeking intersubjectivity rather

than agreement, might yield better results. It is easy to place a half-baked template upon our experiences of 'other' for our own security. Compulsive 'knowing' can also arise from a need for a consistency that may not be there.

Some clinical experiences of living with uncertainty

I remember trying to draw nearer to a client from another culture (doing all the 'right things' as I saw it). I asked him what was important to him, belonging to X culture. He quickly retorted that he wasn't like other people from X: they were just peasants! I had somehow missed the possibility of class distinctions in my seemingly 'open' enquiry. This certainly called my sense of self into question. Professionalism and my skills as a therapist are very near to the heart of how I see myself both ontologically and epistemologically, and I had momentarily failed to live up to it!

But it seems to me that over-tentativeness is a greater danger than 'getting it wrong' or making 'mistakes'. I can remember moments in therapy when the seeming gulf between me and my client, or more importantly between the client and me, was so great that no work could be done. I remember particularly one asylum seeker from a culture I knew nothing about who was referred to me by an agency (it seemed to me disparagingly) as 'this character'. So I was desperate to help. He had suffered a serious injury while doing some work 'on the side' while in the UK. He told me he dared not tell his family back home because he felt he would be a disgrace to them. I got that, and realised it was pointless to argue a case since I did not really understand what contributed to that construction of his injury. His English was poor, but I judged it better to work with him without an interpreter, perceiving a need for at least some form of intimacy. However, there came a time when words were insufficient, so I did the only thing left, and talked him through a relaxation process, as any father might to any child. For a moment, there was a communication which I believe on the basis of his reaction was beyond words. It certainly was for me. (I would have liked to report that the therapy proceeded very successfully, but it didn't. A few sessions later he disappeared from the area, and I heard no more of him). The learning for me from that particular moment was that encounter was possible if I were prepared to be uncertain, to have a mutable sense of self, and to follow through the encounter in ways that my instinct tells me that are common to all peoples and all times. My learning is that if intersubjectivity is present, even for a moment, it is more healing than intellectual constructions; that I am a passing moment in another person's life: that passing moments that are shared are how 'selves' are experienced: that commonality sometimes bridges better than fragile difference.

But that is true of *all* clients. I know nothing about being a woman, except as an observer. I certainly do not have gynaecological experience. I do not know what it is like to be a tattooed biker who has had a terrible road traffic accident and whose only ambition is to get back on a bike, and once more 'have wings'. But I can make myself available to his sense of self whatever I don't know. All true encounters change us. Stereotypes 'meetings' do not. When there is a moment of intersubjectivity, albeit transient, between two people, therapist and client or not, the entity of self is mutated. Perhaps this is the state beneath, behind, above and beyond empathy? Perhaps the nub of intimacy is the willingness to be changed? My clients have changed me thank heavens. And it is gratitude to clients that

keep one from burnout, and not the stresses of being continually in danger of getting it wrong (see Martin, 2003). This is never more the case than in the rough seas of cultural awareness.

Holding our own construction of self both with respect, but also with a laconic disregard, can open up avenues of hope and change. It seems to me that encounter with culture that is unmistakably different from 'home territory', does indeed bring these issues into sharp focus. This focus is extraordinarily valuable, both as an epistemological stretch, and as an existential reminder of the partial vision that our own particular socially-constructed sense of self permits.

Counting the cost of change

There is a need for courage, for robustness, and for mistake-making if we are to make progress in understanding our mutable selves and the selves of others. It costs a great deal, but it is worth it. Polarisation, speaking only in guarded safety, and too-safe a personal space do not work. We have to do better than that.

Moving forward in terms of cultural issues requires courage, mistakes, compassion, re-evaluation, pain and the willingness to be insecure. We need to face our 'fear of litigation, fear of being criticised for not being politically aware, or fear of making some unknown mistake, so that true and liberating dialogue is possible' (Martin, 2015, p.111). Thus we may increasingly widen a circle of trust in which we can all increase interaction and increase compassion. We have to make do with our passing, transient sense of self in order to interact with the 'other'. So it is important that we recognise we are dealing with our culture and our own expression of it, another's culture and their expression of it in order to connect at all. It is important not 'to pour concrete' over any of our perceptions. In the end, relationship is pragmatic, so if we need to proceed with insufficient tools, then that is how it is. No one promised this would be easy, but we have no other sensible option than to take this thorny and deeply rewarding pathway, 'warts and all' . There is no room for narcissism in this human endeavour. We cannot have the satisfaction and the luxury of 'getting it right' with others whatever our selfhood or culture may be. But we can plunge sensuously into the ever-changing warp and weft of humanity, and in so doing open ourselves to mutation and hopefully maturation.

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Making sense of idioms of distress and cultural expression in psychotherapeutic practice

Maureen McIntosh

> *'… although people will always carry with them the psycho-bodily signature of their past social experience, these signatures are affected by the cultural idioms of distress into which they are woven and from which psycho-bodily attention is channelled and given meaning (or not)'.*
> ***(Hollan, 2004, p.62)***

The concept of idioms of distress is a complex area and highlighting current thinking is vital so that our clinical practice meets the cultural needs of individuals from ethnic minority communities. The *DSM-5* (2013) has a section about 'cultural formulation' (p.749), that includes an assessment questionnaire to gather relevant information that increases the likelihood that the clinical work with ethnic minorities will bring forth the understanding that is necessary to meet their cultural needs and help them recover from illness. Culture and diversity is a topic that is continually under discussion and examination as societies all over the world change, merge, separate and try to give clarity to their cultural identity and what that means to them. All human beings have a culture regardless of their ethnic and racial backgrounds. Culture is described as:

> *'Systems of knowledge, concepts, rules and practices that are learned and transmitted across generations [that] includes language, religion and spirituality, family structures, life-cycle stages, ritual, customs, moral and legal systems.'* (*DSM-5,* 2013, p.749)

The inclusion of culture within the DSM-5 (2013) to help increase cultural sensitivity in community services, the National Health Service (NHS) and other institutions may not be sufficient to avoid some clients still experiencing being misunderstood. Kareem and Littlewood (2000) remind us of the importance of including the client's emic perspective when formulating about their difficulties so that they can feel understood. When clinicians can truly comprehend the cultural origins of the client's sense of who they are, then their shared interpretation of what is going on will help the client be seen, heard and believed. This style of collaborating can lead to a genuine therapeutic connection with the client's sense of self.

The focal point here will be about idioms of distress, what it represents for some communities and the individuals from that cultural context. Idioms of distress is conceptualised as the 'collective, shared ways of experiencing and talking about personal and social concerns' (*DSM-5*, 2013, p.749). This article is a reflective piece that encompasses literature, observations and case studies to demonstrate how I as a Counselling Psychologist have learnt from my clients and come to understand and work creatively with how clients present their distress in clinical therapeutic practice.

Keywords: Idioms, distress, stereotypes, attitudes, understanding, interpretations, assumptions, therapeutic relationship, cultural sensitivity, curiosity.

Introduction

Culture permeates every aspect of a person's life and it is conveyed in how people interact and what they communicate (Bhugra & Mastrogianni, 2004). Idioms of distress can intrude upon the person in ways that create difficulties in everyday living. A UK study (Bhui et al., 2001) suggests that individuals who are from Southern Asia who see their GPs may not always be identified as having low mood, instead they are frequently recognised as having symptoms that affect their body when compared to Caucasian patients. It is argued (Ahmed & Bhugra, 2007) that the dominantly held perspective of the majority culture on some mental health problems that ethnic minority individuals present with may differ from the description that has the most meaning to them. Hinton and Lewis-Fernandez (2010) describe that the meaning given by a culture about an idiom of distress can vary between different communities. Awareness by the practitioner should be brought to the interaction between the client's interpretation of the 'idiom' and the cultural communication of it (Hinton & Lewis-Fernandez, 2010). This is so the meaning of what is going on for the client is not lost through mis-communication, as this could impact on the outcome. For example in the case study where I discuss Leroy's experiences he felt misunderstood and not taken seriously when he would tell ward staff that he did not sleep all night, sometimes this went on for days. In the ward round, nursing staff reported to the multi-disciplinary team [MDT] that night staff checked to see if he was sleeping and found him to be asleep. This report invalidated his experience and he felt no one could understand his suffering.

In clinical practice, when a referral is made by the GP or psychiatrist to psychology for a client who presents with physical health problems, the referral may be explicit and indicate that medical investigations have been conducted which show no disease processes. The narrative within some referrals can often close down further exploration of the meaning behind what is being communicated by the client. The client may then be classified as having medically unexplained symptoms [MUS]. This can be experienced by the client as invalidating their experience because it suggests that the problem is psycho-somatic. GPs for instance may feel (Commissioning Support for London, 2011) conflicted between their belief that there is no medical cause of the patient's distress and their frustration that they may have overlooked something. Medical professionals are encouraged within the Commissioning Support for London document to believe in their skills and the rapport they build so that the person feels heard.

The cultural make up of Britain's multi-cultural society is not just based on skin colour due to the multiplicity of cultures (Chakrabortty, Mai Sims & Shabi, 2012). Mckenzie-Mavinga (2004) made a powerful point when she suggested that the narrative of past unjust treatment of ethnic minorities from deep within a person's ancestry is still alive in communities, internalised in the person's sense of who they are and is never too far away. The lived experience of ethnic minorities may be impacted by the degree of acceptance, understanding, prejudicial attitudes, stereotyping, and ignorance that exists within the dominant culture where they reside. Feeling accepted within the dominant culture even if the individual is born there is a vast, intricate area to understand and often painful to explain.

Living in a multi-cultural society is not enough to contribute to the acceptance and understanding of the diversities in colour, language or customs of ethnic minorities. To consider the potential cultural obstacles that may arise within the psychotherapeutic setting, it is important to understand that these barriers are not exclusive to the therapy session but can be created within the very establishment that purports to recognise the needs of ethnic minorities. When all of the person is not seen because there is an absence of the cultural context in which they were born this can serve to marginalise and negatively stigmatise client groups who may have to deal with oppression in different corners of society.

Accessibility to culturally appropriate therapeutic provision is important (Eleftheriadou, 1993; Kareem & Littlewood, 1994) and this is more likely to happen if there are 'culturally sensitive' care pathways and services (Eleftheriadou, 1993, p.116). At the other end of the spectrum it is often apparent to me that people of colour and also other ethnic minorities are underrepresented at different levels, especially high roles within the psychology profession. Arguably, there is room for so much more to be done to give ethnic groups equality; one example of this is to create a more representative number of ethnic minorities so that it reflects the multicultural diversities that exist in society today. As a Black-British Senior Counselling Psychologist and Chair of the Division of Counselling Psychology, I have worked within culturally diverse communities that have socio-economic problems and also communities that may not encounter as much of those difficulties due to the demographic context. I am aware that within my own race and culture, ethnic minorities have historically and currently experience marginalisation. When negative, stereotypical societal discourses are espoused about communities who are culturally different it can create social injustices and reinforce a divide that can be filled with unhelpful assumptions.

As a counselling psychologist I acknowledge that 'humanistic approaches' (Moller, 2011, p.9) about the subjective experience of the person are inherent within counselling psychology. Building a strong therapy relationship with my clients is always central to my work. My preferred way to deliver therapy is to utilise theoretical models to help the client through the development of a formulation that offers a shared explanation for the problems they face.

Breaking down the barriers of cultural ignorance and naming the value judgements that some may have in regard to minority groups is difficult but essential. Value judgements can cover so many areas, for instance when people of colour are judged to have less intelligence, not likely to benefit from therapy, or to be more aggressive or the increased likelihood that they will be stopped and searched by the police because they are perceived to have criminal intent. When individuals meet a person for the first time they do not completely have an open mind, they use pre-determined ideas to inform them about ethnic minority groups. This stereotyping can lead to judging others based on an incorrect frame of reference. It is important to value people as people, irrespective of their cultural background. When this happens society is going some way to dispelling unhelpful ideas and this challenges the notion that the dominant culture is superior to other cultural groups. Moreover, it breaks down the walls of negative prejudicial attitudes that suppress whole communities.

Appreciating and understanding the differing kinds of people that are referred to the mental health system is one starting point. However, accepting difference does not necessarily mean that one will be more effective in the therapy session. What ensures efficacy in practice is how psychologists use the knowledge they have learnt, and how multicultural awareness is assimilated into clinical practice. Palmer and Laungani (1999) stress how crucial it is that the therapist gets to understand their own internal process before they can provide a safe and contained therapeutic milieu. It is important to keep in mind that some clients may not always find it easy to talk about psychological problems due to feelings of shame (Ahmed & Bhugra, 2007). They may have their own culturally based ways of making sense and dealing with difficulty (Kohrtet al., 2013). There may be occasions during the assessment process that the absence of a thorough exploration of the client's issues from their perspective can lead to misunderstandings about what the client's experience really means. Collaborating with the client and genuinely hearing them can strengthen the therapy relationship so that the psychological work can lead to positive outcomes.

In the next section I will elaborate on research focusing on one of the poorest parts of Haiti situated in the countryside, known as 'Central Plateau' (Keys et al., 2012, p.1). I have chosen this part of the world to show that when the whole person is not fully taken into account during the assessment phase and throughout the work then often important parts of the client's story and their way of understanding the problem is absent.

Haiti's central plateau

The study revealed the difficulty to develop a system to provide good enough psychological support for the Haitian community. This was due to the client's cultural expression of distress being omitted in treatment centres following the natural disaster (Keys, Kaiser, Kohrt et al., 2012). The introductory findings of how '*tet*' ['head'] and '*ke*' ['heart'] idioms were understood in a local clinic came from information collected from indigenous people and those that work in that community (Keys et al., 2012, p.3). The data was analysed and the results showed that over half of the coded areas featured 'idioms of distress' about the *head* and *heart* (p.4). The findings demonstrated that there were dissimilar conclusions reached by those with and those without specialised knowledge of the meaning of these presentations. Those without specialised knowledge but with rich experience of the community had varied explanations that resonated with the Haitian people. The professionals made sense of the presentations using biology and medicine which did not include consideration of psychological processes. There is a greater need to understand the cultural context and the meaning making that is derived from that lived experience so that psychological models are used flexibly so they relate to the client's needs.

An example is given in the study (Keys et al., 2012, p.4) to expand on how different beliefs about what idioms of distress mean to the client and how this can influence treatment outcomes. The authors describe that a woman in her 20s came to the local area after losing her family and home in the earthquake. She lived with others in a small property and she began developing symptoms of 'tet fe mal' ['head that hurts']. She connected the health problems to other unpleasant experiences ('startling easily, distracted, sleep problems, crying, and no appetite, feeling sad and thinking too much'). She blamed

herself for the disaster that befell so many and her belief was that it is 'God's punishment'. After visiting the clinic she was prescribed sleep medication that helped her but she was still psychologically disturbed by her experiences. Although practitioners were aware of her anguish, they simply did not make further exploration part of their routine evaluation (Keys, Kaiser, Kohrt et al., 2012). It is argued that in order to fully know the person's experience the correct assessment and clinical pathways need to be available so that the client's whole needs can be met (Keys et al., 2012). James et al. (2012) developed a way of bringing together both native and 'Western' ways of thinking to help the people of Haiti recover from their difficult experiences. Treatments that are thoughtful and relevant to the client which draw from both native and 'Western' ideas may produce a way of working that is integrative and promotes wellbeing (James et al., 2012, p.110).

When the clinician hears the client's story without allowing their own assumptions to intrude, then a collaboration with the person will develop a shared meaning of what is going on, demonstrating the clinicians expertise (Farooq & Abbas, 2013) in understanding and working with ethnic groups. Farooq and Abbas (2013) illustrate that there is not just one way to understand a person and the only way to explore what's going on is through dialogue, good communication and being self-aware. Language is such a powerful tool; the client may use a word, phrase or make a statement that the psychologist feels sure that they understand the meaning of. But pausing and checking in with the client about what they mean can open up a window that sheds more light upon what could be taking place.

In this final section I will use case studies to reflect on my experiences when engaging with clients from a culturally different background. I will express my sense of the work through the strength of the therapeutic relationship where we developed a shared understanding of the problems, despite cultural, generational, and gender differences.

