

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

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

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

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

*Corresponding author: Jaclin' Freire, CIS-IUL, ISCTE-Instituto Universitário de Lisboa, Portugal; Email: jesfe@iscte.pt

Carla Moleiro, CIS-IUL, ISCTE-Instituto Universitário de Lisboa, Portugal

David H. Rosmarin, McLean Hospital, Harvard Medical School, USA

Introduction

Despite of the historical and explicit tension between health sciences and religion, the interest in the role of religiosity and spirituality¹ in health, and specifically in mental health, has increased significantly during the past few decades². While initially in research empirical studies of religiosity and spirituality were included as add-on variables in the context of other research agendas³, they rapidly became a focus of research, mostly on the potential impact which religion and spirituality could have in peoples' lives⁴. More recently, the interest also covers their influence and effectiveness when integrated into psychological treatment⁵. However, these dimensions are still understudied in the scientific literature⁶; and the educational and training programmes for (MHPs) (whether graduate or postgraduate) do not offer much guidance on how to accurately integrate these issues into clinical practice⁷. Also, many studies have indicated that MHPs are usually less religious than other health professionals and the general population and are often ill-prepared to deal with their clients' religiosity and spirituality⁸. For these reasons (among others) religious and spiritual matters are often ignored, superficially considered or referred to other types of professional.⁹

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

Studies conducted aiming to understand the impact of spirituality, religiosity and faith related issues have suggested the existence of a positive relationship between religiosity/spirituality and better indicators of physical and psychological well-being¹⁰. In particular, studies have reported that religious people tend to demonstrate not only much less physical illness and psychological disorders and a greater sense of social support¹¹, but also experience much more positive emotions¹². This pattern seems to be closely linked to

1 The authors are aware of the importance of conceptualising religion, religiosity and spirituality, as this has been a source of ambiguity and confusion in both research and clinical practice. However, this was not a focus for the present study. These terms have been discussed and conceptualised in many other contexts, Pargament, "The psychology"; Hill "Conceptualizing"; Hill and Pargament, "Advances". Therefore, religion/religiosity/spirituality might be used interchangeably throughout this paper referring to the relationship with God(s) or Higher Power that leads ultimately to a religious community/institution.

2 Bartoli, "Religious and spiritual issues", 54-65; Post and Wade, "Religion and spirituality", 131-146; Koenig, "Research on religion", 283-291.

3 Hill, "Advances", 64-74.

4 Bartoli, "Religious and spiritual issues", 54-65.

5 McCullough, "Research", 92-98; Wade, "Effectiveness", 91-105; Post and Wade, "Religion and spirituality", 131-146; Waller, "Addressing spirituality", 95-106;

6 Hill, "Advances", 64-74; Paloutzian and Park, "Integrative themes", 3-20.

7 Hill, "Advances", 64-74; Cates, *Counselor Spiritual Competencies*; Dein, "Working with patients", 287-294; Hage, "A closer look" a, 303-310; Mayers, "How clients", 317-327.

8 Miller, "Spirituality", 3-18; Hill, "Conceptualizing", 51-77; Coyle, "Twelve myths of religion and psychiatry", 149-174; Hill, "Advances", 64-74; Gollnick, "Religion, Spirituality and Implicit Religion", 120-141; Moreira-Almeida, "Religiousness and mental health", 242-250; Baetz, "Clinical implications", 292-301; Rosmarin, "Attitudes toward spirituality/religion", 424-433.

9 Although in this paper the authors did not specify (nor considered preferable) any type of mental health professional, nor a treatment modality, interventions aiming to provide specifically a spiritual counselling or direction were not covered (not discarding or questioning their value). In other words, religious and spiritual professionals trained with the knowledge of psychology, psychotherapy or counselling; or mental health professionals trained to work exclusively with religious and spiritual issues were not covered. However, in a previous paper (Freire, "Religiosity, spirituality, and mental health", 17-32) a multicultural training in spirituality and religiosity for MHPs was discussed and considered preferable.

10 Miller, "Spirituality", 24-35; Arveson, "A conceptual model", 109-112; Oman "Do religion and spirituality influence health?", 435-459; Nelson, "Psychology, Religion, and Spirituality", 313-318; Rosmarin, "Do gratitude and spirituality", 1-5.

11 Koenig, "Religion and medicine" I, 385-398; Koenig, "Religion and medicine II", 97-110; Koenig, "How religious beliefs", 1-20; Baetz, "Clinical implications", 292-301; Agishtein, "Integrating spirituality", 275-289.

12 Hackney, "Religiosity and mental health", 43-55; Cohen, "Religion and Mental Health", 255-258; Rosmarin, "Do gratitude and spirituality", 1-5.

lifestyle habits, social support and religious coping strategies (e.g. prayer, meditation and religious rituals) often inherent to religious/spiritual daily life¹³.

