‘A Soul Wound’

Exploring the Therapeutic Practices of Christian Psychological Therapists Addressing Religious or Spiritual Abuse that Occurs within a Christian Religious Setting.

Madeline Saunders

Middlesex University and Metanoia Institute

Doctorate in Counselling Psychology and Psychotherapy
by Professional Studies

2020

Acknowledgements

Starting and finishing a doctorate takes a village! I am so grateful to all of those who have facilitated my journey on the DCPsych.

There are too many to mention individually, but starting with my research supervisor, Dr Janet Penny - thank you for your commitment, knowledge, insight and enthusiasm, I have felt incredibly well supported. Thank you also to my clinical supervisor, Dr Saira Razzaq, for supporting me in my development as a practitioner and for your invaluable expertise around the viva process. Thanks also to Gilly Charkham for proofreading.

To my husband, Hugh, I am so grateful for your long-term thinking so that I could do this training and I know that you have made many sacrifices. To my parents, who have supported us with childcare. And to my precious boys, Zack and Sebastian, you are so loved, and I can’t wait to start the next chapter with you.

Thank you to my participants - your generosity made this research possible and you are doing such important work.

And to anyone reading this who may have experienced spiritual abuse, I hope this work is of some encouragement to you that healing is possible and that you don’t have to be alone on the journey.

Table of Contents

Abbreviations **5**

Tables & Figures **6**

Abstract **7**

Chapter 1: Introduction **8**

Personal Connection to the Research *8*

Defining Religion and Spirituality *9*

Spirituality and Mental Health *10*

Defining Mainstream Christian Settings *12*

Spiritual Abuse as a Contentious Issue *13*

Early Definitions of Spiritual Abuse *14*

Spiritual Abuse as a Separate and Distinct Form of Abuse *15*

Arriving at a Definition of Spiritual Abuse *17*

Critical Reflexivity Related to Using the Term 'Spiritual Abuse' *18*

What Might Religious and Spiritual Abuse Look Like? *19*

Conclusion *23*

Chapter 2: Literature Review **24**

The Timing and Scope of this Review in Relation to Grounded Theory Methodology *24*
Church Sexual Abuse versus Spiritual Abuse 26

Classifying Forms of Abuse within Spiritual or Religious Contexts *27*
Abuse Perpetrated by Religious Leadership 27
Abuse Perpetrated by a Religious Group 28
Abuse with a Religious Component 29

Differentiating between Cults and Mainstream Christian Settings *30*

Addressing Religious and Spiritual Abuse when Exiting a Cult Compared with a Mainstream Christian Setting *32*

The Challenge of Bringing Spirituality into Psychotherapy *33*

The Impact of Religious and Spiritual Abuse upon Individuals *35*

How Do Therapists Experience Working with Religious and Spiritual Abuse? *38*

How Should Christian Therapists Work with Clients who have Experienced Religious and Spiritual Abuse? *39*

The Incorporation of Spirituality and Religion into Training Programmes *40*

Aim of the Research *45*

Conclusion *46*

Chapter 3: Methodology **47**

Rationale for a Qualitative Approach *47*

Epistemological Position *47*

Ontological Position *48*

Grounded Theory and the Current Research *48*

Epistemological and personal reflexivity *49*

Ethical Considerations *50*
Dealing with Historical and Current Disclosures of Abuse 50

Self-Care 51

Criteria for Participation 52

Recruitment Strategy 52

Participant Characteristics 53

Reflexivity Relating to the Limitations of the Current Sample 54
A Lack of Diversity Within the Current Sample 54
Justifying the Recruitment of 'Christian Identifying' Therapists 58
The Voices of Victims in This Research 61

Interviewing and Self-Disclosure 62

Recording and Transcribing 62

Theoretical Sampling and Theoretical Sufficiency 63

Assessing Quality in Grounded Theory 63
Sensitivity to Context 64
Commitment and Rigour 64
Transparency 65
Importance 66

Data Analysis 66
Generating Theory - Using NVivo 12 Coding Software and Coding Strategies 66
Initial Coding and Using Gerunds 66
Focused Coding and Constant Comparative Analysis 67
Generating Theoretical Sufficiency (Second-Round Data Collection) 71
Memo Writing 71
Conclusion 72

Chapter 4: Findings 73

Developing the Grounded Theory 73

Personal Reflexivity Relating to the Data Collected and Theory Developed 73

Overview of the Grounded Theory Presented 74

Category 1: Positioning Self Alongside the Client 77
Personal - Sensitive Use of Self-Disclosure 77
Professional - Actively Exploring Issues of Spirituality and Faith from Assessment 82
Professional - Focus on the Therapeutic Relationship 83
Professional - Reflect on Power Processes 85
Professional - Emphasise Client-Led Process 87

Category 2: Holding Tensions and Boundaries 88
Personal - Informed by the Christian Narrative (but Not Dominated by it) 89
Professional - Choose to Label Religious and Spiritual Abuse or Not 92
Professional - Enable the Story of Religious and Spiritual Abuse to Emerge 94
Professional - Assess the Appropriateness of Spiritual Interventions 95

Category 3 - Orienting Towards Hope and Healing 98
Personal - Manage Self-Care and Negative Impact 98
Professional - Prioritise Therapy Over Theology 102
Professional - Choose Appropriate Therapeutic Interventions 104
Professional - Supporting Clients Towards Self-Discovery and Awareness 108

Concluding Comments 111

Chapter 5: Discussion 112

Overview 112

Developing an effective therapeutic bond when working with RSA 113

Cultural Competence as an Important Therapist Quality 114

Compassion Fatigue and Vicarious Traumatisation 116

Personal Faith as a Supportive Mechanism when Working with Abuse 119

Bringing Spirituality into Psychotherapy ... *122*
The Implicit Presence of the Therapist's Faith ... *122*
The Choice to Disclose One's Own Faith ... *124*
Using Religious Interventions in Therapy ... *125*
The Humanistic Approach and Religious and Spiritual Abuse ... *127*
Reflecting on the Integration of Spirituality into Counselling and Psychotherapy ... *131*
Distinctive Contribution to Knowledge ... *136*
For Practitioner Psychologist and Psychotherapy Programmes ... 137
For Counsellors, Psychotherapists & Clinical Supervisors ... 140
For Victims of Religious and Spiritual Abuse ... 141
For the Provision of Mental Health Care in Church Settings ... 142
Recommendations for Therapeutic Practice ... *142*
Person-Centred Principles ... 143
Use of Personal Religion and Spirituality ... 144
Religious and Spiritual Abuse as a Distinct Form of Abuse ... 144
Responses to Religious and Spiritual Abuse ... 145
Changing Relationship with Religion and Spirituality ... 145
Significance of the Therapeutic Bond ... 146
The Power of Biblical Discourse and Using Scripture ... 146
Good Quality Supervision ... 146
Vicarious Traumatisation ... 147
Limitations and Suggestions for Further Research ... *147*
Final Comments ... *150*

References ... **151**

Appendix 1 - Participant Information Sheet ... **174**

Appendix 2 - Copy of Information Sent Out to Participants ... **177**

Appendix 3 - Consent Form ... **178**

Appendix 4 - Protocol for Ensuring Anonymity of Participants ... **180**

Appendix 5 - Ethics Committee Approval Letter ... **183**

Appendix 6 - Ethical Protocol for Safeguarding and Disclosures of Historical Abuse ... **184**

Appendix 7 - Examples of Core Memos used During Research Process ... **188**
Research Diary extract ... 188
Reflective Journal Extract ... 188
Reflective Memo: Shifting the Analysis Towards 'Action Based' Processes ... 189
Reflective Memo: Integrating the Focused Codes 'Choice to Disclose Personal Faith or Not' and 'Sensitive Use of Self-Disclosure' ... 190

Appendix 8 – Transcript to illustrate analysis process ... **191**

Appendix 9 - Initial Interview Schedule ... **204**

Appendix 10 - Transparency Exercise ... **205**

Appendix 11 - Email Calling for Second Round of Participation ... **208**

Appendix 12 –Working with Faith & Belief in Relation to RSA - Sample Reflective Questions as Part of a Workshop or Seminar ... **209**

Abbreviations

ACC - Association of Christian Counsellors

BBC - British Broadcasting Corporation

BPS - British Psychological Society

CBT – Cognitive Behavioural Therapy

CCPAS - Churches and Child Protection Advisory Service

CGT - Constructed Grounded Theory

EATAG – Evangelical Alliance Theological Advisory Group

EMDR – Eye Movement Desensitisation and Reprocessing

GT - Grounded Theory

IPA - Interpretative Phenomenological Analysis

MHF – Mental Health Foundation

MREC - Metanoia Research & Ethics Committee

PIS - Participant Information Sheet

RSA - Religious and Spiritual Abuse

SA - Spiritual Abuse

STS - Secondary Traumatic Stress

UKCP – United Kingdom Council for Psychotherapy

Tables & Figures

Table 1: Participant Characteristics 54
Table 2: An illustration of how raw data fitted into open codes, focused codes and core categories 70
Table 3: Core Categories and Associated Focused Codes 76

Figure 1: Key Characteristics of Spiritual Abuse (Oakley & Humphreys, 2019, p.64) 22
Figure 2: Pictorial Representation of Grounded Theory 75

Abstract

This research explored the therapeutic style and practices of Christian-identifying psychological therapists, working with clients who have experienced spiritual abuse [SA] from within a Christian setting. Religion and spirituality are often central in people's lives and can be a source of support as well as associated with shame and struggle. However, religion and spirituality are often left unaddressed by psychological therapists, unsure how to accommodate this aspect of clients' experiences into their therapeutic practice. Whilst religion and spirituality have been discussed at length in the counselling and psychotherapy literature, minimal empirical work documents the nuances of working therapeutically with SA. There is a lack of research literature pertaining to how therapists work with clients who have experienced struggle and toxicity within the same community of faith that they, the therapist, identify with. Therefore, I conducted nine semi-structured interviews with accredited Christian-identifying therapists exploring the manner in which they therapeutically address SA, using a full, social-constructivist version of grounded theory. Three major categories emerged in the data reflecting the core processes that the participants were engaging with as they worked with SA; positioning self alongside the client, holding tensions and boundaries, and orienting towards hope and healing. These core processes are arguably universal within therapeutic practice and therefore the conclusions drawn apply to clients and therapists without faith. However, this research has particular relevance for an aspect of therapeutic practice where minimal empirical research exists. What emerged strongly in the data was the extent to which the therapists' own experience of faith impacted their capacity to both recognise SA and manage it therapeutically. This research has relevance for practitioners wanting to integrate working with the more challenging aspects of religion and spirituality, which perhaps has particular relevance at a time when SA is entering the wider discourse. Following a full analysis and discussion of the results, I offer recommendations for practice and outline the intended contribution of this research.

Chapter 1: Introduction

In this chapter, I offer a personal perspective on why I have engaged with spiritual abuse [SA] as an area for research. I define religion, spirituality and mainstream Christian settings for the purposes of this thesis, offer a brief synopsis of the history of psychology and religion, and consider the connection between spirituality and mental health. I then explore the contentious debate occurring relating to SA and offer critical reflection on these issues including my own stance as a practitioner-researcher.

Personal Connection to the Research

In order to position myself reflexively as a practitioner-researcher, and because I have not personally experienced SA, I include this section to bring to life my interest in, and resonance with, the issues explored within this thesis. I recognise my own stance as constructivist; in doing so I acknowledge my subjectivity and the ways in which my own story both shaped the construction of the idea to engage with this area and contributed towards the development of data within this project. I am not a neutral observer or value-free expert (Charmaz, 2014) therefore it seems appropriate, at the start of my thesis, to share some of my personal story with regards to faith.

I became involved with a local church youth group in my late childhood, finding that the structure and boundaries offered by Christianity provided some soothing and necessary containment at that point in my life. I feel a sense of gratitude for the community it afforded me. However, it has taken me until my thirties to develop a healthier relationship to my faith. In my early twenties I began to experience the evangelical Christian narrative that I was exposed to as disturbing, alongside a sexual narrative taught in church settings that was oppressive and a patriarchal culture that frustrated me. Letting go of this evangelical stance was a deeply challenging and deconstructive process, and undoubtedly influenced my choice of doctoral research focusing on SA. As part of my deconstruction process I became aware of the ways in which theology and Christian narratives have been used to control and oppress individuals, especially marginalised groups. Historically my faith has perhaps represented a lack of psychic and emotional integration as I struggled to reconcile these harmful and divisive messages with a more inclusive and embracing version of Christian theology.

I sought out the Christian community because I wanted to feel connected with people and with something greater than myself. One strength of the parenting I received was the impartation of a sense of inclusivity and liberalism, a value that did not always sit easily with the more didactic and instructive elements of church teaching. It took me 3 years to begin talking about faith in my own therapy at which point I began to recognise the power of defensive compartmentalisation and shame, ultimately grounded in feeling as if my theological perspectives were simply unacceptable in the evangelical church context that I had been a part of. This meant that much of my faith lived in the shadows, resulting in a deep sense of painful inauthenticity and inadequacy, both when in church settings and not.

Psychotherapy supported the undoing of this segmentation, a liberating process that continues to this day; it enabled the development of a narrative so that I could seek a more integrated state with regards to the positioning of faith within my identity. This process coincided with a personal awakening, in which I realised my desire to contribute to the development of support for those who have had traumatic and hurtful experiences within the community in which they should ultimately feel safe and cared for. My personal and research journey have complimented one another and involved immersion in various sources of literature and media that have both helped me understand my struggle, and to articulate some of the unease and the contradictions that seemed inherent within my faith. In this respect, engaging in this project has been deeply transformative on many levels (Etherington, 2004). As a therapist interested in supporting people with faith-related difficulties, I appreciate the wounded-healer paradigm (Jung, 1963, p.164). I anticipate that this research process will continue to support my own recovery from faith which has, at times, felt toxic, and therefore set apart from my own therapeutic practice. I am particularly interested in the participants as therapists with their own stories of faith and the manner in which this impacts their capacity to work with spirituality when it has become destructive or harmful.

Defining Religion and Spirituality

I have used the word faith to describe my own experience because I resonate with the explanation 'our handle on what we can't see' (Hebrews 11:1, The Message Bible). In terms of my choice to depart from more rigid conceptualisations of theological truth, I find the term faith more inclusive and less attached to any particular theological perspective or standpoint. When discussed in the literature, or from a less personal standpoint, the terms religion and spirituality tend to take precedence. I therefore

briefly explain the differences between them particularly because one is often mistaken for the other.

Generally speaking, religion refers to ritualised and institutional practices whereas spirituality refers to personalised experiences and searching for the sacred (Wood & Conley, 2014). In this respect, the most basic function of religion is spiritual (Pargament, 1999). Whilst religiosity may be very closely related to spirituality, this is not always the case because 'the concepts of transcendence, meaning, and connectedness are inclusive enough to provide a basis for communication among persons with a wide range of beliefs and worldviews, including the non-theistic' (Sherwood, Wolfer & Scales, 2002, p.3, as cited in Dehan & Levi, 2009). I interpret this to mean that whilst religion may incorporate spirituality, spirituality may not always involve organised or mainstream religious practice. In choosing to let go of faith narratives which felt more harmful than helpful, I found myself needing space from formal church settings. A dissociation between religion and spirituality is also often necessary for those who have experienced SA, so that a sense of spirituality can be preserved despite detaching from religious places or processes that feel harmful (Kinmond & Oakley, 2013). For victims of SA, linking their core spirituality to the Bible or religious discourse could evoke a traumatic response. I therefore use the terms religion and spirituality fluidly throughout this review depending upon the context and whether I am referring more broadly to institutional experiences or to those of the individual.

Spirituality and Mental Health

Initially associated with philosophy and theology, the early 20th Century saw psychology align itself with the natural sciences, and religion was seen as an impediment towards rational efforts to improve psychological wellbeing (Pargament, 2011). B.F. Skinner and Sigmund Freud were both raised in religious households but later rejected their beliefs, believing religion to be rooted in controlling behaviour and early dangerous forces that lead to hopelessness and a desire for security, respectively (Pargament, 2010). Following on from Freud, who referred to himself as 'the Godless Jew', Carl Jung, the founder of the term 'collective unconscious', believed the absence of religion was a primary cause of adult psychological disorders (Hall, Francis & Callaghan, 2011). Historically, psychiatrists and sociologists have given more weight to issues of religion, spirituality and their relationship to mental wellbeing. At the start of the new millennium, psychology was showing signs of belatedly catching

up as a discipline interested in the study of religion and its effects (Loewenthal & Lewis, 2011). Despite psychoanalysts' premise that religion and spirituality are neurotic, comforting and regressive (Cook, Powell & Simms, 2009), increasingly clinicians seek to understand clients' lives from a religious and/or spiritual angle, or to incorporate spiritually-based practices even if spiritual concerns are not the primary focus (Cook et al, 2009).

Those who have a well-integrated spiritual dimension within their lives have a better chance of staying mentally well, or recovering if they become unwell (Archbishops' Council, 2004). Whilst the Archbishops' Council is not an unbiased source of information because of their agenda to promote faith, empirical research suggests that religion and spirituality have the potential to create a protective impact on mental health (e.g. Seybold & Hill, 2001; Weaver et al, 2003). In the context of a society that has seen many destabilising changes over the past 100 years (Crowley & Jenkinson, 2009), faith communities are significant within many people's day-to-day lives and supportive of those in distress, welcoming to those who may feel excluded and able to foster helpful spiritual and non-spiritual practices that create a sense of belonging and affirmation (Archbishops' Council, 2004). Furthermore, cohesive, stable social structures, including the family, are losing their status (Murray, 2004). Therefore, a clearly guided path that promises the answers to existential questions and relief from suffering and self-transformation, feels important to many (Crowley & Jenkinson, 2009). Despite these expectations, many people have negative experiences within faith communities including an emphasis on guilt, identifying sin as the root of illness, feelings of inadequacy generated by liturgical readings and teachings that conflict with secular views regarding issues such as divorce, abortion and homosexuality. Many expect a welcome but find exclusion while others feel vulnerable and exposed during prayer and worship (Archbishops' Council, 2004).

Weber & Pargament (2014) reviewed the capacity of religion and spirituality to promote or damage mental health, given that religion and spirituality are part of the cultural context in which mental illness occurs. Studies indicated that mental health is promoted through community, support and positive beliefs, summarised as positive religious coping (e.g. Pieper, 2004; Rosmarin, Bigda-Peyton & Ongur et al, 2013). Furthermore, many studies have shown a positive impact when religion or spirituality are appropriately incorporated into mental health assessment and treatment (Weber & Pargament, 2014). However, these authors highlighted that religion and spirituality

also result in negative religious coping, leading to misunderstanding, miscommunication and negative beliefs. Other authors highlight the connection between religion and spirituality and delusions, hallucinations and psychosis (Mitchell & Roberts, 2009).

The Mental Health Foundation [MHF] (2006) suggests that the relationship between spirituality and mental health is complex, shaped by intrapsychic, interpersonal and transpersonal elements. Whilst some research seeks to establish linear relationships between spirituality and particular mental health outcomes, the MHF report (2006) suggests that the relationship between the two is bi-directional, interactive, and open to influence from other factors. The current research sought to unravel some of the complexity of therapeutically treating clients when their spirituality has become a wounding rather than a protective factor in their mental health. The interviews addressed therapeutic issues within intrapsychic, interpersonal and transpersonal domains of relating, with the intention of illuminating how therapeutic practice can support clients towards healing, and what the experience of this is like for the therapist.

Defining Mainstream Christian Settings

For the purposes of this research, I define mainstream Christian settings as representing any group of individuals who identify as Christian and participate in organised worship. Given that worship traditionally happens in churches in the U.K., I include any recognised denomination within the scope of what may be defined as mainstream rather than as a cult. The expression of Christian church across different denominations (e.g. Pentecostal, Methodist, Anglican, Baptist, Catholic, Independent churches) is incredibly broad, and an important element of the diversity present within the Christian faith. A number of recognised Independent churches also exist (e.g. Vineyard and New Frontiers International) who have a strong presence in the U.K. and a transparency in their beliefs and leadership that warrants inclusion alongside the more broadly recognised denominations or expressions of Christianity. Whilst the denominations or theological thinking behind the contexts are not explored within this review, it is important to note at the outset that the participants all discussed clients whose experiences stemmed from within a broadly recognised Christian setting, as defined above. For clarification, when I state ‘Christian setting’ I am referring only to places of worship and not pastoral or Christian counselling centres. The participants all worked in private practices, and whilst one was affiliated with a Christian charitable

organisation, her work was sought independently by the clients who had encountered SA.

Spiritual Abuse as a Contentious Issue

At the time of preparing my research proposal (2016/2017), SA was gaining traction as a term used to highlight abuse of a non-sexual nature occurring within religious settings. For this reason, the term SA was decided as appropriate, particularly because I intended to highlight this as an under-researched focus of study in the psychotherapy and counselling psychology literature. However, the term SA is now contentious and subject to debate, particularly in terms of the legal ramifications when defining it as a separate form of abuse.

Shortly before I began data collection, The Evangelical Alliance Theology Advisory Group [EATAG] published a report entitled 'Reviewing the Discourse of Spiritual Abuse: Logical Problems & Unintended Consequences' (EATAG, 2018a), which sparked a debate around terminology. As stated in the foreword of this report, SA as a term distinct from other forms of abuse already recognised in statutory law was claimed to be deeply problematic. It is therefore important to note at the outset that I recognise the timing of this thesis as coinciding with a likely shift in the way this controversial phenomenon is both understood and labelled. In order to position this thesis amongst the debate currently taking place, I now reflect on some of the core considerations in more depth. However, I believe that in what appears to be a shifting area for discussion both in the church and wider context, this only affirms the field as a much-needed area of study.

As I hope will become apparent through the use of my own critical reflexivity, my opinion about the necessity of the term SA has become more nuanced. I recognise that my view has been shaped by the wider discourse occurring and by the research itself. In this respect, I understand myself to be an active participant in the co-creation of narratives that emerged within this project. In light of the widening debate about how to define abuse perpetrated in a religious setting, it seems a fertile time to explore the views of practising therapists, addressing the issue of spiritual woundedness with their clients. Whilst an academic debate seems to be occurring, I hope this work will contribute a valuable psychological perspective from those based in clinical settings.

Early Definitions of Spiritual Abuse

Humphreys (2018) suggests that issues around coercive control and misuses of power have long been discussed in relation to the Christian context (e.g. Enroth, 1992). However, SA is a reasonably new term in the literature, first defined in America by Johnson & Van Vonderen (1991). This definition focused on the abuser and implied that the abused were needy or vulnerable prior to the onset of the abuse beginning (Oakley & Kinmond, 2013). Blue (1993) later shifted the target of the definition towards the leader assumed to be the perpetrator of the abuse. However, this assumed that the person committing the abuse is a leader in a position of power and it is clear that leaders often experience SA too (Oakley & Humphreys, 2018). Furthermore, although Blue has a theology doctorate, there is no reference to empirical research in his writing. The first British definition of SA (Hall, 2003, p.3) suggested abusive processes refer to 'someone using their power within a framework of spiritual belief to practice and satisfy their needs at the expense of others'. Whilst holding power is not in itself abusive, the implication here is that the abuse of personal power can result in abuse towards others.

Oakley (2009, p.214) then defined SA as 'coercion and control of one individual by another in a spiritual context. The target experiences SA as a deeply personal emotional attack'. This definition reflects a move away from the leader having power, and towards the notion of personal power being the significant factor (Oakley, 2009). Indeed, peer-to-peer abuse is a common manifestation of spiritually abusive processes, often bypassing leaders. Oakley (2009) observed that the vast majority of literature was American and in descriptive format, written by those in positions of religious authority (e.g. Johnson being the senior pastor of a large U.S.A. church) rather than empirically based. As a survivor of SA, Oakley noted a knowledge-void that resulted in her experience being both difficult to label and acquire help for. Therapists may have limited experience of working with an issue that is under-reported, thus perpetuating the silence around SA. This itself might generate hesitation on the part of therapists in terms of exploring these issues with their clients. Oakley & Humphreys (2019, p.40) cite a respondent in their survey 'Understanding spiritual abuse in Christian communities' (Oakley, Kinmond & Humphreys, 2018) as stating that "clear descriptions of abusive behaviour help to lift the blanket of silence and 'not seeing'". Thus, from a victim's perspective, naming SA seems to validate the existence and experience of abuse perpetrated within religious settings. The EATAG (2018b) critique this survey on the basis that prior to entering, respondents needed to have

heard of the term SA. They suggest that instead of being subject to the necessary critique, the term has been fuelled by those interested in propagating the terminology and is harmful insomuch as further use ‘risks damage to fundamental freedoms of religious thought, expression and assembly’ (EATAG, 2018b, p.4).

Spiritual Abuse as a Separate and Distinct Form of Abuse

Oakley’s (2009) PhD argued that SA should be considered distinct from other forms of abuse and the original proposal for this research echoed this viewpoint. Whilst it is important to consider parallels with other forms of abuse, to assume that SA can be fully understood within other categories of abuse (e.g. emotional, sexual, domestic violence) potentially confounds the problem, further silencing those experiencing it. However, the EATAG (2018a) hold strong opposition towards the term SA becoming a separate and legally recognised category of abuse, on the grounds of potential legal and safeguarding implications, the potential threat of religious discrimination, and damage to inter-faith relations. The EATAG (2018c) further state that while rejecting the terminology of SA, they are not denying the phenomenon of domination and denigration it has been taken to describe.

The EATAG highlight that the majority of texts written about SA refer to the Christian faith and yet the word spiritual rightly refers to multiple religious traditions. To use the term SA, they argue, is presumptuous and amounts to parochialism (2018a; 2018b). Parochialism of this nature could be deemed discriminatory, given it casts Christianity as more prone to ‘spiritually abusive’ teaching and theology (EATAG, 2018a). They warn against this insomuch as racism and ethnocentrism could be stirred up if practices deemed coercive and controlling by safeguarding agencies within other religions (e.g. intra-religious marriages insisted upon, Islamic or Hindu shame and honour mores) were pursued as vigorously as SA in a Christian context (EATAG, 2018a). In light of these serious issues, the EATAG (2018a) urge all churches to reject the language of SA and apply the existing legal terminology of ‘emotional and psychological abuse in religious contexts’. The legalities of defining SA separately headline the EATAG’s argument for avoiding use of this terminology. They highlight concerns that legal professionals could be sanctioned to make theological judgments about spiritual aspects of abuse on a case-by-case basis, which they fear might be disastrous for hard-won religious liberties. They claim that whilst emotional and psychological abuse should be dutifully punished, religious and non-religious people

should be equal before the law. From a legal perspective, the outcome should be no different, irrespective of where the abuse occurs (EATAG, 2018a).

Whilst I concur with the EATAG's criticisms of the term SA being written into law, I perceive the 'hard-won religious liberties' they want to protect as including ideologies that can be perceived as discriminatory and harmful (e.g. conservative theological perspectives on homosexuality, gay marriage, women in leadership, abortion). These issues may themselves be at the heart of spiritually abusive practices. The definition proposed by the EATAG does not, in my view, account for the fact that ideologies as well as interactions can be experienced as spiritually harmful. From an evangelical perspective, it might therefore be advantageous to ensure that the term SA is removed from public discourse given its de-legitimisation of conservative Christian theology, much of which is upheld within evangelical contexts.

In a further critique of the term SA, Kandiah (2018) writes that every public institution in the UK should be confronting issues relating to abuse because of the inevitable power-asymmetries present within these structures. Recent notable examples include the Football Association, the British Army and the Harvey Weinstein scandal in the film industry. The EATAG (2018a) also argue in light of broader contextual movements such as the 'Me Too' and 'Time's Up' hashtags that emotional and psychological abuse exists across many settings, but that they are unlikely, for example, to be deemed as context specific 'sports abuse' or 'political abuse'. The film industry, Kandiah suggests, have done the polar opposite of sub-sectioning a form of abuse, and created an enormous sense of solidarity through use of the 'Me Too' hashtag, thus universally highlighting abusive relationships. Kandiah suggests that all institutions, not just the church, have legitimising discourses and narratives for abuse, and so the ultimate issue remains the abuse of power.

Kandiah further suggests that all abuse contains a spiritual element; biblically speaking the body is considered a spiritual vessel, and home and work contexts could also be considered spiritual. Whilst Kandiah is a Christian apologist and those who reject religious schools of thought may disagree with him, I believe the point he is making is that the term SA does not add anything to already established forms of abuse, if the primary issue is an abuse of power. Given the fierce debate that is now raging about the appropriateness of the term SA, Kandiah proposes ways in which recognising abuse in Christian contexts might indeed be useful. These include further sensitivity

and accountability within churches towards abuses of power, and especially deeper accountability, transparency and compassion towards those who have experienced abuse, or are most vulnerable. I would add to this that the usefulness of the term SA, even if untenable legally, is the recognition that psychological interventions might differ when the abuse has deliberately and systematically impacted a person's spirituality. It is the specificity of these interventions, and how they are delivered, that I am seeking to explore in this research.

Arriving at a Definition of Spiritual Abuse

Oakley & Humphreys (2019) suggest that the term SA may evolve, and that other, perhaps more useful terms, have already been suggested. However, the current discourse used by victims, and in the literature, is SA, and I will continue to use this terminology throughout this thesis in order to reflect the terminology that resonated with the therapists who came forward to participate in this study. If I were to propose this project again, I might adopt the less catchy, but more inclusive 'psychological abuse linked to faith or belief'. Where possible I now refer to 'religious and spiritual abuse' [RSA] to account for the fact that abuse might be construed as occurring within the religious, rather than spiritual, domain. What remains clear to me, and particularly in light of the discussions with my participants, is that RSA clearly holds weight psychologically, and points to a discussion that needs to happen both academically and clinically in order to effectively address the experiences of those wounded within their church settings.

The Churches Child Protection Advisory Service [CCPAS] released a position statement regarding SA, suggesting that the terminology of SA remains in use, but with careful qualification (Humphreys, 2018, p.6). CCPAS advocate the following definition:

> "SA is a form of emotional and psychological abuse. It is characterised by a systematic pattern of coercive and controlling behaviour in a religious context. SA can have a deeply damaging impact on those who experience it".

This definition continues to state,

> “However, holding a theological position is not in itself inherently spiritually abusive, but misuse of scripture, applied theology and doctrine is often a component of spiritually abusive behaviour” (Humphrey’s, 2018, p.6).

This definition avoids the need for SA to become separately criminalised and distinct from other, recognised forms of abuse. Oakley & Humphreys (2019, p.31) further delineate SA to include,

> “manipulation and exploitation, enforced accountability, censorship of decision making, requirements of secrecy and silence, coercion to conform, control through the use of sacred texts or teaching, requirement of obedience to the abuser, the suggestion that the abuser has a ‘divine’ position, isolation as a means of punishment, and superiority and elitism”.

CCPAS proposes that the spiritual element of abuse needs to be addressed (namely the religious context in which the abuse occurs) but not through the term being written into law. Instead, they consider this to be the responsibility of the church or other faith context in which the abuse occurred. Whilst the principle of the offending person or institution taking responsibility for their actions is laudable (and perceived as biblically correct by many), it is controversial in as much as victims of abuse within a religious setting might find this retraumatising. This could support cover-ups as happened in the high-profile catholic sex abuse scandal. This lends further weight to the suggestion that the psychological needs of victims need greater prioritising, which perhaps has not been the case as churches, and those in power within them, have publicly debated how best to manage perpetrators of abusive acts towards others.

Critical Reflexivity Related to Using the Term ‘Spiritual Abuse’

I have highlighted some of the original arguments for a separate definition of SA and countered these with more recent, diverse perspectives. I now want to state my position having completed this piece of research, using the term SA. Oakley, whose PhD (2009) and ongoing discourse inspired my thinking on this subject area, explains how her own beliefs have recently shifted from believing that a separate category of SA is necessary, towards now believing this not to be the case (Oakley, 2018). Oakley (2018) concludes that SA is a form of emotional and psychological abuse and states that classifying it this way might provide the additional pastoral advantage of recognition within existing frameworks of law (Oakley, 2018). I concur with both Oakley

(2018) and the Evangelical Alliance (2018a) in believing that a separate term for SA enshrined within British law would be problematic on many levels. Furthermore, the terminology used to describe the phenomenon requires serious consideration to avoid unintended harm or discrimination. However, I also found my participants' arguments compelling; they described the particular impact that abuse in a religious setting can inflict, and the significance for victims of this abuse being labelled in a manner that honours the complexity of abuse including a spiritual or religious dimension. Furthermore, despite awareness of abuse perpetrated in religious settings, I perceive the voices of victims to be missing within the argument presented by the EATAG. I perceived this to be a fundamental strength of Oakley's PhD and a key reason behind my decision to engage with the subject area.

Oakley & Humphreys (2019) found that survivors interviewed for their recent publication were only satisfied with the term SA. The voices of survivors in creating definitions related to their abuse is critical but the tension here seems to be that using the term SA is legally untenable. Whilst the legal implications of terms are undeniably significant, the aim of this thesis is to support the development of practice-based recommendations so that victims are better supported in the consulting rooms of therapists. Hence, considering how individuals would label their experiences, irrespective of the legalities, is important. The views of those who have experienced abuse must be privileged and it is critical that this information is translatable to those with the power to effect change. This is important in supporting victims psychologically and when facilitating the development of healthier churches, particularly where abusive cultures have previously flourished (Oakley & Humphreys, 2019).

What Might Religious and Spiritual Abuse Look Like?

Despite the challenges present in defining RSA, the clearest argument for researching this issue is, I believe, the experiences of those who have felt spiritually wounded. Whilst the definition of RSA has evolved since the inception of the term in America, I rely on Oakley & Humphrey's (2019) explanation given the recency of this publication and their focus upon the British context. As discussed, these authors are involved in current debate and have engaged extensively with arguments exploring the usefulness and validity of the term. I recognise the dominance of Oakley & Humphrey's (2019) depiction of RSA in this thesis, given their emphasis upon defining the concept grounded in data they have collected. I also note Ward's (2011) assertion that spirituality is a deeply personal phenomenon and deciding at what point it becomes

toxic is difficult. The three principle characteristics of abuse deemed spiritual are that it must be justified by appeal to the divine, the perpetrator must be in their role or function as religious and it must occur in settings identified as religious (EATAG, 2018b). In order to give prominence to the victims of RSA, I incorporate short quotes illustrating theoretical descriptions of what RSA might look or feel like to those experiencing it.

Diederich (2017) asserts that the defining feature of RSA is that a spiritual authority invokes God to sanction the abuse and it always contains elements of emotional and psychological abuse. It may or may not contain elements of sexual abuse and financial control. Oakley & Humphreys (2019) corroborate Diederich’s assertion that RSA is often challenging to detect, a concern for clients who may struggle to report what is happening to them and a warning sign for therapists that RSA could be easy to miss. Coercion and control are considered hallmarks of RSA, for example, pressurising individuals into giving more time, service or money than they feel able to decline (Oakley & Humphreys, 2019). If able to meet these demands, the projection onto these individuals might be that they are spiritual and have a good relationship with God. Conversely the judgement might be that that person should give an account of themselves, feeling that life is under scrutiny or that they are a spiritual failure. As Sophie in my research described of her clients who have experienced RSA, “They're gonna think they're unworthy and they're horrible people and they should go to hell, as they have been told.”

Oakley & Humphreys (2019, p.44) describe individuals feeling forced to conform to expectations and believe exactly the same as other church members. Gaslighting is another common manifestation of controlling behaviour, whereby an individual or group are led to doubt themselves, sometimes to extreme dimensions, including doubting their own sanity. This might be followed by the demand to stay silent, as a sign of love and obedience to the church, God, and those in authority. This silence extends into commanding people not to share their story for fear of damaging God’s, or the church’s, reputation (Oakley & Humphreys, 2019). Churches that are notable in their RSA of others tend to perceive themselves as holding the highest truth, perhaps with a deeper understanding of scripture than other churches. Therefore, to leave that setting places the person in danger spiritually and socially. As described by Ann, a therapist in this study and victim of RSA, “Part of you is absolutely furious at what's

happened and can't wait to get out, and part of you is terrified of leaving because it's all you know, and actually all your friends are in there, and your social life is in there".

Oakley & Humphreys (2019) further describe how the use of fear is very common in stories of RSA, particularly with regard to the threat of public shaming or humiliation. As Julia, another participant, described, "If they've been taught that they are sinners and if they don't repent immediately, they won't receive forgiveness then they go into shame, guilt, blame self-loathing". A common phrase heard in many Christian contexts is 'because the Bible says so!', thus giving the biblical text enormous power, and also the one wielding it for their advantage (for emotional, physical or financial gain). For Christians in particular, this might mean fear of retribution, judgement, not going to heaven, or other spiritual consequences. I reproduce Oakley & Humphrey's (2019, p.64) table below to illustrate in pictorial form the key characteristics of RSA as it is currently understood.

Coercion and control	
Manipulation, pressure & exploitation	
Expectation of excessive commitment and conformity	
Enforced accountability	
Censorship	Inability to ask questions Inability to disagree Inability to raise concerns Inability to discuss the topic of spiritual abuse both individually and collectively
Requirement for obedience	
Fear	
Isolation and rejection	
Public shaming & humiliation	

Spiritual aspects of abuse
Use of scripture to coerce and control
Use of 'divine calling' to coerce
Use of God's name or suggested will to coerce

Figure 1: Key Characteristics of Spiritual Abuse (Oakley & Humphreys, 2019, p.64)

Conclusion

In this chapter I positioned myself and my relationship to faith as a means to identify why the issue of RSA resonated with me as a potential subject to research. I provided definitions of religion, spirituality and mainstream Christian settings. Finally, I addressed the somewhat contentious nature of SA particularly related to how this phenomenon should be labelled. In the following chapter I explore the literature related to SA thus expanding upon the concept, and how it is both experienced and managed, in more depth.

Chapter 2: Literature Review

This chapter begins with a statement as to the timing of conducting this literature review related to grounded theory methodology. It highlights how I approached the literature with a view to undertaking this project and the steps taken to ensure that I was adequately informed by the existing material, without being unduly influenced by it for the purposes of data collection and analysis. The literature review is then presented in order to contextualise this project within the existing literature available, followed by a statement of the aims of the research and the research question.

The Timing and Scope of this Review in Relation to Grounded Theory Methodology

Traditional grounded theorists advocated delaying writing the literature review until completion of the analysis, with the intention of avoiding forcing preconceived ideas onto the work (Glaser & Strauss, 1967). However, when proposing a project, this is practically impossible because an assessment of the available literature is essential in order both to evaluate and justify the necessity of the research (Tummers & Karsten, 2012). Adopting Charmaz' (2014) constructionist perspective on grounded theory, the preconceived knowledge of the researcher should be acknowledged, and steps taken to ensure that the early literature review does not overshadow the emerging data. In order to sharpen my perspective in terms of a suitable research question and seeing where a valuable contribution might be made, I wrote an initial literature review prior to data collection and then developed it for the purposes of this thesis as my research intentions became clearer.

Writing the initial literature review was a challenging process because despite a plethora of information related to spirituality, religion and mental wellbeing, minimal empirical research could be found which examines RSA in a Christian setting. Spirituality can be argued to have a fundamental role in healthcare (Royal College of Psychiatrists, 2015) and thus, a plethora of research emphasises the connection between spirituality and mental wellbeing. Voluminous literature also considers toxic religion and the impact of religious fundamentalism on individuals and society. However, to cover these broader issues would have been to detract from the research question. In order to manage the tension between addressing only relevant literature whilst also highlighting issues that connect with the subject under study more broadly, this review is in two parts.

The first part of the literature review, presented here, provides an extended and updated version of the review originally presented to justify this research. In this chapter, I provide a narrowly focused review of RSA in terms of the available empirical research. Given minimal empirical work available related to RSA in mainstream Christian settings, I consider selected research into therapy for cult-leavers and critically reflect on some of the differences that might be present for victims of abuse in a mainstream Christian setting. I then consider the challenge of bringing spirituality into psychotherapy and reflect on the importance of this, given the empirically identified impact of RSA upon victims. In order to justify the current project, I then considered what the literature already suggests in terms of best therapeutic practice when working with victims of RSA.

In order to be methodologically and philosophically aligned with Charmaz' position, I then let this original material 'lie fallow' (Charmaz, 2014, p.307) throughout the data collection and analysis phase, remaining critically reflective and theoretically agnostic about the emerging data (Henwood & Pidgeon, 2006). Thornberg (2012) suggests this critically reflective stance is more important than the timing of the review. I then extended the literature review specifically in response to the data collected, and present this in the discussion chapter, so that the emerging theory is brought to life in relation to the question under study. By presenting the literature in this manner, I have been able to narrow my focus and simultaneously address relevant material in depth.

Religious and Spiritual Abuse in British Christian Settings

RSA in Christian settings is under-researched, although an increasing amount of anecdotal accounts are being published (e.g. Baker, 2019; Hoffman, 2018) as awareness of the experience grows both within public discourse and within churches and church leadership. An initial exploratory study known as the church experience survey was conducted by Oakley & Kinmond (2013; 2014). The purpose of this survey was to explore positive and negative aspects of church, including issues connected with RSA such as general awareness of it, how to define it, and where to go for support. Results highlighted confusion as to the nature of RSA, for example, whether it needed to contain elements of physical or sexual abuse or not. This is important, as RSA therefore might remain under-reported. Of 502 people who completed the survey, 17% reported experiencing shame and blame in their church setting, 45% felt scripture was used to control behaviour and 74% cited feeling damaged by an experience at church. A later survey conducted by Oakley, Kinmond & Humphreys (2018) concluded

that out of 1591 people who completed an online survey, 1002 reported having experienced RSA themselves. Though the authors state that this was a self-selecting sample and cannot be verified, there was a diversity amongst participants in terms of their age and denomination. Whilst only a minimal percentage of U.K. churchgoers participated in the survey, the results suggested that awareness of RSA is growing and therefore needs attending to at both policy and practice-based levels.

Given that, understandably, most who experience RSA do not seek support from the church setting where it happened, therapists addressing RSA could benefit from guidance related to safe working practices and effective safeguarding (Oakley & Kinmond, 2015). Christian counsellors, whilst perhaps assumed to be a positive resource for victims of RSA given their understanding of the context of the abuse (Oakley & Kinmond, 2007), might actually compound the issue if they have little awareness of the problem or how it might manifest. Given that RSA has only been newly recognised, as far as I am aware no research has documented the experiences of those already addressing RSA in their practice. I therefore explore related literature in the remainder of this review and conclude this chapter with the aim of this current research.

Church Sexual Abuse versus Spiritual Abuse

Irrespective of the contentious legal issues around how RSA is named, it is clear that people within religious settings are responsible for the abuse of individuals, and the needs of victims or survivors should be privileged (Pope Francis, 2019). Abuse in the church context (mostly of a sexual nature) was first significantly publicised in the 1980s, and gained worldwide momentum in terms of journalism in the 1990s. Church sexual abuse was a major worldwide news story by the early 2000s and cases involving high-ranking Catholic clergy have continued to come to light, most recently clergy at Ealing Abbey, London (BBC, 2019). Sexual abuse in religious settings is now common knowledge and is perhaps additionally shocking in this context because ‘it is in contrast with its moral authority and its ethical credibility’ (Pope Francis, 2019).

Whilst RSA is gaining traction as a term (Oakley & Humphreys, 2019), it should be noted that RSA incorporates an emotional and coercive component that may exist alongside or separate from sexual abuse perpetrated in a religious setting. Much as sexual abuse in other settings was initially subject to cover-ups and denials, the emotional and psychological components of RSA still remain somewhat in the

shadows. This perhaps further undermines the likelihood that victims of emotional and psychological abuse in religious or spiritual settings will disclose and seek help for fear of the problem not being considered as significant as sexual abuse. Whilst the impact of clergy sexual abuse should not be minimised, it is important that non-sexual abusive practices in religious settings are not ignored. I therefore now pay further attention to how RSA might be understood within a religious setting beyond sexual abuse.

Classifying Forms of Abuse within Spiritual or Religious Contexts

There is a lack of empirically grounded literature pertaining to the manner in which abuse is inflicted in religious settings outside of the Catholic church sex abuse scandal. Existing literature is either conceptual or anecdotal in nature, albeit often powerful and compelling (e.g. Diederich, 2017; Johnson & Van Vonderen, 1991; Rauch, 2009). Furthermore, the majority is not found within the psychotherapy and counselling psychology literature, instead being located within the fields of social work, theology, or pastoral work (e.g. Henke, 1996; Purcell, 1998). Research that does exist is also often focused on children. One such example of this is work by Bottoms, Goodman, Tolou-Shams, Diviak & Shaver (2015), who classified three forms of religion-related child maltreatment; maltreatment perpetrated by persons with religious authority, the withholding of medical care for religious reasons and abusive attempts to rid a child of supposed evil. These forms of maltreatment could similarly also occur within an adult population. I perceive the clearest example of a classification of RSA as that provided by Swindle (2017) and therefore explore RSA in relation to these categories in the following paragraphs.