Case study – 'Anxious Heart': The idiom of stress and anxiety

Adah was born in South Asia, she spoke in her mother tongue and she was over 65 years old. We worked therapeutically together using an interpreter for over 30 sessions to make sense of her very distressing experiences. A psychiatrist in the CMHT referred her because of her anxiety. The psychiatrist was also from South Asia and when he spoke about the referral he used the term idioms of distress when describing her somatic symptoms of anxiety. I visited Adah at home for the first session and she presented with low mood. She explained that sometimes her 'health' is better and sometimes it is not. She talked about her experience of anxiety and she felt this mostly in her upper body. The uncertainty of not knowing what was going on made her feel as though she was 'not well'. All of her usual household duties became more difficult for her to do and this was out of character and her family were very worried about her. In order to maintain continuity and a strong therapeutic alliance the same interpreter was used for the majority of our sessions, and when she was unable to attend another interpreter was sent that had worked with Adah previously. The interpreters were an important cultural connection for Adah not just in conveying the language but also in helping to bring a sense of home and belonging to the therapeutic work.

Adah would meet me in my outpatient clinic and in our sessions she told me about her 'anxious heart' and how fear and uncomfortable feelings in her body would build up and create negative thoughts in her mind ('something bad is going to happen'). She

spoke about her fears and they were experienced as bodily sensations, like tension in her face and she expressed how unwell it made her feel ('I'm constantly stressed [and] worried'). I wondered with her about what was going on and she tried to make sense of her experiences ('I just feel anxious in me', 'sometimes I feel happy, sometimes…sad') and she indicated that she did not feel she had any control ('feelings coming and going by themselves') over her distressing experiences.

Many times she would ask the question – Why am I not getting better? And that was her goal in therapy to feel better. Her focus was always on the sensations in her body and her question about why she was not feeling better would dominate the sessions. My response to her worry was to stay present with it and to create space for more in depth exploration. Also in supervision I was able to reflect on how stuck I felt at not being able to support my client to move beyond the distress in her body. I found that Adah struggled to see herself or the problem from other perspectives. Her family and values were her main strength and my feeling was that I would need to connect more deeply with that part of the self to create a shift that I hoped would bring some relief from the distress of her 'anxious heart'.

The turning point came after some sessions where she engaged in brief mindfulness practices and would remain in the present moment through focusing on the breath and sensations in her body. During one of those sessions I asked Adah to tell me more about her childhood in South Asia and what she enjoyed. I noticed that as she spoke her body seemed more relaxed as described that as a child she was fearless and she would play freely outdoors. My sense was that the distress she experienced in her body, mind and heart obscured her resilient nature and fighting spirit. I felt that because she was able to re-visit a time when she felt strong this created a positive shift in the course of our work.

Adah was able to reconnect with her fighting spirit through her faith and her ability to feel confident about hoping again that she could get better. By the end of our work she appeared more relaxed, and she told me that she felt better in herself and when the tense sensation in her face occurred it was not a barrier to her doing things that she enjoys ('I can control it… my mind is completely clear'). Adah told me that before therapy began her 'mind was full of worries and stress' and now at the end of our work 'they've just gone'. I was curious about what she thought had changed and she talked about the medication, therapy and all the support she had received ('I started improving').

As we ended therapy we were able to reflect upon her perseverance and the strength she demonstrated during her therapy journey and she reflected back to me on how therapy helped her through her difficulties ('You've helped me a lot'). My feeling was that the therapeutic work helped her learn how to make sense of the sensations in her body differently rather than just connecting with the fear the experience generated. She was able to build up her ability to tolerate distress and her response was to not let it prevent her from doing the things she enjoyed, in turn this helped her regain her resilience and fearless self just like when she was a child.

In this next case study I worked with Leroy for nearly two years. I will reflect upon his story to be heard, his struggle to feel better and how this was understood. I will attempt to show how I remained present with him on his difficult journey. By collaborating with

Leroy the therapy work lead to a reduction in his distress and by the end of therapy he was empowered to re-engage with life from a place of resilience.

Case study – The idioms of depression, anxiety and insomnia

Background information

Leroy was in his late 70s when he was referred by his GP for psychological therapy in a secondary care service for anxiety and depression. He had a course of Cognitive Behavioural Therapy (CBT) in the past which he expressed he benefited from as it helped him to relax. He had a history of suicidal ideation and there were no past attempts when assessed by a member of the Community Mental Health Team (CMHT). Risk issues did arise and were monitored throughout by the CMHT and during therapy. Leroy had physical health problems and long-term conditions (e.g. hypertension, heart problems and arthritis) which he took medication for, and he had also experienced a bereavement about 12 months before starting therapy. Due to the complexity of his presentation he was also assigned a Community Psychiatric Nurse (CPN) as his care co-ordinator.

Leroy was of African descent and he lost his parents during his early life but was cared for by other family members. After finishing his education he took up employment in a variety of jobs until his 20s before moving to England in the 1960s. He was separated and his adult children maintained intermittent contact offering support.

I invited him to tell me about his experiences and he spoke about his sleep problems and medication. I was open to listening, summarising and paraphrasing to be 'empathic, warm and accepting' (Hyer, Kramer & Sohnle, 2004, p.276) to engage with him whilst also building the therapy relationship. He believed the medication contributed to his loss of appetite, loss of motivation and lack of concentration. He added that when he did not take the medicine he felt his 'mind is clear' and it is like he is 'back again'. During the assessment he explained various problems and how it impacted on him.

Depression

He expressed that when he looked at himself in the mirror he had thoughts about whether he would live to see tomorrow, and he indicated that he felt it was somehow a miracle that he was still alive. I wondered about feelings of helplessness and a loss of control. He also spoke about how his experiences made him feel he was 'suffering'. His negative thoughts expressed his view of self ('I know I'm not going to get any sleep') and his view of the world ('people do not understand my suffering') and his view of the future ('I know I'm going to become addicted to the medication'). My sense was that he felt abandoned, alone and his faith in God wavered because he felt powerless to change his situation. Taking medication created a great deal of fear within Leroy and he would express it in words and passively by not taking the medication. In my experience many clients worry about the side effects from some medicines and I would always advise my clients to speak to their GP or prescribing doctor if they have any concerns about their medications as this is not my area of expertise.

Anxiety

He spoke about when he took his medication he would notice physical sensations, for instance, his heart beating and he would feel 'weak'. Leroy's distressing interpretations of

his beating heart indicated how helpless it made him feel. We explored this in our work together and he acknowledged that his fear driven interpretations of his bodily sensations influenced his decision not to take the medication. Leroy's particular way of describing his idiom of distress was to explain that the sleep problems are in his heart. He struggled with these fears triggered by physiological changes such as his heart beating fast and upsetting thoughts of coming 'near to death', which then increased his worry. He talked about his fear of 'dying' and the impact, which left him feeling low and worried.

Insomnia

Leroy said that the problem causing the most impact on his life, was the insomnia which left him worried. He described being in a 'vicious cycle' when he talked about only sleeping for a few hours a night, which left him tired, with no motivation, experiencing poor concentration and a reduced appetite. He said his worst fear would be that he would die from a lack of sleep.

Leroy's experience of suffering, trying to hold onto hope (Snyder et al., 1999) and the therapeutic relationship illustrates the complexity of the work. It was complex because Leroy experienced some of the wider CMHT as not understanding his suffering. Leroy felt this was due to assumptions about how he appeared physically well on the outside but no one could understand his suffering within. My sense was that he perceived this as invalidating his experience by some in the team. He felt that others did not believe him when he spoke about not sleeping. When the client does not feel heard and believed by those who are meant to support him it can lead to isolation, despair, and hopelessness. As part of the CMHT my role was to help the MDT understand the issues from Leroy's perspective. Some members of the team were able to take on board his subjective view however, there were times I felt as though I were a lone voice advocating for Leroy. This was something I would take to supervision and I would continue to put forward Leroy's viewpoint to the team during the course of the work. Eventually they softened and my feeling was that they could in the end understand Leroy's struggle to cope with life, manage fears about death and find peace within himself. In the therapy room we created that safe place where he could talk about the pain of suffering and not being believed by others.

This was a challenging but rewarding case that shows how the issues that Leroy presented with relied upon a strong therapeutic relationship where he felt believed, heard and understood, and this helped empower him to achieve his goals. The flexible use of models such as CBT and mindfulness with Leroy allowed for an understanding of what was taking place in the therapeutic relationship and this facilitated a 'change' (Laughton-Brown, 2010, p.6).

Although Leroy engaged well in therapy at the beginning, mid-way there was a noticeable shift in Leroy's mental health. He expressed that he did not think he was anxious, he denied being particularly worried, or thinking about problems, and my impression was that he seemed to avoid 'owning' his experiences (Neenan & Dryden, 2000, p.45; Hyer et al., 2004). It was important to be flexible and take account of the relational context (Hyer et al., 2004), therefore sensing some resistance and fear I adjusted my pace and attention to what was occurring within the therapeutic relationship. His sense of suffering with these problems kept him alert physiologically and sustained his worry cycle which prevented

him from sleeping (Borkovec, 1994). In addition, his fearful evaluations of his somatic symptoms (Taylor, 2000) also caused him great distress triggering concerns about his heart. Using the therapeutic relationship to guide and pace my responses to his narrative meant that there was a real sense of him being present in the sessions because of the empathic engagement. His openness about his efforts to regain a sense of control helped me understand what other components underpinned these behaviours.

Mid-way I observed that he was finding it more difficult to engage with the interventions, and due to a lack of sleep, he experienced problems in concentration, and a loss of enjoyment in reading newspapers. He described that he was depressed and he talked about his heart. During these low states, which were frequent, I had to adapt therapy to match with what Leroy could usefully take from our sessions as he struggled to engage and to manage his anxiety and worry. Within the therapy relationship we could explore the complex layers of his difficulties and it provided a space for him to explore his experience of suffering and this kept him engaged. Leroy would often refer to his lack of sleep as his 'illness' and he believed that his 'natural sleep' had been 'replaced by pills'. We talked about managing his thoughts about his insomnia and he reflected on how hard this was for him to do – *'I'm beginning to feel bad, when depression hits you, you can't pin point it'; 'it's like a monster who keeps reminding you of negatives, helplessness and hopelessness.'*

I was aware of the differences between Leroy and myself in age, and gender in addition to the similarity of our skin colour despite being born in different countries. I felt a sense of ease with Leroy that was connected to the therapeutic relationship. Working with all my clients from a thoughtful and compassionate perspective means that I appreciate all of who they are regardless of their cultural background.

We worked together to learn strategies to help him stay calm (Salkovskis, 1989) and not to ruminate in order to reduce his distress. For example, by using breathing exercises to help him relax and engage in activities to aid distraction from worrying. Leroy expressed how difficult it was to stay motivated when he perceived the therapy interventions not to work. He explained that when he used strategies to help himself he expected that it would work immediately and when it did not he lost hope in its effectiveness. It was important for our therapy relationship for him to speak openly about how he experienced the interventions we were using and this indicated that there was trust between us.

I reformulated around Leroy's difficulties in supervision. Throughout this case I used supervision to reflect upon the therapeutic work regarding feeling stuck and the risk issues that emerged. I discussed issues of 'countertransference' (Prasko et al., 2010, p.189) about working with Leroy and I had considered that his lack of faith in the interventions may be an indication of my skill in using the model. My supervisor was able to help me appreciate that I had a genuine interest in helping my client feel better. We spoke about continuing to utilise the trust built through the therapy relationship to work through the barriers with Leroy in order to move therapy forward. I came away from supervision reminded that similarly to Leroy I too needed to manage my expectations and remember that the strength within the work was about being flexible.

I also talked in supervision about using mindfulness and how it fits well with approaching idioms as it teaches a person to remain curious about what is taking place. Mindfulness-

based strategies can help give the client greater choice and control in the present, it is about developing an 'ability to pay attention in the present moment' (Kabat-Zinn, 1990, p.11; Williams & Penman, 2011; Siegal et al., 2008) to manage worrying thoughts and feelings. The aim is to discover how to approach life experiences mindfully which gives an opportunity to decide how to respond and cope with difficulty (Williams & Penman, 2011). Eventually the individual will be able to perceive unhelpful thoughts; tolerate these thoughts and alleviate distress leaving them feeling more calm (Williams & Penman, 2011).

I spoke about the rationale for this suggestion and Leroy was open to this idea of mindfulness meditation. Using mindfulness to develop ways of being in the present moment I felt could help Leroy find peace as his heart was full of fear and he struggled so hard with being in the present. I reflected on slowing the pace down and how it can be helpful to show some compassion towards oneself to help him hold onto the hope that things would get better.

We used mindfulness of the breath to help him *'learn how to let things be just as they are, by tuning into moment to moment changes in the mind and body'* (adapted from a tape given to me by a mindfulness tutor Christene Burgess). We used meditation during the session which included mindfulness of thoughts where he would imagine himself placing worrying thoughts on a leaf and watching it float down a stream. Leroy made use of the mindfulness practice but this was a pattern in the therapy work, where he would arrive in the session low because he had not managed to have any sleep. I would ask about whether he used the strategy of focusing on the breath and he would say he tried it for one night (*'it helped me'*). I asked him to tell me a little more about when he focuses on the breath and he described that he did not think about what was happening to him at those times. It sounded as though he was able to let go of the worry during those moments and this helped to take his mind off what he felt was his *'very bad situation'*. I asked what he meant by *'bad'* and he explained that this is when he thinks about death. He had indicated that thoughts about death left him feeling depressed, hopeless, suffering and frightened.

Despite the fluctuations in his progress, lapses and hospital admissions we had built a strong therapeutic alliance and we continued to persevere towards his goal of feeling better. He at times expressed his doubts that he could one day take control over his thoughts. I continued to remain open and curious when I asked him if he believed he could let go of the suffering and he said he would try, but it was very hard. I expressed agreement that it is hard to do; but I believed he could re-claim control over his thoughts. When we reflected together on the vicious cycle and being more compassionate towards himself he spoke about wanting his *'whole confidence back'*. Leroy would talk about how he experienced being in therapy – *'Since I've been working with you you've never tried to deliberately impose anything on me and I like that we work together.'* My sense was that he felt the strength within our therapy connection, which was empowering him to believe in himself and to see that change was possible.

Leroy was a very wise man, he was a person that would ponder many issues and in those quiet moments during the session he would find his own way to make a connection to what we talked about. The openness and genuineness that developed allowed him to find himself again, to re-connect with his heart so he could find his voice and strength. As therapy continued he showed signs of increased hope that things would change for

the better. He gave me feedback about the links he had made between the theory, the therapeutic interventions and the choices he had decided to make:

'The way I understand it is that thoughts are there and people like me are suffering from depression, most of it are thoughts. Not so comforting thoughts can make you very unhappy. If I try to deal with it by avoiding it the thought forms a relationship with you, the more it tries to control you maybe counter it with good thoughts and that way you may return to normality…'

I felt confident in Leroy's ability to sustain what would help him to stay strong and hopeful and I knew this because I had observed him grow and change in therapy. I believed that we worked hard to cultivate a strong therapeutic relationship which helped us both keep going even when it may have felt very hard to do. In our last session Leroy talked again about his experience of the therapeutic relationship and my sense was that he felt ready to say goodbye.

'I don't think I can thank you enough, it's not the end, all the sessions we've been through, so much to learn, I'm taking it out with me, I'm grateful… everything has to come to an end.' I showed my agreement that our work had successfully come to an end.

During the process I learnt about myself as a therapist from my interaction with Leroy. I learnt more about patience and persevering, although I know about these qualities I try to be open to learning from all my clients. It was a complex case and there were times I questioned my own abilities to be effective, however, supervision and being a reflexive practitioner helped me work through those doubts. The therapeutic connection with Leroy helped me 'to be with' him (Garner, 2003, p.540) through his difficulties, until he was ready to re-establish a relationship with his resilient self.

When working with idioms it is important to understand that preconceived ideas about how clients are supposed to behave can be a potential barrier in the client-therapist relationship. It cannot be assumed that having the same skin colour or even having an assessment scale that is developed to formulate from a cultural perspective transcends to deeper understanding of cultural diversity in the context of working with idioms. Eleftheriadou (1993) posits that therapists should embrace the clients' map of who they are and be aware of not enforcing the customs of one's own culture upon the client.

Conclusion

In their article entitled *Silenced: the Black student experience*, Ellis and Cooper (2013) reflect on how sad it is that ethnic minorities feel they do not have a voice. To ignore cultural differences within and outside of the therapeutic setting, serves to perpetuate the ignorance and divide between professionals and in the therapist-client relationship. However, if notions of this kind are held to be true by some what is the alternative? The way forward is for clinicians to be more 'culturally aware' (Kareem & Littlewood, 1992, p.24; Mckenzie-Mavinga, 2004) and have open and honest conversations about culture and diversity throughout their career, in the therapy room and in all contexts, so that it feels more natural to communicate about this topic. This can enhance the client work we are engaged with so that ethnic minorities do not experience the wrong type of care.