However, persons with faith-based worldviews (as with the general population) are not exempt from mental illness and suffer from a range of mental disorders and often having serious comorbid problems¹⁴. Also, studies have reported an association between the onset and/or aggravation of psychopathological symptoms and the increased importance of religion/spirituality in the life of many clients¹⁵. Furthermore, when facing psychological distress (or even religious or spiritual struggles, as portrayed in DSM-5¹⁶), religious clients tend to recover faster and with better outcomes when MHPs seek the integration of their clients' religious beliefs and practices into treatment¹⁷, religiosity and spirituality also being part of the solution. Therefore, many clients wish their religiosity/spirituality to be respected and integrated into their psychological treatment¹⁸, emphasising the importance these dimensions have in their personal development and healing process¹⁹.

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

The research field and clinical context have only recently begun to learn about client's views and experiences of religiosity/spirituality in the therapeutic relationship²⁰. Clearly, such information would be essential to inform MHPs about the appropriateness of such integration, and also on "when" and "how" to include a client's spiritual and religious perspective into psychological treatment. Nevertheless, it seems consensual that this process should always be conducted with caution; in a clinically, professionally competent and sensitive way²¹.

This inclusion/integration appears to have a significant impact on the quality of the therapeutic relationship between clients and MHPs; meaning that clients seem satisfied with the perception of MHPs' openness and sensitivity towards discussion of religious/spiritual issues and perceived negative responses as risky to the therapeutic relationship²². This could be particularly important among (but not limited to) highly religious clients, who may fear being judged or misunderstood in secular settings²³, or for those who are in need of professional help but choose not to use mental health services (MHS) or consider it as a last resort²⁴.

Many reasons have been highlighted in an attempt to understand such patterns. It seems, for instance, that those who conceptualise their psychological problems primarily as spiritual or religious²⁵ perceive seeking professional help as conflicting with their religious beliefs²⁶, and are concerned that the

¹³ Arveson, "A conceptual model", 109-112; Nelson, "Psychology, Religion, and Spirituality".

¹⁴ Koenig, "Religious versus conventional", 1-11.

¹⁵ Baetz, "Clinical implications", 292-301; Gockel, "Client perspectives on spirituality", 154-168.

¹⁶ DSM-5, "Diagnostic and statistical manual", 725.

¹⁷ Curlin, "Religion, Spirituality, and Medicine", 1825-1831; Koenig, "How religious beliefs", 1-20; Baetz, "Clinical implications", 292-301.

¹⁸ Rose, "Spiritual issues", 18-33; Knox, "Addressing religion", 287-303; Martinez, "Spiritual interventions", 943-960; Plante, "Integrating spirituality and psychotherapy", 891-902; Baetz, "Clinical implications", 292-301; Fridman, *Client-Rated Helpfulness*.

¹⁹ Knox, "Addressing religion and spirituality", 287-303; Cates, *Counselor Spiritual Competencies*; Gockel, "Client perspectives on spirituality", 154-168; Rosmarin, "Interest in spiritually integrated psychotherapy", 1149-1153.

²⁰ Gockel, "Client perspectives on spirituality", 154-168.

²¹ Arveson, "A conceptual model", 109-112; Peres, "Espiritualidade, religiosidade e psicoterapia", 136-145; Sloan cited in Plante, "Integrating spirituality and psychotherapy", 891-902.

²² Knox, "Addressing religion and spirituality", 287-303; Martinez, "Spiritual interventions", 943-960; Wade, "Effectiveness", 91-105; Fridman, *Client-Rated Helpfulness*; Gockel, "Client perspectives on spirituality", 154-168.

²³ Dein, "Working with patients with religious beliefs", 287-294; Knox, "Addressing religion and spirituality", 287-303; Richards, "A spiritual strategy for counseling", 47; Martinez, "Spiritual interventions", 943-960; Gockel, "Client perspectives on spirituality", 154-168.

²⁴ Leavey, "Identity and belief", 37-58.

²⁵ Ibid.

²⁶ Mayers, "How clients", 317-327.

traditionally-secular practice might undervalue or misunderstand their spiritual/religious beliefs²⁷, tend to turn initially – and often only – to religion or a religious source, instead of seeking help from secular MHS²⁸.

Related to this, a number of studies were conducted in an attempt to understand the “religiosity gap” phenomenon between religious clients and their MHP²⁹, covering also the impact that religious (un)match would have on the (perceived) quality and effectiveness of psychological treatment. However, most of recent studies did not find clear evidence supporting the existence of such a gap when regarding treatment effectiveness³⁰.

However, one must acknowledge that many other aspects may play an important role prior to the evaluation of the treatment efficacy. From the client’s perspective, it is important to consider: how they conceptualise their psychological problems, the role their faith community plays (whether mediating or obstructing) in their help-seeking process, their perceptions of MHPs’ openness and willingness to address religion/spirituality, their perceptions of MHPs’ prejudices against religion/spirituality, and their attitudes about the helpfulness or usefulness of psychological treatment.

On the other hand, it also seems important to analyse how MHPs’ personal religious/spiritual attitudes and commitment impact their religiously-defined and spiritually-related goals and interventions in psychological treatment³¹. Specifically, it is imperative to understand how their religious and spiritual awareness, knowledge and training (or the lack of these) impact their willingness to engage in an accurate integration of these issues into clinical practice³².

