

ORIGINAL ARTICLE OPEN ACCESS

Religion and Spirituality in the Therapy Room: Perspectives From British Psychologists

Hannah Wall¹ | Maxinne C. Panagopoulos¹  | Christopher E. M. Lloyd² 

¹University of the Highlands and Islands, Inverness, UK | ²Centre for Psychological Sciences, University of Westminster, London, UK

Correspondence: Christopher E. M. Lloyd (C.Lloyd3@westminster.ac.uk)

Received: 22 October 2025 | **Revised:** 24 June 2026 | **Accepted:** 1 July 2026

Keywords: cultural competencies | professional training | psychologists | religion | spirituality | therapy

ABSTRACT

Background: Psychologists often receive limited formal training in addressing clients' religious or spiritual concerns, leaving many underprepared when such issues arise in clinical practice.

Methods: This qualitative study explored UK psychologists' experiences of engaging with religion and spirituality in therapy to identify key challenges and opportunities for professional learning and support. Semi-structured interviews were conducted with 14 qualified psychologists and analysed using thematic analysis.

Results: Four interrelated themes were constructed: (1) Cultural Framing of Religion and Spirituality in Psychological Practice, illustrating how British cultural norms influence openness to discussing religion and spirituality in therapy; (2) Lack of Support for Religious and Spiritual Competence, describing the absence of religion and spiritual content in training and continuing professional development; (3) Reflexivity and the Negotiation of Therapeutic Boundaries, reflecting variation in psychologists' comfort and confidence when addressing religious and spiritual issues; (4) Navigating Religious and Spiritual Issues in Therapeutic Practice, capturing differences in therapeutic approach and the management of self-disclosure.

Discussion: The findings highlight the influence of cultural attitudes on therapeutic engagement, limited institutional and supervisory support for addressing religion and spirituality, and variation in practice with clients. Greater professional recognition of religious and spiritual competence, enhanced supervision and reflexive training are recommended to promote more inclusive, confident and ethically grounded practice.

1 | Introduction

Although UK-specific evidence is limited, international research suggests psychologists and psychological practitioners tend to be less religious or spiritual than many of the clients they serve (Bergin and Jensen 1990; Hunt 2024). This is in line with US counterparts (Hofmann and Walach 2011) and has been termed the religiosity 'gap' (Delaney et al. 2007; Plante 2008). Studies from the United States have shown that psychologists' own religious and spiritual (non) beliefs can be a source of conflict for them and personal religious and spiritual positions can affect best intentions to work on religious and spiritual issues raised by clients (Barnett and Johnson 2011; Brown et al. 2013;

Delaney et al. 2007). In extremis this can lead to ethical issues such as judgmental practice (Magaldi-Dopman et al. 2011) and spiritually avoidant or dismissive care (Lloyd, Cathcart, and Panagopoulos 2026; Lloyd, Reid, and Cathcart 2026; Saunders et al. 2010) even though up to one third of clients may benefit from religious and spiritually informed support (Vieten and Lukoff 2022).

Captari et al.'s (2018) meta-analysis of 97 studies found that any form of religious and spiritual engagement by therapists tended to yield better client outcomes than no engagement at all. Research further suggests that therapeutic success relies on therapists' warmth, empathy, authenticity and openness—qualities

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Implications for Practice

The findings from the present study have several direct implications for practice and how psychologists (and wider therapists) are trained, supervised and supported to work with R/S in therapy:

- Make space for R/S in supervision and training: Participants often reported having little formal preparation for working with religious and spiritual issues, both during their professional training but also beyond this. Supervision and CPD could function as useful spaces for psychologists to reflect on their own assumptions and possible discomfort around R/S.
- Understand R/S within the client's specific cultural context: The findings suggest that religious and spiritual beliefs may be *misunderstood* when viewed singularly through secular British cultural norms. Practitioners should therefore be cautious about interpreting unusual or strongly held religious or spiritual beliefs as pathological without regard to their cultural, relational and personal meaning for the client
- Approach self-disclosure carefully: Participants differed in how they understood the role of psychologists' own R/S beliefs in therapy. This suggests a need for careful reflection about whether, when and how therapist self-disclosure is used. Specifically, the function of disclosure matters, and where disclosure occurs, it needs to be guided both by the client's preferences and requirements and therapeutic benefit.