Abuse Perpetrated by Religious Leadership

The Evangelical Alliance's preferred term for RSA is now 'Emotional and Psychological Abuse in Religious Contexts' (EATAG, 2018a) but this does not consider other, recognised forms of abuse, such as physical or financial abuse (NHS England, 2015), both of which could legitimately fall under this broad category of abuse perpetrated by religious leadership. Sexual abuse would also fit into this category. Swindle's (2017) 'Abuse perpetrated by religious leadership' is broad enough to validate the experiences victims may have within religious settings deemed as abusive, but it should be noted that RSA is not unidirectional; leaders or ministers can experience RSA from their congregants as well, and peer-to-peer abuse is a further common manifestation of RSA. Whilst the Evangelical Alliance have sought a more inclusive term, their narrowing to emotional and psychological abuse could imply that physical, sexual or financial abuse does not have a spiritual component.

Abuse Perpetrated by a Religious Group

Most notable in Swindle's (2017) second category is the way in which religious groups may use targeted teachings to oppress marginalised groups. This could be one person as part of a wider group, or it could be the stance assumed by an entire group. Many authors have discussed the experiences of LGBTQ people in religious settings and the particularly oppressive non-affirming stance held within many mainstream Christian settings (e.g. BBC 2019c; Freeman-Coppadge & Horne, 2019; Lomash, Brown & Paz, 2018; Todd, McConnell, Odahl-Ruan & Houston-Kolnik, 2017; Wood & Conley, 2014). Wood & Conley (2014) suggest that when religious and spiritual beliefs become a source of pain, the religious and/or spiritual identity of that individual falls into jeopardy. These authors provide a thoughtful and insightful theoretical conceptualisation of the loss of a spiritual identity for LGBTQ people, particularly how the literature on religious or spiritual struggles, defined as efforts to conserve or transform a spirituality that has been threatened or harmed, impacts identity (Pargament et al, 2005).

Wood & Conley (2014) address implications for counselling given the relationship they outline between RSA and loss of a religious or spiritual identity. However, they acknowledge that their line of reasoning is conceptual and use a fictional client to emphasise priorities for therapists (a focus on disenfranchised grief, the need for religious literacy and the development of competency standards). These authors acknowledge that their concepts do not have an empirical basis and warn against uncautioned extrapolation of their suggestions due to the individual differences existing in experiences of RSA. Whilst the current research also addresses therapists, they have worked with individuals who have experienced RSA and therefore the data collected reflects actual practice rather than hypothetical scenarios. Although issues of generalisability remain, particularly because of the white, female, cis-gendered and Judeo-Western bias, it is intended to support the development of supportive practice-based guidance for other therapists interested in working with RSA. Other forms of group-perpetrated RSA include prejudice or bias against other social issues. These may include sexism and the oppression of women (e.g. refusal to allow women in leadership). Although this tends to be seen more in American (compared with U.K) churches, it may also include the refusal of a minister to marry an inter-racial couple or refusing to allow a person of colour to join the church (Swindle, 2017). These clear examples of oppressing marginalised groups reflect a broader oppressive and abusive

attitude towards individuals wanting to integrate themselves into mainstream religious settings.

Abuse with a Religious Component

This refers to abuse justified by distorted religious beliefs, for example, the beating of children in order to have the devil beaten out of them (Bottoms et al, 2015), or domestic violence situations in which religious beliefs are used to justify beatings (Damiani, 2002; Simonic, Mandelj & Novsak, 2013). Women may be subjected to misinterpretations of scripture related to submission and authority, leading them to stay in abusive relationships. Churches may compound this if their teachings on divorce are ultra-conservative. Other examples could include women being pressured into not terminating pregnancies as the result of rape or incest because of supposedly biblical teachings relating to the sanctity of life. Sexual abuse perpetrated by a member of clergy may also fall within this category, if the sacred element is used to enhance the secrecy or sense of shame around the abuse (e.g. 'You will go to hell if you tell anyone about this') (Swindle, 2017). Swindle (2017) further cites the example of a congregant being manipulated into substantially financially giving to a church via the promise of personal favour with God.

Abuse is often justified and sanctioned because of corrupted religious theology, legitimising behaviour and maintaining a positive self-image on the part of the perpetrator (Simonic, Mandelj & Novsak, 2013). Dehan & Levi (2009) provide an example of abuse being justified on religious grounds in their research considering SA within the marriages of eight ultra-orthodox Jewish women. The inclusion of SA as a separate dimension of abuse was not initially considered in the participatory action research model used to examine the experiences of these women. However, it became clear that the women's experiences were not being adequately captured (Dehan & Levi, 2009). The research coordinator then presented the participants with the option to include a dimension related to SA and reported the women felt their experiences were being validated for the first time. As the women added further examples of the SA they had experienced, the validity of the concept was enhanced.

Dehan & Levi's (2009) conclusions suggest that the additional dimension of spirituality and religion within abusive dynamics and relationships should not be ignored or entirely subsumed within categories of abuse that perhaps overlap with, but cannot fully accommodate, the religious or spiritual component. The value of this research is

confirmation from the participants themselves that the notion of SA matched their experience. The authors concluded that in the context of wife-abuse, SA has three levels of intensity; belittling the woman's spiritual worth, beliefs or deeds, preventing the woman from performing spiritual acts and causing the woman to transgress spiritual obligations or prohibitions (Dehan & Levi, 2009). For these women, spirituality may be the only means by which life can be given meaning, otherwise perceived as chaotic and without significance; SA thus has the potential to disrupt their sense of identity and wellbeing. Multiple accounts corroborate this perspective from an anecdotal perspective (e.g. Diederich, 2017; Hoffman, 2018). Failing to acknowledge the religious or spiritual components of already recognised forms of abuse might lead to the same legal conviction but does not address the existential and psychological complexity with the addition of the sacred text into the abusive situation. The current research seeks to address how therapists approach the religious or spiritual components of their clients' abusive experiences. The following section outlines some of the challenges in differentiating between abusive cult and abusive mainstream settings, as this has implications for both therapeutic interventions and recovery processes.

Differentiating between Cults and Mainstream Christian Settings

As Jenkinson (2016, p.75) writes, one person's religion, spirituality, psychotherapy or political group is another's harmful cult, depending on experience and perspective. Healthy versus pathological spirituality can be difficult to define; it can therefore be helpful to consider a continuum, bearing in mind that the same religious group may be at a healthy point on the continuum in some respects, at an unhealthy level on others and innocuous in relation to other factors (Crowley & Jenkinson, 2009; Kendall, 2006). Whilst it is too simplistic to assume that abuse is only abuse if deemed that way by the individual experiencing it, the problem of personal perception is highlighted by Jenkinson's comment. A mainstream Christian setting that would not on the whole be defined as a cult might meet Langone's (1993) cult criteria, depending upon the type of RSA perpetrated by the setting or an individual within that setting. For example, the stories of abuse that I heard as the interviewer in this research included excessive psychological dependence upon church leaders, separation from family members and controlling behaviour used to manipulate victims. In order to critique the clinical differences involved in therapeutically addressing RSA when exiting a cult or mainstream Christian setting, I first explore the definition of a cult.

Langone (1993) defines a cult as a group or movement that, to a significant degree, exhibits great or excessive devotion to some person, idea or thing; uses a thought-reform programme to persuade, control and socialise members; systematically induces states of psychological dependency; exploits members to advance the leadership's goals and causes psychological harm to members, their families and the community. Jenkinson (2013) summarises this as the use of potent psychological techniques to entrap victims into the powerful body of the cult. These techniques might include the use of authority, mystical manipulation, prioritising the doctrine over the person, provoking phobias or fears to enforce obedience and ensuring members are too frightened to leave, and separation from family and friends (Cialdini, 2006).

Cults or ritual abuse on the fringes of religion are assumed to cause harm because they exist outside of normative religious practice. Conversely, mainstream religious settings are often assumed to be safe. Various authors challenge the rigidity of this dichotomy (e.g. Oakley, 2009; Oakley & Kinmond, 2013; Winnell, 2011). However, emotional abuse and mind-control can occur in mainstream religious settings too, hence the need for the current research to explore this in greater depth. Winnell (2011) argues that the sanitisation of religion and normalisation of unhealthy practices makes RSA all the more insidious. Christians might also perceive God as the great physician, an implication of this being that only faith or prayer is required for mental health to improve. This has the potential to perpetuate the silence and oppression that characterises a fundamentalist belief system (Winnell, 2011). Whilst Winnell's approach has been criticised for not highlighting the positive elements of spirituality and failing to outline the differences between the way fundamentalism is perceived between the U.S.A & the U.K (Waller, Randle & Jenkinson, 2012), her work does help dismantle the division between mainstream religion as benign, and cults as harmful, a split which remains evident in the public consciousness. More recent literature (Diederich, 2017) summarises 4 main types of RSA; insensitivity, toxic faith, SA and mind control. Mind control, as defined by Diederich (2017), involves spiritual leaders stripping people of their identity and reshaping them into their own image. This terminology seems highly resonant with Langone's (1993) definition of cultic practices and Jenkinson's (2016) description of the pseudo-identity, discussed further below.

Addressing Religious and Spiritual Abuse when Exiting a Cult Compared with a Mainstream Christian Setting

Much more is known about the stance taken by therapists working with cult leavers than that taken by therapists who work with SA experienced within mainstream Christian settings. Specialist therapy for cult leavers has been developed most recently by Jenkinson (2018), whose PhD research involved interviewing 29 former cult members to establish what helped them recover (Jenkinson, 2016). Jenkinson developed a 4-phase model of cult-recovery therapy based on her findings (Jenkinson 2016; 2018; 2019). According to this model, cult members develop a pseudo-identity based on internalised introjects as a result of cult membership. Recovery therefore entails a deconstruction of these introjects and the pseudo-personality in order to free the authentic self (Jenkinson, 2016). Only then can emotional healing from self-suppression, traumatic loss, grief and pre-cult vulnerabilities begin, thus facilitating a focus on post-traumatic growth and recovery (Jenkinson 2018; 2019). Discussion with Jenkinson (June 3rd, 2019) suggested that parts of the phased model might apply to mainstream settings whereas other parts would feel irrelevant (e.g. psychoeducation around cult definitions and practices). Non-cult context is difficult to define, because as stated, abusive situations in mainstream religious settings may overlap in their characteristics with cults depending upon the abuse perpetrated.

An intended outcome of the current research is that preferred approaches for therapeutically addressing RSA in mainstream (as opposed to cult) settings might be highlighted. This is important because the options facing those who have experienced RSA in cults (versus those within mainstream settings) might be quite different. Jenkinson’s model is oriented towards leaving the cult. This might not be the case for a Christian who perhaps desires to maintain a relationship with a healthier branch of the church and not abandon their faith and therefore recovery from RSA is perhaps more nuanced compared with completely dissociating from a toxic cult ideology. The literature is much scanter in terms of delineating whether those who have experienced RSA in mainstream Christian settings choose to completely leave their faith or not. The general consensus appears to be that support is required to find a healthy alternative to toxic spirituality (e.g. Diederich, 2017). This has implications for the therapist, particularly if they sense a parallel agenda to the therapeutic task, and believe it is their role to keep people ‘for the faith’. Gubi & Jacobs (2009) found that counsellors felt they needed to justify or vindicate God and protect the spiritual community when working with RSA. This might be the case in the current research,

where I will be interviewing therapists of the same faith as that held by the perpetrators of the abuse.

The current research aims to fill a gap in the literature by providing a clinical perspective on how to support clients with their decision to remain involved with organised religion or not, and how therapists manage their own agenda in this, if they have one, given their Christian faith. Do they function differently from someone with a pastoral role, for example? And how does this decision remain with the client, so as to avoid a parallel process with the potentially coercive dynamics of RSA? By exploring this with therapists, I hope a more nuanced picture might start to emerge in which clinicians' perspectives are further understood and used to help take seriously the therapeutic needs of those who have survived RSA in a mainstream Christian setting.

The Challenge of Bringing Spirituality into Psychotherapy

Despite the apparent centrality of spirituality and religion in many people's lives, Pargament (2011, p.14) likens spirituality to the 'elephant in the room' in psychotherapy, whilst asserting that the two cannot be separated. Many psychotherapists are uncomfortable discussing religion and spirituality, unsure about how to deal with religious and spiritual issues or hesitant to engage the client in areas of discussion that may feel too private even for therapy. However, religious and spiritual issues are likely to emerge in therapy regardless of whether they are actively invited or not, including the client discovering sacred losses or violations, resolving existential questions of meaning, identifying and accessing spiritual resources or developing a relationship with a sacred character (Pargament, 2011). Pargament articulates the choice therapists have either to look the other way, thus proceeding with limited vision, or conversely, to address religion and spirituality directly and knowingly. The current research considered how therapists attune to the spiritual lives of their clients, and the means by which RSA comes to be both disclosed and discussed in therapy.

Despite evidence that spirituality can be both supportive and unsupportive in clients' coping strategies (Koslander et al, 2012; Weber & Pargament, 2014) the question relating to why psychotherapists might find these issues difficult to discuss warrants further exploration. Bergin & Jensen (1990) concluded that American psychologists tend to identify as less religious than the general population, a finding that has been replicated with British psychiatrists (Cook, 2011) and clinical psychologists (Smiley,

2001). Zenkert et al (2014) suggest that therapists with faith may be wary of pushing their beliefs upon clients or experience apprehension that the religious and spiritual domain is hazardous (Cornish & Wade, 2010) and therefore avoid it. Leighton (2014, p.295) asserts that;

> "religion has become a pariah, avoided by many mental health providers hiding behind value neutrality, unexplored transferential dynamics with religion as well as the belief that religious values are mutually exclusive with psychological principles".

The current research explores the views of therapists for whom the avoidance of spirituality was antithetical in itself, thus contributing a different narrative to previous research investigating therapists' feelings about discussing religious and spiritual issues with their clients.

Zenkert et al (2014) examined therapists' reactions to discussions of religion and spirituality with trauma and nontrauma clients, given that whether therapists introduce religion and spirituality differently with traumatised versus non-traumatised clients was predominantly unknown. The main difference between the traumatised and non-traumatised populations was the way that therapists used religion and spirituality as a means to examine existential questions, such as searching for meaning within their trauma, and acknowledging that religious and spiritual communities can provide an important form of support. Furthermore, as individuals often experience changes in religious or spiritual practices and beliefs following a traumatic event, therapists must be knowledgeable enough to help clients navigate their way through this (Zenkert et al, 2014). The authors explored therapists' overall feelings in response to the inclusion of religion and spiritual issues in secular therapy and concluded that many therapists hesitated, with some stating they had never considered it. This paper did not explore trauma when it was inflicted by the religious or church context itself and when it is, therefore, not a form of support or a sound basis for healthy existential questioning. Zenkert et al's (2014) research reflects a lack of guidance available for supporting clinicians who have hesitation or concerns about raising religious and spiritual issues. Their work also reflects the significance of the therapist in what is addressed or raised in therapy, highlighting that hesitation on the therapists' part might mean religious and spiritual issues are never addressed. Thus, offering guidance to clinicians based upon knowledge of therapists' experiences who have addressed RSA in their clinical

practice, could be instrumental in supporting a greater body of clinicians to do the same.

Zenkert et al (2014) refer to research by Hayes, Gelso & Hummel (2011) whereby countertransference is shown to impact therapy outcome and felt concerned that the therapists paid little attention to this realm. They responded by strengthening the call from earlier research (e.g. Schafer et al, 2011) for more explicit guidelines within training programmes relating to how to work with religion and spiritual issues in secular therapy, particularly how to help integrate these aspects of clients' identities into the work. Whilst this study did not explore therapists' responses towards uncovering or discussing RSA, participants explained that personal struggles might cause clients to question their religious beliefs or practices. Examples included abuse by a religious leader, or leaving an abusive marriage when religion dictates that divorce is wrong (Zenkert et al, 2014). Whilst these forms of abuse are predominantly recognised as falling under emotional or psychological abuse rather than RSA, it becomes challenging to ascertain whether the spiritual component of the trauma added a different dimension to the therapists' interventions, which is partly how I envisage this research to make a practice-based contribution. Pressley & Spinazzola (2015) suggest that when the faith beliefs of clients and therapists become an added dimension within the therapeutic relationship, the parallel processes within the dyad take on further complexity. For example, certain religious or spiritual beliefs may hold certain weight for the client and not the therapist or vice-versa. This research seeks to add narrative to this complexity and bring into the light how therapists address toxic or challenging spiritual issues with their clients.

The Impact of Religious and Spiritual Abuse upon Individuals

While existing research considers religious functioning and outcomes following trauma (e.g. Park et al, 2017), minimal empirical research considers the lived experiences of those who have experienced RSA in mainstream settings, and perhaps even less considers the means by which therapists address these experiences with their clients. Most work available is anecdotal, intending to reach a broader audience also seeking healing from their toxic church experiences (e.g. Diederich, 2017; Nelson, 2015).

Oakley (2009) built her understanding of SA upon 11 survivors' stories and established two superordinate themes; 'power' and 'spiritual abuse is abuse'. Within these superordinate themes further subthemes were noted; coercion and control, divine

position, defining SA, SA as abuse and attack on self. Whilst Oakley used her PhD initially to argue for a subcategory of SA alongside widely known definitions of abuse, her work remains deeply important in explicating the detailed experiences and voices of those impacted by SA in a way that had not been heard before. Oakley states (2009, p.136) that participants recounted their experiences as abusive, and draws parallels to emotions experienced when other forms of abuse have taken place (e.g. initial positive feelings, changing perceptions of reality, anger, blame, fear, distrust, isolation, secrecy and silence, long term impact and powerlessness). Whilst Oakley's work contributed to the broader narratives that supported the development of understanding around SA, including bringing it more into general discourse, her view has shifted towards incorporating SA with other, more recognised forms of abuse. Her most recent work (Oakley & Humphreys, 2019), aimed at non-clinicians, continues to emphasise the experience of survivors of SA, with the intention of supporting the creation of healthy Christian cultures. Whilst Oakley & Humphreys (2019, p.103) summarise the main features of responding well to SA, they are not specific enough to be used in a clinical setting, a further intention of the current research. Oakley & Kinmond (2013), in their seminal text about spiritual abuse in the UK context, do offer recommendations for therapists. However, it can be frustrating for practitioners to access texts when they are perhaps prohibitively expensive.

Ward (2011), an Australian social worker, wrote a paper entitled 'The lived experience of spiritual abuse'. He noted the lack of studies exploring the subjective, internal experience of victims of SA and conducted an interpretive phenomenological analysis [IPA] of six individuals who had left Judeo-Christian religious groups. This study discovered 6 main themes: leadership representing God, spiritual bullying, acceptance via performance, spiritual neglect, manifestation of internal states and expanding internal and external tension. Ward (2011) concludes that SA is a multi-layered and multi-faceted experience that is both event and process, impacting the bio/psycho/social domains of the victim. A strength of this study was the extent to which the experiences of victims overlapped despite their exiting from different religious groups; this adds weight to the concept of SA and provides a starting block from which to understand their personal experiences (Ward, 2011). Ward (2011) further suggests that the stories of SA offer another perspective on inappropriate leadership that does not meet religious cult criteria. Whilst Ward (2011) asserts that RSA is a phenomenon in its own right, which is currently contentious, he contends that abuse can hold a spiritual or transcendental dimension that should not be ignored.

Furthermore, Ward (2011) highlights spirituality as part of a holistic whole, drawing attention to the composite nature of human beings. Ward (2011) acknowledges the limitations of this study, namely the small sample size, self-reporting nature of the methodology used and Christian bias.

Swindle (2017) completed an (unpublished) PhD entitled 'A twisting of the sacred: the lived experience of religious abuse'. Having read this work, I believe this author was not familiar with Oakley's earlier PhD, given her assertion that there was an existing gap in the literature concerning the lived experience of those who have experienced RSA. Swindle's PhD explicitly intended to aid counsellors working with RSA, though her conclusions are predominantly focused upon counsellors abiding by standards designed to aid assessment of spiritual and religious functioning. Seven American participants who self-identified as having experienced RSA in a Christian setting shared their lived experience using semi-structured interviews. Ten key themes emerged; emotional trauma, betrayal, rules prioritised over people/devalued, abuse of power/use of the sacred to control or manipulate, spiritual transformation, isolation, healing, gender bias/discrimination, stigma and victim-blaming. Both Swindle's (2017) & Oakley's (2009) work validate the emotional experiences of individuals who have experienced emotional or psychological abuse in a religious setting with overlap apparent between their categories (e.g. the abuse of power). I believe this emphasises the need for good quality therapeutic input following an experience of RSA, hence the decision to embark upon the current research.

Swindle (2017) uses her findings to emphasise the significance of counsellors following competencies defined by the American Counseling Association to assess whether clients are coming from a religious or spiritual worldview. She suggests that the themes identified within her data could be used to assess themes emerging in clients' descriptions of their religious or spiritual experiences. Further research is clearly required to ascertain whether clients would find this helpful. Swindle does not describe the means by which this assessment could be most effectively completed without further re-traumatising the client, or what the impact of the therapist themselves upon this process might be. She does make reference to the significance of self-reflection to help reduce the counsellor's bias and either behaving defensively or denigrating all religion. I envisage the current research to make a practice-based contribution via discussions with therapists regarding their approach to working with Christian religion and spirituality, especially when there is an abusive component

involved. The following section explores one paper which did intend to capture the lived experiences of therapists working with RSA in the Christian church. Swindle further acknowledges the challenges in recruiting diverse populations, with her own sample comprised of white, heterosexual women. It is undoubtable that different cultural contexts, sexual/gender-based preferences or perhaps even socio-economic standing, will impact the experiences of survivors victimised in religious settings.

How Do Therapists Experience Working with Religious and Spiritual Abuse?

Given the plethora of literature related to the religious and spiritual dimension in therapy and a growing body of literature related to RSA, I was surprised to discover that minimal literature explores therapists' experiences and perspectives when working with clients who have experienced RSA in a mainstream setting. As far as I am aware, only one book explores this in any depth (Oakley & Kinmond, 2013) and one paper explores this empirically. Gubi & Jacobs' (2009) paper is entitled 'exploring the impact on counsellors of working with spiritually abused clients'. Gubi & Jacobs (2009) commented that little has been researched regarding the experiences of therapists who work with clients disclosing RSA compared to other, more recognised, forms of abuse. Five self-identified Christian counsellors were interviewed, and the data was analysed using interpretive/heuristic phenomenology. Emerging themes were grouped around 'aspects of experience': understanding of RSA; working with spirituality; impact on counsellor; management of responses; supervision; training; and personal experiences of RSA. When asked whether the work had personally impacted them, participants disclosed anger, sadness, frustration and feeling "gob-smacked" (p.197). In a form of emotional contagion (Rothschild, 2006), some could relate to the dissociation that their clients were experiencing. Participants described feeling newly cautious around their churches, cynical, and "personally angry with God" (p.198). Four out of five counsellors reported a sense of personal trauma or "carrying" their client's stories of RSA. Two out the five counsellors interviewed found their supervision traumatic but struggled to find supervisors who would support them with their work. A desire to "justify God but also her own beliefs" (p.197) was expressed by one of the counsellors, a potentially powerful dimension to the countertransference within this sort of work.

Gubi & Jacobs (2009) illuminate the challenge for therapists working with clients of the same faith who have experienced RSA; perhaps wanting to "keep God's reputation intact" (p.202) or to protect the spiritual communities' reputations. Whilst this research

covered the faith context of interest within this proposal, and the counsellors identified as Christian, the data did not delve into how this sort of therapeutic work was instigated and maintained, or how the counsellors dealt in the here and now with the material brought by their clients, given their knowledge and experience of the Christian faith context themselves. Whilst Kinmond's (2013) guidance for professionals working with RSA offers the most comprehensive advice related to working with individuals who have experienced this, the current research is intended to explore the suggested interventions in further depth from therapists' perspectives. Indeed, Oakley & Kinmond (2013) note the very scant literature that focuses on the manner in which therapists might work with individuals who have experienced RSA. I intend to bridge this gap with the current research.

How Should Christian Therapists Work with Clients who have Experienced Religious and Spiritual Abuse?

Kinmond (in Oakley & Kinmond, 2013) proposes that a foundation of person-centred principles is necessary to support clients' development of trust. It is suggested that a person-centred approach may need to be used alongside a more cognitive approach if the client requires guidance due to the loss of self-structures because of the RSA. I would further argue that work with RSA must be trauma-informed (e.g. Rothschild, 2011; Van Der Kolk, 2015) to avoid re-traumatisation, given the potential for disturbing or traumatic material to emerge in the course of the therapy. Kinmond cites Beck (1976), who asserts that cognitive restructuring enables the client to change distorted perceptions about themselves and the abuse. Kinmond then discusses the significance of psychoeducation to support returning control to the client and, importantly for the purposes of this research, explains that utilising her own spirituality and religion in the therapeutic space is important. Whilst Kinmond (2013) states the importance of not thrusting her religion or spirituality onto others and therefore remaining client-led rather than model-led, presumably space limitations prevented further exposition around how she might gauge this, and if there are ever occasions where the use of her own religion and spirituality feels inappropriate. Kinmond states some of the problems that therapists might encounter when their clients begin to discuss RSA. In a manner similar to those who have experienced domestic violence, she suggests that people may initially be willing to explore the hurt and trauma only to realise it is too painful and shut down. Further problems could be denial or repression of RSA because of the pain it caused, requiring skill and sensitivity on the part of the therapist.

The current research is intended to contribute further depth to Kinmond's (2013) arguments from a broader base of therapist participants, especially where she advocates working with what the client brings. A closer look at this from the perspective of practising therapists is intended make a practice-based contribution to psychotherapy and counselling-based literature. Oakley & Kinmond (2013) highlight the challenges a victim of RSA might have in trusting a therapist, but state this trust is absolutely foundational for effective therapy (Bordin, 1979). It is intended that the current research fleshes out how therapists achieve this trust, and particularly, how they use themselves and their own experiences of RSA, or healthy spirituality, to support the client into a secure therapeutic relationship which can foster their healing. However, given the potential complexity of integrating spirituality into therapeutic work, particularly when spirituality has been disruptive to the persons' identity, it is reasonable to assume that specialist training is necessary to equip clinicians for this. The following section addresses literature relating to the spiritual and faith literacy of training in religion and spirituality for therapists.

The Incorporation of Spirituality and Religion into Training Programmes

Teaching about spirituality is ethically contentious because the value-laden term 'spiritual' evokes religious connotations and can raise questions about evidence-based practice within a secular context for providing healthcare (McSherry, Gretton, Draper & Watson, 2008). However, spirituality plays a significant part in the identity, values and worldviews of clients across diverse populations (Jafari, 2016). This explains Kelly's (1994) initial call for religious and spiritual values to be incorporated into practitioner education and Pate & High's (1995) assertion that practitioners need to develop competencies to work with spiritual and religious issues in counselling (Swinton, 2016). The training of psychological therapists does not seem to match demand with the growing recognition of the significance of spiritual and religious matters in client's lives. Importantly for the context of this research, practitioners report difficulties and confusion when working with spiritual issues in therapy, and these difficulties are most acute when the person's beliefs undermine their wellbeing (Jackson & Coyle, 2009; Swinton, 2016).

Since Bergin's (1980) ground-breaking article in The Journal of Clinical and Consulting Psychology entitled "Psychotherapy and Religious Values", a significant amount of writing and research has been dedicated to examining how spiritual and religious

values have been integrated into psychotherapy (Plante, 2016). In counselling psychology, this is particularly important given the field's commitments to egalitarianism and holism requiring the practitioner to actively engage with the clients' meaning-making and life-worlds (Coyle, 2010). An inability to work in this way would limit the populations with which counselling psychologists could work, given, for example, that the role of the transcendent is a standard feature within African world views (Coyle, 2010). A client's spirituality and religion are therefore seen as important components of their cultural identity, and both UKCP (2019) and BPS (2014) ethical guidelines state the imperative for psychologists and psychotherapists to be able to engage with issues of diversity as they relate to the practice of psychological therapy.

There are challenges with this endeavour, not least the potential ethical dilemmas involved with the integration of spirituality into psychotherapy. These include the need to respect a client's religious values and beliefs, mitigate any harmful impact of one's own values and biases, and consider each client's religious and spiritual beliefs within formulation and treatment plans (Barnett & Johnson, 2011). As Magaldi-Dopman et al (2011) discovered in their grounded theory study exploring psychotherapists' spiritual, religious or agnostic identities and their practice of psychotherapy, psychologists received little support in their own spiritual/religious identity process but are still required to support their clients with these matters. All the psychologists interviewed felt their training did not allow for ample exploration of their own religious/spiritual/nonreligious backgrounds and the conflicts and challenges related to this part of their identities. Furthermore, these authors conceded that spiritual/religious discussions in psychotherapy are sensitive and activate feelings within the therapist, and without due ethical attention, psychologists' own biases and conflicts can be introduced into the therapeutic work. This reinforces the significance of reflective opportunities to be integrated into training courses, to enable adequate self-awareness development exercises and spiritual exploration for trainee therapists (Bartoli, 2007; Magaldi-Dopman et al, 2011).

When a client has experienced RSA and seeks psychological therapy, it is likely that their experience has both prompted their need to seek help and addressing it will form part of their journey towards regaining a sense of wellbeing. Whilst it is incumbent upon therapists to be able to ethically address the harmful impact of their client's spiritual and religious experiences, one might ask how therapists acquire the skills to safely and effectively achieve this given the paucity of effective training in these

matters for trainee therapists and psychologists (e.g. Jafari, 2016; Swinton, 2016; Hunt, 2019; Woodhouse & Hogan, 2020). I now reflect on some current U.K. evidence which investigates the incorporation of spirituality and religion into the training of psychological therapists.

Swinton (2016) undertook a study using the Human Inquiry paradigm to investigate whether spirituality was absent from the process of training. This study is important because participants were all in secular training, which is representative of most therapy and practitioner psychologist courses within the U.K. Secondly, both the implicit and explicit dimensions of spirituality were recognised and addressed. For most of Swinton's participants, spirituality was not explicitly experienced in the context of counselling training. Some participants mentioned that if it had been, they might have felt disinclined to apply. This has implications for trainers writing curriculums and suggests that spirituality might be downplayed in terms of its importance to mental health, both to the trainees and to the clients they will eventually provide therapy for. Swinton (2016) cites Reason (1994), who explains that in Western society, we tend to separate intuitive, affective or spiritual ways of knowing from propositional (expressed through theories and statements) knowledge. The very notion of teaching spirituality, an inherently relational process with the divine, other people and the environment, might explain why propositionally based training courses generally struggle to incorporate the spiritual dimension (Swinton, 2016).

The most recent review of religion and spirituality within counselling and clinical psychology training programmes was conducted by Simon Jafari (2016). Jafari (2016) notes that whilst considerable attention is paid to developing practitioner competence, a lack of coherent frameworks exists for addressing spiritual and religious content in clinical practice. Similar to Swinton (2016), Jafari (2016) notes the emphasis upon empirical and logical modes of investigation in contemporary psychology. When combined with the finding that psychologists tend to have the highest levels of agnostic or atheistic beliefs compared to other mental health professionals (Walker, Gorsuch & Tan, 2004), this raises questions regarding how effectively the relational dimension of spirituality is being addressed with trainees. Jafari's review yielded six papers which fitted the criteria for the review, but none of these were U.K. based, so it is clear further work is required in order to make reliable conclusions relating to UK teaching practices.

Trainees identified clinical supervision, peer support, reading and direct learning from clients as their main forms of learning, with didactic teaching remaining extremely rare. Spirituality therefore tends to be addressed indirectly, which corroborates Swinton's (2016) findings. Students reported receiving no instruction on how to integrate spiritual interventions into their therapeutic work and spirituality was the least represented of the diversity trainings received (e.g. gender or socio-economic). Systematic implementation of training was found to be poor but increasing, and one quarter of students reported receiving no form of training at all (Schafer et al, 2011). Concerningly, a number of trainers were reluctant to integrate spirituality and religion into future training courses and knowledge of religion and spiritual traditions was perceived to be beyond the remit of clinical expertise. This was clearly different in courses with a religious affiliation, as would be expected in the U.K., where certain counselling trainings are clearly affiliated with the Christian faith (e.g. Waverley Abbey College). A positive finding was the support for trainees conducting their research into religious matters, which corroborates my experience as a postgraduate applied psychology trainee in the U.K. Jafari (2016) notes that the extant literature is all U.S. based thus potentially limiting the generalisability of the findings but similarly emphasising the need for empirical assessment of trainings within the U.K.

More recently, Hunt (2019) explored how counsellors who are practising believers of a world religion or faith tradition experience undertaking counsellor training, citing West's (2000) earlier call for greater input on religion and spirituality into the U.K.'s counselling curriculum. This is important, because the challenges identified by these participants who ascribe to Christianity as the dominant religion in the U.K., (Office for National Statistics, 2012) are potentially amplified for those from minority faiths. Hunt references two earlier studies, both of which concluded practitioners felt that no substantial teaching related to religion or spirituality was included in their training (Martinez and Baker, 2000; Christodoulidi, 2011). Hunt (2019) interviewed 4 religious participants, all of whom identified as practicing Christians. Four themes were noted: talking about religious faith in the context of training; relating faith to counselling theory and practice; teaching on religion in counselling training and finally, being equipped to work with religious clients. All participants disclosed fear when discussing their religious faith, expecting judgement and rejection, negative assumptions and a perception of weakness. Whilst a small sample, participants unanimously commented that their training involved no substantial input on religion, with a sense that it was generally regarded as irrelevant.

These findings are critical for trainers to behold because participants were anxious with regard to the implications of discussing their faith. Hunt (2019) comments that structured opportunities for trainees to think through complex issues like disclosure of their faith to clients is important. However, an implication of the findings is that opportunities for discussion might be shut down by religious trainees if they are too anxious to share their faith. It is intended that the current research might be significant in its capacity to elucidate key strengths emerging in the discussions between the therapist and client about RSA, thus supporting trainers to better know which questions to ask of their trainees to facilitate discussion and reflective thinking in relation to this issue.

Hogan & Woodhouse's (2020) thematic analysis investigating trainee counsellor/psychotherapists' experiences of spirituality in therapy highlighted two major themes, the second being 'spirituality is relevant but undervalued'. This theme captured their participants' sense that training and support associated with spiritual development are relevant to their therapeutic development; however, such support and training was rarely available, and inconsistencies are present from training through to supervision. Participants rejected the idea of dogma but were interested in developing a deeper understanding of spirituality. This is challenging when so little time is spent on spirituality in training courses, perhaps because the concept itself is difficult to explain (Hogan & Woodhouse, 2020). As corroborated by other authors (e.g. Hunt, 2019), therapeutic training can provide a platform for personal spiritual formation thus giving trainees the opportunity to discover the significance of spirituality in their own lives. Hogan & Woodhouse's (2020) participants expressed feeling ill-prepared to integrate spirituality into therapy, but a religious and spiritual background, in conjunction with theoretical orientation, informs therapeutic work when integrating spirituality. These authors conclude that integrating spirituality into therapy is complex and nuanced, and that future work should explore how training and CPD could support practitioners' confidence in working therapeutically with their clients' spirituality.

Important assumptions can be drawn from Swinton (2016), Jafari (2016), Hunt (2019) and Hogan & Woodhouse's (2020) conclusions, namely that teaching related to religion and spirituality in therapy training is somewhat lacking. Therefore, training related to working with clients presenting with RSA is rare, if covered at all within secular (and therefore the majority of) U.K. training syllabi. Whilst training related to

spiritual matters is lacking, significantly more research exists with regard to including spiritual interventions into clinical practice. This is interesting, because one could ask on what basis therapists implement these ideas if they have experienced only minimal training in spiritual matters? A distinction is evident here between using spiritual tools as a therapist and integrating your personal faith and experiences into the clinical encounter. It may also be the case that trainee therapists have experienced challenging or ambivalently felt personal experiences related to spirituality. This might impact their capacity to engage with training material related to spirituality and make their integration of spiritual matters into psychotherapy seem or feel more tenuous. This idea is something that will be developed within the research, because it is possible that the therapists interviewed integrate spirituality into psychotherapy *because* they have experienced their own challenging experiences related to religious and spiritual settings. This might prove to be more important than their training in how equipped they feel to engage with RSA in clinical practice. I anticipate the current study will delineate more about the personal integration of spirituality into clinical practice, in both implicit and explicit ways. This has important implications for the necessity of the current research and will be expanded upon in the discussion chapter.

Aim of the Research

Whilst SA continues to gain traction as a term, minimal work addresses the techniques and experiences of clinicians working with clients who present with RSA. In light of minimal empirical research related to therapeutic interventions for those who have experienced RSA, the aim of this research was to establish how Christian-identifying therapists work with clients who have experienced RSA in Christian settings go about this, and to establish commonalities that could translate into implications for practice. The literature is currently lacking in material pertaining directly to this but evidence from the church experience surveys (Oakley & Kinmond, 2015; Oakley, Kinmond & Humphreys, 2018) suggest that this needs to shift in order for effective policy and practice-based guidelines to be developed. This research will address the personal and professional challenges that therapists might face, including the personal impact of addressing the traumatic side of a faith that they share with clients, and how to navigate this professionally in the best interests of the client. Whilst RSA is increasingly explored on an anecdotal level (e.g. Diederich, 2017) and for lay-persons interested in supporting those with experiences of RSA (e.g. Oakley & Humphreys, 2019), no research as yet investigates the therapeutic choices made by therapists to

facilitate recovery from this perhaps contentious, but increasingly evidenced, form of abuse.

Given the extent to which religion and spirituality have been shown to impact upon mental health and either trauma symptomology or posttraumatic growth, this seems like a gap in the literature and will make a practice-based contribution. I will be exploring therapeutic processes and interventions, choices made by the therapist in terms of disclosure and the use of their own personal experiences of religion and spirituality, and what they are aiming for therapeutically with their clients. The intention is that this will support the development of guidance, which can be used to help other therapists integrate the dimension of religion and spirituality into their work with clients, particularly when their clients' experiences of church or religion in the Christian context have been abusive or traumatic. It is intended that the current work might support the development of materials which could be used to facilitate and stimulate discussions for therapists-in-training, given the lack of formal training in these matters.

Conclusion

Within this chapter I have explored the literature related to RSA and set out my argument for the current project. In the following chapter, I discuss the methodology used to bring to life the research questions and process.

Chapter 3: Methodology

Rationale for a Qualitative Approach

In this chapter I outline the philosophical background behind my research question and justify the grounded theory methodology chosen to address it. Research methods provide a path towards approaching and answering research questions (Willig, 2013). It is therefore important to choose the appropriate method to answer the chosen question(s). Given that the aim of this research was to explore how individual therapists conducted their therapeutic work with clients who have experienced RSA, I needed a methodology that could both capture their experiences and support the development of a theory, so as to contribute to practice-based knowledge aimed at supporting therapists wanting to conduct similar work. Whilst quantitative data underpinned by deductive logic (the development of hypotheses and theories) has been the mainstay of psychological research, quantitative approaches neglect the purpose and meaning of participants' experiences (Guba & Lincoln, 1994). I am particularly interested in exploring participants' experiences and opinions, more aligned with a qualitative framework and inductive logic, whereby the gathered data becomes the guide. The information provided by participants then becomes assimilated into a theory that emerges from the body of information collected (Smith & Davis, 2012). I address my epistemological and ontological position in the following subsections so as to align my philosophical beliefs with my methodological choices.

Epistemological Position

As a psychotherapist and trainee counselling psychologist used to practising within a relational, integrative approach, I am interested in how the co-creation of material between a therapist and their client emerges, and believe this co-creation extends into the researcher-researched dyad. This speaks to the emphasis I place therapeutically upon a co-created working alliance and the development of an intersubjective framework, within which change begins to occur (e.g. Bromberg, 2011; Stolorow & Atwood, 1996). I hold the constructivist-interpretivist epistemological position (Denzin & Lincoln, 1998), which highlights the researcher's involvement in both the construction and interpretation of the data, because 'subjectivity is inseparable from social existence' (Charmaz, 2014, p.14; Ponterotto, 2005). Within this framework, both researcher and participant may be changed as a result of their dialogical interactions, positioning the researcher as neither a neutral observer nor value-free expert (Charmaz, 2014; Ponterotto, 2005).

Ontological Position

Ontology is concerned with the nature of reality and what we can know about that reality (Ponterotto, 2005). I hold the ontological position of relativism, believing that multiple, constructed realities exist, rather than a single true reality. This aligns with my clinical positioning as an integrative psychotherapist and trainee counselling psychologist that 'no one approach has all the truth' (United Kingdom Council for Psychotherapy [UKCP], 1999, p.xiv, as cited in Lapworth, Fish & Sills, 2005). No single truth is sought, and multiple interpretations of the same data are possible. I see a parallel process in terms of how my own spiritual and faith-related views have become more nuanced and embracing of multiple interpretations. In many ways this research, certainly at the point of its inception, felt like a kick-back against the myriad of ways in which my own church experiences left me feeling as if their way was the highway, and my own individual interpretations were unacceptable.

Grounded Theory and the Current Research

Having decided to employ qualitative techniques, I then needed to decide which methodology to use. If I were asking phenomenological questions of therapists pertaining to their lived experience of working with survivors of RSA then I would have selected interpretative phenomenological analysis [IPA] or narrative enquiry (Willig, 2013). However, I wanted to go beyond exploring the lived experience of my participants as I felt this work had already been done (e.g. Gubi & Jacobs, 2009), and was interested in the 'so what?' component of the research, particularly the opportunity to offer practice-based recommendations. Whilst ample literature discusses the incorporation of spirituality into therapeutic work, little empirical work documents the experiences of therapists that can be used to inform and support the development of theory related to working therapeutically with RSA. Given that the research question posed has not directly been studied before, I wanted to use a method to develop an explanatory framework for practice, which could then be usefully adopted by other therapists. I intended to focus on the exploration of a particular aspect of practice with the intention that a theory would emerge highlighting how to manage RSA in therapeutic practice. Grounded theory [GT] works well when the research questions are oriented towards explanatory rather than descriptive themes, particularly when the phenomenon being researched is under-studied, as in the case of RSA.

Not all versions of GT align with my philosophical stance and methodological intentions. Glaser and Strauss' (1967) original assumption in earlier versions of GT

posited that both data and theories can be 'discovered'. This aligns more closely with a realist and objectivist approach towards knowledge and reality, thus standing in contrast to my values as both a clinician and researcher. Charmaz (2006, 2014) moved away from the positivist assumptions within the original GT (Wertz, 2011), introducing a more social constructionist version of GT [constructed grounded theory, CGT]. She suggested that categories and theories do not simply emerge but are instead constructed by the researcher through an interaction with the data. Pidgeon & Henwood (1997) subsequently substituted the term theory generation for theory discovery so as to capture the constructed nature of theory development (Willig, 2013). Within CGT, the researcher ultimately proposes a theory that reflects the experiences of the researched and the researcher (Higginbottom & Lauridsen, 2014) but the theory produced depends on the researcher's perspective (Charmaz, 2006). This calls for a reflexivity which suits my stance and skillset as a relational psychotherapist, and ultimately is a more enjoyable and personally authentic means by which I can gather and analyse data.

However, GT is not a suitable methodology when applied to questions about the nature of experience as it becomes reduced to a technique for the systematic categorisation of data (Willig, 2013). Whilst this may support an understanding of participants' experiences, it does not amount to theory development. GT is therefore well suited to questions that hold an explanatory, rather than descriptive, framework within them. The emphasis upon how Christian therapists work with their clients led towards a methodological framework that could ultimately lead to theory development. I have opted to use the full method of GT; this enables the research focus to change depending upon the categories emerging within the data collected. I believe this mirrors the therapeutic process that may also occur between a therapist and a client as the client's story evolves over time. Given that this research is focused on therapeutic processes, I was attracted to a methodology with this degree of flexibility and acceptance of shift and change as new information comes to light.