Drawing on all the information the client shares, and what's important to them can deepen understanding and teach clinicians something about the persons' strengths, values beliefs, their family, cultural norms and also the communities to which they belong. Hinrichsen (2006, p.30) argues that discussions about 'cultural differences' within the therapy dyad are hardly a feature. Culture should be included within therapy and psychologists should be curious about the kind of relationship the client may have with their culture (Eleftheriadou, 2000) as it can strengthen the therapy connection so that the client feels heard.

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Islam and counselling psychology: Soul to soul?

Zakia Mahmood

Background and purpose

Muslims form 4.8 per cent of the population in England and Wales. The population has increased from 1.55 million in 2001 to 2.71 million in 2011 (*The Guardian*, 2015). The Muslim population is larger than all other non-Christian faith groups put together. Forty-seven per cent of Muslims are UK-born. The Muslim population is ethnically diverse including Muslims from Asia, Africa, Arab states and Europe (Muslim Council of Britain, 2015). It is likely that by the next census the Muslim population may double and constitute 10 per cent of the total UK population (*Huffington Post*, 2012).

Islam and counselling psychology indeed constitute two very pertinent areas for me, personally and professionally. Hence, being approached and asked to put something on paper about these two disciplines (*I use the word 'discipline' loosely here*) felt critical. I confess that I am not in any way a religious expert on Islam. Instead, the aim and objective in this article is to explore whether there are points of possible convergence and dissonance for Islam and counselling psychology. This includes a brief examination of the underlying values underpinning both Islam and counselling psychology. I am not aiming to provide an intellectual, political, theological or indeed a sociological debate regarding this topic. At the same time, it is acknowledged that one must consider the relationship that exists between the person, the familial, wider society, and global political context. The intention is also to highlight some of the factors that counselling psychology may need to consider whilst working with individuals conforming to Islamic-based principles and values. What might we need to consider as practitioners who are dedicated to furthering our knowledge and understanding clients' subjective world views as well as their therapeutic journeys? This would entail not only highlighting some of the challenges that might exist for counselling psychology whilst working with Islamic clients, but also help think about how the relationship between the two can possibly be fostered. I feel that this is particularly important given the increased negative spotlight that Islam has come under in light of the wave of global terrorism resulting in feelings of insecurity, fear, doubt and anger amongst many individuals including Muslims themselves. I will endeavour to reflect upon my own clinical practice to help demonstrate some of the tensions and challenges that might exist whilst working with such populations.

Keywords: Counselling psychology, Islam, spirituality, religious beliefs, cross-cultural.

Increasing attention is being paid to how counselling psychologists should attend to the religious and spiritual commitments within the context of a secure therapeutic relationship to help enrich their clients' lives. Pargament (2007) outlines the importance of proactively assessing religious beliefs and one's 'spiritual story' particularly if it is relevant to the presenting problem or as useful resources to resolve difficulties. It is possible that some therapists may over-identify or collude with clients' religious beliefs and practices. For instance, a Muslim client engaging in obsessive-compulsive rituals and

providing a religious justification for it. Indeed there is a large emphasis on cleanliness and hygiene within Islam. However, it is possible that a Muslim therapist who adopts similar views may potentially undermine the unproductive role that such rituals might be playing in their client's life and hence end up colluding or over-identifying with the client's unhelpful beliefs. Also, it is worth considering that this may partly be driven by the therapists' concerns of coming across as religiously insensitive or of the client prematurely terminating the treatment. Indeed many religions encourage the experience of visions, voices and demons but this does not suggest that they directly promote psychotic experiences (Loewenthal & Lewis, 2011). Hence, failure to deconstruct such experiences may result in misinterpreting, misdiagnosing and misjudging the clients' experiences. Many religious individuals may thus feel reluctant to seek psychological therapy owing to such fears (Mayers et al., 2007). Furthermore, much of the literature on religion, mental health and therapy originates from the US (e.g. Aten & Leach, 2009; Miller, 1999), and may not necessarily be applicable to other cultural settings. It is believed that the training received by counselling psychologists renders them less equipped to address issues of religion and spirituality, particularly if they are secular in their views, and hence lack clear guidance around this issue (Milton, 2010). Given the above factors, it therefore becomes highly relevant to focus on the current area.

I identify myself as a British Muslim counselling psychologist working currently within the context of IAPT where largely the focus is on improving recovery through adherence with evidence-based treatments including cognitive behavioural therapy (CBT). It is important to reiterate that the predominant narratives and discourses centred around religion including Islam may be argued as being quite 'provocative' as they may potentially stimulate much controversy and debate (Davis, 2012). My objective here is to present an honest and authentic view of how I feel counselling psychology should commit to enhancing understandings of areas of difference such as that of religion and in this case, Islam. Being Muslim and Pakistani, I have frequently engaged in a process of questioning not only how my own religious identity informs my clinical practice but also how this influences me on a personal and intrinsic level. Unfortunately, I have not felt that my training has adequately promoted or encouraged dialogue and exploration of such issues. This appears to be an experience shared by some of my colleagues and peers who went through a different counselling psychology training programme. I wonder whether this may partly be informed by a lack of coherent guidance on 'how' to effectively go about incorporating such an area into the curriculum. Additionally, counselling psychology courses in the main emphasise incorporating integrated theory, personal and professional development, research-based skills and clinical practice. Thus, empirically supported treatments informed by research using randomised controlled trials appear to be given precedence over qualitative methodologies. Capturing the individual lived experience of clients presenting with questions about religion appear to sit more comfortably with the philosophical principles underlying the qualitative paradigm. Subsequently, educational and healthcare systems may feel disempowered in some way owing to the control and political agenda of more powerful institutions such as that of the government. The recent global wave of terrorism and Muslim's alleged association furthers my interest in this particularly complex and intriguing topic.

The British Psychological Society's *Code of Ethics and Conduct* (2009) stipulates the

importance of respecting and valuing individuals' religious beliefs, values and norms, and practising in a fair and unprejudiced manner. Counselling psychology is heavily rooted in the humanistic tradition, it emphasises the value basis of practice, and is aimed at the exploration of the subjective worldviews of clients as meaningful and valid in its own terms. In this way it does not make assumptions about an objectively discoverable 'truth'. Central to this is the role of the therapeutic relationship in facilitating the development of insight and increased capacity for choice (Strawbridge & Woolfe, 2003). Hence as practitioners, we need to be able to take into account the reality of religious ideas, norms and beliefs and the impact that this might have upon individuals, at both conscious and unconscious levels. An ongoing commitment to researching religious-based perspectives within psychotherapy, effective training and supervision can all assist with the process of incorporating them into meaningful therapeutic frameworks.

My interest within the realm of religion/religiosity had motivated and panned the way for my Master's level research many years ago. I was seeking to develop an understanding of how second generation British Pakistanis conceptualise being 'Muslim' and to capture the diversity, complexity and subjective meanings that they ascribe to their religion (Mahmood, 2008). This study revealed that the process of religious identity development helped in explaining aspects of religiosity and its impact upon participants' lives. For instance, they seem to prioritise their Muslim sense of belonging or 'worldview' to their 'Pakistani' and 'British' way of being. There appeared to be considerable variation in participants' religious practises and values. There is a tacit assumption that the experience and practice of one's religion is homogenous. However, it is imperative to consider how culture, ethnicity, and more largely how sectarian differences, such as that of Sunni and Shia Muslims and their accompanying theological differences may influence such religious diversification.

Like other religions, Muslims may interpret their religion differently and try to practice this interpretation within a larger British context. Although the participants in my study (Mahmood, 2008) seem to highlight their positive distinctiveness from other groups, they also communicated a sense of feeling misunderstood by the wider community and the need to challenge negative stereotypical notions of being a Muslim. Family was considered integral to coping with problems. However, prayer was also viewed as one of the most effective components of help seeking for these individuals. The importance of *Salat* (prayer) in promoting physical and emotional health has been prescribed by the *Qur'an* (Baqutayan, 2011). Current literature has demonstrated how the integration of prayer within mainstream psychotherapy can lead to several ethical dilemmas such as it being used as a defence or when it is not part of the client's agenda (Gubi, 2008).

Participants in my study (Mahmood, 2008) also expressed fears of being judged negatively by counselling professionals mainly owing to their religious affiliation. This study stressed the need for counselling psychologists to adopt an integrated and holistic approach of helping Muslim clients and incorporating the role of the family and the community. Furthermore, it emphasised how counselling psychologists should be wary of their own presuppositions and prejudices whilst working with Muslim clients on the basis of their own knowledge and understanding of Islam. For instance, deliberately not enquiring about Muslim clients' sexual experiences or drug and alcohol use owing to concerns that this

might be perceived by Muslim clients as highly inappropriate or intrusive. Thus culturally informed formulation models should be considered to incorporate all aspects of an individual's narrative through a 'process of ongoing collaborative sense-making' (Harper & Moss, 2003, p.8). Arguably this is an area that still requires a lot more work and attention (Fernando, 2002). At the same time the current literature demonstrates the rising use of culturally-based formulation models to help understand multidimensional aspects of clients' experiences (e.g. Bäärnhielm & Ross, 2009; Byars-Winston, 2010; James et al., 2013).

Religion and psychotherapy: Tension or ties?

Counselling and psychotherapy (including counselling psychology) as a profession, essentially remains Eurocentric, ethnocentric and individualistic as nearly all current counselling and psychotherapeutic theory appears to reflect White, Western psychology (Laungani, 2004; Mckenzie-Mavinga, 2011; Moodley 2007). This is pertinent particularly bearing in mind that ethnic minority clients are still underrepresented in counselling and therapy (Lago & Thompson, 2005). Additionally, the relationship between religion and psychotherapy has for most part of the 20th century frequently been tenuous and marked by conflict, complexity and antagonism. Within psychological writings (e.g. Ellis, 1971; Freud, 1961), it was widely recognised that these two areas were not connected.

Historically, this became evident through the split between the church and religion where religion became associated with being superstitious and backward, and secularism linked with being progressive, rational and liberated. This was further reinforced by psychology's attempts to maximise and emphasise the rigorous scientific approach largely to research and clinical practice, as most religious and spiritual phenomena are not directly observable and measurable. This unfortunately meant that silence had to be maintained by some practitioners who were interested in integrating such ideas into their clinical work (Plante, 2007).

This appears to parallel the discourse (Ellis, 1971; Freud, 1961; Watson, 1983) highlighting the conflict between science and religion. For instance, Freud (1961) equated religious ideas with 'illusions, fulfilments of the oldest, strongest and most urgent wishes of mankind' (p.30), he referred to religion as an 'obsessional neurosis' (p.43). Similarly, for Albert Ellis the belief in religion, God, and supreme authority is the source of mental health problems (Bernard, 2011). More recently, within the Western liberal discourse religion has been associated with negative connotations pertaining to control, conflict, judgementalism, and anti-intellectualism (Coyle & Lochner, 2011). This seemed to create tension amongst psychologists in an attempt to align themselves to both religion and psychology.

Fortunately, the aforementioned views are now outdated and the importance of incorporating spirituality and religiosity within multicultural frameworks are on the rise (Corey, 2013). Much of the literature on religion and spirituality originates from the US (e.g. Aten & Leach, 2009; Miller, 1999).

An ongoing challenge as previously raised, is the consideration of training and how such issues are introduced into various counselling psychology training programmes, an often neglected area. It can be argued that a certain kind of silence or possibly ignorance

still occurs inferring religion and psychotherapy as constituting two distinct areas. I have witnessed a mixed range of responses from my superiors, colleagues and indeed my own supervisees in relation to discussing such topics within practice. The main themes involve a lack of confidence, awareness and knowledge of one's client's spiritual background, practitioners' fears and reticence in terms of disclosing their own religious orientation to clients owing to concerns of how this might impact upon the therapeutic relationship, and adopting keenness and curiosity regarding exploration of such issues. Partly, this may reflect the ongoing tension that exists for counselling psychology in trying to maintain a balance between the opposing tendencies of 'being-in-relation' and 'technical expertise' (Strawbridge & Woolfe, 2003, p.5). The former is rooted in humanistic philosophy emphasising an engagement with subjective lived experience whereas the latter has its roots in experimental behavioural science. Indeed reflecting upon my own cultural and religious identification has served as an impetus to commit to such concerns.

Given the nature of the historical debates existing amongst psychotherapy and religion, it is only fairly recently that psychology is evolving in accommodating religious perspectives into the profession (Miller & Thoresen, 2003). The Division of Counselling Psychology's *Code of Ethics and Conduct* (2009) clearly stipulates the importance of considering issues of religion and spirituality along with other aspects of diversity such as that of age, gender, ethnicity, disability, and sexual orientation. This includes psychologists conducting themselves in a fair and unprejudiced manner. The need to incorporate clients' religious values and belief systems within the therapeutic context has been well documented (Aust, 1990; Haque, 2001; Hayes & Cowie, 2005; Williams, 2005; Zinnbauer & Pargament, 2000). It is a recognised fact that one may turn to religion for coping with life stressors and adversities (Ano & Vasconcelles, 2005; Chan & Rhodes, 2013; Sibley & Bulbulia, 2012). The fear of death, the desire for life after death and a quest for exploring the existential meaning of life have all been proposed as other reasons for why people turn to religion (Zuckerman, 2008). Hood et al. (2009) assert how engagement in religious rituals and prayer may provide a sense of self-control, control over one's life and help to strengthen social connectedness and group unity.

For UK Muslims, religion and culture constitutes an important part of their overall identity. Interestingly, within the Islamic tradition science and religion are considered complementary and not contradictory (Rezaeitalarposhti & Rezaeitalarposhti, 2013). Hence the utility of integrating religion into psychotherapy cannot be underestimated. For many Muslims, the social stigma that surrounds mental illness is profound. Adherence to a true Islamic lifestyle is believed to be strongly associated with positive mental health (Ali, Milstein & Marzuk, 2005; Ghaffari & Ciftci, 2010). Furthermore, indicators for mental health and pathology are not universal (Hodge & Nadir, 2008). Amongst Muslims, mental illness is not always bio-medically conceptualised; they tend to attribute demonic possession, black magic, the curse of the evil eye and separation from the divine as some of the causal explanations of emotional difficulties (Salib & Youakim, 2001). As a result, many Muslims typically seek traditional, non-clinical treatment such as Islamic faith healing (Farooqi, 2006; Kianpoor & Rhoades, 2005). Hence, this warrants an understanding of Islam and its varying accompanying principles and guidelines to help assist Muslim clients.

Islamic faith system

The word 'Islam' comes from Salam (peace) and refers to submission to Allah. Islam is a monotheistic religion (Sarwar, 1980). The fundamental belief of Muslims is that of a single God who is both omnipotent and merciful, and who created the universe. Islamic belief is derived from the *Qur'an*, the Holy Book of Muslims and the Sunnah, documenting the life and practices of the Prophet Muhammad (May peace be upon him). The Islamic code of conduct comprises of the Five Pillars of Islam (Kaltner, 2003). The pillars include declarations of faith, daily prayers, customary giving, fasting during the month of Ramadan, and pilgrimage to Mecca where health and finances permit. Although the five pillars are a central element of the Islamic tradition, it incorporates a number of other observances and obligatory practices (Esposito, 2005). Islamic prayers include ritual and supplication prayers. Islamic prayers may produce a spiritual energy through forging a close connection with Allah, which assists in solidifying and strengthening one's faith. This can be described as attaining a higher state of consciousness (Henry, 2013). Prayer also helps to address feelings of guilt through the process of seeking repentance from Allah for one's sins (Hamdan, 2007).

The Muslim faith encompasses observance to the *Shariah*, a set of regulations, principles and values from which Islamic legislation and laws are drawn. It guides Muslims in every action and sphere of life. The Islamic belief system has been conceptualised as a way of life for Muslims and encompasses all aspects of their lives (Mababaya, 2016). According to the *Qur'an*, man embarks on a journey throughout the course of his life that begins from Allah and ends with Allah as his final destination.

> *'And now you have returned to Us alone! As We created you at first, leaving behind all that we bestowed on you.'* **(The Qur'an, 6:94)**

Islam plays a major part in shaping Muslims' understanding, experience and expression in mental distress (Ansari, 1992; Hussain, 1999). I have witnessed countless examples in my own clinical work where Muslims draw upon religious perspectives to help make sense of their experiences. For instance, Muslims attributing their distress to the belief that they are being tested by Allah or have perhaps been punished by Allah for their sins. For these clients, adversity and psychological suffering in this world occurs owing to the will of Allah (*Qadr*), and hence Allah has all power and authority to alleviate the person of this. They describe powerful spiritual experiences highlighting their deep connection to Allah whilst also turning to the Divine for guidance and advice. In this way, their faith has introduced a rich meaning to their lives through building inner resilience and fostering inner contentment. For instance, Islam is strictly against suicide and Muslim clients will often bring this up when I have questioned them about death and dying. Also, I recall specifically many examples of Muslims' narratives centred on the theme of *sabr* (patience) following adversities such as bereavements and trauma.