Implications for Policy

- Include R/S more explicitly and substantively in professional standards and training programmes: Participants' accounts suggested that R/S is not yet consistently recognised and embedded across professional psychological training, supervision or professional development in the United Kingdom. Furthermore, training bodies and professional organisations could address this by including religious and spiritual awareness more explicitly within accreditation criteria, CPD guidance and supervision frameworks.

essential when working with clients who bring religious and spiritual issues to therapy (Brown et al. 2013; Knox et al. 2005; Mayers et al. 2007). However, religious and spiritual clients often report anxiety about raising such topics, fearing judgement or incompatibility between their faith and therapy (Knox et al. 2005; Mayers et al. 2007; Vieten and Lukoff 2022), a dynamic described as the 'Therapist versus God' problem (Magaldi-Dopman et al. 2011, 293).

Research demonstrates that existential, religious and spiritual issues are often deeply intertwined with mental health, identity and well-being, particularly for clients who identify as religious or spiritual (Lloyd 2021; Lloyd et al. 2025a; Lloyd et al. 2025b; Lloyd and Waller 2019; Lloyd and Connolly-Panagopoulos 2023). It is therefore essential that psychologists are equipped to engage with religion and spirituality (R/S) when it arises in therapy. The

present study explores psychologists' experiences and perceptions of R/S within therapeutic settings in the United Kingdom.

1.1 | The Move Towards Increased Religious and Spiritual Competence in Therapy

The limited recognition of R/S within British professional frameworks may reinforce its marginalisation. The British Psychological Society (BPS) has not published explicit guidance on R/S since a 2011 special issue (BPS 2011), in contrast to the American Psychological Association (APA), which incorporates R/S into its multicultural guidelines and maintains an active Division of Psychology of Religion and Spirituality (APA 2017). The absence of comparable structures in the United Kingdom may perpetuate a lack of professional confidence and competence in this area.

While international efforts have defined clear R/S competencies for psychologists (Vieten and Lukoff 2022) and developed both secular and faith-based therapeutic models (Barnett and Johnson 2011; Scott Richards and Worthington 2010), UK psychologists continue to rely on generic approaches without reference to R/S specific frameworks (Crossley and Salter 2005).

Awareness of the need for greater competence in addressing R/S is growing. Recent UK research highlights therapists' desire for more knowledge and skills to engage effectively with clients' religious and spiritual concerns (Hunt 2024; Woodhouse and Hogan 2020). In both the United States and the United Kingdom alike, psychologists reported a 'lack of specialised training in religion and spirituality offered to trainees' (Jafari 2016, 5). A more recent UK study of six trainee psychotherapists and counsellors found that any training was minimal, more was wanted, and they felt unprepared to manage R/S issues with clients (Woodhouse and Hogan 2020). Hunt (2024) found minimal R/S training among therapists and trainees from UKCP, BPC and BACP-accredited programmes. Specifically, Gonsiorek et al. (2009) found US psychologists with a lack of training and a lack of confidence using R/S interventions which were found to be wholly unethical, such as unsubstantiated diagnoses and using religious directions as therapy. Therapists were also found to stereotype clients of certain beliefs and generally regarded R/S issues as signs of low intelligence, rigidity and lack of coping.

The profession has begun recognising the potential benefits of R/S for mental health and recovery (Delaney et al. 2007; Vieten and Lukoff 2022). As Plante (2008, 432) observes, psychology has even 'taken principles and techniques from religious and spiritual traditions, secularized them, and repackaged them as modern empirically supported positive psychology related interventions'. Mindfulness, derived from Buddhist traditions, is now incorporated into NHS treatments for mental well-being and recommended by NICE for mild to moderate depression (NHS 2022; NICE 2022).

This qualitative study aims to develop an in-depth understanding of psychologists' personal experiences and perceptions of

R/S in therapy to inform future training and professional development within the UK context.

2 | Method

2.1 | Research Design Overview

A qualitative approach with semi-structured interviews, which were analysed using Thematic Analysis (Braun and Clarke 2006), was chosen to allow for in-depth exploration of practitioners' subjective experiences (Magaldi and Berler 2020). Ethical approval was obtained from University of the Highlands and Islands ethical clearance (reference ETH2425-0054).