Not only do the above-noted factors impact care, but also others (separately or combined) may be compromising, delaying or preventing religious clients from seeking professional help. On the other hand, it might also be contributing to maintaining the gap between clinical practice and clients’ needs in psychological treatment³³, as well as fostering the difficulty in developing skills and strategies to accurately work with religious clients³⁴.

And this may be particularly true for the Portuguese mental-health field, where there is clearly a lack of scientific research. So far, only a few studies were conducted and most of them in the context of quality of life and well-being. Only recently, and from a multicultural perspective, have issues related to ethnicity, race, sexual minorities, religion and spirituality been systematically investigated³⁵.

Religiousness and Spirituality in Portugal (A Brief Characterisation)

Portugal is a non-confessional secular state; however, culturally, it is undeniably a highly religious society. In 2007, a transnational comparative study between eight European countries³⁶, reported that 92% of the Portuguese population believes in God. More specifically, up to 78% of the participants reported belief in a ‘personal God’, whereas 15% articulated belief in a ‘spirit, higher force or life force’. The percentage of non-believers was 3%³⁷. More recently, the results of the national census indicated that nearly 85% of the Portuguese population identified themselves as being religious³⁸ (Table 1).

27 Ibid.; Myers, “Merging the horizons”, 59-77.

28 Leavey, “Identity and belief”, 37-58.

29 For review see: Sørgaard, “Religiosity and help-seeking”, 180-185; Mayers, “How clients”, 317-327; Crosby, “The religiosity gap”, 141-159.

30 Sørgaard, “Religiosity and help-seeking”, 180-185; Dein, “Religion, spirituality and mental health”, 63-64; Cook, “The faith of the psychiatrist”, 9-17; Crosby, “The religiosity gap”, 141-159.

31 Kellems, “Working with clients”, 139-155; Rosmarin, “Attitudes toward spirituality/religion”, 424-433.

32 Knox, “Addressing religion and spirituality”, 287-303; Martinez, “Spiritual interventions”, 943-960.

33 Hill, “Advances”, 64-74.

34 Arveson, “A conceptual model”, 109-112

35 See for example: Moleiro, “Health and mental health”, 15-24; Freire, “Religiosity, spirituality, and mental health”, 17-32; Moleiro, “Cultural and individual diversity”, 101-113.

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

37 Menéndez, “Religiosidade e valores em Portugal”, 757-787.

38 INE, *Census 2011*, 530.

Historically, Portugal shares a particularly long and strong relationship with the Roman Catholic Church, the predominant religion of the country (81% of the population). However, lately the group of non-Catholic, non-Christian and non-religious people has been growing rapidly, representing almost 11% of the population³⁹.

Table 1: Religious identification (affiliation) of Portuguese population at age 15 years and older

		N	%
Religion	Portugal	8.989.849	100.00
	Catholic	7.281.887	81.00
	Orthodox	56.550	0.63
	Protestant	75.571	0.84
	Other Christian	163.338	1.82
	Jewish	3.061	0.03
	Muslim	20.640	0.23
	Other non-Christian	28.596	0.32
	Not religious	615.332	6.84
	Did not answer	744.874	8.29

Table reprinted and adapted from INE (2012, p. 530), based on 2011 Census.

On the other hand, as a civil society, Portugal has taken important legal steps in terms of religious protection and care. For instance, regarding the national health-care system, the Portuguese State guarantees any citizen the right to have his or her spiritual and religious needs understood and included when seeking health care (Decree Law nº 253/2009⁴⁰). However, and due to the lack of scientific research in this area, it is still unclear how this law has so far affected mental-health clinical practice.

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

Furthermore, it is still unclear what the current state of clinical practice is regarding the integration of religious and spiritual matter in psychotherapy. Especially considering that Portugal is a highly religious society and the educational and training programs do not prepare MHPs in how to accurately integrate these issues in clinical practice.

Consequently, an important question arises: are the Portuguese mental health system and mental health professionals currently meeting their clients' religious/spiritual expectations and needs? This study was conducted aiming to address this question, contribute to the discussion of psychological treatment with individually and culturally diverse clients and ultimately to contribute to a more sensitive practice towards such diversity.

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

³⁹ INE, *Census 2011*, 530.

⁴⁰ Decree Law No. 253/2009 of 23 September – spiritual and religious assistance in hospitals and other establishments of the National Health Service.

Methods

Following a more pragmatic perspective about what is important when seeking knowledge – what are the problems and the solutions to the problems, rather than only the type of methods used to achieve the knowledge⁴¹ – a mixed method approach was chosen to conduct this study. In order to maximise the advantages of both quantitative and qualitative methodologies (methodology triangulation), different forms of Sampling and Data Collection (data triangulation), and data analysis (investigator triangulation) were used⁴². The ultimate goal is to explore and provide both quantitative and qualitative information about participants' perceptions of religiosity, spirituality and mental health in Portugal and the context in which they experience these issues⁴³. The analytic plan behind each process is presented below.

Sampling and data collection

Regarding the sampling process, and in a first phase, participants were recruited through formal contact with religious institutions, according to their representation in the last national census (see Table 1). Therefore, invitation letters (via email) were sent to the institutions requesting the individual participation of a leader or representative (results will be presented in another paper). Since only three positive responses were received using this method (namely Jehovah's Witnesses, Latter-day Saints and Baha'i Faith), the strategy of 'snowball or chain sampling', as proposed by Patton⁴⁴ was used. Key respondents/personal contacts were used, resulting in the participation of other religious groups (namely Catholic, Seventh Day Adventist, Orthodox, Pagan and Evangelical).