Epistemological and personal reflexivity

GT originally subscribed to a positivist epistemology thus sidestepping questions of reflexivity (Willig, 2013). Charmaz' CGT supports a more reflexive approach whereby it is recognised that rather than emerging from the data, categories are co-constructed by the researcher and participant during the research process (Willig, 2013). It is assumed that the researchers presuppositions and privileges may shape the analysis,

and personal values can impact the very facts that are identified. Research is therefore treated as a construction that occurs under specific conditions, not all of which we may be aware of, or of our choosing. This aligns with Marx' (1852) suggestion that 'Men [sic] make their own history, but they do not make it just as they please; they do not make it under self-selected circumstances, but under circumstances existing already, given and transmitted by the past' (Charmaz, 2014, p.13). Since my clinical practice is philosophically grounded in recognising intersubjectivity, I believe that CGT is congruent with me as a developing clinician-researcher. It will enable recognition of my contribution to the research, both explicitly in terms of my interpretation of the data and implicitly in relation to the biases and assumptions that form part of my perspective. Furthermore, I noticed a dissonance between the vast data available relating to religion and spirituality in mental health, and the perception that there is further work to be done in this field (Jenkinson, 2017). I therefore want to employ a methodology flexible enough to cope with the data that emerges and enable leads to be followed up as a result of what the participants themselves state as critical in relation to their clinical practice.

Ethical Considerations

The BPS Code of Ethics and Conduct (2018) and the Code of Human Research Ethics (BPS, 2014) demand a focus upon respect, competence, responsibility, integrity, scientific integrity, social responsibility and the minimisation of harm/maximisation of benefit. Each (pseudonymised) participant received a participant information sheet [PIS] (Appendix 1) following an initial email contact (Appendix 2) enabling the provision of informed consent prior to taking part, documented on an approved consent form (Appendix 3). This informed participants regarding their right to withdraw, modification of their data contribution and data storage (BPS, 2014; Metanoia Institute Research and Ethics Committee [MREC], 2019). I considered the anonymity of participants carefully at the outset of planning this research (Appendix 4) given the greater likelihood of overlap when occupying both Christian and therapeutic or therapeutic training spaces. See Appendix 5 for the letter of ethical approval from the MREC.

Dealing with Historical and Current Disclosures of Abuse

Given the potential for disclosure of historical abuse I developed a protocol using a publication produced by the British Psychological Society (2016) entitled 'Guidance on the management of historical (non-recent) disclosures of child sexual abuse'. This formed part of the necessary risk assessment as stipulated by the MREC. The protocol took into account the safeguarding of adults and children should the following

situations arise: therapists disclosing historical abuse that has not yet been documented or appropriately reported at the time of the interview being conducted; therapists disclosing their own experiences of historical abuse during the research interviews; and individuals contacting me directly as a result of seeing the advert, perhaps not as potential participants, but those viewing research as a suitable means through which to tell their story, perhaps if counselling has not previously felt acceptable to them. Due to the in-depth nature of this protocol and the fact that I did not need to use it, I have included it for reference in Appendix 6. Given the potential for the participants to feel as if their work was being scrutinised, I paid particular attention at the start of interviews to ensuring that participants were mindful of their clients' confidentiality, and avoided transcribing details that could have identified clients in any way. My sensitivity to this issue evolved as the research interviews progressed, particularly my ability to ask questions that got to the heart of their practice style, without compromising any confidentiality.

Self-Care

A further stipulation within the ethical approval for this project was that I paid more attention to self-care. Emotionally demanding research impacts the researcher because of its potential to trigger emotional reactions, which interact with existing emotional states. Kumar & Cavallero (2018) define 'emotionally demanding' as including a focus on sensitive issues, and when the subject under study resonates in some form or another with the researcher. Consideration must therefore be given to issues surfacing that require reflection and proactive self-care. Perhaps related to this, Etherington (2004, p.15) highlights that research is often 'transformational' for the researcher. I wanted to make space for this transformation, particularly because my interest in the subject area was borne out of my own difficult experiences in a church setting and the associated growth towards a more authentic experience of spirituality. The nature of the project meant that I reflected upon alternative means of seeking support outside of my usual networks. Spiritual directors are defined by the London Centre for Spiritual Direction (2019) as individuals who contemplatively support individuals to 'awaken to the mystery called God in all of life, and to respond to that discovery in a growing relationship of freedom and commitment'. I reflected upon potential parallel processes by choosing to see a Christian spiritual director, namely that the process may start to stagnate if an objective, outside voice is not invited in. Whilst I have not felt this to be the case, it was useful to have a 'plan B' in which I could consult someone outside of the faith context who could offer some useful objectivity

and help provide space from the material for deeper processing to occur. Journaling is an expected aspect of GT methodology and I discuss my use of this further when explaining my data generation methods. I anticipated that this form of external processing would assist my ability to remain grounded in my capacity as researcher, whilst also exploring my own material in relation to this project. I found that seeing a Christian spiritual director as part of my self-care facilitated reflexivity through supporting me to process my own material. I extended the impact of this by journaling my experience, an excerpt of which I include in Appendix 7.

Criteria for Participation

I interviewed psychological therapists who identified as holding a personally meaningful Christian faith with at least 5 years' experience post qualification, who had worked, or were currently working, with individuals who have encountered RSA within a mainstream Christian setting. Participants were required to hold a master's degree in counselling or therapy so as to ensure an appropriate level of experience; however, I did interview therapists who held diploma level qualifications if they specialised in RSA. Whilst it is likely that my participants' clients will also identify as Christian, I had no way of verifying this by asking them directly. However, given that the abuse needed to have occurred within a mainstream Christian setting, it is likely that they would identify as Christian over other religions. Some clients may have changed their beliefs or perhaps had their beliefs misinterpreted by my participants, and so to allow for either of these possibilities I generally refer to them simply as 'clients' instead of Christian clients. It should be noted that on the whole the clients my participants discussed were regarded as holding a personal Christian faith and were therefore working with a therapist of the same faith as them. I discuss the decision to interview Christian-identifying therapists in more depth below, explaining how I reached this decision and reflecting on the possible impact upon this work. I did not eliminate anybody who enquired directly, but two therapists decided not to participate; one decided they did not meet the criteria, and another was concerned about anonymity.

Recruitment Strategy

Therapists who identified with the Christian faith in a way that is meaningful to them were invited to take part in the research via an approved recruitment email sent out to the membership of the Association of Christian Counsellors [ACC] (purposive sampling strategy). I then sent out approved PIS sheets to those who were interested. Providing they fulfilled the criteria specified, and were still willing to participate, I then arranged interviews via email contact. Eight participants were recruited this way; I was

surprised by the interest this email garnered, and though concerned about the potential lack of diversity within my sample, did not feel that I could reject interested therapists because the number of those working with RSA (who met the criteria) is not extensive. I wrote an article for the publication sent out to members of the ACC (Saunders, 2018) to support the recruitment email, and was contacted by one participant who had seen both the email and the publication. I emailed the British Association of Christians in Psychology, London School of Theology and also approached the Royal College of Psychiatrists Spirituality Division (for psychotherapy-trained psychiatrists); these latter avenues proved unfruitful in terms of potential participants. In retrospect, this might have been because of the contentious debate about spiritual abuse that was occurring. Alternatively, the stipulation to identify as a Christian might have been off-putting. Given the relatively few therapists who state they work with RSA, I interviewed every willing potential participant who came forward and was eligible to participate (see Participant Characteristics, Table 2, p.53-54), resulting in 9 completed interviews.

Participant Characteristics

The table below shows demographic information collected for each participant, deliberately brief to ensure their anonymity. All therapists were trained to a minimum of level 4 diploma in counselling and many held additional roles, including lecturing posts, researchers, or acting as clinical supervisors. When asked to describe their own expression of faith, the responses were varied, ranging from charismatic, evangelical, liberal Christian, and Romo-Mystic. I have not identified the denomination of participants, again to avoid any possibility of identification. This diversity of Christian expression represents important diversity within the sample as the work becomes more translatable across the different denominations of Christianity and beyond.

Pseudonym	Demographic characteristics	Role & experience	Second round of data collection
Hannah	Female, White British	Diploma/BSc counselling	Y
Lucy	Female, White British	MA relational counselling & psychotherapy, clinical supervisor	Y

Sophie	Female, White British	Clinical psychologist	Y
Emily	Female, White British	Accredited counsellor, research psychologist, Clinical supervisor	N
Ann	Female, White British	MA counselling & psychotherapy, supervisor	N
Joanna	Female, White Irish	Diploma in Counselling & Psychotherapy & Supervisor	Y
Ashley	Female, White British	Diploma in Counselling	N
Monica	Female, White British	MA relational counselling & psychotherapy	N
Julia	Female, White British	Diploma in Counselling	Y

Table 1: Participant Characteristics

Reflexivity Relating to the Limitations of the Current Sample

A Lack of Diversity Within the Current Sample

From a personal perspective, part of my deconstructive process has involved recognising the often patriarchal, heteronormative and colonial aspects of white Christianity. I believe this is why I found discussing issues of faith with my therapist, a black woman, particularly challenging and exposing. I felt ashamed when talking about my faith, not only because of my personal challenges with it, but also because I was aware of the myriad of ways in which Christianity has been used to oppress and control non-white individuals in different contexts. Christianity has also been used as a tool to oppress those from the LGBTQ+ community and more generally speaking, women (Wood & Conley, 2014; Moder, 2019). Acts of racism and historic colonialism have also been justified using the Christian narrative. Conversations with my therapist, and my own reflections, made me consider the possibility of a diverse sample on paper perhaps doing more harm than good in relation to this particular piece of research. Although embracing identity politics can be important for marginalised communities because of the sense of strength, community and intellectual development it can

foster, the danger with identity politics is that it risks conflating intra-group differences (Crenshaw, 1994). Therefore, to have a diverse sample of therapists (on paper) through tokenistic representation of these marginalised groups, intensifies the likelihood of failing to address the particular needs, desires and struggles of these therapists (and their clients) in any depth, in a manner similar to how the church has historically treated these groups. This is particularly important because the voices of clients/victims of RSA are not directly communicated through this work.

There may be important parallels between the findings from the limited sample I interviewed and therapists working in more marginalised communities. However, to interview one therapist from the LGBTQ+ community, or one black psychotherapist for example, is tokenistic and could amplify the lack of representation rather than diminish it. My preference, therefore, would be to take the data from this research and then *ask the question* – 'in what ways do these findings hold true when working with marginalised populations and in what ways might they differ'? It is also important to recognise that when interviewing those in positions of power relative to their clients (therapists), representation should be sought for the sake of clients. Ensuring I interviewed one black therapist for example, does not mean that the needs of black clients can confidently be inferred. In light of this, I would prefer that further research sought out a group of therapists from a marginalised community, to increase the likelihood that the complexity of what marginalised groups face when experiencing RSA is more fully understood. This would also align with the principle of intersectionality, which recognises that different forms of oppression intersect to create a different experience than the traditional boundaries of discrimination might traditionally realise (Crenshaw, 1994). For example, whilst RSA might occur within the black community, working with this as a therapist would require an understanding of how RSA might be experienced differently if you are black and female in this context, as the experience might be very different as a black male. I believe a strength of the current sample is that it does not undermine the experiences of victims of RSA further, through a tokenistic attempt at representing very specific experiences.

As a researcher, I would like to have recruited a more diverse sample and important questions must be asked regarding why this did not happen. A stipulation of this work prior to its commencement was that I interviewed therapists who identified as Christian and this in itself felt limiting. In retrospect, I wonder if this left me with the expectation my sample would be non-diverse, and I therefore accepted this too readily. The

sample within this project is not representative of those professing a Christian faith within the U.K. This represents a broader problem, in that those working in the therapeutic professions are similarly not representative of the U.K. population. For example, I only heard from women in response to my advert, which may reflect a greater proportion of women working in the therapeutic professions. In retrospect, I wondered whether the greater media coverage of men as perpetrators of abuse in the Christian church creates an unspoken barrier in terms of male therapists participating in the healing of those damaged within a Christian faith context. I might have foreseen this and included a particular request for male therapists. I also did not interview any participants openly identifying with the LGBTQ+ community. Given that many Christian religious settings have a non-affirming stance, LGBTQ+ identifying individuals are at a greater risk of abuse in religious and spiritual settings. In order to fully understand the implications of RSA for LGBTQ+ individuals, and how to work therapeutically with them, it is reasonable to expect therapists to have some knowledge of the sexual microaggressions that can occur as a particular form of RSA (Wood & Conley, 2014). Whilst personal experience of a situation is not a pre-requisite for working effectively with different forms of trauma, further research is required to examine effective therapeutic interventions that would meet the needs of a population who may experience RSA in different forms to non-LGBTQ+ individuals.

Enabling participants to self-identify as meeting the research criteria has the potential to communicate important information about who is prioritising, or feels able, to engage in this sort of work. In retrospect, perhaps it is more likely that I needed to use different methods in order to find those doing this work, in more marginalised communities. Because my participants were recruited via a membership list of a Christian organisation, those non-affiliated with the Christian faith would not have seen the advert. A way of broadening the reach of the advert might have been to have searched for local counselling services, in areas recognised for their populations of marginalised communities. This might have increased the likelihood of being able to recruit therapists originating from these communities. Advertising in local newspapers might also have supported more diverse recruitment or emailing organisations with traditionally higher percentages of non-white members (e.g. United Pentecostal Churches in Europe). I recognise that the current sample could reflect a lack of capacity in terms of reaching therapists in harder-to-reach communities, thus presenting a limited view of who is carrying out this work. This was also a small-scale project which set up limitations in itself, both in terms of the timeframe I had to

complete this work and also in terms of the quantity of data that was realistic to obtain and analyse.

I contacted a number of organisations to try and mitigate against recruiting a non-diverse sample and allowed sufficient time to respond. For pragmatic and ethical reasons, I conducted interviews with those who presented themselves as willing to take part and did not exclude on the basis that I had reached particular demographic quotas. Whilst I was concerned about tokenistic representation, this could also reflect a lack of confidence on my part as a novice researcher, in both locating and interviewing other therapists working with shadow issues such as RSA. I recognise this could perpetuate the problem of RSA predominantly being centred around the (white) Christian literature, because it clearly occurs in other cultures and religious settings also (e.g. Oluwole, 2010; Malik-Rabata, 2020). Therefore, a key limitation of the current sample is that the findings cannot definitively answer whether the conclusions apply more broadly beyond a female, Christian and white interpretation of how to work clinically with RSA. Although RSA is known to occur across different faith settings, minimal literature documents RSA outside of a Christian framework or how it manifests within other cultural or demographic contexts. This has implications for the training of therapists in religious and spiritual matters, which I expand upon in the discussion section.

In summary, I acknowledge that I interviewed only white, female therapists within the Western-Judeo Christian tradition and appreciate that this lack of diversity has implications for generalisability across different subcultures of both therapeutic and Christian thought. For example, the expressed therapeutic preferences of white, female therapists in a generally middle-class Christian setting might be quite different from the manner in which RSA would be therapeutically addressed across socially and culturally diverse Christian settings. However, given the breadth of diversity present within both the experience of RSA and the different faiths RSA could present within, to conflate diversity with representativeness is potentially problematic. Furthermore, representativeness is not the primary aim of qualitative research but requires careful consideration which I have attempted to address. Given that I am approaching this research as a co-researcher, shaped by my own history, preferences and biases, I view this piece of research as an initial discussion that could then expand to broader people groups and subcultures of Christianity.

Justifying the Recruitment of 'Christian Identifying' Therapists

The stipulation to interview 'Christian-identifying therapists' might have excluded therapists from responding to the advert if their faith is important to them, but they do not wish to identify themselves in this way. The only way to determine this would be further research, with an emphasis upon seeking out a more representative population of Christian therapists within the U.K (especially those of different nationalities, LGBTQ identifying clinicians and men). In this particular project, I intended to interview therapists who matched their clients in respect to their Christian faith orientation. This decision was complex and poses limitations upon the work as well as potential strengths, because it is clear that RSA occurs in other cultural and religious settings. Whilst representativeness is not the primary aim of qualitative research, it is important to consider the implications of interviewing only Christian-identifying therapists. I might have generated a more heterogeneous sample had I asked the broader question, *'how do you work therapeutically with RSA as a psychological therapist?'* rather than specifying *'Christian identifying therapist'*. Presumably, this would have resulted in a sample who weren't necessarily matched to their clients in terms of faith identification, especially if the practitioner identified as atheist or agnostic (as is common within those working in the psychological professions). Whilst asking non-religiously affiliated therapists how they work with RSA is an important question to ask, this research was designed to specifically investigate the experiences of same-faith therapists and the results reflect the significance of factors which would not have been as evident had this not been the case (i.e. the significance of personal faith). To ask Christian therapists about their experiences with clients who have experienced RSA is a valid starting point, given little empirical research with this particular demographic.

Potential weaknesses of a fully Christian-identifying sample include failing to capture whether there are practice-based differences between different populations, how they identify their faith/denomination, and their style of practice. Whilst this would be interesting information to elicit in further research projects, qualitative research is designed to elicit depth not breadth. Diversity isn't necessarily representative of how to work with a particular clinical presentation, if the key issues haven't been explored in any depth. This present sample clearly cannot capture whether, for example, black African therapists employ different techniques to their white counterparts when working with RSA.

On the surface, the research question explores a very practical issue – *how* do therapists work with RSA? However, I expected this work to capture a phenomenological and experiential nuance that went beyond a checklist of therapeutic activities or interventions. Prior to conducting this research, it was challenging to anticipate exactly what this nuance would be. There is a lack of research literature pertaining to how therapists work with clients who have experienced struggle and toxicity within the same community of faith that they, the therapist, identify with. In comparison, extensive literature details the development of cultural competence when working with clients who express alternate or fundamentalist/dogmatic faith views. Clients' faiths and beliefs therefore have the capacity to present as a barrier or as a resource in treatment. Because of this, an extra layer of complexity tends to be present when working with clients who have a faith (Pressley & Spinazzola, 2015). In order to focus on the research question and not become distracted by issues of competence when working with difference (i.e. whether a therapist can adequately work with a client without faith and vice versa), this contributed to my decision to interview therapists who identify with the Christian faith. Interviewing therapists who understood the faith context in which the RSA occurred meant that I could infer their understanding of the client's core theological framework and instead focus on addressing the 'how' of their therapeutic practice.

Research by Motalová & Řiháček, (2016) concerning the 'religiosity gap reversed' refers to the counsellors' religiosity presenting in a predominantly non-religious environment. This research is both interesting and relevant to my choice to interview only Christian-identifying therapists. The authors' main finding was that participants strongly emphasised their religion as their own personal matter. Similar to the participants in the current research, they valued their own religiosity as an integral component of their selfhood and viewed it as a valuable clinical resource. However, it was clear that their own faith explicitly entered the therapeutic space only if this was client-led. As Motalová & Řiháček conclude, this fits with Tan's (1996) conceptualisation of the implicit and explicit integration of spirituality and religiosity in psychotherapy. Given that a likely outcome of the current work is how therapists integrate their own religiosity when working with complex issues related to faith, such as RSA, interviewing non-Christian identifying therapists would presumably not speak as richly to this dimension of integration. Conversely, interviewing therapists of other faiths might reveal different elements of this integration dilemma, and provide an overwhelming volume of data thus sacrificing depth. This is a key rationale behind the

decision to interview Christian-identifying therapists. In order to adequately capture both the implicit and explicit dimensions of the therapeutic relationship, particularly with a complex construct such as RSA present, this further confirms my decision to interview those with the same faith as their clients.

As Oluwole (2010) explores, doctrines exist within particular cultural contexts and these cultural narratives can be deeply influential upon one's experience of spirituality and its abuses. For example, Oluwole's (2010) work highlights that understanding the impact of RSA needs to be contextualised within wider cultural discourses e.g. generational curses (demons) because doctrines are based in culture, superstitions and particular belief systems. Exploring the experiences of therapists who likely understand the context of their clients, enables an emphasis to emerge related to how their own understanding of that context shapes and influences their practice. This is a strength of the current sample. Upon reflecting further on the nuance this research might uncover, I realised that a key finding might relate to how therapists integrate their own faith (and therefore their implicit understanding of their client's faith contexts) such that they can use their own faith therapeutically with clients. This consolidated my decision to only interview therapists who identified as Christians. I reflect more on this issue of integration of personal faith into clinical work in the discussion chapter, and the broader implications for the field of psychotherapy.

Gubi & Jacobs' (2009) paper highlighted that Christian counsellors often found hearing accounts of RSA and working with it difficult. This, and other work, makes it apparent that RSA needs to be addressed therapeutically but limited literature discusses therapists who perceive this to be a successful and enjoyable element of their practice. I hoped to elicit the ways in which therapists engaged successfully and meaningfully with this clinical need. In this respect, the grounded theory to emerge from this work will highlight the nuances of what it is like to address an issue pertaining to abuse as a therapist, which intersects deeply with an aspect of the therapist's spiritual identity. It is unknown whether practitioners from different cultural and religious contexts integrate their faith clinically in different ways to a white British, female, Christian sample. This research might prove to be a springboard from which this and similar questions could be explored in more depth.

Given that this research project is intending to elicit a roadmap for other therapists wanting to work with RSA in their practice, I wanted to explore successful elements of

practice. The literature suggests that culturally responsive clinicians achieve better outcomes when working with clients (Fuertes, Costa, Mueller & Hersh, 2005). Interviewing therapists working with the same faith as their clients perhaps assumes that a reasonable degree of cultural competence is already in place. Magaldi-Dopman, Park-Taylor & Ponterotto (2011) studied psychotherapists' spiritual, religious or agnostic identities and their practice of psychotherapy. They concluded that when psychologists and clients were matched in terms of spiritual/religious/agnostic background, fewer challenges were reported. This was assumed to be because shared language and knowledge of customs helped place them at ease. Practitioners find it challenging and confusing to work with spiritual difference, especially when clients' spiritual beliefs are perceived as undermining their psychological wellbeing (Jackson & Coyle, 2009). In these contexts, therapists experience a conflict between respecting their clients' beliefs and their aim to enhance psychological wellbeing. Jackson & Coyle (2009) concluded that this conflict is the greatest challenge for therapists working with different spiritual beliefs. This literature further reinforces my decision to address the practices of therapists identifying with the same faith as their clients. If this research was primarily about the challenges of working with RSA, then interviewing therapists of any religious or spiritual orientation would have made more sense. Magaldi-Dopman et al's (2011) research suggests that beginning this current work with therapists with the same faith as their clients will enable a deeper focus on the 'what' and the 'how' questions, rather than focusing on difficulties that might arise in this sort of therapeutic work.

The Voices of Victims in This Research

I recognise that my own positioning as a researcher may privilege some experiences above others. A personal challenge in designing this research was whether to interview therapists or survivors themselves, given the possible parallel process of victims' voices being further suppressed. In light of Oakley's work, and work that has followed (e.g. Swindle, 2017; Ward, 2011), I decided to interview therapists as they may well be the gatekeepers to narratives of abuse that otherwise might not be heard. I appreciate that therapists themselves might also privilege some stories above others, and their own biases impact the way material is understood. I therefore took great care in this project to address therapists' own stories and the manner in which they feel this has impacted their capacity and willingness to address RSA in their consulting rooms. This emerged as an unexpectedly rich broader theme alongside the practical

recommendations that emerged from the data and is reflected upon in greater depth in the discussion chapter.

Interviewing and Self-Disclosure

I began each interview stating the overall purpose of the study and then asked an open question to invite respondents into discussing the phenomenon under investigation 'what would you like to tell me about the way that you work with SA and trauma?' thus bracketing my own assumptions and orienting the participant towards action and process (Willig, 2013). Charmaz (2014) notes that using 'what' and 'how' questions bring an analytic edge and supports the iterative practice of moving backwards and forwards between data and analysis. As the interviews progressed, I became more confident to follow the lead of the participant rather than my interview schedule (see Appendix 9) and found that this supported my following of the theoretical direction (Charmaz, 2014), thus deepening the emerging narratives.

I met six participants in their own therapy rooms to reduce inconvenience and financial costs given the self-funded nature of this project. I took appropriate lone-working precautions. I conducted three interviews over Skype due to distance (one participant lived in Northern Ireland) and my own recovery from illness, which made travelling unreasonably difficult at the time the participant was available. All interviews were undisturbed and took place in quiet rooms that were fit for purpose. Some participants wanted to know about my training and personal beliefs. I discussed this in advance with my supervisor because I did not want to be perceived as obstructive or distant but felt mindful of influencing the participants with my own stance. I settled on answering that faith has been a part of my story for a long time and I feel familiar with the Christian narrative and settings. During the interviews I used a mixture of content mapping to open up the dialogue and content mining to explore the details that emerged (Legard, Keegan & Ward, 2007).

Recording and Transcribing

I used a digital recorder for each interview with the voice memos function on my iPhone for backup. Although arduous, self-transcribing extensively familiarised me with the interview data (Charmaz, 2006). Given that I was not undertaking full linguistic analyses, and feedback from my first interview suggested that it was challenging to read verbatim transcripts, I began excluding participants' natural faltering over words and most of my interruptions (e.g. 'yeah', 'mmm'). Brinkman & Kvale (2015, p.204) suggest that 'to transcribe is to transform' and essentially, transcriptions are de-

contextualised renderings of live conversations. Given the focus in this research upon communicating the nuances of the story to the reader and highlighting particular points, over the psychological interpretation of pauses and anxiety for example, I felt that a non-verbatim transcription better facilitated the later analytical processes that would follow. My experience was that this decision supported the analysis by focusing my analytical efforts on the words which held tangible meaning. Any identifying information was removed during the transcription stage and if there were any ambiguities concerning data that might be identifying, I checked with my participants regarding their willingness for it to be transcribed verbatim or not.

Theoretical Sampling and Theoretical Sufficiency

GT invites the researcher to continuously review the direction of the research and adjust it as necessary (Charmaz, 2014; Willig, 2013). During the interviews, topics of interest emerged that I had not explicitly raised with earlier participants. Asking subsequent participants questions shaped by previous participants' responses employed the GT method of theoretical sampling whereby emerging data informed subsequent data collection and contributed to a refining of the codes and focused codes. The primary purpose of theoretical sampling is to 'elaborate and refine the categories constituting your theory' (Charmaz, 2014, p.193).

In order to focus on the quality of data collected, sample sizes were not predetermined before the research began and the emphasis was upon the quality of data as it emerged. I planned to interview 9 therapists and realised that the data was rich and varied enough not to require further participants. I had further avenues that I could have pursued in terms of recruitment but did not want to collate more data than I had the capacity to analyse. However, in order to extend theoretical sampling towards theoretical saturation, I returned to existing participants to gather further data once the initial round of coding was complete. See the section entitled 'second stage data collection' (p.56) for further explanation of this. Dey (1999) suggests using the term sufficiency instead of saturation, which appears to better complement the less positivist GT. I therefore adopt the term theoretical sufficiency in the remaining sections.

Assessing Quality in Grounded Theory

Quality control varies in research, and indeed within different GT perspectives, depending upon the particular epistemological and theoretical perspective adopted. Lincoln & Guba (1994) suggest that the worldview of the investigator guides the

researcher, not only in terms of the method but also in epistemologically and ontologically fundamental ways. For example, the positivist benchmarks of rigour used within the quantitative paradigm include validity, reliability and objectivity, as would be expected of a scientific observer. However, when the investigator is seen as the orchestrator or facilitator of qualitative inquiry, their ability to convey data with authenticity and trustworthiness becomes more relevant (Lincoln & Guba, 1994).

Yardley (2017) asserts that assessing quality within the qualitative paradigm can be broadly grouped into four different dimensions: sensitivity to context; commitment and rigour; transparency and coherence; and impact and importance. I find the non-prescriptive nature of Yardley's (2017) criteria as set out below compatible with the constructivist approach to GT and therefore explain in more detail how I believe this study has meets Yardley's criteria. Specific elements of increasing quality within GT methodology are woven into Yardley's (2000; 2017) criteria as appropriate, as adopted from Hutchinson et al (2010) and Charmaz (2014).

Sensitivity to Context

This is displayed by showing awareness of the participants' settings and perspectives, the socio-cultural context of the research and how this is influenced by myself as the researcher. I acknowledge the limitations inherent within this study given the Western-Judeo Christian bias both in terms of context and participant characteristics; this should be taken into account when considering the generalisability of the conclusions. Whilst this study explored the therapeutic stance of Christian therapists working with clients who have experienced RSA from within Christian places of worship, some therapists discussed how their work translated into work with clients of other religions (e.g. Maria). The analysis must be sensitive to the data itself and not impose preconceived categories upon the data. In GT, this is achieved through a process of concurrent data collection and analysis, meaning that ongoing data collection is shaped by the analysis that comes before it (Charmaz, 2014; Hutchinson et al, 2010). In the current project I remained sensitive to the evolving data by updating the interview schedule based on previous interviews and themes that seemed to be emerging.

Commitment and Rigour

These are achieved through in-depth engagement with the subject area via sufficient data collection and in-depth analysis. Rigour refers to the completeness of the data collection and analysis. I explain the use of initial coding and coding with gerunds as

methods for staying close to the data in the following subsection on data-analysis. Triangulation is suggested as a means to achieve a multi-layered understanding of the research topic, of which there are different forms (Denzin, 1978; Patton, 1999); I conducted triangulation of sources, which involves collecting data at different points in time. Nine participants were interviewed in the first round and five of these participants returned a second round of data collection (via email, thus also generating data via a different source). This process ensured consistency between responses, which increased my confidence in the original data collected and contributed towards theoretical sufficiency, ensuring that no new insights were being generated (Hutchinson et al, 2010). I also employed respondent triangulation by sending copies of the transcripts to all of my participants and requesting their feedback upon whether it was an accurate reflection of the interview. Following feedback from one participant, who found verbatim transcription difficult to follow, I decided to use the non-verbatim method as described by Brinkmann & Kvale (2015). Systematic comparisons are an important component of GT methodology and I therefore employed memo writing and constant comparative analysis. I discuss these processes as they relate to GT in the following sub-section.

Transparency

Transparency demands clear interpretations of the data and an audit trail of the research process which I believe I have made clear with a detailed explanation of the methodology chosen and techniques used. Along with respondent triangulation, I asked two critical research friends from Metanoia (one of whom was using the full social constructionist method of GT) to cast their eyes over a segment of the analysis and match up the focused codes that I had chosen with the raw data. This ensured that I was following the data accurately and I include an example of this exercise in Appendix 10. I include rich quotes and excerpts from the data within the analysis, including opposing views (Charmaz, 2014).

Having recently left church settings because of my own interpersonal and intrapsychic struggles with the context, I felt at risk of holding potentially negative preconceptions about the usefulness and effectiveness of therapeutic training grounded in Christian principles. However, as a psychotherapist, I am practiced at reflexively attuning to the other whilst bracketing my previous knowledge and remaining in touch with my own thoughts and feelings (Etherington, 2004). Holding a reflexive position means examining the influence of my own assumptions, positions and interests on the

developing inquiry, whilst paying attention to the very ways in which my own position brings me into the research process (Charmaz, 2014). Engaging in reflexive practice is critical because it prevents a forcing of my own preconceptions as a researcher onto developing focused codes and categories. The suggested remedy for this is to treat my own ideas as problematic as well as those of my research participants (Charmaz, 2014). I kept a reflexive research journal after each interview to support the management of any preconceptions or biases, which might have impacted further interviews, and to illustrate my part in the co-creation of the data collected transparently. An example of a reflective memo can be seen in Appendix 7.

Importance

This refers to the significance of generating useful data. I have reflected at all stages of the process upon why I believe this is an important area for research and believe that the data collected reflects the question that was asked of participants, with applicable implications for practice that could be used, and extended, by other therapists interested in engaging with RSA in their practice. See pages 137-142 where I discuss the contribution of this research and recommendations for practice in depth.

Data Analysis

Generating Theory - Using NVivo 12 Coding Software and Coding Strategies

In this section I explore the data analysis procedures employed within this project and my usage of NVivo 12 for MacOS. Hutchinson et al (2010) suggest that computer-assisted qualitative data analysis software (CAQDAS) can facilitate the development of good quality GT research. Bringer et al (2006) demonstrate how CAQDAS can successfully facilitate GT investigations, explaining that QSR-NVivo helps with the progression of analysis from thick description towards explanatory models grounded in data. Critically, NVivo can be used to facilitate the iterative process of GT thus enhancing the study validity (Bringer et al, 2004). I felt at risk of being overwhelmed by the more manual, paper-based approach, and with 110,000 words of interview data, feel in retrospect that using CAQDAS supported an organised and methodical approach which ultimately enabled me to remain creative rather than feeling swamped. The following sections highlight how NVivo was used to facilitate a CAQDAS bringing-to-life of GT methodology within this study.

Initial Coding and Using Gerunds

After uploading transcripts into NVivo, I embarked upon initial or line-by-line coding (Charmaz, 2014). This was an intense process, generating over 2000 initial codes

(labelled 'nodes' in NVivo but referred to as codes from here-on-in). Coding with gerunds refers to the process of categorising segments of data with a short name, simultaneously summarising and accounting for each piece of data (Charmaz, 2014). Gerunds foster theoretical sensitivity by encouraging the coding focus to become enacted processes thus facilitating the development of connections within the data (Charmaz, 2014). I did not use existing literature at this point and remained open to the myriad of different theoretical directions in which my data could have taken me. In this way, codes were created from the data itself (Charmaz 2014). Codes were assigned twice to different pieces of data if the content was practically identical between transcripts. Given more experience with NVivo, I would have begun the process of focused coding sooner, but a full and sensitive immersion in the initial coding process meant that I progressed to develop focused codes and analytical themes quickly. When participants said something particularly poignant or representative of an emerging theme, I coded it 'in-vivo' (verbatim). I conducted initial coding after each interview, except on two occasions where two interviews were conducted across two days for geographical reasons. The benefit of concurrent data collection and analysis was the gradual refining of the interview schedule depending upon interesting themes emerging, in line with the iterative requirement for GT (Hutchinson et al, 2010).

Focused Coding and Constant Comparative Analysis

Focused coding means using the most significant or frequent earlier codes to sift through and synthesise large amounts of data. This helps determine the adequacy and conceptual strength of initial codes and begins to advance the theoretical direction of the study (Charmaz, 2014). I found myself moving initial codes around so that they better reflected the title of the focused code. Sometimes I used the most powerful sounding initial code as the name of the focused code, and other times I chose a name which could broadly accommodate a group of initial codes. I reflected upon the analytical power of groups of initial codes and ensured that several transcripts were represented within each focused code. This is where NVivo12 really began to shine, because this sort of comparison between transcripts is what it was designed to achieve. As an analytic tool, it can be used creatively and sensitively by the researcher (Jenkinson, 2014), whilst ensuring validity, accuracy & rigour (Richards, 2014). This systematic comparing of codes between transcripts in order to organise the initial codes (Charmaz, 2014; Hutchinson et al, 2010) supports the development of both conceptual and theoretical depth (Pidgeon, 1996). This constant comparative analysis

as a key feature of GT (Glaser & Strauss, 1967) ensures that analytic distinctions are made at each level of the work and that comparisons are made both within and between transcripts. Spacing my interviews so that I had time for initial coding between most of them meant that this level of comparison of transcripts could be undertaken in meaningful depth. Owing to the volume of data collected, I decided that attempting to represent every focused code within the grounded theory presented would risk diluting the findings and not address the chosen research. Therefore, in the appendix where I give an example of two transcripts (Appendix 8), the term ‘unused focused code’ can be seen where initial codes had been grouped into a focused code, but this focused code spoke less directly to the question under the spotlight. This data has significance, largely because it speaks to the clients’ experience; further research questions might therefore be asked of this data. Appendix 8 includes segments of data from different transcripts, highlighting the allocation of initial codes to focused codes and ultimately, the three core categories. In the table below, I illustrate examples of how representative interview responses were assigned to initial codes, focused codes and core categories.

Interview responses	Initial code	Focused code	Core category
‘my experience has been that it fosters much more trusting relationship between me and my clients’ ‘I rarely disclose my own background unless I believe it would be helpful’ ‘a little bit of self-disclosure has always opened the doors for them to feel safe’	Mutual disclosure of faith increased client’s sense of support Own spirituality rarely disclosed Self-disclosure facilitating client’s sense of safety	Therapist’s choice to disclose faith	Positioning self
‘it helps them to see that they were powerless in that situation and that actually, it wasn’t their fault’ ‘There also are implicit ways that I try and balance that power’ ‘Somehow that's not quite magic, but what about their prayers? Whenever it has happened, I've encouraged the client to pray as well’	Powerlessness of client Implicitly managing power dynamics Encouraging equality when praying	Reflect on power processes	
‘Once you can separate church from Jesus then they can start to realise actually that wasn’t a really positive experience was it?’ ‘sometimes when it’s appropriate I’ll try and show people how David handled his anger in the Psalms. That doesn’t happen very often but occasionally, occasionally…’ ‘I think it's essential, actually, for therapists	Jesus and church need to be separate constructs Biblical examples used when appropriate Working with spirituality	Informed by the Christian narrative, but not dominated by it	Holding tensions and boundaries

that are going to work with spiritual components to know what they're talking about, to know whether what's happening is biblical, so they can tell what's going on'	demands knowledge of theology		
'I think there are some people who are immediately in tears and can talk about it quite openly and I think there are others who find it extremely difficult to talk about, and actually, it takes time to actually tease out the details'	Clients respond differently to knowledge of their spiritual abuse and trauma	Choose to label RSA or not	
I am going to be triggered with regards to how I work out my faith in my life when you've listened to so many stories' 'I think I keep a healthy balance in my life by … I wouldn't want to work with too many clients who have been abused in any way at the same time'	Impact of the work feeds back into the therapist's faith Managing caseload to ensure self care and availability for clients	Manage self-care and negative impact	Orienting towards hope and healing
'I don't do discipleship, no' 'It's not all my responsibility, you know, growth and faith are not necessarily my job' 'I'm not their minister, and I don't believe it is helpful for them for me to start having a debate about why theologically there are other views or whatever, because then it just becomes an academic exercise.'	I don't do discipleship, no. Therapist not responsible for all elements of client wellbeing Not letting therapy become a theological academic exercise	Prioritise therapy over theology	

Table 2: An illustration of how raw data fitted into open codes, focused codes and core categories

Generating Theoretical Sufficiency (Second-Round Data Collection)

The main aim of a second round of data collection was to develop the conceptual and theoretical development of my analysis (Charmaz, 2014, p.198). Throughout the first round of data collection I developed my questions depending upon what was emerging in the data, and then used the second round of data collection to further build on these themes. Data collection was therefore informed by the analysis in a continual manner throughout the process. The second round of data collection therefore focused on the categories emerging when focused codes were grouped together. For example, it became clear that I needed to ask more questions pertaining to the specific interventions therapists make when working with RSA and how they cope with the negative impact of focusing upon trauma in their clinical practise (see Appendix 11 for the final letter sent to participant requesting their participation). Instead of adding new participants, I aimed to saturate existing categories. Having received data from the second round of questioning I was confident I had reached theoretical saturation; no new properties were emerging, and patterns could be seen within the data (Charmaz, 2014). Sampling at this stage was therefore aimed at theory generation and contributed towards achieving theoretical density (Hutchinson, 2010) thus further fulfilling the methodological stipulations of GT.

Memo Writing

Memo writing is the intermediate step between data collection and analysis in GT; it prompts early analysis of data and codes within the research process and from collections of memos, categories start to form (Charmaz, 2014). There is no one specific way to write a memo, the process being idiosyncratic to each researcher. Hutchinson et al (2010) delineate different types of memo including that of a research diary, reflective or conceptual memos, emergent questions, explanatory or technical memos and literature-related. I kept a research diary throughout the process, and reflective memos which I completed after every interview. This helped me go into each interview with a clear mind for each participant whilst acknowledging any impact of interviews that had come before. Willig (2013) suggests that memos should always show up changes in the direction of the analytic process and emerging perspectives, as well as reflections on the adequacy of the research question. I significantly changed my theory between drafts 1 and 2 of this thesis because it became apparent that my codes needed to better reflect action-based processes. I detail my thinking on this subject in a memo, and give examples of other memos that I found helpful in Appendix 7. Because of the depth of initial coding and the links that emerged organically

between focused codes, most of my memos were written as I reflected upon writing up the analysis and developing a theory.

Conclusion

In order to identify and refine categories, and ultimately create a theory, grounded theorists use various key strategies to support this process (Willig, 2013). These strategies contribute to the rigour of an effectively executed GT methodology. This chapter has elucidated the key methodological components of GT and how I have incorporated them into the current research with a particular focus on ensuring both quality and validity. I then outlined my usage of these procedures thus evidencing my progression from data collection through to theory generation. Each of these analytical constructs form the building blocks of the GT method (Willig, 2013). The following chapter reflects the analysis of the data that emerged as a result of the interviews undertaken for this research.

Chapter 4: Findings

The aim of this research was to develop a theory reflecting how Christian therapists work with clients, who have experienced RSA in a Christian setting. I reflexively consider the process of developing the GT before presenting a pictorial overview and then a detailed explanation of the three major categories that emerged from the data. I conclude by reflexively commenting on my experience of the theory-building process and researching this topic.

Developing the Grounded Theory

The prospect of developing a theory initially seemed grandiose and somewhat overwhelming when considering my amassed data of over 110,000 words. These feelings were compounded by my not having a clear sense of what theory actually is. Charmaz (2014, p.231) notes that theory is a slippery construct both within GT and across the social sciences, with both positivist and interpretivist elements; 'it relies on empirical observations and depends on the researcher's constructions of them'. I have been engaged in an active process of interpreting the amassed data so as to best represent the core themes. Henwood & Pidgeon (1992) suggest that from the initial unstructured chaos of raw data the lenses become sharper as order is generated. The process of generating a theory involved coding individual pieces of data into approximately 2200 gerunds grounded in action-based process. Due to the active and interpretivist nature of this process (rather than dispassionately uncovering facts, as is implied by the term 'theory building') I adopt Henwood & Pidgeon's (1992) term theory generation. However, as Blumer (1979) suggests, any emergent theoretical account should be seen as the result of a constant flip-flop between ideas and research experience. This seems to fit with Glaser & Strauss' (1967) observation that each glance at the data could stimulate fresh perspectives, thus acknowledging the emergent, fluid properties of a GT.

Personal Reflexivity Relating to the Data Collected and Theory Developed

Arriving at the point of writing up my theory, I feel connected to my data having lived and breathed it for the past year through the planning, collection and coding stages. On the other hand, I have needed to be selective with the data presented in order to achieve the necessary depth of thought and analysis required. It feels uncomfortable not representing categories which, in many ways, speak to why I have undertaken this project in the first place. For example, my participants all spoke about their perception

of RSA; what it is, how it differs from other forms of abuse, and how their clients have experienced it. This resulted in focused codes labelled ‘describing SA’, ‘profiling a spiritually abused client’ and ‘perpetrator characteristics’. These codes are clearly significant in understanding the lived experience of those who suffer RSA and their voices need to be heard. This data, though descriptive, rich and substantive in its own right, does not go as far towards answering the posed research question. I wanted to acknowledge this before proceeding to an overview and then more detailed analysis of the theory presented.

Overview of the Grounded Theory Presented

Whilst there is considerable overlap in how the interviewed therapists would work with clients presenting with other issues (e.g. reflecting on power processes, developing realistic aims with clients), the GT presented intends to draw out the nuances of the therapeutic relationship between a Christian-identifying therapist and their client when RSA is part of the client’s experience. Results indicated a particular emphasis upon how the therapists position themselves in relation to their clients, how they hold the tensions and boundaries inherent within this type of work, and their orientation towards hope and healing. A GT model illustrating this is presented below in Figure 1. The model is intended to demonstrate that the journey through therapy with each client is based upon the therapist navigating the tension between the personal and professional aspects of self as they relate to these three broad components. However, navigating these tensions may not happen linearly; as in a trauma-informed approach, the different components will be revisited depending upon the therapeutic emphasis at the time.