2.2 | Reflexivity Statement

The first author (HW) is a manager in the NHS and has recently graduated with a MSc Psychology Conversion with a view to pursuing a new career in a psychology profession. She is an atheist with a particular interest in religion and spirituality, in particular how this helps or hinders existential questions and life satisfaction. The second author (MCP) is a practicing Christian, a psychology lecturer and researcher. Her academic training is in the Psychology of Religion. She aims to promote holistic psychological and spiritual care for individuals experiencing existential struggles. The third author (CL) is a Christian, Counselling Psychologist and experienced qualitative researcher and thus brings an intersectional standpoint to the topic of Christianity and mental health. He has intimate knowledge and experience of this faith community but acknowledges the tensions that this may bring for such communities when mental distress may arise.

2.3 | Participants and Sampling Strategy

Participants were (a) qualified psychologists (defined as the date from achieving BPS chartered status); (b) practicing in the United Kingdom either currently, or within the last 5 years; and (c) listed as such on the BPS website. Random sampling of the BPS 'Find a Psychological Professional' web search facility which includes all known UK-BPS registered psychologists (approximately 1800). Sampling began by contacting 289 professionals, selected at random with no incentives offered for taking part. Fourteen psychologists took part. All participants were still practicing at the time of interview. Psychologists interviewed varied in the approaches, techniques and frameworks they used in their practice (see Table 1).

2.4 | Procedure

Informed written consent was obtained prior to interview, and participants were advised they could withdraw at any time. Interviews were conducted online face-to-face via Teams on a 1:1 basis and covered demographics and five core questions (see Table 2). Interviews ranged from between 45 and 90 min. No participant refused to answer any question. Support materials were signposted, and a welfare check was conducted post interview.

TABLE 1 | Participant demographic information.

	Age	Qualified	Gender	Therapeutic modality
1	53	2011	M	Existential
2	48	2013	M	Existential
3	44	2011	F	Cognitive behavioural therapy (CBT), person-centred, psychodynamic
4	51	2010	F	CBT, eye movement desensitisation reprocessing
5	75	2005	F	Person-centred
6	44	2024	M	Psychodynamic/CBT/Dialectical/Acceptance and commitment therapy (ACT)/Gestalt
7	64	2009	M	CBT/Cognitive
8	61	2005	F	Integrative
9	41	2009	F	ACT/Compassion/CBT
10	48	2009	M	Blended integrative
11	67	2002	F	Relational/Psychodynamic
12	45	2005	F	Integrative
13	53	2003	M	Various—client dependent
14	40	2010	M	Compassion focused therapy

Note: Table above indicates the demographic information of all participants ($n = 14$). This included seven Males and seven Females, all white, with an age range of 40–75 ($M = 52.4$).

2.5 | Data Analysis

All transcripts were subjected to six phases (1–6) of thematic analysis (Braun and Clarke 2020). The dataset was read for familiarisation, then read again where points of significance were highlighted within the text and initial codes generated. Codes were extracted from the main transcript, repeating codes were grouped together by similarity and other meaningful patterns were identified by the lead author. Grouped codes were named as themes and then data and investigator triangulation was undertaken to ensure themes made sense, related to research questions and corroborated with transcripts. This was completed by the lead author with supervision and advice from the other authors.

3 | Results

Four themes were constructed that illuminate psychologists' engagement with R/S in professional practice; they trace a movement from the broader cultural context and systemic omission, through personal reflexivity and finally to applied therapeutic practice. Collectively, all themes (Table 2) reveal a profession

TABLE 2 | Summary of participant interview questions.

1. What previous training have you received on R/S issues—either formally or informally?
2. How competent/confident do you feel when working with a client's R/S?
3. What experiences have you had in working with clients who present with R/S issues?
4. What approaches do you take when working with clients who raise R/S?
5. What extra support (if any) would help you when working with clients?

navigating R/S within an environment marked by limited support, diverse personal reflexivity, and strong cultural boundaries around spiritual discourse (Table 3).