The case study below illustrates some of these themes:

> *Ayesha is a 19-year-old British Indian Muslim presenting with reactive symptoms of depression and complicated grief following a sexual assault by a group of White British men in early 2015. She wears the hijab (Muslim headscarf) and is a practising Muslim. Owing to feelings of shame she did not disclose the assault to anyone including the police. After several weeks, Ayesha discovered she was pregnant. Consequently, she began to feel more anxious and depressed, had*

sleepless nights and started to engage in prolonged periods of crying. She also started to avoid her friends, and stopped attending university. After a few weeks, Ayesha's mother learnt about her pregnancy and urged her to have an abortion whilst swearing her into secrecy. Following the abortion, Ayesha seemed to be torn between her feelings of guilt about the abortion and that of anger towards her mother for forcing her into the abortion. Ayesha experienced strange dreams in which she would notice herself caressing a baby; she would often wake up with feelings of panic. She consequently dropped out of university and found herself disconnecting from her faith. Her family became increasingly concerned about her emotional health. It was at this point that Ayesha reluctantly decided to seek psychological help following recommendations by her GP.

My initial hypothesis was that Ayesha's current distress was primarily caused by the trauma of the rape. However, I was wrong and learnt through the course of our work that it was in fact her experience of numerous losses i.e. losing her baby, loss of social contact, loss of her academic life, and losing her connection with Allah that proved to be extremely difficult for Ayesha. Her main goal was to address her depression and anger. She expressed strong feelings of guilt around the anger she felt towards her parents and the abortion. This was further exacerbated by her strong belief that her symptoms were a punishment from Allah. Within Islam abortion is largely a condemned act and obedience to parents is considered obligatory (Al-Issa, 2000). Ayesha's anxious feelings may be a product of her dissonance between her religious beliefs around abortion and her desire to have kept her baby. This dissonance became especially salient with the insistence of her mother not permitting her to speak about the assault and her disengagement with her faith.

For Ayesha, Islam formed an integral part of her identity as she complained of feeling disconnected from Allah since the assault. Therapy with her therefore drew largely upon utilising an Islamic therapeutic framework. This comprised of providing Ayesha space to explore her feelings of guilt, anger and grief within the light of the Qur'anic teachings, reminding her that all adversity comes from Allah and encouraging her to place complete trust in Allah. For Ayesha, she not only felt violated physically and sexually but also religiously. She felt she had been stripped of her right to openly live her life as a Muslim woman by her perpetrators as she would often fear being targeted and discriminated against because of her religious orientation. Ayesha recognised that this internalised racism (Ali et al., 2004) heavily influenced her non-engagement with Islamic prayers.

The work included assisting Ayesha to form alternate Islamic interpretations of her unproductive beliefs ('I will go to hell because of the abortion and my anger'). This facilitated her understanding into the fact that all trials and tribulations come from Allah and helped build her resilience. The fact that Allah is compassionate, loving and merciful felt empowering and had a healing effect on Ayesha. Furthermore, religious coping mechanisms included listening to the Qur'anic recitations, engaging in prayers and meditation. She spent time engaging in the act of prayer and dhikar (remembrance of Allah) which helped her to experientially connect with Allah and restore inner peace. This is exemplified in the Qur'an (13:28, Ali, 1975): 'Surely in the remembrance of Allah do hearts find rest'. I believe that belonging to the same religious background assisted in facilitating the therapeutic alliance and trust through use of my own of knowledge Islam and the use of self-disclosure. This is not to infer that a non-Muslim psychologist would lack such cultural sensitivity and competence. Indeed it is important to adopt respectful curiosity and take the time to learn and develop such knowledge. At times, I experienced the challenge of Ayesha expecting me to offer her expert knowledge regarding Islam. I suggested she seek advice from her local Imam, but at the time she did not feel ready for this owing to the stigma around mental illness. Instead she opted to access support from a

local Muslim women's support group which she found beneficial. Thus, being alert to one's intrareligious countertransference reactions (Abernethy & Lancia, 1998) becomes vital. For instance, my increased feelings of responsibility in wanting to 'rescue' Ayesha as I perceived her to be 'one of my own' became prominent. The use of supervision helped to manage certain issues such as an overemphasis of religion at the expense of other communications expressed within the therapeutic encounter. Ayesha valued therapy and over the course of time her symptoms gradually diminished and she was able to renew her faith in Allah.

It is hoped that the example above encapsulates the credibility of utilising a religious framework within clinical practice.

Differences between Western and Islamic psychology

In order to enhance multicultural ways of working, it is vital to appreciate incompatibility of the principles underpinning Western and Islamic psychology. Inayat (2005) asserts that Western psychology makes assumptions that the universe is a material entity without any purpose of meaning whereas Islamic psychology is determined by the belief that the universe was created in accordance with Allah's will and hence is purposeful. Furthermore, the Western view of human nature depicts either neurotic tendencies (self-psychology) or an innate goodness (humanistic based) whereas the Islamic viewpoint contends that human beings are located between angels and animals and therefore share both natures (Inayat, 2005). Maintaining self-esteem and a strong sense of ego identity are viewed important for Western psychologists and psychotherapists whereas in Islamic psychology, acting in relation to the 'divine will', with humility and valuing a collective actualisation is fundamental (Williams, 2005). Shah (2005) postulates that within the West, ego psychology is concerned with aspects of pain and pleasure; the behaviourist tradition recognises man as a social animal and dependent upon environmental stimuli, and the psychoanalytic model recognises humans as slaves to their unconscious drives. These models tend to advocate a value-free approach to psychotherapy (Shah, 2005).

In contrast, Islamic psychology tends to provide a more holistic view of human nature and existence. From the Islamic perspective, there is recognition for the innate goodness and divine goodness of man, referred to as fitrah. Hence, any effort to gain an understanding of the self requires a study of the spiritual aspect of the self. This appears to be in direct contrast to the philosophical concepts of Cartesian dualism (Duncan, 2000) existing within the West viewing the mind and body as separate entities. Ironically, the term psychology is derived from the Greek word psych meaning 'soul' or 'spirit'. In this way, psychology is then about the study of the soul. In a similar vein, Jafari (1993) contends that Western psychology's commitment to empirical methodology and its prioritisation of logical reasoning is at odds with the Islamic perspective, which emphasises the spiritual evolvement of humans as the core purpose of life. The *Qur'an* provides useful insights into various aspects of human behaviour. In the West, human functioning and well-being is confined to this world, whereas within Islam it extends to life after death:

'Oh Lord, give us good in this world and good in the hereafter.' **(The Qur'an, 2:201).**

It is often conceded that Western psychology is based heavily upon a secular ideology and that their view of human nature is contrary to that of Islamic psychology, which focuses

on moral and religious values (Shah, 2016). Interestingly, many Islamic scholars have made major contributions to the field of Western psychological theories and practices. For instance, Ibn Arabi's writings on the soul, perception, imagination, dreams and the nature of desire (Haque, 1998). He believed the human heart is connected with the body and mind whilst also being an independent mechanism that reveals esoteric knowledge. He described the heart as a rational symbol that has the ability to perceive reality. He emphasised the human soul as possessing a rational, animal and vegetative aspects (Haque, 1998). Ibn Sina's influential work led him to be the first to coin the term 'psychosomatic' (Haque, 1998), and Abu Bakr Ibn Bajjah writings mainly focused on the role of active intelligence. For Abu Bakr, matter, form and intelligence are important components that make up the 'soul' and it is through spiritual knowledge, active intelligence and divine intervention that humans can acquire freedom (Badri, 1979).

Value systems within Islam and counselling psychology

There is research evidence to suggest that similarities in client and therapist values predict positive therapeutic outcomes (Bachelor, 2013; Bryan et al., 2004; Zane et al., 2005). Islamic-based counselling is concerned with the study of the self (Nafs) or the science of the self (Nafsiyat). It is primarily concerned with connection and relationship with the creator and has a spiritual dimension to it. Inayat (2005) outlines the Islamic model of the self. She explains how the ego (nafs), spiritual heart (qalb), the soul (ruh) and divine potential (fitra) are considered the core elements of the human psyche within Islam. The soul encompasses the mind, body and spirit, and includes several levels that require balancing in order to achieve a state of harmony. Man is considered pure as even before he is born, his soul has met with the divine. Hence, fitra is actualised through maintaining a sense of control over ones negative or animalistic tendencies (lower self) and attain a higher level of spiritual growth through serving Allah. The qalb is considered the seat of intuitive knowledge and deep spiritual wisdom. Hence, psychological suffering occurs when there is stuckness at different levels of the nafs or ruh. Muslims may understand symptoms of mental illness as evidence of spiritual disease and a distancing from Allah: *'In their hearts is a disease'* (2:10, Ali, 1975). Indeed Muslims' tendency for somatisation is prevalent throughout the literature (e.g. Al-Krenawi & Graham, 2000; Dwairy, 2006).

Due to the differing possible states of the self, different types of 'Nafs' have been described in the Qur'an. Nafs Ammara, the commanding or lower self (*Qur'an*, 12:53). This self is prone to the lower aspects of the self, representing the negative drives and impulses inherent in man. It can be viewed as analogous to the Freudian concept of 'id'. *Nafs Lawwama*, the self-reproaching self (*Qur'an*, 75:2), this state corresponds to the self that is to do with one's conscience. A parallel between the Freudian concept of 'superego' and *Nafs Lawwama* may be drawn. *Nafs Mutmainnah*, the peaceful self, (*Qur'an*, 89:27–28). This indicates the state of inner peace, contentment and happiness. In order to achieve this state, one has to activate the remorseful self (e.g. through sincere repentance) and control of the lower commanding self (through self- discipline).

Western counselling differs from Islamic counselling in three ways. Firstly, Islamic counselling portrays Islamic spirituality and religiosity as a way of life (Lubis, 2011). Secondly, Islamic counselling does not place emphasis on conditioned behaviour based

on social expectations and norms, rather, it instills standards that are to be internalised, and which later serve to condition society (Badri, 1996). Thirdly, Islam is inconsistent with the underlying philosophical principles inherent in approaches valuing individualism, relativism, and humanism (Abdallah, 2011; Badri, 1996). Thus in Islam, the aim for man is to achieve the highest sense of morality through its comprehensive system of living. This involves complying to a set of beliefs but also a course of action.

One of counselling psychology's core values is its orientation towards empowering others. In line with Roger's (1957) views it believes that every person has the ability to direct and change their lives in accordance with their values and beliefs. When working with Muslim clients I hold this in mind as whilst they wholly align themselves with a fatalistic philosophy, they are not completely devoid of the idea of self-responsibility and free will. Beshai, Clark and Dobson (2013) tend to emphasise fate as a dynamic reciprocal interaction between the will of Allah and the will of the individual. Several verses in the *Qur'an* (e.g., 13:11) state that humans, with the assistance of Allah, must work towards changing their condition.

Counselling psychology is very much rooted within the humanistic tradition as its primary aim is to facilitate growth and the actualisation of the potential. In Islamic terminology, self-actualisation corresponds to the *fitrah* which guides humanity to the true faith of Allah and complete fulfilment of their potential (Utz, 2011, p.47). Thomas and Ashraf (2009) posit that a primary area of dissonance between Western psychotherapeutic traditions and Islamic ideology is the specific emphasis that Western therapies place on individualism. Islamic teaching emphasises values that are community led, consensus, interdependence, self-control, complementary gender roles, implicit communication that safeguards others' opinions, and identity rooted in religion, culture, and family (Hodge & Nadir, 2008). From an Islamic point of view, self-actualisation can only be achieved through the path laid down by Allah and the guidance of the Prophet Mohammed (Rasool, 2016). The concepts of 'self-actualisation' or 'self-esteem' can be offensive from the Islamic perspective which tend to promote the concepts of collective actualisation, healthy altruism and individual submission to Allah. I am not sure that I concur entirely as I have worked with Muslim clients including Ayesha who have demonstrated the ability to self-actualise and have exhibited individualistic values. However, this may be dependent upon many factors such as educational and social status, age, level of acculturation, and intergenerational issues.

The goal of counselling psychology however appears to be congruent with that of Islamic teaching in terms of their focus on increasing self-awareness and development through gradual movement towards change. Within the context of counselling psychology these stages of change will vary depending upon the individual journeys that ensues. Similarly, within the Islamic framework, the fully-functioning Muslim will move through the various stages of the *nafs* in order to reach satisfaction with the self and with the Divine will. Islam invites one to follow the moral code of conduct as outlined in the *Qur'an* and Sunnah. Within the Western worldview, the concept of freedom is deemed to be highly significant. However, within Islam there are clearly defined limits regarding this as for each and every action, one is held accountable to Allah. Whilst it can be argued that Islam and counselling psychology both promote the idea of nurturing a safe, enriching and trustworthy space for the individual to develop, within Islam Allah asks all humans to place their complete trust

in Allah. Within the context of the therapeutic relationship evidently there are limitations and boundaries to adhere to, but when one is engaged in a deep connection with the Divine, there is no veil or boundaries between man and that of Allah:

> '*… And with Him are the keys of the unseen; none knows them except Him. And He knows what is on the land and in the sea…'* **(The Qur'an, 6:59)**

In a similar vein, there appears to be divergent views with regards to the idea of acceptance. Unconditional positive regard and acceptance are considered to be one of the core conditions of person-centred therapy (Rogers, 1986). It can be argued that there are certain conditions attached to the parameters of this relationship. For instance, being interested in therapy outcomes and working within economic and time constraints. However, for Allah, his acceptance and love for man is unconditional and is not restricted in any way or form.

Counselling psychology seeks to understand the holistic nature and development of humans, and it promotes the notion of one taking responsibility and control for their lives. On the contrary, Islam strives for the holistic consonance of man with God through maintaining connection with Allah and pleasing Him. This is accompanied by the belief that Allah is in complete control of all events in this life, and submission to the will of Allah and reliance on Him is the ultimate goal. However, at the same time Islam states that maintaining an internal locus of control towards self-rectification can lead to spiritual, behavioural and emotional health (Keshavarzi & Haque, 2013). It is through the act of repentance of one's sins (*tawbah*) that Muslims are able to achieve the compassion and forgiveness of Allah and obtain spiritual purification.

In view of the above, it is apparent that several principles driving Islamic thought are compatible with that of counselling psychology. However, one cannot disregard the many more areas of dissonance that occurs between the two areas as this will have implications for counselling psychologists. For instance, counselling psychologists need to be sensitive about several factors such as Muslims tendency of maintaining a collective actualisation, an emphasis on pleasing Allah and not humankind, and surrendering to his Will to achieve a higher sense of morality and spiritual growth. Also failure to attend to client's spiritual narrative may damage the therapeutic relationship or even cause harm to the client (Reddy & Hanna, 1996). Undertaking interventions that are congruent with Islamic values is therefore vital. This would help to minimise the potential for therapist biases and stereotyping within the therapeutic context, and help to ease clients' fears, build trust, and communicate respect (Hodge & Bushfield, 2006). It is however noteworthy that not all individuals will conceptualise their difficulties within a religious framework.

Muslims and counselling psychology: Mind the gap

The focus on improving access, and offering culturally appropriate services to help meet the needs of various UK based populations has been rising (Nadirshaw, 1992). This is indeed a concern shared by counselling psychology. Inayat (2007) highlights some of the barriers to Muslims underutilisation of mental health services such as mistrust of service providers, fear of treatment and discrimination, language barriers and culture.
For instance, it is commonly believed that Muslims perceive services to be insensitive

towards their cultural and religious needs, for example, lack of provision of a prayer room, exclusion of one's family within treatment, and being misunderstood by practitioners. Owing to language barriers and lack of information, Muslims may not have an adequate understanding of services and this may cause confusion and fears of Westerners imposing their own beliefs upon them. They may subsequently feel disempowered and helpless, and thus be more likely to disengage from treatment. It has been noted that Muslims have an increased tendency to conceptualise illness and difficulties as occurring according to the will of Allah and of maintaining optimism regarding the healing process (Nabolsi & Carson, 2011).