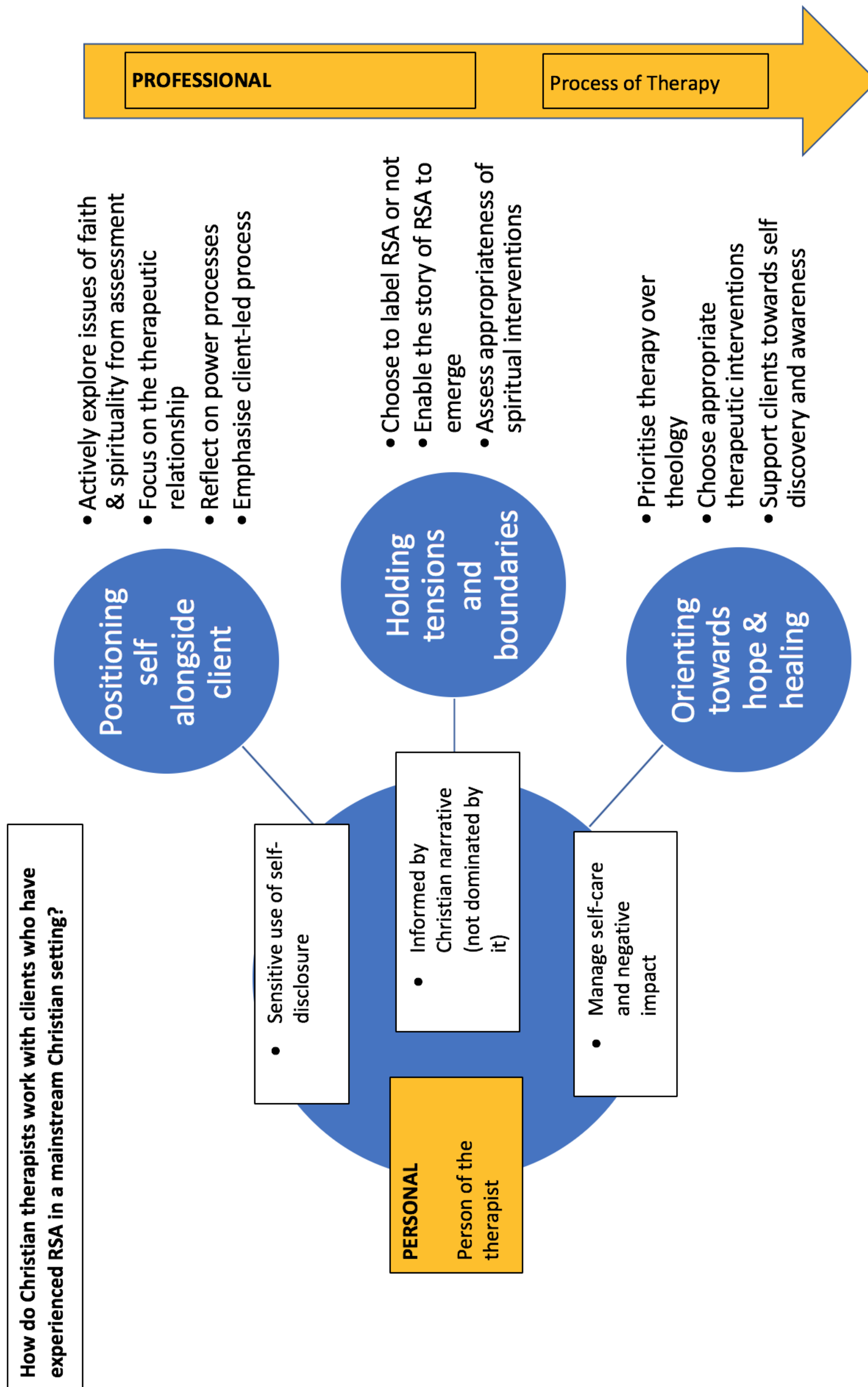

Figure 2: Pictorial Representation of Grounded Theory

• CORE CATEGORY	• FOCUSED CODES	
	Personal	Professional
Positioning self	• Sensitive use of self-disclosure	• Actively explore issues of faith & spirituality from assessment • Focus on the therapeutic relationship • Reflect on power processes • Emphasise client-led process
Holding tensions and boundaries	• Informed by the Christian narrative but not dominated by it	• Choose to label RSA or not • Enable the story of RSA to emerge • Assess appropriateness of spiritual interventions
Orienting towards hope & healing	• Manage self-care and negative impact	• Prioritise therapy over theology • Choose appropriate therapeutic interventions • Support clients towards self-discovery and awareness

Table 3: Core Categories and Associated Focused Codes

As the analysis unfolded, it became apparent that three core categories represented the therapeutic processes with which the therapists in this study were engaging during

the course of their clinical work. I conceptualise these three core categories as holding a professional component, which translates into therapeutic action, and a personal component, which may or may not result in disclosure to the client but nonetheless will shape the therapist's stance. The personal elements are represented to the left of the blue core categories and the professional elements, to the right. In this way, it becomes possible for the therapists to engage in a particular process (e.g. being informed by their own knowledge of the Christian narrative) but choose to manage this differently, depending upon their own preferences or the needs of the client in front of them.

Category 1: Positioning Self Alongside the Client

This category brings to life the process therapists went through in order to position themselves alongside their clients. As with the other two core categories, the professional positioning of self as the therapist was impacted by their personal positioning or choices, and thus there is a relationship between these two dimensions. At the heart of this core category were the processes involved in striving for equality and minimising power imbalances when developing a trusting therapeutic partnership with their clients.

Personal - Sensitive Use of Self-Disclosure

The two main issues subject to disclosure were whether the therapist disclosed their own experiences of abuse, and also, how they perceived an explicit disclosure of their personal faith when working with clients. This was a densely saturated code, particularly in the second round of data collection, speaking to the extent to which the therapists' personal experiences impacted both their choice and capacity to work with RSA. As Ann said, "the biggest thing I bring is experience. Personal experience". Overall the therapists were incredibly positive about the use of personal experience and felt that it added to their attunement, capacity for insight and relating at depth with their clients.

It seemed that personal experience of RSA, or abuse in other contexts, contributed significantly to the therapists' ability to tune into this aspect of their clients' experience, particularly because churches are stereotypically perceived as warm and inviting places. This in itself might make clients less likely to disclose RSA, for fear of not being believed. Because of this, there may be occasions where the therapists' self-disclosure reassures the client that they will definitely be believed when they share their story. Indeed, some clients had chosen their therapist because the therapists'

own stories were available in the public domain. Whilst the possibility for *"contaminating a client's story"* was raised by one participant (Monica), there was a general consensus that the empathic capacity of the therapist was enhanced by having weathered their own abusive experiences. Sophie explained that she would theoretically be in favour of disclosure, despite not having experienced RSA herself;

> *"If the therapist has received therapy and has processed and managed their trauma well, my experience is that the therapist is able to relate much better to the client undergoing a similar experience. We may show more empathy and may be even able to use ideas that helped them."*

Hannah reinforced this perspective;

> *"Having experienced considerable spiritual abuse myself, it is vital to work on one's own trauma/abuse issues first so that we are not triggered by a client's abuse issues. However, when clients can see that I have experienced abuse and have come through the experience with greater confidence and self-assurance it gives them confidence that they too can do the same."*

Lucy explained that her own experience of abuse was not of the spiritual nature, but,

> *"...has become a real source of strength in my therapeutic work because it does mean that I am able to stand with clients and not be overwhelmed by their story and know that there is hope for change."*

However, Emily raised an important point, that it is not necessary as a therapist to have experienced everything our clients have encountered, and indeed this would be impossible;

> *"Do you have to be gay in order to counsel gay people? Do you have to be transgender to counsel transgender people? Do you have to have been abused domestically to counsel those who've been abused domestically?"*

Sophie suggests that with regards to her faith (rather than a background of personal abuse);

> *“even though elements are the same, how the client and myself have experienced it are very different”*

I interpreted this as promoting a non-assumptive stance despite parallels existing between the clients’ and therapists’ stories. Self-disclosure in this sort of therapeutic work might also be important from the ethical stance of attempting to minimise power imbalances that would have been present in the abuse of power in the religious context.

This conversation seemed to align with a further question I asked of participants, relating to whether they felt only Christian therapists should do this work. Interestingly, whilst those with personal experience of RSA tended to feel passionately that this experience could be supportive to their clients when used appropriately, these same therapists did not believe that a Christian therapist is necessarily the right therapist for a spiritually abused client, particularly if seeing a Christian therapist might feel triggering. Early interviews with participants involved a discussion about whether they felt an explicit disclosure of their own faith was necessary in terms of positioning themselves alongside their clients. In line with the iterative nature of GT methodology, I began to enquire about this in later interviews. In retrospect, I wonder if my choice not to include this overtly as a research question in the first round of questioning reflected my own bias against sharing personal faith with my clients and my assumption that this might be a more private aspect of the self that should be bracketed off during clinical work. Deciding whether to explicitly disclose one's own faith to a client is significant from a personal perspective and is impacted by the therapists’ beliefs about the use of self-disclosure. However, from a professional standpoint, it might enable a more trusting partnership to form and implicitly communicates an awareness of the power imbalances that the client might have experienced. Alternatively, the therapist might feel that a personal disclosure would not benefit the work, and this is a valid professional choice. However, it became clear that in terms of positioning oneself alongside the client, sharing personal experience of faith might be an important factor in the client coming to trust the therapist. I was not initially expecting the participants’ choice to disclose their own faith or not as such a significant factor in their capacity to work with RSA or trauma. However, Sophie explained that,

"....my experience has been that it [disclosure] *fosters much more trusting relationship between me and my clients, when I feel I am able to be open about my beliefs. They see me more as a human than a professional, so can relate better with me. I feel more able to be myself, and not 'monitor' what I say as much as I would in secular practise."*

Sophie therefore felt that it impacted her authenticity, and in turn, this perhaps impacts the client's capacity to share their authentic experiences with her. Whilst this might seem unintuitive, especially when faith has been part of what was traumatic for the client, there was a sense that the therapists retaining their authenticity was seen as more beneficial to the client, rather than attempting to hide it. Indeed, many therapists questioned whether it is even possible to hide their faith, given its centrality in their lives, and this was reflected in their personal confidence in the clinical benefit of self-disclosure. Another therapist expressed similar views in the following way;

"I'm ok with my clients knowing I'm a Christian - it's a normal part of my contracting. I've worked hard on my own congruence in this area and no longer feel the need to hide or cover my spiritual identity. It's a significant part of who I am. In the same way as a black or Asian person cannot cover that part of their identity but they work with it in the client space. I won't introduce faith into the work unless the client introduces it and then we will work with it. It's no different in the secular space because spirituality often emerges in the work irrespective of whether or not they find me via the ACC." (Julia)

Perhaps given that faith is such a core aspect of one's personhood, to deny its existence is impossible. However, when faith has been part of what has caused the trauma experienced by the client, the choice to disclose personal faith is perhaps particularly weighted. What this does not mean is that it always needs to be explicitly expressed. Ashley expressed that;

> *"as far as I'm concerned, the only way in which my Christianity is in the room is because it's an intrinsic part of me…..It informs my decisions and informs my beliefs, but that's often where it stops, if I'm making sense….It is not going to come out of me in terms of any way of being construed as me trying to convert or just proselytise, whatever, I would only mention anything to do with it if it came from the client first".*

Monica expressed similar views;

> *"Also, my faith is very much part of me, so I can only sit with my clients as me. I can't sit as any other therapist. It would be wrong to even try to do so. I can't extricate my faith even when it doesn't get mentioned in the room, which is often, you know. Let's be real here. There are lots of clients I work with who come and they go, and they have no idea about my faith, and that's okay as well".*

Julia's view corroborated Monica's;

> *"I can't just say, ok God, get in your box, I'm going to do my client work and then I'm going to come back to you in a bit, it's part of who I am as well"*

Perhaps integration of faith into one's being is easier the more spiritually developed one becomes. As one therapist explained,

> *"it's coming out of Dualism and being much more open … I've become much broader and in some ways, it's made me secure in my faith and where I'm at with it" (Hannah)*

I developed a sense throughout the interviews that the therapists' groundedness in their own faith was related to their ability to both hold the presence of their faith in the room with clients, whilst simultaneously not projecting it, or an associated agenda, onto their clients. This led towards curiosity about whether they felt it important that their clients know about their personal faith or not. It became apparent when exploring the therapists' feelings about disclosing their own spirituality that it was a valuable perspective to address in terms of the way that they bring themselves therapeutically to clients. It seemed to me as if there was a tension to be held between not denying

faith as an important part of oneself whilst simultaneously remaining comfortable with the fact that it may, or may not, reach the point of overt disclosure to the client, and this tended to be client-led. The client's needs, therefore, mediated the therapists' decision to disclose or not.

Professional - Actively Exploring Issues of Spirituality and Faith from Assessment

"I want to know their whole context of faith and spirituality and how it fits into their life" (Joanna)

This was a densely saturated code and was not directly asked via the interviews; the importance of a rigorous assessment process organically emerged during questioning participants. It was clear from talking with all therapists that building a clear picture of their clients' spirituality felt clinically significant and connected to working with trauma when it originates from within a spiritual context. Therapists considered carefully how to frame their questions around assessing for spiritual or religious backgrounds, and open questions were considered important. Sophie explained that she asks very simply given the *"whole array of beliefs out there, and I would check in with someone about that, 'What is your faith?"*. This participant often worked with serious mental health illness, and when manifesting alongside spiritually based hallucinations/delusions, she routinely enquires as to;

> *"'...What do you believe this is? Where do you think this has come from? What kind of spiritual implements might this be?' I'd get that idea of what their spiritual background is. So, I'd assess what their spiritual beliefs are to determine what they think of it, then how they make sense of it."*

When the client knew that the therapist identified as a Christian, therapists made efforts to explore this choice with their clients rather than assuming their rationale for this. Ann explained that she will ask, *"You've come because I'm a Christian counsellor. Why is that important to you?"*. Other therapists discussed the importance of not making assumptions despite knowing that there may be a similar faith background.

Ashley explained,

> *"If it's somebody that I know from the start is a Christian, I will not automatically assume that they are believing to the same degree that I do. I would be very hesitant to do that. I would try to work out where somebody's at."*

Monica explained that her intuition plays a role in a faith-based assessment. She asks,

> *"either an implicit or an explicit question at assessment about whether someone has a faith if I sense that they do".*

Irrespective of whether the therapist established information implicitly or explicitly about their client's faith life, each prioritised addressing issues of spirituality or faith with their clients as part of their usual process at the start of therapy. When clients presented with known RSA, the need for this was even more obvious. It seemed as if the intention behind this was to gauge the extent to which clients were comfortable with explicit references to their shared faith, thus facilitating the development of a space which would lead to the conditions required for healing and growth rather than re-traumatisation.

Professional - Focus on the Therapeutic Relationship

Whilst not limited to working with RSA, the therapists I interviewed were unanimous regarding their perspectives on the centrality of the therapeutic relationship when addressing acknowledged or suspected RSA. The significance of establishing *"psychological contact"* (Julia) and properly connecting with an individual were at the forefront of the discussions which emerged along this theme. As well as the significance of psychological contact, Sophie highlighted that connecting spiritually with someone when a spiritual component enters the work is also important, perhaps more so than the particular therapeutic skills being used (e.g. cognitive behavioural therapy [CBT] or Eye Movement Desensitisation and Reprocessing [EMDR]). In retrospect, I might have found out more from the therapists about what it felt like to connect on a spiritual level with someone as opposed to not achieving this. In exploring with therapists the processes which best supported their clients' healing, Hannah responded;

“I believe that the one thing that underpins a client’s change or growth is the therapeutic relationship. They have been damaged in relationship and can be healed through a relationship that is the antithesis of an abusive one.”

Monica spoke poetically about the possible impact of the therapeutic relationship;

“It holds us in this beautiful therapeutic dance that can happen, or this challenging therapeutic dance that can happen, particularly when somebody has been extremely wounded at their core.”

Joanna spoke about how the therapeutic relationship goes above and beyond her expertise;

“I might have expertise or knowledge or whatever, but I never ever think they’re you know, ‘I’m this and they're that’ so it’s the therapeutic relationship and the trust in that therapeutic relationship and their trust in me”

Lucy spoke about the therapeutic relationship being grounded in the client-led principles of following the client’s pace, and that this facilitates the trust required so that;

“you're able to get to the bottom of the pit; without that trust, you’re never going to get to the bottom of the pit because they’ll never tell you what the bottom of the pit looks like because actually there’s always part of them that’s thinking, ‘I'm not sure I can handle that or ohhh, I'm not sure we can go there’”.

The therapists prioritised working relationally and with immediacy, thus emphasising the potentially reparative nature of developing a different template of relationship with the therapist that could be transferred to other relationships. Ann explained that *“what will happen in this relationship will help them have a context to explore where they're going and who they want to be”.* None of the therapists interviewed privileged their techniques over and above facilitating the development of a trusting and stable therapeutic relationship. Therapeutically, this can support the undoing of a religiously abusive context or relationship in which the victim is positioned lower than scripture or a person in perceived authority might be demanding of that individual. The centrality of the relationship in therapy is therefore a vehicle towards facilitating the development

of being able to trust again, when this has previously been broken within abusive dynamics. The nuance in working with people who have experienced abuse in religious contexts is that they might desire a healthier relationship with the context in which the abuse happened (e.g. church). In other abusive situations, the person might just be encouraged to leave. The significance of the therapist having their own faith might therefore directly model what a healthier, non-abusive shared faith relationship might look like.

Professional - Reflect on Power Processes

Participants gave rich descriptions regarding how they perceived RSA and at the core of these descriptions were abuses of power. I directly asked participants how they worked with differences of power in the therapy space and how they positioned themselves in relation to clients in order to impact any sense of power imbalance. As explained above, the client may be seeking a renewed, healthier relationship with their faith or those in power within their faith. The Christian therapist therefore plays an important role in modelling what a more equal relationship might feel like. Emily stated a central component of addressing issues of power in the therapy relationship;

> *"it's really challenging. Because that power dynamic …. You don't want to be another form of abuser"*

Joanna explained that the nature of being a 'professional' therapist sets up a power dynamic,

> *"the very sense that I might have some more knowledge or that I might have some more qualification or something like that brings a client into a place of looking to me as a person of experience and whatever and therefore the position in itself creates that dilemma"*

Monica explained that she wants *"to ameliorate the power imbalance as much as possible".* However, the therapeutic relationship can also be seen as a place to re-learn healthy power dynamics, as Joanna explained;

"if it ever comes up in me explaining about power in a Christian context then I will liken it, or explain a little bit about the dynamics in a therapeutic relationship to try and help the client understand the difference".

There were a number of ways, both in the implicit and explicit realms of relationship, in which the therapists communicated to their clients their awareness of power issues. Lucy spoke about encouraging a client to choose the colour pen that they would be using in their creative work; Monica spoke of deliberately choosing matching chairs in her therapy room to communicate a sense of equality; Julia spoke about wearing casual clothing because *"power was very much like the suit and tie"* in her previous church experiences. Julia also spoke about the significance of therapeutic pacing, *"being able to work with where they are"* and openly stating as the therapist when she feels she may have made a mistake. Sophie spoke of paying very close attention to her body language and tone of voice, and also the manner in which she talks her clients through issues, holding a curious and empathic stance. Sophie further acknowledged that in her work as a clinical psychologist,

"Even as hard as I might try to put a client at ease and to lower myself with them and be alongside them, they'll still be very unwell people that will still feel attacked and abused just sitting in a room with me."

This led into a discussion about how self-disclosure has sometimes, when used appropriately, *"been so helpful to change that power dynamic"* (Sophie). Ann corroborated this perspective;

"I've found self-disclosure has been very, very important to level the relationship".

Julia spoke about the possible benefit and necessity of addressing power and submission issues early on in the contracting phase, for example, in her work with men;

“if they’ve grown up with this theology of women submitting to men that women can’t be teachers, then I have to be really explicit with men about how they’re going to work with me on that one, because they will have a very different perspective of power.”

Julia also acknowledged that,

“in a way you work with spiritual abuse and power dynamics in the same way that you do with any issue”

Working with power in the therapeutic relationship is a central task, particularly when the presenting issue involves abuse. The process behind the therapists’ emphasis on reducing power inequalities was grounded in facilitating client autonomy; in the instance of RSA this was intended to help clients recognise and avoid abusive dynamics in future spiritual contexts.

Professional - Emphasise Client-Led Process

Therapists were unanimous in their client-led approach, the intention being to minimise power differences and support the development of their client’s autonomy. In the case of the clinical psychologist I interviewed, who worked with the most serious presentations, she was very clear with her clients in private practise that she,

“...would take on a non-expert role so I'm aligning myself with them, and saying, "Yes, I'm trained in this, but I'm here to go through the process with you. You are the expert of your experiences"’.

Perhaps unsurprisingly, given the client led emphasis, most of the therapists spoke about their work being underpinned by Rogerian core conditions. Working in a person-centred way seemed to align with Christian values, as explained by Julia;

“Offering the 6 necessary & sufficient conditions to develop congruence and awareness which facilitates forgiveness and healing especially in a faith-based context”

However, there was more of a sense that because of the deeply controlling and coercive nature of RSA, working in a person-centred way is necessary in order to

facilitate *"a collaborative exploration of your issues, this is not about me giving advice"* (Joanna), as this could mirror unhealthy power processes. Therapists perceived benefits of working in a person-centred way; Lucy spoke of learning from her clients and their personal expertise. The therapists were often careful to critique person-centred ways of working for its non-directiveness and limited use of challenge. For example, Lucy states;

> *"...it's not client-led in as much as I don't challenge because I definitely do, so it's not kind of person-centred inasmuch as you know, where the counsellor doesn't really challenge or suggest … but it's client led, to make that distinction, if that makes sense"*

And Julia,

> *"….if I sat with empathy and my incongruence and their incongruence and I was just non-judgemental they will never get there in a million years all I'll be doing is colluding with their abuse [mm] because I'll be avoiding them too so it doesn't help them at all so I almost say to them would it be helpful if I showed you this or if we talked a bit about this"*

Whilst the therapists interviewed offered the core conditions of empathy, unconditional positive regard and congruence, (and these core conditions are essential components of any trauma work), I believe the therapists were attempting to convey the extent to which they facilitate a client-led approach, with the intent of undoing harmful power imbalances as experienced because of the RSA. The data should perhaps be interpreted as conveying that whilst client-led, there is a potency within the work and role of the therapist that they feel perhaps isn't captured when only describing their work as person-centred. Sometimes it appeared that person-centred and client-led approaches were being conflated by the participants. This perhaps reflects a misunderstanding of the person-centred approach, or at least, a stereotyping of this approach as non-challenging. I consider the appropriateness of a person-centred approach for trauma work, and with RSA, in more depth in the discussion.

Category 2: Holding Tensions and Boundaries

This category highlights the fact that, as with other presentations, there is no one size fits all when it comes to treating RSA. Additionally, the inclusion of faith-based

narratives into therapy means that therapists were perhaps navigating more tensions than if spirituality had not been present or welcome in the work. Holding tensions and boundaries is intended to show that there is no right way to conduct therapy; in fact, to state that a certain way of practising is correct might uncomfortably mirror some of the fundamentalist and rigid theological frameworks experienced by the clients and many therapists within this study. Instead, there was a fluidity to their clinical choices. The therapists I interviewed explained, for example, that prayer might be appropriate in a session with one client, whilst being inappropriate for another. The nuance is that behaviours which might be non-negotiables in the therapists' lives (e.g. the use of scripture or prayer) could also be used therapeutically as clinical interventions as well, rather than the purely professional techniques they are trained in (e.g. EMDR). Managing the boundaries of using a non-negotiable in their own life therapeutically might involve being informed by Christian scripture, but not being dominated by the need to use this if not appropriate for the client in front of them. I explore this personal tension in more depth below. From a professional standpoint, a further tension to navigate is whether naming RSA is helpful for the client, and this is also explored in more depth within this category. In terms of the relationship of this category to the other core categories, the therapists' management of tensions and boundaries supports them in positioning themselves helpfully and therapeutically alongside clients. The aim of the therapeutic relationship is to facilitate healing from RSA and an orientation towards a healthier experience of faith or faith-based relationships.

Personal - Informed by the Christian Narrative (but Not Dominated by it)

The personal component of managing tensions and boundaries as a Christian therapist related to whether their role was to teach or disciple their clients back to a place of spiritual wellness. This might be tempting given the centrality of their own faiths and personal belief that spirituality is an important element of wellbeing. Despite the therapists' general sense of caution regarding retaining their therapeutic role over a role that might be better suited to a church minister, it was clear that their own biblical views and faith often informed the therapeutic process. Managing this tension often seemed to involve deciding whether it was appropriate for their background Christian knowledge to form part of the therapeutic dialogue or not, and if so, when to use it. Joanna explained that,

“I believe my awareness and knowledge of the dynamics of faith only seeks to build the therapeutic relationship and trust.”

Their biblical background seemed significant in supporting clients out of frameworks of belief that were perhaps scripturally unhelpful and psychologically damaging, for instance the oft-quoted example that to feel angry as a Christian is wrong. Lucy highlighted this;

“.... you know good Christian people don’t get angry and so, to give her permission actually, to be angry that no, this is appropriate anger and even looking at the times when Jesus was angry in the bible, and you know, the times when Jesus was angry, it's all about injustice”

Julia spoke of her own confident biblical knowledge as supporting clients to see forgiveness differently, despite their resistance towards this;

“So, when you can address the idea that God’s forgiven you, and then they’ll say to me well where does it say that in the Bible? And I’ll show them the scripture, I will say would you like me to show you? And they say, ‘yes please’, and then they’ll look at it and they’ll say, ‘I’ve never seen that before’”.

Julia further referred to a powerful example of her own understanding of forgiveness being used to transform a client’s relationship to themself, enabling self-forgiveness and ultimately, the ability to implement behavioural change and move on. Emily discussed that an understanding of the Bible, religious artefacts and theology, is helpful and supportive when it means that clients do not have to explain themselves or worry that they are not being understood. More generally,

“And in the same way, it's very important with any form of abuse, not just spiritual abuse. That you understand. And you don't go, ‘Yes, yes ... what’ Because then you've lost them.”

Sophie echoed this,

“I think it's essential, actually, for therapists that are going to work with spiritual

components to know what they're talking about, to know whether what's happening is biblical, so they can tell what's going on."

She explained that whilst she would treat Christian-identifying clients and non-Christian clients very similarly,

"the only difference would be that I would overtly talk about ... If they've overtly come as a Christian, wanted to talk about a Christian issue, then we might refer to biblical verses openly, like, "This feels quite biblical, how do you make sense of that in a biblical way?"

thus attuning to the needs of the client sat before her. Sophie had the experience of remembering being a therapist before she was a Christian, and researching something that a Christian-identifying client had said to her. She explained how her effort to do this, and to support her client's re-interpretation of a verse of scripture which had deeply impacted his mental health, was a turning point for him. This perhaps reflects the broader significance of therapists not dismissing a client's faith, and indeed showing interest in it, irrespective of whether they hold that perspective themselves. It was clear across conversations with my participants that their personal knowledge of God's love was something that informed their practice both implicitly and explicitly, and could be used as a therapeutic tool when appropriate. Sophie explained her ability to do this whilst maintaining her stance as a therapist;

"I would stick to the 'being a therapist' position. Kind of in a CBT way I would challenge their views of, 'Oh, God hates me,' with, 'Actually, let's look at the evidence of God loving you'".

For the therapist who has a personally meaningful and well-integrated Christian faith, it seemed as if this was an aspect of their personhood that was represented in their therapeutic style. Perhaps the overlapping intentions of being a Christian and a therapist converged in the consulting room, for example, the desire to serve and support others, and to help people who feel wounded to find healing. This code addressed how the Christian narrative as an integrated aspect of the self could be used in the service of clients and within the confines of working ethically, without scripture becoming a tool for coercion or control.

Professional - Choose to Label Religious and Spiritual Abuse or Not

Whilst the therapists I spoke with had differing personal opinions about whether RSA should be explicitly named with clients, there were some common threads in their responses. Firstly, as Hannah suggested,

> *"many Christians believe it's just part of being a Christian; it takes time for them to see that the behaviour is not acceptable, that it is abusive behaviour"*

This response highlighted that, as with other forms of trauma, the client may experience denial as a form of defence against the pain of having experienced abuse. For some Christians, who may focus on subservience and denying themselves for the sake of others, naming abuse as abuse may feel particularly indulgent, exposing or shaming. In order to counter this perhaps, the therapists unanimously spoke about the importance of labelling RSA in a manner that was attuned to the client in front of them. Sometimes this might mean not labelling RSA directly because of concern around shutting down the client. Managing this tension of naming or not naming RSA was held by some participants alongside whether this is the therapist's role anyway;

Hannah further described how clients ideally discover what RSA is for themselves,

> *"I hope that the work I do enables them to discover it for themselves because I think it resources them in a way that telling them wouldn't"*

Whereas Joanna stated that;

> *"it's very important to put a name to it because they otherwise will be left with, what is this you know?"*

And she felt this was significant because;

> *"when the client hears the word abuse it is putting the shift from them onto the other person, and so it's giving them then the sense and the realisation that the person was harming or harmful to them".*

Emily concurred with this, explaining that she may say to a client;

“Everything you're telling me is something that's been written about and it's called this form of abuse."

Emily sensed that this might be helpful because;

“And very often, the label helps. Like, ‘Wow, yeah. It's real, it's not in my head’".

I think it’s significant to note that both Emily and Ann were situated more closely to RSA because of their particular backgrounds, and so are perhaps more likely to encounter clients with a greater awareness that this is what has happened to them. I therefore felt that their interventions were validating what may already be known at some level, rather than perhaps illuminating RSA for the very first time. Both of these therapists still trod carefully, with Emily explaining that;

“.... you’ve got to be careful that people don't feel really stupid. Because, ‘What? How? How? How have I gotten into this situation? I've been abused? I've been abused?’"

Sophie also suggested that if a client had perhaps experienced RSA but did not have any sense of spiritual activity in their lives currently, it may be undermining of their perception of the therapist to experience it being named directly. If this were the case, Sophie explained,

“If I still believed there was a spiritual component, I'd continue exploring with them, but I wouldn't name that overtly, and I'd try and guide them to say those things themselves, or to figure those things out for themselves.”

Therefore, the choice about whether to name RSA with clients was a nuanced decision made sensitively by the therapist depending upon the client’s needs. This is where RSA differs to sexual abuse, for example, where there perhaps would be much less debate about whether it is appropriate to name it. However, given the nature of RSA as being open to interpretation and personal perception, the skill of the therapist was perhaps partly reflected in their ability to sensitively determine the needs of the client in relation to whether defining their experience as RSA would help or harm their healing process.

Professional - Enable the Story of Religious and Spiritual Abuse to Emerge

Monica reflected upon the reality that,

> *"often when clients come, and we work out what the presented issue is, or they tell us what the presented issue is, holding the possibility that that may not be the deep presenting issue"*

This implies that RSA is not always obvious, or indeed explicitly labelled by the client. I wondered if part of what supported Monica in her recognition of RSA, especially if it's a hidden aspect of the client's experience, is her belief that spirituality is;

> *"a very important, precious part of that client, whether they acknowledge that or not."*

This suggested to me that therapists' personal beliefs about the inherent value of spiritual processes impacted their choice of therapeutic interventions and whether to explicitly name RSA, especially when it has never previously been named as such. However, rather than being therapist-directed, the mutuality of the process of attuning to RSA in her clients' narratives was described by Monica;

> *"more often than not in my experience, there's a gradual, maybe a mutual understanding if I'm working one on one with somebody, that maybe something wasn't right".*

Joanna concurred with this, as did Julia;

> *"very often you don't know spiritual abuse is there until you get into the work"*

Emily fleshed out what this might look or sound like as the therapist receiving this information;

> *"Sometimes it comes up just as an aside, almost as they say, the doorknob effect…. sometimes it's just dropped into the therapy session and left hanging just to see if I'll pick it up. Sometimes it's an odd word or a phrase, almost to test the water to see if I'll pick that up."*

This wasn't a universal experience, however, and two therapists suggested that their clients were much more upfront about their experiences of RSA, likely because of the positions held by those therapists. Ann explained her experience;

> *"I suppose I've always found that it's come up really quickly because they're in therapy because it's a big deal... it's a miracle they're sitting there. So, I would have to assume they're ready to face the trauma of the abuse and talk about it"*

Sophie corroborated this point,

> *"It's just generally people feel like they want to offload this kind of thing, that they don't want to keep it secret"*

Perhaps unsurprisingly, therapists who were known for their work in this area experienced clients disclosing their experiences of RSA faster compared with therapists for whom this type of work wasn't necessarily their specialism. The implication of this is that the clients' perception of their therapists' willingness to receive their story holds an important bearing on whether their experiences of RSA will come to light. In this study, all of the therapists interviewed were prepared to hear stories of RSA and facilitated the development of a therapeutic space that enabled narratives containing RSA to emerge.

Professional - Assess the Appropriateness of Spiritual Interventions

This code explores whether therapists holding a personal Christian faith use spiritual interventions in the room with clients and whether this is more of an implicit or explicit process. More so, when Christian clients have experienced these expressions of faith in a way that could have caused harm, how do therapists use them in a way that isn't retraumatising and non-therapeutic? I see this code as a professional counterpart to being informed by the Christian narrative; should knowledge of faith and expressions of faith as personally experienced by the therapists come into the therapeutic space, and if so, when and how? Lucy suggested that,

> *"it's important when working with people of faith that you don't make any*

assumptions and that actually you know, even though they are people of faith, the ones that I work with even today, I still have conversations around, ok, so how much of God do you want to be in this process?"

This relates also to how the therapist positions themselves alongside the client, particularly the way in which they might choose to actively explore issues of faith and spirituality from assessment. Lucy explained finding the language of 'continuum' enabling for clients;

> *"I would say it's really important that they're not shamed in that process, so I say to them, some people, I've got clients who don't want prayer at all, I've got other clients who do want prayer, I've got other clients who want verses of scriptures and I've got others that don't – where are you on that continuum?",*

thus emphasising a client-led process in terms of introducing spiritual concepts and God into the therapy space. She warned against failing to address this early on though, because,

> *"I think as a therapist you always have the responsibility to talk about the elephants"*

In this context, elephants refer to unspoken expectations from the client about how much they would like spirituality to be present in their therapy, but the responsibility was firmly felt by Lucy, and other participants, to belong to the therapist rather than the client. This was perceived to be particularly important when the client knows that the therapist is a Christian - what does it perhaps communicate to the client if, as a Christian therapist, this is not outwardly addressed?

> *"If I don't have that conversation, how do I know that the client is not thinking 'oh, I wish she'd pray, or it's awful that God's not part of this process'".*

Some therapists spoke about the inevitability of spirituality being present, simply because it is a part of them that cannot be removed *but "whether that's acknowledged or not is client-led"* (Monica). Lucy echoed this almost entirely;

"So, my faith absolutely underpins who I am, which facilitates me being who my clients need me to be but how much God is in the room very much depends on the client and very much depends on, even where they are at in their story"

Therapists also tended not to make the assumption that just because it has been acceptable to bring God or religious interventions into the room overtly at one point in the therapy, it will always remain this way. The process is an ongoing negotiation with clients, requiring attunement and sensitivity. Removing the shame from either option was also considered important, particularly for Christian-identifying clients who may not want God or spiritual processes mentioned in their therapy at all (Lucy). Julia spoke of managing this ongoing negotiation through careful use of language, using whatever language her clients were using. She also spoke about more implicit dimensions of spirituality being present;

"very often you're sitting with a client and you can feel the holy spirit in the room, and in the silences, you can feel the love of God just touching them"

Emily highlighted that even when clients bring spirituality into the room overtly,

"they don't necessarily want you to come back with it because that's part of the oppression that they've come out of"

again, reinforcing the extent to which therapists seemed to be keeping one foot in their own experience and using it if required, but the other foot firmly planted in the reality of their client's experience within any given moment. Emily also said;

"Never be dismissive. Never, I never quote ... I'm Christian, I haven't gotten knowledge of Koran or anything else, I don't pretend to have. But clients I work with are, they're coming generally through a Christian form of belief. Never quote the Bible back at them."

We discussed more practical expressions of spirituality used in therapy, such as prayer, but the decision to use this outwardly seemed less usual than the therapist finding it a personally supportive mechanism in their role as therapist. For example, Sophie explained;

> *"I have been known, on more severe occasions, when the client's left the room, to pray it over their chair and to continue praying in the room after they've left, for a few minutes, and to hold them in my mind and keep praying strongly for them...I believe the power of prayer in therapy is also very useful, whether or not you're saying it out loud to the person."*

Sophie further described how powerful she experiences prayer to be;

> *"I think that was one of my defining points with my faith and my practice, when I certainly realised, 'Hang on a minute here, this is actually real, and I've gotta take this seriously, and I've got to do more prayer in sessions 'cause this is what really works'".*

Ashley also mentioned the personal impact of prayer for herself;

> *"Before every session with every client, I do a quick prayer to ask God to get me in the right frame of mind to be as I need to be, and to acknowledge that he's with me."*

The use of prayer was also noted to be linked to possibly detrimental power processes, because the client may perceive the therapist's prayers to be more powerful than their own, or to be linked to a belief in the client that God might start working (Monica). Monica remarked that she rarely prays in the room with clients, but when this has occurred, she has asked them to pray as well to ameliorate the impact of any perceived power imbalance.

Category 3 - Orienting Towards Hope and Healing

This code intends to represent the orientation of the therapists towards supporting their clients towards freedom from their abuse. I labelled it as 'hope and healing' because some therapists suggested hope was held by them when the client couldn't hold it for themselves, and healing, because this intersects with the Christian narrative.

Personal - Manage Self-Care and Negative Impact

In supporting clients towards healing, and because of the trauma-based nature of this work, the data reflected an emphasis upon the therapists' self-care so that they could effectively and ethically sustain their practice. The participants spoke about the impact of community and general wellness, personal beliefs and supervision in terms of their

self-care needs and how they go about facilitating these. Hannah commented how she *"has a huge amount of support in all sorts of ways"* including *"about 10 people who pray for me regularly".* Furthermore, she perceived her pastor, eldership, church and friends to also be very supportive figures for her and therefore did not see herself as working in isolation. Monica discussed the significance of;

> *"Making sure that I have fellowship myself, that I connect with people outside of the counselling world, that I also have a hobby that fulfils me and takes me completely away from this sort of work, which is music for me, in any one way, shape or form, so that my life doesn't become totally about this work."*

Monica further commented on the Christian organisation she works for who provide a very supportive team environment. Joanna spoke about these trusted people who understand her personal journey and about her work life, but that the number of people has narrowed, as she has discovered what she needs and who can be of the most support to her. She also spoke about *"connecting with other people who are counselling in this area"* thus emphasising again the significance of peer support from trusted colleagues. Sophie spoke of the shared faith that she has with her husband, and that sometimes they pray together about her work. In terms of personal beliefs, Sophie discussed how;

> *"The external intellectual side of theology, but also, the internal guidance of God, I think would be my influence."*

and,

> *"I believe that my faith is much stronger than what the world says, and biblically we're told that the world will criticise our faith and will attack us for our faith and what we do with our faith, so I should expect the world not to like my ideas".*

It seemed clear from these comments that the personal faith identity of the therapist deeply contributes to her resilience to work with the intensity of presentation and abuse that she encounters in her daily work. Julia also spoke about her own faith and beliefs as being incredibly supportive to her;

"I think the trajectory of change that I am on as Christian all the time is growing in the awareness of grace and that's a good thing"

Lucy has reflected on the question around negative impact for the therapist and explained that;

"the thing that facilitates me not being burdened by another's story is that I know it can change and I know it can be redeemed and because I fully know that and that is partly because of my own story, but because I fully know that I am never over-burdened by another's story because it sounds like it can change"

Indeed, Monica explained that she felt her own faith has grown stronger as a result of being a therapist, evidencing that whilst there is the potential for loss, difficult emotions and vicarious traumatisation, perhaps there is an element of the therapists' own faith that is stimulated by the challenge of working with toxic spirituality; perhaps highlighting what it is they hold onto, or what sustains their own experiences of faith and spirituality. Christians are typically encouraged to foster community both as a means to support each other and similarly, to create opportunities to talk about their faith to non-believers. Church provides an ideal place to develop community connections and I wondered with my participants how they manage this alongside their therapeutic endeavours. For example, what if one of their clients attends their church? Or, might they acquire clients from within the church setting? The issue of dual roles was discussed at length in this study and it came down to where the therapist drew their own personal boundaries dependent upon their own self-care requirements. Sophie challenged the notion of boundaries altogether, wondering,

"Thinking about why we need those boundaries, why do we need so much separation, at the end of the day we're all humans. Why do we need to hide ourselves so much with our clients?"

"If I were to say it like that, shouldn't we be seeing it as Christians to other Christians, shouldn't we be seeing this as we are brothers and sisters in Christ helping each other? …. in which case, there should not be therapeutic boundaries, just loving boundaries."

This discussion around boundaries seemed to raise a sense of internal conflicts between the role of a therapist and the position that a Christian may take on these matters. Sometimes, the therapists seemed to wrestle with reconciling the two roles, finding it difficult to retain the same type of boundaries they might otherwise employ, particularly because of the Biblical mandate to support those in need. Other narratives suggested that this felt unhelpful and failed to protect the therapists' boundaries enough, conflicting with their need for self-care. For example, Monica spoke of choosing not to work with clients from her own church to "keep life a little less complicated" and wondering how she would maintain appropriate containment for the client if they had seen her respond in an emotional way in the church setting. Joanna wondered about this also, but from the client's perspective;

> *"...what do you do when you see your client go in the front for prayer weeping copiously? Do you go and back them up? Do you ignore them? Do you step away?"*

Other therapists were much more comfortable with dual roles and seemed to feel an obligation to use their therapeutic skills in the church setting, because of their faith, and they manage this through implementing clear boundaries about the differences in the church and therapeutic relationships. For example, Lucy states;

> *"I do believe that I have decent skills and that these are my family so I actually, it's never felt comfortable to have all these skills and say oh I love you, but you can't have my skills …. that's not who I am…."*

> *"…. I make my boundaries very, quite strict, so it's like when I ask you how you are on a Sunday morning, that's different to how I ask you how you are on a Wednesday morning"*

In terms of supervision, this was discussed intensely, with an emphasis upon the significance of professional support of this kind. There were issues with it as well, including, as Ashley remarked, finding herself needing to *"cherry pick"* what she shared in supervision, because of the fact that her supervisor is not a Christian, and prefers that she does not bring her faith into the room. Sophie also experiences this working in the NHS context, where there is a stipulation that all clinical supervisors are

secular. Emily further discussed the challenge of supervision, and of finding the right supervisor;

> *"It's no good having a supervisor that you're not comfortable with, who is going to be feeling that their faith is being attacked or anything else…"*

And,

> *"it's a very fine balancing act actually because you don't want, it's difficult, you don't want a supervisor who is so entrenched in religion that they go 'oh you're insulting my religion I can't possibly talk about that' but equally you need someone who is open to religion and spirituality and it's a very fine balance, there aren't that many people out there…"*

Julia spoke about being aware that she needs to change her supervisor, because;

> *"what I don't want to be doing is dumping a whole load of negative baggage about church on someone who doesn't know how to receive that, so I find myself almost protecting my supervisor' which isn't healthy"*

It is therefore clear from the participants' comments that self-care is a lifestyle and not something that gets slotted in; it sustains their capacity to work in an effective and ethical manner with their clients presenting with RSA.

Professional - Prioritise Therapy Over Theology

I was aware of my own prejudice prior to conducting the interviews, wondering if Christian therapists might have an agenda to 'grow' their clients spiritually, or to ensure they found their way back to church. In this respect, I wondered whether this code should be situated in the previous core category 'holding tensions and boundaries'. However, I placed it here because the emphasis in the discussions was upon how the therapists positioned themselves when clients were ready to move on having worked through their trauma. I appreciated that this was partly because of how I framed the question, focusing it on whether therapists feel they have a responsibility to disciple their clients or help them navigate spiritual settings after an abusive church experience. However, I decided to continue to place this code within this category thus reflecting my own interpretation of the data provided, as is expected within the constructivist/interpretivist grounded theory methodology. Monica felt that "it's appropriate to recognise that therapy and spiritual direction overlap" but she also

explained that “I'm not a theologian and I'm quite happy to say that I'm not a theologian, I'm a therapist, but being open to referring somebody to see someone else is really important.” I felt this opened up a distinction between therapeutic work and work that is perhaps better suited to be managed by someone with a more in-depth theological training. There was an awareness amongst my participants that this can be a fine line to tread;

> *“I think one of the things we often struggle with is the boundaries between what we would call discipleship and the therapeutic space and where do they cross over?”*

> *“…we walk that tightrope all the time and I think a lot of it comes down to the boundaries that you establish in the first place and also, again your contract, what have you contracted to work with…” (Julia)*

Julia explained that whilst she doesn’t have an agenda for whether clients end up back in church or not, she does feel that it is her role to support the client in developing a healed view of who Jesus is. Sophie perhaps echoed this, explaining that in her practice with Christian-identifying clients,

> *“I'm a strong believer in reminding people about the positives, like the basics of Christianity.”*

Lucy explained that she sees her *“job as restoring her to the wholeness and the freedom that Christ came to set us free for”* but this is not to be confused with *“getting her to a place where she's a super-duper Christian”.* In summary, *“It's not all my responsibility, you know, growth and her faith are not necessarily my job”.*

Ann suggested why this might be the case;

> *“I'm not their minister, and I don't believe it is helpful for them for me to start having a debate about why theologically there are other views or whatever, because then it just becomes an academic exercise.”*

However, Ann highlighted the challenge in this, especially if clients want to get into theological discussions with her. And Sophie again registered the potential conflict

between being a *“discipler”* in the Christian sense and nurturing clients in their faith, compared to being their therapist;

> *“It's a bit of a personal dilemma there, that struggle between guiding someone with their discipleship, and being their therapist, and when can we be both”.*

Emily discussed the significance of non-defensiveness;

> *“I don’t thrust religion or spirituality down anyone’s throat, in any sense of the word, but I am open to discussing it”*

> *“I think it helps clients if they know you have some understanding of what they’re talking about whatever the situation is, but not to be defensive and try to defend religion or church or spirituality in any way”*

The therapists seemed to be holding in tension their role as a therapist and their role as a Christian, with the latter informing the former; however the extent to which this was obvious in the therapy relationship was determined by their clients. Irrespective of clients’ choices regarding the explicit nature of faith in the therapy room, the consensus remained that the role of therapist took precedence over a role of spiritual influence over the client.