3.1 | Cultural Framing of R/S in Psychological Practice

The first theme finds that limited engagement of R/S in therapy may be reflective of wider sociocultural norms and a broader discomfort within British culture towards sharing personal religious or spiritual beliefs. Participant 12 captured this observation when describing their transition from South Africa to the United Kingdom: ‘It was definitely a cultural adjustment when I moved here to see how, you know, we might talk about sex, we might talk about money, but we do not talk about religion’. This comment highlights how social taboos surrounding religious and spiritual expression extend into therapeutic spaces, where both clients and psychologists may avoid such discussions due to cultural expectations of privacy and restraint.

Several participants reflected on how these norms shape professional perceptions of what is considered ‘appropriate’ for therapy. Participant 2 described an encounter with a client whose spiritual beliefs were deeply embedded in their cultural worldview:

I’ve had an African client... It was totally normal in their culture to talk to dead ancestors. Now if you didn’t know that, you’d get into trouble with that client, right? Cos obviously the question—‘Are you hearing voices?’—yeah of course I am. It’s my mum and my uncle and this is totally culturally normal, right? Now we might call a psychiatrist, but the whole country’s doing this. And they’re getting replies so you’re like yeah, ok.

This example demonstrates how Western cultural assumptions can lead to misunderstanding or even pathologising clients from different cultural and religious backgrounds. Participant 2’s account illustrates the risk of misinterpretation when therapists apply Western diagnostic frameworks to non-Western spiritual practices. Without cultural and spiritual literacy, psychologists may inadvertently impose their own cultural norms, potentially leading to misdiagnosis or inappropriate treatment.

The interconnectedness of religion and culture was also emphasised by Participant 6, who stated:

We have to acknowledge that it is a cultural component and cultures incorporate religion and make it part of their own. And so we have to be kind

of very cognizant of trying to see it as a separate entity to culture because... culture drives religion and religion drives culture in a way.

This observation reflects the reciprocal relationship between cultural identity and spirituality, suggesting that attempts to isolate R/S from cultural context may oversimplify clients’ lived experiences.

Collectively, participants highlighted that R/S cannot be understood in isolation from its embedded sociocultural frameworks. For psychologists in the United Kingdom, this presents both an ethical and practical challenge: to recognise how British cultural reticence towards religious discussion may influence clinical work, and to avoid projecting Western secular assumptions onto clients from more spiritually expressive cultures. This theme demonstrates how broader cultural norms may reinforce professional and personal hesitations and shape how R/S is conceptualised and negotiated within therapy.

3.2 | Lack of Support for Religious and Spiritual Competence

Participants indicated that R/S were not addressed as a core component of their psychology curriculum at undergraduate or master’s level. As Participant 2 stated, ‘I’d say yes I’ve done it but no it wasn’t part of my training, so I got to doctoral level without ever having heard of it’. Another participant reflected on the limited coverage of R/S within doctoral training: ‘I think it was only really covered fairly briefly as part of more of a kind of general cultural awareness’ (Participant 9).

Therefore, among study participants there appeared limited training and continuing professional development (CPD) on R/S in the United Kingdom, a gap participants felt compelled to address themselves, after qualification. As Participant 6 explained:

Just browsing the CPD that’s available, I often notice that there is a degree of a lack of focus on religion. There’s a lot of good cross-cultural stuff, but it would be good to incorporate more of the idea of what religion is and the elements of religion.

A further gap identified by several participants was the lack of available support, both professional and personal. Participant 6 described a dearth of structured training on R/S, suggesting that this absence perpetuates the idea that R/S is not a relevant or important topic within professional psychology. Participant 2

TABLE 3 | Description of themes.

Themes	Description	Illustrative quotations
(1) Cultural framing of R/S in psychological practice	How British cultural norms of privacy influence openness to discussing R/S in therapy	'...we might talk about sex, we might talk about money, but we do not talk about religion.'
(2) Lack of support for religious and spiritual competence	Religious and spiritual content missing from training and continuing professional development. This reinforces the marginalised status of R/S in therapy.	'On the therapist side there's probably a lot who are put off talking about spiritual stuff with their clients 'cos there's no support for that or supervisors wouldn't understand it'.
(3) Reflexivity and the negotiation of therapeutic boundaries	R/S negotiated by each individual therapist's belief, comfort, judgement or individual ethics. Thus, variation in psychologists' comfort and confidence when addressing R/S issues.	'...if it was a real religious crisis, I think that might be a bit of a... bad fit for the kind of therapeutic approach and work that we would offer'.
(4) Navigating R/S in therapeutic practice	A spectrum of therapeutic approach and the management of self-disclosure, neutrality or caution relating to religious and spiritual issues.	'I'm not separate from the therapy I do. If someone was to ask me my religion, I would absolutely share that'.