After the interviews with the leaders, they were invited to organise a group meeting. Interviews were conducted at worship places, before/after religious services/rituals. Each focus group member and in-depth interviewee was offered a gift card as a reward for their participation. All participants signed an informed consent form, agreeing, for instance, to be quoted.

The study included the participation of a total of forty-one (41) members of different religious denominations (Baha'i Faith, Jehovah's Witnesses, Seventh Day Adventist Church, Orthodox Church, Evangelical Alliance, Pagan Federation International, Catholic Church and Latter-day Saints). Of those, forty (40) participated in focus group interviews, and three (3) in in-depth individual interviews (two of them had previously participated in the focus groups interviews).

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

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

In-depth individual interviews: Of the 11 participants with experience in the MHS, two agreed to participate in an in-depth individual interview, in addition to another participant who did not participate in the focus groups. All participants were female and Portuguese. The following are some further details about the causes for seeking help in MHS:

Participant 1: age 34 years old; Pagan; diagnosed with severe anxiety and psychosomatic symptoms, with several admissions to psychiatric emergency services.

⁴¹ Patton, cited by Creswell, "Research Design: Qualitative", 3-26.

⁴² Patton, "Qualitative Evaluation", 230, 243-248, 442-444; Creswell, "A Framework for Design", 3-26.

⁴³ Creswell, "A Framework for Design", 9-11.

⁴⁴ Patton, "Qualitative Evaluation", 230.

Participant 2: age 63 years old; Catholic Nun; diagnosed with depression and suicidal attempts; she reported having been hospitalised in a psychiatric hospital for three weeks.

Participant 3: age 32 years old and Evangelical. Regarding the reasons for seeking help, she reported being diagnosed with an eating disorder (anorexia and bulimia).

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

Table 2: Demographic characterisation of the sample (N=40)

	Freq.	%		Freq.	%
Age (N=39; 1 missing)			Gender		
Mean = 41.40 years-old			Female	27	6
Std. Deviation = 12.39			Male	13	32
Minimum = 24					
Maximum = 71					
Marital Status			Educational attainments		
Single	16	40	Secondary degree or less	17	43
Civil union	1	2	Bachelor's Degree	1	2
Married	20	50	Licenciatura (BSc)	14	35
Divorced	3	8	Master's Degree	6	15
			Doctorate degree	2	5
Citizenship			Native Language, if not born in Portugal (N=15)		
Portuguese	25	63	English	1	6
CPLP*	11	27	Portuguese	8	54
Other EU	3	8	Creole	2	14
Other	1	2	Romanian	3	20
			Tetum	1	6
Occupational status			Experience in (psycho)therapy		
Studying (N=40)	6	15	Yes	14	35
Working (N=39)	34	87	Clinical Psychologist	7	50
			Psychiatrist	4	29
			Psychotherapist	3	21
			No	26	65

*Community of Portuguese Language Countries (in this sample: Angola; Brazil, Cape Verde, Mozambique and Timor).

Table 3: Distribution of focus group interviews

Group	N (participants)	Duration	Transcriptions
Catholic (members)	10	1h27mins	13 pages
Catholic (nuns)	3	1h03mins	19 pages
Baha'i Faith	3	1h04mins	16 pages
Jehovah's Witnesses	7	40mins	9 pages
Seventh Day Adventist	6	1h06mins	16 pages
Orthodox	3	19mins	5 pages
Pagan Federation International	3	2h33mins	26 pages
Latter-day Saints	4	56mins	18 pages

Measures

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

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

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

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

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

Quantitative measures: Also, two additional quantitative measures were used, the *Spiritual Well-being Scale (SWBS)*, developed by Paloutzian and Ellison in 1982⁴⁵ and the *Multidimensional Measurement of Religiosity and Spirituality*⁴⁶ aiming to assess participants' religious/spiritual history, private/public religious practices and spiritual well-being (these measures were used previously⁴⁷). The descriptive results are presented in Table 4.

Data analysis: Prior to the thematic analyses performed using the qualitative software MAXQDA 11, a number of stages and methodological efforts were involved in analysing and interpreting the data, so that the final result accurately represented the participants' perspectives. Thus, and firstly, all taped interviews were transcribed by a CIS-IUL intern, and afterwards transcriptions were read with their audios, by the first author, to check/correct mistakes and doubts, and also to enable immersion in the data. Once transcription was completed, and in a first stage of thematic analyses (*reflexivity*), nine (9) different core themes were created in accordance with the interview guide questions, which later led to the categorisation in code (35) and sub-codes (90), in total 1,562 units of analysis. A working draft of a code book was developed throughout this stage. In a second stage, data were analysed by an independent coder (PhD Researcher), using the *Intercoder agreement* available on MAXQDA 11. Using this method and in a three phase process, the

⁴⁵ Ellison, in "The spiritual well-being scale", 1-10.