Inayat (2007) makes suggestions such as counselling professionals gaining knowledge of Islam and its impact upon daily life and expressions of distress. Elsewhere, the need for professionals to consult with Islamic religious leaders, organisations, or individuals to gain a deeper understanding of a particular issue from an Islamic standpoint has also been emphasised (Altareb, 1996). For instance, some Muslims are likely to seek more traditional treatments from pirs (spiritual guides) and hakims (traditional healers) as opposed to accessing psychological help as they may attribute a more supernatural explanation to their psychological difficulties. They may believe in the effects of black magic, the 'evil eye' and demon possession as causing mental health problems (Khalifa et al., 2011; Lim, Hoek & Blom, 2015; Rassol, 2016). It can be argued that only a specialist in religious experience may adequately perceive these distinctions and manage these properly (Utz, 2011). This is not to discount the collaborative efforts that counselling psychology can undertake to assist Muslims and inform their clinical practice. This however highlights the need for counselling psychologists to engage in specialist training to further their knowledge. There is some evidence of mental health practitioners forming partnerships with Muslim religious experts to enhance culturally sensitive practice and reduce the risk of incorrect understandings of religion being incorporated into the therapy. For instance, Meer and Mir's (2014) study of depression with Muslims in primary care and Wandsworth's community empowerment network led by Malik Gul was set up to help bridge the gap between local communities and mainstream services. Similarly, it may be worthwhile for counselling psychologists to consider in what way they can be pro-active. I am not suggesting that counselling psychologists work towards becoming 'religious experts' regarding clients' experiences, but instead propose that they enhance their current knowledge base and consider collaboration and partnership working with Islamic faith leaders. Meanwhile, counselling psychologists currently face the challenge of reducing and minimising health disparities across various groups (Tucker et al., 2007).

Through the lens of the therapy room

Arguably, research has documented that it is in fact therapeutic variables such as goal consensus, empathy and a positive therapeutic alliance that determine positive therapy outcomes (Ackerman & Hilsenroth, 2003; Barber et al., 2010). Being aware of one's own values and beliefs and assessing those of the clients helps build the therapeutic relationship. It may be helpful to acknowledge and discuss differences (Sue & Sue, 2012). Demonstrating an openness and willingness to be curious about such issues within the context of a safe therapeutic space may enhance client collaboration and facilitate therapeutic growth. This is consistent with the ethos of counselling psychology as it is

concerned primarily in exploring subjective lived experience, feelings and meanings (Woolfe, Dryden & Strawbridge, 2003). Disclosure of therapist's own religious and spiritual outlook however needs to be informed by the needs of the client and how it might expedite the therapeutic process (Farber, 2006).

In order to inform culturally sensitive ways of working, counselling psychologists need to be mindful of the role of interpreters and the complex dynamics that may occur during this process. Tribe and Lane (2009) provide useful guidelines and suggestions for health and service providers for this purpose. The major interpreting models include linguistic or literal translation, the psychotherapeutic model (which is concerned with ensuring that emotions are effectively conveyed by the interpreter to the clinician) and the advocacy model, i.e. interpreter acting as an advocate (please refer to Tribe & Raval, 2002). Tribe and Thompson (2009) highlight how power dynamics within the changing triangular relationship may be reflective of the global structures of power within society. The closeness of the clinician and the interpreter and their ability to reflect jointly on the work as opposed to thinking about the interpreter purely as a translating machine can help towards managing and negotiating any pulls existing within the three-way relationship (Tribe & Thompson, 2009). Hence interpreters have the capacity to bridge the linguistic and cultural misunderstandings that exist between therapist and clients but one must be alert to the many challenges that accompany this too. For instance, one example might be the divergence between the interpreter and client religious and political ideas and the way this gets unconsciously communicated within the therapy context. I have indeed experienced this myself as it has the potential to stir up some complex dynamics (and indeed emotions) within the room. Using supervision effectively can assist with managing this sensitive and intricate process.

Bridging the gap: Implications for counselling psychology

There has been a growing need to incorporate Islamic beliefs and practices within psychotherapy and counselling (Ahmed & Amer, 2012; Altareb, 1996; Khalid, 2006; Rizvi, 1989). Islamic-based interventions mainly comprise of fasting (*sawm*), repentance (*taubah*), prayer (*salat*), and regular recitation (*dhikr*) of the *Qur'an*. Muslim religious clients report fears that Western practitioners are likely to promote secular views and worldviews and thus may undermine their values (Myers, 2004). 'Secularism' refers to the belief that religion should not be involved with the ordinary social and political lives of human beings (*Cambridge English Dictionary*). Religious clients may feel that they do not have the permission to bring religious/spiritual ideas into therapy. Furthermore, concerns that Western therapists are not adequately able to understand and respect clients' worldviews, and worries around them being judged negatively by their therapist may also be prevalent. Gregory et al. (2008) suggests that therapist disclosure of own religious identification can have an impact upon therapy, i.e. highly religious clients reported a preference to see a therapist affiliated with a major faith rather than someone of no faith. This raises the important issue of client-therapist matching as it is not always possible to meet this provision given there is a shortage of ethnic minority therapists within statutory services. At the same time, research has suggested that client-therapist matching may not necessarily be therapeutically beneficial, and that treatment success may be independent of therapist's race/ethnicity (Smith & Cabral, 2011). Introducing cross-cultural assessments during training may be one way to approach this issue.

An awareness of therapist's own perceptions, stereotypes and beliefs about Islam is paramount. An inclusion of religion and spirituality-based themes within the context of formal counselling psychology training programmes and supervision can possibly aid this process. In an empirical review of studies on religion and spirituality, Post and Wade (2009) highlight how therapists were more likely to pathologise religious/spiritual beliefs whom they had less knowledge about; Islam was perceived to be more pathologised in comparison to Catholicism. Following the terrorist attacks of 9/11 and the ever-increasing association of Muslims with terrorism, Muslims in the West have been questioning 'who are Muslims?' and 'what is Islam?' (Ali & Liu, 2004). The challenge of living an Islamic lifestyle seems to be exacerbated by the increased misinterpretation of Muslims in the media and the associated rise of Islamophobia (Dodd, 2015; *Huffington Post*, 2015). Muslims around the world are up against the challenge of any religious enthusiasm being misinterpreted as a sign of possible terrorism. Consequently this resulted in feelings of guilt, shame, fear and even anger, and of questioning their own religious identity. The average Muslim today deals with not just the everyday stressors of life but also the responsibility of defending basic religious rights and values as normal and acceptable. Such misconceptions may impinge upon the work of counselling psychologists. Adopting sensitivity whilst working with religious clients is therefore essential, if ignored, at best a client may feel misunderstood, disempowered and disrespected. Consideration should be given to factors such as involvement of family members, exploring cultural and family barriers to treatment, dealing with issues of shame and stigma, and use of cross-cultural supervision. There is a slow rise in the domain of research investigating cross-cultural supervision perspectives (e.g. Sato, 2014; Wong et al., 2012).

I have encountered at times when Muslim clients have disclosed to me their level of relief at working with a Muslim psychologist whom they feel is able to understand their sorrows and pains. Ayesha expressed this sentiment too. This does not suggest that a non-Muslim practitioner would not be able to listen attentively to their experience. Within the context of counselling, an awareness of Muslims' sensitive issues and practices and working within the boundaries of Muslim beliefs is warranted. For instance, it may be deemed inappropriate for a female client experiencing psychosexual problems to be working with a male therapist as Islam enforces strict boundaries between men and women. Discussion of such intimate issues between a man and a woman (except for his wife) are not permitted. This is encapsulated within the concept of modesty (*purdah*). Regulating eye contact between the genders within the therapy setting therefore becomes vital given such rules and religious guidelines. An alternative suggestion to help meet this need might be to signpost clients to Islamic counselling services. Furthermore, in order to enhance cross-cultural ways of working, there is a dire need for statutory services to offer specialist training centred around religion and spirituality.

Many authors have outlined a number of guidelines and practical considerations to assist in working with Muslim clients (e.g. Abu Raiya & Pargament, 2010; Carter & Rashidi, 2004; Keshavarzi & Haque, 2013). At the same time, research has also highlighted the dissonance that can occur between Western therapies (including CBT, e.g. Beshai et al., 2013; psychoanalytic approaches, e.g. Akhtar, 2008; psychodynamic models, e.g. Ahmed & Amer, 2013) and Islamic-based therapies. Nevertheless, CBT has been argued to be one of the

most effective therapeutic model for use with Muslims (Ahmed & Amer, 2013). The use of CBT interventions that comprise of self-statements that are Islamically oriented to facilitate the therapeutic process are recommended. In terms of process, cognitive therapy appears be congruent with some Islamic values. As a general therapeutic approach it advocates reason, logic, scientific exploration, focus on current and future functioning, consultation, focus on behavioural and emotional change, self-control, and education, all of which are widely endorsed within Islamic discourse (Hodge & Nadir, 2008; Rasool, 2016). Hamdan (2008) suggests that unproductive beliefs are identified and modified and replaced with beliefs derived from Islam, which is a variation of cognitive therapy using religious themes. As a psychologist who largely utilises a CBT-based approach this is encouraging. Also, there is a growing evidence of Culturally Adapted CBT which involves incorporating Islamic-based teachings (e.g. Naeem et al., 2015; Mir et al., 2015).

There is not one monolithic Islamic tradition. The degree of religiosity is also related to the cultural background of the client. Immigrant Muslims, for instance, have different experiences compared to UK-born Muslims. While the former may be dealing with issues of adjustment to the host culture, the latter may be dealing with integrating their personal practice of Islam into their everyday life. The intersectionality of culture, gender, ethnicity, and race needs to be considered. Hodge and Nadir (2008) contend, 'no single Islamic narrative exists, just as no single Western narrative exists. Rather, a multiplicity of narratives exist, each shaped by local cultures, race and ethnicity, political realities, degree of spirituality and other contextual factors such as the degree of familiarity with the dominant culture' (p.32).

Islamic worldviews differ and are influenced by the various cultural and social contexts in which they are developed, and by various scholarly interpretations of Islamic laws and norms. This can be a challenging task for counselling psychologists as consideration must be paid to the diversity of various sects or groups within religions as each sect will have their own set of individual beliefs and values. Eneborg (2013) emphasises the prevalence and popularity of a particular form of Islamic healing approach Ruqya Shariya amongst the predominantly educated Muslim youth living in East London. This method endorses both biomedical and Qur'anic knowledge to help alleviate human suffering. He contends that the practice of Islam has become culturally transfixed and rooted within cultural practices as opposed to supporting the notion of a more universal Islam.

Within the UK, there appears to be an ever-increasing growth of specialist Muslim counselling services that help to readdress the balance of statutory services not being able to adequately meet the needs of Muslim clients. Examples of free Islamic counselling provision within London include the Muslim Women's and Families Helpline, Tayyibun Islamic Counselling, Muslim Youth Helpline, and the Arab Counselling Service, which operates as part of the Child and Adolescent Mental Health Services in West London. This is being enhanced by the introduction of various platforms such as the *Journal of Mental Health*, and various network groups such as the International Association of Muslim Psychologists. As practitioners, it is perhaps time to reflect, and implement innovative ways of how both Islam and Counselling Psychology can collaborate and create further

meaningful dialogue to assist each other. To summarise, it is imperative that counselling psychology works towards culturally modifying interventions that are consistent with clients' worldviews. For Muslim religious clients, this would entail therapy to be tailored in accordance with the tenets of Islamic teaching to facilitate a more positive therapeutic journey. Inevitably there will be many challenges along the way and it is acknowledged that this may only be the beginning. Such multicultural ways of working may enhance the philosophy of what counselling psychology stands for and hopefully enrich the lives of many individuals.

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Modern feminism and counselling psychology: The danger of a single story – considering Black women in feminism

Ohemaa Nkansa-Dwamena

In her TED talk 'We should all be feminists', Chimamanda Ngozie Adiche defines a feminist as: 'a man or a woman who says, 'Yes, there's a problem with gender as it is today, and we must fix it, we must do better'. She goes on to point out:

> *'Gender as it functions today is a grave injustice. We should all be angry. Anger has a long history of bringing about positive change, but in addition to being angry, I'm also hopeful because I believe deeply in the ability of human beings to make and remake themselves for the better […] Because gender can be a very uncomfortable conversation to have, there are very easy ways to close it, to close the conversation.* (Adiche, 2013)

Ms Adiche raises pertinent points about the importance of continuing to have a dialogue around gender equality and applying this to action. The progression of gender equality is not just the responsibility of women; the expansion of feminism falls to all of us: men and women in all fields and all walks of life. In a sense, anyone who believes and supports the idea of female equality could be called a feminist. In its simplest form, feminism is about equality; equal rights in the areas that matter for all individuals. It does not purport that males and females are the same but that opportunities, existence, and progression are available and equal for both men and women. Feminism is a progressive movement, and a social justice issue, therefore a much needed area of action and discussion.

The advancements in the area of gender equality and feminism have emerged in different forms over the years. The increase in positons occupied by women in civil society and politics, an elevated presence of women in the workforce and academia, development of female empowerment, and improvement in health-related issues are just some of these. In some ways, the dialogue around female equality has moved from covert dialogue to overt debate, and more importantly, engagement in action which has advanced the rights of women across the world (although more advanced in certain areas than in others). However, female existence is still not as 'equal' as we would hope for it to be, and 'feminism' as a concept is complex, as it intersects with many different areas including race, class and sexuality. It is also relevant to the area of mental health, psychological development and development of a sense of self. In this regard, the role of counselling psychology has an important one to play. Although historically, counselling psychology has adopted feminist ideologies and social justice (in line with its ethos as a profession), in what ways does it, as a field, engage with contemporary feminism, its growth and the way in which it affects the individuals it works with? From a clinical perspective, from a research standpoint, from an activist view and in the development of counselling psychologists, where does feminism sit? Counselling psychology has emphasised gender as a significant factor that can affect functioning and growth. This emphasis has been shaped by counselling psychology's affirmation of women's issues and feminist's interests, but perhaps

the interest has been relegated predominantly to delivery of individual interventions and research pieces which may be disconnected and at times unspoken. Additionally, counselling psychology may not account for the layered diversity existent within feminism as it pertains to different groups of women.

These observations are particularly relevant when we consider the emergence of ethnic minority female narratives in contemporary feminism, who may have felt that previous incarnations of feminism ignored their unique experience of intersectionality. That is to say, their struggles were and are not couched in just gender inequality, but are also rooted in the experience of racism in the wider community, and the concept of women hood both in relation to mainstream society and within their own communities. As contemporary feminism and social justice movements grow, it is worth considering with whom counselling psychology engages with when it adopts these platforms. If social justice applies to all groups and individuals, how true is it that women from ethnic minority backgrounds benefit from a counselling psychology feminist platform? In considering this complexity and intersectionality, this article will attempt to elucidate counselling psychology's relationship with contemporary feminism, with a specific focus on counselling psychology's engagement with feminism for Black women. The following areas will be touched on:

- Counselling psychology and feminism, considering Black feminist thought.
- Acknowledging and working with Black female experiences: the role of social justice and clinical practice
- Acknowledging and working with Black female experiences: research in the counselling psychology field

Keywords: Black British women, modern feminism, counselling psychology, Black feminism, psychology, gender equality.

Contemporary feminism and counselling psychology: The absence of black feminist thought

Much debate has ensued with regards to feminism's relationship with women from ethnic minority backgrounds and international communities (Hooks, 2000; Mirza & Joseph, 2010; Phoenix & Brah, 2004). Several areas of thought have arisen from this debate, including that of Black British feminism. Although Black British feminism has been written about in relation to education (Mirza et al., 2010), comparison to other black feminisms (Wright, 2014), little has been documented about the relationship between counselling psychology and Black British feminism.

Black British feminism was borne out of the notion that Black British females inhabit a space which is unique to their experiences as they 'occupy an ideological blind spot in a racial discourse, where the subject is male; in a gendered discourse where the subject is white, and class discourse where race has no place' (Mirza, 2009, p.8; Prins 2006). This is to suggest that there has existed an invisibility of black women in a lot of contemporary theorising. Often, when feminist interests and women's interests are discussed and explored in the counselling psychology field, it is with a homogenous view which does not always account for aspects of intersectionality that black women face both here in Britain and in other communities. Black British feminism takes the stance of working

within, through and across cultural differences (Phoenix & Brah, 2004). It attempts to acknowledge and encompass the differences in being a Black woman who has to intersect diverse platforms and identities. Black British feminism reconceptualises the relationship between domination and resistance by departing from a general approach adopted by mainstream feminisms, and instead uses a critical intersectional framework. This approach:

> *'Counters the notion that one fundamental type of oppression is the major source of all hierarchies. Instead, gender, race, sexuality, class, ethnicity and context are examples of social markers along which power and oppression build up, establishing historical, intertwined social relations patterns. Since it is used as a tool for identifying particular forms of oppression – for instance, oppression faced by black women living in poor neighbourhoods or by black men subjected to police brutality – intersectionality also denotes a rather loose definition of social groups and counters the notion that individuals are statically placed in segments of the population.'* (Pereira, 2015, p.2330).