Professional - Choose Appropriate Therapeutic Interventions

Given the emphasis in the research question relating to how therapists work with RSA, this was a densely saturated, action-based code and I present the highlights here. It was clear that the therapists worked integratively and incorporated elements of Gestalt and phenomenologically oriented psychotherapy, psychodynamic principles, CBT and humanistic frameworks into their approach. What was most clear, however, was the rootedness of the therapeutic relationship, and the extent to which this was understood to be the overarching factor impacting client outcomes. Thus, the person-centred approach was not core to their work but perhaps underlined it. Julia explained how she aims for *“a greater level of congruence in line with the 6 necessary and sufficient conditions in person-centred theory”.* As they become more congruent, they are able to see the abuse for what it was and recognise that this is not necessarily happening now”. Given that developing the core conditions as part of a stable working alliance is a well-established finding across modalities of psychotherapy, I emphasise

interventions that are grounded in the trauma-focused approach and abuser/abusive narratives instead within this analysis, and discuss in greater depth the appropriateness of a person-centred approach in the following chapter. These findings were grounded by the second round of data collection in which participants were asked what they felt underpins therapeutic change. Lucy discussed the shame that clients feel when they perceive themselves to be at fault for the abuse, particularly arising from a sense of not being able to keep oneself safe. She talked about helping clients to understand that because of the manipulation and grooming *“they were powerless in that situation and that actually, it wasn’t their fault”.* Lucy emphasised working with child parts to support clients into a more compassionate understanding of themselves if they were younger when the abuse occurred, and to help victims to understand why the perpetrator might have preyed upon certain vulnerabilities;

> *“we talk about what was going on for her at that age and stage of childhood, so that she’s beginning to understand the mindset of the needs of that little girl really and so that she can understand why she was drawn in by her abuser…”.*

As is characteristic of trauma work for other forms of abuse (e.g. child sexual abuse), Lucy noted,

> *“the thought processes tend to end up being stuck around the age and stage that the abuse happened and so being able to bring an adult’s perspective into it can just change that childlike thinking which can just move it along the process a bit really”.*

Having identified child parts and supported the client into a more compassionate understanding of them, Ann described how;

> *“I think ultimately my aim would be to integrate the child parts into the adult part and basically, because the child parts have had the attention that they need, they’ve essentially been loved better, so they just then disappear because they’re not needed anymore….so it’s that integration process that brings the healing”.*

Ann described her work with dissociative identity disorder as a result of profound abuse and her thinking about parts also integrates with less severe abuse and trauma

presentations. She referred to;

> *“working with the configurations of self, I will explore with them their different reactions”. More broadly, “So you've got your configurations of self, you've got your parent-adult-child of TA, and you've got the whole is greater than the sum of your parts of Gestalt, and what's in the foreground and what's in the back”.*

Joanna also emphasised the significance of psychoeducative processes underpinning effective therapeutic interventions for trauma;

> *“Separating God/faith from the abuser is a big part of the process of therapy because in a lot of clients’ minds they will be previously amalgamated. I use tools & questionnaires to help them understand this - what is spiritual abuse? How the abuser got the client to conform - what would the consequences have been? This helps them to understand the psychological dilemma they may have been in and the ’splitting’ between cognitions/beliefs and their traumatic responses of survival.”*

She is mindful, however, that,

> *“I would say there has to be, there’s a bit of a balance for me with regard to how you put the brake on and how you accelerate”*

thus applying Rothchild’s metaphorical approach towards how to work with trauma (Rothschild, 2011). And not undermining the importance of;

> *“tenderly working with the client to help them understand power and control”*

A CBT element was perceived as significant by Joanna here;

"Through using CBT to give an understanding of how the environment we grow up in helps to build our beliefs and thoughts about ourselves, others and the world - I will use timelines, genograms etc to help the client understand their attachment, family, environmental history that has informed them from childhood into adulthood. I'll look at previous traumatic history/events and what they learnt out of those. Through Sensorimotor Psychotherapy I'll help them understand the nervous system and neuroscience of body responses in terms of survival."

Sophie, a clinical psychologist, also emphasised the important role of CBT-based psychoeducation;

"I have recently found that a CBT approach to challenging thoughts has been useful, and incorporating religious beliefs into this….if they have fixed upon an unbiblical idea that makes them feel bad about themselves, I teach them in a CBT manner, to examine these thoughts and use discernment to see evidences for and against them, sometimes using the bible as evidence."

Modelling and educating clients about a healthy approach towards dealing with anger was mentioned by several therapists. Julia explained that she finds herself *"teaching people how to deal with anger before God"* and Hannah described that she *"work(s) with them to try and help them own the anger about it themselves".* Lucy described supporting her clients to feel *"permission, actually, to be angry that no, this is appropriate anger"*. However, the therapists used their sensitivity and experience to gauge appropriate pacing, as Julia describes;

"I think you have to be careful about pace because what you don't want to do is cause a situation where someone becomes derailed so much from what they knew of God [yeah] before they've integrated this new version of God."

Emily explained her emphasis upon,

> *"the mirroring, the pacing, all those techniques; I use those all the time, particularly with abuse clients"*

She also described the significance of language and the significance of careful phrasing. Sophie reinforced this,

> *"I think the words that you use when people are talking about these things can really, really help in terms of believability and empathy."*

Perhaps there is a tension here to be held between recognising the power of working with RSA effectively and with sensitivity, but similarly not elevating it beyond therapeutic capacities that the majority of well-trained therapists would hold, especially those with a trauma focus. Sophie reiterated this point stating that she is *"finding [her] feet dealing with each client as it comes, and playing it by ear, really"* thus distancing herself from a formulaic approach to trauma. This emphasis upon what each individual client needs speaks to a relationally oriented approach that emphasises co-creation and an equalising stance towards the client. Sophie explained how discussing her therapeutic stance towards RSA was quite challenging because;

> *"It's quite vague, but I think it's important to use those standard therapeutic skills that we would use with any other practice, and not treat it any different, not treat spiritual abuse any differently."*

This point has particular relevance given the intention of this project to diversify the body of therapists currently prepared to work with RSA.

Professional - Supporting Clients Towards Self-Discovery and Awareness

It was clear after speaking with my participants that a large part of what fuelled their passion for engaging in this sort of work was the hope they had for their clients' healing and self-discovery processes as a result of engaging with psychotherapy. I asked participants who engaged in the second round of questioning what they thought underpinned healing and effective interventions with clients and allude particularly to these responses here. Whilst RSA has elements of nuance that require different treatment compared with other forms of abuse, core psychotherapeutic processes still

apply, for example, the development of self-awareness. For example, Sophie explained;

> *"With any topic, they're just the same, we treat them as any other topic if they're talking about some grief or bereavement or something, we've got to guide them to discovering something themselves."*

This is true, also of trauma treatment, irrespective of the mode of abuse. Emily discussed a trauma-informed approach, recognising that therapy might be slow in *order to enable the client to develop a stronger sense of self;*

> *"'self' is quite possibly not the self that was; it can be really hard to let go of"*

> *…."that's why first stage [stabilisation] can take such a long time because clients often don't know what a new self might look like and feel like, what might it be like, how might it be relationally, how might it be inwardly, how might it be subjectively? All those things. And so, to develop that self, that's what really takes them a lot of time and a lot of energy, and bravery"*

Lucy spoke about helping clients into *"finding a place of peace"* particularly with regards to traumatic thoughts, so that *"they don't demand attention all the time".* Ultimately, *"it's that integration process that brings the healing"*. Her aim is;

> *"for them to feel powerful and autonomous, that's part of being an adult. It's part, it's part of being who God created us to be".*

This also illustrates the integration of her personal faith values and how they meet the therapeutic process, reflecting the unique element of RSA interweaving with faith compared with non-religious forms of abuse. Joanna's approach could be summarised as being grounded in empathic psychoeducation including naming and explaining RSA, helping the client understand how the abuser got them to conform and then dealing with psychological processes. The overall aim would be that clients can forgive themselves and engage with their anger, grief, sadness and loss. Joanna describes how, in her own practice,

> *"The greatest psychological change will be the reduction of blame, shame and guilt of self and placing the responsibility where it lies - on to the person in power!"*

Alongside helping *"them to understand the psychological dilemma they may have been in"* and the 'splitting' between cognitions/beliefs and their traumatic responses of survival."

The therapists also talked about how to help their clients be alert to the abusive processes they found themselves involved with, and to facilitate their clients taking responsibility for their own healing by ensuring they avoid abusive dynamics in the future where possible. Hannah explained that;

> *"part of my energy goes in helping them and supporting them and helping them to see and hopefully helping them to find wisdom and common sense, so they don't get themselves into that situation again".*

This might align with an emphasis Lucy placed upon helping clients find;

> *"an understanding of what was going on for the abuser as well and how they got to that place because you know, I think that can actually be really helpful for clients, to understand what was going on for the abuser that – because again they come believing that it was all about them and so often it's not".*

Ann explained this as enabling the client to see how;

> *"those narratives have may be been abused or manipulated, in order that the client is further controlled".*

In summary, clients' self-development was facilitated through an emphasis upon the development of their autonomy, in contrast to the controlled position that had caused them to become victims of abuse. A compassionate, trauma-informed approach underpinned the means by which therapists worked towards supporting their clients towards healed relationships with themselves and others.

Concluding Comments

Within this chapter, I have illustrated with quotations and examples how therapists work with RSA in their practise. I have highlighted the most salient codes within each category as they emerged from the data and will return in the discussion to points that warrant further thought. A key aspect of the findings relates to the person of the therapist and their own experiences of faith and RSA, and how these are (or are not) incorporated into their therapeutic practise.

Chapter 5: Discussion

"Man [sic] lives in three dimensions: the somatic, the mental, and the spiritual. The spiritual dimension cannot be ignored, for it is what makes us human".

Victor Frankl (1973)

As described in chapter two, I conducted the literature review in two stages in order to honour grounded theory methodology. Whilst the first part introduced the concept of RSA in the literature and made the case for conducting this project, in this discussion chapter I look more broadly to research that reflected the direction taken by the data. However, as is characteristic of a constructionist approach, I recognise that my own subjectivity is present (Charmaz, 2014). I continue to position myself as co-creating the following discussion between the data that emerged, my personal interests and inherent biases, which I explore throughout this chapter.

Overview

At present, minimal research pertains to how therapists work with RSA within mainstream Christian settings, the majority being anecdotal or written from the perspective of a pastor/lay-person without core therapeutic training (e.g. Diederich, 2017). Therefore, the primary aim of this research was to ascertain how Christian therapists work with clients who have experienced RSA in Christian settings, using a full social constructionist version of GT. Results indicated that therapists engage in three core processes, each of which has a personal and a professional component that needs to be navigated in an attuned manner based upon the needs of the client in the consulting room. The role of the therapist when counselling clients who have experienced RSA is largely similar to when working with any other form of abuse or trauma. The nuances this research uncovered were the ways in which the faith life, and sometimes the personal history of the therapist, influenced their clinical potency and decision-making. These findings have relevance for other therapists identifying as Christian, wondering how their own practices might extend into counselling those who have had experienced RSA. In a climate where many therapists find it difficult to talk about faith, and fear the appropriateness of this, the findings highlighted how the participants made space for their own faith and that of their clients, in a manner that contributed to the therapeutic work rather than detracted from it.

Later in this chapter I discuss how these findings might extend to therapists who either do not have a faith, or who hold a different faith perspective. In light of this, I discuss cultural competency as an important element of working with spirituality and religion in therapy, irrespective of the position of the therapist with regards to faith. I then discuss the potential impact of positioning oneself alongside a client with a trauma narrative, and the positive influence of personal faith as a supportive mechanism. This is followed by a brief discussion regarding bringing spirituality into psychotherapy and the implicit presence of the therapist's deep-rooted faith. I explore the choice to explicitly disclose one's personal faith and the use of religious interventions in the therapy room. Finally, I consider whether a humanistic approach is suitable for trauma-informed work related to spirituality and religion.

Developing an effective therapeutic bond when working with RSA

Voluminous psychotherapy research pertains to the significance of developing a solid working alliance for effective therapeutic outcomes, and the quality and strength of the collaborative relationship between client and therapist (Bordin, 1979; Cooper, 2008; Gelso & Carter, 1994; Horvath & Bedi, 2002). Accepted components of the working alliance include the therapist and client's agreement on the goals of therapy (the anticipated outcomes), the tasks of therapy (the processes that form the substance of the work) and the bond between the therapist and client, based on mutual trust, acceptance and confidence (Bordin, 1979). A core element of the findings related to how therapists relationally positioned themselves so as to develop an effective therapeutic bond with their clients and begin to address RSA. The tasks and goals of therapy, whilst an important component of the working alliance, are not as complex as relational positioning in order to develop an effective therapeutic bond. I therefore focus on issues in this discussion that pertain more specifically to the bond between the therapist and their client.

The personal component of positioning oneself as the therapist alongside the client was related to the sensitive use of self-disclosure both of personal faith and also, experiences of abuse. Kinmond in Kinmond & Oakley (2013) discusses the value she perceives in her own faith emerging in the work to support clients in their own recommendations for practice when working with RSA. The discussions in this area were rich and have been included for further discussion below. It seems pertinent to address whether a personal faith is an important component of developing an effective therapeutic bond when working with RSA. I acknowledge a limitation inherent within

this, because I did not discuss working with RSA from the perspective of a therapist who does not identify with the Christian faith. A corollary to this discussion became more personal, and moved from an academic discussion of whether being a Christian is important or not, towards the therapists' personal experiences of faith, and sometimes, their own experiences of RSA. I wondered what the impact of having experienced the same form of abuse as your client might be, and the potential benefits and pitfalls of this. Given that a stated aim of this thesis is to support other therapists to work with the religious and spiritual wounds that their clients may bring, it seems important to address these sorts of questions over and above the perhaps more practical and commonly accepted aspects of developing a solid working alliance within this discussion e.g. assessment and contracting.

Cultural Competence as an Important Therapist Quality

Therapists found benefit in disclosing their own experiences of navigating through RSA because of the sense of connection and hope this generated, so I explored whether it is necessary to be a Christian in order to work with Christians who have experienced RSA, given the potential impact upon the implications for this study. As is evident in research considering why religious clients choose Christian counsellors, social identity theory is seen to play a significant role in which an 'us' and 'them' mentality often develops (Greenridge & Baker, 2012; Turner & Tajfel, 1986). As far as I am aware, no literature exists relating to whether those who have experienced RSA will seek out a therapist of the same faith. From the general literature, Morrison et al (2009) state that believers from different denominations seek counselling with greater frequency and many therapy clients see religion and spirituality as fundamental aspects of their lives (Post & Wade, 2009). Religious people may oppose therapy with a non-religious therapist for fear of their values being undermined, feeling misunderstood or wrongly diagnosed in some way (Worthington et al, 1996). However, similarities between therapist and client on levels of religious commitment do not predict better outcomes (Worthington & Sandage, 2002). In concordance with the majority of outcomes research in counselling and psychotherapy (see Cooper, 2008), a key indicator of a client's preference for a therapist is grounded in whether they believe they will receive acceptance and understanding, regardless of their levels of religiosity. A limitation of this research was therefore not hearing directly from clients regarding their experiences, and so I am unable to ascertain clearly whether the therapist and client having the same faith is directly related to clinical outcome. The sense I held after conducting the interviews was that, regardless of the religious or

spiritual position held by the therapist, the critical factor is whether the client believes their therapist can help them or not, and this is largely down to the individual client. I understand this through two different lenses, the first being client and common factors research in psychotherapy, and the second, the means by which cultural differences are assessed in psychotherapy, which I apply to the subculture of religious thought.

Lambert's (1992) seminal work suggested that 40% of therapeutic improvement is due to client variables and non-therapeutic events, and this figure is higher when expectancy and the therapeutic relationship are also understood as partly client factors too (Cooper, 2008). In a Christian context this deserves particular thought in terms of the development of a working alliance. Some therapists felt that a counsellor without any faith beliefs might be a welcome relief for some clients, perhaps because they were keen to avoid associations with their abuse. From the clients' perspective this could be interpreted as a healthy shift away from a normalised, but hierarchical, relational template towards the divine, and more towards a desire to create an equalising bond between two people, healing perhaps in and of itself. The therapeutic relationship creates a power imbalance at a structural level due to the natural roles of helper and helped being adopted (Totton, 2017). Due to the inevitable complexity of power relations in abusive Christian environments, a relational and co-created exploration of the client's choice in relation to the therapist's faith preferences is therefore likely of therapeutic significance, and contributed to the therapist positioning themselves alongside rather than above the client. In order to solidify their therapeutic bond, the participants in this study tended to be open with clients from the start about their intention to create a therapeutic space that felt safe for the client - this meant agreeing how and when faith and faith-based interventions might be used, with an emphasis on the client's choice.

Some participants opposed the view that not identifying as a Christian might be preferable for RSA clients because of the therapist subsequently failing to understand faith from a personal perspective. I understand this through the perspective of considering culture, explained by Rohner (1984) as a highly variable learned phenomenon. Christianity, whilst a subculture given the existence of other religious groups, can be considered a culture from both this definition and for the purposes of this study. Cultural differences have been understood through three different perspectives: universalism, particularism and trancendism (La Roche & Maxie, 2003). A universalist perspective suggests that common factors, such as warmth and

understanding, are necessary to facilitate a good therapeutic outcome. As related to the current research, all participants affirmed the personal qualities of the therapist as important. The difference pertained to whether being a Christian themselves was the critical factor. For some participants, a nuanced view of the particularist perspective was held. This view proposes that culture has a crucial impact on an individual's experience and therefore those from different cultures cannot understand each other. The application of this would be that a non-Christian therapist should not work with a Christian client and vice versa, as the gulf between them would be too great to traverse. Whilst the therapists did not suggest that therapy would fail in a faith/non-faith context, some narratives centred upon the benefit of a shared faith for the development of mutual understanding. Lastly, the transcendist perspective suggests that people from different ethnic and racial (and for the purposes of this research, faith) backgrounds are psychologically different but these differences can be transcended and psychotherapy successful.

Religion and spirituality are therefore important aspects of multicultural competency for therapists (Walker, Gorsuch & Tan, 2004) and an important implication is that secular therapists should be able to work with RSA if they are prepared to develop their cross-cultural knowledge. One therapist spoke about a Hindu client who had purposefully come to see her knowing that she was a Christian, and this was a successful therapeutic partnership. As concluded by La Roche & Maxie (2003) therapists should develop cultural competence when working with clients from different backgrounds from their own, a viewpoint corroborated by participants in this study. This includes holding onto clinical judgement and considering individual differences. Whilst La Roche & Maxie (2003) offer ten highly relevant suggestions for working within and across cultural differences, space limits a full exposition of these. The following subsection attends to resonance with the client's story at a layer beneath sharing faith and holding cultural competence; what is the possible impact of sharing aspects of the client's abuse/trauma history? The available literature considers this in relation to vicarious trauma in particular.

Compassion Fatigue and Vicarious Traumatisation

The participants interviewed for this research all had experience of working with clients who had personally encountered RSA. It was clear they were attuned to the issue of RSA and the data reflected this in their poignant descriptions of their clients' experiences. Of the nine participants interviewed, five had personally experienced

RSA. Therapists spoke about the insight they felt their personal experience had given them, a sense of resonance with clients and the experience of being 'tuned in'. They discussed feeling hopeful that their clients could recover, given their own experiences, and being able to relate to an individual with deeper empathy. According to Jones (2018), understanding the impact and possible therapeutic value of one's own experience as a mental health clinician is difficult to quantify. Writing from the perspective of someone who experienced considerable early relational trauma, intuitive skills are hard to quantify beyond the five recognised senses but contribute enormously to her empathy and counselling toolkit. Jones (2018) suggests that when therapists have had their own therapy to manage within their own histories, their own senses can become highly cultivated towards others' pain. However, she warns against pain by proxy stating the significance of being aware of whose material is whose, and that an unprocessed vicarious need to heal through the work is damaging, along with personal identification with the clients' material.

Jones (2018) does not explore in any depth when personal experience can damage the therapist because of a reactivation of earlier trauma, or the client, because of the inevitable impact upon the therapeutic relationship if the therapist is negatively triggered. As stated by Tehrani (2007), spiritual beliefs and values are highly sensitive to the effects of trauma and trauma support work. This corroborates Pargament, Murray-Swank & Mahoney's (2008, p.398) view that 'where we find trauma, we often find spirituality'. This speaks to the psychic interweaving of spirituality and identity, both of which can be shaped and altered by an experience of trauma at a multitude of levels, from the relational (De Young, 2015) to the physical (Van Der Kolk, 2015). The interviews probed how the therapists managed this psychic interweaving of working with trauma and spirituality, especially given the relatively high prevalence of having experienced RSA themselves.

Jung (1946) extended the Freudian interpretation of countertransference to include the process by which the sufferings of the client are taken up and shared by the therapist; this might be more likely when the therapist shares some of the client's experience or can relate because of a nuanced understanding of the context in which the abuse occurred. There was an element of this narrative present within the therapists' stories; they spoke of anger towards the church, religious leadership and the Christian communities that perpetuate abusive dynamics. Anger was often coupled with a *"deep, overwhelming sense of sadness that this can actually happen"* (Joanna).

In this respect, the current research corroborated Gubi & Jacobs' (2009) research exploring the impact on counsellors (notably anger) working with RSA. However, Gubi & Jacobs (2009) also concluded that the counsellors' own relationships with God were profoundly strengthened because of their work with victims of RSA. In this respect, the challenging countertransference experienced was a catalyst for growing in maturity as spiritual beings. As stated by Tehrani (2007), the term countertransference can be subject to criticism because it may make determining the effects of secondary traumatisation, compassion fatigue and burnout more challenging. This is significant, given that a person-centred focus upon the necessary and sufficient conditions was emphasised by participants. Qualities such as empathy, compassion and caring increase clinicians' vulnerability to the effects of compassion fatigue and burnout (Figley, 1995; Thompson, Amatea & Thompson, 2014).

Understanding how contextual factors contribute to burnout and compassion fatigue can support counsellors to protect their own wellbeing whilst providing an effective therapeutic bond (Dunkley, 2018; Thompson et al, 2014). Research has suggested that therapists in private practice experience less burnout than those in inpatient settings, perhaps because of the greater sense of autonomy and fewer systemic stressors (Thompson et al, 2014). All but one of the therapists I interviewed worked predominantly in busy private practices and the challenge instead seemed to be finding adequate supervision. However, the lack of support in private practice might increase isolation and perhaps therefore vulnerability to heightened burnout. Workplace factors are insufficient in and of themselves to account for negative outcomes in mental health professionals (Thompson et al, 2014). Indeed, research exists showing conflicting results for wellbeing depending upon number of years in practice, differences between males and females, and the age of the therapist. It is therefore clear that contextual factors alone cannot account for personal wellbeing when working therapeutically. This led me to question whether a personal faith can mediate or buffer against the impact of hearing traumatic/abusive content as a psychotherapist in relation to the broader literature available.

In brief, vicarious traumatisation [VT] results in shifts in the ways in which the self, others and the world are perceived, as a direct result of working with traumatised clients. In relation to the current research, I reflect upon this issue in terms of whether participants reported challenges in their positioning of self alongside clients because of possible VT. Compassion fatigue occurs when therapists lose their ability to

empathically resonate with clients, and parallels a diagnosis of PTSD (Figley, 1995; Merwe & Hunt, 2019). Secondary traumatic stress [STS] as a result of indirect trauma exposure in healthcare workers is characterised by the cognitive shifts and emotional disruptions routinely seen in a presentation of PTSD. The severity of STS is considered to be impacted by the listener's own trauma history. Whilst quantitative research would be required to substantiate this, I did not detect a difference between my participants who had experienced RSA, and those who had not, in terms of their portrayal of how stressful they found the work.

A previous history of trauma has been shown to result in greater symptoms of STS (Cieslak et al, 2013). Whilst Cieslak et al's (2013) meta-analysis focused upon military stress, a number of different professionals were considered (e.g. rescue/social workers and mental health providers), suggesting greater generalisability of these findings across different contexts. Therapists in the current research spoke about RSA as being a 'soul wound' and deeply impacting their own identities (if they had experienced it) and those of their clients; it might therefore follow that to hear narratives from clients resonating with their own, perhaps unresolved, trauma histories, results in more challenging countertransference as they absorb their clients' explorations of traumatic emotions (Collins & Long, 2003). Trauma narratives that touch upon the therapist's personal history may lead to a sense of numbness and not being able to hear the client (Tehrani, 2007). However, this did not seem to be the experience of the participants in my study. In fact, their faith seemed to offer a protective impact in terms of their capacity and willingness to relationally position themselves alongside their clients. Perhaps this was because of a sense of having a calling to do the work, a feeling that they had something to offer which a non-religious therapist might not, and the internally supportive element of a framework of faith within which to live. I therefore reflect further upon the impact of having personal faith as a factor that could support therapists in their work with RSA.

Personal Faith as a Supportive Mechanism when Working with Abuse

Therapists working with difficult narratives and traumatised clients might rely on their own spirituality for internal support to better enable their capacity for the particular therapeutic work they are doing. One therapist in my study spoke about the concept of grace and there being *a "common grace … it's like it doesn't matter how big, how big the trauma"*. This therapist went onto say, *"I'm very sure of who I am and where I stand and that I can stand on my firm foundation, which facilitates me helping clients*

to stand on the firm foundation" (Lucy). Firm foundations could include their own theological understanding and spiritual communities (e.g. churches, homegroups), as illustrated by Lucy in this study. Harrison & Westwood (2009) investigated factors that protected mental health therapists against vicarious traumatisation and countering isolation within spiritual realms was cited as being a helpful tool. Hardiman & Simmonds (2013) reported similar; existential wellbeing was reported as a protective factor against emotional burnout when working with traumatised clients, as assessed within 89 Australian counsellors and psychotherapists. In this respect, faith might offer a specific and distinctive way of managing problems (Pargament & Saunders, 2007).

Whilst self-care was discussed by my participants, I did not hear stories of exhaustion or overwhelm and was more aware of the sense of fulfilment and passion for working with RSA, despite the obvious sadness and anger that it provokes. This is perhaps expected with the sense of calling or vocation that Christians often express when working in a helping capacity. However, this could also reflect the possibility that therapists burnt out or traumatised by engaging with this sort of work would be less likely to volunteer to participate in research of this nature. When illuminating the manner in which therapists work with RSA, reflecting on how they care for themselves is both an ethical and clinical imperative if the work is to be effective (Dunkley, 2018). This seems to resonate with broader campaigns at present, particularly in the NHS, relating to the mental health care of staff (The National Workforce Skills Development Unit, 2019). Whilst I have been unable to find any literature documenting the impact on the therapeutic process when both client and therapist share a similar abuse or trauma history, voluminous research exists discussing the impact of working with trauma generally, in terms of the negative factors (e.g. Collins & Long, 2003) and less so, but still prevalently, in terms of a potentially transformative personal and professional impact (e.g. Simms, 2017).

So how might holding a personal faith, as all the therapists in this study were required to have for their eligibility to participate, impact upon their capacity to be effective clinicians when working with abuse and trauma narratives? It is important to state at the outset that the therapists in this study were not immune to distress. Yet it was clear that the therapists' own experiences of faith had been predominantly supportive, and perhaps mediated against the distress caused by hearing triggering stories of RSA. My experience during the interviews was that the therapists were secure, confident and grounded in their own faith, and I felt surprised by my own emotional response to

this. My judgement prior to starting the research might have been that this would prevent the therapists from being able to be client-led in their agenda for the client. However, I discovered that their own groundedness in their faith seemed to reduce the extent to which they wanted, or needed, to project Christianity or theology onto their clients. Perhaps their faith acts as an anchor or secure base, from which they can freely explore difficult terrain with their clients and then return to for their own nourishment (Bowlby, 1988).

Personal faith and support from religious communities are primary coping strategies in studies of resilience and trauma (Gall et al, 2005) and those who treat trauma often have a more spiritually satisfying life (Newmeyer, et al, 2016). This is proposed to be the case because those who have a strong sense of spirituality report an increase in their wellbeing in trying to help trauma victims make sense of their suffering, and journeying with them through their spiritual development (Newmeyer et al, 2014; Newmeyer et al 2016). I wondered if this might underpin the therapists' orientation towards hope and healing, a core category that emerged throughout the process. Yanakakis' (2017) unpublished PhD dissertation considered the experiences of practitioners working primarily with traumatised clients, with an emphasis on examining whether their spiritual beliefs formed a protective buffer against the possible impact of vicarious traumatisation. The results, collated by interviewing twelve trauma specialists, highlighted that a personal sense of spirituality enabled the therapists to maintain a trauma-focused approach over a sustained period of time. Spiritual beliefs and practices were identified as effective coping strategies and a particular focus on therapists extending their own self-compassion and positive emotions was shown to promote treatment quality for individuals who have been impacted by trauma. Having discovered the way that my participants experienced their own faith, I believe that Yanakakis' (2017) findings are of relevance within the population I interviewed. From this, I would suggest that if Christian therapists are engaging in trauma-based work, then their own spiritual needs are worthy of prioritisation and will support them in continuing to compassionately and effectively support their clients. The therapists I interviewed were all actively engaged in spiritual contexts, perhaps offering a strong foundation grounded in their own self-care from which they could nurture and support others. In this respect, they could be seen to be navigating the tension between the personal and professional components of 'orienting towards hope and healing', as described within the grounded theory presented.

Bringing Spirituality into Psychotherapy

Pargament (1997) highlighted that people repeatedly turn to spirituality for support during stressful times and that there is a spiritual dimension to both human problems and solutions. This highlights the complexity of spirituality as an aspect of human functioning, both when there is a sense of wellbeing and also when there is not. Either way, spirituality seems to be implied. More recently, Pargament (2013) suggested three ways in which both theistic and non-theistically oriented practitioners might access spiritual resources to enhance hope in their work with despairing clients, thus openly bringing spirituality into therapy. These three factors include recognising the sacred nature of mental health work, attending to the sacred dimensions of their clients' lives, and attending to the experience of sacred moments in the therapeutic relationship. A strong narrative within the interviews centred on attending to the sacred dimensions of clients' lives in particular, but this was also an area in which the therapists were engaged in holding different tensions and boundaries within their therapeutic work. This makes sense given the traumatic element of spirituality experienced by the clients. The therapists therefore needed to tread with sensitivity so as not to ignore the traumatic elements of RSA but equally, not to remove hope from the clients that they might be able to find a healthier version of their faith. This tension was particularly evident when clients had processed their trauma and were moving towards perhaps healthily reintegrating their faith. Indeed, participants discussed how rewarding it was to hear about their clients' evolving relationships with God. It could be that the therapists' preparedness to openly bring spirituality into therapy meant that clients felt comfortable to share this aspect of their growth with their therapist. This also meant that the therapists benefitted from the positive feedback related to the client's spiritual growth in a manner that might not have been possible, had spirituality been a neglected component of the therapy. There are therefore benefits for both therapist and client when spirituality enters the therapeutic frame. The sense I had from the therapists was that whilst they had an explicit, personal choice to make about whether they discussed their own faith with their clients, they didn't have a choice about the implicit aspect of faith as a part of their personhood being present in the room, which I discuss next.

The Implicit Presence of the Therapist's Faith

An article in the British Journal of Music Therapy explores how music therapists' experiences of Christian spirituality may be relevant to their work (Barton & Watson, 2013). Using IPA, three music therapists were interviewed, and spirituality was found

to be a significant resource within their work. Barton & Watson (2013) poignantly suggest that if there is room for the whole of the client in (music) therapy, then surely there is room for the whole of the therapist too, including their spirituality. They suggest that if the therapist has a personal faith, then whether disclosed or kept private, this part of the person cannot help but feature in their therapeutic resources, a point which was also noted in the current work. Watson & Barton (2013) cite Freeman (2003, p.60), who connects intuition with spirituality, an example of how spirituality might form a helpful aspect of the therapist's resources. Freeman writes 'my own spiritual self is also a very important part of my work, and re-emphasises… bringing one's whole self, body, mind and spirit, into attentiveness in the clinical context'. These authors give a further example of how the Christian faith might be what the therapist holds in common with the client, even if the rest of their background, cultural context and personal stories differ (e.g. Shrubsole, 2010). In line with the current data, the music therapists all felt that their personal experience of faith helped them to better understand their clients, and to note the spiritual themes that emerged in the work. However, sharing the same beliefs was not as important as the mutual recognition of the importance of spirituality. Of particular relevance to the current research, 'spirituality can form a container for hope which supports the therapist to continue working'. This is corroborated by Simmonds' (2004) research, in which the wider view of spirituality offers a potentially soothing inter-relatedness, especially when challenging issues such as death, ageing and loss are present, or perhaps as in the current research, abuse and trauma (Barton & Watson, 2013). For each of the music therapists interviewed, the more their spirituality was integrated into the work the better able they felt to support their clients. In turn, the therapists spoke of their own spirituality being strengthened as a result, a point I discussed previously in relation to the clients sharing growth in their spirituality with therapists as a result of therapy.

Whilst this paper explored the experiences of music therapists, the applicability to the current research is that the paper aimed to explore how the spiritual outlook of the participants influenced, supported or challenged their practice. In retrospect, the current research considering therapists' ways of working with RSA strongly mirrored Barton & Watson's findings across several focused codes. For example, Barton & Watson (2013) identified 'spirituality as a resource when working' (superordinate theme), with the associated core codes including 'therapists using their faith to help them understand the client's' and 'spirituality supporting work in extreme situations'. Whilst not labelled identically, associated focused codes from the current research

echo their findings e.g. ‘decide whether to disclose personal faith or not’. A further theme identified by Barton & Watson (2013) entitled ‘therapists’ spirituality changing and developing as a result of their experiences as a music therapist’ included the sub-themes ‘adaptive faith’, ‘importance of spiritual support’, ‘work impacting upon therapists’ spirituality’. Whilst a different sub-population of therapists, similar focused codes emerged in the current research, including ‘manage self-care and negative impact’. It would seem that whilst spirituality has huge potential to support therapists and enhance the quality of their work, the way that spirituality is integrated into the work is as nuanced as the individuality of the therapist. I wanted to reflect further on the therapists’ perceptions of this and how they felt about the disclosure, implicitly or explicitly, of this part of themselves.

The Choice to Disclose One’s Own Faith

When considering the impact of identifying as a Christian when working with those who have experienced RSA, further reflection led me towards being curious regarding the way that Christian therapists integrate their spirituality both clinically and personally into the work. Do they self-disclose? Do they assume the client ‘knows’ about their faith? Do they wait to be asked? Beyond the questions about whether it is important or helpful for clients to have a therapist of the same faith, is personal faith something that can be bracketed anyway during the course of clinical work? I reflect on this question with vested interest, because prior to the personal psychotherapy that was a mandatory aspect of my training, I would not have considered integrating my faith into my clinical work and indeed, found it difficult for my faith to feel like an integrated aspect of my personhood at all. I am curious about other therapists who may feel as if their faith is not welcome in the clinical space, therapists for whom their faith is heavily in the space, and whether this is problematic either way when working with abuse and trauma. Given that there is not any available literature looking at this specific to RSA, I consider this issue more generally.

Watson (2003, p.135) wrote ‘I have sometimes misguidedly attempted to separate out what “spirituality” and “music therapy” mean for me in my life, the first marked “personal” and the second “professional”! Of course, it is complete nonsense to compartmentalise ourselves in this way.’ This comment deeply resonated with me given my personal experience, especially that of an integrative psychotherapy training, and was a clear point that emerged from the data as I spoke to the Christian therapists interviewed for this research. Walker et al (2004) conducted a 26-study meta-analysis

of 5759 American therapists and their integration of religion and spirituality in counselling. Their results clearly demonstrated that personal religiousness was associated with the capacity to integrate religion and spirituality into different aspects of counselling. They concluded that because of the lack of consistent training in this area, the therapists' own intrapsychic spiritual or religious experience was the most important factor beneath their capacity to successfully integrate religion and spirituality into counselling. They suggest that whilst this might make religious rather than non-religious therapists better equipped to provide religious interventions, the danger of this is an inappropriate imposition of personal values or application of spiritual or religious interventions. The importance of good boundaries is therefore obvious and was repeatedly highlighted in the data. The results from the current study spoke to the importance of attuning to the client and being client-led firstly in terms of whether to explicitly disclose faith, and secondly, whether to develop the theme of faith within the therapy. So, whilst the therapists were unanimous in their inability to fully bracket their own faith, they were also clear that integrating spiritual components into the therapeutic process was largely dependent upon the client in front of them and their therapeutic needs.

Using Religious Interventions in Therapy

It is important here to define what is meant by a spiritual or religious intervention. Broadly speaking, they fall into three categories; firstly, any secular technique used to strengthen the faith of a religious or spiritual client. Secondly, they could include secular techniques modified to include religious content (e.g. Christian cognitive therapy) and thirdly, an action or behaviour as derived from religious practice (e.g. prayer, blessings, Bible readings) (Post & Wade, 2009). This discussion pertains to the third form of intervention only because none of my participants discussed using modified secular techniques. Walker, Gorsuch & Tan (2005) cited the most frequently identified factors associated with the use of religious or spiritual interventions in counselling as being therapists' personal religious attitudes or behaviours. From the data collected in this study, participants were clear that their primary intention was not to strengthen the faith of their clients but instead to support their healing and recovery from RSA. Furthermore, their preference for the use of spiritual/religious interventions was nuanced depending on the client; both their client's preferences as discussed during the assessment stage of therapy and their changing preferences as therapy progressed.

Wade, Worthington & Vogel (2007) found that clients with high religious commitment reported greater closeness with their therapists and greater improvement in their presenting concerns when receiving religious interventions compared to clients with low religious commitment. This study did not include the dimension of RSA, which likely adds a complexity to the therapist's decision to use religious interventions or not, given the clients' previous experience of abusive power imbalances. However, it would appear that clients with a desire to maintain their religious beliefs after an experience of RSA might benefit from the sensitive use of spiritual or religious interventions in therapy, and an attuned therapist is able to detect when the client feels comfortable with this approach. Whilst the broader literature is generally favourable in terms of the use of religious or spiritual interventions, my participants did not mention interventions beyond prayer and very occasional scripture usage. Whilst this does not mean no other interventions are used, it perhaps reflects the additional complexity of working with spiritually abusive or traumatic content and the greater likelihood of possible interventions used being considered ethically inappropriate. My participants articulated some of the potential complexities in using interventions, for example, Monica mentioned the possibility of a client feeling their prayers are not as effective as those of the therapist, thus strengthening possible power imbalances and reinforcing a negative self-concept.

Whilst a discussion about the ethics of prayer is beyond the scope of this discussion, if a therapist was considering using prayer in therapy, I would refer them to a detailed discussion such as that by Weld & Eriksen (2007), who particularly warn against using prayer to avoid referral, difficult issues or when it might inadvertently strengthen pathology. Further guidance can be found in a paper by Gubi (2004, p.471), which explores mainstream counsellors' use of prayer. Several constraints are offered, perhaps all of which would be particularly pertinent when the client has the additional complexity of having experienced RSA. For example, 'the counsellor must not impose her beliefs upon the client or use the space to express her beliefs, however subtly'. Gubi (2004) suggests that prayer influences many therapists at philosophical, covert or overt levels, but the overarching principle that emerged from discussions with my participants was one of being client-led, corroborated by Kinmond (2013) in her recommendations for practitioners. I therefore now discuss the humanistic orientation towards being client-led through the lens of trauma work.

The Humanistic Approach and Religious and Spiritual Abuse

Whilst my participants included integrative therapists and the majority identified their professional orientation in this way, every therapist situated themselves within the humanistic (rather than purely cognitive or psychodynamic/analytic) approach, and person-centred was the most-quoted form of theoretical orientation. This aligns with Kinmond and Oakley's (2013) suggestion that the person-centred approach is most appropriate when working with RSA, because of the fundamental significance of creating a therapeutic space characterised by warmth, genuineness and unconditional positive regard [UCPR]. It is prudent to mention here that as churches have become more involved in the counselling of individuals, particularly in the charismatic and evangelical movements, two different sorts of counselling can broadly be identified; biblical counselling and the more non-directive pastoral counselling. The former is characterised by the counsellor being more aware of the redemptive aspect of the work of the Holy Spirit and holding the intention to bring the person back towards a relationship with God, with a focus on sin as the root of a spiritual battle for wholeness and healing (Hughes, 1982). Conversely, the non-directive pastoral approach might be defined as seeking an integration of psychological and spiritual insights in the care and counsel of individuals (Fouque & Glachan, 2000). No participants in the current study identified themselves as biblical counsellors and many stressed that they were 'counsellors who are a Christian' rather than 'Christian counsellors', which seems to be a colloquial way of distinguishing between those who identify as biblical counsellors and those who don't. There was an emphasis on a client-led approach, and I wondered if the context of RSA meant that the interviewed therapists, although not directly questioned about this, were disassociating themselves from the directive biblical counselling approach. Fouque & Glachan's (2000) research considered 49 individuals' perceptions of Christian and professional counselling experiences, involving issues of power, trust, directive approach, use of scripture and prayer, responsibility and outcome. Christian counselling was perceived as more negative, directive and powerful compared to the professional counselling model. Given that the Christian counsellors were perceived as blaming the individuals for their continued distress and as having different goals to the clients, it is perhaps unsurprising that the therapists working with RSA were so clearly client-focused in their stance and use of therapeutic interventions in the current research.

The person-centred approach falls within the humanistic branch of psychotherapy and counselling, with the stance of meeting a client in an inquiring, open manner, as a

skilful co-researcher of the client's world rather than as an all-knowing expert (du Plock, 2010). Humanistic approaches therefore prioritise personal meaning, self-worth and subjective experience over notions of psychopathology and objective measurement (du Plock, 2010). Three basic assumptions unite the humanistic approaches; a focus on the here and now, a holistic perspective, and acknowledgement of the client's autonomy (du Plock, 2010). In the context of RSA, participants spoke about their clients feeling voiceless, powerless, and as if a core aspect of their identity had been violated. To counter this with the humanistic principle of having the client as the expert on themselves therefore seems warranted and potentially reparative in terms of facilitating the development of healthier relational templates. However, this led me to ponder the client who has been so conditioned to submit, obey or follow orders, that facing their own autonomy could potentially reinforce any shameful feelings about their involvement with church or religion in the first place. Participants discussed the shame clients felt for choosing to be involved with an organisation that then hurt them, as if it was their fault for becoming involved. Their feelings of shame might make it difficult for them to engage with meaningful therapy (Oakley & Kinmond, 2013). Many people feel that those who choose to belong to a religious organisation deserve whatever happens to them in that context, only adding to the interpersonal trauma experienced and increasing the challenge of disclosure (Oakley & Kinmond, 2013). An important question, therefore, is whether the humanistic approach can be successfully used when the client's narrative is steeped in abuse, trauma and identity-loss, without exacerbating their shame.

The participants convincingly argued for the necessity of a humanistic and client-centred approach when working with individuals who have experienced abusive situations and this view appears to be corroborated in the wider literature (e.g. Oakley & Kinmond, 2013). In a conceptual paper connecting the person-centred approach with trauma, Joseph (2004) suggests that Rogers' theory provides the theoretical underpinnings for experiential and client-centred ways of working with traumatised individuals, and encourages therapists to adopt a more positive psychological approach when understanding how people adjust to traumatic events. Whilst Joseph's paper relates to a client-centred model when working with PTSD (and clearly not everyone who experiences RSA will develop PTSD), some useful conceptual points emerge of relevance to this critique and I will now explore these in further detail.

The crux of person-centred theory is in facilitating the individual towards finding their own meaning and discovering their own solutions to problems, defined by Rogers (1959) as the actualising tendency. This stands in sharp contrast to the biblical counselling model, which squarely places the responsibility for finding solutions to problems on removing sin from one's life (Fouque & Glachan, 2000). If sin is believed to be the root of the person's problems, then therapists would be effectively blaming clients for their experiences of abuse. None of the therapists interviewed held this stance and all were of the view that the individual needed reminding of their personal value, not their personal sin. In this respect, the biblical counselling model of removing sin stands in contrast to the person-centred ideal of supporting self-actualisation.