Note: Table above presents all major themes, a description of their content and an illustrative quote. All of which present the core finding of each theme.

similarly observed that limited supervisory and institutional support discourages practitioners from engaging with clients' spiritual concerns:

I think the sadness for me is probably that a lot of people are put off going there in the first place because there isn't the support. On the therapist side there's probably a lot who are put off talking about spiritual stuff with their clients 'cos there's no support for that or supervisors wouldn't understand it.

This sense of isolation extended beyond supervision to broader professional spaces. Participant 8 recalled attempting to raise the topic of spiritual practice at a professional conference, noting that 'those discussions weren't really welcomed, certainly within the division of counselling psychology'. Such experiences suggest both structural and cultural barriers to the integration of R/S in psychological practice.

Overall, participants reported that R/S often needed to be pursued through self-directed CPD. Consequently, many psychologists encountered clients with religious and spiritual concerns without a foundational understanding of the topic. Participants also described feelings of hesitance and isolation, attributed to the scarcity of post-qualification peer and professional support and, in some instances, active resistance to discussion from colleagues. Collectively, these findings highlight a profession-wide lack of infrastructure and cultural openness in engaging with R/S in practice.

3.3 | Reflexivity and the Negotiation of Therapeutic Boundaries

Many participants expressed uncertainty about whether R/S were suitable topics for therapy. Their views were often polarised: some psychologists positioned religious and spiritual issues as beyond the remit of psychological practice, while others demonstrated openness to integrating clients' religious and spiritual experiences within therapy as part of a holistic understanding of the self. This diversity highlights the influence of individual reflexivity in shaping how R/S are conceptualised and managed in clinical contexts.

Several participants expressed hesitation about working directly with religious and spiritual material. Participant 12 explained:

And then, you know, if they want to work on the spiritual stuff, that's when I would advise them back to their spiritual counsellor, guidance church, you know, and we would sort of go, maybe, you know, this is not quite within psychology. So this is where we might need somebody else. But I think it's quite important to be able to distinguish when it's a relational thing or communication thing, which is something that falls within my remit, and when it becomes spiritual to the point of things needing outsourcing.

Similarly, Participant 14 stated:

If someone was coming to me with a distinctly religious query or problem, I would kind of gently be questioning if this was what was going to be helpful for them. Because that's certainly not me, and I'm not going to be able to, from any position of authority or knowledge, help them with their religion outside of the context of mental health.

Both described uncertainty about professional boundaries when working with clients whose difficulties were framed in explicitly religious or spiritual terms. Participant 12's reflection illustrates confusion regarding the limits of psychological practice, resulting in reliance on external support such as clergy or faith leaders. Participant 14 delineated a clear boundary between clinical and religious issues, suggesting that therapy should focus on mental health rather than spiritual concerns. Such positions may unintentionally communicate to clients that aspects of their religious and spiritual identity or distress are not appropriate for discussion in therapy.

In contrast, other participants articulated greater confidence and flexibility in engaging with religious and spiritual issues. Participant 1 noted:

I do actively bring in religion because I think a lot of clients do think, oh, I can't talk about that here. Either because we don't speak about religion in psychotherapy or I as a Muslim can't talk to [therapist name].

Participant 6 described a similarly open approach:

I've never had issues working with people with religious concern. I actually find a lot of that stuff... it opens [things up] and you can work with those clients pretty straightforward[ly] as long as you're working within their paradigm of belief and you don't devalue what they're bringing to the table.

Both participants highlight how an inclusive stance can normalise conversations about R/S in therapy. Participant 1 actively signals permission for clients to explore religious and spiritual topics, while Participant 6 demonstrates reflexive awareness of the importance of respecting clients' beliefs and working within their frame of reference. Participant 13 echoed this empathic approach, explaining, 'I would ask curious questions or tell me more about this. No judgement, just a curiosity, a warmth, an empathy, sensitivity, a respect'.