⁴⁶ Fetzer, "Multidimensional Measurement of Religiosity", 65-69.

⁴⁷ Moleiro, "Effects of age", 93-111.

final result of agreement between the two coders was 85.8%, (the *Segment agreement* function was used). Finally, all results were again analysed by the authors in order to present the reflections, commonalities, variations and new issues. A similar methodological approach is described in other studies⁴⁸. All measures, interviews, data analysis and the complete information on the coding process and results are available for external analysis within the limits of confidentiality.

Table 4: Religious and Spiritual characterisation of the sample (N=40)

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

⁴⁸ Carey, "Intercoder agreement", 1-5.

Results

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

Spiritual Well-Being Scale (SWBS): Participants in the study scored positively and within the limits of the typical score for many religious groups⁴⁹, with an average score of SWBS for our sample of 102.27 ($SD=4.87$). As for the sub-scale Existential Well-Being (EWB), participants scored 51.72 ($SD=4.66$) and for the Religious Well-Being (RWB) 50.55 ($SD=8.53$). Likewise, religious community was considered to be an important source of comfort and support (mean=19.40, of a possible total score of 24). A more detailed statistical presentation is provided in Table 5.

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

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

^a. Multiple modes exist. The smallest value is shown

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

Religious/Spiritual Role (referring to the role – impact and importance – religion and spirituality play in participants’ lives): when asked ‘What does it mean being (e.g. Catholic)?’ participants reported their religiosity/spirituality as important dimensions in their life; seen mostly as a way of making sense of life and giving meaning/purpose to their life and understanding their roles and responsibilities in this world: ‘...the fact that I have a religion in my life allows me to see my place in this world and realise that this world is much more than what I live every day and it goes far beyond my existence.’ [LDS_P2].

Also, being a religious person was often referred to as a way of life and mostly mentioned as ‘a privilege’, ‘a gift’ or ‘honour’: ‘Being a Jehovah’s Witness is one of the greatest privileges I have had... I’m one of the people who were gifted to be a Witness.’ [JW_P4].

Religiosity was often seen as a personal and close relationship with God (divinities or a Higher Power), and turning to God in search of comfort, hope, and the feeling of being loved and valued in the midst of

⁴⁹ Typical score for many religious groups: SWB=82–109, out of 120; RWB=34–56, out of a possible 60; EWB=46–53, out of 60.

difficulties, the often reported: ‘Jesus for me isn’t a distant person, is very close to me. I feel sometimes, when I am in prayer... when I pray, I talk to Jesus as if I’m talking to a real person and I feel, in fact, that is a dialogue, a relationship.’ [CNun_P1].

Participants reported using specific practices in their daily life (e.g. praying, meditation, reading sacred scriptures, attending worship services), not only to maintain or restore health, but also as a way of testifying their belongingness to a religious community: ‘The church also gives us doctrines, truths, and it asks me to practice them in my daily life... my life in church.’ [CC_P10].

The faith community was often seen as, or compared to a (spiritual) family; providing a sense of belongingness, meaning and purpose; and also giving support for enduring chaotic, stressful and suffering moments: ‘Family is not just blood, I found here, in every brother a family that I didn’t have.’ [SDA_P4].

Some participants also reported some negative aspects of their religion/religiosity, such as guilt, doubts and the negative impact these might have in life, mental health status or when suffering: ‘There are lot of these situations... people who somehow couldn’t deal with their guilt and that developed into a problem.’ [CC_P1].

Coping mechanism (references to strategies used to cope with disease, suffering, pain, sadness and stress): participants of this study often reported using religious and spiritual practices/strategies as coping mechanisms and as a resource in terms of comfort. The most common strategy was: ‘turning to’ or ‘relying on’ God through prayer or reading the sacred scriptures: ‘We are always praying, asking for God’s help, and when we are really distressed we ask even more.’ [OC_P3].

Participants also reported turning to their faith community, or receiving support as a way to cope with their problems. Accordingly, relying on religious leaders would be a first step when seeking professional help: ‘...we ask for help of our Lord; and the church leaders also have some answers for us. And they help us! Sometimes they are inspired and they tell us what we should do.’ [LDS_P4].

Also, participants often reported seeking (secular) professional help, but not as a first resort, since most stated seeking help first within their religious sources (God, religious leaders, family or community): ‘So, my first thought would be to look for someone within my community. Not because there is a restriction in our faith, but because I think he/she would better understand what I’m going through.’ [BF_P2].

Another coping strategy reported was related to the way participants perceived or faced problems, i.e. having a more positive and hopeful view of suffering, illness and stress or understanding the problem: ‘I think we look to suffering differently, to sacrifice, to pain, differently from those who don’t believe, because we know suffering has a purpose.’ [CC_P1].

Experience in the MHS (encompasses all references of having or not experience in the MHS, including their expectations and perceived barriers or difficulties): as reported previously only 11 participants reported having experience in the MHS. However, participants were able to share their relatives and friends’ experiences. When asked: ‘When to seek professional help?’ participants reported: ‘So we have to fight cancer; to fight depression; we go to psychologists, we seek friends.’ [LDS_P5]; ‘If you lose sight of your own life, and you can’t deal with it alone.’ [OC_P2]; ‘As soon as it starts affecting me physically.’ [PFI_P1]; ‘When there are cases of abuse, sexual violence, addiction... alcohol, drug... it is important to see a professional.’ [LDS_P4].