Person-centred therapy is usually considered too superficial to be able to account for PTSD but Joseph (2004) suggests this misrepresents Rogers' understanding of working with trauma, particularly given his experience with war veterans. Most importantly, traumatic events present us with stimuli or information reflecting a deep incongruence between self and experience, namely the values and assumptions that dictate how we live our lives (Joseph, 2004). Given individual differences, what is incongruent to one person might not be incongruent to another and this is a useful perspective given the context of RSA. To return to Jenkinson's (2009) perspective, what is experienced as an abusive cult to one, might be a growthful experience for another. Client-centred therapy is not limited to person-centred approaches and it should be noted that the therapists in this study did not always associate a client-centred approach with person-centred principles. However, there did seem to be a general consensus that therapy pace should be set by the client, and that their own motivation to increase congruence between self and experience would materialise, given the right therapeutic conditions, as similarly described by Joseph (2004). The participants in this study did not discuss a right relationship with God or spiritual disciplines as the path to healing; spirituality was in the background unless brought up by clients.

Rogers (1957, p.96) proposed that six necessary and sufficient conditions provide the actualising tendency. The first, psychological contact, is critical for working with survivors of abuse and trauma. The current data reflected an emphasis upon the relational approach in which the presence of the therapist was more important than a blank, neutral or aloof response. The therapists discussed using a trauma-informed approach to ground their clients, particularly if they were experiencing dysregulation

or dissociative tendencies. In this respect, being trauma-informed and client-centred were compatible. Secondly, the client is in a state of vulnerable or anxious incongruence, as would be expected of victims of RSA. Thirdly the therapist is congruent and integrated within the relationship; this might be particularly important in cases of RSA, where clients may feel deeply deceived or betrayed by those whom they trusted. Fourthly, the therapist experiences UCPR for the client and fifthly, the therapist employs empathy to convey an understanding of the client's experience. Again, UCPR & empathy might be particularly critical when clients feel as if their experience will not be believed or validated, especially in the context of church communities, which are generally believed to be supportive. Lastly, the therapist manages to communicate their empathic understanding and UCPR to the client. Joseph (2004) defines a client-centred therapist as someone who holds a deep understanding of themselves, such that they can extend this into an authentic way of being with a client in a non-imposing manner. Kinmond (2013) discusses in Oakley & Kinmond (2013) as not advertising herself as a Christian therapist, but similarly not avoiding the issue of her own religion and spirituality in the therapeutic space. The non-imposing stance was echoed by each of the therapists within this study.

Joseph (2004) suggests that the most significant feature of PTSD as it applies to understanding trauma is that the person's self-structure can be built in one of two directions; either in line with their post-trauma conditions of worth or with the client's innate actualising tendency. The implication of this is that only therapeutic approaches supporting the client to integrate their self and experience congruently result in post-traumatic growth. This is an interesting point and one which deserves attention given current thinking about post-cult recovery, in which traditional psychotherapeutic models are deemed inadequate. Jenkinson (2019) writes that the aim of post-cult recovery is to help the survivor deconstruct their pseudo-identity and rebuild their autonomous, authentic self. Jenkinson (2018; 2019) believes that a traditional psychotherapeutic approach, including the person-centred approach, is inadequate for survivors of severe cult trauma and likely inadequate for those who have experienced RSA in mainstream settings also. Her belief is that if therapy only reaches the pseudo-identity, or the introjects internalised by the client rather than their authentic self, then true change is not possible. Instead, a relational-psychoeducative approach is required when working with RSA and this clearly goes beyond the six necessary and sufficient conditions proposed by a predominantly person-centred model.

Therapists spoke extensively about their clients' experiences of abuse, and how a purely client-led approach, when victims have been made to feel voiceless and powerless, could serve to compound a traumatic sense of loss rather than help heal it. Whilst the Rogerian person-centred approach is often misunderstood at a conceptual level and over-simplified, the general sense was that to rigidly adhere to person-centred principles might be collusive. Sometimes the use of psycho-educative strategising is appropriate, perhaps more aligned with Jenkinson's (2018; 2019) phased model of recovery and Oakley's & Kinmond's (2013) suggestions for therapists. To corroborate these concerns, one participant discussed how a more therapist-led intervention can feel containing in the face of distress, and another spoke about the core conditions as seeming necessary, but insufficient in and of themselves.

To summarise, I noticed a conflation between client-led and person-centred approaches during the interviews, probably because relationship factors are central to all trauma therapies (Meichenbaum, 2013). Whilst a client-led approach was used more than a person-centred one, the emphasis was upon clients being the experts themselves. This was considered reparative against the abusive church system that disempowered victims and left them feeling out of control. Whilst a person-centred model might provide a framework for a particular stance held by the therapist, and some of its perceived inadequacy might be due to an incomplete grasp of the complexity of Rogers' understanding of trauma, an integrative, trauma-informed approach with client-centred elements best summarises how the therapists described their therapeutic practice for RSA. Whilst being able to integrate different schools of thought is considered clinically effective, what about the integration of the therapist's spirituality? This held significant presence throughout the interviews and I now consider this in more depth.

Reflecting on the Integration of Spirituality into Counselling and Psychotherapy

According to the British Psychological Society [BPS] practice guidelines (2017), spiritual beliefs may be helpfully incorporated into any therapeutic intervention to achieve a positive impact where appropriate. These guidelines also acknowledge that in some circumstances, a client's faith or belief may be detrimental or harmful. Ade-Serrano (2017) comments that counselling psychology has been criticised recently for its excessive focus on the individual and insufficiently on his/her social systems, thus

failing to consider where the collective impacts individual functioning. Ade-Serrano (2017) argues that whilst this is a constructive criticism on one level, spirituality is primarily a tool used to enhance connection with others. Therefore, understanding the value of spirituality to an individual, and supporting this inner development as a pathway to better connectedness, should be prioritised. Whilst other countries (e.g. the U.S.A.) have delineated spiritual and religious competencies for psychologists (Vieten et al, 2016), Ade-Serrano's (2017) article highlights the complexity of spirituality, and could perhaps be taken to imply that to reduce spirituality and religion to a set of competencies is a reductionist exercise. There is a potential challenge for this in trainers of psychological therapists and counselling psychologists; how can spirituality and religion be incorporated into training curricula, without becoming engulfed by issues of definition and deconstruction of these concepts (Ade-Serrano, 2017)? This is an important question to ask when reflecting on the clinical integration of spirituality and psychotherapy, as presumably effective teaching and training paves the way for integration in practice.

A glance through my own training syllabus yielded two days' worth of content on 'the place of transpersonal processes in an integrative approach to psychological therapy'. The focus is upon 'transpersonal/spiritual dimensions of self-development from a variety of perspectives; an introduction to, and exploration of, the work of practitioners who attend to transpersonal processes at work within, and between, psychotherapist and client; an emphasis on developing a critical understanding of what this relationship dynamic might mean and its potential importance as part of an effective therapeutic encounter'. I completed a highly relational training with an emphasis upon implicit – and therefore relational and connective - dimensions of practice. Whilst this training compares favourably to courses which contain little or no emphasis upon spiritual matters, there was no explicit mention related to the toxic edges of spirituality, except within peer discussion; and this was instigated by me, as an interested party.

According to Coyle (2010), some of the principals involved in working with spiritual and religious material can be understood as reflecting good practice in counselling psychology, but this should not be seen as simply stating the obvious. Coyle (2010) suggests that creating a therapeutic relationship in which the client is comfortable both raising and exploring spiritual issues, where there is an openness to spiritual relatedness, and maybe the transcendent too, might echo the qualities of any effective therapeutic alliance. However, practitioners who lack training in this domain may feel

unskilled creating this therapeutic environment, particularly if they perceive themselves to be ‘outside’ religion and spirituality. Whilst it requires skill to develop a therapeutic relationship of this nature, working with religion and spirituality does not require an entirely new set of competencies (Coyle, 2010). The current research affirms this view, suggesting that instead of emphasising particular techniques required to work with RSA, the skill is in the practitioners’ ability to create and sustain a therapeutic relationship in which spiritual and religious material is both embedded and embraced. This relationship is noted by Hayes & Cowie (2005) to have spiritual qualities in and of itself, as it aligns with Buber’s (1937) notion of the ‘I-Thou’ relationship. Importantly, as evidenced by participants in the current project, this relationship is characterised by engagement in and absorption with the other, without any sense of self-seeking or manipulation (Hayes & Cowie, 2005).

A working model for the integration of spirituality into counselling has been proposed by Matise, Ratcliff & Mosci (2018), and might suit exactly the therapists Coyle (2010) describes above, who consider themselves spiritual or religious outsiders. Matise et al (2018) suggest that firstly, therapists need to decide whether or not it would be effective to invite the integration of spirituality into the therapeutic process using a spiritual awareness decision tree. Secondly, a spiritual awareness guide is proposed to support the practitioner in directing the therapy to fit the client’s area of concern. However, these authors suggest that therapists must be aware of the possibility of RSA. They specifically state that the spiritual awareness guide is only applicable if the client’s religious or spiritual perspective is *not* harmful. While comprehensive in terms of considering multiple styles of spiritual development and how to best therapeutically promote spiritual growth, this model is not suitable when RSA forms part of the client’s presentation. Furthermore, Matise’s et al’s (2018) model emphasises explicit, technique-based interventions (e.g. a compassion collage or guided imagery), whereas the current research focused upon the therapist’s experience of not being able to remove their personal spirituality, and how this shaped their capacity to work with RSA.

Barnett & Johnson (2011) address the ethical concerns and challenges that arise when spiritual or religious issues present themselves at the outset of psychotherapy thus providing a platform upon which practitioners could safely integrate spiritual and religious dimensions. This comprehensive model related to the integration of spirituality and religion into psychotherapy is grounded in clinical examples. The

authors propose key reasons to integrate spirituality and/or religion into psychotherapy, and in a related teaching presentation (Barnett, 2012) outline the potential risks of failing to address religious and spiritual issues including overlooking the significance of these issues in the client's life, over-pathologising spiritual and religious issues and mis-managing countertransference reactions. Barnett & Johnson (2011) propose a 9-stage model for helping therapists determine whether a client's religious or spiritual beliefs have saliency, and if so, how the ethical principles underpinning practice might support the provision of psychotherapy when religious and spiritual issues are primary concerns. This model covers the assessment process in psychotherapy, developing an understanding of the connection between the presenting problem and religious or spiritual beliefs, gaining informed consent, evaluating competence and making decisions about whether referrals are required, or clergy should be sought. Whilst the therapists in the current research did not explicitly mention this model, the above indicators of good practice all featured within their work. The contribution of this current research is the inclusion of how the therapist's personal experiences of faith contributed to their capacity to adapt models such as Barnett & Johnson's (2011) proposal, when RSA is part of the clinical picture.

Matise et al (2018) and Barnett and Johnson's (2011) frameworks are undoubtedly helpful in supporting practitioners to consider the integration of the spiritual dimension in a clinically safe and effective manner. The recommendations these authors suggest could be applied by therapists of different orientations and faith backgrounds and arguably should form part of training requiring rigorous thought on these matters. However, the implication is that the therapist has a choice about whether they proactively integrate religion and spirituality into the work with clients and there is little (if anything) mentioned about integrating the spiritual or religious dimension implicitly because it is part of the therapist, or when RSA is or becomes part of the therapeutic work.

Integration of spirituality into psychotherapy isn't only understood via models promoting particular styles of intervention or questioning. Theoretical models also discuss how spirituality is integrated into the human psyche (e.g. Petruska Clarkson's [1992] five-facet of relationship model and Ken Wilbur's [1997] developmental stage model). This work differs from that of educators such as Barnett & Johnson (2011), who support therapists in their attempts to proactively bring spirituality into psychotherapy. As a trainee counselling psychologist, my experience of training has

been an emphasis upon models explaining how spirituality might be integrated into the psyche, rather than practice-focused models such as that proposed by Barnett & Johnson (2011). It would appear therefore that there is a gap between understanding the integration of spirituality into the human psyche (e.g. Clarkson) and theoretical models proposing how to integrate spirituality into the therapeutic dialogue. The gap relates to how individual therapists use their own internal experience of spirituality to translate this into psychotherapeutic interventions (for RSA, in the case of this research).

This project filled some of that gap, given the emphasis in the GT presented between the personal faith of the therapist and how this translated into therapeutic practice. Initial literature searches prior to data collection related to how therapists work in practice, especially when RSA has entered the therapeutic dialogue. As explained, this yielded minimal return hence the current project. At one level, this project answered an unexpected question, related to how therapists integrate their own spirituality into their clinical work, because this seemed to form an important element of the question, 'how do therapists work with RSA'? A further search of the literature yielded minimal work in this vein, but a PhD by Ann Scott (2011) caught my attention. Scott (2011) considers Christian therapist's experiences of integrating faith into psychotherapy and refers to Bochner's (1982) acculturation model applied to Christians entering the world of psychotherapy. At stage 4, there is an appreciation of both Christian and psychological perspectives; the worlds are perceived to overlap to a high degree and the individual is comfortable in both, experiencing them mostly as one. This work is particularly relevant to the current research as the interviewed participants had perhaps all reached stage 4 - a genuine integration of both systems with complimentary value systems bringing meaning (Bochner, 1987, as cited in Scott, 2011).

As Scott writes, much of the available literature purports a top-down view from academics in the field and therefore is often couched in language making it difficult for the practitioner to implement. Scott's work addresses the practical questions of how much of this information has filtered down to therapists - what do they actually do to integrate their faith and practice? Scott structured her interview findings around four major themes of which there are significant overlaps with the current work. This is important because it again directs attention to the integrative processes the therapist is engaged with, rather than a set of original competencies or techniques. The four

areas Scott details are: attention to internal processes of the therapist, spiritual and psychological; external support for therapist, spiritual and psychological; awareness of the client's spirituality and/or religious tradition; context and language of therapy. Each of these four areas are important for safe, ethical and fruitful spiritually-aware therapy to take place. Scott mentions how her work 'stands in the gap' (p. 148) between the academic and professional world, in terms of understanding how therapists experience the integration of their spirituality into their professional work. My sense is that this project also stands in the gap between the theoretical literature written about RSA and the way that therapists actually clinically intervene. This leads me to reflect on the value of the current research to the world of psychotherapy. In particular, what could the integration witnessed as part of the findings of the current work contribute to the patchy training related to the spiritual dimension of psychotherapy? It is to this that I now turn my focus.

Distinctive Contribution to Knowledge

The major contribution of this research relates to how this particular stratum of therapists integrate their own personal faith and use this to support and enhance the therapeutic encounter when working with someone impacted by RSA. As this research highlights, the personal integration of spirituality as experienced by these therapists directly impacted their capacity to integrate spirituality into their clinical work, including when RSA is part of the picture. I did not begin this research with the expectation that the therapists involved would be delivering ground-breaking therapeutic techniques, or even that the clinical interventions would overtly differ from those delivered within other trauma-based narratives. However, when reflecting on the impact of this research, and the potential unique contribution that this work could make to counselling psychology and psychotherapy literature and practice, no work to date has considered how Christian therapists work when confronted by RSA within their own tradition. There is a lack of research literature pertaining to how therapists work with clients who have experienced struggle and toxicity within the same community of faith that they, the therapist, identify with. Whilst the sample of participants interviewed is very specific, this work could support therapists who are working within the same community of faith as their clients, from a non-religiously affiliated perspective. Although an increasing volume of theoretical writing conveys the significance of the integration of spirituality into therapeutic work, less work considers how this is experienced and practiced on the ground, and as far as I am aware, no work has previously focused on working with RSA. The benefit of having interviewed therapists

who could personally identify with the faith position of their clients, was that this drew out a particular richness in terms of how they understood and employed their own spirituality in the practice of psychotherapy. This work is different to Scott's (2011) because of the particular emphasis upon working with RSA, although there are many overlapping findings. I now consider the different ways in which I anticipate these findings might impact the wider context of psychotherapy, beginning with practitioner psychologist and psychotherapy trainings.

For Practitioner Psychologist and Psychotherapy Programmes

Whilst there has been an increasing focus upon RSA over the past two decades within counselling and clinical psychology, I described in the literature review that formal training in religious and spiritual issues is patchy, as assessed within a recent systematic review of UK based training courses (Jafari, 2016). Jafari (2016) suggests that there appears to be minimal consensus among clinical and counselling psychologists regarding the development of effective ways of working with religious and spiritual content therapeutically. Attuning to the spiritual needs of clients can be complex, particularly given the tendency of psychologists to profess less belief than their service users (Delaney, Miller & Bisono, 2007). This disparity can lead to therapists entirely avoiding the topic or communicating a sense of taboo to clients, thus preventing the client from having a safe therapeutic space in which to discuss a central topic within their lives (Magaldi & Trub, 2018). Therefore, a greater understanding of how clinicians work with spiritual or religious clients presenting with RSA may positively develop the training content around spiritual or religious issues aimed at counselling/clinical psychology and psychotherapy trainees.

As explained, the GT presented could be interpreted as rather general and applying to many different therapeutic contexts. However, the model is also about the integration of faith and spirituality into therapy, particularly the ways in which participants engaged with the personal and professional elements of the core categories presented. As far as I am aware, no empirical research has considered the ways in which Christian therapists work with RSA or how this intersects with their own faith. For example, perhaps all therapists, regardless of the focus of the work or modality, commit themselves in some way to the first core category 'positioning self alongside the client'. On the surface, this is not new information. However, what is apparent from this particular stratum of participants is that self-disclosure represents an important element of this positioning.

An obvious question to arise from this finding, is how to best support therapists to manage self-disclosure when discussing faith with their clients, and to reflect further on how to integrate this knowledge into practitioner training programmes. Current research related to self-disclosure of faith and/or religion suggests that embedding spiritual and religious exploration within curricula is recommended (Magaldi & Trub, 2018). Given that the U.K. clearly has a way to go until discussing religion and spirituality is the norm in training curricula, this research could support awareness of how to frame issues of therapist self-disclosure when the client is reporting toxic faith experiences. Furthermore, training programmes should provide culturally competent supervision and workshops with a more self-reflective component (Magaldi & Trub, 2018). As these authors suggest, this is a crucial time for the psychological therapies to incorporate more traditional notions of religiosity into conversations; the intention being that rather than issues of faith being related to client capacity and ability to initial discussion, they are grounded in exploring critical issues related to spiritual and religious identity. But what might this reflective component look like? And how could it be facilitated, especially on secular training courses?

Self-disclosure is a contentious issue in the psychological therapies. Research by Magaldi & Trub (2018) suggests that a shared religious background tends to prompt disclosure and enables a common language, which puts clients at ease. These authors also concluded that therapists who place a high value on religious and spiritual processes, were more likely to sense clients' spiritual or religious struggles and invite these discussions into therapy – even if they didn't disclose their own background. Therapists within the current study corroborated this perspective, stating that they perceived their own faith to support their attunement to their client's difficult faith-based experience. Whilst therapists might find themselves working with RSA even if they have no faith, both the current research and Magaldi & Trub's (2018) work suggests this is less likely. However, cultural competence as a key therapist characteristic was highlighted earlier in this chapter, because this supports the capacity of therapists to discuss the identity variables between therapists and clients, especially those that differ (Sue & Sue, 2008). The issue of self-disclosure is therefore important because it can counteract the negative impact of differences between the client and therapist (Magaldi & Trub, 2018). The primary question relating to the application of the current findings, is how psychotherapy training might more consistently integrate education around the importance of self-disclosure related to faith-based matters. It could be proposed that trainee therapists (with and without faith) could engage in reflective,

non-didactically based dialogue to support their capacity to engage with faith-based issues in practice.

Scott (2011) produced a diagram to illustrate her own integration journey with the idea that she could use it to invite practitioners to examine their own integration processes. I would like to suggest that the present findings could be used to facilitate deeper, reflective and non-didactic conversations with practitioners about the nature of the spirituality and religiosity, and how this enters (or doesn't enter) the therapeutic frame. Please see appendix 12 for examples of questions that might be used to stimulate discussion related to these matters, both for training and established therapists. Given that learning from peers is a primary way that trainees learn about faith-related issues in counselling (e.g. Swinton, 2016), stimulating reflective discussion amongst peers as a trainer could be a fruitful way to model the integration of spirituality into practice. Whilst not all therapists have a personal faith to disclose or may decide not to disclose their religious or spiritual orientation, reflecting and practicing the stance they might take with peers could better prepare the next generation of psychological therapists to address challenging issues related to their client's spirituality.

Scott (2011) found that when she presented workshops disseminating her 'faith world/counselling world' model, even participants who disagreed with her version of the model reflected on the issue of integration and what it meant for them, which ultimately was the purpose of the teaching. This suggests that teaching focused particularly on working with the challenging sides of psychotherapy, and how this might be facilitated, could be a worthwhile endeavour. Although this work focuses on working with RSA, and would therefore necessitate additional discussion around these issues, I am hopeful that practitioners not directly working with RSA could consider the impact of their integration or dissonance between their personal faith and their clinical practice.

I have wondered if proposals for workshops have relevance beyond purely Christian groups of therapists. Scott (2011) found that counsellors with a high degree of input from the secular world were more likely to have worked on their integration and were also more likely to have found a support network. This is perhaps because there is less of a tension between the faith-psychology worlds in a secular context, and less attention might have been paid to the significance of implicit communication when outward expressions of faith are acceptable and perhaps even expected. The

implication of this is twofold; firstly, a workshop on secular programmes might stimulate reflection related to spiritual processes or religious allegiances that trainees might not have previously considered. Secondly, workshops with Christian participants via Christian organisations, training institutions or CPD events, might deepen understanding relating to the positioning of their own spiritual and religious processes, especially when addressing complex issues with clients.

For Counsellors, Psychotherapists & Clinical Supervisors

When used tactfully and with respect, theology can be a vital and dynamic determinant in a client's outcome (Leighton, 2014). This view is corroborated by multiple authors from different specialisms within mental health (e.g. Larson, Larson & Koenig, 2001; Pargament, 2011; Smiley, 2001; Van Deurzen, 2014), though the emphasis upon the Judeo-Christian tradition should be acknowledged. However, many therapists do not address religion or spirituality in standard westernised clinical practice, and therefore neglect a significant aspect of their clients' worldviews (Begum, 2012). During my own psychotherapy, my reticence to speak about faith alerted me to the fact that I would feel uncomfortable addressing related issues with my own clients. I concluded that spirituality was a poorly integrated aspect of my identity largely due to the dissonance it created on a number of issues, thus generating avoidance and internal conflict.

Whilst a plethora of literature exists regarding the benefits of religion and spirituality and also how to successfully integrate religious and spiritual issues into therapy (e.g. Griffith & Griffith, 2003), there is a paucity of material aimed at supporting psychotherapists/psychologists to understand how to identify and respond to individuals who have encountered toxic spirituality. Whilst some of this material might be taught on courses sensitive to religious and spiritual issues, it is perhaps more likely that therapists will first encounter RSA in their practice, and therefore consult their supervisors about this issue. As the current research showed finding adequate supervision is challenging, echoing Scott's (2011) findings. The current research highlighted that therapists were incredibly grateful for effective supervision which is sympathetic to the issue of RSA and the integration of spirituality into practice. This supports the evidence suggesting that competency-based supervision enhances competence through attention to the skills, attitudes and knowledge required to apply psychological interventions that are sensitive to the religious and spiritual beliefs, commitments and values of clients (Shafranske, 2016). This highlights the important role that supervisors have in developing therapist's practice. Writing an article about

these findings might alert supervisors to the collective needs of therapists and is a possible application of the findings of this work which could contribute a tangible benefit to the counselling and psychotherapy literature.

Although the data reflects the nuances of working therapeutically with RSA from the perspective of having a personal faith, the core categories within the GT presented speak to active therapeutic processes that would be familiar to therapists with no faith. This suggests that the data presented have relevance for those who might find themselves discussing the shadow sides of religion and spirituality with their clients, even if they have no faith, or perhaps hold a different faith perspective themselves. I hope this goes some way towards demystifying and destigmatising addressing the thornier issues connected to faith for therapists who are interested in doing so, and thereby makes a contribution to practice. If more therapists feel confident that whilst personal faith can be advantageous, it is not an absolute necessity for addressing RSA, this opens up a wider field of practitioners who could acquire both the confidence and the competence to address this form of abuse and trauma.

For Victims of Religious and Spiritual Abuse

Many individuals who have encountered RSA never seek therapy, and those that do often encounter multiple challenges (Oakley & Kinmond, 2007). Clients are unlikely to find a therapist who is aware of the potential secrecy surrounding, and complexity inherent within, RSA and many therapists simply feel uncomfortable working with spirituality (Oakley & Kinmond, 2007; Oakley & Kinmond, 2013; Parish-West, 2009). Kinmond & Oakley (2006) found that Christians who had experienced RSA were less likely to choose a Christian therapist, suggesting that secular therapists encounter individuals with this form of trauma and abuse history more often. Henzel (1997, as cited in Oakley & Kinmond, 2013) found that Christian therapists tended to dismiss stories of RSA, believing they were too subjective to be taken seriously. For those who identify as having experienced RSA, finding appropriate therapeutic support is clearly difficult. The data within this study revealed that despite these challenges, RSA is addressed with competence and confidence by some therapists. An intended contribution of this study is that their practice can be discussed more openly as a result of this work, thus undoing the tendency for empirical findings (with the possibility to impact those who would most benefit from them) to remain in the ivory towers of academia.

For the Provision of Mental Health Care in Church Settings

The first conviction for SA in an Oxfordshire church in 2018 triggered the terminology debate discussed in chapter 1, and these discussions are currently ricocheting through different church governing bodies and policies within the U.K (e.g. Faith and Order Commission, 2016; Methodist Church Policy for Safeguarding Children and Young People, 2017). Despite this conviction, a lack of clarity remains about how to define RSA, and this could compound the challenges victims face when seeking support. Although this study did not intend to further define RSA, it is hoped that it goes some way towards constructing an argument for the provision of specialist therapeutic help when it is clear that church members have experienced RSA. If mental health care and the provision of psychological support within churches is to be better understood, the bottom-up approach within this study could add weight to the discussions happening at an academic level within the aforementioned governing church bodies. There are currently more churches than health centres in the UK (Straine, 2019) and places of worship remain a place of welcome for many who desire psychological or physical healing. I believe this emphasises the significance of resourcing churches with the creation of proper policies, effective governance, and tools to equip individuals who could impact the psychological and physical healing of others. This study therefore intended to provide an invitation to reflect on what constitutes harmful relational and spiritual practices, and how those impacted by them might find healing and contribute to the development of healthier church cultures.

Recommendations for Therapeutic Practice

I now outline recommendations for practice using Kinmond's (2013) framework. The aim of this project was to explore how Christian therapists work with clients who have experienced RSA within a mainstream Christian setting. Whilst RSA has been the subject of much debate, and this will likely increase awareness of the phenomenon amongst possible clients and therapists alike (including demand upon therapists to address these issues in their practice), there is a paucity of research-based evidence to support therapists in addressing RSA with their clients. Whilst this work is intended to speak to Christian therapists in particular because this was a stipulation for participation, the work has relevance for those who come across RSA in their practices, but who don't have a faith. Similarly, the perspectives offered by participants could be interesting and applicable to therapists from different faith orientations working with clients who have experienced RSA in other faith contexts. Further

research could explore the extent to which the perspectives offered here extend into other faith communities.

A particular intention was to explore whether the recommendations made by Kinmond (2013) are seen within a broader body of therapists actively engaging in this form of work, and to contribute to a wider understanding of how therapists support clients to make coherent sense of a personal story of RSA. Kinmond's (2013) work theoretically addressed working with individuals who have experienced RSA, albeit from Kinmond's professional experience as a psychologist and counsellor. I present the core findings of this research broadly adhering to the points suggested in Kinmond's (2013) chapter related to working with individuals who have experienced RSA. Given the minimal amount of literature available, it seems prudent to contribute to a framework already offered, and the subheadings below all featured in the current research. I therefore suggest these implications following the structure already laid out by Kinmond (2013). The following headings are not intended to function prescriptively, but rather to serve as illustrations of issues to consider for the therapist interested in working with RSA. I am not intending to provide a checklist of how a therapist should practise when working with RSA but hope instead that the data conveys a useful narrative that others could learn from and feel inspired by in their own practices.

Person-Centred Principles

Following the betrayal of RSA and the inevitable challenges of trusting individuals in positions of power (e.g. church leaders, therapists), a client-centred approach founded upon person-centred principles was most frequently discussed, and provided a framework for the application of more integrative therapeutic principles. Whilst it is important that person-centred is not conflated with a lack of challenge, the therapists interviewed unanimously described an approach founded on the core conditions espoused by Rogers (1959). It seemed that this approach was experienced as the most effective in dissolving power imbalances and better enabling clients to find a more equal footing, having been victims of abuses of power. It is important to note that the person-centred approach was described as a means to convey a sense of the climate that the therapists were seeking to develop in their consulting rooms and the language offered by the person-centred model perhaps captures this well, e.g. the core conditions. This is not to say that therapists trained in different models could not effectively work with RSA, but perhaps this model uses language that best captures the intended stance of the therapists within this study.

Use of Personal Religion and Spirituality

As discussed by Kinmond in Oakley & Kinmond (2013), neglecting the truth of one's own faith would be an inauthentic expression of self and this was corroborated by all of my participants, even if they choose not to disclose their faith unless directly prompted by their clients. Whilst ethical frameworks must be adhered to (e.g. UKCP, 2019) including respecting diversity, managing power imbalances and avoiding behaviour that could be deemed abusive, it would seem that one's own faith as a therapist can be used healthily to encourage the client towards disclosure of the impact of their own spirituality and religion. Truax & Carkhuff (1965) refer to this as the dyadic effect, whereby disclosure begets disclosure. Whilst it is possible that a client who has experienced RSA might become anxious upon hearing their therapist speak of issues related to their own faith (Maroda, 2012), judicious use of self-disclosure might support the creation of an empathic and responsive environment in which the client knows that the depth of their pain will be met with understanding. In terms of the grounded theory presented, my sense was that the therapists implicitly model a healthier, non-toxic form of faith through disclosure of their own spirituality to clients. This could support both the therapist and client in orienting towards hope and healing, as described within the final stage of the model presented. Maroda (2012) highlights how little theoretical information exists to provide a framework that could serve as a clinical gauge in terms of how much or how little disclosure is helpful. In this respect this research perhaps goes some way towards undoing the taboo nature of discussing one's own faith in the therapeutic context (Leighton, 2014).

Religious and Spiritual Abuse as a Distinct Form of Abuse

RSA as a distinct form of abuse is contested in the U.K. As Oluwole (2010) asserts, spiritual abuse is often overlooked because it occurs in conjunction with other forms of abuse (primarily emotional abuse). However, whilst the spiritual component becomes minimised, it is often this element that provides the environment, leverage and platform of power, upon which the abuse occurs. The points raised by Oakley & Kinmond (2013) are worth noting, namely that people's responses to RSA may differ from other forms of recognised abuse. For example, it may be perceived that the person entering the abusive situation had more choice in their involvement, and this could exacerbate the culture of secrecy and silence. This reflects the significance of therapists having an awareness of RSA, and particularly, how much the client may expect their story to be discredited. In relation to this particular piece of research, the codes pertaining to how RSA enters the therapeutic frame are especially relevant. For

example, therapists may legitimately choose to address the issue directly, or wait until it emerges, but the important thing is not to dismiss the client's experience, and to recognise the extent to which RSA ricochets through the experience of identity and selfhood. I believe this point also confirms that it is not necessary to have experienced RSA oneself in order to work with it therapeutically. For example, many therapists work with clients who have been sexually abused but have not experienced this themselves. Perhaps what is most important is the choice to engage professionally with understanding the nuances of RSA such that the client trusts the therapist's understanding of the subtleties involved with this particular form of abuse and trauma.

Responses to Religious and Spiritual Abuse

First and foremost, it is important to 'engage in therapy with the person and the issues they bring' (Kinmond, 2013, p.107). RSA may be the reason for attending therapy or it may emerge within the process. Either way the therapist should be prepared for the material to become challenging, and possibly to the extent that the client withdraws or finds therapy too intense. Whilst the Rogerian core conditions might be necessary and sufficient for supporting the creation of an effective working alliance, if the person-centred approach is employed then it should be used within a trauma-informed way. Whilst there is research available to suggest this is possible (e.g. Joseph, 2004), there is the possibility for work with RSA to become re-traumatising if trauma-informed approaches are not integrated into the work. Kinmond (2013) discusses the significance of responding appropriately to uncertainty and unpredictability, namely a willingness to work with both, and an ability to work flexibly, detouring towards and away from RSA as the client's needs dictate. Therapists should not interpret detours in content or clients struggling to regularly attend therapy as resistance, but be able to engage relationally with these issues as part of the presentation of abuse (Kinmond, 2013).

Changing Relationship with Religion and Spirituality

Academic research (e.g. Oakley, 2009; Ward, 2011) highlights that people's relationship to religion and spirituality changes following an experience of RSA (Oakley & Kinmond, 2013). Discussions with participants in this research largely focused upon clients' spiritual rebuilding and spiritual separation. Oakley & Kinmond (2013) argue for fluidity in terms of the therapist understanding Biblical discourse and being able to use this if appropriate, which was corroborated by the current participants. Whilst therapy was always prioritised over theology, and scripture used very sensitively (see below), an understanding of theological concepts was explained as important for

reducing the client's sense of isolation and enabling them to relate to the therapists. However, it was clear that the participants unanimously remained personally neutral in terms of their clients' choices to return to faith communities or not, so as not to abuse their positions of power as therapists or dictate in any way what healthy recovery might look like. The significance of personal reflexivity and sensitivity, though obvious (Kinmond, 2013) cannot therefore be highlighted enough in work with RSA.

Significance of the Therapeutic Bond

'The central and most fundamental aim of therapy with individuals who have been spiritually abused is to create a safe therapeutic space in which the client might begin to trust, construct meaning out of the chaos of the abuse and find inner peace as they begin to reconnect to themselves and others' (Kinmond, 2013, p.106). I have discussed at length the significance of the therapeutic alliance and the centrality of the therapeutic relationship in creating a healing environment from RSA. This is not new information and will be obvious to therapists, but the context of RSA particularly calls for the client to develop a core sense of their worth (Kinmond, 2013). Clients may fear entrapment and further abuse upon a foundation of already distorted perceptions regarding who they are and their belief sets. Only when the client feels secure and empowered can therapy begin effectively (Herman, 2001, as cited in Kinmond, 2013). This often begins with a normalising of responses to the abuse, thus corroborating the significance of trauma-informed work and psychoeducation with these clients.

The Power of Biblical Discourse and Using Scripture

Abusive biblical discourse can govern the abused individual's behaviour, thoughts and reason and so the therapist must understand and work within this discourse (Kinmond, 2013). However, it should be noted that if the therapist is not confident with the use of scripture and their client believes that the word of God is irrefutable, then the therapist might end up appearing lacking in the client's eyes (Oakley & Kinmond, 2009). Therapists in this study mentioned being able to reframe their clients' faulty beliefs with a different interpretation of scripture, and could use Biblical passages to affirm the worth of their clients. There was, however, a general sense of caution evident because of their awareness that the Bible had previously been used to command obedience and control. Therefore, any use of scripture tended to be client-led.

Good Quality Supervision

Kinmond (2013) discusses this at length and it was a code that was heavily saturated within the current research; in summary, good supervision when working with RSA is paramount but difficult to come by. Participants spoke about not wanting to speak too

negatively about religious and spiritual issues to non-believing supervisors because of the negative influence of abusive spirituality and feeling unsupported in their work because of RSA being poorly understood. However, the paramount importance of self-care was also discussed given the soul-level and identity-shaping impact of religion and spirituality. Good quality supervision related to these issues has long been difficult to find (Gubi, 2007) and this is an area for further research. The positive impact of a framework for effective practice is therefore clear and could help therapists who work with RSA to communicate their skill-base and to identify areas of challenge to supervisors and interested colleagues.

Vicarious Traumatisation

Gubi & Jacobs' (2009) work reflects most intensely the possible impact on therapists when they work with RSA, and a possible negative impact discussed in the current research included the effects of anger and sadness on the therapist. Trauma work is known to have an impact on those providing it; empathic resonance is both necessary for addressing trauma and the factor most likely to cause harm to the therapist (Benatar, 2011; Figley, 1995). As previously discussed, the participants in this study spoke of their faith providing an internal sense of security and groundedness, which facilitated their capacity to conduct their therapeutic work without feeling overwhelmed. This was aided by healthy self-care practices integrated into their lifestyles, including a necessary distance from therapeutic work at times.

Limitations and Suggestions for Further Research

The data collected focus on the very specific therapeutic elements of working with RSA for therapists who identify as Christian. It is therefore unknown if this work would generalise to RSA in other religions or contexts, and the nuances of working with difference have not been explored in any great depth either (e.g. a non-Christian identifying therapist with a Christian client). The current study is also limited by the fact that the focus was relatively narrow upon the particular stance and interventions used by the therapists. It is therefore unknown what works for whom, and indeed, whether the data is generalisable in this respect. However, given that minimal data exists specifically for therapists working in this field, the current research could act as a springboard for broadening the understanding of how Christian therapists work with clients who have experienced RSA or trauma. Furthermore, the lack of diversity is problematic in this study; only white women were interviewed, and further research should seek to diversify the participants so as to represent more accurately the diversity within Christian culture. Another point in terms of diversity is the rather narrow

focus on the Western-Judeo Christian tradition. This criticism extends to the entire discussion about spiritual abuse, given that most of what has been written relates to the Christian tradition (EATAG, 2018a). This research occurred within the U.K. context, but much of the earlier research and thought took place in America, which although Westernised, has a different spiritual landscape to that of the U.K. I recognise that to limit this work to the UK context reduces the diversity of the sample and will over-represent the western-Judeo Christian perspective.

As stated in the methodology section, an interesting extension to this work would be to interview therapist stating that they work with spiritual abuse from different, or no, faith orientations. This would add breadth to the sample and capture those for whom their therapeutic work focuses on the difficult sides of spirituality, but for whom Christianity does not best describe their spiritual or religious allegiance. This might extend the potential generalisability of the conclusions drawn.

As explained in the discussion, this research relates to professional Christian therapists rather than Biblical counsellors and should be interpreted in light of this, with further research perhaps needed to consider the impact of the Biblical counselling model on clients who may be vulnerable to RSA. Also, there is the danger in speaking only to therapists that an echo chamber is created in terms of what is perceived to be therapeutically helpful. Ethically speaking, perhaps the focus should shift towards what clients find the most healing after a damaging experience of church or Christianity. This illustrates an important avenue for further research.

Literature suggests that religion and spirituality can positively or negatively affect people's lives (e.g. Ahrens, Stansell & Jennings, 2010; Exline & Rose, 2005; Pargament, 2011; Weber & Pargament, 2014). So whilst I may be able to make suggestions for therapeutic practice based on the participants' experiences, it is unclear how an individual's spiritual background before the abuse occurred, and the subsequent intrapsychic relationship they hold to their own experience of faith, will impact their capacity to respond favourably to psychotherapeutic interventions aimed at addressing RSA. Furthermore, it should be acknowledged that serious mental illness in the form of psychosis is often associated with religious and spiritual issues. In psychosis, meaning-making may become distorted, leading to the elaboration of delusional beliefs into identity-reconfiguring systems (Mitchell & Roberts, 2009). This can result in delusions of a divine nature being applied to self and/or others. These

authors further explain that beliefs can develop out of psychosis, which amount to fundamentalism, tenaciously sustained even in the face of disconfirmation and transformed into further sources of confirmation. Whilst people with psychosis may experience RSA, this research did not address the nuances of working with severe mental illness alongside religiously or spiritually abusive situations, and any recommendations made for therapists as a result of the current research should consider this.

Churches tend to position themselves as welcoming homes for the needy and vulnerable. Whilst there is no doubt that the church should take responsibility when its members have suffered directly due to SA, perhaps it should also be acknowledged that already-existing negative religious coping (Weber & Pargament, 2014) might result in someone misinterpreting their experience of church, such that genuinely innocent behaviour is construed as abusive or traumatic. Ahrens, Stansell & Jennings (2010) concluded that higher levels of negative religious coping led to higher levels of depression, which could potentially increase an individual's bias towards negativity and a sense of feeling victimised. Further research could therefore explore the interaction between an individual's religious or spiritual history and their current perceptions of churches and the relationships within them.

Final Comments

This research concluded that three main processes characterise the way that Christian therapists interviewed in this study worked with RSA: positioning themselves alongside their clients, holding tensions and boundaries, and orienting towards hope and healing. Using a full constructionist model of grounded theory, a model was developed representing these core elements of therapeutic practice as described by nine participants. This adds empirical data to the core text written by Oakley & Kinmond (2013), within which Kinmond (2013) offers recommendations for therapeutic practice. Data from the current research corroborated the guidance provided by these authors and has hopefully contributed to the literature in a manner that expands upon some of the critical issues and questions that therapists engaging with this work might find themselves asking. Whilst there were important limitations, namely the lack of diversity, and being unable to interview the clients of these therapists to assess the effectiveness of the therapy directly, this work perhaps offers a basis from which further research could examine more nuanced issues related to therapeutic practice and RSA.

References

Ade-Serrano, Y. (2017) The essence of spirituality and its applicability to practice – an alternative perspective. In: Ade-Serrano, Y., Nkansa-Dwamena, O. & McIntosh, M. (eds.) *Race, culture and diversity: A collection of articles*. The British Psychological Society, pp. 70-81.

Ahrens, C., Stansell, J., & Jennings, A. (2010) To tell or not to tell: The impact of disclosure on sexual assault survivors' recovery. *Violence and Victims*. 25 (5), 631-648.

Archbishop's Council (2004) *Promoting mental health: A resource for spiritual and pastoral care*. Available from: https://www.churchofengland.org/media/45468/parishresource.pdf [Accessed: 17th July 2017].

Baker, C. A. (2019*)* *Traumatized by religious abuse: Courage, hope and freedom for survivors*. Eugene, Luminare press.

Barnett, J. E. & Johnson, W. B. (2011) Integrating spirituality and religion into psychotherapy: Persistent dilemmas, ethical issues, and a proposed decision-making process. *Ethics & Behavior*. 21 (2), 147-164.

Bartoli, E. (2007). Religious and spiritual issues in psychotherapy practice: Training the trainer. *Psychotherapy: Theory, Research, Practice, Training*, 44 (1), 54–65.

Barton, M. & Watson, T. (2013) Inner spirit: Investigating how music therapists' experiences of spirituality may be relevant in their work. *British Journal of Music Therapy*. 27 (2), 40-51.

Beck, A. T. (1976). *Cognitive therapy and the emotional disorders. Madison, CT, International Universities Press.*

Begum, N. (2012) *'Trainee clinical psychologists talking about religion and spirituality in their work'*. Unpublished PhD Thesis: University of East London.

Benatar, M. (2011) *How Conducting trauma therapy changes the therapist.* Weblog. Available from: https://blogs.scientificamerican.com/guest-blog/how-conducting-trauma-therapy-changes-the-therapist/ [Accessed 30th October 2019].

Bergin, A. E. (1980). Psychotherapy and religious values. *Journal of Consulting and Clinical Psychology*. 48(1), 95–105.

Bergin, A. E. & Jensen, J. P. (1990) Religiosity of psychotherapists: A national survey. *Psychotherapy.* 27, 3-7.

Blue, K. (1993) *Healing spiritual abuse - How to break free from bad church experiences.* Illinois, Intervarsity press.

Blumer, M. (1979) Concepts in the analysis of qualitative data. *Sociological Review.* 27, 651-677.

Bochner, S. (1982). Cross cultural interaction: theory and definition of the field. In: Bochner, S. (ed.) *Cultures in Contact, Studies in cross-cultural interaction. International series of experimental social psychology*. Oxford: Pergamon Press, pp.3-4.

Bordin, E. S. (1979) The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice*. 16 (3), 252–260.

Bottoms, B. L., Goodman, G. S., Tolou-Shams, M., Diviak, K. R., & Shaver, P. R. (2015) Religion-related child maltreatment: A profile of cases encountered by legal and social service agencies. *Behavioral Sciences & the Law*. 33 (4), 561–579.

Bowlby, J. (1988) *A secure base: Parent - child attachment and healthy human development.* New York, Basic Books.

Bringer, J. D., Johnstone, L. H. & Brackenridge, C. H. (2004) Maximizing transparency in a doctoral thesis: The complexities of writing about the use of QSR*NVIVO within a grounded theory study. *Qualitative Research*. 4 (2), 247–265.

Bringer, J. D., Johnstone, L. H. & Brackenridge, C. H. (2006) Using computer-assisted qualitative data analysis software to develop a grounded theory project. *Field Methods*. 18 (3), 245-266.