Black females often have to fight against issues pertaining to race and gender, and have been suggested to be doubly oppressed (triply oppressed when sexuality is also considered in this frame). In relation to mental health and research, this is often an underrepresented group (in terms of accessing therapy) and under researched group. Mirza (2014) suggests that contemporary Black British feminists also have to 'tussle with the simultaneous consequences of the illusion of post racial equality alongside the continued intransigence and violations of gendered racisms' (p.126). This is to suggest that Black women can experience forms of oppression which occurs at the intersection of race and gender, and may stem from societal perceptions, images and stereotypes about Black women. Furthermore, although counselling psychologists may engage in debate and action pertaining to Black women with regards to sexual violence and harassment, other areas prevalent to the unique experiences of this group are not often engaged with. If they are, it is not consistently a part of overt dialogue within the counselling psychology field. In relation to this, Mirza (2014) contends that Black British feminism needs to be anchored in a collective struggle for a justice of economic redistribution and a politics of our recognition' (p.128). To this end, it is important that counselling psychology engages with this dialogue, from clinical, research and activist perspectives. However, it is easy to suggest this in theory. In reality, it is difficult to imagine that this can just 'happen' within a backdrop where perhaps these very issues are not acknowledged as pertinent to explore.

The absence of this dialogue in counselling psychology is problematic in itself because it denies and erases the experiences of so many clients and indeed so many Black female therapists within the counselling psychology field, replicating the minimisation of Black female experiences within mainstream society and within the psychology field. The other concern is that as with other areas pertaining to psychological thought, there is the danger of counselling psychologists engaging with Black female experiences from a monolithic standpoint, and trying to impose this thinking on how Black feminism should exist. The meaning of feminism and womanhood does not necessarily fit with the notions sometimes espoused within one particular society or cultural context. Nnaemeka (2004) expands this in her paper on feminism and African women, where she elucidates

the importance of recognising that Black feminism for Black women is located in their unique experience, and that it may not necessarily fit with the notion of independence and singularity espoused in some areas of mainstream definitions of feminism and female identity. In other words, it is important that counselling psychology does not engage with a single story of feminism which is rooted within one standpoint, and one environment. This is applicable to clinical practice, research focuses and theoretical orientations and development in this field. In the same way that cognitive behavioural therapy is not the only therapeutic framework applicable to all psychological presentations, theories and approaches for 'women' are not commiserate with all female experiences.

Interestingly, the raising of awareness and the tackling of issues pertaining to Black female experiences has often been addressed by Black feminist activists who do not necessarily sit within the counselling psychology field. Mirza (2009) points out that even in the absence of support and engagement from mainstream organisations, 'Black women activists have long drawn on their collective social and cultural knowledge to form a strategic space of radical opposition and struggle for new forms of gendered citizenship in their communities' (p.138). Counselling psychology can work within this as it complements the very ethos on which the field was built. Additionally, Patel and Siddiqui (2010) also point out that Black women's coalitions have campaigned for black women's rights over many years, and have also tried to create in the present, solidarities across religious, ethnic and cultural lines, in which counselling psychology and practitioners could be a stronger partner. Counselling psychologists in their identity as scientists/practitioners/researchers can perhaps progress Black feminism through their clinical practice, their social justice activities and through the research they choose to engage with and facilitate. What this looks like in reality will be explored further in this article.

Acknowledging and working with Black female experiences: Advocacy and clinical practice

As previously mentioned, although the popular notion in the feminist movement today is that we 'are all feminists', not all adopt this stance in practice and action. Feminism is a social justice issue which should benefit all women, and actions related to feminism should reflect the differences and diversities of women. To engage in dialogue about female inequality but ignore the multiple layers which pertain to Black female individuals is essentially rendering their experiences and voices invisible. If counselling psychology as it stands today seeks to empower all individuals and groups, how are counselling psychologists actually engaging with this in a balanced and realistic way? In a therapeutic sense, how do the frameworks which counselling psychology utilises cultivate a sense of equality and womanhood, and attend to Black British females? How active are we as psychologists in the area of feminism as it pertains to Black women? When we consider the tenets of therapy, how applicable are they to the experiences of women from diverse communities?

Black feminism and the experiences of Black females are not relegated to theory. If counselling psychology is to engage with contemporary feminism which acknowledges and works with the individuals who fall within this group, then a varied and informed approach must be taken. It is possible for the tenets of Black British feminism to be applied through the avenues of social justice and clinical practice to improve counselling psychology's relationship with contemporary feminism and Black women.

Black feminism, counselling psychology and social justice

Cooper (2015) suggests that 'if we genuinely want to help our clients feel better, then directly engaging in social and political change processes may sometimes be as important as one-to-one therapeutic work' … 'even if we choose not to… it may be important to remember that such political processes are fundamentally aligned with what we are trying to do with our clients and not of an entirely different order' (Cooper, 2015, p.11).

A social justice standpoint emphasises societal concerns including issues of equality, equity, interdependence and social responsibility. Feminism is about social justice; and social justice is at the heart of feminism in that the existence of sexism, gender inequality, marginalisation and gendered violence are what account for the unbalanced experiences of women from different groups and communities in the UK, and across the world in different forms. The tenets of feminism and social justice intertwine with the ethos of counselling psychology, perhaps most represented in counselling psychology's commitment to recognise social context and discrimination and to work in ways that empower individuals and discourage anti-discriminatory practice.

Privilege and justice lends itself to the idea couched within counselling psychology that clients exist within and are consistently affected by environmental contexts and effective helping requires the development of awareness and knowledge that injustice, oppression, discrimination, marginalisation and social cultural privileges affect individuals in contemporary society. To apply this approach to Black British feminism and the experiences of Black females requires counselling psychologists to actively and consciously develop an understanding and awareness of their experiences, cultures, contexts and identities. This is to hold in mind that for many Black British women, the effect of societal pressures, norms and expectations have multiple effects – that in various levels of society, their voices are marginalised. But this is also to acknowledge their Black female experiences as unique, and not necessarily experienced by women in mainstream society. Bell Hooks (2014) seems to espouse this best where she states 'No other group…has had their identity socialised out of existence as have Black Women. When Black people are talked about, the focus tends to be on Black men, and when women are talked about, the focus tends to be on White women' (p.7). In addition to experiencing discrimination as women, they experience racism as Black individuals, an intersectionality that is not applicable to other women. An example of this is in workplace settings, where at times Black women not only have to battle against unequal pay on account of their gender, but may also have to simultaneously battle with lack of recognition of their skills owing to preconceived biases or notions about their race, in addition to experiencing micro aggressions.

Crethar et al. (2008) suggest that the advancement of the feminist and social justice movements have allowed many counselling psychologists to re-examine how these factors affect their clients' lives, and psychological interventions. If this is true, then in engaging with Black women, applicability of a social justice and Black feminist approach could allow practitioners to enlarge their view of counselling which has historically overemphasised an individual and intra-psychic approach, and move more towards a culturally respectful method which emphasises the unique aspects of gender and other cultural signifiers.

Empowerment and advocacy from a feminist and social justice perspective involves taking a course of action intentionally designed to increase the awareness of persons in marginalised and devalued groups. This includes increasing people's awareness of the ways in which social and institutional barriers and injustices adversely affect individual and client group wellbeing. Counselling psychology perhaps most exemplifies this with its engagement in issues pertaining to gendered violence and sexual harassment. However, in relation to Black women, other issues such as racism, equal pay, colourism, police violence, incarceration, representation are all pertinent, and this is by no means an exhaustive list.

Vera and Speight (2003) suggest that counselling psychology's operationalisation of competency has been focused narrowly on how within the context of counselling, mental health professionals can work effectively with women. They suggest that a multicultural competency, within which Black feminism can sit, should not be limited to just an awareness of difference, of injustice and of marginalisation, indeed it should be grounded in a commitment to action which necessitates an expansion of professional activities beyond the therapy room. As counselling psychologists, a dis-engagement with the activities which could eliminate oppressions, inequalities and marginalisation is a weakened stance in the engagement with modern feminism. Such activities do not necessarily need to be associated with taking a precise political stance, however, counselling psychologists position as scientist/researcher/practitioner lends itself to a myriad of ways in which they can promote feminism and empowerment for Black women. This could include collaboration with other organisations and individuals who are committed to this cause as previously mentioned, carrying out research which can influence policy and inform, and lending skills to contexts external to the field which can further the cause of feminism. Edge (2013) suggests that collaborative working between community organisations and mental health workers and providers has potential to positively impact on mental health and wellbeing of Black women, their families and communities. She also suggests that through the lens of social justice and intersectionality, Black British women can be seen and heard in ways they are not always allowed to because they and their experiences are considered 'other' and silenced, worse yet ignored.

Black feminism, counselling psychology and clinical practice

Exploring and acknowledging the intersections of ethnicity and gender for Black women can also help to facilitate improved understanding of culturally-based help seeking and inform clinical practice. Recognising and engaging with the multiple aspects of black female identity also helps to generate awareness and improve access to help seeking which is not entirely present within mental health services at present in the UK for Black British women (Edge & Mackian, 2010).

Conceptualisation of Black female experiences particularly as they pertain to mental health have been suggested to be pejorative (Edge, 2013) as labelling of their experiences fails to take into account the factors which shape their lives. Edge (2013) goes on to suggest that traditionally, clinical practice has not always acknowledged the ethnic and culturally based explanatory models of mental health within which a Black feminist approach can sit. Black women may present differently in terms of their difficulties, and their explorations in therapy may be underlined or informed by spoken and unspoken themes pertaining to race, culture, their positioning in their communities, families and society. Black women

may not even access traditional mental health services at all, and it would be a misstep to suggest that this is as a result of being hard to reach. Rather, it may be due to services being ill informed, unaware, or assuming that traditional, mainstream services are the only avenues of engagement for Black women. (Edge, 2013; Fitzpatrick et al., 2014)

In considering a feminist approach which includes Black women, it requires practitioners to adopt a holistic approach which allows for exploration of Black female identities, and the multiplicity which sits within it. A relationship with contemporary feminism also requires counselling psychologists to respectfully enquire, and to formulate with black females in a way which encompasses their self-constructions of womanhood, gender identity, racial identity and their negotiation of these.

Another framework from which counselling psychologists can draw from and adopt Black feminist thinking is feminist therapy. Developing considerably in the 1960s, feminist therapy consists of therapeutic components including consciousness raising (actively raising consciousness around issues pertaining to the female experience for the client and in the wider society), social and gender role analysis and re-socialisation and social activism. Feminist approaches exist in relation to depression, anxiety, sexual abuse trauma, however, there is less research around the specific mechanisms utilised in feminist therapy and its effectiveness.

Feminist therapy was born out of female psychotherapists critique of traditional patriarchal views of mental health and saw the need to develop a model that would be supportive of women's mental health and functioning, and capable of empowering women in a patriarchal society. Many of the core tenets of feminist therapy evolved to fit this purpose, and address these issues. Feminist therapy is also influenced by feminist movement activists, including consciousness raising. The emergent model incorporates 'biological, social and cultural issues of poor function in the aetiology of psychological difficulties' (Israeli & Santor, 2000, p.234). Most importantly, feminist therapy acknowledges that sex roles, female socialisation, and women's status in a patriarchal society are in themselves sources of psychological difficulty.

Feminist therapy does not just advocate traditional therapeutic intervention, but also involves interventions such as social activism, in order to affect societal changes, therefore the therapist's work, in conjunction with their client extends beyond the therapy room. Feminist therapy engenders the notion that personal experiences are therefore embedded in a political context and reality, and that in order for female mental health to improve, the wider society which facilitates marginalisation and oppression must be changed.

Israeli and Santor (2000) suggest that feminist theorists and therapists treat clients as unique individuals rather than assuming that all individuals have homogenous experiences. Instead, it is explicitly highlighted that a client's status may affect their psychological functioning – this is in reference to their gender, race, cultural and ethnic status. Feminist therapists and theorists recognise that women from ethnic groups may be at greater risk for developing difficulties, as they may be blamed for their difficulties, implying that their difficulties stem from innate origins creating further oppression, than that experienced by females in the dominant majorities. This could be due to assumptions

or stereotypes made about Black women in their different contexts which have affected the narrative surrounding their experiences. This is why taking aspects of feminist therapy and combining it with the ideas of intersectionality, then applying it in clinical practice could foster long lasting therapeutic outcomes and also hold black female clients in such a way that they are not marginalised, misunderstood or minimised within a mainstream or Western framework which does not speak to or necessarily recognise their unique experiences. The following case vignette is a brief example of incorporating the ideas and approaches previously discussed.

Rae was a Black woman in her mid-thirties who at the time of her referral, had been struggling with day to day functioning due to severe low mood, and other trauma-related symptoms. She presented with a trauma reaction as a result of multiple abuses she had suffered in her early years.

She came to our service following a long engagement with the mental health system and two previous engagements with therapy.

> *Rae relayed to me that over a long period of engagement with both primary and secondary care services, she had received multiple diagnoses. She recalled feeling persistently seen as a Black women experiencing overt mental health difficulties, but did not feel she was engaged with beyond this description. She stated it seemed easier for medication to be prescribed to her than for her trauma to be processed.*
>
> *She also experienced silencing and minimisation in her own family. In speaking about the abuse she had experienced, her parental figure first stated it was not possible for it to have happened, and later blamed Rae for its occurrence, inferring that her 'femininity' had something to do with it, and culturally, this was not something that Black families either experienced or spoke about.*
>
> *She stated she felt she had never really had the space to heal from the trauma she had experienced, as she felt she was never really engaged with. She experienced multiple levels of silencing – in her own family, where her experience of abuse dismissed, and in a mental health system where she felt she was treated as a diagnosis. She felt silenced in her previous engagements in therapy where in her experience, her various diagnoses were focused on, and not her story. She relayed to me she felt her previous therapist with whom she had had the longest engagement seemed to both misunderstand her. She also felt that she had not had the opportunity to develop a sense of self and understand her identity as a Black woman.*
>
> *Our work together focused on Rae being able to build a narrative around her trauma – the impact this had, the guilt and blame she carried, her sense of herself as a woman and what it meant to her to be rejected on multiple levels with regards to her experiences, her racial and gender identities and how she could begin to build her sense of self. We explored her history, understanding her place in her family as a woman, the cultural influences which shaped her environment, and the impact of the absence of secure attachments which adversely affected her view of herself and the abuse which ensued. We explored her experience of abuse as a black girl, and how this was dealt with within her family. We also took the time to understand her subsequent mental health difficulties as a response to the multiple levels of abuse she had suffered. For her, it was important to explore much of this through the lens of being a Black woman, an identity she was still trying to make sense of, and in her experience, one of the factors*

which had lay cause to the difficulties she experienced in her family and subsequently in systems who may have relegated her presupposed framework. But mostly because nobody had given her the opportunity to build this narrative.

Of most importance was allowing the space for Rae to be seen. It was about allowing her whole self to be present and recognised in the room. By allowing this, she was able to explore all parts of herself, the vulnerable part which had endured abuse, the part of herself which had also experienced discrimination in her own family and subtle ignorance and minimisation by those who seemed to misunderstand and not 'see' her.

For my client, her healing was not only related to the abuse she had experienced, it was also connected to being engaged in a system where she felt relegated to a diagnosis, and where she persistently felt that a Black woman, she had been silenced, and her story had been unheard. She also spoke about the importance for her in moving forward in her full womanhood, but being unable to do so as she felt stuck and also others seemed to hold a perception of her which was not holistic.

Acknowledging and working with Black female experiences: Black women and research in the counselling psychology field

Much of the work counselling psychologists do is evidence based and research is also used as a platform to highlight emerging theory and give voice to the experiences of the individuals counselling psychology engages with.

Contemporary feminism has become a more accessible 'concept' to the wider community as a whole at least in part to research, media and activism, but it is the tool of research (in its many forms) I would like to concentrate on in this section. As more individuals debate and consider feminism, what it means and how it looks in this era, new generations are proffering their opinions on female issues and experiences in novel ways, and from the perspective of different viewpoints, including that of a psychological nature.

Most of the work around research pertaining to women can be credited to feminist academics and activists, however, there have been some criticisms directed to this work, and in particular when one considers the work in the field of counselling psychology. Ahmed et al. (2009) suggest that whilst such research has been important as a 'means to address issues of gender and patriarchal power' (p.7); this work does not always attend to the plethora of experiences that women from different communities' experience. Additionally, research which may encompass the experiences of the diversity within the female landscape is not always made widely available. They also go on to suggest that feminist focused research has been accused of 'assuming Western models of patriarchal power and intimate relations that are not always appropriate for non-Western women' (p.8).