These accounts illustrate that personal comfort significantly influences whether therapists perceive R/S as relevant to their clinical work. Where practitioners felt at ease and confident, religious and spiritual issues were approached with curiosity and inclusivity. Conversely, when therapists experienced uncertainty or discomfort, religious and spiritual topics were more likely to be avoided or referred elsewhere. Unless therapists are explicit about their stance, such variation may lead to disparities in how clients experience therapy, shaping both their sense of inclusion and the extent to which R/S are explored.

This variability appeared closely linked to the absence of professional training and guidance to explore R/S identified in Theme 1. Thus, therapists were left to navigate their own comfort levels and ethical boundaries independently. Consequently, personal experience, belief and confidence became the main determinants of whether R/S was integrated into therapeutic work. This finding suggests that the profession's structural and cultural neglect of R/S contributes directly to inconsistencies in practice, leading to divergent client experiences depending on each therapist's individual stance.

3.4 | Navigating R/S in Therapeutic Practice

Regardless of personal reflexivity, participants emphasised that core therapeutic skills, particularly empathy, warmth and curiosity, were more central to their approach with clients who presented religious and spiritual issues than doctrinal expertise. As Participant 3 explained, 'When that other human comes and sits in front of you, that's not what they need. They don't need you to be an expert in their background; they need you to care, and they need you to be interested'.

Several participants also described integrating religious and spiritual themes into therapy when clients presented existential concerns. Participant 3 elaborated:

Anyone who is coming with those questions of what happens after we die or why... why do bad things happen to good people? Those existential universal questions—I will always... ask them, well, do you have a belief system around that? What do you think happens? Do you have any spirituality? Do you have any faith?

They described that spiritual frameworks could offer meaning for highly traumatised clients when traditional psychological models fell short: 'You can't just cognitively restructure... how you think about a particular trauma. You just can't. It was a random misfortune. That's when we need something else. And it usually is something higher'. These reflections highlight an openness among some psychologists to consider spiritual meaning-making as a valid therapeutic tool, particularly when clients grapple with existential questions or trauma beyond rational explanation. In these cases, R/S was viewed as a potential source of resilience.

At the same time, participants recognised that their own beliefs and backgrounds could complicate this process. Participant 7 acknowledged the challenges of managing overlap between personal and client belief systems: 'The more overlap, especially kind of demographically, the more overlap I have with a patient, the harder I have to work to make sure that what's been brought into the room is theirs and not mine'. In contrast, Participant 14 described their own faith as integral to their professional identity, stating, 'I'm not separate from the therapy I do. If someone was to ask me my religion, I would absolutely share that'. These accounts illustrate a spectrum of self-disclosure, shaped by therapists' personal comfort and understanding of professional boundaries.

While some viewed sharing their beliefs as a way to foster trust and connection, others were more cautious. Participant 12 reflected:

If they have struggles with Christianity, I might say to them, I am a Christian. I don't mind disclosing that if it could be helpful—if we have a relationship where this could be helpful. Or if they're from a different religion and think I'm not religious and therefore won't understand.

These examples reveal a delicate ethical balance between authenticity and neutrality. For some therapists, limited self-disclosure was seen as a means of building rapport and demonstrating understanding. For others, it risked shifting the focus from the client's experience to the therapist's own worldview.

This theme demonstrates that therapists' personal experiences, ethics, self-awareness and contextual sensitivity about R/S directly inform their therapeutic approach. Participants described developing their own frameworks for navigating boundaries, which ranged from cautious neutrality to selective, intentional self-disclosure. This variation showcases that, in the absence of consistent professional guidance, therapists' personal stances shape how religious and spiritual issues are engaged within therapy.

4 | Discussion

The first theme of Cultural Framing of R/S in Psychological Practice underscores the influence of British cultural norms and values on attitudes towards R/S. Echoing findings from Crossley and Salter (2005) and Woodhouse and Hogan (2020), participants described R/S as a culturally uncomfortable topic, a discomfort extending into therapy itself. Expectations of clients' behaviour in relation to R/S were seen as similarly constrained by cultural norms, with deviations often misunderstood or pathologised. Such cultural biases, whether conscious or unconscious, could have implications for client experience and treatment outcomes if they result in discriminatory practice. Psychologists play influential roles in multidisciplinary teams, formulation and treatment planning, yet most participants reported that their only formal exposure to R/S was within multicultural awareness components of their doctoral programmes. Many had received no further training since, which was felt to detract from ethical therapeutic competence in working with matters of R/S in therapy.