British Broadcasting Corporation (2019) *Ealing Abbey: Paedophiles acted 'like the mafia'* Available from: https://www.bbc.co.uk/news/uk-england-london-50165998 [Accessed 3rd September 2019].

British Broadcasting Corporation (2019c) *Hillsong: A church with rock concerts and 2m followers.* Available from: https://www.bbc.co.uk/news/world-us-canada-49186785 [Accessed 13th October 2019].

British Psychological Society (2014) *Code of human research ethics.* Available from: https://www.bps.org.uk/news-and-policy/bps-code-human-research-ethics-2nd-edition-2014 [Accessed 1st May 2018].

British Psychological Society (2016) *Guidance document on the management of non-recent (historic) child sexual abuse*. Available from: https://www.bps.org.uk/news-and-policy/guidance-management-disclosures-non-recent-historic-child-sexual-abuse-2016 [Accessed 2nd April 2018].

British Psychological Society (2017) *Practice guidelines (3rd ed).* Available from: https://www.bps.org.uk/news-and-policy/practice-guidelines [Accessed 27th July 2020].

British Psychological Society (2018) *Code of ethics and conduct*. Available from: https://www.bps.org.uk/news-and-policy/bps-code-ethics-and-conduct [Accessed 1st May 2018].

Bromberg, P. (2011) *The shadow of the tsunami and the growth of the relational mind*. New York, Routledge.

Buber, M. (1937) *I and Thou*. Translated by Smith, Ronald Gregor. Edinburgh: T. & T. Clark.
Charmaz, K. (2006) *Constructing grounded theory: A practical guide through qualitative analysis.* London, Sage.

Charmaz, K. (2014) *Constructing Grounded Theory: A practical guide through qualitative analysis*. 2nd edition. London, Sage.

Christodoulidi, F. (2011) *Counselling, spirituality and culture*. In: *West, W. (ed.) Exploring therapy, spirituality and healing.* Basingstoke: Palgrave Macmillan, pp. 91–108.

Cieslak, R., Anderson, V., Bock, J., Moore, B. A., Peterson, A. L. & Benight, C. C. (2013) Secondary traumatic stress among mental health providers working with the military. *The Journal of Nervous and Mental Disease*. 201 (11), 917-925.

Clarkson, P. (1992) *Transactional analysis psychotherapy: an integrated approach. London*: Routledge.

Collins, S. & Long, A. (2003) Too tired to care? The psychological effects of working with trauma. *Journal of Psychiatric and Mental Health Nursing*. 10 (1), 17-27.

Cook, C. C. H. (2011). The faith of the psychiatrist. *Mental Health, Religion & Culture*. 1 (4), 9-17.

Cooper, M. (2008) *Essential research findings in counselling & psychotherapy: The facts are friendly.* London, Sage.

Cordani, A. (2018) Spotlight with Gillie Jenkinson: ‘With cult leavers, traditional therapy isn’t enough’. *New Psychotherapist.* 69 (Autumn), 52-53.

Cornish, M. A., & Wade, N. G. (2010). Spirituality and religion in group counseling: A literature review with practice guidelines. *Professional Psychology: Research and Practice.* 41 (5), 398–404.

Coyle, A. (2010) Counselling psychology contributions to religion and spirituality. In: Milton, M (ed.) *Therapy and beyond: Counselling psychology contributions to therapeutic and social issues*. New Jersey: Wiley-Blackwell, pp. 259-275.

Crenshaw, K. w. (1994) Mapping the margins: Intersectionality, identity politics, and violence against women of colour. In: Fineman, M. A., Mykitiuk, R. (eds.) *The public nature of private violence*. New York, Routledge, pp. 93-118.

Crowley, N. & Jenkinson, G. (2009) Pathological spirituality. In: Cook, C. Powell, A. & Simms, A. (eds.) *Spirituality and psychiatry*. London, RCPsych, pp. 254-272.

Damiani, R. (2002). Spiritual abuse within the church: Its damage and recovery process. *Evangel.* 20, 42–48.

Dehan, N., & Levi, Z. (2009) Spiritual abuse: An additional dimension of abuse experienced by abused Haredi (ultraorthodox) Jewish wives. *Violence Against Women*. 15, 1294–1310.

Delaney, H. D., Miller, W. R., & Bisono, A. M. (2007) Religiosity and spirituality among psychologists: A survey of clinician members of the American Psychological Association. *Professional Psychology: Research and Practice*. 38 (5), 53-546.

Denzin, N. (1978) *Sociological methods: A sourcebook.* New York, McGraw Hill.

Denzin, N.K. & Lincoln, Y.S. (1998) *The landscape of qualitative research*. London, Sage.

Dey, I. (1999) *Grounding grounded theory*. San Diego, Academic Press.

De Young, P. (2015) *Understanding and treating chronic shame: A relational/ neurobiological approach.* London, Routledge.

Diederich, F. R. (2017) *Broken trust: A practical guide to identify and recover from toxic faith, toxic church, and spiritual abuse*. LifeChange Publishing.

Dunkley, F. (2018) Who cares for the wounded carers? *Therapy Today*, 29 (2), 30-33.

du Plock, S. (2010) Humanistic approaches. In: Woolfe, R., Strawbridge, S., Douglas, B. & Dryden, W. (eds.) *Handbook of counselling psychology*. London, Sage, pp. 130-150.

Enroth, R. (1994) *Recovering from churches that abuse*. Grand Rapids, Zondervan.

Etherington, K. (2004) *Becoming a reflexive researcher: Using our selves in research*. London, Jessica Kingsley Publishers.

Evangelical Alliance Theological Advisory Group (2018a) *Reviewing the discourse of spiritual abuse*. Available from: https://www.eauk.org/resources/what-we-offer/reports/reviewing-the-discourse-of-spiritual-abuse [Accessed 2nd April 2019].

Evangelical Alliance Theological Advisory Group (2018b) *Reviewing the discourse of 'spiritual 'abuse': Logical problems and unintended consequences*. Available from: https://www.eauk.org/assets/files/downloads/Reviewing-the-discourse-of-Spiritual-Abuse-EXECUTIVE-SUMMARY.pdf [Accessed 2nd April 2019].

Evangelical Alliance Theological Advisory Group 2018c). *Reviewing the debate on spiritual abuse.* Available from: https://www.eauk.org/news-and-views/reviewing-the-debate-on-spiritual-abuse [Accessed 2nd April 2019].

Exline J. J., & Rose, E. (2005). Religious and spiritual struggles. In: Paloutzian, R. F. & Park, C. L. (eds.) *Handbook of the psychology of religion and spirituality*. New York, Guilford Press, pp. 315–330.

Faith and Order Commission & The Church of England (2016) *The Gospel, sexual abuse and the church: A theological resource for the local church*. London, Church House Publishing.

Figley, C. R. (Ed.). (1995) Brunner/Mazel Psychological Stress Series, No. 23. *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. Brunner/Mazel.

Fouque, P. & Glachan, M. (2000) Impact of Christian counselling on survivors of sexual abuse. *Counselling Psychology Quarterly*. 13 (2), 201-220.

Frankl, V. E. (1973) *The Doctor and the Soul: From Psychotherapy to Logotherapy* (2nd ed). London, Souvenir Press.

Freeman-Coppadge, D. J., & Horne, S. G. (2019) "What happens if the cross falls and crushes me?": Psychological and spiritual promises and perils of lesbian and gay Christian celibacy. *Psychology of Sexual Orientation and Gender Diversity*. 6 (4), 486–497.

Fuertes, J.N., Costa, C.I., Mueller, L.N., & Hersh, M. (2005) Psychotherapy process and outcome from a racial-ethnic perspective. In: Carter, R.D. (ed.) *Handbook of racial-cultural psychology and counseling* (pp. 256-276). Hoboken, NJ: John- Wiley & Sons.

Gall, T. L., Charbonneau, C., Clarke, N. H., Grant, K., Joseph, A. & Shouldice, L. (2005) Understanding the nature and role of spirituality in relation to coping and health: A conceptual framework. *Canadian Psychology/Psychologie Canadienne*. 46 (2), 88-104.

Gelso, C. J., & Carter, J. A. (1994). Components of the psychotherapy relationship: Their interaction and unfolding during treatment. *Journal of Counseling Psychology*. 41 (3), 296–306.

Glaser, B.G. & Strauss, A.L. (1967) *The discovery of grounded theory*. Chicago, Aldine.

Greenridge, S. & Baker, M. (2012) Why do committed Christian clients seek counselling with Christian therapists? *Counselling Psychology Quarterly*. 25 (3), 211-222.

Griffith, J. L. & Griffith, M. E. (2003) *Encountering the sacred in psychotherapy: How to talk with people about their spiritual lives.* London, The Guilford Press.

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In: Denzin, N. K. & Lincoln, Y. S. (eds.) *Handbook of qualitative research*. Thousand Oaks, Sage Publications, pp. 105-117.

Gubi, P.M. (2004). Surveying the extent of, and attitudes towards, the use of prayer as a spiritual intervention among British mainstream counsellors. *British Journal of Guidance and Counselling*. 32 (4), 461-476.

Gubi, P. M. (2007) Exploring the supervision experience of some mainstream counsellors who integrate prayer in counselling. *Counselling and Psychotherapy Research*, 7 (2), 114-121.

Gubi, P. M. & Jacobs, R. (2009) Exploring the impact on counsellors of working with spiritually abused clients. *Mental Health, Religion and Culture*. 12 (2), 191-204.

Hayes, M. A. & Cowie, H. (2005) Psychology and religion: mapping the relationship. *Mental Health, Religion & Culture*, 8 (1), 27-33.

Hayes, J. A., Gelso, C. J., & Hummel, A. M. (2011). Managing countertransference. In: Norcross, J. C. (ed.) *Psychotherapy relationships that work: Evidence-based responsiveness,* Oxford University Press, pp. 239-258.

Hall, J., Francis, L. & Callaghan, B. (2011) Faith and psychology in historical dialogue. *The Psychologist*. 24, 260-262.

Hall, S. (2003) Spiritual abuse. *Youthwork*. March, 32-35.

Harrison, R. L. & Westwood, M. J. (2009) Preventing vicarious traumatization of mental health therapists: Identifying protective practices. *Psychotherapy (Chic).* 46 (2), 203-19.

Henke, D. (1996) *Spiritual abuse.* Available from: https://watchman.org/profiles/pdf/spiritualabuseprofile.pdf [Accessed 12th April, 2019].

Henwood, K. L. & Pidgeon, N. F. (1992) Qualitative research and psychological theorizing. *British Journal of Psychology*. 83 (1), 97-111.

Henwood, K. & Pidgeon, N. (2006) Grounded theory. In: Breakwell, G. M. S., Hammond, S., Fife-Shaw, C. & Smith, J. (eds.) *Research methods in psychology.* London, Sage.

Higginbottom, G. & Lauridsen, E. I. (2014) The roots and development of constructivist grounded theory. *Nurse Researcher*. 21, (5), 8-13.

Hoffman, N. (2018*) Is it me? Making sense of your confusing marriage: A Christian woman's guide to hidden emotional and spiritual abuse*. Rosemount, Flying Free Media.

Horvath, A. O., & Bedi, R. P. (2002). The alliance. In: Norcross, J. C. (ed.) *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients.* Oxford, Oxford University Press, pp. 37-69.

Hughes, S. (1982) *A friend in need: How to help people through their problems*. Eastbourne, Kingsway Publications.

Humphreys, J. (2018) *Spiritual abuse: A position paper*. Available from: https://thirtyoneeight.org/media/2191/spiritual-abuse-position-statement.pdf [Accessed 17th June 2019].

Hunt, J. (2019) An exploration of how trainee counsellors who are practising believers of a world religion or faith tradition experience undertaking counsellor training. *British Journal of Guidance and Counselling*, 47 (4), 420-431.

Hutchison, A. J. Johnston, L. H. & Breckon, J. D. (2010) Using QSR-NVivo to facilitate the development of a grounded theory project: An account of a worked example. *International Journal of Social Research Methodology*. 13 (4), 283-302.

Jackson, J. & Coyle, A. (2009) The ethical challenge of working with spiritual difference: An interpretative phenomenological analysis of practitioners' accounts. *Counselling Psychology Review*, 24 (3 & 4), 86-99.

Jafari, S. (2016) Religion and spirituality within counselling/clinical psychology training programmes: A systematic review. *British Journal of Guidance and Counselling.* 44 (3), 257-267.

Jenkinson, G (2016) *'Freeing the authentic self: Phases of recovery and growth from an abusive cult experience'*. PhD thesis, University of Nottingham.

Jenkinson, G. (2019) Out in the world: Post-cult recovery. *Therapy Today*. 30 (2), 23-26.

Jenkinson, G. (2019) *Personal Communication*, 3rd June.

Johnson, D. & Van Vonderen, J. (1991) *The subtle power of spiritual abuse.* Minnesota, Bethany House Publishers.

Jones, S. (2018) Experts by experience. *Therapy Today*. 29, 2, 20-23.

Joseph, S. (2004) Client-centred therapy, post-traumatic stress disorder and post-traumatic growth: Theoretical perspectives and practical implications. *Psychology and Psychotherapy: Theory, Research and Practice.* 77, 101-119.

Jung, C. G. (1946). *The psychology of the transference.* Collected Works (Vol. 16). Princeton, Princeton University Press.

Jung, C. G. (1963). *Memories, dreams, reflections*. New York, Random House.

Kandiah, K. (2018) *Does the church's first spiritual abuse verdict give critics a new weapon?* Available from: https://www.christianitytoday.com/ct/2018/january-web-only/spiritual-abuse-church-england-guilty-verdict-ccpas-survey.html [Accessed 3rd March 2019].

Kelly Jr., E. (1994). The role of religion and spirituality in counsellor education: A national survey. Counsellor Education and Supervision, 33 (4), 227–237.

Kendall, L. (2016). *Born and raised in a [sect]: You are not alone*. Moscow, Progression Publishing.

Kinmond, K. S. (2013) Working with spiritual abuse: Professional and personal issues. In: Oakley, L. R. & Kinmond, K. S. *Breaking the silence on spiritual abuse.* New York, Palgrave MacMillan, pp. 107-119.

Kinmond, K. S. & Oakley, L. (2006) *This is abuse and people need to know that – counselling for spiritual abuse*. [Presentation], British Association of Counselling and Psychotherapy, Marriott Hotel, Portsmouth.

Koslander, T., Lindstrom, U. A. & da Silva, A. B. (2012) The human being's spiritual experiences in a mental health context; their positive and negative meaning and impact on health – A hermeneutic approach. *Scandinavian Journal of Caring Sciences.* 27, 560-568.

Kumar, S. & Cavallero, L. (2018) Researcher self-care in emotionally demanding research: A proposed conceptual framework. *Qualitative Health Research*. 28 (4), 648-658.

Kvale, S. & Brinkmann, S. (2015) *Interviews: Learning the craft of qualitative research interviewing.* 3rd Edition. Thousand Oaks, Sage Publications.

Lambert, M. J. (1992). Psychotherapy outcome research: Implications for integrative and eclectical therapists. In: Norcross, J. C. & Goldfried, M. R. (eds.) *Handbook of psychotherapy integration.* New York, Basic Books, pp. 94–129.

Langone, M. (Ed.) (1993). *Recovery from cults: Help for victims of psychological and spiritual abuse*. Thousand Oaks, WW Norton.

Lapworth, P., Fish, S. & Sills, C. (2005) *Integration in counselling and psychotherapy: Developing a personal approach*. London, Sage Publications.

La Roche, M. J. & Maxie, A. (2003) Ten considerations in addressing cultural differences in psychotherapy*. Professional Psychology: Research and Practice*. 34 (2), 180-186

Larson, D. B., Larson, S. S. & Koenig, H. G. (2001) The patient's spiritual/religious dimension: A forgotten factor in mental health. *Directions in Psychiatry*, 21 (21), 1-37.

Legard, R. Keegan, J. & Ward, K. (2007) In-Depth Interviews. In: Ritchie, J. & Lewis, J. (eds.) *Qualitative research practice: A guide for social science students and researchers.* London, Sage Hill Publications, pp. 138-169.

Leighton, T. J. (2014) The therapeutics of counselling religious clients: Intake and assessment. *International Journal of Mental Health and Addiction*. 12, 295-311.

Lomash, E. F., Brown, T. D., & Paz Galupo, M. (2019). "A whole bunch of love the sinner hate the sin": LGBTQ microaggressions experienced in a religious and spiritual context. *Journal of Homosexuality*. 66 (10), 1495–1511.

London Centre for Spiritual Direction (2019) *What is spiritual direction*? Available from: https://www.lcsd.org.uk/spiritual-direction/ [Accessed 30th June 2019].

Magaldi-Dopman, D., Park-Taylor, J. & Ponterotto, J. G. (2011) Psychotherapists' spiritual, religious, atheist or agnostic identity and their practice of psychotherapy: A grounded theory study. *Psychotherapy Research*. 21 (3), 286-303.

Magaldi, D. & Trub, L. (2018) (What) do you believe? Therapist spiritual/religious/non-religious self-disclosure. *Psychotherapy Research*. 28 (3), 484-498.

Malik-Rabata, A. M. (2020) Conference report on spiritual abuse: Education and prevention for our communities. *The Journal of Islamic Faith and Practice*. 2 (2), 129-130.

Maroda, K. J. (2012) *Psychodynamic techniques*. New York, Guilford Press.

Martinez, S. & Baker, M. (2000) Psychodynamic and religious? Religiously committed psychodynamic counsellors, in training and practice. *Counselling Psychology Quarterly*. 13 (3), 259–264.

Marx, K. (1852) *The eighteenth Brumaire of Louis Bonaparte*. Available from: https://www.marxists.org/archive/marx/works/1852/18th-brumaire/ch01.htm [Accessed 17th September 2019].

Matise, M., Ratcliff, J., & Mosci, F. (2018) A working model for the integration of spirituality in counseling. *Journal of Spirituality in Mental Health*. 20 (1), 27–50.

McSherry, W., Gretton, M., Draper, P. & Watson, R. (2008) The ethical basis of teaching spirituality and spiritual care: A survey of student nurses perceptions. *Nurse Education Today*. 28 (8), 1002-1008.

Meichenbaum, D. (2013) The therapeutic relationship as a common factor: Implications for trauma therapy. In: Murphy, D., Joseph, S. (eds.) *Trauma, recovery and the therapeutic relationship: Approaches to process and practice*. New York, Palgrave MacMillan, pp. 12-24.

Metanoia Institute (2018) *Code of ethics and conduct*. Available from: http://www.metanoia.ac.uk/media/1563/ab15160207-metanoia-institute-code-of-ethic

s-and-conduct.pdf [Accessed 4th July 2018].

Methodist Church (2017) *Safeguarding policy, procedures and guidance for the Methodist Church*. Available from: http://www.methodist.org.uk/media/2660915/Methodist%20Safeguarding%20Policy %20Procedures% 20and%20Guidance%202017.pdf [Accessed 20th July 2017].

Mitchell, S. & Roberts, G. (2009) Psychosis. In: Cook, C., Powell, A. & Simms, A. (eds.) *Spirituality and psychiatry*. London, RCPsych, pp. 39-60.

Moder, A. (2019) Women, personhood and the male God: A feminist critique of patriarchal concepts of God in view of domestic abuse. *Feminist Theology*. 28 (1), 85-103.

Morrison, J., Clutter, S., Pritchett, E., & Demmitt, A. (2009) Perceptions of clients and counseling professionals regarding spirituality in counseling. *Counseling and Values*. 53 (3), 183.

Motalová, K. & Řiháček, T. (2016) Religiosity gap reversed: how religious counsellors' belief system presents when working with clients in a non-religious environment. *British Journal of Guidance & Counselling*. 44 (3), 277-288.

Murray, S. (2004) *Post-Christendom: Church and mission in a strange new world.* Paternoster.

Nelson, S. (2015) *Spiritual abuse: Unspoken crisis*. Geeky Christian.

Newmeyer, M., Keyes, B., Gregory, S., Palmer, K., Buford, D., Mondt, P., & Okai, B. (2014) The Mother Teresa effect: The modulation of spirituality in using the CISM model with mental health service providers. *International Journal of Emergency Mental Health and Human Resilience*. 16, 13–19.

Newmeyer, M., Keyes, B., Palmer, K., Spong, S., Stephen, F. & Troy, M. (2016) Spirituality and religion as mitigating factors in compassion fatigue among trauma therapists in Romania. *Journal of Psychology & Theology*. 44 (2), 142-151.

NHS England (2015) *Safeguarding Adults*. Available from: https://www.england.nhs.uk/wp-content/uploads/2017/02/adult-pocket-guide.pdf [Accessed 3rd April 2019].

Oakley, L. R. (2009) *'The experience of spiritual abuse in the UK Christian church'.* PhD Thesis, Manchester Metropolitan University.

Oakley, L. R. (2018) *Understanding spiritual abuse*. Available from: https://www.churchtimes.co.uk/articles/2018/16-february/comment/opinion/understanding-spiritual-abuse [Accessed 30th March 2019].

Oakley, L. R., Kinmond, K. S., & Humphreys, J. (2018). Spiritual abuse in Christian faith settings: Definition, policy and practice guidance. *Journal of Adult Protection.* 20(3/4), 144-154.

Oakley, L.R. & Humphreys, J. (2019) *Understanding spiritual abuse in Christian communities*. Available from: https://thirtyoneeight.org/media/2185/spiritualabusesummarydocument.pdf [Accessed 30th April 2019].

Oakley, L.R. & Humphreys, J. (2019) *Escaping the maze of spiritual abuse*. London, SPCK.

Oakley L. R. & Kinmond, K. S. (2007) Spiritual abuse: Raising awareness of a little-understood form of abuse. *Thresholds*. Summer, 9-11.

Oakley, L. R. and Kinmond, K. S. (2013) *Breaking the silence on spiritual abuse.* Basingstoke, Palgrave Macmillian.

Oakley, L. R., & Kinmond, K. S. (2014). Developing safeguarding policy and practice for spiritual abuse. *The Journal of Adult Protection*. 16 (2), 87-95.

Oakley, L. R. & Kinmond, K. S. (2015) Working safely with spiritual abuse. *The Journal of Adult Protection.* 16 (2), 87-95.

Office for National Statistics (2012) *Religion in England and Wales 2011.* Available from:

https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/religion/articles/religioninenglandandwales2011/2012-12-11. [Accessed 25th August 2020]

Oluwole, A. (2010) Spiritual abuse and masculinity construction among African adolescents. *The Journal of Pan African Studies*, 3 (5), 93-113.

Pargament, K. I. (1997). *The psychology of religion and coping: Theory, research, practice.* New York, Guilford Press.

Pargament, K. I. (1999). The psychology of religion and spirituality? Yes and no. *The International Journal for the Psychology of Religi*on. 9, 3–16.

Pargament, K. I. (2011). *Spiritually integrated psychotherapy: Understanding and addressing the sacred.* New York, The Guilford Press.

Pargament, K. I. (2013). Conversations with Eeyore: Spirituality and the generation of hope among mental health providers. *Bulletin of the Menninger Clinic*. 77, 395–412.

Pargament, K. I., Murray-Swank, N. A. & Mahoney, A. (2008) Problem and solution: The spiritual dimension of clergy sexual abuse and its impact on survivors. *Journal of Child Sexual Abuse*. 17 (3-4), 397-420.

Pargament, K. I., Murray-Swank, N., Magyar, G. M., & Ano, G. G. (2005) Spiritual struggle: A phenomenon of interest to psychology and religion. In: Miller, W. R. & Delaney, H. D. (eds.) *Judeo-Christian perspectives on psychology: Human nature, motivation, and change*. Washington, American Psychological Association, pp. 245–268.

Pargament, K. I. & Saunders, S. M. (2007) Introduction to the special issue on spirituality and psychotherapy*. Journal of Clinical Psychology*. 63 (10), 903-907.

Parish-West, P. (2009) *'Spiritual abuse within the Judaeo-Christian tradition: Implications for practice'*. MA Thesis, University of Derby.

Park, C. L., Smith, P. H., Lee, S. Y., Mazure, C. M., McKee, S. A. & Hoff, R. (2017) Positive and negative religious/spiritual coping and combat exposure as predictors of posttraumatic stress and perceived growth in Iraq and Afghanistan veterans. *Psychology of Religion and Spirituality*. 9 (1), 13-20.

Pate Jr., R., & High, H. (1995) The importance of client religious beliefs and practices in the education of counsellors in CACREP-accredited programmes. *Counselling and Values*. 40 (1), 2–5.

Patton, M.Q. (1999). Enhancing the quality and credibility of qualitative analysis. *Health Sciences Research*. 34, 1189–1208.

Pidgeon, N. (1996). Grounded theory: Theoretical background. In: Richardson, J.T.E. (ed.) *Handbook of qualitative research methods for psychology and the social sciences*. Leicester, British Psychological Society, pp. 75-85.

Pidgeon, N., & Henwood, K. (1997). Using grounded theory in psychological research. In: Hayes, N. (ed.) *Doing qualitative analysis in psychology*. Psychology Press/Erlbaum (UK). New York, Taylor & Francis, pp. 245–273.

Pieper, J. Z. T. (2004) Religious coping in highly religious psychiatric inpatients. *Mental Health, Religion & Culture*. 7 (4), 349-363.

Plante, T. G. (2016). Principles of incorporating spirituality into professional clinical practice. *Practice Innovations*, 1 (4), 276–281.

Ponterotto, J. G. (2005) Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. *Journal of Counseling Psychology.* 52 (2), 126-136.

Pope Francis (2019) *Concluding address to participants of Vatican summit on child protection.* Available from: http://www.ncregister.com/blog/edward-pentin/pope-francis-concluding-address-to-participants-of-vatican-summit-on-child [Accessed 15th May 2019].

Post, B. C., & Wade, N. G. (2009). Religion and spirituality in psychotherapy: A practice-friendly review of research. *Journal of Clinical Psychology: In Session*. 65 (2), 131–146.

Pressley, J. & Spinazzola, J. (2015) Beyond survival: Application of a complex trauma treatment model in the Christian context. *Journal of Psychology & Theology.* 43 (1), 8-22.

Pretorius, S. (2007) Seemingly harmless new Christian religious movements in South Africa pose serious threats of spiritual abuse. *HTS* 63 (1), 261-281.

Purcell, B. C. (1998) Spiritual abuse. *American Journal of Hospice and Palliative Medicine*. 15 (4), 227-231.

Rauch, M. (2009) *Healing the soul after religious abuse: The dark heaven of recovery*. Westport, Praeger.

Reason, P. S. (1994) *Participation in human inquiry.* London: Sage.

Rogers, C. R. (1957) The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*. 21 (2), 95–103.

Rogers, C. R. (1959) A theory of therapy, personality and interpersonal relationships as developed in the client-centered framework. In: Koch, S. (ed.) Psychology: *A study of a science. Vol. 3: Formulations of the person and the social context.* New York, McGraw Hill, pp. 184-252.

Rohner, R. P. (1984) Toward a conception of culture for cross-cultural psychology. *Journal of Cross-Cultural Psychology.* 15, 111–138.

Rosmarin, D. H., Bigda-Peyton, B., Ongur, D., Pargament, K. I. & Bjorgvinsson, T. (2013) Religious coping among psychotic patients: Relevance to suicidality and treatment outcomes. *Psychiatry Research.* 210, 182-187.

Rothschild, B. (2006). *Help for the helper.* New York, W.W. Norton & Company.

Royal College of Psychiatrists (2015) *Spirituality (SPSIG*) Available from: https://www.rcpsych.ac.uk/mental-health/treatments-and-wellbeing/spirituality-and-mental-health [Accessed 1st November 2019].

Saunders, M. L. (2018) Christian therapists working with spiritual abuse and trauma. *Accord Magazine (Winter),* pp. 10.

Schafer, R. M., Handal, P. J., Brawer, P. A., & Ubinger, M. (2011) Training and education in religion/spirituality within APA accredited clinical psychology programs: 8 years later. *Journal of Religion and Health.* 50, 232–239.

Scott, A. (2011) '*An exploration of the counsellor's experience of integrating Christian faith with clinical practice'*. Unpublished Doctoral Thesis, University of Manchester.

Seybold, K. S. & Hill, P. C. (2001) The role of religion and spirituality in mental and physical health. *Current Directions in Psychological Science.* 10 (1) 21-24.

Shafranske, E. P. (2016). Finding a place for spirituality in psychology training: Use of competency-based clinical supervision. *Spirituality in Clinical Practice*. 3(1), 18–21.

Shrubsole, B.L. (2010) Faith and music: A personal exploration of the implication of religious faith in music therapy, within an intercultural, group music-making context. *Approaches: Music Therapy and Special Music Education.* 2 (2), 55–61.

Simmonds, J.G. (2004) Heart and spirit: Research with psychoanalysts and psychoanalytic psychotherapists about spirituality. *International Journal of Psycho-Analysis.* 85, 951–971.

Simms, J. (2017) Transformative practice*. Counselling Psychology Review*. 32 (2), 46-56.

Simonic, B. Mandelj, T. R. & Novsak, R. (2013) Religious-related abuse in the family. *Journal of Family Violence.* 28 (4), 339–349.

Smiley, T. (2001). *'Clinical psychology and religion: A survey of the attitudes and practices of clinical psychologists in South East England'.* Unpublished Doctoral Thesis, University of Surrey.

Smith, R. A. & Davis, S. F. (2012) *The Psychologist as detective: An introduction to conducting research in psychology.* Cambridge, Pearson.

Stolorow, R. D. & Atwood, G. E. (1996) The intersubjective perspective. *Psychoanalytic Review.* 83, 181-194.

Straine, G. (2019) *Healthy healing hubs Intro*. Available from: https://gohealth.org.uk/healthy-healing-hubs/ [Accessed 3rd November 2019]

Swindle, P. J. (2017) '*A twisting of the sacred: The lived experience of religious abuse.'* PhD Thesis, The University of North Caroline, Greensboro.

Swinton, V. (2016) Research to develop spiritual pedagogy, awareness and change. *British Journal of Guidance & Counselling*. 44 (3), 268-276.

Tan, S. (1996) Religion in clinical practice: Implicit and explicit integration. In: Shafranske, E. P. (ed.) *Religion and the clinical practice of psychology.* Washington, DC: American Psychological Association, pp. 365–387.

Tehrani, N. (2007) The cost of caring -The impact of secondary trauma on assumptions, values and beliefs. *Counselling Psychology Quarterly*. 20 (4), 325–339.

The Mental Health Foundation (2006) *The impact of spirituality on mental health: A review of the literature.* Available from: https://www.mentalhealth.org.uk/sites/default/files/impact-spirituality.pdf [Accessed 10th March 2019].

The Message: *The Bible in contemporary language.* NavPress, 2002.

The National Workforce Skills Development Unit (2019) *Workforce stress and the supportive organisation.* Available from: https://www.hee.nhs.uk/sites/default/files/documents/Workforce%20Stress%20and%20the%20Supportive%20Organisation_0.pdf [Accessed 10th May 2019].

Thompson, I., Amatea, E. & Thompson, E. (2014) Personal and contextual predictors of mental health counselors' compassion fatigue and burnout. *Journal of Mental Health Counseling.* 36 (1), 58-77.

Thornberg, R. (2012) Informed grounded theory. *Scandinavian Journal of Educational Research*, 56 (3), 243-259.

Todd, N. R., McConnell, E. A., Odahl-Ruan, C. A., & Houston-Kolnik, J. D. (2017). Christian campus-ministry groups at public universities and opposition to same-sex marriage. *Psychology of Religion and Spirituality*. 9 (4), 412–422.

Totton, N. (2017) Power in the therapeutic relationship. In: Tweedy, R. (ed.) *The political self: Understanding the social context for mental illness.* New York, Routledge, pp. 29-42.

Truax, C. B. & Carkhuff, R. R. (1965) Client and therapist transparency in the psychotherapeutic encounter. *Journal of Counseling Psychology.* 12 (1), 3–9.

Tummers, L. & Karsten, N. (2012) Reflecting on the role of literature in qualitative public administration research: Learning from grounded theory. *Administration and Society.* 44 (1), 64-86.

Turner, J. C., & Tajfel, H. (1986). The social identity theory of intergroup behavior. *Psychology of Intergroup Relations.* 7-24.

United Kingdom Council for Psychotherapy (2019) *UKCP code of ethics and professional practice.* Available from: https://www.psychotherapy.org.uk/wp-content/uploads/2019/06/UKCP-Code-of-Ethics-and-Professional-Practice-2019.pdf [Accessed 17th August 2019].

Van Deurzen, E. (2014) *Transcendence and the psychotherapeutic quest for happiness.* Available from: https://www.rcpsych.ac.uk/pdf/Emmy%20Van%20Deurzen%20Transcendence%20and%20the%20Ps ychotherapeutic%20Quest%20for%20Happiness.pdf [Accessed 16th June 2017].

Van Der Kolk, B. (2015) *Mind, brain and body in the transformation of trauma. London, Penguin Books.*

van der Merwe, A., & Hunt, X. (2019). Secondary trauma among trauma researchers: Lessons from the field. *Psychological Trauma: Theory, Research, Practice, and Policy.* 11 (1), 10–18.

Vieten, C., Pierce, A., Ammondson, I., Scammell, S., Pilato, R., Pargament, K. I. & Lukoff, D. (2016) Competencies for psychologists in the domains of religion and spirituality. *Spirituality in Clinical Practice.* 3 (2), 92-114.

Wade, N. G., Worthington, E. L. & Vogel, D. L. (2007) Effectiveness of religiously tailored interventions in Christian therapy. *Psychotherapy Research.* 17 (1), 91-105.

Walker, D. F., Gorsuch, R. L. & Tan, S-Y. (2004) Therapists' integration of religion and spirituality in counseling: A meta-analysis*. Counseling and Values*. 49 (1), 69-80.

Walker, D. F., Gorsuch, R. L. & Tan, S-Y. (2005) Therapists' use of religious and spiritual interventions in Christian counseling: A preliminary report. *Counseling and Values.* 49 (2), 107-119.

Waller, R., Randle, G. & Jenkinson, G. (2012) *Religious trauma syndrome.* Available from: https://www.mindandsoulfoundation.org/Articles/289535/Mind_and_Soul/Articles/Religious_Trauma_Syndrome.aspx [Accessed 31st March 2019].

Ward, D. J. (2011) The lived experience of spiritual abuse. *Mental Health, Religion and Culture.* 14 (9), 899-915.

Watson, S. (2003) Spiritual Dialogue: A personal experience of life and death in music therapy with people with learning disabilities. In: *Community, relationship and spirit: Continuing the dialogue and debate, papers from the BSMT/APMT Annual Conference;* BSMT Publications, pp. 135–139.

Weaver, A. J., Flannelly, L. T. Garbarino, J. Figley, C. R. & Flannelly, K. J. (2003) A systematic review of research on religion and spirituality in the Journal of Traumatic Stress: 1990-1999*. Mental Health, Religion & Culture*. 6 (3), 215-228.

Weber, S. R. & Pargament, K. I. (2014) The role of religion and spirituality in mental health. *Current Opinion in Psychiatry.* 27 (5), p. 358-363.

Weld, C. & Eriksen, K. (2007) The ethics of prayer in counselling. *Counseling and Values*. 51, 125-138.

Wertz, F. J., Charmaz, K., McMullen, L. M., et al (2011) *Five ways of doing qualitative analysis: Phenomenological psychology, grounded theory, discourse analysis, narrative research, and intuitive inquiry.* The Guilford Press, New York.

West, W. (2000). *Psychotherapy and spirituality: Crossing the line between therapy and religion.* London: Sage.

Wilber, K. (1997). An integral theory of consciousness. *Journal of Consciousness Studies* 4 (1). February 1997.

Willig, C. (2013*) Introducing qualitative research in psychology* (3rd ed.) Berkshire, Open University Press.

Winnell, M. (2011) *Understanding religious trauma syndrome: It's time to recognise it.* Available from: https://www.babcp.com/review/RTS-Its-Time-to-Recognize-it.aspx [Accessed 13th March 2019].

Wood, A. W. & Conley, A. H. (2014) Loss of religious or spiritual identities among the LGBT population. *Counseling and Values*. 59 (1), 95-111.

Woodhouse, R. & Hogan, K. F. (2020) "Out on the edge of my comfort": Trainee counsellor/psychotherapists' experiences of spirituality in therapy – A qualitative exploration. *Counselling Psychotherapy Research,* 20, 173-181.

Worthington, E. L., Kurusu, T. A., McCullough, M. E. & Sandage, S. J. (1996) Empirical research on religion and psychotherapeutic processes and outcomes: 10-year review and research prospectus. *Psychological Bulletin*. 119 (3), 448-487.

Worthington, E. L. & Sandage, S. J. (2002) Religion and spirituality. In: Norcross, J. C. (ed.) *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients*. New York, Oxford University Press, pp. 383-399.

Yanakakis, M. N. (2017) '*The relevance of the mental health practitioner's spiritual life when working with traumatised clients'.* Unpublished PhD Thesis, William James College, Massachusetts.

Yardley, L. (2000) Dilemmas in qualitative health research. *Psychology & Health*. 15, 215-228.

Yardley, L. (2017) Demonstrating the validity of qualitative research. *The Journal of Positive Psychology.* 12 (3), 295-296.

Zenkert, R.L. Brabender, V. & Slater, C. (2014) Therapists' responses to religious/spiritual discussions with trauma versus non-trauma Clients. *Journal of Contemporary Psychotherapy.* 44, 213-221.

Appendix 1 - Participant Information Sheet

METANOIA INSTITUTE & MIDDLESEX UNIVERSITY

PARTICIPANT INFORMATION SHEET (PIS) AND CONSENT FORM

You are being invited to take part in a research study. Before you decide to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. If there is anything that is not clear or if you would like more information, please email madeline.saunders@metanoia.ac.uk.

Take time to decide whether or not you wish to take part.

Thank you for reading this.

TITLE OF STUDY: An exploration of how Christian therapists work clinically with individuals who have encountered spiritual abuse and/or trauma within a Christian context.

Why this research? Research tells us that spirituality is important to people and yet it can often be difficult for clients and psychotherapists alike to discuss issues related to religion and spirituality in the consulting room. This might be even more challenging when the spiritual and religious experiences have felt traumatic or abusive to the client. I am interested in how you as a therapist go about addressing these issues with clients, particularly if this feels like an important part of your practice. I anticipate that talking about this amongst therapists might enable more therapists to discuss these issues with their clients thus undoing some of the silence that can exist around spiritual abuse and trauma.

I anticipate that this study will take approximately 1 year from the beginning of data collection (July 2018) to the end of the analysis and write-up (July 2019).

Why have I been chosen?

You have been invited to take part because I have either spoken to you about this research and you have indicated your willingness to be involved, or because I have seen your details either online/in a publication and you may fit the criteria I am looking for. Or, your details may have been passed on to me by someone who has already taken part in the study, and they have suggested that you may also be willing to participate.

Do I have to take part?

It is up to you to decide whether or not to take part, this information sheet is an invitation to participate if you feel interested by the study being undertaken. If you do

decide to participate then you will be given this information sheet to keep and will be asked to sign a consent form. If you decide to participate you are still free to withdraw at any time and without giving a reason.

What do I have to do if I decide to take part?

I will ask you for a tape-recorded interview, which will take anywhere between 45-90 minutes. I will then ask you to read the transcript of the interview once it has been transcribed, so that you can check the accuracy of the material and confirm that you are willing for me to use the data for the analysis and write-up.

Please note that in order to ensure quality assurance and equity this project may be selected for audit by a designated member of the committee. This means that the designated member can request to see signed consent forms. However, if this is the case your signed consent form will only be accessed by the designated auditor or member of the audit team.

What are the possible disadvantages of taking part?

This may feel like emotive material for you to discuss and the interview may therefore feel triggering or upsetting. Should you start to feel as if you do not want to continue, we will stop the interview and only continue if you choose to do so. I am unable to reimburse you as per the ethical guidelines for conducting research under my supervising bodies and appreciate that you will therefore be sharing your time with me for no financial gain.

What are the possible benefits of taking part?

There is no direct benefit to you of taking part however you may find it helpful to reflect on your practice in this capacity, and the intention is that this material supports other therapists to develop their own skills and expertise in this sensitive and under-researched area of work.

Will my taking part in this study be kept confidential?

All information that is collected about you during the course of the research will be kept strictly confidential. Any information about you which is used will have your name and address removed so that you cannot be identified. Furthermore, if talking about your clinical work, the utmost care will be taken to ensure that no case you have discussed is remotely identifiable.

All data will be stored, analysed and reported in compliance with GDPR.

What will happen to the results of the research study?

The results of this study will be analysed in depth and written up as part of a doctoral award in counselling psychology and psychotherapy. I will be aiming to publish my

research findings in relevant publications for example, 'Thresholds' and Counselling Psychology Review. I may also post general information and thoughts about the process on my website and blog, www.chichesterpsychotherapy.co.uk

Who has reviewed the study?

The Metanoia Research Ethics Committee are responsible for the reviewing of this study to ensure that it meets the ethical standards demanded of research of this nature.

Contact for further information

If you have further questions, please contact either me, Maddie Saunders or Dr. Janet Penny, research supervisor:

Metanoia Institute,13 North Common Road, Ealing, W5 2QB

janet.penny@metanoia.ac.uk Madeline.Saunders@metanoia.ac.uk

Appendix 2 - Copy of Information Sent Out to Participants

Copies of communication that will be sent to participants

> "Do you work with clients who have experienced spiritual abuse and/or trauma from within a U.K. based Christian setting and are you yourself a therapist who identifies with the Christian faith? If so, would you be willing to be interviewed for a doctoral research project in counselling psychology & psychotherapy? The aim of this research is to find out from therapists how they address issues relating to spiritual trauma and abuse with their clients in the consulting room.
>
> The aim of this work is that it helps therapists discuss the significance of this under recognised and under documented form of personal trauma and abuse in the consulting room. If you would like to find out more, or would like to take part, please contact Madeline Saunders at madeline.saunders@metanoia.ac.uk"

Initial email contact for participants

> Thank you for getting in touch, I am pleased to hear that you are interested in participating in this research and believe that this work will make an important contribution towards how we address issues of spirituality and trauma in the room with clients as psychotherapists.
>
> Please find attached the information sheet related to this project. I would be grateful if you could have a read, and then email me to confirm your willingness to participate. We will then arrange a convenient time and place for your interview.
>
> Please do contact me if you have any further enquiries and once again, thank you for your interest.
>
> Warm regards,
>
> Madeline Saunders
>
> Trainee counselling psychologist and qualified integrative psychodynamic counsellor

Appendix 3 - Consent Form

Participant Identification Number:

Title of Project: An exploration of how Christian therapists' work clinically with individuals who have encountered spiritual abuse and/or trauma within a Christian context.

Name of Researcher: Madeline Saunders

CONSENT FORM –

[PLEASE INITIAL THE BOXES INSTEAD OF TICKING THEM]

1. I confirm that I have read and understand the information sheet dated ....for the above study and have had the opportunity to ask questions.

   ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. If I choose to withdraw, I can decide what happens to any data I have provided.

   ☐

3. I understand that my interview will be taped and subsequently transcribed

   ☐

4. I agree to take part in the above study.

   ☐

5. I agree that this form that bears my name and signature may be seen by a designated auditor.

   ☐

Name of participant	Date	Signature
____________________	_______	______________________________

Name of person taking Consent (if different to Researcher)	Date	Signature
____________________	________	____________________________

Researcher	Date	Signature
____________________	________	____________________________

Appendix 4 - Protocol for Ensuring Anonymity of Participants

Given the size of Christian subculture and the oft-connectedness of these communities whether in person at live events or via social media, the most important message is to advise therapists to not use their client's identifying information in interviews. It is possible to break anonymity without breaking confidentiality within Christian circles, and I will need to make it clear to my participants what I mean by anonymity and confidentiality.

"There can be no absolute safeguard against breaches of confidentiality - that is, the disclosure of identified or identifiable data in contravention of an implicit or explicit obligation to the source" (Social Research Association [SRA], 2003, p.39)

The use of subject pseudonyms or anonymity do not guarantee confidentiality alone. A particular configuration of details may alone identify a particular individual (SRA, 2003).

The UK data service provide useful information for the anonymisation of data;

"Anonymisation is a valuable tool that allows data to be shared, whilst preserving privacy. The process of anonymising data requires that identifiers are changed in some way such as being removed, substituted, distorted, generalised or aggregated" (UK data service, 2018)

They distinguish between direct identifiers (e.g. names, postcodes) and indirect identifiers (e.g. information, which when linked to other data, could identify participants such as workplace, occupation, age or salary).

A combination of pseudonym, aggregation and redaction results in useable data without disclosing individual identities.