This raises three issues. The first is in relation to counselling psychology and its commitment and engagement with research pertaining to the experiences of women. The second relates to the way in which research involving female participants adopts an epistemology representative of the group/individual being studied. The third area highlights the importance of feminist focused/counselling psychology research which represents the diverse experiences of women, and brings these experiences to the fore.

Nnameka (2004) and Brown (2012) both suggest that in conducting research about Black women, it is important to work from a reference point which is true to the subjects of the research, and to adopt an epistemological reflexivity which allows the researcher to consider their influence and framework in shaping the ideologies which may emerge from research.

It is interesting that research couched in counselling psychology and in relation to Black women for instance is relatively low in comparison to research about the experiences of women from other groups (Edge, 2013). Ahmed et al. (2009) suggest that there are several reasons for this, including the difficulty in accessing women from ethnic minority groups, partially due to their reluctance to come forward and partially due to the reluctance to access services through fear of discrimination, which may be grounded in the delivery of sometimes uninformed clinical and counselling services. As a result, at times the delivery and encouragement of research and policy development which actively highlights the experiences of diverse groups of women has fallen to community-based voluntary organisations (e.g. Southall Black Sisters) who may or may not necessarily be associated or borne out of the counselling psychology field. There is perhaps an opportunity here for counselling psychologists to join forces with third sector organisations to produce joint pieces of research work and for counselling psychologists to liaise with other existing platforms to generate informed pieces of work which draw on their expertise as psychologists (for instance, see the collective group Black British Feminists (www.blackfeminists.org) and Southall Black Sisters (www.southallblacksisters.org.uk). Additionally, it is important to consider the type of research conducted in the area of women's issues which accurately reflect their experiences; for instance a narrative approach, the use of creative tools, qualitative methods and media outlets such as film and documentaries, which are all valid means of informing the counselling psychology field.

It has been suggested that particularly when engaging in feminist research, an epistemological stance which truly represents the group being studied is imperative, and none more so than in capturing the experiences of women and in this era. Collins (2000) suggests that the epistemological stance is important when carrying out research as 'epistemology constitutes an overarching theory of knowledge, it investigates the standards used to assess knowledge or why we believe what we believe to be true' (Collins, 2000, p.252). Collins (2000) proposes that when a researcher investigates the subjugated knowledge of women, and in particular women of colour, a degree of ingenuity is required. She also suggests that defining the epistemological standpoint in the research of Black women is particularly important because it helps to determine which 'areas merit investigation, which interpretative frameworks will be used to analyse findings and to what use any ensuing knowledge will be put' (p.252). She posits that Black feminist epistemology encompasses standards for assessing truth that are widely accepted amongst Black women (Collins, 2000). Therefore, in relating to a Black Feminist epistemological standpoint, it is important that the interpretative framework chosen allows for the participants to express their own standpoint using a narrative tool.

It has been proposed that because Black women may share common experiences, and that certain characteristic themes will be prominent in Black women's standpoint (Richardson

1987). These themes may include the legacy of struggle (against sexism and racism), the interlocking nature of race, gender and class oppression, replacement of denigrated images of Black womanhood with self-defined images, Black women's activism as mothers, teachers and Black community leaders and sexual politics (Collins, 2001). However, Collins (2001) clearly points out that the existence of these core themes does not mean that Black women respond to them in the same way. Diversity among Black women produces different concrete experiences that in turn shape various reactions to the core themes. This may be due to differences in social class, sexual orientation, ethnicity, country of origin, urbanisation and age. She further asserts that Black women as a group experience a world different from that of those who are not Black and female; these concrete experiences can stimulate a distinctive Black feminist consciousness with regards to that reality (Collins, 2001).

Black feminist thought revaluates and articulates taken for granted knowledge shared by Black women and can be instrumental in transforming them (Collins, 2011). Through the process of re-articulation, via research, the telling of stories, various writings, Black female intellectuals offer Black women a different view of themselves and their world from that presented by the dominant group. Collins (2015) asserts that in contributing her framework of Black feminist thought, she was attempting to dismantle assumptions and develop a way of engaging with the Black female narrative away from already existing frameworks which were not neutral or objective. It is interesting that her thoughts still resonate in relation to research pertaining to Black women. Counselling psychologists are well placed to be able to adopt an epistemological stance, which truly represents the experiences of Black women and lends itself to a renewed way of giving voice to a group which has not been traditionally represented in counselling psychology research.

Conclusion

It has been asserted that counselling psychologists have 'always been concerned with promoting social environmental changes that foster healthy human development, especially among those who are adversely affected by social injustices' (Crethar et al., 2008, p.269). However, counselling psychologists and the field as a whole could be doing more, particularly as contemporary feminism as a movement continues to grow, and more individuals become aware of the fight for gender equality and female empowerment. A feminist narrative and ideologies without action is a weakened stance and approach. Furthermore, a feminist narrative and counselling psychology interventions which does not take into consideration the unique experiences and complexity of all women is also weakened. If counselling psychology is to be more proactive in engaging with a contemporary feminist platform, which elevates the experiences of Black women, the following could be adopted:

- Advocating with and on behalf of Black women and including Black women in the conversation, particularly in areas related to their psychological health and wellbeing.
- Improving access to mental health services. Although predominantly, the focus has been on Black men and their engagement with the mental health system, Black women also have their own unique difficulties and struggles with a system which has come under criticism for an unequal approach to its users (Fernando, 2009).

- Joining aspects of culture and feminist therapy in clinical practice: In arguing that feminism although stated as inclusive, and feminist therapy alludes to the importance of individuality (within this race and culture) these could be better acknowledged and engaged within clinical practice as an active way to improve the relationship between Black British feminism and counselling psychology.
- Training for counselling psychologists: shining a light on intersectionality and the experience of Black British females, encouraging critical thought and action in relation to this.
- Highlighting the experiences of Black women through research, and maintaining a space for their stories and voices to be heard.

Contemporary feminism is not monolithic, and certainly more individuals are defining their own feminisms overtly in a way that cannot be ignored. The emergence of narratives from Black female individuals who have felt that feminism has not represented their experiences is certainly representative of this evolution. Counselling psychology can engage with contemporary feminism, particularly for Black women, through various avenues, including research, clinical work, advocacy and action. However, acknowledging the importance and existence of these narratives is important in the first instance. It is also prevalent that this engagement is continuous and evolves over time, and does not become a temporary platform within the field.

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The essence of spirituality and its applicability to practice – an alternative perspective

Yetunde Ade-Serrano

Spirituality within the context of the 'room' is not a new phenomenon to practitioners or indeed to those who dedicate time to its examination. There are numerous publications, including: *International Journal for the Psychology of Religion, Psychology of Religion and Spirituality, Journal of Muslim Mental Health, Journal of Religion and Spirituality in Social Work, Research in Nursing and Health* to name but a few, where we can read about the influence of spirituality on multiple elements of the human existence. It is, however, fast becoming a 'hot potato' in the UK where counselling psychologists and Mental Health Practitioners (MHP) are encouraged to deliberate on it, explore it with clients and colleagues, and accommodate it within the narratives being presented.

Attendance at the annual conference for the Division of Counselling Psychology in 2013 in Cardiff bore witness to this enthusiasm and sense of enquiry. Whilst at the conference, a workshop presentation on 'Spiritual perspectives of mental health and therapeutic/ supervisory practices' (Cranbourne-Rosser, 2013), highlighted the relevance of spirituality for qualified and in-training professionals in considering the implications of spirituality on clinical practice, research, supervision, provision of psychological services, implementation of policies and legislations, as well as on service users themselves (and not forgetting those who provide the service). Consequently, the Division now has a spirituality interest group, led by Melody Cranbourne-Rosser, where spirituality related issues and challenges are explored.

In an interview with Bob Edelstein (2007), Yalom states that:

> *'I have a lot of trouble with the concept of spirituality, and every time someone uses the term I can't discuss it with them until I find out exactly what they are thinking. Everybody talks about something very different. Some people talk about a sense of awe and magic in the universe, looking at the skies and the cosmos, their sense of smallness, and the glory of the heavens. You don't need religion to have that. So, I want to find out exactly what spiritualism is for that person. It comes in a rainbow of flavours, so I need to find out what they mean.'*
> *(See April/May 2007 edition of the* AHP Perspective *for the full interview transcript).*

To this end, the question remains – 'What is spirituality?' How do we understand it? How does it provide significance within our lives – either personally or professionally? It could be argued that these questions and similar queries are scrutinised in order to facilitate critical thinking and in some sense raise awareness around the concept of spirituality.

This article attempts to challenge the academic examination of spirituality, and instead of the intellectualised approach frequently taken in relation to the subject area, offering in its place spirituality as a connective tool with which one ascertains one's positioning to the other, and allowing for a culturally diverse opportunity to transcend such connections.

This does not mean that counselling psychologists should not use their knowledge of spirituality or evidence-based practice (Pargament, 2013), but rather endeavour to deemphasise the importance of what I refer to as a 'model-based spiritual connection'.

Keywords: Spirituality, counselling psychology, religion, connectedness.

In discussing the concept of spirituality and acknowledging the stance I take as it influences my writings here, it is important to establish context. Over the course of my practice and being, spirituality and religion have always been at the core of my existence. For me, spirituality is a personal relationship with God, it is an openness and respect to listen intently, learn and embrace the connections with people, things and places. Therefore, in my experience, it is not about differentiating between the two constructs because they are intertwined and form the crux of my connection to God. Perhaps, this presents its own challenges further down the line because as I make this statement, I am acutely aware that spirituality is not the same as religion for some. And so for the 'other', spirituality may not be equated with or within religion.

Growing up with both Muslim and Christian faiths meant that I existed within both religious realms. I observed Islamic and Christian practices, and these formed part of my identity. To me, God and/or Allah are my strength and constant. It is, therefore, rather strange that until two to three years ago I had never consciously considered what spirituality meant for me within my professional standing.

Therefore, as a starting point, I present a few recent definitions I have come across. Whilst this is not an extensive exploration of descriptions, or indeed an undertaking to critique existing meanings, the significance of spirituality permeates the essence of human nature. Be mindful then that my choices are selective in highlighting the notion that spirituality can and indeed is a tool at our disposal. Like Del Rio and White (2012), I understand and accept that readers' own implicit principles and values, spiritual or not, as well as professional discipline will influence how and what they make of the points of this article.

There are limitations within this article:

1. Minimal consideration is given to spirituality as it can be applied to a collective. In recent times, counselling psychology in particular, as evidenced by recent discussions with colleagues, has been viewed as having excessive focus on the individual and not enough on his/her social systems. It is proposed that whilst there is ground for such criticism in some instances (e.g. in situations where policies need to be implemented or in cases where consideration for the collective impacts individual functioning), it is not always a constructive reproach. Within this context, the philosophical stand I take is that a shift is possible only when it begins with the individual. This comes from believing in the saying 'charity begins at home'. In the words of King (1992), '…it is essential for humanity to respond to this unique opportunity for a global revolution and find the wisdom needed to respond to it in a commensurate manner. Such upsurge of wisdom, which must feed the will to action, can probably only come through the inner development of each individual' (p.14). Hence, for the profession of counselling psychology to expand its knowledge of

spirituality to the collective, it is contended that we first need to fully comprehend the value of spirituality to the individual.

2. There is no explicit consideration given to spirituality as a social construct. Forster (2006) purports that spirituality is a social paradigm because according to her participants, it is a depiction of faith via practices and connections with others. One could therefore argue that the fluidity of personal relationships exemplifies an association between spirituality as a connective tool and spirituality as a social construction.

3. The possibility of spiritual abuse is not considered in this article. Instead, readers are directed to the scope of literature beginning to emerge in this field (see Oakley & Kinmond, 2014; Oakley & Kinmond, 2013; for definition and background).

Some definitions of spirituality

As mentioned above, spirituality within the milieu of my experience has been and continues to be about the link to God. At moments when I am connected, I become humbled. It is therefore a unique experience that I alone can testify to – the spirit lives within me, and for me, it is very much embedded within religious beliefs. What becomes evident is that spirituality is private, emergent, and emotional (Bender, 2007). Whilst I am confidently rooted in my relationship with God, I am also sensitive to the beliefs of others, which is sometimes often different from mine. Hence, I strive not to let my connection with God interfere with what others believe. In my clinical practice, I pray for trust and grounding in myself so that the 'other' beliefs may flourish.

Historically, religion and spirituality went hand-in-hand, intersected, and often used interchangeably. Religion was perceived as the relationship to the divine while spirituality was alleged to be the arm extended to 'worldly ways' (Rizzuto, 2005). As such, theologians according to Nelson (2009) preferred spirituality to represent the living reality of religion as experienced by an adherent of tradition (i.e. religion). However, due to global revolutions and persecutions, religion and spirituality have become separated.

Spirituality is derived from the Latin word 'spiritus' which means breath – an experience surpassing physical needs – an infusion of life with meaning, integrity, connection and hope (Wasner, Longaker & Borasio, 2005). Equally, the Association of Hospice and Pallative Care Chaplins (AHPCC) propose that spirituality encompasses all the elements of human existence that entails the capacity for self-transcendence, relationship, love, desire, creativity, altruism, faith and belief (AHPCC, 2004). Spirituality is a yearning for purpose or connectedness, a desire to be in unity, search for peace or hope, a sense of a 'beyond' or the experiencing and valuing of beauty or of love (Bridges, 2013).

Holbrook, Hahn-Holbrook and Holt-Lunstad (2015) propose that spirituality comprises of profound personal connections to a sacred reality typified by comfort and peace. This could suggest a philosophical reverberation of belonging where the self (true or false) longs for the memories of been part of another without the rigidity of a deity. This fits with how the Royal College of Psychiatrists (RCPsych, 2015) subscribe to spirituality – something that everyone can experience, helps people to find meaning within their lives

whether through positive or negative experiences. Thus, it can be inferred that spirituality enables people to have 'mindful' relationships with themselves and others.

In a paper, exploring spirituality as separate from religion, Del Rio and White (2012) describe spirituality as an attitude towards life, a way of making sense of life, pursuing unity with the transcendent as well as a means of relating to others. Similarly, West (2012) also distinguishes between religion and spirituality. He presents religion as a framework under which people gather whereas spirituality conveys individual beliefs and experiences.

Regardless of the viewpoint held about the separateness or togetherness of religion and spirituality, what all the above definitions emphasise, is the individual experiencing and the task to connect. For those unable to explore this under the umbrella of religion, spirituality offers the alternative.

Conversing on spirituality

In preparing to write this article, it was important for me to gain an outsider insider perspective – i.e. explore the similarities of my understanding of being a Christian and the potential differences between how I experience Christianity and how another from a different Christian faith may engage with it in order to in part conceptualise spirituality. The interview was thus conducted with a man who has been given the pseudonym, Tristan, to protect his anonymity.

Tristan is a practicing Christian in his 50s. I met him through a mutual friend about three years ago. In this time, our contacts although limited have been quite informative. What follows below is an extract from our conversation.

Y: What does spirituality mean to you?

T: Hmm … right … the thing is … you can't really understand this until when you get involved … hmm … before when I was like 16, 18 running around with my friends doing what I thought I enjoyed. Basically there came a time when I thought, no, there is something missing here and so in the quest of talking to various people who i.e. they were supposedly spiritual a lot of questions was raised by myself and what spirituality means to me is that there is a lot of questions within yourself that you do not even know those questions exist. And so what happens is … there comes a point when you feel I need to fill this void somehow, I need to understand certain aspects of life so when it comes to spirituality … what it means to me is that … when those answers, sorry when those questions are been answered you feel fulfilled that a direction in life … is … is … is… what can I say? You feel like your direction in life is being lit up … is like take for instance you are driving and there are no road lights and somebody turns the road lights on and you were happy because the struggle …

Spirituality is like a way of guiding you through life … happy with that guidance … is the way I would put it.

Spirituality probably should be your centre… but the problem is there is an aspect of self and self tends to want to go in a different direction and spirituality says you

need to go this way… So the struggle between self and spirituality, so, it's if a person was completely surrendered to spirituality then you can say spirituality is your everything but when there is a struggle going on then to me it becomes a guide… you have a choice if you want to follow it or not…

Y: How do you explain a guide?

T: A guide literally is basically like you enter into an unknown country and you have no idea as to street names, buildings, landmarks. Sometimes people hire guides and these guides would lead them to what they need to do in the new country they are in… spirituality is a bit like that when you enter into unknown territory and you are not sure of where the territory is going to take you or how you will get to this territory I should say… spirituality says I will be your guide but sometimes even as a tourist… spirituality will say look come this way because if you go the other way it might be a bit dangerous… the mind is sometimes attracted to those things unseen and may want to wonder off to that particular area but the guide will say look you need to stick with me. If you surrender yourself to spirituality you can end up being a safer wiser person… erm… and sometimes if you follow your own way I believe… erm… you will end up in a worse position.