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

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

Some participants also lacked information or hold preconceptions about the role of a MHP; especially regarding the work of a psychologist: ‘Psychology uses hypnotism; reincarnation and these kinds of things that go against what we believe in. They prescribe allopathic medicines while we seek for homeopathic medicines.’ [SDA_P2]; ‘You said that psychologists are not medical doctors. I always thought psychologists were physicians too.’ [BF_P3].

Perceptions of MHPs’ multicultural competencies: Regarding participants’ perception of a competent and helpful professional, the most common competencies are listed below:

Open, respectful and non-judgmental attitude: ‘Respect our beliefs, and if they don’t know what we believe in, ask us.’ [JW_P3].

Knowledge and understanding of patients’ religion: ‘Especially our doctrines; what we believe in; our foundations; commandments. Yes, it is important to have this knowledge too. I think they will be better able to help us this way.’ [LDS_P3].

Avoid, ignore, counteract or confront religion or spiritual beliefs: ‘If they ignore this issue or don’t take it into account at all; thinking for instance that it doesn’t influence our mental health state, and not consider it in our treatment... I mean; this wouldn’t help me go there.’ [JW_P5].

Be religious (belonging to the same or a different faith), or be a spiritual person: ‘He/she has to be good Christian, I think! To know the importance of this relationship with God... the spiritual part.’ [OC_P2].

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

Perceived quality of service received: For those who have had experience in MHS, most of them reported having a good to a very good experience, since only two of them dropped out. To be precise, four participants (three Catholics and one JW) would recommend their MHP unreservedly: ‘I never had a single problem with my psychologist.’ [CC_P1]. Whereas two other participants interviewed individually (PFI_P1 and EC_P3), even though assessing their experience as positive (mostly related to symptomatic relief and the acquisition of strategies to cope with these), they would recommend their MHP with some hesitation: ‘From my experience the sensibility is zero. I mean as professionals they were excellent, except that sensibility (towards religious and spiritual issues) was zero. I heard things like: “The less you believe in those magical things, the better for you”.’ [PFI_P1].

Additionally, these two participants reported seeking help from a MHP within their faith community, expecting a comprehensive approach. However, they also reported some concerns: ‘when I was feeling better I saw an evangelical psychologist. He was a Pastor and it was very good. I mean I think technically the other one was better, but with him (evangelical psychologist) I felt that I could talk about everything... specially that missing part.’ [EC_P3]; ‘I felt hurt with it (MHP sleeping during therapy) ... so I thought it was time for me to get out. I mean, at the time I didn’t know what was therapeutic intervention and what was channelling?’ [PFI_P1].

Likewise, three other participants also reported concerns whether psychological treatment was an appropriate context to discuss religious and spiritual matters: ‘I mean, the psychologist would be working in an area and I would have my prayers and my faith to help me in another side... I mean, I might not need to reveal it because it might not be the place for doing so.’ [BF_P3].

Finally, some participants reinforced the need for further sensitivity, knowledge and skills when working with (but not restricted to) religious clients, while recommending religion and spiritually to be

considered as important factors in clinical practice and training. In fact, the lack of specific knowledge and training were pointed out as one of the main reasons for MHPs' lack of sensibility: 'I believe, as with most things, health professionals are not trained... maybe if you are Portuguese, you'll know what Catholicism is; but, for instance if a Muslim shows up I'm sure there are things that this psychologist won't use because he doesn't know it. I think there is no specific training, as in other areas, for this.' [CC_P2].

Discussion and Conclusions

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

Religion and spirituality represent key dimensions in the lives of many people around the world, including mental health clients; emphasising the positive impact these dimensions may have, for example, in obtaining more stable and long-term psychotherapeutic results. This fact was present in our participants' discourse, who recognised and reinforced that their religious or spiritual beliefs should not be concealed or marginalised within their psychotherapeutic process, but rather could be used complementarily or even as an integral factor towards a positive and long-lasting outcome. Similar results were found in other studies⁵⁰.

When (or if) in psychological distress, participants in this study reported turning firstly to resources within their religious community (e.g. God, religious leaders, family), rather than to MHPs (seen as a possible help, but often as a last alternative). This help-seeking pattern is similar to what we found previously⁵¹, as well as in other studies with minority groups⁵².

It seems that the decision to seek help, by religious people, may involve many factors, including: the positive association between religiosity/spirituality and physical and mental health; the positive impact of social support; the use of appropriate and effective coping strategies, such as prayer and meditation; positive health behaviours; as well as preconceived ideas and prejudices about the role of MHPs⁵³. It also seems that religious people seek for religious leader and MHP help for different reasons⁵⁴, in our study being the former for religious, personal and emotional problems and the latter when problems/symptoms were/are more severe or long lasting; or when in need of pharmacotherapy (although the latter was in some cases controversial).