Guidance from the UK data service that will be followed throughout the project

Plan anonymisation early in the research process

Do not exclude data which makes the data unusable

Personal data should never be disclosed including name, age or address

Pseudonyms or generic information should be used instead of 'blanking out' information

If possible, ask participants not to mention disclosive information directly, which would need to be excluded in the interviews, and include this in a pre-interview briefing. For example, brief participants to not mentioning a particular church or individual involved in the spiritual abuse or trauma but referring generically to 'the church' or 'the vicar' or 'the parishioner'

Use the same pseudonyms throughout the entire project

Use the ‘search and replace’ function carefully so that unintended changes are not made, and misspelled words are not missed

Identify replacements clearly within the text e.g. with [brackets]

Retain copies of unedited documents for preservation

Create an anonymisation log of all suggestions, replacements, aggregations or removals and store separately from anonymised files

If there is an increased risk of harm or disclosure, consider redacting statements.

Steps suggested by the UK data service for anonymising data

Find and highlight direct identifiers by reading the transcript

Assess indirect identifiers:

Can the identity of a participant be known from information in the data file?

Can a third party be disclosed or harmed from information in the data file?

Assess the wider picture:

Qualitative: which identifying information about an individual participant can be noted from all the data and documentation available to a user?

Remove (or pseudonymise) direct identifiers

Aggregate or blur (in)direct identifiers

Redact indirect identifiers

Re-assess any remaining disclosure risk

Storing and sharing research data in accordance with General Data Protection Rules

According to operational guidance produced to advise researchers on implications of the GDPR in the implication of UK-based research, “participant data that are no longer identifiable or where the participant cannot be identified directly or indirectly is no longer personal data, and the GDPR transparency requirements do not apply”

Greater safeguards for research apply under new GDPR rules, including data minimisation (not collecting personal information unless absolutely necessary), consider security and storage of data and pseudonymise wherever possible. In pragmatic terms, this will look like an encrypted recorder, laptop, and any sensitive

documents containing confidential information being stored in a difficult to find, locked filing cabinet within my home.

Under most circumstances, transparency information must be provided on participant consent sheets (see GDPR operational guidance).

Appendix 5 - Ethics Committee Approval Letter

METANOIA INSTITUTE
13 Gunnersbury Avenue
Ealing, London W5 3XD
Telephone: 020 8579 2505
Facsimile: 020 8832 3070
www.metanoia.ac.uk

Madeline Saunders
Doctorate in Counselling Psychology and Psychotherapy by Professional Studies (DCPsych)
Metanoia Institute

11th September 2018
Ref: 12/17-18

Dear Madeline,

Re: An exploration of how Christian therapists work clinically with individuals who have encountered spiritual abuse and /or trauma within a Christian context

I am pleased to let you know that the above project has been granted ethical approval by Metanoia Research Ethics Committee. If in the course of carrying out the project there are any new developments that may have ethical implications, please inform me as research ethics representative for the DCPsych programme.

Yours sincerely,

Dr Sofie Bager-Charleson
Director of Studies DCPsych
Faculty of Post-Qualification and Professional Doctorates

On behalf of Metanoia Research Ethics Committee

Registered in England at the above address No. 2918520

Registered Charity No. 1050175

Appendix 6 - Ethical Protocol for Safeguarding and Disclosures of Historical Abuse

- Historical abuse is assumed to be of a sexual nature in policy documents and children are therefore also assumed to be at risk. Where allegations may involve questioning the safety of children as part of my research, further guidance comes into play e.g. (Working Together to Safeguard Children, 2015).
- For the purposes of this project, it also needs to be noted that historical abuse may be of a non-sexual nature, and therefore there may be less-robust reporting mechanisms. Spiritual abuse is not currently recognised as a separate form of abuse because it tends to be subsumed within other categories (e.g. emotional or sexual).
- There is no legal requirement for researchers to disclose allegations of abuse made towards them. However, as a trainee psychotherapist/counselling psychologist, I am bound by ethical guidelines of the bodies that I am both training under and will register with. Therefore, I will assume the position of a research-practitioner and adhere to the guidelines set out by these bodies (BPS, HCPC, UKCP). These 'divided loyalties' (Gilbert, 2008, p.76) can create ethical dilemmas.

  "The National Society for the Prevention of Cruelty to Children (NSPCC) defines non- recent abuse (also known as historical abuse) as an allegation of neglect, physical, sexual or emotional abuse made by or on behalf of someone who is now 18 years or over, relating to an incident which took place when the alleged victim was under 18 years old."

  Whilst I will be interviewing therapists and not their clients directly, there remain possible scenarios within which historical abuse may be disclosed during the course of the research. These include, but are not limited to;

- Therapists (research participants) disclosing historical abuse that has not yet been documented or appropriately reported at the time of the interviews on behalf of their clients
- Therapists (research participants) disclosing their own experiences of historical abuse during the interviews with myself
- Individuals contacting me directly as a result of seeing the advert, perhaps not as potential participants, but those viewing 'research' as a suitable means through which to tell their story perhaps if counselling has not previously felt acceptable to them. Whilst I would not engage with these individuals from a research perspective, it may be that I work with them therapeutically as clients, in which case all protocol for managing disclosures would be managed appropriately as per the standard BPS (2016) guideline, but this would be outside the remit of the specific research ethics.

  I therefore need to have a protocol in place should any of the above, or similar, eventualities arise. The primary reason for disclosure needing to be well managed is because the experience of disclosure itself can either hinder or promote the potential for post-traumatic growth. Secondly, mechanistic or hasty decisions that are not well planned increase the likelihood of losing the engagement of the individual, increasing their risk of harm to self or the loss of critical safeguarding information (BPS, 2016). Given that I will be meeting individuals in a research context, I have used the BPS guidance as a framework for developing a protocol that is suitable for use within this frame.

The stance taken prior to conducting any interviews

Explain the usual boundaries to confidentiality, including that some situations may allow for disclosure without consent, and that data cannot be removed from my knowledge, and therefore my professional obligations surrounding safeguarding, even if it isn't published in the main body of work. These scenarios tend to be limited to:

- Client safety
- Safety of other persons who may be endangered by the client's behaviour
- The health, welfare of safety of children or vulnerable adults (BPS Code of Ethics, 2009).

The stance of the researcher at the time of a disclosure

- Demonstrate empathic listening and take the disclosure seriously
- Powerfully communicate that the disclosure has been heard thus validating their experience of making the disclosure, that it was not their fault and that the responsibility always lies with the perpetrator
- Do not encourage details but do not prevent the individual sharing them either (BPS, 2016)

Given the nuances of the research frame, I outline a protocol based on what I imagine would be the two most likely possible scenarios in terms of historical disclosures of abuse.

1. If a therapist discloses historical abuse that happened to them whilst being interviewed as a research participant:

- Hold the empathic and affirmative stance outlined above
- Given the non-therapy nature of the research interview context but the therapeutic potential of disclosure, a balance needs to be struck between enabling the individual to share their story without promising ongoing therapeutic intervention
- I would see my role as predominantly one of signposting and guidance, based on a clear understanding of the protocol to be followed as per the BPS guidelines for disclosures of abuse. See Figure 2 (p. 9) BPS Guidelines for managing different scenarios involving disclosure to other services and consent to do so
- The research interviews will be recorded, and I will need to recheck the client's consent for any material to be included. See further protocol to ensure anonymity of participants involved.
- Be aware of the psychological impact of disclosure, particularly given the fairly transient nature of the research/participant relationship, and ensure the participant has access to support following any disclosure
- If the participant would like to be accompanied to make a formal disclosure, then I would view this as part of my duty of care for them as the researcher/practitioner, accepting that an unusual situation calls for going beyond the usual or typical role (BPS, 2016, p.12)
- In the interests of safeguarding, confidentiality can be broken if further people are believed to be at risk and the perpetrator is obviously identifiable. If this were the case, I would need to gently explore the individual's specific fears, and

whether there are dangers of retaliation by the alleged perpetrator or their community (BPS, 2016, p.12) and signpost to further support.

2. If a therapist discloses historical abuse that happened to one of their clients, and for whatever reason, has not responded according to the BPS/HCPC/UKCP ethical guidelines:

- First and foremost, at the start of all of the interviews, I will need to make it very clear to the therapist participants that there are exceptions to confidentiality. If it were the case that the therapist had not responded appropriately/with due professional care, this would clearly need to be sensitively managed, especially if it appears that the therapist is unaware of the significance of appropriately managing historical disclosures, doesn't believe their client or has avoided appropriate professional action in order to protect Christian perpetrators/collude with them for fear of defamation. Although these are unlikely scenarios, the needs of their client versus other (potential) victims needs to be considered (BPS, 2016, p.14).
- Concern is heightened if the abuse has not been reported and there has been no previous intervention from police, social or medical services; the alleged perpetrator has not been reported previously; they are a family member with ongoing contact with children; the alleged perpetrator holds a position of trust; it was organised or ritual abuse; the client is continuing to be abused by the perpetrator; the client is aware that other young people were abused (BPS, 2016, p. 14-15). I would add to this people who may be endangered by the therapists' behaviour also.
- I would need further supervision if these complex scenarios were to occur, both to ensure appropriate and ethical action, preventing a unilateral decision (BPS, 2016, p. 16) and to support me in managing difficult, ethical dilemmas.
- Access to an individual with safeguarding expertise would also become necessary, given that I will be working in a relatively isolated capacity as a practitioner-researcher. In either of the scenarios below, an anonymous conversation with the police may assist in deciding upon the best course of (non)action, especially if collusion is expected and a perpetrator is considered to be active given the contents of the therapists' interview.
- If their therapeutic relationship is ongoing: gently orientate the therapist participant towards the BPS guidelines and their own supervision to help them manage the complexity that has prevented the necessary steps from being taken towards supporting a client in their decision to disclose or not to additional services.
- If the therapeutic relationship has ended: this poses a particular ethical dilemma for me as the researcher, particularly if the identity of the perpetrator has been identified. Access to safeguarding expertise would become necessary.

In addition to the therapeutic stance held above, the following should also occur:

- Clarify whether any children are currently at risk from the alleged perpetrator
- Ascertain whether the adult is aware of the alleged perpetrator's whereabouts and any contact the perpetrator may currently have with children
- Advise the adult (therapist) to make a formal complaint to the police, explaining that perpetrators usually continue abusing
- Offer the adult support in making a complaint to the police; this can be done by first calling 101 who will put the individual through to a specially trained officer, who would take an initial first statement.

- Signpost to relevant services

Possible relevant services to signpost towards:

- https://www.pods-online.org.uk/ - excellent resources surrounding trauma and dissociation, also have a helpline.
- https://www.nspcc.org.uk/preventing-abuse/signs-symptoms-effects/non-recent-abus e/ - helpful advice and support for adults who were abused as children.
- https://www.victimsupport.org.uk/crime-info/types-crime/childhood-abuse
- https://napac.org.uk/resources/ - National Association for People Abused in Childhood provides resources that are useful for victims of childhood abuse and those supporting them.
- http://www.theliturgists.com/podcast/2017/5/16/spiritual-trauma - an overview of spiritual trauma and how it impacts the body, mind and soul. Informative and affirming.

For professionals:

- https://www.bps.org.uk/news-and-policy/guidance-management-disclosures-non-rece nt-historic-child-sexual-abuse-2016 The BPS guidance on managing disclosures.

Appendix 7 - Examples of Core Memos used During Research Process

Research Diary extract

31.10.18

"I felt aware of holding the tension between steering towards what I need to know but also being spontaneous and following her lead. I think some of the richest material emerged when I managed to hold my intention in mind but go with where we were led by her narrative e.g. there was an interesting section on attachment that may not have emerged had I not asked a particular question. I found myself making lightly observing statements as a way to clarify what I had heard. The themes today seemed to be attunement, the importance of modelling something different and ensuring that the client is always the one that holds the power. I left feeling as if my participant had shared her story, I wasn't aware of difficult transference given my assumptions about Christian counsellors. In that respect it was humbling. That on-the-ground experience is to be valued if it is held within a consistent, boundaried frame. I noticed that I didn't feel unsafe even when asked whether I am a Christian, something I had reflected on beforehand. We talked about Fowler's stages of faith and I explained that I feel I'm in a period of transition, but faith has been a part of my story for a long time. When I heard this participant's own experience of SA, I felt so grateful for her generosity of spirit. This also made me reflect on how self-disclosure might be used to foster a strong therapeutic relationship and help others trust that there is hope for their healing".

Reflective Journal Extract

15.5.19

"Having seen my spiritual director today, and discussed how I consider a God figure, I realised that I had been carrying a lot of shame about how I perceive God and whether I could be called a Christian in light of that conceptualisation. I think becoming less judgemental of myself in terms of how I experience and understand my faith will lessen the likelihood of me projecting my fear that others will do the same. Importantly for this project, I have become more aware of my prejudice against Christian counsellors and recognise this to be based on my own experience of judgement from those with power over me. I feel reassured that I have seen through the interviews with participants that it is possible to hold a position of power without using that as a platform to project the intensity of one's views and beliefs".

Reflective Memo: Shifting the Analysis Towards 'Action Based' Processes

15.10.19

I had completed my analysis, but it felt as if it read more like a narrative enquiry and did not speak enough to action-based processes. Furthermore, it felt as if there was not a core process upon which to hinge the 'action-based' nature of a grounded theory. My thinking before this was that I wanted to document the journey through therapy and did not want to neglect the experience of the client or the therapist, however this made it feel too broad without enough focus. I initially landed on 6 core categories:

1. The person of the therapist
2. Therapeutic foundations
3. RSA in the room
4. When RSA emerges in therapy
5. Therapeutic aims for clients
6. Sustaining the therapist

I felt there were three core categories which coincided with the numbered points above; developing a solid working alliance (1. the person of the therapist and 2. therapeutic foundations), enabling a co-created space in which RSA can emerge and be seen (3. RSA in the room, 4. when RSA emerges in therapy) and the reconstruction of selfhood (5. therapeutic aims for clients and 6. sustaining the therapist). I then positioned focused codes into three blocks coinciding with these categories. The problem with this model was twofold; it was difficult to know which focused code went with which category (as it could have been one of two) and there wasn't an overarching process that could be seen within the whole theoretical model.

I therefore set about simplifying it and extracting the process-based actions and landed on the following core categories:

1. Positioning self, alongside the client
2. Holding tensions and boundaries
3. Orienting towards hope and healing

I felt that these titles captured the experience of not only the participants in the study but are also common within psychotherapeutic processes. Whilst similar to the first

model I developed, the titles of these categories speak to action rather than description. I felt the core process captured is the therapists' dance between the personal and professional use of self, and the new model captures the personal and professional component of the three core categories, as it relates specifically to faith-based processes in the therapeutic setting. I was therefore able to position my focused codes as either relating to the personal or professional component of the three new categories outlined above. This seems simpler, more coherent, and more focused upon the action-based processes therapists engage in when working with RSA from the position of holding faith themselves.

Reflective Memo: Integrating the Focused Codes 'Choice to Disclose Personal Faith or Not' and 'Sensitive Use of Self-Disclosure'

6.11.19

Initially these codes were separate. 'Choice to disclose personal faith or not' was positioned under the personal aspect of 'Positioning self alongside client' and 'Sensitive use of self disclosure' was positioned under the professional aspect of 'Holding tensions and boundaries'. However, I decided that the underlying process was the same, which was predominantly around how the therapist felt they could position themselves in order to establish the most effective working alliance with their client. Whilst they managed their disclosures in a manner that paid attention to appropriate therapeutic boundaries, I felt this was secondary to the reason for the disclosures in the first place. I therefore decided during writing up the analysis that these codes were best represented under the same focused code, which is now entitled 'Sensitive use of self–disclosure'.

Appendix 8 – Transcript to illustrate analysis process

'→' refers to when I missed out lower levels of coding because I was able to assign the data to a higher level of coding.
'Unused focused code' refers to data that did not directly support an answering of the research question and so was excluded for the purposes of this project.

Hannah: Interview 1.

R/P	Interview	Initial coding	Focused code	Core category
R	If a client were to come into your therapy space, do you tend to find that they bring up the issue of spiritual abuse and trauma or do you feel like this might be something that comes in more from your reflections on their situation?			
P	Yes, because I think what you're saying is that there are a lot of people who come for therapy not realising what they've experienced is spiritual abuse but it's the same as other abuse too - often people don't realise that what they've experienced is abuse and actually gently, as we work, helping them to realise that it's abuse, for example, I do quite a lot of work with clients finding, pointing out what they need as a child, and we look at initial needs- what did they need and did they get it? If they didn't get it from... who they got it from and what they didn't get and is it being met today. I've got a set of brilliant cards I use for that and in the process, you know, talking about it, one can discover not only has there been physical abuse, emotional abuse, but there's been spiritual abuse as well.	Client experience Noticing client naivety Clients not realising their story contains abuse Explaining inner-child work Explaining different therapeutic interventions Earlier developmental process brought into therapy Spiritual abuse may be uncovered in developmental history	Unused focused code Choose appropriate therapeutic interventions Enable the story of RSA to emerge	→ Orienting towards hope and healing Holding tensions and boundaries
R	So you might use, those prompt cards for example, that might be something you would use that would support you in, it sounds like it would support the client to			

	come to realise what they've experienced - partly for themselves as well			
P	I mean I think it's much better if the client discovers it for themselves because I think the lightbulb goes on [yeah] rather than being told [and has that been your experience?] that's what I endeavour to do, to make sure that the client themselves owns it [mm] and sees it for themselves and I hope that the work I do enables them to discover it for themselves because I think it resources them in a way that telling them wouldn't	Client self-discovering spiritual abuse	Choose to label RSA or not	Holding tensions and boundaries
R	I was just wondering if there might be some parallel processes possibly, in terms of power, I don't know if that means anything in terms of kind of, your experience and what you've discovered in working with clients			
P	Absolutely, because I think the important thing is that the power dynamic between the two of us is so important to work that we're equals, we're in it together, we're on a journey of discovery together and for example, I may know something more than you but you know yourself much better than I do, so it's an equal journey that we're making	Noting the power dynamics	Reflect on power processes	Positioning self
R	I can hear that sense of collaboration, it sounds like that's really important			
P	Because I believe that as a good therapist I empower my clients [mm] I don't diminish them [mm, mm] so it's finding ways to empower them because so often clients have been depowered, particularly with spiritual abuse and particularly in the Christian context [mm] I think being a Christian, if, adds to problems for people because I ought to put up with this or you know, there are so many Christians who are not self compassionate [mm] despite the fact that 9x in the new testament	Awareness of skill level → Lack of self-compassion as a trigger for spiritual abuse	Therapist identity Client experience Informed by Christian narrative, not dominated by it	Unused focused code Holding tension and boundaries

	'love your neighbour as yourself' - I do point that out occasionally too for people, it's about self compassion, it's about kindness to oneself, considering oneself, looking after oneself, erm, and there is a lot of false ideas about in, particularly in the Christian, you know, I have to bend over backwards, I need to be a doormat, I need to, I have to put up with things and of course, so often, it's quoting scripture out of context, just one line, and, no that's not what it says, let's read the whole thing	Using biblical encouragement to support clients	Client experience	→
R	Yeah, so reading scripture might be something that you would do with your clients [only...] if it felt ...			
P	Only, only if ... in my therapy agreement, I always ask people do you have a faith, do you want it involved or not, how, how do you want me to deal with this so that we write it into the contract so that I know there are Christians who come and say, oh yeah, I want you to, I want you to use scripture, I don't even mind if you pray with me and I say, oh ok, we'll see how we go! But I get from them what they want in their therapy so that they decide, they choose.	Boundaries and contracting Not assuming spiritual matters involved in the therapy Client-led process	Manage self-care and negative impact Emphasise client-led process Emphasise client-led process	Orienting towards hope and healing Positioning self Positioning self
R	Through being a therapist and working with spiritual abuse and trauma, what would you say, one of the, or the most important lessons you've learned about this kind of work is?			
P	I think it is to model something very different from what they've experienced. ***excluded excerpt as client identifying information*** I just think, I did my job [mmm] and, and, it's about, it's about seeing transformation I think, and I think it's about, it's about listening with compassion, hearing what somebody's heart really is saying [mm] often not what they're	→ Explaining stance as a therapist Focus on the therapeutic relationship	Choose appropriate therapeutic interventions Supporting clients towards self-discovery and awareness Emphasise client-led process	Orienting towards hope & healing Orienting towards hope & healing Positioning self

	saying with their lips but what their heart is saying [mm, mm] and finding the right words and sometimes, not being, most of the time not being afraid of silence.	Attuning to client's emotional state	Focus on the therapeutic relationship	Positioning self
R	Say more about that?			
P	Yes, I think there is a tendency in Christian circles to jump in and rescue. Yes, I think there is a tendency in Christian circles erm, to jump in and rescue. And I think that sometimes we just need to sit with somebody and just hear their pain, and feel their pain, and not...words are inadequate I think so the work in the implicit realm is very powerful so I have learnt not to be afraid of silence and, I mean, I have one client who processes so slowly that I have had to learn to listen for a very long time. But it's tracking isn't it, it's tracking your client, going with them really	Therapeutic challenges Challenging Christian tendencies Attuning to client's emotional state Welcoming silence Implicit levels of working Words are inadequate	Unused focused code Unused focused code Focus on the therapeutic relationship Choose appropriate therapeutic interventions	Positioning self Orienting towards hope & healing
R	Yeah, it's making me think about those processes of attunement and erm, yeah, it sounds to me as if that feels really central in your work			
P	You know, not quoting scripture at them, mmm, which is one of the worst things you can do, but just hearing their heart, sitting alongside them,, maybe just being quiet, erm, you know, I will even say to my clients sometimes, do you need connection, would it help to just sit with you	Therapist identity Explaining stance as therapist →	Focus on the therapeutic relationship Choose appropriate therapeutic interventions	Positioning self Orienting towards hope & healing
R	And then what would that actually entail?			
P	Well, it depends what they want therapeutic touch, you know, would it be ok if I just held your hand, would you like that, would that help? And most people say, oh yeah, I just need some connection at the moment when they're in that pain. It's being very sensitive to what, and of course, I tend to get to know my clients and then working with them, know	→ Attuning to client's emotional state	Choose appropriate therapeutic interventions Focus on the therapeutic relationship	Orienting towards hope & healing Positioning self

	what they find helpful and what they don't find helpful	Therapist identity	Unused focused code	→
R	And this is leading me to think about the way that people communicate their distress when they've experienced spiritual abuse and I'm wondering if you could say a bit more about your experience of erm, people's distress as it relates to this form of abuse and trauma?			
P	I think there are varieties of reaction to it. I think there are some people who are immediately in tears and can talk about it quite openly and I think there are others who find it extremely difficult to talk about, and actually, it takes time to actually tease out the details, if needed and how they feel about it so there's such a variety depending on the personality of the person and how they react to it And you know, I do have clients who basically say, oh it doesn't matter, it was alright and then you have to say, ok, let's just look at it you know, if that happened to somebody else how would you feel about it? Oh yeah, I would feel quite cross about that! But it happened to you. You know, and having to tease out how they really felt rather than what's coming over on the surface	→ Attuning to client's emotional state → Modelling anger Therapeutic interventions for modelling anger	Choose to label RSA or not Focus on the therapeutic relationship Choose appropriate therapeutic interventions Choose appropriate therapeutic interventions	Holding tensions & boundaries Positioning self Orienting towards hope & healing Orienting towards hope & healing

Monica: Interview 1.

'→' refers to when I missed out lower levels of coding because I was able to assign the data to a higher level of coding. This participant was my penultimate interview and therefore when able to, I went straight to focused coding.

R/P	Interview	Initial coding	Focused code	Core category
R	In terms of that mutual discovery, I think that's a really interesting phrase. Is there anything else that you think particularly characterises that or anything that's made you more open to those mutual discoveries?			
P	I think for me in practice, holding curiosity with any client about	→	Choose appropriate	Holding tensions

	what might emerge. When I say that, what I mean is that often when clients come and we work out what the presented issue is or they tell us what the presented issue is, holding the possibly that that may not be the deep presenting issue. They may present with anxiety, the present with stress, they may present with relational difficulties, but holding the curious possibility that something deeper might emerge. And for me personally what is really important is recognising that, whether the client has a faith or not ... I do work a lot with Christians these days, but I also like working with people of other faiths or not faith. That's really important for me. That said, I believe that the Spirit is present in the room and can enlighten understanding in that therapeutic space, which is really important, and being open to that, and therefore being curious about what might emerge in that space.	Presenting issues may hide deeper issues → Holding curious possibility that something deeper may emerge Therapeutic understanding facilitated by holy spirit Openness to the spirit facilitates and deepens curiosity	therapeutic interventions Enable the story of RSA to emerge Enable the story of RSA to emerge Enable the story of RSA to emerge Spiritual processes in the therapy room Spiritual processes in the therapy room	and boundaries Holding tensions and boundaries Unused focused code
R	So, the Holy Spirit or that sort of presence of God, somehow, forms part of that kind of therapeutic third?			
P	Indeed, yeah, absolutely.			
R	Yeah, so there's something extra?			
P	Which quite frankly is a bit of a relief, because it's kind of not all up to me	→	Therapist's stance towards spirituality	Unused focused code
R	Yes, yes. So there's something maybe that isn't that tangible or perhaps that easy to explain in the beginning, but over time this mutual discovery might occur, unless it's been brought into the room very obviously, like with the first client you spoke about?			
P	Yes.			
R	But just to come back to, are there any really red flags? Things where you would think, "I would be very surprised spiritual abuse isn't present here." Or is it not that cut and dried or black and white?			

P	I don't think it's always that black and white, and I would ... It depends when it starts to emerge, but again I would hold it as a possibility sometimes. If I start to sense that there might be something, I would hold it as a possibility. The same if the client says they've been abused in any way, if it's that explicit, and often it isn't, actually. What I've found over many years in practice is that sometimes it's a gradual unfolding, and that possibility is to do with trust as much as anything, as well. Sometimes clients come and they will disclose the most enormous things straight away, and they might say to you, "I've never said this to anyone before," but more often than not in my experience, there's a gradual, maybe a mutual understanding if I'm working one on one with somebody, that maybe something wasn't right……{excluded text because possibly identifying} **Some transcript excluded here as potentially identifying**	Describing spiritual abuse Spiritual abuse perhaps more in the shades of grey than in black or white Enable the story of RSA to emerge Usually the narrative about abuse emerges slowly and mutually The disclosure of abuse is grounded in trust Psychotherapy as a 'quick release' for some, when disclosing trauma	Unused focused code → Enable the story of RSA to emerge Focus on the therapeutic relationship Enable the story of RSA to emerge	→ Holding tensions and boundaries Holding tensions and boundaries Positioning self alongside the client Holding tensions and boundaries
R	You said that over the course of your time in practice you've worked with lots of clients who've experienced abuse and trauma in many different guises, and I'm wondering, how do you feel that spiritual abuse is different? What defines it as different to emotional abuse or sexual abuse, for example?			
P	An excellent question, isn't it? It's hard to word my response to that, actually, but for me I'm not saying that the other forms of abuse don't wound you at your core because I think they do, potentially. But there's something about spiritual abuse that can wound you at soul level. I'm very curious about if you've suffered spiritual abuse, whether ... how does that affect you spiritually if you have suffered spiritual abuse? In my own family,	Careful to distinguish spiritual abuse, but not to reify it Soul-level damage	Describing spiritual abuse Classic profile of a spiritually abused individual	Unused focused code

	out of the three of us I'm the only one who has a faith, and I think that is a result of what happened in our growing up years in terms of spiritual abuse. My siblings have both gone "Don't want	→	'Classic profile' of a spiritually abused individual	Unused focused code
	anything to do with that religious stuff, thank you very much." So, it is something about how does it	→		
	affect us at soul level. As I say, any form of abuse affects us at our core as to who we are and what we are, but there's something about spiritual abuse, I think that ... I don't want to say	Other forms of abuse may not impact spirituality so deeply	Describing spiritual abuse	Unused focused code
	that it's even more significant. I don't mean that, because any form of abuse is absolutely wrong, but does it affect our spiritual	Client experience	Unused focused code	→
	area? Sometimes ... I don't want to generalise because each client that presents with any form or abuse is affected differently. In one way it's not the abuse, it's	Important to recognise individual reactions and impact	Choose appropriate therapeutic interventions	Orienting towards hope & healing
	how it affects the client that's important, and it's in sitting with the client with the core conditions, the UPR [00:23:42], the empathy, that is what for me starts the	"it's not the abuse, it's how it has affected the client that's important"	Core conditions begin the healing process from spiritual abuse	Positioning self alongside the client
	healing process, and particularly in spiritual abuse it starts the healing process because maybe they can talk about things. I think with spiritual abuse, often it has	→	Emphasise client-led process	
	never been talked about. That's true of any form of abuse, as well. But if something's going on in your church, if something's going on in	Spiritual abuse starts to heal by talking about it	Client development and healing	Unused focus code
	your family spiritually, it's very hard to talk about it because you actually can't argue with God. If somebody says, "God has said	→	Enable the story of RSA to emerge	Holding tensions & boundaries
	this," how do you even begin to make sense of that? Because you can't argue with that. It puts that person in a place of being	Spiritual abuse may be particularly hidden & silent	Choose to label RSA or not	Holding tensions & boundaries
	unchallengeable, in my humble opinion, particularly if it's	→	Describing spiritual abuse	
	somebody who is a figure of authority, whether that's a priest, a vicar, minister, a church leader, a scout leader, a parent. Whoever it	Unchallengeable authority figures when they use God's authority to back them up	Perpetrator characteristics	Unused focused code

	happens to be, then it's very difficult to address that. **Some transcript excluded here as potentially identifying**	Feels like 'arguing with God' to name spiritual abuse God's name is abused to give people a sense of power	Choose to label RSA or not Describing spiritual abuse	Holding tensions & boundaries Unused focused code
R	Yeah, so processing some of that anger, that's something I have to say I've heard in other interviews as well. A sense that this shouldn't happen, and a sense that the church is meant to be a safe place, and when that goes wrong, when it's been wrong, that ... One of the biggest impacts on the therapists I've spoken to does seem to be a sense of injustice.			
P	Yes, absolutely, and that's one of the things that does make me angry is the injustice, but particularly when it's injustice within a spiritual setting, or when it has spiritual flavour to it, the injustice of that makes me very angry, actually.	→	Therapist's feelings about spiritual abuse and trauma	Unused focused code
R	Does that ever come into the room with clients? Is that something you've experienced clients express, too? How do you manage that anger therapeutically?			
P	I'm thinking of the client I spoke about whose parents were missionaries, and I myself have worked for a missionary society. She was extremely defensive of her parents. They were great parents, and they were. I had to be very ... and I felt some anger with them, actually, that their children were sent back to the UK and dealt with in such a way. We have to recognise the era of that, as well, but I very gently and very sensitively, over a period of time, fed back my sense of anger at the abandonment. I probably didn't use that word, but at the abandonment that went on, until eventually she started to realise ... Well, I think she did realise, but	Client experience Feeling angry about client's experiences but bracketing own response → Using own anger congruently to support client back into contact with their own anger	→ Therapist's feelings about spiritual abuse and trauma Client experience Choose appropriate therapeutic interventions	Unused focused code Orienting towards hope & healing

	started to knowledge that as not being right. But then of course it brought up the question, "But Mum and Dad actually were doing what they felt God called them to do. So how do I marry that?" So, we gently explored that together as I recall the work. But yeah, I think sometimes congruence is appropriate when we're feeling angry for a client, but sometimes we hold onto that anger until the time is right to maybe gently share some of that with the client. And we may never be able to do that, so we need to have somehow a way of processing that anger maybe outside the therapeutic sessions.	Feeling like the intentions of those who hurt clients can't be questioned if done in the name of God Gauging whether sharing anger with clients is appropriate or not Clients may never be able to own their anger	Client experience Emphasise client led process Client experience	Unused focused code Positioning self alongside client Unused focused code
R	Yeah, and how do you do that?			
P	It's usually something physical for me. That's how I express my anger, but I often feel my anger in my legs. So, kicking something like a ball or a beanbag or something like that, or doing something very physical, going out and walking very fast, or something like that, so that those stress hormones are discharged from my body. Really important, just so that I'm left holding onto that.	Discharging anger appropriately after client work	Manage self-care and negative impact	Orienting towards hope and healing
R	Yeah, part of your self-care.			
P	And then obviously, if I felt I needed to, I'd take myself back in therapy, as well.	→	Manage self-care and negative impact	Orienting towards hope and healing
R	Yeah. Something else that I think characterises spiritual abuse and trauma is an abuse of power, of course, and that control, and when we work as therapists there's inherently a power dynamic present. I'm wondering how you manage the power difference that's there between therapist and client anyway, and if you feel like there's anything that maybe heightens that when spiritual abuse is present or has been part of the client's experience?			

P	I think power generally, if I start there, as you're saying is implicit		Emphasise client-led process	
	in the relationship, and what I try to encourage clients to see is that they are the experts on themselves. I happen to have some training and some	Client as expert	Reflect on power processes	
	experience, but they know this very well. So to explicitly knowledge that and to encourage the clients to believe in that is really important. There also are implicit ways that I try and balance that power. One is by empowering the client, but also in my room I ensure that all the seats are the	Making it explicit that clients are the experts on themselves	Emphasise client-led process	
	same. I once had a therapy session myself when I was training, within an established therapeutic relationship, where the therapist was sat higher than myself, and that was amazingly disempowering, even in an	Empowering the client to feel equal to the therapist	Emphasise client-led process	Positioning self
	established therapeutic relationship, actually. So, making sure that we're sat on the same chairs implicitly ... it may sound really small and really	Using physical space to reduce power imbalances	Reflect on power processes	
	insignificant, but I think it's important, personally. We're on a level here, is what it's saying, and let's explore together. One of the	→	Actively explore issues of faith & spirituality from assessment	
	things I say about the assessment session is it's an opportunity to mutually explore how we might work together, so that right from the beginning I'm saying to the	Using assessment as a way to begin addressing implicit power differences	Actively explore issues of faith & spirituality from assessment	
	client, "You're important here."	'Right from the beginning I'm saying to the client "you're important here"'	Choose appropriate therapeutic interventions	Orienting towards hope & healing
	In terms of spiritual abuse, I think there's a real dilemma about spirituality entering the room. For example, I don't normally pray with my clients. I have colleagues who do. I never say never because once or twice it has happened, particularly is for client has asked for it. One of the reasons for that is that I believe	Not clear-cut whether spirituality should enter the room	Assess appropriateness of spiritual interventions	Holding tensions and boundaries
	my prayers are no more effective than the client's prayers. This is my personal belief, that if I pray, that somehow there might be a	Spiritual processes in therapy room	Unused focused code	→

	belief in the client that God will work. Somehow that's not quite magic, but what about their prayers? Whenever it has happened, I've encouraged the client to pray as well. So, I think it's in those ways that there is hopefully a conveyance of the fact that I want to ameliorate the power imbalance as much as is possible, and I think particularly with spiritual abuse you have to be so careful talking about spiritual issues, because I would not want to come across as a spiritual authority when a client has been abused by somebody in authority.	Prayer should be client-led Careful with prayer as it can introduce power differences Encouraging equality when praying Therapist committed to ameliorating power imbalance Talking about spiritual issues must be careful to avoid re-enacting abusive processes	Spiritual processes in the therapy room Reflect on power processes Therapeutic challenges	Unused focused code Positioning self Unused focused code
R	Yes. I think that's why a lot of therapists, from what I understand, really avoid bringing spirituality into the room.			
P	Yeah			
R	That sense of really not wanting to impose, not wanting to sound judgmental. Like you said, not wanting to come across as having too much power. What do you think it is that makes it safe in the way that you do it? And I can hear that you're really careful around that. What makes it safe and what gives you the courage to recognise that spirituality is important in people's lives and that some people really do want to talk about it and express it in therapy?			
P	Yeah. It doesn't feel like it takes courage actually, for me now. It would have years ago. As I said, my first placement was at a	Talking about spirituality doesn't feel courageous	Assess appropriateness of spiritual interventions	Holding tensions and boundaries

	Christian counselling agency where in one way it was an advantage over private practice because clients coming knew that the counsellors were all Christians, and so it much more naturally came into the room. I think in private practice it's different because there's not that explicit acknowledgement. I don't have on my website or anything that I'm a Christian. I'm not the ACC, I'm listed but that's about it [00:50:52]. It just seems to happen naturally now, is the way I would put it, and I think it's partly because that I ask at assessment. That kind of opens up a possibility at an early stage of that happening. Also, my faith is very much part of me, so I can only sit with my clients as me. I can't sit as any other therapist. It would be wrong to even try to do so.	Contextual issues Private practice is usually more unknown in terms of faith status of therapist and client Addressing spirituality at assessment paves a way for it to come into the room "Also, my faith is very much part of me, so I can only sit with my clients as me". Being authentic as a therapist is ethical, the only option	Unused focused code Therapist's choice to disclose faith or not Actively explore issues of faith and spirituality from assessment Therapist's choice to disclose faith or not Therapist identity	→ Positioning self alongside client Unused focused code
R	And so you can't extricate your faith either?			
P	I can't extricate my faith even when it doesn't get mentioned in the room, which is often, you know. Let's be real here. There are lots of clients I work with who come and they go and they have no idea about my faith, and that's okay as well. But also, my experience is that people want to talk about their spiritual lives.	Therapist's choice to disclose faith or not →	→ Assess appropriateness of spiritual interventions	Positioning self alongside the client Holding tensions and boundaries

Appendix 9 - Initial Interview Schedule

Interview Questions

- How do you, as a Christian therapist, explore and work with spiritual abuse and trauma with your clients?

- How does material of this nature come into the room?

- What are the particular characteristics of this work?

- What are the particular challenges of this work?

    For you?

    For your clients?

- How do you, as a Christian therapist, help your clients navigate their religious communities and connections following an exploration of spiritual abuse and trauma in therapy?

- What do you, as a Christian therapist, experience as the impact upon your clients when spiritual issues, particularly those that relate to abuse and trauma, start to become better integrated? How do you facilitate this?

- How do you experience the relationship between you when spiritual trauma has entered the therapeutic space in being named?

- What are the possible pitfalls or risks of harm that could become apparent when working with those who have experienced spiritual abuse and trauma?

- How do you manage your countertransference responses to this material?

Appendix 10 - Transparency Exercise

Analysis Validation Exercise

How do Christian therapists work with clients who have experienced RSA in a mainstream Christian setting?

From the analysis of data within this project, I developed three main categories. Under each category, I give a short explanation as to what the category means and then I list the focused codes contained within those categories.

I would like you to match the quotations below (arranged alphabetically) with the focused codes as they are listed under the three numbered core categories below.

Thank you for supporting my work in this way.

1. Positioning self alongside the client
   a. Sensitive use of self-disclosure [Personal]
   b. Actively explore issues of faith and spirituality from assessment [Professional]
   c. Focus on the therapeutic relationship [Professional]
   d. Reflect on power processes [Professional]
   e. Emphasise client-led process [Professional]

2. Holding tensions and boundaries
   a. Informed by Christian narrative (not dominated by it) [Personal]
   b. Choose to label RSA or not [Professional]
   c. Enable the story of RSA to emerge [Professional]
   d. Assess appropriateness of spiritual interventions [Professional]

3. Orienting towards hope and healing
   a. Manage self-care and negative impact [Personal]
   b. Prioritise therapy over theology [Professional]
   c. Choose appropriate therapeutic interventions [Professional]
   d. Support clients towards self-discovery and awareness [Professional]

Category 1 – Positioning self alongside the client	Which focused code? [1a, 1b etc]
"Having experienced considerable spiritual abuse myself, it is vital to work on one's own trauma/abuse issues first so that we are not triggered by a client's abuse issues. However, when clients can see that I have experienced abuse and have come through the experience with greater confidence and self-assurance it gives them confidence that they too can do the same."	

“I might have expertise or knowledge or whatever, but I never ever think they’re you know, “I’m this and they're that” so it’s the therapeutic relationship and the trust in that therapeutic relationship and their trust in me”

“I want to know their whole context of faith and spirituality and how it fits into their life”

“....my experience has been that it [disclosure] fosters much more trusting relationship between me and my clients, when I feel I am able to be open about my beliefs. They see me more as a human than a professional, so can relate better with me. I feel more able to be myself, and not 'monitor' what I say as much as I would in secular practice”

“the very sense that I might have some more knowledge or that I might have some more qualification or something like that brings a client into a place of looking to me as a person of experience and whatever and therefore the position in itself creates that dilemma”

“...would take on a non-expert role so I'm aligning myself with them, and saying, "Yes, I'm trained in this, but I'm here to go through the process with you. You are the expert of your experiences"’.

Category 2 – Holding tensions and boundaries

“I hope that the work I do enables them to discover it for themselves because I think it resources them in a way that telling them wouldn’t”

“I would say it’s really important that they’re not shamed in that process, so I say to them, some people, I’ve got clients who don’t want prayer at all, I’ve got other clients who do want prayer, I’ve got other clients who want verses of scriptures and I’ve got others that don’t – where are you on that continuum?”

“more often than not in my experience, there's a gradual, maybe a mutual understanding if I'm working one on one with somebody, that maybe something wasn't right”.

“.... you know good Christian people don’t get angry and so, to give her permission actually, to be angry that no, this is appropriate anger and even looking at the times when Jesus was angry in the bible, and you know, the times when Jesus was angry, it's all about injustice”

Category 3 – Orienting to hope and healing

“It's a bit of a personal dilemma there, that struggle between guiding someone with their discipleship, and being their therapist, and when can we be both”.

“So you've got your configurations of self, you've got your parent-adult-child of TA, and you've got the whole is greater than the sum of your parts of Gestalt, and what's in the foreground and what's in the back”.

“the thing that facilitates me not being burdened by another’s story is that I know it can change and I know it can be redeemed and because I fully know that and that is partly because of my own story, but because I fully know that I am never over-burdened by another’s story because it sounds like it can change”

“With any topic, they're just the same, we treat them as any other topic if they're talking about some grief or bereavement or something, we've got to guide them to discovering something themselves.”

Appendix 11 - Email Calling for Second Round of Participation

Dear …………………………..

Many thanks for participating in my research a little while ago. I have now completed the first round of analysis and wondered if you would be prepared/able to consider a few further questions? I recognise that every client is different, so these questions are asking you to reflect on your practice quite broadly. The questions are as follows:

1. When you consider your client's healing processes from spiritual abuse and trauma:

a) What are the most significant psychological changes that you notice in them and what do you feel underpins their changes/growth therapeutically?

b) Which interventions/stances within your model of practice, do you feel facilitated these changes?

2. How do you understand any risks or negative impact when working with spiritual abuse & trauma, both for yourself and for clients?

3. What is it like for you as a therapist to have your own spiritual identity known in some way by the client, even if it isn't openly discussed with them? How do you think this alters the dynamic between you compared to if you were working in a purely secular context?

4. Whether you have experienced spiritual abuse or trauma or not yourself as a therapist with faith, what do you feel is the impact therapeutically when working with someone who has encountered a similar form of abuse and/or trauma?

Once again I am very grateful for your time and do ask me if you have any questions. I wonder if you may be able to get in touch with me by Sunday 24th March, either with your added thoughts or if you would like to answer these questions but would perhaps prefer a phone/skype conversation instead. If I haven't heard from you at all by then, I will assume that you'd rather not participate again at this stage.

Warmest regards,
Maddie
0781 4474 951

Appendix 12 –Working with Faith & Belief in Relation to RSA - Sample Reflective Questions as Part of a Workshop or Seminar

The sample questions could be used to promote a reflective, non-didactic dialogue between trainee therapists with faith or no faith and could be adapted depending upon the context. If, for example, a training course had no participants of faith, the first question might be adapted to instead establish what tensions might arise, if the trainee was part of a supervision group and another trainee started discussing their faith.

- As a therapist, do you see yourself as sitting more within the faith world or more within the counselling world, and what tensions does this create for you?
- How supported do you feel in supervision, if you discuss matters related to the integration of spirituality into counselling?
- Do you have any spiritually challenging experiences which might impact your capacity to attune to your client's spiritual needs or wounds?
- How do you feel about the prospect of clients coming to you because they have been hurt within the church? What are your immediate responses to this, and what might the impact of these responses be upon both yourself and your client?

How does it feel to make the following statements or questions (Leighton, 2014) when imaging yourself working with clients with fundamentalist or dogmatic views?

- 'I really appreciate you sharing your beliefs with me and I am picking up on some uncomfortable tensions perhaps between counselling and your faith and want to make sure I am accurate in this?'
- 'I can appreciate your belief as being the only truth for you. How do you think this is going to fit or not fit with psychology and our work together?
- 'I want you to know that I will take your religious beliefs seriously here. I am sensing some discomfort that this won't be the case and I really want to invite open discussion about this'