Consistent with the work of Crossley and Salter (2005), Woodhouse and Hogan (2020) and Hunt (2024), participants perceived a lack of professional training and support in managing religious and spiritual issues within UK psychological practice (Theme 2: Lack of Support for Religious and Spiritual Competence). In this study, participants were divided in preferences for formal versus informal support: some valued professional guidance for its practical relevance, while others emphasised the need for more open discussion about R/S within the profession. The shortage of supervisors willing or able to provide religious and spiritual-related support was also viewed as a particularly significant gap, given that supervision

is fundamental to reflective and ethical practice. Open and inclusive supervision should be accessible to all psychologists, not only those who find supervisors with a shared interest or willingness to engage with R/S.

Participants' views on the legitimacy of R/S as a topic for therapy were also consistent with reports from Crossley and Salter (2005), who detail mixed attitudes towards addressing religious and spiritual concerns in clinical work (Theme 3: Reflexivity and the Negotiation of Therapeutic Boundaries). A client's R/S matters to widely varying degrees with participants in this study, with the most self-reported interest from those with a personal awareness of the topics. Ambivalence from others is perhaps unsurprising, given the limited professional support described above. Given that the majority of the UK population reports some form of faith or belief (Office for National Statistics 2021), and that British clients have expressed a desire to discuss R/S in therapy (Mayers et al. 2007), there is clear evidence of a demand for therapeutic support on these issues, whether as an alternative to or alongside other forms of care.

Participants were divided in their approaches to clients presenting religious and spiritual issues. Some integrated these concerns as part of a client's holistic presentation, drawing on general therapeutic tools, a strategy that has shown efficacy in prior research (Brown et al. 2013). Others, however, conceptualised religious and spiritual issues primarily within a mental health framework, treating them only when they appeared as part of a diagnosable condition. While this was not explored in detail within this study, Magaldi-Dopman et al. (2011) observed that psychologists who reframe R/S into scientific or theoretical terms may be subconsciously distancing themselves from discomfort with the topic. Similarly, Knox et al. (2005) found that clients felt trivialised when clinicians used technical or Freudian language to describe their religious and spiritual experiences. As Schreurs (2001) cautions: Therapists should neither steer clients away from their religious beliefs nor adopt such a rigid stance of therapeutic neutrality that religious and spiritual meanings remain unexplored. In contrast, therapists require sufficient religious and spiritual literacy to engage this material thoughtfully, critically and without imposing their own worldview.

No prior UK studies were identified that examined psychologists' own religious and spiritual self-disclosure; therefore, the results of this research represent an opportunity for new insights into this aspect of professional practice. Some participants in the present study recognised that shared beliefs do not necessarily equate to shared experiences, and that therapy should prioritise the client's agenda. Others interpreted client disclosure, or perceived hesitancy, as permission to share their own beliefs as part of the therapeutic process. This study did not explore the outcomes of such disclosure, but prior research suggests it can both strengthen and strain the therapeutic relationship (Magaldi and Trub 2018). Self-disclosure may enhance rapport but also risk boundary violations, countertransference or the imposition of personal values (Walker et al. 2004). The variation reported in this study reflects differing theoretical traditions and guidance on self-disclosure (Myers 2020), but Magaldi and Trub (2018) argue that effective religious and spiritual disclosure depends on therapists' self-awareness and skill in managing such discussions as a result of exploration of their own beliefs within

training and supervision. In any event, therapist disclosure should only ever be undertaken in the best interest and for the benefit of the client (Zur et al. 2009).

A therapist's beliefs matter here because therapy is never entirely value free (Wyatt and Johnson 1990). Research has shown that highly religious and spiritual therapists should remain aware of potential bias (Saunders et al. 2014). Plante (2008) highlighted ethical risks around promoting one's own beliefs, especially when shared with clients, including the potential for favouritism. Gonsiorek et al. (2009) found that psychologists with strong faith commitments may face ethical challenges when their religious and professional roles intersect. Reliance on one's own faith as a form of competency may not suffice. This is highly relevant in the UK context, where 46% of the population identifies with an active faith or belief (Office for National Statistics 2021). Consequently, a proportion of UK psychologists will fall within this cohort. The impact of self-disclosure on clients should not be underestimated, and the integration of psychologists' personal R/S beliefs into therapy may benefit from professional guidance rather than being left entirely to personal discretion.