Also, religious and spiritual clients may firstly face a dilemma between 'self-censoring these beliefs or risking further pathologization by mental health staff'⁵⁵ or in a very best scenario seeing their religious foundations ignored or 'just' recognized as important dimensions in life and/or the healing process, having a minor importance to the latter. Although, this was true for our participants who presented some level of fear, dilemma and doubt (e.g. of being judged, misunderstood, mistreated), it is important to highlight that these factors did not explicitly prevent participants from seeking professional help.

Also, not all participants felt compelled to conceal their religious identity in clinical settings. In fact, of the 11 participants who reported having had experience in MHS (and excluding four who reported having only a couple of sessions or dropped out of therapy), the three Catholic and one Jehovah's Witness clients reported feeling very comfortable in the therapeutic setting, and also very satisfied with the service provided to them.

⁵⁰ Rose, "Spiritual issues in counselling", 18-33; Knox, "Addressing religion and spirituality", 287-303; Mayers, "How clients", 317-327.

⁵¹ Freire, "Physical and psychological health", 1-18.

⁵² Abe-Kim, "Religiosity, spirituality, and help-seeking", 675-689; Mayers, "How clients", 317-327; Moleiro, "Health and mental health", 15-24.

⁵³ Hill, "Conceptualizing", 51-77; Vogel, "The role of outcome expectations", 459-470; Arveson, "A conceptual model", 109-112; Baetz, "Clinical implications of research on religion", 292-301; Dein, "Religion, spirituality and mental health", 63-64; Freire, "Physical and psychological health", 1-18.

⁵⁴ Sørgaard, "Religiosity and help-seeking", 180-185.

⁵⁵ Mayers, "How clients", 318.

As presented previously, only the Pagan and Evangelical clients raised concerns regarding their therapeutic process and sensibility towards their religious background; whereas the Latter-day Saints client never revealed her religious identity (for unknown reasons).

Most of the concerns raised by the Pagan and Evangelical clients were: having their religiosity or spirituality *regarded* as problematic and/unhelpful to treatment; a mismatch in language regarding their religious beliefs; and having therapists who were not sensitive enough to know how to address religion or spirituality in treatment or completely ignored these dimensions. In fact, these were the main reasons for seeking another MHP who matched their own religious and spiritual beliefs.

This last question was raised by our participants, who reinforced the importance of MHPs: 1) sharing their religious beliefs or being religious; 2) knowing their religious/spirituality beliefs and practices; 3) demonstrating openness to know and understand them; 4) or yet were trained to address spiritual and religious matters in treatment. These types of fears and wishes are not unfounded, given that studies tend to indicate that: MHPs' personal levels of religious or spiritual commitment can be related to their religious/spiritual goals and interventions i.e. if therapists value religion and spirituality, they might place more importance on religious/spiritual goals and use more religious/spiritual interventions⁵⁶.

However, many recent studies have suggested that similarity/match (either for gender, race, ethnicity, religion or sexual orientation) between therapist and client may not relate to the accurate integration of these multicultural features or affect the outcome of therapy⁵⁷; or yet negatively influence the strength of the therapeutic relationship⁵⁸.

Somehow religious/spiritual awareness and formal knowledge may play an important role in enhancing MHPs' work with religious clients or those presenting religious and spiritual issues in treatment⁵⁹. In fact, these may be particularly useful, leading MHPs to: learn more about different religious and spiritual traditions; know how to improve (and best fit) their language/communication when dealing with religious and spiritual concerns, and perhaps define what techniques might be most effective with their religious clients.

However, these alone do not necessarily mean religiosity/spirituality are accurately and effectively integrated. Sometimes it can be quite the opposite, since the fear of imposing own values and beliefs; the discomfort in discussing a personal and private issue, and fearing compromise of the therapeutic relationship, may inhibit MHPs engaging in religious and spiritual discussions⁶⁰.

In contrast, the lack of self-awareness, knowledge and the disparity between how much clients value religion and spiritual issues (tending to be high among these clients) and how much MHPs tend to value religion and spirituality (lower than clients) may also create barriers and difficulties to religious and spiritual integration. Many authors have alerted that, in these cases, MHPs might tend to be unaware of the importance religiosity and spirituality might have in their clients' lives and in the worst case scenario devalue, criticise, pathologize (explicitly or implicitly), their clients' religious/spiritual beliefs and practices⁶¹.

In fact, the ability to sensitively work with religious clients (with all its implications) needs to be acquired, learned⁶². Accordingly, studies have shown that MHPs' religious and spiritual training can contribute to their decision to engage in the integration of religious/spiritual issues into treatment and their self-perceived competence to help a client with religious/spiritual concerns⁶³.

⁵⁶ Asselt, "Influence of counselor spirituality", 412-419; Kellems, "Working with clients", 139-155.

⁵⁷ Worthington, "Religion and spirituality", 473-478; Knipscheer, "A need for ethnic similarity", 543-554; Kellems, "Working with clients", 139-155.

⁵⁸ Knox, "Addressing religion and spirituality", 287-303; Wade, "Effectiveness", 91-105; Kellems, "Working with clients", 139-155.

⁵⁹ Bartoli, "Religious and spiritual issues", 54-65; Schafer, "Training and education", 232-239.