Y: Is spirituality within the context of religion or is it separate?

T: It is in the context of religion… this is where it can be strange… the context of religion does not explain what spirituality is… because it is almost a different element of religion… so who is to say that spirituality is the right way to follow? … that is left to the individual.

Y: Is it possible for someone who does not have a religion to have the spiritual guide?

T: Some people are self-confessed atheist… an atheist is someone who doesn't really believe in God… so when that person makes decisions they make decisions believing that they themselves are guiding those decisions… if they are making progress or make a mistake what they are going to do is praise themselves or have self-conflict within themselves knowing that… whatever decision they make it is going to be about self regardless of the purpose of their decision… spirituality I believe is… erm… a different aspect… it's a guide and its opposite to you directing yourself.

For someone who is not religious somehow they are spiritual… this needs to be explored… the problem is that if they claim they are spiritual then they are being guided in some way on a spiritual level… the spiritual level comes from somewhere… spirituality I think is a gift from somewhere… you are taught or you are given…

Y: Where do you think it's from?

T: I think spirituality is divine… erm… divine means it is from a supernatural source

so even though it is divine, some folks get that through reading, through inspiration by other people, so forth… but it's still something that is outside yourself.

Y: How do you get it?

T: Go back to the scenario in a different country… you realise you need help so… a guide won't come to you, well some do, some guide will come to you and say I see you are struggling with… to find out where you need to be and they will probably offer their services… well most of the time I think when people go into a different territory they seek help so they will speak to someone who can put them on to an agency or a service that can connect them to… spirituality is something I think you seek… some people grow up with it with their parents.

Y: As a client, would spirituality be important for you?

T: Erm… now this is the thing… sometimes… for me as an individual I can say yes but if I am thinking broadly I think… important… influenced by it and the influence is the main key… for example a lot of people do not believe in good luck and bad luck… but yet if they see you going to walk underneath a ladder they say oh you are gonna walk underneath a ladder, they might not necessarily believe in that stuff but wherever they got that information from they are happy to mention it to another person as if its important to them. We are influenced by spirituality and we don't realise…

Y: Are you influenced by spirituality?

T: I totally believe I am influenced by spirituality.

Y: In what way would I as a therapist be able to explore your issues within the context of spirituality? What would you be looking for?

T: One of the first things for you… I think is… sharing the definition that you understand that spirituality is important to me… because there are going to be areas of importance which influence my behaviour.

Y: When you say definition, do you mean definition of spirituality?

T: Erm… there needs to be a definition of spirituality. So once you have identified that there is spirituality in this individual then you will see through conversation that I am been influenced in different aspects of my life whereby spirituality is involved. You cannot separate spirituality from the cause of the issues. You need to explore what spirituality has to do with those problems as well. Spirituality is part of the person…

Y: Can somebody who does not identify with a religion be spiritual?

T: An atheist for example may be spiritual because they have grown up with the influence of spirituality somewhere in their lives, e.g. from parents. They may

have denied religion. It is worthwhile exploring how an individual has become spiritual because there is a conflict of interest going on… in respect of I am not religious but I am spiritual… so you need to understand how they have separated the two… the important thing is that they have accepted somewhere in their lives that they are spiritual and what they are actually saying is that I am guided by the spiritual influence in my life… if they are not accepting the aspect of religion, it is understanding what aspect they have rejected, or if they have separated the two you need to understand what they have separated. How much of their lives are influenced by the spiritual aspect they have accepted?

Y: I want to understand the different aspects of spirituality.

T: Spirituality can be based on reincarnation. It is a spiritual belief. For example, if you believe you can be reincarnated as a cat/dog that is then a way you will be treating animals.

This conversation with Tristan provides a strong basis for the case to establish spirituality as a connective tool. As evidenced from his responses, religion and spirituality can come as a package but is sometimes 'separated' and may be 'divorced' from each other. Concepts drawn from the conversation with Tristan that strike me as psychologically relevant to the notion of spirituality and the dialogue of are: loneliness, struggle, conflict, existential understanding of being, denial, uncertainty, rejection (not the experience of being rejected but the human basis of doing the rejecting), and influences.

From the spiritual definitions presented above, it can be deduced that the human drive to understand the individual self or the determination for the individual to seek appreciation of his/her connections with others employs spirituality to 'unpack' the nature of these concepts.

Spirituality and clinical practice

When engaging with clients and exploring spirituality, I would encourage a 'working definition' model. That is, cultivate a definition of spirituality that befits the client's purpose, reason and understanding. This means that for each and every client this 'working definition' will be inherently different. As counselling psychologists, I purport that this is not a far-fetched process for us. We work with meaning making processes, helping clients to negotiate and navigate their experiences in the maze of life.

Counselling psychology and other mental health professions can risk intellectualising what spirituality epitomises for clients. The appraisal of spirituality cannot be framed in the same way as we might assess depression for example. As indicated by Tristan, spirituality is an intricate part of an individual's narrative even if it does not have a voice or showing. It intersects with the many aspects of a lifeworld and to somehow pathologise the multifaceted expressions of spirituality is simply unethical and will be harmful to both client and therapist.

What is the real intent behind the interventions that focus on spirituality (Fenwick & English, 2001)? The integrative and congruent function of spirituality dictates that it cannot be condensed to a naïve point of study or measure. It is understandable that as

scientist practitioner psychologists we want to examine this phenomenon in order to satisfy academic curiosity, explicate the nature of spirituality or make interpretations about its impact on clients' and communities' wellbeing. Conversely, Miller and Thoresen (2003) assert that spirituality should be and can be studied scientifically. I would argue that the instruments of assessment in these cases are flawed because they measure religiosity instead of spirituality due to how spirituality has intertwined with religion historically. For example, Rauer and Volling's (2015) attempt at investigating the role of spirituality in the lives of happily married couples used tools measuring religiosity and yet the investigation was about spirituality. It can be deduced then that results, interpretations, conclusions and recommendations of such studies have no applicability to spirituality.

Colleagues in psychiatry have postulated that asking questions such as 'What gives you hope?' and 'Would you say you are spiritual or religious in any way? Please tell me how.' (RCPsych, 2015) are qualitative inquisitive ways of evaluating spirituality. It can be argued that this way of questioning has some value, it does distinguish between spirituality and religion. It gives clients the space to express whether they relate to both or one of the entities. For Tristan, the practitioner also gets the opportunity to observe and engage in dialogue about the client's history of spirituality and its influence on their lives. Drawing thus on the positive elements of the client's belief in facilitating a shift in their circumstance. At the same time, these questions feel quite 'freezing' for me. I struggle here to articulate what I mean by 'freezing'. As a counselling psychologist, I imagine that some clients might experience this as imposing – pressure to conform as opposed to an invitation to explore. In this state, a client may find it somewhat difficult to share their thoughts, feelings and experiences, which in turn may make dialogue more challenging. Delivery of these questions therefore has to be within context and appropriate in the moment.

What about the relational aspect of spirituality? The common thread that binds the definitions presented earlier in this article is the focus on the individual's experience and the striving for increased connectedness, whether with ourselves, others, or a connection with a religious figure (e.g. God, Buddha, Allah, and Earth). Zinnbauer et al. (1999) posit that modern psychological methods of considering spirituality have emerged from changes in religious and spiritual life. However, our understanding as it applies to our clients should not be overly clouded by where modernity has taken spirituality. In my view, spiritual experiences cannot be intellectualised, and as practitioners we will do a great disservice by attempting to engage with it in this way. Further, I would argue that it embeds a barrier against the connection that a client requires. Take for example, a client whose understanding of spirituality differs from you as a practitioner, the client's aim is still to be able to connect, understand patterns of behaviour, become aware of maladaptive ways of thinking etc. As we know, the practitioners engage influences the client's interpretation and response (positively or negatively).

The presentation of the client below reveals an engagement where spirituality played a crucial role in the mean making processes of the client but also for me being in relation with him.

Referral:

MC is a father of one in his mid-50s who had been referred by the hospice where his wife had recently passed away. It was customary for the hospice to refer families for psychological therapy either before the patients pass away or after. MC had chosen to take up the offer following his wife's passing.

Therapeutic process:
When I met MC for the first time, to me he was very charming, well-spoken and very well mannered. He told me that as a direct consequence of being recently bereaved, he was struggling with bringing up his son (AC) by himself. His wife had provided most of the everyday care. He told me that grieving for her made it difficult to be 'strong' for AC who was seven at the time. He reported having difficulty sleeping and in addition, AC's routine had been broken and he did not know what to do. Although I experienced MC as being articulate, I felt clear that he was distraught about losing his wife.

In this vulnerable state, for me the first session was not ideal for the exploration of the client's spirituality and/or religion. I am aware that for others this would have been the opportunity to explore existential queries including using these concepts in understanding the loss of his wife.

MC and I spent the first few sessions discussing only the practicalities of parenting. I was aware that on some level he was presenting with avoidant behaviour – of course, it was easier to focus on looking after AC and providing the care that AC needed. However, I was mindful that MC also needed looking after. During the fifth session, MC disclosed to me he had requested a Jewish therapist. This surprised me because I would have expected the hospice to communicate this to the psychological services at the time of referral. Nonetheless, the disclosure enabled us to discuss MC's perception of me as a non-Jew, Black African younger woman, and the conflicts that occurred for him the first time we met.

It was important for me to connect with MC despite the conflicts he had 'laid on my lap'. Contrary to my perception that we had made a connection, his true perception of me seemed hidden. One of the ways we managed to resolve the conflict and solidify a therapeutic relationship was through the shared belief in an after-life and that death in itself was not the tragedy. This for me was an opening to explore spirituality and religion within the context of MC's experiencing. Although a shared belief, I was open for him to lead me in his navigation of how these concepts had influences or not. The disclosure of his perception was also a way in to exploring the impact of losing his wife. We worked very hard to reflect on his life experiences and how those were different from mine on every level. We also agreed to the mutual respect for each other's stance.

If the need to connect was not present on our parts, and both MC and I became too overwhelmed by the conflict that I would not understand his faith, we would not have been able to get through this time together.

> Earlier I referred to 'embedded barrier', for MC and his impression of me as a non-faith modern woman, the barrier had been erected because he thought that I could not possibly comprehend where his platform was. This may have been linked to the avoidant behaviour I had picked up from him earlier in our sessions. We had to work through this barrier, discussing at length what having a therapeutic relationship meant for him even with the differences that existed between us. Thankfully, subsequent interactions indicated we had managed a shift from first impressions and frustrations, enabling us to lower the barrier and allow a spiritual healing facilitated by our shared belief. If in some way I had reinforced MC's initial impression of me then I do not imagine that we would have even contemplated permitting that connection.

I would suggest that in-depth examination of spirituality should not be in the first initial conversation. For me, and like Tristan suggested during our conversation, genuineness is the key, once established; the exploration of spirituality is perhaps more easily received and not viewed as a judgement both on the part of the practitioner and the client. Of course, the caveat to this is if the client specifically brings this material for discussion.

As a human being and within the context of our psychological world, it is necessary and appropriate to consider and reconsider our lifespan development. That is to say, we are continually growing emotional objects. We accept, we reject, we dilute, we magnify, we reduce, and we are context driven. Within this contextual foundation is the consideration given to our cultures and how the experience of spirituality will be driven and explored within it. So, here I introduce the opportunity to ponder on a culturally diverse spirituality. Again, this is an invitation to be really open, listening intently to how culture influences spirituality and how history is placed within this. Things such as spiritual practices will differ depending on one's culture. For example, one of the experiences and teachings I had was to serve someone less fortunate than me. One of the ways to do that was through giving alms. This practice allows for a spiritual connection and humility. Spiritual practices will also vary to some degree depending on which part of a culture one belongs to. Counselling psychologists will have to take this into account when working with a client's spirituality.

The implications of a culturally diverse spirituality necessitate a celebration of difference in practice. When we connect with a client using spirituality as tool, norms and expectations do not constrict since their relevance is minimal within the setting. The critical nature of spirituality thus lends itself to an in-depth exploration of 'us' as a phenomenon regardless of beliefs, gender, religion, age, sexuality, race or culture.

Remembering the conversation with Tristan, where he employs us to explore how clients have come to separate spirituality from religion, he refers to the split as a 'denial' of religion. Perhaps and probably contrary to his belief, individuals opt instead for an eclectic view of spirituality where they pick and choose what 'guides' them. The argument for separation and divorce are ones that can facilitate an in-depth understanding of our client's frame. We do have to be prepared to work with those who have no conscious idea as to how this has occurred. The spiritual milieu reminds us that the relationship/

exploration with the 'other' is not guaranteed the same experience. Indeed, our endeavours as counselling psychologists should not foster the same experience but instead honour each and every spiritual connectedness that graces our paths.

It may be argued that the use of spirituality as a tool stems from a place of struggle, individuality vs. the collective, subjective vs. objective. On reflection, I say yes maybe it does. As a practitioner who strives for continual self-awareness, my sense of self and who I am is imperative to my existence (or how else can I relate to the other?), at the same time my sense of wanting to belong to the other, to my culture, to my society and to my environment is also necessary to my existence. It is the realisation that all of these have had an impact on me as I have on them.

As indicated above, spirituality cannot be separated from the being of the clients or groups we work with. Pargament (2011) denotes spirituality as another dimension of the human existence whether implicitly or explicitly expressed. As counselling psychologists, some of us do this really well in recognising the intersectionality and complexity of the human existence. We often challenge the cognitive notions of this existence when it interferes or unsettles our clients' daily functioning. However, it is argued that in some instances we may be misinterpreting the significance of spirituality in the way we understand and make it applicable to our practice despite what research indicates about the contribution of spirituality to mental health and wellbeing (Brown et al., 2013; Deary, 2015; Miller & Thoresen, 2003). Coming from a European culture, Scandinavia to be precise, Stifoss-Hanssen (1999) expresses reluctance at referring to the interest into spirituality as 'psychology of spirituality' (p.27). The reluctance for him stems from the separation from religion as highlighted above, and the lack of concrete definition when studying 'a phenomenon relevant to all'. If we take the stance that spirituality is pertinent to all regardless of its confrère to a religion then surely the notion of spirituality as a connective tool is valid. Thus, psychology as a whole and particularly counselling psychology can with its ethos and standing foster the connective abilities of spirituality without getting engulfed by issues of definition and the deconstruction of these concepts.

Suggested benefits to counselling psychologists using spirituality as a connective tool

1. It allows us to relate with others who may not consider themselves to be spiritual, defusing any judgements of being or not being in this state.
2. The concept of spirituality as a connective tool offers the possibility of engagement at an in-depth level that is not intellectualised but simply intimate.
3. Perhaps if we allow spirituality to be a connective tool then our journeys with our clients (or those we are in relationship with) can be transformational.
4. Permitting this connective tool means we do not need to be overly consumed by definition (albeit defining isn't so bad).
5. Spirituality as a connective tool can be a platform that does away with religious associations (this is despite what we as counselling psychologists may subscribe to).
6. Ultimately it can open the window for us to observe the client's value system and how this can help inform their circumstance(s).

7. Spirituality can facilitates a deepened awareness of our own positioning relative to the other. No explaining or compromising is thus necessary.

8. It can help remove barriers because it permits us to intimately meet with our clients wherever they are.

Conclusion

In sharing my thoughts about embarking on writing this article with a mental health practitioner I met at a conference, he said this to me:

> *'When two people meet it is not uncommon for there to be a sense of something grander than what they are able to acknowledge occurring. I have begun to notice there are times when I am walking with a client I am silent for most of the 50 or so minutes. Then when I summarise key themes something truly surprising happens – I transmit information that I had not thought of saying … The client smiles as if they know what I say has hit the nail, and I am taken aback as I do not know where or how what has just happened has happened. I think this is spiritual. No religion is guiding my words. But the intention is to offer healing and insight for the client's self-improvement or at least to help them to take a step.'*

Encapsulating this sense of profoundness, Martin (2011) states that 'as psychologists, we share most phenomena with every other being born of women, we experience birth, life, death and incompletion' (p.10). I argue that spirituality is all-of-the above, but more so about our (both therapist and client) 'incompletion'. Since it is in this incomplete state that we sojourn with the other looking for meaning and connectedness.

Taking away the intellectualised rationale for spirituality can promote pure experience, which in turn can mean that whatever kind of being we are (i.e. whatever our view of the world), or how we are, connection will always be possible.

And so I conclude on spirituality as a connective tool … *for when I feel I am no-one since I perceive the world reacts to me not, and then I connect with another and instantly I am someone because I am touched and have been touched by the other.*

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