Finally, findings from this research highlight recognition among some participants that R/S can play a valuable role in supporting clients experiencing severe or enduring existential crises or trauma (Theme 4: Navigating R/S in Therapeutic Practice). Participants observed that conventional psychological approaches cannot always provide satisfactory explanations or comfort to clients in such cases, whereas religious and spiritual frameworks, by their nature, address meaning and purpose. This is a salient finding, especially given participant reports that R/S remains unpalatable to many UK professionals who, in seeking to maintain an empirical and scientific stance, may inadvertently distance themselves from less conventional understandings of human experience. Andersen et al. (2025) point to the need for psychological professionals to be educated in the diverse approaches clients take to existential issues, including R/S. They found that incorporation of academic learning on existential communication at postgraduate level expanded participants' horizons, altered standpoints from 'avoidance' to confidence in the topic and facilitated a more open-minded and accepting attitude of R/S being inside the 'psychological realm' (p1).

5 | Conclusion

This study has examined UK psychologists' experiences of working with religious and spiritual issues in therapy. In so doing, the research has aimed to generate insights that could support professionals in responding more effectively to religious and spiritual concerns in the therapeutic setting. Key findings include the recognition of the influence of UK cultural norms on the discussion and integration of R/S within therapy, a perceived lack of institutional interest and support structures, limited consensus on the appropriateness of R/S as a therapeutic focus and variation in therapeutic approaches, differing attitudes towards self-disclosure and the potential for R/S in supporting clients with existential concerns.

The results are significant because many UK clients express a desire to explore religious and spiritual issues in therapy, yet

inconsistency in training, practices and personal beliefs around R/S may affect the quality and equity of care provided to clients seeking help for these issues. Supporting trainee and qualified UK psychologists to develop confidence and competence in engaging with all aspects of R/S is therefore essential to ensure ethical, culturally sensitive and effective therapeutic outcomes for clients.

5.1 | Strengths and Limitations

This study benefited from the flexibility and depth afforded by its qualitative design, which permitted the exploration of lived experience. Semi-structured interviews created space for reflective discussion that extended beyond the researcher's initial prompts and allowed for a deeper exploration. However, the study is subject to a number of limitations which must be considered. Firstly, participants were self-selecting volunteers who may have had a personal or professional interest in the topic, introducing potential representation bias. To mitigate this as much as possible, random sampling from the full list of British Psychological Society (BPS) members was utilised, rather than recruiting from a group with a declared interest or specialism in R/S. Future studies may wish to include psychologists with differing levels of engagement in R/S in order to yield more comparative data.

5.2 | Future Research

Several areas for further study emerged from this research. Firstly, the perceived lack of professional support, particularly within supervision, warrants further investigation. Future research could examine what forms of formal and informal support psychologists would find most useful and how these could be implemented within professional development frameworks in relation to working with R/S therapeutically. Secondly, further research is needed to explore UK-based psychologists' willingness and openness to engage with R/S as a legitimate focus within therapy, and to understand how this is shaped by UK cultural norms. Such work could usefully examine the extent to which R/S is addressed within professional training programmes and consider how greater inclusion might support culturally competent practice. Finally, the relative benefits and challenges of psychologists' self-disclosure of personal religious and spiritual beliefs in therapy merit more detailed study. While US research has produced mixed findings on the impact of religious and spiritual self-disclosure on therapeutic outcomes, a UK-based investigation could clarify its effects within the distinct cultural context of British psychological practice. Finally, future research may wish to start evaluation of university training programmes for R/S matters in therapy. Such research may take a qualitative and indeed quantitative lens to explore how training in R/S is experienced and recommendations for future enhancement.

Funding

The authors have nothing to report.

Disclosure

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Ethics Statement

This project received full University of the Highlands and Islands ethical clearance (reference ETH2425-0054). The authors abided fully by the Ethics Guidelines for Internet-mediated Research (BPS 2017) and the British Psychological Society's Code of Human Research Ethics (2014).

Consent

All participants provided informed written consent.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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