⁶⁰ Plante, "Integrating spirituality and psychotherapy", 891-902; Hodson, "Religion and therapeutic intervention", 28-33; Kellems, "Working with clients", 139-155.

⁶¹ Plante, "Integrating spirituality and psychotherapy", 891-902; Vieten, "Spiritual and religious competencies", 129-144.

⁶² Richards, "A spiritual strategy for counseling" 191, 193; Hage, "Multicultural training", 217-234; Savage, "Developing competency", 379-413; Schafer, "Training and education", 232-239; Vieten, "Spiritual and religious competencies", 129-144.

⁶³ Asselt, "Influence of counselor spirituality", 412-419; Kellems, "Working with clients", 139-155.

Therefore, a MHP must, not only, become aware of this new trend of research; be able to recognise this dimension as a key factor in many people's lives; be aware of the impact their personal religious/spiritual matters might play in therapeutic settings; but also and more importantly acquire knowledge and practical tools for a more sensitive intervention, applicable to each client and therapeutic orientation⁶⁴. This could be particularly important to Portuguese mental health professionals, since nothing (or little) has been done in this area, neither in terms of scientific research, nor as regard to MHPs' training and education in religion/spirituality. Consequently, an important question arises: Is there a 'religiosity gap' between the expectations and experiences of religious members/clients and what Portuguese MHPs can or are providing to their clients in terms of religious and spiritual matters? Particularly when it concerns religious minorities or yet unknown faith communities?

Limitations of the Study

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

Sampling: Firstly, all participants in the study were invited and/or chosen by their religious leader, who also organised most of the meetings. Therefore, one limitation might be the impossibility of preventing the effect of social desirability within some groups, due to the presence of participants with different religious hierarchies (i.e. members, ministers, deacons), which might have hindered some contrary ideas being raised.

Furthermore, this study was restricted to: 1) religious members who had no experience of receiving mental health treatment and 2) were having or had completed psychological treatment. It would also be interesting and valuable to have the experience of those who did not choose to seek professional and secular help due to some (perceived) barriers.

Methodology: As stated before a mixed-methods approach was chosen to conduct this study in order to explore different methods of collecting data, different sources of information and different data analysis methodologies. Ultimately, the aim was to provide a pluralistic approach to participants' perceptions on religiosity, spirituality and mental health in Portugal, rather than a single-method or yet a competitive approach between methodological paradigms – quantitative and qualitative⁶⁵.

Although this pluralistic approach allowed some interpretations and conclusions to be drawn on a non-competitive basis, many assumptions underlying qualitative and exploratory approaches should be considered. Firstly, the integration of different religious communities was intentional, according to the religious diversity in Portugal, however it is important to highlight that few idiosyncrasies were analysed in this paper.

Secondly, and as is well-known, a qualitative approach can be a powerful way to generate rich descriptions and in-depth explorations of a phenomenon, however this method does not allow for generalisation beyond the sample⁶⁶. As with most in-depth qualitative studies, this sample may be considered small and obviously the results do not represent the experiences of individuals within the general population or even from other religious groups. Yet again, it is important to highlight that 'generalisation' was not (and it is not) the primary goal of this study. Rather, the aim was to provide the reader with a focused contextualisation of the problem; participants consistent with the research design (clients and prospects) and a solid research design, so that the question: 'will knowledge of a single or limited number of cases be useful to people who operate in other, potentially different situations?'⁶⁷ could be answered affirmatively.

⁶⁴ Baetz, "Clinical implications", 292-301.

⁶⁵ Hiles, "Axiology.", 52-56.

⁶⁶ Donmoyer, "Generalizability", 371-372.

⁶⁷ Ibid., 372.

Furthermore, this study relied primarily on people's abilities and/or willingness to express (share) and/or remember, not only their religious daily life, but also and more importantly the kind of help they once received or considered to be ideal. This 'willingness' and/or 'capacity' has been found problematic elsewhere⁶⁸. Also, this study was based on people expressing attitudes, with the well-known discrepancy between behaviour and attitude as a consequence⁶⁹.

Implications for Future Research

From our results and as in previous researches, it seems clear that religious members (clients and prospects), wish their religiosity/spirituality not to be concealed in a clinical context, and also wish these topics discussed and integrated. However, many factors may be compromising the achievement of an optimal result.

It is also true that perceiving a MHP as open and not judgemental to spiritual/religious issues may help clients to freely disclose and adhere more to treatment and ultimately enhance its effectiveness. Additionally, and considering the impact religious and spiritual practices have on people's lives (e.g. as an important factor for health maintenance, or as coping strategies when suffering), MHPs are challenged to provide the best and most appropriate care to their religious/spiritual clients.

Considering (but not limited to) these factors, it seems important to also bring these issues to the other part of the equation, the MHP. Therefore, a subsequent multistage mixed methods study will address Portuguese MHPs, expecting to describe how and when these professionals integrate and work (or not) with religion and spirituality in general and/or their clients' religiosity and spirituality. The following topics await examination:

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

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⁶⁸ Rogler, cited by Sørgaard, "Religiosity and help-seeking", 180-185.

⁶⁹ Sørgaard, "Religiosity and help-seeking", 180-185.

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